Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Ms. Martina Corrigan
Director of Public Inquiries and liaison
Surgical Clinical Director
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant

information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance

in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by USI

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 24 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Ms. Martina Corrigan
Director of Public Inquiries and liaison
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 29th April 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 24 of 2022]

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.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, the Medical Director, Associate Medical Director, the Clinical Lead, urology consultants or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern

catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

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

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. 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.

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?

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

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

26. What, if any role did you have in staff performance reviews?

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

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

30. 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.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. 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?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

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

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

39. 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. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Medical Director(s);
    (iii) the Director(s) of Acute Services;
    (iv) the Assistant Director(s);
    (v) the Clinical Director
    (vi) the Associate Medical Director;
    (vii) the Clinical Lead;
    (viii) the consultant urologists.

    When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

    (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and

detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(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?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding

concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were

those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

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

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

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

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

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

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

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

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 24 of 2022

Date of Notice: 29th April 2022

Note: An addendum amending this statement was received by the Inquiry on 23 June 2023 and can be found at WIT-98544 to WIT-98770. Annotated by the Urology Services Inquiry.

Witness Statement of: Martina Corrigan

I, Martina Corrigan, 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 I commenced as Head of Service for ENT and Urology in September 2009, having previously worked in the Western Trust in various roles from 1987 until 2009 – this is addressed in more detail in Question 4. The Head of Service role was a new post that had been created along with Head of Service for General Surgery, Breast and Endoscopy and Head of Service for Trauma and Orthopaedics and Ophthalmology, which all sat in the Surgery and Elective Care Division in the Acute Directorate.

1.2 I remained in the role of Head of Service until June 2021, when I moved into my current role of Assistant Director for the Public Inquiry and Trust Liaison.

The Assistant Director is a temporary post for which I sought and was granted a secondment from my Head of Service role. The Head and Service role has expanded over the years to take on Outpatients and Ophthalmology - this is addressed in more detail in Question 5, which also details the job summary of both posts.

1.3 In the paragraphs below I have provided a chronological list of events of my involvement in and knowledge of all matters falling within the scope of the Urology Services Inquiry Terms of Reference.

2009-2013

1.4 Key events during this time period were:

a. Regional Review of (Adult) Urology Services (2009) and the Implementation of Team South (Nov 2010) – this is addressed in more detail in questions 9, 10, 13, 14, 15.
b. Issues around accommodation in the Thorndale outpatients unit and, during this time, we secured funding and refurbished an area in Main Outpatients and we were able to move the Thorndale unit in October 2013 - this is addressed in more detail in questions 7 and 48.
c. Ongoing recruitment and retention issues – this is addressed in more detail in Questions 16, 17, 18 and 19.
d. Issues raised about staff within the Urology Team – this is addressed in more detail in question 19, 39 and 45.

1.5 Issues raised about Mr O'Brien during this time period were:

a. Administering of regular IV Antibiotics and Fluids – addressed in more detail in Questions 54, 55, 56 and 69.
b. A question was raised on the number of benign cystectomies that had been carried out by Mr O'Brien - addressed in more detail in Questions 54, 55, 56 and 69.

c. Hospital notes that were thrown in the bin on Ward 3 South - addressed in more detail in Question 54.
d. An ongoing issue with non-conforming with triage - addressed in more detail in Questions 30, 52, 54, 55, and 56.
e. An ongoing issue escalated in around 2013 in that Mr O'Brien had quite a number of patient records in his home and Health records staff had to keep asking him for these - this is addressed in more detail in questions 54, 55, 56 and 57.
f.

2014-2016

1.6 Key events during this time period were:

a. The successful recruitment of two new consultants – Mr Haynes and Mr O'Donoghue (the Trust went at risk for the second of these posts) and this was the first time that there was a team of 6 consultants to deliver the urology service - addressed in more detail in Questions 16 and 17.
b. In September 2014, Mr Haynes and I prepared a paper called 'The Vision' and this was presented and accepted by the Department of Health. This is addressed in more detail in question 51 and 62.
c. In October 2014, we moved to the Urologist of the Week model and, in January 2015, the one-stop clinics in the Thorndale Unit commenced - this is addressed in detail in question 51.
d. In February 2014, Mrs Burns and I met with Mr O'Brien and put a plan in place to support Mr O'Brien with his triage (Mr Young took this task on) - addressed in more detail in Questions 55, 56, 58, 62 and 64.
e. During 2014, a change was made so that patients would, in default of triage, be added to the outpatient waiting lists on the clinical priority that was on the GP referral letter - addressed in more detail in questions 56 and 58.

2016-2017

1.7 Key events during this time period:

a. January 2016 - Mrs Trouton and Mr Mackle met with the newly appointed Medical Director, Dr Wright, to advise of the ongoing issues in relation to Mr O'Brien and the concerns in relation to non-triage, notes at home, no letters dictated, and review backlog – addressed in more detail in questions 54, 55, 56 and 57.
b. On 30 March 2016, Mr Mackle and I met with Mr O'Brien and gave him the 23 March 2016 letter outlining the four concerns and requesting that he comply and let us know the actions he would be taking to address these four issues. This is addressed in further detail in question 54, 55, 56 and 57.
c. In April 2016, due to the Director of Acute Services, Mrs Gishkori, reorganising her structure, Mr Carroll replaced Mrs Trouton as Assistant Director and Mr Mackle resigned from his post of Assistant Director. This was after Mr O'Brien had been issued with the 23 March 2016 letter requesting his attention and it is my opinion that this change in personnel meant that the letter of March 2016 was not followed up as it should have been.
d. June until October 2016 - There were a number of meetings in this period which discussed Mr O'Brien. I can confirm I was not aware of these meetings at the time.
e. November 2016 - Mr O'Brien went off on planned sick leave for a procedure on 17 November 2016, and had planned to return to work on 3 January 2017. However, as a result of a letter of concern received by Mrs Boyce on 16 December 2016 from Mr Glackin (who had chaired the SAI panel for patient Patient 10 [redacted] it was determined by the Oversight Group that Mr O'Brien would not be allowed back to work until the extent of the issue was investigated.

2017-2022

1.8 Key events during this time period were:

a. After a meeting to advise him of his exclusion on 30 December 2016, Mr O'Brien contacted me to advise me of his intention to return the patient notes that he had at home and that these would be left in his office on the 2nd floor of the main hospital over the weekend. I retrieved these notes and I can confirm that there were a total of 307 charts returned from his home; this included 94 Southern Trust notes that Mr O'Brien had seen privately but where he had written his private notes in these charts. I also checked his office and I can confirm that there were an additional set of 88 notes in his office.

b. On 9 January 2017, Mr O'Brien contacted and met with me (in the carpark at the hospital) to inform me that he had letters in the drawer of his filing cabinet and that I had permission to retrieve these. On 9 January 2017 I collected these letters and discovered that there were 783 letters not triaged with the longest going back to June 2015 (although it should be noted that this patient had been seen as they had been picked off chronologically even though they had not been triaged, so the longest waiting was in fact August 2015). I, as Head of Service, worked with the other consultants on getting these letters triaged and it was from this exercise that the 5 SAIs were identified as being patients who had come to harm as they had not been upgraded. Mr O'Brien also gave me four letters that had been sent direct to him and that had not been recorded on any system anywhere and I included them in with the other letters for triage.

c. At this meeting Mr O'Brien also provided me with copies of all the outcome sheets from the patients (571) that he had seen at clinic but had not dictated on and, on checking, there were a further 97 who had no outcome at all. I carried out an admin review on these patients to check whether they were on the right waiting lists, had they their tests ordered if appropriate, and then organised for the consultants to go through the notes and ensure that no patients needed to be seen face to face.

d. When ringing me to organise this meeting on 9 January 2017, Mrs O'Brien asked to speak with me. She was, naturally, upset with what had been happening but she was also verbally abusive to me on the phone and was blaming me for what was happening to her husband. I tried to calm her down by explaining that this was not due to me but due to issues that had arisen through her husband's actions. However, I could not appease her; so much so that I had to tell her that I was not prepared to take this verbal abuse any longer and that I was ending the call, which I did. When Mr O'Brien met with me he apologised for his wife, saying that he knows it was unacceptable the way she had spoken to me but that she was upset. I accepted the apology and I acknowledged that it wasn't him and that he had remained courteous throughout his recent contact.

e. In February 2017, Mr Carroll, Assistant Director, shared the Return to Work Plan with me that Mr O'Brien had agreed to adhere to in order to allow him to return to work. He asked me to monitor all four elements which I agreed to do and I commenced this and continued until March 2020 (when, due to Covid, there was no longer any triage/clinics/theatres and I was unable to get access to the office due to restriction of movement throughout the hospital). This is addressed in my response to question 58, 59, 60 and 61.

f. I continued to monitor this return to work agreement and send reports to Dr Khan until, in June 2017, Dr Khan asked for these reports to be by exception only (i.e., if Mr O'Brien was in default). I did this on a weekly basis every Friday (apart from those Fridays when I was on annual leave and also for the 18 weeks when I was off [redacted] from 25 June 2018 until 5 November 2018).

Irrelevant information redacted by USI

g. Mr Weir and Mr O'Brien met on 24 February 2017 to discuss his return to work and, as I was on annual leave, they agreed to meet again on 9 March 2017. The below issues were discussed at this meeting:

i. Enniskillen Clinics
ii. Admin since return to work
iii. New Outpatient Clinics
iv. Annual Leave
v. Review Backlogs
vi. MDT
vii. Investigation.

h. It was during [redacted] (June-November 2018) that Mr O'Brien started to deviate from his return to work agreement - this is addressed in more detail in question 60.

i. Once I had returned [redacted] in November 2018, I re-commenced monitoring Mr O'Brien regarding his return to work agreement and he adhered to this up until September 2019, when he deviated for reasons related to [redacted] and an inpatient during his week oncall. After speaking with him about this deviation he got back on track.

j. In May 2019, Mr O'Brien sent an urgent and lengthy written request (with 55 sections) via Mrs Toal to a number of staff. This request was looking for details of emails, correspondence, and communications in respect of issues over the years. I had to provide Human Resources with any documentation/correspondence I had in relation to triage escalations, notes at home, meeting notes and agendas etc.

k. In November 2019, I was asked to arrange a meeting to discuss with Mr O'Brien and Mr McNaboe his September deviation from his return to work agreement and Mr O'Brien wrote to me to advise that he found the time unsuitable and that, in fact, he was now outside of the monitoring period for his return to work agreement. This is addressed in more detail

in question 60. I tried to reschedule the 8 November 2019 meeting for December, as we still needed to discuss the deviation plus his job plan had still not been sorted. Mr O'Brien came to see Mr McNaboe outside of the planned meeting and I was not involved in any of these discussions.

l. On 8 March 2020, Mr O'Brien telephoned me, communicated his intention of retiring, and discussed with me the possibility of returning to work part-time. I advised him that, whilst I had no issue with this, it was not within my gift and that he needed to raise this through his medical management route and Human Resources. I then received his letter of resignation on 26 March 2020, with his intention to retire on 30 June 2020 and return to work part-time on 3 August 2020.

m. During the first wave of Covid – March 2020 until May 2020 - all elective surgery was stood down. However, on risk assessing this it was decided that each of the specialties would have access to an urgent bookable list in Daisy Hill Hospital. The purpose of this list was to allow for cancer and clinically urgent patients to have their procedure in a safe environment in what was termed a 'green' site, which they tried to ensure was free from Covid positive patients. Mr Haynes was co-ordinating the scheduling of these patients and it was as a result of a request for patients that Mr O'Brien copied Mr Haynes into an email that he sent to the Trust's pre-assessment team on 7 June 2020, listing 10 patients who needed to be added to Urgent Bookable list and therefore needed to be pre-assessed for fitness for surgery.

n. Mr Mark Haynes then forwarded it Dr O'Kane, Mrs McClements, Mr Carroll, myself, advising us of his concerns *(set out in the below extract from his email):*

> *'As far as I can tell the patients highlighted should have been added to the waiting list on the date shown, but are not on the*

waiting list and I believe have been added to the waiting list more recently (on the back of the email below). While it would appear he has a system whereby he is aware of these cases, standard procedure is that a patient is added to the PAS WL at the time of listing, not at the time of offering a date for surgery and the concern would be that there are other patients who are not administratively on the WL (on PAS) but should be. On the mild side this distorts our WL figures, as a risk I would be concerned that patients get lost.'

o. As a result of this concern, Mr Haynes spoke with me and asked me to identify all the patients that had had emergency surgery done, initially in the previous 6 months, and then it was agreed that, as some had been waiting nearly a year, I should go back to January 2019 to assure that there were no patients that had ureteric stents inserted by Mr O'Brien that we were not aware of. This administrative exercise highlighted a number of concerns:

i. <u>Patients sorted but highlighted issues:</u>
   - 13 patients were not added to the waiting lists when they should have been but were mostly done a few days before Mr O'Brien had them admitted;
   - 1 patient was readmitted as an emergency and had their stent removed under a different consultant; there appeared to be no plan to admit them by Mr O'Brien and had been waiting 7 months;

ii. <u>Concerns and or follow-up:</u>
   - There were 11 patients who had been readmitted but we were unable to determine if they had stents removed as there was no letter dictated on NIECR (patients subsequently had their notes reviewed and all had had their stents removed);

- A further 11 patients needed their hospital notes requested as there was no plan nor were they listed on either PAS or NIECR, so they needed looked at in more depth;
- 9 patients had had a stent inserted recently and these patients were moved to one of the other consultants' waiting lists to ensure that they had a follow up;

iii. Other issues:

- 6 patients had been brought in electively and were operated on the emergency list, other patients admitted for issues not relating to stents and no letters dictated nor follow-up recorded on PAS.

Delays in dictation from clinics/theatres.

p. As a result of the concerns raised from the emergency patient administrative lookback it was agreed that patients that had been brought in electively under Mr O'Brien's care should also have an administrative lookback and, again, it was agreed that this would be from January 2019 until 11 June 2020. Again, I was asked to carry this exercise out and, as a result, I looked at 334 episodes and the findings are outlined below:

i. Was there a discharge letter on NIECR for this episode?

- 298 patients had a discharge letter;
- 36 patients had NO letter relating to their admission on NIECR; of these:
  - 4 patients - needed a clinical opinion;
  - 1 patient - no concern as they had been followed-up after an emergency admission;
  - 7 patient - no concerns but I included comments that I picked up from other information that was on NIECR;
  - 3 - on waiting list for procedure (PAS);
  - 13 - on review backlog waiting list (PAS);
  - 8 patients - I requested notes to determine their plans.

ii. *If so who dictated it?*

- 112 patients - had an electronic ward discharge;
- 12 patients - had their letter dictated by another member of the urology team (other consultant/registrar/specialty doctor)
- 174 patients - were dictated on by Mr O'Brien.

iii. *Was there a delay in dictating this letter?*

- 120 patients - had a delay in getting their letter dictated after their discharge; the delay for these patients varied from a few weeks to up to 41 weeks;
- Out of 120 delayed:
  - 48 patients - had no concerns/issues with their pathway;
  - 1 patient - should have had a repeat procedure in November 2019 but was not added to the waiting list until December 2019, so missed their follow-up date and still had not been seen;
  - 5 patients - I needed a further clinical opinion on these because of concerns I had from going through their information;
  - 28 patients - were in the OP review backlog waiting past their due date for an appointment;
  - 15 patients – were on a waiting list for a procedure and were past their due date;
  - 8 patients – where I needed to request their hospital notes because it was unclear from NIECR and PAS what their plans were;
  - 15 patients – where, whilst I had no concerns, I added in comments that I had picked up whilst going through their histories.

Urology Services Inquiry

Summary table:

ISSUE	Number of patients
NO concerns or issues	177
Concerns (for further advice)	18
outpatient delay – in review backlog	70
Follow-up procedure delay	34
Issue as a result of a delay in dictation	1
Whilst no issues – comments that I have picked up that I want to highlight	19
Patients I need notes so that I can follow-up on their plans	15

q. All of the above were shared with the Urology Oversight Group – Dr O'Kane, Mrs McClements, Mr Carroll, Mr Haynes and Mr Wallace - and it was through this exercise that a number of concerns were raised on some patients who met the threshold for a Serious Adverse Incident (one patient was in the oncology review backlog, one patient had had an MRI scan and it appeared that the result had not been actioned, and one patient was on bicalutamide, an unlicensed drug). It was as a result of these concerns that an Early Alert was sent to the Department of Health in July 2019. Dr O'Kane also had preliminary meetings with Royal College of Surgeons and the General Medical Council about the concerns being raised.

r. As a result of the issues raised in June 2020, Mr O'Brien was contacted formally by Mr Haynes and advised that he would not be returning to work in August 2020 (as Mr O'Brien had originally requested in March 2020). I was not involved in this correspondence and I was contacted by Mrs Hynds in July to advise that Mr O'Brien wanted to remove his personal belongings from his office. Initially, we had planned that these would be left at his house [redacted] and that his laptop, keys, and ID Swipe card would be returned. However, through his solicitors he asked to do this task himself and I agreed that I would accompany him while he cleared his office. On 27 July 2020, Mr O'Brien rang me to arrange the time and his wife asked to speak with me and, similarly to what had occurred in January 2017, she became very aggressive and started

shouting at me down the phone about: how dare I allow this to happen to her husband who had put his whole life into the Urology Service at Craigavon Hospital; that, only for him, there would be no urology service; and that it was shameful the way he was being treated. As with my previous contact with her, I tried to reason and calm her down and I advised her that I wasn't prepared to be shouted at and therefore I had no option but to end the call.

s. I duly accompanied Mr O'Brien to his office and we spent nearly 3 hours going through everything that was there and identifying items such as his own private patient notes, journals, pictures etc. that he then took with him. We both remained professional throughout and I did feel sad for him that, after 28 years, he was leaving the service this way. He returned his keys and ID swipe card and we had previously agreed that he could hold onto his laptop and IT would remove any personal communication that he had on it before it was returned.

t. During August and September 2020 further cases were screened and met the threshold for an SAI and, because of the cohorts that they were being identified from, the following cohorts were identified as needing looked at:

    i. Patients on Oncology Review Backlog waiting list – to identify if they were on the correct management plan. These patients were sent to the independent sector provider, Orthoderm, and were reviewed by Mr Patrick Keane.
    ii. Patients who had been discussed at Oncology MDM to make sure they had had follow-up – these were reviewed by Professor Krishna Sethia, external consultant urologist, recommended by British Association of Urological Surgeons and Royal College of Surgeons.

iii. Histopathology results of patients who had had a biopsy done to ensure their result had been actioned - these were reviewed by Mr Haynes and Dr Darren Mitchell, oncologist.

iv. Patients who had had a radiology test and where the result had not been signed off electronically - to ensure they were on the correct management plan and that their result had been actioned; these were reviewed by Professor Sethia.

v. Patients who had contacted the information line, which was set up by the Trust to support any patients who may have had a concern or issues with respect to their care under Mr O'Brien, or wanted further information on what to expect from the Inquiry. The information line is manned by Admin Staff who take the patient's details and then a Clinical Nurse Specialist will make the initial call back and for those patients/families who needed further follow-up these were included in a cohort of patients who needed contacted – an acknowledgement letter was sent to these patients/families and follow-up is being currently put in place, reviewed by Mr Haynes.

vi. Patients that were on the Review Outpatient Backlog list - to put a management plan in place with a new consultant; reviewed by Mr Haynes, Mr Young, and Mr O'Donoghue.

vii. Patients that are currently waiting on Mr O'Brien's elective waiting list - to ensure that they still need surgery and to put a management plan in place with a new consultant; reviewed by Professor Sethia.

u. In October 2020, Mrs Brigeen Kelly returned from her Head of Service role [redacted] and it was agreed that Wendy Clayton who had been covering this role would continue as a Head of Service and support me so as to allow me to concentrate on some aspects of the lookback, support to the urology oversight meetings, and support meetings that were established with the Health and Social Care Board. I still maintained overall responsibility but Wendy took over day to day running mostly of the urology

Personal Information redacted by the USI

service and the ward and I concentrated on the lookback issues, along with maintaining the day to day running of ENT, Ophthalmology and Outpatients.

v. In November 2020, the Minister for Health announced the Public Inquiry.

w. An information line and email address was established for any patients/families who may have wished to make an enquiry to do with the Minister's announcement and I managed both of these methods of communication.

x. Dr Dermot Hughes (who was appointed as the Independent Chair of the Serious Adverse Incident panel in September 2020) produced an interim report to the Health and Social Care Board in January 2021, with the final report containing recommendations shared in March 2021.

y. It was as a result of this report that the Trust established a Steering Group to address the recommendations of the SAIs and, after the initial June 2021 meeting, Mr Carroll and Dr Shahid Tariq were appointed joint Chairs and it was agreed that this should not only be for Urology but for all the Multi-disciplinary tumour sites. I am also a member of this group.

z. As part of the recommendations was to involve service users, the Trust established a Service User Group for which I organised the first meeting on 1 September 2021. I co-chaired the Group with Mr Carroll. There are two service users who input into these meetings, an oncology patient of Mr O'Brien's and a daughter of a recently deceased oncology patient.

aa. I am a member of the Trust's Urology Oversight Group and it was agreed at these meetings that, in order to prepare for the commencement of the Public Inquiry, we would need a director responsible and Mr Devlin agreed that this would initially be Mrs Heather Trouton, Executive Director of Nursing, Midwifes and AHPs, later to be replaced in February 2022 by Mrs Jane McKimm. It was also agreed that the Public Inquiry Team would need an

assistant director to support the director and, as previously mentioned, I requested a secondment, applied for the post, and was successful.

2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.**

2.1 I can confirm that most of the documents relevant to my responses have been provided by the Trust. Any additional documents are being provided in response to this Section 21 notice.

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.**

Your position(s) within the SHSCT

4. **Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.**

4.1 <u>Qualifications</u>:

a. BA (Hons) Public Policy and Management – awarded in July 1993;
b. Masters in Business Improvement – awarded in November 2000.

4.2 Occupational History prior to commencing employment with SHSCT

a. 1987-2009 I worked in the Western Health and Social Care Trust (and its predecessors) where I held various posts, and I worked in the following hospitals during this time:
   i Tyrone County Hospital – Omagh
   ii Tyrone and Fermanagh Hospital – Omagh
   iii Erne Hospital – Enniskillen
   iv Altnagelvin Hospital – Derry
b. 1987-1988 – Band 2 Clerical Officer – Medical Records and Outpatient Receptionist
c. 1988-1990 – Band 3 Secretary for Catering Manager
d. 1990-1992 – Band 3 Medical Audit Officer
e. 1992-1997 – Band 4 Team Leader for Visiting Consultants
f. 1997-2000 - Band 5 Assistant Business Manager
g. 2000–2004 - Band 7 Project Manager for Emergency Planning Project with Cross Border and Working Together (CAWT)
h. 2004-2007 - Band 8a – Business Manager for Acute Services Directorate
i. 2007-2008 Band 8B – General Manager for Urology/ENT and Ophthalmology (covering 1 year Maternity Leave)
j. 2008-2009 Band 8a – Outpatient Services Manager.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 From September 2009 until June 2021 I was Head of ENT, Urology, Ophthalmology and Outpatients. (Band 8B). This role entailed being responsible for the operational management and strategic development of ENT, Urology, Ophthalmology and Outpatients across the Southern Trust. I was responsible for leadership, service provision and service development of ENT, Urology, Ophthalmology and Outpatients and ensuring high quality patient centred services. I was responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets. I worked in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Directorate's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources. As a head of service, I was a member of the division's senior management team and contributed to policy development within the division towards the achievement of its overall objectives. It is important to note that, from October 2020 to June 2021, Wendy Clayton shared this Head of Service post with me. She mainly covered the day-to-day operational aspect and I worked with Dr O'Kane, Melanie McClements, Ronan Carroll, Mark Haynes, and Vivienne Toal on the issues emerging from the further concerns about Mr O'Brien that emerged in June 2020.

The following document is attached 1. Head of Urology and ENT Job Description and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

5.2 When I first took up post in September 2009 I was employed as the Head of Service for ENT and Urology. In and about 2011 when the Trust moved to using HRPTS (Human Resource Database) there needed to be a Head of Service responsible for Outpatients and, with my previous history of managing outpatients in the Western Trust, my Assistant Director, Heather Trouton, asked me to take on this role and I agreed as I had a Lead Nurse, Connie Connolly, who managed the day to day running of this area.

5.3 In June 2016, due to the Head of Service for Trauma and Orthopaedics and Ophthalmology securing a new role (Head of Governance), there was a new appointment to her post, Brigeen Kelly, and when she took up post she clearly stated that she would not be doing ophthalmology as part of her role as she had all the Nursing within Surgery and Elective Care (SEC) reporting through the Lead Nurses to her. When, at a Performance Meeting, the question was asked who the Head of Service was for Ophthalmology, the Assistant Director, Ronan Carroll, advised that I would be taking this on. I spoke to him after the meeting as this had been the first that I had heard of this plan and he advised that, as it was a visiting outpatient service, it was felt that it could be added, and was relevant, to my role as Head of Outpatients.

5.4 I have attached my original Job Description for Head of Urology and ENT and this Job Description describes the role that I held except that it expanded, as explained above, to include the Head of Service for Outpatients and Ophthalmology.

5.5 I have been Assistant Director for Public Inquiry and Trust Liaison (Band 8C) since 7th June 2021. My duties and responsibilities are contained within the *attached document – 2. Public Inquiry AD JD and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments*

Job Description

5.6 After the Public Inquiry was announced the Trust took steps to put a process in place to manage the Public Inquiry responses. Mrs Heather Trouton, Executive Director of Nursing, Midwifery and AHPs, was allocated the role of Director for the Public Inquiry and I applied and was appointed as Assistant Director to the Inquiry. The Trust took cognisance of the perceived conflict of interest for both Mrs Trouton and myself and appointed a Programme Director for the Public Inquiry, Mrs Jane McKimm, who has never had any operational responsibility for Urology services. The Trust then also appointed Mrs Margaret O'Hagan as the Independent Trust Advisor for the Urology Services Inquiry. She is on secondment from the Northern Trust. For the Trust to respond fully

to the Inquiry, and as I have the knowledge and experience of working within the Urology Services for 12 years, I continue to provide support to the Trust's Public Inquiry Team through being a member of the three workstreams (The Response Group, The Oversight/Lookback Group, and the Quality Assurance Group which are overseen by a Programme Board which is chaired by the Trust Chief Executive) and my role on these groups is to contribute from my knowledge and experience of the Urology Services. I work closely with Mrs McKimm, Mrs O'Hagan and the Directorate of Legal Services in order to ensure that there is independent oversight and assurance in the respect of the delivery of my role.

6. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

6.1 From 2009 until 2021 I was in the Head of Service Role – Urology ENT Ophthalmology and Outpatients. *Please see the following attached document – 3. 202001-SEC Organisational Chart and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments*

6.2 As Head of Service, I reported directly to the Assistant Director. The Assistant Directors from 2009 until 2020 were:

a. Simon Gibson: 28 September 2009 – 30 September 2009
b. Heather Trouton: 1 October 2009 – 31 March 2016. Please note Trudy Reid was Assistant Director between March 2012 and December 2012 due to Heather being on secondment.
c. Ronan Carroll: 1 April 2016 – 6 June 2021.

6.3 Lead Nurses reported to me operationally and reported professionally to Head of Service with Responsibility for Nursing – listed below:

a. 2009-2016 – Trudy Reid
b. 2016-2021 – Brigeen Kelly.

Urology Services Inquiry

6.4 Lead nurses who reported to me operationally were:

a. Shirley Tedford – Urology and 3 South (2009 -2011)
b. Noleen O'Donnell/Kathleen McGoldrick (job share) – 2009-2010
c. Connie Connolly – Outpatients (2009-2017)
d. Gillian Henry – Thorndale and ward 3 South (2011-2018)
e. Linda Hamilton – Thorndale and Ward 3 South (2018-2019)
f. Sarah Ward – Thorndale Unit and Ward 3 South (2019-2021)
g. Dorothy Sharpe – Elective Admissions Ward (2009-2021)
h. Josie Matthews – Outpatients (2017-2021).

6.5 The Ward Sisters from 3 South/Elective Admissions Ward/Thorndale Unit and Outpatients reported to the Lead Nurses and then, operationally, I had overall responsibility for the budgets and the running of the services.

6.6 As Head of Service, I managed the Consultants operationally with respect to the day-to-day running of each of the services:

a. Schedules (outpatients/day cases/inpatients/admin)
b. Annual leave
c. Any changes to clinics
d. Involved in working with the Team on service development and the implementation of same please see *attached documents named 4. Stone Treatment Centre Improvement Project and 4a. 20140902 The Vision located in folder - Martina Corrigan - no 24 of 2022 - attachments*
e. Keeping the Clinical Teams appraised of any new developments/changes in guidance/standards and guidelines etc.

Please see sample emails attached:

5. 20150925- E Learning from medication incidents June 2015
6. 20150925- E Learning from medication incidents June 2015 A1
7. 20150925- E Learning from medication incidents June 2015 A2
8. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY

9. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A1

10. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A2

11. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A3

12. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A4

13. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A5

14. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A6

15. 20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A7

16. 20151025 - E Management and advice for patients-clients with swallow-dysphagia problems

17. 20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A1

18. 20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A2

19. 20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A3

20. 20151029-E Whistleblowing Policy

21. 20151029-E Whistleblowing Policy A1

22. 20120930-E - Management of Seasonal Flu

23. 20120930-E - Management of Seasonal Flu A1

24. 20120930-E - Management of Seasonal Flu A2

25. 121125-E-TYC Presentation

26. 121125-E-TYC Presentation A1

27. 121125-E-TYC Presentation A2

located in folder - Martina Corrigan - no 24 of 2022 - attachments

6.7 It is my belief that my job description for Head of Service is an accurate reflection of the duties and responsibilities of my role of Head Of Service. But please note that my job title was never amended to reflect that I had taken on the areas of Outpatients and Ophthalmology which in my opinion added to my workload in that, over my tenure, my areas of responsibility increased from 2 specialties to 4 specialties, which at times was operationally challenging. For example, whilst it was deemed that Ophthalmology was a visiting outpatient service this ended up being a demanding aspect of my job from the period November 2018 until June 2021 due to two reasons:

a. Outpatient ophthalmology services were centralised from being on three outpatient sites (Craigavon, Daisy Hill and South Tyrone Hospitals) to being on one site which was based in Banbridge Polyclinic. These premises underwent total refurbishment to accommodate this move and I was the point of contact with all parties involved to ensure that this move was operationalised and this involved numerous meetings with Belfast Trust, Ophthalmologists, Southern Trust Estate Services, nursing staff, health records, secretarial managers etc. This planning commenced, after public consultation, in November 2018 and all clinics were fully operational by January 2020, before Covid. The Banbridge Polyclinic became one of the Covid GP Hubs and we had to cease these clinics which had only just commenced at a reduced capacity before I moved to my Assistant Director role.

b.South Tyrone Hospital was identified as one of the Day Elective Centres for Cataracts (one of three in Northern Ireland) and I was also involved in operationalising this innovative way of working. South Tyrone Hospital was the first of the Elective Day Care Centres to start operating on cataract patients in 2019 and I was a member of the Steering Group Chaired by Raymond Curran (Department of Health) and Julie Sylvester (Lead Ophthalmologist) and I worked with members of this group, Southern Trust Estate Services, Nursing, health records, IT,

etc. to ensure that the area was refurbished and systems and processes were in place for this service.

The Outpatient aspect of my role was not as demanding as the nursing team were managed by a Lead Nurse (Mrs Connolly/Mrs Matthews) who reported to me and the workload was in respect of accommodation requests and staffing issues, which in my opinion still needed time allocated to this as part of my role.

6.8 My current post is Assistant Director for Public Inquiry and Trust Liaison. As Assistant Director I report directly to Director of Public Inquiry who was Heather Trouton from April 2021 until January 2022 and now it is Jane McKimm. The Business Support Manager/Document Librarian, Emma Stinson, reports directly to me.

6.9 It is my belief that my job description for Assistant Director was an accurate reflection of the duties and responsibilities in my role up until February 2022 when Jane McKimm was appointed as the Programme Director for the Public Inquiry and Trust Liaison. *attached document named 28. Public Inquiry JD Programme Director 8d located in folder - Martina Corrigan - no 24 of 2022 – attachments*. It is my observation that Mrs McKimm's job description and mine are almost similar and now, to ensure independence and assurance, she has overall responsibility and carries out a number of tasks that are in my job description which I would have carried out and had responsibility for before she took up post (I have included a few examples to support my observation);

a. Main link between the Trust and Department of Legal Services and other external stakeholders;
b. Lead on the administrative systems and processes for the management of the public inquiry;
c. Lead on briefing and correspondence related to the Public Inquiry, ensuring that the Senior Management Team and Trust Board are kept up to date;

d. Assume overall responsibility for briefing and supporting staff who are required to participate in the Inquiry and for providing guidance on best practice throughout the Inquiry process;

e. Respond to any queries of the Inquiry Panel and the Director of Legal Services.

6.10 The second area that I believe no longer reflects my roles and responsibilities is in respect to the Lookback Exercise. Again, it is my opinion that, up until April 2022, this area in my job description reflected my role. However, Mrs Margaret O'Hagan has taken up the post of Independent Advisor for the Public Inquiry in April 2022 and she has taken over the Lookback exercise to provide independence and quality assurance and therefore is no longer part of my role.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1 My roles and responsibilities are outlined in my job description 1. *Head of Urology and ENT Job Description and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments* and, with specific reference to the operation and governance of the urology services, I would have assisted the Assistant Director and Associate Medical Director in particular;

a. *To promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential*

i. This was, in my opinion, achieved by the regular meetings that were held with the teams (Assistant Director and Heads of Service meetings/ sisters' meetings/ departmental meetings/ patient safety meetings/ away days/ ad hoc meetings to discuss specific topics, such as the move from the 'old' Thorndale to the current Thorndale in October 2013 - *Attached are samples of minutes from meetings namely:*

29. 20091022-urology away day

30. 20160922 - mins urology departmental meeting

31. 20150618 agenda urology dept meeting

32. 20150403-meeting MC and CNS

33. minutes of meeting re urology 17 june 2010

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

b. *Be committed to supporting honest, open communication and effective multi-disciplinary working*.

i This, in my opinion, was achieved through my 'open door' ethos where I encouraged and welcomed all staff to call and speak to me if there were any issues or they needed anything done (e.g., annual leave approved/ idea about equipment/ concerns/ etc.). I also included all of the team in the sharing of any correspondence that was relevant or if I felt they needed to see for information. I also regularly would have called to the Thorndale Unit to see how things were going and these were informal visits that I tried to do every few weeks.

c. *Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services*.

i. In my opinion this was achieved, and over my tenure we would have engaged with staff, service users and patients when we were designing the 'New' Thorndale. The Clinical Nurse Specialists also completed patient satisfaction surveys and there were also two leadership walks by the Chair, Roberta Brownlee, and a Non-Executive Director, Geraldine Donaghy, during my tenure which allowed for improvement in planning and delivery of services. *Attached are copies of the leadership walks namely:*

34. 20111102- leadership walk

35. 20180305 - leadership walk

36. 20120523 - leadership walk

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

d. *Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies*.

i. I can confirm that monitoring of performance was a significant part of my role so as to ensure the safe and effective levels and I would have worked closely with the urology team to try to the best of our ability with the resources available to address any deficiencies. I have provided more detail of this monitoring in my response to Question 12.

Attachments of performance monitoring namely:

37. 20130123 - E Patients requiring to be seen by the end of March

38. 20130123 - E Patients requiring to be seen by the end of March A1

39. 20130123 - E Patients requiring to be seen by the end of March A2

40. 20130123 - E Patients requiring to be seen by the end of March A3

41. 20130123 - E Patients requiring to be seen by the end of March A4

42. 20130123 - E Patients requiring to be seen by the end of March A5

43. 20130123 - E Patients requiring to be seen by the end of March A6

44. 20130123 - E Patients requiring to be seen by the end of March A7

45. 20130123 - E Patients requiring to be seen by the end of March A8

46. 20130123 - E Patients requiring to be seen by the end of March A9

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

e. *Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.*

i I can confirm that both my Assistant Directors and I received copies of the IR1s from the Datix system as they were raised. Any serious or concerning ones would have been dealt with/investigated

immediately and, as Head of Service, I was accountable for the final approval of any Datix received. Any serious adverse incidents were discussed by the Assistant Director and, if required, then an investigation was carried out. To confirm, I was never involved in any panels for a serious adverse incident during my tenure.

f. *Support the Assistant Director with the implementation of quality initiatives.*

i Examples of quality initiatives in urology that I was involved in were:

A The move of the Thorndale Unit into upgraded accommodation (October 2013) and offering more services (for example, Intravesical chemotherapy, Transrectal Ultrasound (TRUS) prostate biopsy, flexible cystoscopy, urodynamics, etc.);

B In 2015 - One-stop outpatient clinics (for which the Urology Team won a quality award in June 2016);

C In 2018 re-organisation of the stone service and securing research funding *Attached document namely:*

47. 20180202 – Stone Presentation and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

g. *Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.*

i Examples of this were the meetings with GPs, Macmillan, Health and Social Care Board, Western Health and Social Care Trust, Department of Health, and being a participant in meetings such as the Urology Professional Issues Group. *Attached documents namely:*

48. 20150626- Urology PIG Actions

49. 20190911 - E invite to PIG meeting

50. 20190911 - E invite to PIG meeting a1

51. 20190911 - E invite to PIG meeting a2

52. 20201207 - E agenda PIG meeting

53. 20201207 - E agenda PIG meeting a1

54. 20190227-PIG presentation M Haynes-M Corrigan and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

8. **It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, the Medical Director, Associate Medical Director, the Clinical Lead, urology consultants or with any other role which had governance responsibility**

8.1 I have based my response to this question on what I believe worked and happened in practice rather than on a comparison of Job Description documents (which the Inquiry is perhaps best placed to carry out). In my opinion, all of the aforementioned staff (including myself) have a responsibility to have systems and processes in place to ensure patient safety and care at all times from an operational and governance perspective. In the table below I have added in my opinion, based on experience, on what the difference was in their roles and responsibilities:

Post	**Differences**
Director of Acute	Accountable for the Directorate and part of the Senior Management Team and Trust Board and depends on issues being escalated by her team.
Assistant Director	Responsible for their teams and ensuring that there are systems and processes in place to highlight and deal with governance issues that arise and that they escalate to the Director of Acute Services areas of concern that can't be dealt with locally.
Medical Director	Overall accountability for Medical Staff and, as Responsible Officer, to ensure that any areas of concern regarding a medical member of staff is advised to the GMC and also that an Early Alert is sent to the Department of Health in respect of any serious issues.
Associate Medical Director	To work with the clinical directors to ensure that there are systems and processes in place for high quality patient care and that areas of concern are addressed immediately and escalated if appropriate to the Medical Director.

Clinical Director	To work with their consultant teams to ensure that they are aware of their responsibility to report any governance issues or concerns that are affecting patient care and safety and to work with the divisional team, and particularly their head of service, in gathering the data and information on any area of concern and then escalating this to the AD and the AMD.
Clinical Lead	See below for consultant urologist as in my view the clinical lead has the same remit of responsibility.
Consultant Urologist	A responsibility for their own patients but also the patients that are under the care of the Southern Trust and to raise, through the systems (Datix, complaints, whistleblowing, patient safety and morbidity and mortality meetings) any concerns that they may have that affect patient safety.
Lead Nurse	To work with the ward and/or departmental sisters to ensure they raise any risks/concerns or issues that are affecting patient safety. Staff should be aware of the whistleblowing policy and know that there is a safe, open and honest culture within their areas and that they should not be afraid to raise concerns and know that their lead nurse will escalate these and then feedback to the outcome from raising concerns.

Urology services/Urology unit - staffing

9. **The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.**

9.1 As stated previously I commenced my role as Head of Service on 28 September 2009. As part of my induction on this date Mr Simon Gibson, Assistant Director, provided me with a paper copy of the Urology Review for reading, information and preparing for implementation of this Review into the Southern Trust which was the subject of a 12-week consultation from 23 September 2009 until 28 January 2010.

9.2 In December 2009, after consultation with the senior managers including Director of Acute Services (Joy Youart), Acting Director of Performance and Reform (Paula Clarke), and Assistant Director of Surgery and Elective Care (Heather Trouton), we completed the consultation questionnaire and I forwarded this to Mairead McAlinden, then Acting Chief Executive for the Trust's response of this consultation.

Attached documents namely:

55. 20090909- consultation response questionnaire for review of urology

56. 20090909- consultation response questionnaire for review of urology letter and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

9.3 On 24 December 2009, Paula Clarke, Acting Director of Performance and Reform, advised via an email that initial discussions had commenced with the Western Trust. She asked Sandra Waddell, Head of Planning, to work with me in considering key deliverables in preparation of a formal meeting of Team South Implementation Group in early 2010. I am aware that Mr Young, on behalf of the Consultant Urologists, submitted a response in relation to his concerns on the review and the main issue for them that I recall was that Mr Young and Mr O'Brien were opposed to the recommendation of the move of Radical Pelvic Surgery to Belfast.

9.4 Mr Young's response was shared with me from Heather Trouton on email from a report from the Performance Management and Service Improvement Directorate *Attached documents namely:*

57. 21010306 - Summary of consutlation responses

58. 20090101-summary of consultation responses

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

Part of my role was to keep the progress on the recommendations updated and share with Assistant Director (Heather Trouton), Director of Acute Services (Dr Gillian Rankin), and Director of Performance and Reform (Paula Clarke). I also worked closely with Sandra Waddell from Planning (both of us under the

direction of Director of Acute/Assistant Director and Director of Planning and Reform).

9.5 In May 2010 the first meeting of the Steering Group took place and was chaired by Dr Rankin (Director of Acute Services) *documents attached namely – 59. 20100513 - notes of urology steering group and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments*
It was proposed at this meeting that I would be a member of the Steering Group, Project Team and the Clinical Assurance Group. I was also the link at getting together the Western Trust representatives to meet with Mr Young, as Clinical Lead, and with Mrs Trouton and myself. From the Steering Group meeting, Sandra Waddell and I were tasked to work through the actions including writing a Project Initiation Document (PID) - *attached document namely: 60. 20100521- Project Initiation Document and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments* which details out the group membership and the areas that work was required on to get the Recommendations implemented.

9.6 As a result of the meeting on 13 May 2010, Monday evening meetings (5pm-6pm) were established to take forward the implementation plan and used for work analysis. I attended the majority of these meetings and I was responsible for ensuring actions were completed from each of the meetings and *updated accordingly – attached documents namely:*
61. 20100519- E clarity on urology meetings
62. 20100519- E clarity on urology meetings a1
63. 202100517-Urology Action Plan
64. 201005245 E Action note of urology meeting
65. 201005245 E Action note of urology meeting a1
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

9.7 Below are all the areas/documents that I had input into for the implementation of Team South and I have stated what my involvement was in each of these.

a. Investment Proposal Template (Business Case) - Mrs Waddell and I worked together on this document which included contacting all the departments that needed to be included in the costs so that we could present a comprehensive case to the Department of Health for funding. *Attached document namely:*

66. 20120214- Investment Proposal Template Urology and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

b. Project initiation Document – Mrs Waddell and I worked together in preparing this document and presenting this for approval to the overall steering group. *Attached document namely: 60. 20100521- Project Initiation Document and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments*

c. Job Planning (consultants and nursing) – For the consultants and nursing staff I was responsible for gathering their current job plans and I presented this to the steering group. I was also involved in the discussions with Mrs Trouton, Mr Mackle and Dr Rankin as to whether the proposals for the job plans were achievable.

Attached documents namely:

67. 2010-blank template for job planning exercise

68. 20111101- Job Plan AOB

69. 20111101- Job Plan MA and MY

69a. 20100104- proposed urology job plans - 5 consultants model

70. 20121218- consultant 4 and 5

71. 20100310-E uro consultant JP

72. 20100310-E uro consultant JP a1

73. 20130306 job planning meeting notes

and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

d. Setting up the service in Enniskillen – As I had recently worked in the Western Trust and knew the personnel and systems I was tasked with setting up the meetings with staff from both Trusts and working through processes to operationalise this service such as transfer to the Southern

Trust of referrals from GPs, transfer of notes, suitable dates for clinics, equipment, etc.

Documents attached namely:

74. 20120812-E Team South visit

75. 20100622 - E Enniskillen

76. 20100622 - E Enniskillen a1

77. 20100623 E from D McLaughlin Enniskillen

78. 20130218- E OP Referrral Fermanagh

79. 20130218- E OP Referrral Fermanagh a1

80. 20130218- E OP Referrral Fermanagh a2

81. 20130514 - CCG Enniskillen

82. 20130916- E clinics in SWAH

and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

e. Updating the implementation plan - Mrs Waddell and I worked together in preparing this document and presenting this for approval to the overall steering group.

Documents attached namely:

83. 20100614--Team South Implementation Plan V1

84. 20101101- Team South Implementation plan v2

85. 20101105-Team South Implementation Plan V3

and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

f. Providing an update against the recommendations - I worked with various personnel (consultants/nursing/planning) in the regular update of the recommendations and fed into the stocktake of this in 2014.

Documents attached namely;

86. 20100401- update recommendations of Urology review

87. 20130801-update on urology review recommendations

88. 20140401-draft update of recommendations

89. 20140401-Urology review stocktake

90. 20140425-update on nursing recommendations for review
and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

g. Working with the consultants and HR on recruitment - My involvement was to coordinate the updates for the job descriptions between Medical HR and Mr Young so that they were ready to go to specialty advisor for approval.
Documents attached namely;
91. 20111211- Job description – urologist
92. 20131001-job description consultant urologist
93. 20131112- specialty doctor urology advert
94. 20131106- advert consultant
95. 20120106- spec advisor email about job
96. 20120111- replacement post Med HR
97. 20120106 - email EM to MY
and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

h. Involved in the work around the clinic templates according to the BAUS guidelines these discussions took place at the Monday evening meetings which I attended and I worked with Mrs Waddell in working up the proposed activity so that it would meet the agreed levels.
Documents attached namely;
98. 20040804 -clinton review of urology CAH
99. 20001001-BAUS Guidelines
100. 20020201-BAUS Guidelines
Documents and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

10. **What, if any, performance indicators were used within the urology unit at its inception?**

10.1 The following performance indicators for urology were agreed during the implementation of Team South.

10.2 Outpatients

a. New to review ratio
b. Numbers of new and review attendances
c. Waiting time for new outpatient appointment
d. Target waiting times for suspected cancer referrals
e. DNA rates (new and review)

10.3 Elective Inpatient/Day Case

a. Average LOS
b. Average LOS for agreed procedures (to be agreed regionally via the Urology Review Project Implementation Board)
c. Percentage daycase/23 hour stay rate
d. Numbers of elective FCEs and daycases
e. Percentage of patients undergoing pre-operative assessment
f. Percentage of patients admitted on the day of surgery
g. Emergency readmission with 28 days of elective discharge
h. Mortality rate

10.4 Non-Elective Episodes

a. Average LOS
b. Mortality rate

10.5 Patient Experience

a. Numbers of complaints
b. Patient satisfaction surveys

10.6 I have provided the figures for each metric for the year 2010. I have asked the Trust's performance team to provide updated data for me as well.

Document attached namely; 101. 20100603 – Urology Benchmarking and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

11.1 As Head of Service I did not disseminate or provide the Integrated Elective Access Protocol to the urology consultants. When I commenced my Head of Service post in September 2009 I was aware of this Protocol but this was from my previous role as Outpatient Manager in the Western Trust.

11.2 I am not aware if this had been disseminated or provided previously with the urology consultants as it was implemented in April 2008, 17 months prior to me commencing my post in the Southern Trust. However, I do know that the urologists were aware of this. One example of this is an email from Mr O'Brien dated 26 May 2009 where he mentions that, as a department, they understand that the Trust is required to comply with the Elective Reform Program (ERP), Developing Better Services (DBS) and the Integrated Elective Access Protocol. (IEAP During my tenure I would have sent the Urology consultants emails in which I mentioned conforming with the IEAP, including for example, one that I sent on 23 January 2013 to which I attached a copy of a letter from Mr Dean Sullivan, Director of Commissioning, where he reminds of the effective management of all outpatient, diagnostics and inpatient waiting lists.

Attachments namely:

37. 20130123 - E Patients requiring to be seen by the end of March

38. 20130123 - E Patients requiring to be seen by the end of March A1

39. 20130123 - E Patients requiring to be seen by the end of March A2

40. 20130123 - E Patients requiring to be seen by the end of March A3

41. 20130123 - E Patients requiring to be seen by the end of March A4

42. 20130123 - E Patients requiring to be seen by the end of March A5

43. 20130123 - E Patients requiring to be seen by the end of March A6
44. 20130123 - E Patients requiring to be seen by the end of March A7
45. 20130123 - E Patients requiring to be seen by the end of March A8
46. 20130123 - E Patients requiring to be seen by the end of March A9
102. 20090526- E response of department of urology
103. 20090526- E response of department of urology a1
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

11.3 I am also aware from discussions with them regarding triage that they were all aware of the Protocol but I cannot comment if they knew all of the details contained therein. I would note in this regard that I was not provided with a copy of the Protocol by the Southern Trust and I sourced my own copy from my colleague Amie Nelson.
Attached document namely;
104. 20140311- E copy of IEAP
105. 20140311- E copy of IEAP a1
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services?

12.1 The IEAP was developed to improve the patient elective pathway to ensure that all patients would be treated on the basis of clinical urgency, patients with the same clinical need are treated in turn, and that when a patient is added to a theatre list that they must be fit for their procedure (pre-op fit). All of the above was to improve the experience, quality and equality for all patients. It was also to ensure that patients were treated within the time limits outlined in the IEAP. The targets set out for this were that:

a. Maximum waiting time would be 13 weeks for Inpatient/Day care procedure by March 2009.
b. Maximum waiting time would be 9 weeks for first outpatient appointment by March 2009.

12.2 So, in my opinion, the above targets, whilst set out to benefit the patient, did put pressure on the urology teams. During my tenure I was continually monitoring against these targets and having to meet with the team to put plans in place to make sure that we didn't breach any of the targets and produce 'cutting plans' all of which was to ensure that no patients 'breached' the targets outlined in the IEAP.

Attached documents namely;

106. 20121018-cutting plans for urology

107. 20121018-cutting plans for urology a1

108. 20121018-cutting plans for urology a2

109. 20121018-cutting plans for urology a3

110. 20121018-cutting plans for urology a4

111. 20121010 - E performance update report

112. 20121010 - E performance update report a1

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

12.3 To note, when I started in September 2009 there were no breaches of the urology outpatient 9 week target but there were 44 inpatients who breached the 13 week target with the longest waiting 26 weeks for their appointment.

Attached documents namely;

113. 20090930-month end final position IP-DC's- 13 weeks +

114. 20090930-month end final position OP 9 weeks +

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

12.4 In my opinion, I feel that it became a 'counting' exercise and the patient risked being forgotten about in the midst of the need to meet the targets. I would also like to add that this pressure came from Department of Health and we, as

a Urology Team, would often have said that the Performance part of Department of Health didn't see the figures as patients and didn't have a realisation of how it all worked operationally.

Attached documents namely;
115. 20130524- E update from performance meeting
116. 20130524- E update from performance meeting a1
117. 20130524- E update from performance meeting a2
118. 20130524- E update from performance meeting a3
119. 20130524- E update from performance meeting a4
120. 20130524- E update from performance meeting a5
121. 20130909-notes from urology meeting - performance
122. 20130320-performance
123. 20130508 - E performance update for the board
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

How, if at all, were the time limits for urology services monitored as against the requirements of the protocol?

12.5 The time limits for urology services along with all other specialties were monitored on a weekly basis. This was done by the Performance and Reform Department providing weekly reports on Outpatients waiting to be seen by time-band, Inpatients and day cases by time-band, and diagnostics (urodynamics) by time-band *Documents attached namely:*
124. 20140620 - availability of performance reports on SharePoint ICATs
125. 20140620 - availability of performance reports on SharePoint ICATs a1
126. 20140307-availability of sharepoint reports outpatient ptl
127. 20140307-availability of sharepoint reports outpatient ptl a1
128. 20140307-availability of sharepoint reports in's and days
129. 20140307-availability of sharepoint reports in's and days a1
130. 20140306 - availabilty of Actual IP and Daycase waiting lists on sharepoint
131. 20140306 - availabilty of Actual IP and Daycase waiting lists on sharepoint a1

132. 20140303- availability of performance reports - diagnostic physiological measurement PTL a1

133. 20140303- availability of performance reports - diagnostic physiological measurement PTL

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

What action, if any, was taken (and by whom) if time limits were not met?

12.6 It was the responsibility of the Head of Service along with the Operational Support Lead (Sharon Glenny, and then Wendy Clayton), to go through these reports and for each of the patients that didn't have a date provide the reasons why (for example, due to capacity, patient was not fit, date/time didn't suit patient, etc.). During Dr Rankin's and Mrs Burns' tenures as Directors of Acute Services they would have held weekly meetings with all specialties to discuss and come up with plans to try and get patients dates, etc. It should be noted that, whilst this was is in respect of Urology Services, the Inquiry will see from the attached reports that there were capacity issues in most other specialty areas as well.

12.7 When time limits were not met for the Outpatient and Inpatient/day cases we had to do a monitoring report on each patient and describe the reasons why they had breached and what we had done/were doing to prevent this happening again and to ensure that the patient who was breaching had been sorted.

Attached documents namely;

134. 20140407 - month end IP-DC position reports

135. 20140407 - month end IP-DC position reports a1

136. 20140407 - month end IP-DC position reports a2

137. 20090930 - month end IP-DC position reports

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

12.8 One of the key elements that the teams were monitored on was the return of triage of the patient letters that either came from a GP, Emergency Department or from another consultant. The importance in the early days when

I took up post was that we had to have the patients triaged and added to the waiting list so that they could be offered an appointment according to their clinical need waiting time. For outpatients this was only 9 weeks which was why it was important to have the letters returned within the IEAP from triage.

12.9 The Heads of Service had weekly meetings with the Head of the Referral and Booking Centre, Katherine Robinson, who provided us with the monitoring information as to how many referrals were outstanding and then, as Head of Service, I would go and speak to the consultants who all would have had some for returning. However, it was usually only with Mr O'Brien that there was a constant 'battle' to get him to comply.

Documents attached namely;

138. 20130719-E demand capacity for access target

139. 20130719-E demand capacity for access target a1

140. 20130719-E demand capacity for access target a2

141. 20130719-E demand capacity for access target a3

142. 20130719-E demand capacity for access target a4

143. 20120312-E Demand Capacity Triage Urgents

144. 20120312-E Demand Capacity Triage Urgents a1

145. 20120312-E Demand Capacity Triage Urgents a2

146. 20120312-E Demand Capacity Triage Urgents a3

147. 20120312-E Demand Capacity Triage Urgents a4

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

12.10 If, as Head of Service, I didn't get these referrals back I would have escalated to Assistant Directors Heather Trouton or Ronan Carroll (Cancer triage) and we had to involve the Associate Medical Director, Eamon Mackle, and ultimately the Director of Acute Services (Gillian Rankin from 2009 until 2013 and Debbie Burns from 2013 until 2015) to address this with Mr O'Brien. I would wish to confirm that, during my tenure, I never had to escalate the issue to the Assistant Directors or elsewhere for any of the other consultants in any of my teams (Urology/ENT and Ophthalmology).

Personal observation –

12.11 In my opinion, I felt that we as a management team spent a lot of time monitoring these waiting times and producing reports and reasons why we were not meeting the targets. There were weekly performance meetings held from 2010 until 2015 which were normally chaired by the Director of Acute Services and in which the Assistant Directors held the Heads of Service to account for patient waiting times. The Heads of Services were expected to know their performance information and have a reason why the patients would not have a date within the time limits and also an explanation as to what they were doing or had done to prevent patients breaching.

12.12 It was apparent that the Trust was being held to account by the Department of Health and I am aware of the monthly meetings chaired by Dean Sullivan/Michael Bloomfield where comparison with other Trusts on how well they were or were not doing was presented with all Trusts being present. I am aware through others, such as Mrs Debbie Burns, Mrs Heather Trouton, Mr Ronan Carroll, Mrs Lesley Leeman (Assistant Director of Performance and Reform), and Mrs Lynn Lappin (Head of Performance), of fractious conversations with the Department of Health personnel and feel this impacted on the operational teams as they didn't want the Trust looking bad in front of the other Trusts. Whilst I believe this was introduced for the benefit of the patient, I also believe that the patients' needs were at risk of getting lost in the need for the Trusts to be seen to be the best performing in the eyes of the Department of Health. In short, it was all about figures and the patients' needs risked getting lost in the midst of these figures.

Attached documents namely;

148. 20111211 ACTIONS-ISSUES - operational Performance Meeting

115. 20130524- E update from performance meeting

116. 20130524- E update from performance meeting a1

117. 20130524- E update from performance meeting a2

118. 20130524- E update from performance meeting a3

119. 20130524- E update from performance meeting a4

120. 20130524- E update from performance meeting a5

121. 20130909-notes from urology meeting - performance

122. 20130320-performance

123. 20130508 - E performance update for the board

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

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

(I) What is your knowledge of and what was your involvement with this plan?

13.1 Under the direction of Heather Trouton, I was operationally responsible for the implementation and monitoring of the plan. I worked along with the Consultant Urologists, the Clinical Nurse Specialists and the GPs to draw up these plans. This plan was based on what we as a team felt would be workable and achievable and the plan was discussed at departmental meetings and got the agreement from all the Urology Team. Once agreed, we invited Dr Peter Beckett (Associate Medical Director for GPs) on behalf of the GPs to a meeting to discuss.

Documents attached namely;

149. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog

150. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog a1

151. 20101230- E-action plan from urology primary care meeting

152. 20101230- E-action plan from urology primary care meeting a1

153. 20100614-Team South Implementation plan Appendix 2

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

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

Implementation

13.2 The Operational Service Lead (Mrs Sharon Glenny) provided me with patient letters of the last clinic appointment of patients who were in the review backlog. Lead Urology Nurses (Shirley Tedford/Kate O'Neill and Jenny McMahon) then worked with the Consultant team to:

a. Review patient centre letters of patients waiting on a Urology review,
b. To identify those patients that required an urgent review,
c. Identify those patients who it may be appropriate to discharge and
d. Identify those patients who were on the review list due to an administrative error.

13.3 It was deemed that this needed done via the last saved patient centre letters for the following reasons:

a. To cleanse the list from admin error to ensure that appointments were not given to those who should not be on the list.
b. To ensure that those patients who required urgent review were prioritised and were seen urgently.
c. To ensure that patient review slots (that were limited) were utilised for those patients whose clinical need was evident and
d. To ensure that those patients who no longer required a review were identified for safe discharge back to their GP.

13.4 For those patients that needed an urgent appointment the Trust secured funding from the Department of Health so as to allow the consultants to run additional clinics in order to see these patients outside their core activity. All three consultant urologists did these additional clinics to help clear the backlog and were these were paid as waiting list initiative.

Reviewed and assessment of effectiveness

13.5 There was a weekly meeting with me, as Head of Service, and the Lead/Clinical Nurse Specialists where I checked in on how they were getting on with working through the patient centre letters and ensuring they were getting the support from the consultants (and, if not, I would have spoken to the consultant(s) on their behalf).

13.6 For those patients who had been identified as needing discharged back to their GP's care, I would have passed these to the Operational Support Lead for action. Any of those who needed an appointment were left on the waiting list and their clinical status either upgraded to urgent if identified or left as they were already on the waiting list. For those that it was deemed needed a priority appointment, then the additional clinics were set-up and the patients appointed according to their clinical urgency but in chronological order.

Attached documents namely;

154. 20111221- E Additional Urology

155. 20101221 - E - review backlog

156. 20111216- E - Review Backlog Clinics

157. 20101220- E Mr O'Brien's backlog reviews

158. 20111230- E OP REVIEW BACKLOG UPDATE

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

13.7 At the end of each month the Operational Support Lead ran a 'Patient Target List' (PTL) to see if there had been a reduction in the backlog both by numbers and by time waiting and then this was discussed with the team at our weekly meetings and then brought back to the Project Team to ensure the work of the Lead/Specialist Nurses was making an impact on the waiting times.

Attached example reports namely:

159. 20091009 - urology meeting

160. 20111230- E OP REVIEW BACKLOG UPDATE

161. 20150618- update review backlog urology

162. 20150813- update review backlog urology

163. 20150520- update review backlog and performance urology

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

(III) What was your role in that process?

13.8 My role involved leading and assisting with the above and providing the data to bring to the meetings to discuss and agree and also to draw up actions to aid with the implementation of the plan and then providing updates to the Project and Steering groups on its progress. I also worked with the GPs in drawing up pathways to allow the patients to be discharged safely back to their care by providing them with the detail to inform them when seeing the patients back in primary care.

149. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog

150. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog a1

164. 20101230- E-action plan from urology primary care meeting

165. 20101230- E-action plan from urology primary care meeting a1

166. 20110407- GP pathways presentation

167. 20111211- Pathways for Erne and DHH

168. 20110901-Retention of Urine pathway

169. 20110911-vasectomy pathway

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

(IV) Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

13.9 For the period of time that the Urology Team carried out this piece of work it is my view that this achieved its aim. The Consultants empowered the Lead/Specialist Nurses to make decisions and bring them a plan which they then could accept or reject. The waiting times and numbers of patients reduced through this focused exercise. However, I would stress that for the period of time that this was done it worked, and then when the exercise was complete

and funding was no longer available the waiting times started to increase for some of the consultants.

13.10 As previously mentioned, we did have meetings about this with the aim to try and change practice and introduce pathways etc. but, whilst there was enthusiasm for this on the day, in my opinion it didn't work. A main problem was that junior medical staff continued to review the patients and this added to waiting lists.

Documents attached namely;

149. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog

150. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog a1

164. 20101230- E-action plan from urology primary care meeting

165. 20101230- E-action plan from urology primary care meeting a1

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

13.11 Also, the stone patients were added to the waiting list to be brought back every year for a scan. The view was and is that, if after the first year they remain pain/symptom free, instead of being kept on an outpatient waiting list they should be discharged back to the GP with information to the GP and to the patient on what to do if symptoms/pain reoccurs and advice to refer back to the stone service if that is deemed necessary. During my tenure, despite this being a deemed service improvement, it never got put in place. The plan had been that there would be a specialist nurse for this service but funding was never provided as it was felt that Cancer should be the priority and this is where the funding for nurses etc. was provided.

13.12 I have provided a copies of the current and some previous Review Backlogs for Urology to show the difference of practices among consultants which gives proof that, by not reviewing some patients unnecessarily, the review times for an Outpatient appointment are manageable.

The documents attached namely;

170. 20180701- urology performance
171. 20190219- urology performance
172. 20210416- urology performance
173. 20220608- urology performance
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

13.13 Since I took up my post of Head of Service, the Review Backlog was an on-going issue and was always a clinical concern, not only for me as the manager of the service, but for the Consultant body as it was felt that these patients were more of a clinical risk as they were beyond their dates to be seen. From a governance point of view, this had been added to the Divisional and Directorate Risk Registers
The documents attached namely;
174. Divisional SEC risk register - urology access waiting times
175. acute directorate risk register - urology access waiting times
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

14. 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 Review Backlog, capacity, access to theatres and recruitment and retention of staff were reflected on the Divisional, Acute and Corporate Risk Registers and this was discussed at all the internal and external performance meetings. It was the role of the Assistant Director providing the information to the Director of Acute Services to ensure that this was on the Risk Register and that it was highlighted at performance meetings as a risk.
The documents attached namely;
174. Divisional SEC risk register - urology access waiting times
175. acute directorate risk register - urology access waiting times
176. 20121019-OP Review Backlog Update

177. 20121019-OP Review Backlog Update a1

178. 20151012- update urology RBL

179. 20151012- update urology RBL a1

180. 20151012- update urology RBL a2

181. 20151123 - review patients to be booked

182. 20151123 - review patients to be booked a1

183. 20170704 - E-Urology Trust Performance Actions 16-17

184. 20170704 - E-Urology Trust Performance Actions 16-17a1

185. 20091221-ACUTE DIRECTORATE PERFORMANCE RISKS TEMPLATE and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

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 In my opinion, I do not feel that the issues noted in the Regional Review of Urology Services, Team South Implementation Plan were resolved satisfactorily and, from my experience, the problems persisted following the setting up of the urology unit.

15.2 The Regional Review of (Adult) Urology Services was undertaken:

a. In response to concerns regarding the ability to manage growing demand (In my opinion, this is still a concern);
b. To meet cancer and elective waiting times (The current cancer and elective waiting times have increased since the start of my tenure in 2009 – see below);

Year	Outpatient wait	Outpatient wait – cancer	Inpatient and day cases
2009	Less than 9 weeks	Less than 10 days	26 weeks
2022	332 weeks	28 days	409 weeks

c. To maintain quality standards and provide high quality standards (In my opinion, the Urology Service did continue to maintain and provide high quality standards to the majority of patients who came under their care);
d. To provide high quality elective and emergency services (In my opinion, whilst the Urology Service provided high quality services to those who came in as an emergency and for those who were admitted electively, due to capacity - which led to delays throughout the patient journey [first appointment/ diagnostics/ admission for procedure to follow-up] - the urology service, through no fault of themselves, could not provide as high a quality of service as they would have liked).

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

16.1 In my opinion the Urology Unit was not adequately staffed but I can confirm that was not due to funding from the Department of Health to implement the recommendations from the review. I have outlined below the reasons for my above statement.

16.2 When I took up my post in September 2009 the following staff were in post:

a. 3 Consultant Urologists (Mr O'Brien, Mr Young and Mr Akhtar)
b. 2 Registrars (various doctors held this post due to it being a rotational training post)
c. 1 GP with Specialist Interest (7 sessions per week) [redacted]
d. 1 Lecturer Practitioner in Urological Nursing (2 sessions per week) (Jerome Marley)
e. 2 Urology Specialist Nurses (Band 7) (Kate O'Neill and Jenny McMahon).

16.3 The Regional Review recommended that there was an increase in staffing as follows:

a. Consultant Urologists should increase from 3 to 5 consultants - This proved problematic as, although the funding was available, it took some years to get 5 consultants in post and, even when the Trust was successful, some of the consultants only stayed for a short period of time.

   Documents attached namely:

   186. 2009-2022 – Consultants in post

   and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Clinical Nurse Specialist to increase from 2 to 4 clinical nurse specialists. -

   i In 2009 there were two Clinical Nurse Specialists in post, Kate O'Neill and Jenny McMahon. The plan from the Review was to recruit a further 2 nurses who were to be aligned to cancer as per the review.

   ii It was also stated in the Review that this would be taken forward by NICAN during January – March 2011, which meant that the Trust couldn't move to recruit for these two posts until this had been finished.

   iii As Head of Service, I was not involved in this process and this was under the remit of Head of Cancer Services, Alison Porter and then Fiona Reddick, who both reported to Ronan Carroll, Assistant Director from 2009-2016, and then to Heather Trouton from 2016-2018, and then to Barry Conway from 2018-now. So, for this process I had no influence to 'speed it up' which, from a personal perspective, I felt did cause issues for the operational aspect of the service in that, whilst I operationally managed the Clinical Nurse Specialists, I had no influence over how and when they would be appointed.

   iv In October 2014, whilst still waiting on the decision on the Cancer Clinical Nurse Specialists, I prepared and presented a paper to Mrs Burns (Interim Director of Acute Services) in which I requested that we

would appoint 2 x Band 6 nurses so that we could start to train them up to become specialist nurses (there were no Band 6s qualified or with the experience to become Band 7s).

v The funding for this proposal was going to go 'at risk' but I presented that these were needed to assist in tackling the increasing waiting times **for** outpatient appointments. Mrs Burns agreed to go 'at risk' for these posts and we temporarily appointed 2 members of staff who were substantive Band 5s to these and then we backfilled their posts in the unit. To note, both of these Band 6s eventually have taken up permanent Band 7 Clinical Nurse Specialist roles (Leanne McCourt and Jason Young). Furthermore, in 2020 the Clinical Specialist Nurses have increased to 5 members of staff. However, the key issue here is that it took from 2009, when the recommendation was made, until 2020 when there were finally 5 Clinical Nurse Specialists in post.
Documents attached namely:
187. 20141002- paper re 6 and 7 urologist
188. 20141002- paper re 6 and 7 urologist a1
189. 20140915 costs for urology new model
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

16.4 Whilst there was no recommendation for an increase in non-Consultant grades (Trust Doctors/ GPs with Specialist Interest/ Lecturer in Urological Nursing), on-going vacancies and the inability to recruit to non-consultant grade has proved problematic for the Trust and has had a significant impact on capacity. The Trust had funding for 2 Trust Grade doctors which were vacant when I took up post in September 2009.

16.5 These non-consultant grades are of great benefit to the consultant body in that they are qualified to do flexible cystoscopies, prostrate biopsies, local anaesthetic day cases and some general anaesthetic day cases with supervision. They can do clinics on their own, will bolster up the out of hour rotas, and are senior enough to make decisions without having a consultant

with them all the time. Therefore, all of the above alleviates pressure on the consultants and allows them to concentrate on the more complex areas of their workloads.

16.6 However, despite numerous advertisements and changing the job plans and titles of these posts (e.g., 'Staff Grade with Clinical Research'), the Trust had never been successful in permanently filling these two vacancies until 2019. Dr Rogers, General Practitioner with Specialist Interest, retired [redacted] in April 2013 and there was no one available or interested to replace him. J Marley, Lecturer Practitioner, ceased his two clinical sessions due to increasing university commitments in 2012 so the funding for both these posts was converted to another whole time Trust Staff Grade. From April 2021 the Trust have secured 4.23 Trust Doctors and this will greatly benefit the service.

Documents attached namely:
190. 2009-2022 – non-consultant grades in post
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

17.1 Yes, I was always fully aware of the staffing problems in the Urology Service since I commenced in September 2009. Please see my response to question 16 above where I have outlined these staffing problems. The supporting evidence attached at question 16 outlines the dates of when there were issues and, as Head of Service for Urology, it was my role to be aware of these as, when members of the urology team left, I would have escalated this to my Assistant Director and Associate Medical Director and, as part of my role, I would have worked with the Consultant team (in particular, Mr Young as Clinical Lead) and Human Resources to make them aware of this. I was the link

for ensuring the advertisements/job description/job plans were all correct before going outside the Department / Trust.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1 Please see my response to question 16 above where I have outlined the staffing issues and please see my attached supporting evidence.
Documents attached namely:
Documents attached namely:
191. 20130821 - urology plan - staff gaps
186. 2009-2022 – consultant grades in post
190. 2009-2022 – non-consultant grades in post
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

My opinion on how this impacted on the unit

18.2 In my opinion, these vacancies did impact the urology team from both a morale and a workload perspective. In terms of morale, it was very soul-destroying for the urology team to appear to resolve the recruiting issues when members of staff commenced, get them all set up and integrated into the Team, to see them then, after short periods of time, resign and the whole process have to be restarted. There was always a question as to why did staff not stay and whether there was something different that the urology team should be doing? The other impact was the workload in that the absence of full quotas of consultants/ non-consultant grades and specialist nurses meant that patients could not be seen in the volumes that had been agreed and therefore the main impact these vacancies had was on the patient, as waiting lists increased and patients were waiting longer to be seen, which in turn led to more complaints/ queries and informal queries through myself, as the Head of Service, to the members of the Urology Team.

How staffing challenges and vacancies were managed and remedied

18.3 To the best of my ability, and with the support of the other members of the teams, as soon as a vacancy arose I went out to recruitment again to avoid any dela,y but the process in itself is very long. I also would have requested CVs from agencies, shared these with the teams, and appointed anyone deemed to be suitable.

18.4 We changed job plans to try and make the posts more attractive. For example, for the non-consultant staff we added in time to their work plans to do clinical research; we also agreed to reduced working hours to attract staff.

18.5 I also continued to work with my colleagues in Performance and Reform and in Finance to ensure that unused funding for the unfilled posts could be diverted and be offered to the Consultants and Nursing staff to do additional clinics/theatre sessions to address the gaps and the waiting list rates. It should be noted that not all consultants were interested in this option and also, whilst there may have been willingness at the outset, the consultants and nurses became tired of doing the additional sessions and the uptake in latter years was poor.

Documents attached namely;
192. 20140614 - activity
181. 20151123 - review patients to be booked
182. 20151123 - review patients to be booked a1
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

19.1 As discussed in my previous response, due to staffing problems waiting times increased, which ultimately had an impact on clinical outcomes of patients and their care. This also led to time being spent dealing with patient calls about their care, queries as to when would they be seen and asking for timescales or advice on what they should do be doing. This further impacted on the provision of the service as the urology staff were spending time responding to queries and searching for notes to attend to these queries, instead of seeing patients or following up on their administration duties.

19.2 As a urology team, one of the main governance concerns that was seen as a risk was the volume of patients on waiting lists and the issue that patients were waiting much longer times than specified when they had been in clinic and added onto the waiting list as there was no way of identifying if the patients clinical priority had changed during the time that they had been seen at the outpatient clinic and added to the waiting list.

19.3 Whilst it may appear that, from time to time, the urology team was staffed fully, there was the impact and governance around the staff that were coming in to join the team particularly from agencies. These staff may have appeared to be suitable and qualified on paper from their CVs but actually, when working within the department, some gave rise to concerns and ended up creating more work for the substantive consultants than having them employed was worth.

<u>Locum Consultants</u>

19.4 Below are temporary members of the team who were employed in good faith but ended up causing issues for the provision, management and governance of the urology service:

a. Personal Information redacted by the USI , he was being paid per hour that he worked, so the first issue was he would not agree to the volume of patients on a clinic (14 patients) and would only agree to see 9 patients per four hour

session. He didn't agree with his timetables as felt he should be allocated more admin time (he was allocated the same as the substantive consultant team) and, when we wouldn't agree to this additional time, he ended his contract and left. There had been quite a bit of time spent (or, as it turned out, wasted) by myself getting him trained on systems, issuing passwords, creating waiting lists and by Mr Young and I negotiating with him over the above issues.

b. Personal Information redacted by the USI He left a large backlog of patients on his review backlog list.

c. Personal Information redacted by the USI He was very disagreeable with staff and myself. I had to get Mr Haynes, as Associate Medical Director, to assist and this took up substantial time trying to appease him.

Documents attached namely;

193. 20190919 Personal Information redacted by the USI *theatres*

194. 20190719- Personal Information redacted by the USI *ext of contract*

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

d. Personal Information redacted by the USI Mr Haynes and I had to meet with him and terminate his contract due to issues with his clinical ability and the poor quality of his clinical letters and communications with patients. This led to an additional workload as all of his clinical letters had to be rechecked and amended, if required.

Documents attached namely;

195. 20210521 - E re Personal Information redacted by the USI

196. 20210521 - E re Personal Information redacted by the USI

197. 20210521 - E re Personal Information redacted by the USI

198. 20210521 - E re Personal Information redacted by the USI

199. 20210521 - E re Personal Information redacted by the USI

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

Urology Services Inquiry

Locum Staff Grades

19.5 The main issue with locum staff grades is that they only ever stayed for a few months and, as they were from an agency, they didn't have to give notice and regularly left the Urology Team short-staffed and patients had to be cancelled at short-notice.

19.6 Other issues with specific doctors included the following:

a. Personal Information redacted by the USI – issues with his clinical ability and he was reported to the Medical Director (Dr Simpson) and a referral made to the GMC.
b. Personal Information redacted by the USI – Mr Young had to terminate his agency contract due to unacceptable behaviour
Documents attached namely;
200. 20130123 - letter Personal Information redacted by the USI
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

19.7 Outside of specific staffing issues, the Urology service was unable to meet the activity that had been agreed with the Department of Health (Service Budget Activity - SBA), which put pressure on me as the manager as I had to continually justify and provide reasons for underperforming and breaching targets. That, in turn, meant that I was continually having to discuss these issues individually and collectively with the consultants and nursing staff and think of ways to overcome these.

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

20.1 Whilst actual posts didn't change during my tenure I can confirm that some of the roles, duties and responsibilities did as follows ;

a. Mr O'Brien – became Chair of the NICAN Urology Group along with the Chair of the local Oncology Multi-disciplinary Team
b. Mr Glackin – became Chair of the Urology Patient Safety Meetings
c. Mr Haynes – became Clinical Director for General Surgery/ENT and Urology
d. Mr Haynes – became Associate Medical Director for Surgery and Elective Care which included (Urology/ENT/General Surgery and Trauma and Orthopaedics 1 October 2017.
e. The Chair of the Oncology MDTs changed from Mr O'Brien to a rotational role among Mr Haynes, Mr Glackin, Mr O'Brien, and Mr O'Donoghue
f. From 1 September 2017 Clinical Nurse Specialists K O'Neill and J McMahon were re-banded from Band 7 Clinical Nurse Specialist to Band 8A and they came out of day to day management and concentrated on clinical work only.

    i Part of the rationale for this re-banding was their move through training to start to undertake nurse-led procedures that had previously been undertaken by consultants and by non-consultant medical staff. Sr McMahon can now do independent nurse-led flexible check cystoscopies for patients who had previous bladder cancer and require regular surveillance. She is also the nurse-lead for urodynamics and can make independent decisions on these diagnostic tests. She also runs and manages the Lower Urinary Tract clinics which takes pressure from consultants in this common urological condition having to treat these patients. Sr McMahon also is the first Clinical Nurse Specialist in Northern Ireland independently to administer Botox into the Bladder for urinary symptoms.
    ii Sr O'Neill has now been trained to do prostate biopsies, a procedure that had always been done by either a consultant, registrar or staff grade doctor. Sr O'Neill is the first Clinical Nurse Specialist in Northern Ireland to do this; she originally was trained

to do this as TRUS (Transrectal Ultrasound), but she can now do this procedure using the new equipment purchased to do Transperineal prostate biopsies.

g. Two of the Clinical Nurse Specialists (Sr McMahon and Sr McCourt) are nurse prescribers and I, as their manager, supported and encouraged them to do this course.

(For information, the Clinical Nurse Specialists had been active for a number of years in trying to get these nurse-led services up and running but were met with resistance from some of the medical staff who felt that these were not a nurse-role. However, the nurses, along with myself and some of the newly appointed consultants, managed to get these services up and going, which has released pressure on the medical teams.)

h. As part of the Clinical Nurse Specialists coming out of a management role we moved the day to day management of the Thorndale Unit to sit under the Outpatient structure and, through an interview process, appointed one of the Band 5 nurses (Dolores Campbell) to a Band 6 management role where she now manages the Thorndale day to day issues and reports to a Band 7 Outpatient Services Manager.

i. J Holloway, one of the Urology Band 5 nurses who had an interest in the administering of Intravesical Chemotherapy, was allocated to do this full-time in the Thorndale Unit (having previously done this whilst a Band 5 nurse on Ward 3 South) and she was successful in getting this post re-banded to a Band 6. This change in nursing roles and responsibilities has strengthened the skills and the services that the Thorndale units offers to patients.

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1 In my opinion my role in terms of governance has not changed during my tenure.

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 I can confirm that, whilst I know all of the consultant secretaries and would have been in regular contact with them, I do not have sufficient understanding of work allocation, duties etc. to be in a position to respond to this question. Mrs Anita Carroll, Assistant Director for Functional and Support Services, along with Mrs Katherine Robinson, Head of Acute Booking and Secretarial Services, will be in a position to respond to this question.

22.2 However, in respect of the actual day-to-day support of the Thorndale Unit in respect of responding to clinic inquiries and patient contact, I can confirm that I was responsible for the appointing of a Departmental Manager Support (Gemma Robinson) during my tenure. This role sits outside of the secretarial team and is for the admin that was generated within the unit and has meant that the nursing staff are not having to spend their time answering telephone calls or dealing with patients that are waiting or who had personally visited the Thorndale Unit.

22.3 I secured funding for this Band 3 post as it is my belief that all staff should do the role that they are qualified to do. My experience was that, in a lot of instances, nursing staff were having to look for hospital notes, print letters off the Northern Ireland Electronic Care Record ('NIECR') system, look up Patient Administrative System, and answer telephones etc., when in my opinion they should have been in clinics carrying out clinical duties. So, I drew up a job

description and advertised the post for which Gemma Robinson successfully applied and she remained there during my tenure. As I have an admin background I agreed that I would complete her Knowledge and Skills Personal Development Review form on a yearly basis, sign off her annual leave, etc.

22.4 Ms Robinson was a full-time (37.5 hours per week) Band 3 member of staff solely for the Thorndale Unit and below is an extract from her job description:

"The post holder will provide a contact point for operational issues not directly relating to patient care in the Departmental. She/He will play a central role, meeting the administrative needs of Departmental Managers and their deputies, to include staff rostering, completion of appropriate documentation for Human Resources purposes, equipment maintenance and some aspects of health and safety compliance.

The post holder will work closely with, and under the supervision and direction of, the Departmental Managers to ensure continuity in service provision and as such will need to exercise initiative, independent judgement and decision making within a variety of situations.

A key part of the role will be to set up, develop and maintain systems of effective communication to prevent duplication of work and to allow nursing staff to concentrate on patient care."
Document attached namely;
201. *job description ward manager support Thorndale and Outpatients*
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

23.1 As stated in question 22, the only member of the administrative staff that I can comment on was the Department Manager Support. I can confirm that, whilst Ms Robinson was not allocated to particular consultants or Clinical Nurse Specialists, she was flexible in the administrative tasks that she undertook within the Thorndale Unit so, for example, if a consultant asked to be provided with a patient chart she would have sourced this for them or if they needed a patient brought from the Ward or the Emergency Department etc. Ms Robinson was willing and would have carried out this task/ request as it was to facilitate the smooth running of the Thorndale Unit and she became a valued member of the Team.

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1 I can confirm that the Department Manager Support never raised any concerns with me whilst she worked in the Thorndale Unit. And I can also confirm that none of the other administrative staff (secretaries/audio typists etc.) raised any concerns to me.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

25.1 From when I took up post in September 2009 until March 2021, the day to day running of the Thorndale Unit was jointly between the Clinical Nurse Specialists, Kate O'Neill, Jenny McMahon, and latterly Leanne McCourt. During my tenure, the Clinical Nurse Specialists would have reported through the Lead Nurses to myself as Head of Service and I

would then have reported through to Heather Trouton and then Ronan Carroll as Assistant Directors.

25.2 With respect to Ward 3 South, during my tenure the day to day running would have been with the Ward Sisters who would have reported through the Lead Nurses to myself as Head of Service and I would have reported through to Heather Trouton and then Ronan Carroll as the Assistant Directors.

25.3 Whilst the day to day running of the Thorndale Unit and Ward 3 South had the aforementioned managers in place, I ultimately had the overall responsibility for this. On a day to day basis, the time that I would have spent sorting issues in respect of Urology varied from a few minutes to a full day. To try to explain the day to day operational issues in which I would have had to become involved in my Head of Service role, I offer the following examples:

a. Ward Manager/Lead Nurse or Patient Flow contacted me about the being short-staffed (particularly on night duty) and, despite their efforts, they couldn't resolve the issue so I would have worked with them going through various options, e.g., ringing all off-duty staff to see if they could come in to cover (even if it was only for a part of the shift), asking the nurse bank to send out additional messages to look for cover for the shift, sending someone home from day-duty if it was before 11am to come back in at midnight, checking with the other Heads of Service across Surgery and Medicine to see if they could help out, and so on. I can confirm that this was a regular occurrence, particularly over the last 6 years when staff started to leave their substantive posts to work with agencies. As the Head of Service, I would never have left work until I had a plan in place for cover.

b. I regularly had to deal with patient flow issues. For example, Patient Flow would regularly want to send up an additional patient to the ward to relieve the Emergency Department and the Ward Manager/Lead Nurse would have contacted me to intervene if they felt that this move compromised patient safety as there was an agreed nurse ratio for the ward and this extra patient(s) would push them over this. I would become involved and work with all the different staff. For example, it may have been that there were patients who were due to be discharged from the ward but would not be going until late afternoon/evening and I would have organised for them to 'sit out' in the waiting room so that their bed space could be used until they went home (reasons for not getting home immediately could have been they were waiting for a lift or waiting for their medication). Alternatively or in addition, I would have met with the urology team member who was the Urologist of the Week to see if there was any other possibility for movement through, perhaps, escalating blood results/diagnostic tests or results. During these times, I would have spent quite a bit of time on the ward working with all the teams (patient flow/ward staff/medical teams) to resolve this type of issue which, during winter periods, would have arisen a few times a week and always needed a solution because it was a patient safety issue.

c. As Head of Service, it was my responsibility to see the 'bigger' picture so, whilst ensuring that Ward 3 South was looking after their patients safely, I also had to keep in mind that the Emergency Department needed the ability/capacity to exist for patients to move on to the wards so that they could see patients safely and/or so that they had spaces to accommodate patients from ambulances. In short, as Head of Service I was responsible for ensuring the patient flow continued safely.

d. From about 2015, during times of bed pressures, I spent large proportions of my time working with Patient Flow and the wards to try to ensure that there were also beds available so that we could bring elective patients in for their surgery. From about October until April every year this was a regular occurrence and it meant that myself and my colleague Amie Nelson, Head of Service for General Surgery, Breast and Endoscopy, would have had to work through theatre lists and agree who could be cancelled (we had criteria to work through, e.g., cancer patients would not be cancelled, urgent patients [e.g., that had a stent in or a confirmed stone in the kidney] would not have been cancelled, and it was usually the routine patients that had their surgery cancelled). We went through the theatre lists and would discuss with the consultant whose lists they were, obtain agreement, and then contact the patients. As this sometimes occurred in evenings or at weekends, I would personally have rung these patients to advise them of their cancellations. I had to work with the consultants and theatres to get dates confirmed to rebook these patients. I would also have let Ward 3 South know so that they would not think that a patient simply hadn't turned up.

e. As Head of Service, I was responsible for ensuring that there was medical cover for the day to day running of the unit. As referenced in this statement and elsewhere, there have been quite a number of times when there were gaps in staffing numbers and this then impacted on the cover out-of-hours. A week from the end of each month I would have done the out-of-hours rota for Urology and ENT, I would have identified any gaps, and I would have sent this to the Medical Locum Team for cover. I always found that, if these hadn't been picked up by the beginning of the month, there would have been an issue covering and I would therefore always have worked at getting a plan in place in advance. During times when we had nearly our full complement

of staff this was no issue but, over the years of my tenure, ensuring sufficient medical cover in the unit would have taken a substantial amount of my time. I would have asked to increase the hourly rate of pay for the medical locums and to readvertise and, whilst I went ahead and did this, I would have copied my Assistant Director (Mrs Trouton or later Mr Carroll) in so that they could reply with an approval. I would have kept a list of all the past registrars so, if the increase in locum rate didn't work, then I would have sent a message to the past registrars. If there was no pick-up from this cohort of staff then I would have contacted the general surgery team to see if they would cover which, during the weekdays, was never a problem but at weekends this didn't work because they were busy within their own specialties. My final escalation on this front was to speak with all of the consultants and they all agreed in principle as it was for the safety of the patient and actually on a few occasions, Mr Haynes and Mr Young acted down into the registrar's post to cover whichever of the consultants was the Urologist of the Week. As with the ward, I would never have left a shift uncovered and without a plan before I went off duty.

f. Serious patient safety issues were always escalated to me from the Ward or main outpatients. This would have been in the form of an initial phone-call, followed up by a Datix. If I was on site, I would have gone to the ward to talk this through with staff. Examples were: doses missed of a critical medication, critical medication going missing, keys of the medicine cabinet going missing, and a patient self-harming on the ward. Regarding the Thorndale Unit over the years, they didn't have serious patient safety issues but would have involved me if, for example, they had a patient that needed admitted from clinic and they couldn't get a bed or if a patient became very unwell in the Unit. This caused a lot of annoyance for the Unit staff as they had to get

immediate help and this would have been escalated to me to help get this actioned.

25.4 These are a few examples to show the sorts of operational issues with which I became involved in respect of running the urology service and the time that this would have taken. Albeit that I had a team doing most of the day to day issues, I still was very 'hands on' in sorting out the operational issues that, on a day to day basis, arose for urology.

25.5 The Lead Nurses during my tenure were:

a. Noleen O'Donnell and Kathleen McGolderick (job share)
b. Gillian Henry mainly but as she had a job share on occasions if she was not available then they would have reported to Dorothy Sharpe.
c. Linda Hamilton
d. Sarah Ward

25.6 From March 2021 the day-to-day management of the Thorndale Unit moved to sit under Outpatients and Joanne Percival is a Band 7 Sister who reports to Josephine Matthews, Lead Nurse.

26. What, if any role did you have in staff performance reviews?

26.1 I can confirm that, for consultants, the staff performance reviews in the form of appraisals were done by the medical staff and I would not have had any input into these.

26.2 I can confirm that, for nursing staff, staff performance reviews in the form of Revalidation and the Knowledge and Skills Personal Development Review form would have been done by the Clinical Nurse Specialists for the Band 5s and Band 2s/3s who worked in the Thorndale Unit; the Clinical Nurse Specialists themselves would have had their staff performance reviews carried out by the Lead Nurse.

26.3 The only member of staff for whom I would have completed their Knowledge and Skills Personal Development Review form was the Departmental Manager Support, Gemma Robinson as Ms Robinson, on agreement, reported to me with regard to her annual, study and yearly objectives.

Document attached namely;

201. *job description ward manager support Thorndale and Outpatients*

202. 20190419 – KSF Gemma Robinson

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

27.1 Firstly Heather Trouton and latterly Ronan Carroll, as my Assistant Directors, would have completed my Knowledge and Skills Personal Development Review form on a yearly basis. These reviews set out agreed objectives for the year for each of my areas along with any training that was required to meet these. They were then discussed in the next year to see if they had been achieved and the reasons (if applicable) if they had not been achieved.

Attached documents namely;

203. 20190601-MC KSF

204. 20170817-MC KSF

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might

explain the level of your involvement in percentage terms, over periods of time, if that assists.

28.1 It is difficult to quantify the percentage of time that I would have spent engaged with the Urology staff. This is because the nature of my role as Head of Service was very operational so on some days I may have spent most of the day sorting urology issues whereas the next day it may have been my other areas (ENT, ophthalmology or outpatients) or I may have spent my time either attending operational meetings with respect to patient flow, performance etc.

28.2 However, and subject to the above caveat, I would say that the Urology Service did take up a larger proportion on my time overall and I set out below some examples of what I was involved in over the years in respect of Urology:

a. Regional Review of (Adult) Urology Services;
b. Away day in October 2009
c. Working with GPS on pathways
d. Establishment of new Thorndale premises
e. Urology Vision
f. Scheduling for theatres and clinics
g. Performance
h. Induction of juniors
i. Projects such as moving from paper-based triage to electronic triage
j. Stone Treatment Project and presentation to Senior Management Team
k. MHPS in respect to Mr O'Brien – this has been detailed further elsewhere in this Section 21 notice response.

Documents attached namely:
205. 20091022- urology away day
206. 20100427- HM700-ltr to Trust Dir Acute re Urology review implementation
207. urology review report 2009
33. minutes of meeting re urology 17 june 2010

164. 20101230 - Action Plan from Urology primary care meeting

165. 20101230 - Action Plan from Urology primary care meeting att1

208. 20110411-GP Pathway presentation

209. 20131017 - notice of thorndale move

210. 20130921 - New Urology accommodation

211. 20130923-E Thorndale Unit

212. 20131013- E Thorndale Urology Move

213. 20131017- E Thorndale Urology move

214. 20140901- The vision for urology services

215. 20140901- the vision for urology services presentation

216. 20190701 - Urology Team Schedule July 2019

217. 20170101 - Urology Team Schedule January 2017

218. 20151201 - Urology Team Schedule December 2015

219. 20151210 - Paed ESWL list

220. 20141212 - Theatre list monday 29 December 2014

221. 20141229 - E start times monday theatres in January

222. 20190219 - urology performance paper

223. 20150520- urology performance paper

224. 20181109 - Urology performance paper

225. 20130930-email - theatre scheduling

226. 20190601 - Specialty induction for urology

227. 20161230 - e-referrals management

228. 20171117 - new referrals paperless

351. 20170329 - E-Triage

47. 20180202- Stone Presentation

229. 20160304-Proposal for ADEPT Management Project

230. 20180214-Stone Centre Quality Improvement Project

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

28.3 Whilst the above outlines specific areas of involvement with the Urology Staff I can also confirm that a significant proportion of my day-to-day

involvement was in respect of the operational issues of managing the service and I have outlined some of these involvements below:

a. Regularly speaking with consultants and their secretaries regarding issues such as missing triage;
b. Seeking information to respond to complaints, MLA/MP queries, or Freedom of Information requests ;
c. Organising cover for clinics;
d. Service improvements (e.g., the way the stone clinic is being run, one-stop clinics, etc.)
e. Discussing, agreeing and submitting requests for training, courses and conferences and then approving leave to attend (e.g. British Association of Urological Surgeons or British Association of Nursing);
f. Discussion of annual or study leave to ensure needs of service are met;
g. Working with and meeting the staff about their agenda for change;
h. Discussions around equipment requests, maintenance programs, etc. (during my tenure I was instrumental on behalf of the team, after discussions/ meetings, in putting in requests and making a case for purchasing / upgrading equipment; examples include Lithotripster (Stone Machine), Video Cystoscopes, urodynamic equipment, Greenlight Laser, Transperineal Biopsy machine, etc.;
i. Discussion on performance issues such a patients breaching and if there is anything that can be done.

   Documents attached namely:

   231. 20171227- MC to JMCM

   232. 20170204 E IPT stent for BenignProstatic Hyperplasia

   233. 20170204 E IPT stent for BenignProstatic Hyperplasia att1

   234. 20170204 E IPT stent for BenignProstatic Hyperplasia att2

   235. 20171117 - E Personal Information redacted by the USi

   236. 20171114- funding for Trust Doctors

   237. 20171028 - E complaints spreadsheet

   238. 20171028 - E complaints spreadsheet a1

   239. 20171028 - E complaints spreadsheet a2

240. 20171028 - E complaints spreadsheet a3

241. 20171028 - E complaints spreadsheet a4

242. 20171028 - E complaints spreadsheet a5

243. 20171028 - E complaints spreadsheet a6

244. 20171028 - E complaints spreadsheet a7

245. 20171028 - E complaints spreadsheet a8

246. 20171028 - E complaints spreadsheet a9

247. 20171028 - E complaints spreadsheet a10

248. 20140321 E staffing in Thorndale Unit

249. 20140328-EUrology BC

250. 20140328-EUrology BC a1

251. 20140407 - E Mr O'Brien Triage

252. 20140407 - E Mr O'Brien Triage a1

253. 20140407 - E Mr O'Brien Triage a2

254. 20140414 - BP Monitor for Thorndale Unit

255. 20150325 - urology PTL's

256. 20150325 - urology PTL's a1

257. 20190602 - E AFC KoN

258. 20190602 - E AFC KoN a1

259. 20190602 - E AFC KoN a2

260. 20190602 - E AFC KoN a3

261. 20190602 - E AFC KoN a4

262. 20190602 - E AFC KoN a5

263. 20190602 - E AFC JMcM

264. 20190602 - E AFC JMcM a1

265. 20190602 - E AFC JMcM a2

266. 20190602 - E AFC JMcM a3

267. 20190602 - E AFC JMcM a4

268. 20170310 green light laser

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

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

29.1 Please see details below. I have also included samples of notes/minutes from these meetings.

Title of Meeting	Frequency	Length of meeting
Departmental Meeting	Weekly	1 hour
Meeting with lead clinician	Weekly	30 minutes
Urology Scheduling Meeting	Every 4th week	1 hour
Patient Safety Meetings	Bi-monthly	1 hour
Sisters Meetings	Fortnightly	1 hour
One to One meetings with Lead Nurses	Bi-monthly	1 hour
Operational adhoc meetings	As and when required	Dependent on topic
Regional meetings such as Urology Professionals Issue Group	Quarterly	2 hours

Documents attached namely:

269. 20191212 - Urology Elective Care Meeting

270. 20191212 - Urology Elective Care Meeting a1

271. 20150415- Urology Regional Workshop presentation

272. 20160922 - Urology Departmental meeting

273. 20150723 - Urology Departmental meeting agenda

274. 20151008- urology departmental meeting agenda

275. 20191219 quarterly sisters meeting

276. 20191219 quarterly sisters meeting a1

277. 20150626 - Urology Planning and Implementation Group

278. 20151111 - Urology Planning and Implementation Group

279. 20150714 - urology and implementation planning group

280. 20190724 - 1 to1 sarah ward

281. 20180418 1to 1 josie Matthews

282. 20180418 1to 1 josie matthews a1

283. 20180418 1to 1 josie matthews a2

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

Patient Safety Meetings notes can be located in Relevant to Acute – Document Number 27.

30. 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.

30.1 In my opinion, from my knowledge of and work with the Urology Team for the past 13 years and 9 months, and with the exception of Mr O'Brien, the Team did, and indeed continues to, work well with the medical and professional managers.

30.2 For my own managerial role as Head of Service I can confirm that it is my understanding that all of the Urology Team respected and worked well with me. Below are a few examples of this and I can confirm that, over the years, we did build up good working relationships.

30.3 Examples of working well together:

a. All of the Team (Consultants, non-consultant grades, registrars, clinical nurse specialists and secretaries) knew that I had an 'open door' policy and they would have been regular visitors to my office to discuss issues or just for a general catch-up. In my opinion, these ad hoc and informal meetings often achieved more than formal meetings and I felt we all had a mutual respect for each other and that we were able to work through operational issues, e.g., if someone was off due to sick leave, etc.

b. My experience was that I could go to any member of the team if I needed assistance. Examples included: in times of bed pressures I would speak

with most of the consultants who were on-call and they would do an additional ward round or go and request further tests to assist with the patient flow, or they would attend the Emergency Department to assess urology patients to see if they could be 'turned around' without needing to be admitted. I can confirm that this was the case for all consultants with the exception of Mr O'Brien who, whilst he was pleasant and polite the majority of times, would not have agreed to do an additional ward round as his view would have been that, if they were still in the ward, they needed to remain there. My personal opinion was this was frustrating as the bigger picture (that all of the others understood) was that, if someone could go home from the ward, then this freed up a bed for a patient who was waiting admission from the Emergency Department. So, when he would have been the consultant on-call I would not have approached him for assistance.

c. At any time I could approach any of the Team, apart from Mr O'Brien, to discuss any issues in relation to performance and they would have helped me out if they could, for example, adding an extra patient to a clinic, taking a look at notes to see if a patient needed seen urgently if, for example, there had been an informal query from a patient or via an MLA/MP, etc.

Mr O'Brien

30.4 For the purpose of completeness I would like to clarify my working relationship with Mr O'Brien and then outline examples as to why I felt that he didn't appear to have a good working relationship with medical and professional managers.

30.5 At my first introduction to Mr O'Brien on 28 September 2009, after he had greeted me he asked me *what exactly I would be doing and was I yet another manager/administrator who would be 'chasing' the team for information and how exactly did I propose to head up their urology service?* As I was new, and at that stage unfamiliar with what my role would entail, I wasn't able to

respond and I will admit I was quite taken aback as this was my first time meeting the urologists; I should add that both Mr Young and Mr Akhtar were very pleasant and welcomed me to the team.

30.6 After this unsure start with Mr O'Brien, I did manage to build a reasonable working relationship with him. But early on in my tenure I learnt that he was very opinionated and, in my personal view, arrogant, and it was always to be his way or no way. As mentioned above, I learnt early on not to ask for assistance with seeing extra patients or asking him to see if there were any patients suitable to be discharged sooner from the ward as, once I asked, I would always have got a lecture as to how this would be detrimental to other patients and that I, as a non-clinical person in the team, would not understand.

30.7 However, as part of my role it was my responsibility to hold him to account for issues that he was not adhering to, for example, non-triage, scheduling patients out of chronological order, and categorising his own patients using his own clinical priority rather than the recognised way, so that when I asked about chronological management I would get the lecture on how the Trust should not have done away with the 1-4 category and moved to Routine, Urgent and Red Flag, and that he would continue to do it his way as his belief was that he was correct and the system was wrong.

30.8 Behind all of this I knew that he believed that this was what was right for his patients and I also learnt, early on, that there was no backing down by him when he believed that he was correct and it was the system that was wrong, even when there was evidence as to why it was being done that way.

Documents attached namely:

284. 20190206 - patients awaiting results aob

285. 20190207 - patients awaiting results MH KR

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

30.9 I can confirm that the above observations were also applicable to Mr O'Brien's interactions with other medical and professional managers who would have challenged his work methods, in particular, the Directors of Acute, Medical

Directors and Associate Medical Directors. They were not unique to me. During the Review of (Adult) Urology services I can confirm that the weekly Monday evening meetings could become quite fractious as the Department of Health were trying to get the Trust to agree to clinic activity. Mr O'Brien would not agree to the BAUS guidelines of 20 minutes for a new patient and 10 minutes for a review patient (this had been accepted in the other two Urology 'Teams' in Northern Ireland) and, whilst agreement was eventually reached, Mr O'Brien was in the minority as he wouldn't sign up to this activity and would quote this back to me over the years.

30.10 Mr O'Brien was very aggrieved with the Review of Urology Services (2009), particularly the removal of radical pelvic surgery from Craigavon Hospital and it was his view, and he said it on a few occasions, that patients had died as a result of this decision. Mr O'Brien would have openly said that Mark Fordham (external author of the paper) should never have been allowed to be involved in suggesting this recommendation.

30.11 Mr O'Brien didn't hide the fact that he didn't work well with Dr Rankin and Mr Mackle. Both of these managers tried to manage him through the IV fluids and antibiotic review, through radical pelvic surgery moving to Belfast, and through his continuous non-compliance to triaging the new outpatients. Dr Rankin and Mr Mackle would have persevered in holding Mr O'Brien to account which, in my opinion, Mr O'Brien didn't like as he was used to 'doing it his own way'.

30.12 Mr O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices.

30.13 I have an awareness of at least two occasions where managers had been asked to step back from managing Mr O'Brien. In approximately 2011/2012 Mr Mackle had been advised that he was being accused of bullying

and harassment towards Mr O'Brien and that he needed to step back from managing him. I was not present when Mr Mackle was told this but he came straight to me after this happened, told me about it, and was visibly annoyed and shaken and said to me that he would no longer be able to manage Mr O'Brien. I also understand that, in mid-2016, Mrs Gishkori received a phone call from the then Chair of the Trust, Mrs Brownlee, and was requested to stop an investigation into Mr O'Brien's practice. Once again, I did not witness this but I was told later by Mr Carroll that it happened as my understanding is that Mrs Gishkori had told some of her team.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1 My role in governance for all my areas was to promote and ensure that there was high quality and effective care offered to all patients and to ensure that services were maintained at safe and effective levels. I can confirm that I didn't have a direct management role regarding the consultants and other clinicians in the Thorndale Unit.

32. 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?

32.1 The Director of Acute Services had overall responsibility for the governance arrangements in the Urology Service. During my tenure the Directors were:

a. Dr Gillian Rankin;
b. Mrs Debbie Burns - supported by Dr Tracey Boyce (Director of Pharmacy);
c. Mrs Esther Gishkori – supported by Dr Tracey Boyce (Director of Pharmacy);

d. Mrs Melanie McClements.

32.2 The Directors are supported in these clinical governance arrangements by the Assistant Directors for Surgery and Elective Care who during my tenure were:

a. Mrs Heather Trouton (2009-2016);
b. Mr Ronan Carroll (2016-2021).

32.3 The Assistant Directors are then supported in their clinical governance role by the Associate Medical Directors (now known as Divisional Medical Directors) who during my tenure were:

a. Mr Eamon Mackle (2009-2016);
b. Dr Charlie McAlister (April 2016-October 2016);
c. Mr Mark Haynes (1 October 2017- current).

32.4 My role in this, as Head of Service, was to investigate any Datix that was raised and, if appropriate, share the learning. I also investigated any complaints and again, if appropriate, shared the learning. To ensure that this was being done appropriately if there was anything that needed discussion with the teams I would have disseminated this via email or had it added to a departmental meeting agenda for discussion.

Attached documents namely;

286. 20151015 - datix concern

287. 20160701 - datix investigation

288. 20160701 - datix investigation att1

289. 20160526 datix investigation

290. 20160518 datix follow-up

291. 20160207 - results follow-up

292. 20160720 - follow-up from a datix

293. 20160720 - follow-up from a datix att1

294. 20160720 - follow-up from a datix att2

295. 20160720 - follow-up from a datix att3

296. 20160720 - follow-up from a datix att4

297. 20160720 - follow-up from a datix att5

298. 20160720 - follow-up from a datix att6

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

33. **How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?**

33.1 Both of my Assistant Directors (Mrs Trouton and Mr Carroll) would have held a team governance meeting once per month. At these meetings all issues relating to governance were discussed in the form of complaints received, Datix raised, SAIs, discussion from the learning/ recommendations of the SAIs, and quality indicators such as any audits that had been undertaken or patient satisfaction surveys. At this monthly team meeting, which was for all of the surgical specialties, each Head of Service for their respective areas was expected to update on any issues and provide timescales for completion. If applicable to my areas, then I would have shared this with the teams either via email or at our departmental meetings.

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1 Performance metrics in urology were managed by me as Head of Service and I was accountable to the Assistant Director who in turn was accountable to the Director of Acute Services who held monthly Acute Performance meetings which reported to the Senior Management Team Performance Meeting. There were also performance meetings held with the Health and Social Care Board and Department of Health.

34.2 Both of my Assistant Directors (Mrs Trouton and Mr Carroll) would have held a team performance meeting once per month and at these meetings

performance for the surgical specialties was discussed. There was also a monthly cancer meeting which discussed the cancer performance and, at both of these meetings, I as Head of Service was accountable for explaining and advising on the performance in my specialties.

34.3 Cancer performance metrics included 31-day and 62-day pathway adherence, and I would have had to provide explanations as to why there were delays in meeting these targets and assist with the completion of the relevant 'breach reports'. The monthly team performance meeting metrics included: waiting times for outpatients (new and review), inpatients and day case waiting times, and waiting times for urodynamics. This information was shared with my teams at our departmental meetings.

Documents relating to Cancer Performance can be located in Folder Relevant to Acute Document Number 14 – Monthly Cancer Performance

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

35.1 Complaints, reopened complaints, ombudsman investigations, reporting of clinical incidents through the Datix system, issues or concerns raised by staff regarding patient risk and safety were all mechanisms which I used to assure myself regarding patient risk and safety.

35.2 All of the above mechanisms are time-targeted for response and are escalated first to Head of Service, then to Assistant Director, and finally to Director of Acute Services to ensure that they are responded to appropriately. Learning and/or recommendations from complaints / IR1s / SAIs / ombudsman investigations are shared with the teams through patient safety meetings so as to ensure that the issues highlighted do not happen again.

Documents relating to learning and recommendations can be located in folder Relevant to Acute Document Number 2 m and Document No 39 SEC Urology Patient Safety MM Notes

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

36.1 Issues of concern relating to urology services could be brought to my attention through the following methods:

a. Complaints received from patients;
b. Complaints received via local MLA/MPs;
c. Via the Trust's Patient Support Service;
d. Via Patient Client Council;
e. Datix completed by staff;
f. From patient safety meetings;
g. Through team/staff meetings;
h. Reports from the Booking Centre on outpatient performance
i. Monthly backlog reports provided by Service Administrators
j. Through one-one staff meetings;
k. Patient satisfaction surveys;
l. Serious Adverse Incidents;
m. Whistle blowing;
n. Leadership walks by senior staff

Documents attached namely;

138. 20130719-E demand capacity for access target
139. 20130719-E demand capacity for access target a1
140. 20130719-E demand capacity for access target a2
141. 20130719-E demand capacity for access target a3
142. 20130719-E demand capacity for access target a4
143. 20120312-E Demand Capacity Triage Urgents
144. 20120312-E Demand Capacity Triage Urgents a1
145. 20120312-E Demand Capacity Triage Urgents a2

146. 20120312-E Demand Capacity Triage Urgents a3

147. 20120312-E Demand Capacity Triage Urgents a4

299. 20190502 - Backlog report

300. 20190502 - Backlog report a1

34. 20111102- leadership walk

35. 20180305 - leadership walk

36. 20120523 - leadership walk

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

36.2 Systems and processes in place are as follows:

a. Complaints from patients/MLAs/MPs/Patient Supports/Patient Client Council are all responded to. All of these responses are approved by Head of Service, then by Assistant Director, and finally by the Director of Acute Services, so in my opinion any learning, issues or concerns emanating from this process will have had lots of opportunity to be captured.
b. Weekly screening meetings consider any Datix that appears to be of a high risk and, as this is a multi-disciplinary meeting, there are staff from a number of clinical areas that can have an opinion on any concerns and then, if there are any concerns and they meet the threshold for a Serious Adverse Incident, this is an efficient way to work through these concerns. (To note: I am not a member of this screening group and decisions which come from this have never been shared with me).
c. Patient Safety meetings / Morbidity and Mortality meetings / team staff meetings give everyone the opportunity to hear and discuss any concerns or issues.
d. Investigation and reports of Serious Adverse Incidents. (To note: I have never been required to sit on an SAI panel).

36.3 A fault with all of the above systems is that the majority of these are dependent on human factors and on ensuring, in several cases, that staff report verbally or in writing any concerns they have. If staff do not do this then it is

difficult for us, as managers, to know what these risks and concerns are. I know that in this regard the Trust, including myself, have been working at promoting an open and honest culture where staff feel comfortable raising their concerns and also knowing that, if they do, they will be protected and the Trust have done this through promoting the whistleblowing policies.

Document relating to Whistleblowing can be located in Relevant to HR Reference no 2i - Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

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

37.1 I can confirm that the below systems and processes were introduced during my tenure (i.e., the systems and processes I have mentioned at Question 36 were not all in place throughout my tenure and some amounted to new measures);

a. Reports from the Booking Centre on outpatient performance - Dr Rankin introduced these reports and weekly meetings (to provide assurance on demand, capacity and that triage was up to date) were held between the Head of Service and the Head of the Acute Booking Centre;
b. Monthly backlog reports provided by Service Administrators – These were introduced by Mrs Anita Carroll in approximately January 2017 as part of assurance that secretaries' workloads for their consultants were monitored for any backlogs;
c. Whistleblowing (promoted by the Trust to allow the culture of openness and honesty);
d. Leadership walks introduced by the Trust Board and, to my knowledge, to allow Non-Executive Directors to meet with staff and find out their issues to see if they could resolve them and to listen to their concerns if they had any.

Documents attached namely;

138. 20130719-E demand capacity for access target

139. 20130719-E demand capacity for access target a1
140. 20130719-E demand capacity for access target a2
141. 20130719-E demand capacity for access target a3
142. 20130719-E demand capacity for access target a4
143. 20120312-E Demand Capacity Triage Urgents
144. 20120312-E Demand Capacity Triage Urgents a1
145. 20120312-E Demand Capacity Triage Urgents a2
146. 20120312-E Demand Capacity Triage Urgents a3
147. 20120312-E Demand Capacity Triage Urgents a4
299. 20190502 - Backlog report
300. 20190502 - Backlog report a1
34. 20111102- leadership walk
35. 20180305 - leadership walk
36. 20120523 - leadership walk
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments.

Document relating to Whistleblowing can be located in Relevant to HR Reference no 2i - Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

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

38.1 I have always managed with an open door style and I worked hard at building up relationships and trust with all the urology staff over the years. So, it was through this that I depended on them letting me know of their concerns generally within the urology team. Some examples of this are as follows:

a. Sr O'Neill, Clinical Nurse Specialist, came to see me about her concerns regarding Personal Information redacted by the USI and I advised her to speak with Mr Young and I told her I would raise it with Mr Mackle.

b. Sr O'Neill, Clinical Nurse Specialist, came to speak with me and bring me examples of her concerns regarding Personal Information redacted by the USI, locum urologist, which I immediately brought to the attention of Mr Haynes as AMD for Urology.
c. Mr Haynes approached me regarding the team's concerns with respect to Mr Personal Information redacted by the USI and his clinical ability and we raised this with Mr Mackle and a meeting took place.
d. Mr O'Donoghue came to see me to discuss Mr O'Brien's attitude towards him at meetings and said he felt that Mr O'Brien undermined him which made working with him very difficult. I asked him if he needed me to do anything about this but he said at that time he just needed to 'vent' and that he would deal with this himself, however, I did advise him to speak with one of his other consultant colleagues about the issue.
e. During my tenure the ward sisters from Ward 3 South (Sr Magill/Sr Hunter/Charge Nurse Patrick Sheridan/Sr Caddell) would have come to see me in my office regarding their concerns about the levels of staff on the ward and their concern that it wasn't safe. On these occasions, I would have discussed the issue with their Lead Nurse and we would have worked at securing staffing from other areas. If we had been unsuccessful, then we would have spoken with Mr Carroll to assist with a solution.

38.2 During my tenure I would have been involved in responding to patient complaints, patient support queries, MLA and MP enquiries, and so on which meant I was aware of any areas of concern. I also would have attended any meetings with families who had raised a complaint and then I would have fed back any learning to my teams. As I was copied into all IR1s from the Datix system, I would always have read these and, if there were any concerns, acted on them immediately; for example, in the case of a fall of a patient in Ward 3 South who had come to harm, I would have contacted the Ward to find out details; or in the case of a medication incident, again I would have investigated this so that I was appraised of what the problem was.

39. 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?

39.1 I refer back to my response to question 38 in that I had a stable working relationship and trust with the urology team and I trusted that any issues would be escalated to me as they arose, either confidentially directly to me or during a team or patient safety meeting. It was in my experience of the systems and processes mentioned in paragraphs 36.1 and 36.2 above (in response to question 36) that I have evidence that issues were brought to me through these systems and processes which were then addressed through the mechanisms mentioned in paragraph 36.2.

39.2 I confirm that I did not have any concerns that governance issues were not being identified, addressed and escalated as necessary. My reasons for stating this is that, over the years, staff did escalate concerns or issues they had regarding governance issues and we addressed these immediately:

39.3 Examples include:

a. Personal Information redacted by the USI – issues with clinical ability (raised by Clinical Nurse Specialist);
b. Personal Information redacted by the USI – issues with attitude towards staff and refusing to see patients (clinical nurse specialist in the first instance and then Mr Young);
c. Personal Information redacted by the USI – issue with ability for some surgical procedures and hence his ability to carry out on-call duties on his own (raised by one of his colleagues);
d. Personal Information redacted by the USI – attitude towards colleagues (raised by myself);
e. Personal Information redacted by the USI - clinical ability (raised by Clinical Nurse Specialists).

40. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

40.1 Any concerns raised or identified about the Urology Service were escalated to Assistant Director and Director of Acute Services. They would, where appropriate, have added these to the risk registers and any governance documents that this referred to would have been included in the monthly Acute Governance meeting which was chaired by Director of Acute Services and attended by Assistant Directors and Associate Medical Directors. I did not attend these meetings but I can give an example where, due to the accommodation issue highlighted for the Urology Outpatients, we were unable to complete the project due to not being able to relocate the blood room and this risked us losing funding if not spent before the end of year. We raised this as a risk and this was added to the divisional risk register.

Documents can be found namely:
301. 2008 to 2021 Acute Directorate Risk Register
302. 2008-2022 - Divisional SEC Risk Register
303. 20120911 corporate risk register
304. 20151217 - Confidential Meeting Personal Information redacted by the USI
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

41.1 All information regarding a patient and their attendances are captured on the following systems (in brackets after each one I indicate when I believe it came into being):

a. PAS - Patient Administrative System which includes patient demographics, health and care number, and attendances are recorded

for outpatients/ day cases/inpatients and for urology urodynamics (in place when I took up post).

b. EEMs – Emergency attendances (introduced in approx. 2012).
c. SECTRA - Radiology attendances which includes images of any scans (in place when I took up post).
d. TMS – Theatre Management System – captures all procedures carried out in theatre both electively and as an emergency (in place when I took up post).
e. CaPPS – Cancer Patient Pathway System (introduced in approx. 2013).
f. Labs – For ordering and viewing laboratory results (in place when I took up post).
g. NIECR - Northern Ireland Electronic Care Record – This was introduced in so that all patients in Northern Ireland would have their patient records held in one place which could be accessed electronically by health care staff (Primary and Secondary care). The electronic care records have details such as letters relating to inpatient/day case attendances, outpatient clinic letters, GP referral letters, medication records, attendances at emergency departments, attendances at outpatient clinics, radiology (including images), laboratory results, records of multi-disciplinary meetings and outcomes from Patient Safety Morbidity and Mortality meetings (introduced in approx. 2015).

41.2 I can confirm that, to the best of my knowledge and belief, none of the above systems did help identify the concerns with which I believe the Inquiry is concerned. I have reflected whether they could have done and, based on the knowledge I currently have, I am doubtful in this regard. I understand them all to be data collection and storage tools from which reports cannot easily be run. They will give 'raw' data and I believe that you would need to be looking for something specific to discover a problem. For example, CaPPs includes details of the cancer patient's journey so unless you were interrogating it to see if there had been inappropriate delay in respect of a particular patient, it would not highlight concerns.

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

42.1 Each of the above systems are efficient in the data they collect, however, in my opinion they are all 'stand alone' and do not interface which each other and therefore, whilst efficient, it is my belief that, overall, this is not an effective way to collect and retain patient data. The NIECR goes some of the way to allowing access to all of the information held on a patient but systems such as CaPPs, TMS and EEMs are not available on NIECR. It is anticipated that the ENCOMPASS project, when implemented, will allow for this interface and therefore all data will be in one place. Apart from new versions of these programmes and the introduction of NIECR in 2014/2015 I am not aware of any changes to these systems in my tenure.

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

43.1 I can confirm that setting performance objectives for consultant medical staff and for specialty teams was not part of my role as Head of Service. This task was undertaken by medical staff. However I can confirm that I was broadly aware that performance objectives were discussed and agreed but, not being involved in setting these objectives, I am not sure if the objectives that they set were realistic, measurable and delivered within the time specified. In my opinion, I do believe the operational teams (Assistant Directors and Heads of Service) should have been involved in this process as they are best placed to advise on the needs of the service.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

44.1 As I was not involved in job planning and appraisal I am unable to respond to this question. However, I can confirm I was aware of what was agreed in job plans as I would have had to set up clinics/secure accommodation and staff for these clinics and work with the Theatre Head of Service in identifying theatre sessions. As with the performance objectives, it is my opinion that the operational teams (Assistant Directors and Heads of Service) should have been involved as they were responsible for delivery of the service/activity and targets.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 I can confirm that the process involved when a concern was identified, was that the member of the team (including myself) would report the concern in the first instance to their line manager so, for example, the Clinical Nurse Specialists would have raised this with their Lead Nurse or me; the consultant would have raised it with their Clinical Director, Associate Medical Director or me as Head of Service. This could have been done verbally in writing via an email or via an IR1 on the Datix system. Once the concern was raised it would have been investigated by the appropriate team. For example, if the concern was about clinical ability this would have been investigated by the Clinical Lead/Clinical Director and or the Associate Medical Director. If it was deemed a serious issue then it would have been discussed with the Medical Director

and a decision made if this needed to be reported to the General Medical Council. Notes, minutes, and replies to Datix would all have been completed. If the outcome was dismissal then this would have been notified to Medical HR. If it was an issue of clinical ability and an action plan put in place then this was monitored by the most appropriate member of staff. If the issue was concerning how the member of staff interacted with other staff – e.g., they were rude, dismissive or didn't communicate properly/appropriately with individuals or teams - then it would normally have been the Head of Service who dealt with this issue by meeting with them and discussing the perceived problem.

45.2 I have detailed below concerns that were escalated on the clinical ability of the following staff:

a. Personal Information redacted by the USI – Issues with Personal Information redacted by the USI clinical ability were raised by staff in the Thorndale Unit and from the Ward staff to me as Head of Service. I, in turn, escalated this with Mr Brown (Clinical Director) and Mr Mackle (AMD) (and included Zoe Parkes from Medical Staffing in my correspondence). I am aware that this was escalated and dealt with by Dr Simpson, Medical Director, and I am also aware (although I was not involved directly) that this doctor was referred to the GMC.
Documents attached namely:
305. 20120315 E Staff grade urology
306. 20120322 E statement Personal Information redacted by the USI
307. 20120322 E statement Personal Information redacted by the USI
308. 20120621 - E Personal Information redacted by the USI
309. 20120621 - E Personal Information redacted by the USI *ZP*
310. 20120621 - E Personal Information redacted by the USI Patient 99
311. 20120618 - E Personal Information redacted by the USI
and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Personal Information redacted by the USI – Issues with Personal Information redacted by the USI attitude towards staff and with refusal to see patients were raised by a Clinical Nurse Specialist

in the first instance to myself. I escalated this to Mr Young (Clinical Lead) who asked Personal Information redacted by the USI to meet him in his office to discuss. Mr Young had no choice but to terminate his contract.

Document attached namely:

312. 20130126 - my ltr re Personal Information redacted by the USI

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

c. Personal Information redacted by the USI – An issue with lack of decision making and questions over ability on some surgical procedures (and hence his ability to carry out on-call work on his own) were raised by one of his colleagues and escalated to Mr Mackle, AMD, who met with the consultants and agreed a plan on how to support Personal Information redacted by the USI and ensure that patient safety was secure when he was on-call. A number of meetings took place and the consultant team agreed to do second on-call and be available should he need them; they also agreed to mentor and support him. Mr Mackle and I met with Personal Information redacted by the USI in April 2015 and advised him of the plan that had been put in place; he was appreciative and he did his own action plan on how he would work with his colleagues to ensure patient safety.

Documents attached namely;

304. 20151217 - Confidential Meeting Personal Information redacted by the USI

313. 20160417 Personal Information redacted by the USI *courses*

314. 20160418-E Personal Information redacted by the USI *action plan*

315. 2016 mar and apr - Personal Information redacted by the USI

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

d. Personal Information redacted by the USI – His attitude towards colleagues, including myself, was raised by me with Mr Haynes. Mr Haynes supported me with the issues of Personal Information redacted by the USI disagreeing about time allocated for admin sessions, with his contract, and with hours of pay. We tried to compromise with him but he ended up terminating his contract and we were in agreement with this.

Documents attached namely;

316. 20190829 [redacted] *resign*

317. 20190818 - [redacted] *timesheet*

318. 20190818 - [redacted] *different booking confirmations*

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

e. [redacted] – His clinical ability was raised by Clinical Nurse Specialists to Mr Haynes. Mr Haynes spoke to me and I got some clinical letters and shared them with Mr Haynes. It was agreed that, due to patient safety concerns, his employment needed to be terminated and Mr Haynes and I met with him and asked him to leave immediately. Mr Haynes reported him via our Human Resources team to his agency and his Responsible Officer.

Documents attached namely;

195. 20210521 - E re [redacted]

196. 20210521 - E re [redacted]

197. 20210521 - E re [redacted]

198. 20210521 - E re [redacted]

199. 20210521 - E re [redacted]

And can be located in folder – Martina Corrigan – no 24 of 2022 - attachments

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

46.1 I confirm that I have always felt supported by, and I believe I have always had a good working relationship with, the medical line management hierarchy. To help with my response, I want to expand on who I mean from this management hierarchy:

a. Mr Eamon Mackle – Associate Medical Director (Surgery and Elective Care)
b. Dr Charlie McAlister – Associate Medical Director (Anaesthetics)
c. Dr Damian Scullion – Associate Medical Director (Anaesthetics)
d. Mr Mark Haynes – Clinical Director and Associate Medical Director (Surgery and Elective Care)
e. Mr Sam Hall – Clinical Director (ENT and Urology)
f. Mr Colin Weir – Clinical Director (General Surgery, ENT and Urology)
g. Mr Ted McNaboe – Clinical Director (ENT and Urology)
h. Mr Michael Young – Clinical Lead (Urology)
i. Dr Shahid Tariq – Associate Medical Director (Cancer Services)
j. Mr David McCaul – Clinical Director (Cancer Services)
k. Dr Maria O'Kane – Medical Director.

46.2 Examples of how I felt supported are set out below. The majority of my examples of supportive behaviour are not evidenced in documents as many involve instances where I would either have went to speak face to face with the relevant medical line management person or telephoned them. I can confirm that, in my experience, they were always helpful, inclusive and supportive and gave me advice and direction when required. For example, questions on how many patients should be on a clinic (this may have been when a consultant was looking to reduce the clinic). The above always made me feel that they valued my opinion and they would, on numerous occasions, have come to me to ask what I thought and how best to handle, for example, Mr O'Brien when he wasn't triaging. They made me feel part of the clinical management team even though I am not clinical. Every one of them was approachable and helpful if I had a clinical query that I needed assistance with.

46.3 Detailed examples are as follows:

a. During the implementation of the recommendations from the Review of Urology Services in 2009, when we couldn't get the

urology team to agree to clinic templates, Mr Mackle was very supportive and assisted me in getting an agreement of 14 patients. Mr Mackle contacted some of his colleagues in England and got us some contacts from the British Association of Urological Surgeons, who in turn spoke to Mr Akhtar and therefore led to the Trust getting an agreement on the templates.

b. Mr Mackle was always contactable when I required assistance with any urology clinical issues, for example, escalation of triage over the years, assistance with the clinical aspect of a response to complaints, and he would have worked through medication issues that had been raised from the ward by an IR1 on the Datix system and helped me to investigate and close these off.

c. Mr Young and I worked very well over my tenure and I always found that he was supportive and flexible. For example, if I was having difficulty in getting the on-call out of hours rota covered and I had run out of options I always could have contacted him and he would have worked with me on getting it sorted; for example, there were a few weekends where he agreed to act-down into the registrar's post so that there was two-tier cover available for urology as he wouldn't compromise patient safety.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you liaised with, involved, and had meetings with the following staff (please name the individual/s who held each role during your tenure):

(i) The Chief Executive(s);

(ii) the Medical Director(s);

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

(iv) the Assistant Director(s);

(v) the Clinical Director

(vi) The Associate Medical Director;

(vii) the Clinical Lead;

(viii) The consultant urologists.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

47.1 As there is a lot of information to provide in respect of this answer, I have set it out in table format in an attempt to make it easier to digest *document attached namely 319. 20220706- section 21 Notice 24 response to Question 47 And can be located in folder – Martina Corrigan – no 24 of 2022 - attachments*

48. Following the inception of the Urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? without prejudice to the generality of this request, please address the following specific matters:-

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known? Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(c) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

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

(e) If you were given assurances by others, how did you test those assurances?

(f) Were the systems and agreements put in place to rectify the problems within urology services successful?

(g) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

48.1 Concerns raised in respect of urology services were as follows:

48.2 Performance issues – demand was greater than capacity.

(a) Since I took up post in September 2009 until I left in June 2021 (and I am aware that this is still an issue) there has been a concern that the urology service is unable to meet the demand for the patients within its service. This has been raised and was recognised by myself as Head of Service, consultant Urologists, Clinical Nurse Specialists, Assistant Directors, Directors of Acute Service and Performance and Reform, Chief Executives and patients themselves.

(b) In my opinion I consider the performance issues to have impacted on patient care and I continued throughout my tenure to consult and work with all of the Urology Services Team to come up with plans to mitigate this risk. Those plans have included the following. Continuous monitoring and planning has been done collaboratively with the Senior Management Teams and members of the service and any ideas for helping to alleviate this problem have been embraced and worked through. Examples are a change in the way clinics were held (one-stop service), changing the way service was delivered (stone treatment), changing roles (Clinical Nurse Specialists carrying out roles that had previously been done by medical staff etc.), exploring the use of the Independent Sector to see patients, securing funding to allow for additional sessions outside of core hours working with GPs on pathways working with other Trusts to try and establish best practice that could be shared (NICAN/Urology Clinical Regional Cancer Group, Urology Professional Issues Group), and validating waiting lists to determine whether all patients still needed an appointment/procedure.

The following documents are attached namely;
320. 20130515 - IS Service Specification for provision of urodynamics
321. 20120504 - IS Urology Specification
33. minutes of meeting re urology 17 june 2010
277. 20150626 - Urology Planning and Implementation Group
48. 20150626- Urology PIG Actions
49. 20190911 - E invite to PIG meeting
50. 20190911 - E invite to PIG meeting a1
51. 20190911 - E invite to PIG meeting a2
149. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog
150. 20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog a1
151. 20101230- E-action plan from urology primary care meeting
152. 20101230- E-action plan from urology primary care meeting a1

166. 20110407- GP pathways presentation

167. 20111211- Pathways for Erne and DHH

168. 20110901-Retention of Urine pathway

169. 20110911-vasectomy pathway

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

Document 20160301 - Final NICaN Urology Cancer Clinical Guidelines can be located in Relevant to Acute – Document Number 20

(c) Systems and agreements put in place included continuous monitoring (on a weekly basis), implementing initiatives such as validation, sending to independent sector, organising additional clinics, and then monitoring these initiatives to see if they were making a positive impact. The monitoring was done by the Operational Service Leads along with the Heads of Services and the results were discussed with the consultant and nursing teams.

(d) I assured myself by weekly monitoring and then presenting the data at the weekly performance meetings and also sharing with the consultant and nursing teams.

(e) The assurances were by Operational Service Lead and myself and we tested these by proof of an improvement in performance.

(f) Sending patients to the Independent Sector was not successful for a number of reasons. Firstly, because of the nature of urology patients there were large numbers who were not suitable to be transferred out. Secondly, for those who were suitable it was found that, whilst they independent sector could do the initial consultation and diagnostics such as flexible cystoscopy or radiology tests, there were a number of tests and follow-up that the independent sector could not do and this therefore meant that the patients needed to come back to the Trust for these tests or procedures, which led to the patients being added back onto waiting lists and therefore this initiative was deemed unsuccessful and meant that it added to the

consultants' workloads as, once the patients came back to the Trust, it was up to them to add them to waiting lists or organise the further tests.

Documents attached namely:
322. 20130701 Email pt returned from IS
323. 20130227 pt complaint from IS
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

(g) The validation exercise, whilst it assured the Trust that patients were appropriately on the waiting lists (and were still alive and not on more than one list for the same procedure) actually didn't make an impact on the total numbers as the majority of patients, when contacted, confirmed that they wished to remain on the waiting list for their appointment/procedure. The consultants also were not happy with this validation exercise as they felt that some patients who it was deemed needed a procedure were saying to take them off the waiting list and they therefore felt that this was an unsafe method of controlling waiting lists and, as a result of this, we ceased the validation exercise.

(h) The additional clinics and theatre sessions did help but because of the volumes didn't make a significant enough impact. And whilst funding was available to continue this exercise, it needs to be recognised that this measure uses the same staff who were working full-time already and they therefore soon became tired of working extra sessions every week/weekend.

(i) The final point to make about this is that, whilst we continue to monitor and put plans in place to address the performance issues the demand continues to grow and we had all of the issues regarding recruitment that have been highlighted in questions 16 and question 17 above and therefore still have the reduced capacity.

<u>48.29 Conclusion re performance / demand being greater than capacity</u>

To summarise: in my opinion, I do not think that the processes put in place to address the performance / demand exceeding capacity issues were successful and, to quantify and confirm this, we can see a steady increase in the times that patients are continuing to wait to see the consultant urologists and/or clinical nurse specialists. But we do continue to monitor individually each consultant's waiting times and how many are on each of their waiting lists and we also monitor actual activity for each of the consultants.

48.3 Outpatient accommodation issues

(a) The Thorndale Unit was based at the back of the hospital in a modular building that was not linked to the hospital. The Consultant Urologists and Clinical Nurse Specialists raised concerns that this was, firstly, not big enough to accommodate all the services that they offered and, secondly, not safe for patients because, if any of them required urgent medical attention or to be admitted straight from clinic, then they required a 999 ambulance to transfer them from the Thorndale Unit into the Emergency Department/Ward. It also meant that patients who needed to attend the radiology department had to leave the building to go for their appointment which could be very inconvenient if the weather was inclement. The Thorndale Unit aspired to doing flexible cystoscopies at outpatient appointments but were not able to offer this as the scopes would have to be transported to the unit from Clinical Sterile Services Department. Another issue with this accommodation was that the Thorndale Unit had only one toilet which, given the nature of urology, was very unsatisfactory and meant that patients who were attending with a full bladder, for example for urodynamics, were being inconvenienced with no access to toilet facilities. Finally, as it was a modular building it was always very hard to heat in the winter and very hard to keep cool in the summer and there were complaints from staff and patients on this uncomfortable aspect of the accommodation. This issue had been raised with me as Head of Service at departmental meetings and during informal discussions with the Urology Staff.

(b) In my opinion felt that the 'old' premises was impacting on patient care and safety due to the fact that the premises was not connected to the hospital and should there have been a medical emergency for one of the patients they were required to wait for a 999 ambulance to arrive and this could have taken time if there were no ambulances on site. There was a safety issue in the winter time of patients having to leave the building to go to the radiology department and if there was ice/snow or rain this had an impact of the movement of these patients. There was also the security of the premises as it was detached from the hospital and therefore staff were vulnerable if they were in the building on their own (although we implemented a lone worker policy to overcome this issue. There was also the issue of not enough toilets and finally patients were uncomfortable in this building due to it either being too cold or too hot (when we had on occasion's patients fainting/becoming weak due to the extreme heat.)

Document attached namely:
324. 20100201 Lone Working Policy and Procedure
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

(c) The systems and agreements put in place was to actively pursue the idea of new accommodation that was within the main hospital building and keep raising this issue until it was resolved by moving to the new premises.

(d) Steps taken included the following. I escalated this to my Assistant Director, Mrs Trouton, and I worked with our Estates Department in securing a new suitable area to relocate to. I worked with Estate Services and the clinical teams in designing this new area and Estates Services provided costs for this refurbishment. Mrs Trouton brought this to the Capital Equipment and Minor Capital Group and we secured

funding, got the area refurbished, and moved to the new premises on 17 October 2013. The 'new' Thorndale Unit was incorporated within the main outpatients with access to all facilities. It was purposely designed with toilets/changing rooms and treatment rooms in which we had decontamination cabinets installed for the flexible cystoscopies.

(e) The assurances was an increase in activity and positive feedback from patients and the staff located in the 'new' unit.

(f) I can confirm the move of the Thorndale unit to its new location was successful for all of the reasons outlined. The new Thorndale unit was able to provide more suitable accommodation and therefore allowed for more procedures to be carried out (flexible cystoscopies, more urodynamic sessions, etc.). Moving the administering of Intravesical chemotherapies from the ward to the new Thorndale Unit (which was a much more suitable environment) meant that patients were not cancelled for this vital therapy, something which happened regularly on the ward as this therapy was being done in a sideroom which, if needed for inpatients, led to the therapy being cancelled. The sideroom was also in the middle of 3 South Ward so patients who were on therapy were having to walk through and receive their treatment in the ward which not a suitable environment for this outpatient activity.

Documents attached namely:

325. 20120901 – CAH Urology Outpatients Business case
209. 20131017 - notice of thorndale move
210. 20130921 - New Urology accommodation
211. 20130923-E Thorndale Unit
212. 20131013- E Thorndale Urology Move
213. 20131017- E Thorndale Urology move
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

(g) Performance metrics were an increase in activity, the move to one-stop clinics, and more outpatient with procedures being carried out in the Thorndale Unit. In addition, we received more positive (formal and informal) feedback from patients.

Documents attached namely;

326. 20140428- TDU Timetable

327. 20190128 - TDU compliment

and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

48.4 Issues in respect of equipment for the Urology service.

(a) Throughout my tenure, staff within the urology service would have raised issues with me in respect of their equipment. For the purposes of the response to this question, I have just outlined the larger pieces of equipment as there were issues around the smaller (under £5k) pieces that I was able to sort for them much more easily. Issues raised with me regarding the larger pieces of equipment were as follows (and I have provided more detail in part (b) of this question):

i. Equipment was outdated and the issue was escalated to me along with documentary proof that there was more updated and reliable equipment on the market, for example, the urodynamics machine.

ii. The Lithotripter stone machine was escalated to me as an issue on the basis that it was no longer fit for purpose as it was continually breaking down and the shock waves were no longer working adequately, resulting in repeat attendances before a patient's condition was resolved.

iii. Our flexible cystoscopes were condemned as they were continually breaking down and the eyepieces in some of them had become 'blurred' despite repeat repairs.

iv. We had to replace equipment as part of a safety initiative, for example, recommendations from a Coroner's case regarding the use

of Glycine during endoscopic resection (TURP) and the need to replace the resectoscopes in theatres.

(b) As the Head of Service, I had to provide the equipment over £5,000 that was required for my areas to the overall Capital Equipment and Minor Capital Works Group. It should be noted that this group was for the entire Trust so, when requesting equipment, this was being considered along with every other directorate and division. As part of the justification for needing this equipment, I had to risk assess and provide reasons as to why this was required, as all of the above were needed in respect of patient safety. I can confirm that I considered that the pieces of equipment listed in part (a) were needed as, if not purchased, their absence would have impacted on patient care and safety for the following reasons:

i. Urodynamics machine – was continuously needing to go for service due to its age and unreliability in providing the correct output from the diagnostic test.
ii. Lithotripter - was breaking down and it ran the risk of breaking down mid-way through a patient having their treatment (stone being broken down using shockwaves); also it was adding to an increasingly long waiting list as, when the machine broke down, the engineers/parts had to come from France.
iii. Flexible cystoscopes - the Thorndale Unit was using flexible cystoscopes that were 'old' and out-dated. The majority of urology units had moved to using the video-scopes that could give a clearer picture and take photos of the bladder. The scopes were constantly going for repair as the eyepieces were getting damaged due to them going through the decontamination washer. The urology staff were advising that they were concerned as they were not getting a clear enough picture when doing this examination and were afraid of missing a small tumour, for example, in the bladder.

iv. Scopes used in theatres - there was a review of endoscopic resection in Northern Ireland with respect to the use of Glycine and risk of TUR syndrome associated with this (which followed the death of a patient as a result of TUR syndrome following a TCER in glycine). The review recommended switching to Bipolar resection in saline from existing practice of monopolar resection in glycine and this meant that the scopes being used in theatres needed replaced as this was a patient safety issue.

(c) As Head of Service, I would have firstly met and talked through the equipment requirements with all the Team. I would have then discussed our requirements at the Assistant Director and Heads of Service weekly team meeting and then the Assistant Director would have got these requirements added to the capital equipment list. I would have followed up my request with emails and escalation of issues that the team sent me as ongoing evidence as to why our equipment was important (again, I would highlight that the Trust received a 'pot' of money from the Department of Health and this was for all of the Trust, so all areas would have been applying for the same money and for the same reasons of impact on patient care and safety).

(d) The assurance for me and the team was the approval, purchase and delivery and commencement of use of the equipment.

(e) The assurance was the approval of the funding to go ahead and order the equipment.

(f) I can confirm that, for these large pieces of equipment, the Trust did provide funding and it meant we as a Urology Team were able to go ahead and purchase the equipment as requested.

(g) The main performance metric was the equipment being available all the time and no patients needing to be cancelled, albeit that it was hard to

measure this as cancellation of patients continued to happen for a variety of other reasons as well.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

49.1 For the purposes of this response I have only referred to those issues/concerns that I have highlighted in questions 45 and 48 as I have responded to issues of concerns specifically relating to Mr O'Brien separately in the next section (i.e., from questions 52 – 65).

(a) properly identified,

i. With respect to the clinical ability of staff identified in question 45 and the performance issues, outpatient accommodation issues, and equipment issues identified in question 48, in my opinion these were properly identified. My reason for this statement is that they were raised appropriately as being concerns and they were escalated once the staff identified each concern/issue.

(b) their extent and impact assessed,

i. With respect to the issues of concern identified in questions 45 and 48, in my opinion their extent and impact were assessed. Once raised as an issue or concern, the relevant members of the team met and discussed (usually informally) how best to resolve each issue or concern and what the impact would be if each one wasn't resolved.

(c) and the potential risk to patients properly considered?

i. With respect to the said issued of concern identified in questions 45 and 48, in my opinion the potential risk to the patients was properly considered. My reasons for this opinion are as follows:

i. For the staff about whom there was a clinical concern about – that member of staff was spoken to and they either had support put in place to protect the patient and themselves or they had their contract terminated.

ii. Performance issues (demand exceeding capacity) were raised and highlighted within the urology team and escalated right through to the Department of Health and were included on risk registers for both the directorate and at corporate level.

iii. Outpatient accommodation was considered as a patient risk and was addressed by the Trust by providing new purpose-built accommodation to suit the patient needs and safety.

iv. Issues of safety around equipment were raised and highlighted within the urology team and escalated through to the Trust Capital Equipment Group and the equipment issues were added to risk registers.

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

50.1 In my opinion, whilst there was no requirement to offer any additional support to the other urology staff, I can confirm that I personally always offered support to those who had their clinical ability issues raised. In particular, I kept in close contact with Personal Information redacted by the USI, and went to see and offer support to Personal Information redacted by the USI and Personal Information redacted by the USI, which I am aware they appreciated. All staff were aware of my open-door policy and, in the years of my tenure, none of the staff raised any issues/concerns that would have needed additional support. All staff were aware of CareCall and, if required, they knew that they could do a self-referral, or get me as their manager to do a referral, to the Occupational Health Department.

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

51.1 I can confirm that, during my tenure, the Urology department was offered support from myself and the Senior Management Team and Department of Health for quality improvement initiatives and I have summarised these below:

a. In September 2014, Mr Haynes and I did a presentation of the Urology Vision to the Department of Health, which led to the development of one-stop clinics for which initiative the Urology Team won overall best team award at the Trust Excellence awards.

Attached documents namely;

316. 20160311 - nomination for excellence awards

328. 20160608- email trust excellence

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

b. In February 2018, Mr Young, Mr Tyson and I prepared a presentation on the Stone Quality Improvement Project, and this was presented to the Senior Management Team and it received funding for research into quality improvement.

Attached documents namely;
329. TRF1819-03 - Mr M Young - Allocation of Funding - 18.09.18
330. TRF1819-03 - Mr M Young
230. 20180214-Stone Centre Quality Improvement Project
47. 20180202 – Stone Presentation
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

c. From 2015 to present, I worked with the Clinical Nurse Specialists and Mr Haynes and Mr Glackin on the development of nurse-led initiatives that allowed our Clinical Nurse Specialists to provide nurse-led activities and be the first Clinical Nurse Specialists in Northern Ireland to do independent TRUS prostate biopsies (Transrectal Ultrasound) and now, since 2022, they do this as TP (transperineal) prostate biopsies, and our other Clinical Nurse Specialist is administering botox injections into bladders.

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

52.1 My understanding of my roles and responsibilities in relation to Mr O'Brien was the same as that in relation to all of the other consultants in both Urology and ENT, which was: working with them all in managing the

day to day operational running of the service and ensuring that the needs of the patients were met from the perspective of both elective and emergency patients. I also was responsible for working with Mr O'Brien and the others in service development. In my job description it does not state that I was to have operational responsibility for the consultants and I didn't have such responsibility for the other medical staff within my area (except for keeping a record of their leave, which was more for rota purposes that actually managing their leave).

52.2 From February 2017, my role with Mr O'Brien changed in that I had to do a weekly monitoring of his Return to Work Plan and this meant that I spent more time with a focus on the four areas that I had to monitor.

52.3 As Head of Service for Urology the contact with Mr O'Brien was by various methods and for various reasons and therefore the amount of time would have varied. There were times, such as the meetings with the Department of Health when we were working on the Team South Implementation Plan, that I would have contact with Mr O'Brien at least once per week when he attended our weekly Monday meetings and this went on for approximately 15 months (2010-2012). I would also have met with him and the rest of the Team on a Thursday lunchtime when we had our Departmental meeting, although Mr O'Brien didn't always attend. We would also have had regular meetings during the summer and autumn of 2014 when we were planning for the meetings with the Department of Health with the proposal for going forward with the 'blue-sky' thinking for urology services. There would also have been ad hoc meetings when I needed the Team to meet with GPs about pathways, etc.

52.4 I would have had ad hoc, face to face meetings with Mr O'Brien as and when required, for example, to discuss patient flow issues, triage issues, needing a response to complaints, etc. These were not normally planned and were in the nature of the operational management of the service.

52.5 I would also have been in email contact with Mr O'Brien on a daily, weekly, and monthly basis and this would have been to escalate triage, red flag escalations, send performance data, advise of additional sessions, share emails with information that had come about safety notices, standards and guidelines, pharmacy issues, etc. Some of the above were shared as a team email whereas the examples of escalations would normally have been on an individual basis.

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

53.1 Job plans were not part of my role but I would have assisted in getting meetings organised with Mr O'Brien and the Clinical Directors to discuss. Apart from one meeting in March 2017 when I accompanied Mr Weir to meet with Mr O'Brien to discuss his return to work and job plan, I had no other involvement with Mr O'Brien in respect to his job plan.

The documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20170313- email meeting with AOB and CW 9 March 17
20170313- email meeting with AOB and CW 9 march 17 – attachment
20170313-email meeting with AOB and CW 9 march 17
20170318-email update of meeting AOB and CW 9 March 2017V2 – attachment

The documents namely:
331. 20191204 E - Job Plan
332. 20191204 E - Job Plan reply
73. 20130306 job planning meeting notes
333. 20130302 – Email – Urology Job Plans

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

Urology Services Inquiry

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

54.1 To respond to this question, I have listed below the issues of concern regarding Mr O'Brien that I have been aware of since I took up post in 2009.

i. *Not triaging GP referral letters*

This was raised to me by the Booking Centre Staff in April 2010. *The documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan*

20100407- email triage escalation
20100413-email escalation triage
20100414-email escalation triage
20100416-email re_triage

ii. On discussion regarding this issue, I was advised by other operational staff that this was an ongoing issue with, in particular, Mr O'Brien and they advised me that this went back to 2008/2009, when the Integrated Elective Access Protocol was introduced and the need to add the letters to the Patient Administrative System to ensure they were appointed to clinics. Another Head of Service, Mrs Louise Devlin, advised me at the time that, on one occasion before I started, she had to go to his office and retrieve letters from his drawer as he was on annual leave and they needed the letters for clinics. She advised me that, on that

occasion, he was very angry and confrontational with her for removing these letters which upset her at the time. This appears therefore to have been an issue and a concern from at least 2008/2009 and I am unable to comment if it had been a problem before this. However, I can confirm that it has been a common concern and issue for me since I commenced in 2009 and I spent a significant proportion of time contacting Mr O'Brien, working with booking centre staff and his secretary, and monitoring and escalating this issue. This came to a head in 2016 when, after concerns were raised about large number of letters not being triaged, with Mr O'Brien's permission I discovered 783 letters in the drawer in his filing cabinet that had not been triaged. For the purposes of this response I have attached samples of emails where triage was escalated.

The documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20110406-email re meeting with AOB
20110406-email attachment of note for meeting AOB Urology Triage
20110224-email RF triage escalation
20130417-email untriaged
20130921-email untriaged referrals
20130513-email urgent action triage
20130513-email urgent action triage att 1
20130513-email urgent action triage att 2
20130513-email urgent action triage att 3
20130513-email urgent action triage att 4
20130513-email urgent action triage att 5
20130513-email urgent action triage att 6
20130513-email urgent action triage att 7
20130513-email urgent action triage
20131008-email outstanding triage HT

20131126-email missing triage - AOB response

20140328-email confidential

20140319-email missing triage to AOB

20140319-email attachment 1 missing triage

20140319-email attachment 2 missing triage

20140318-email missing triage to KR

20150420-email outstanding triage

20120213-email about late triage

iii. Patient notes at home

This issue was escalated to me around 2013 when the Health Records staff started to complete IR1s on the Datix system when they couldn't get the notes either in Mr O'Brien or his secretary's office. On request, Mr O'Brien would bring these notes in from home. I am advised by others that this had been an on-going concern for years and the concern was that, if any of the patients had been admitted out of hours and there was no access to the notes yet there was some important medical information in the notes that was needed, then the absence of the notes was a patient safety issue. Despite numerous conversations with Mr O'Brien and requests to bring all the notes in from home (including March 2016), Mr O'Brien did not conform and this also came to a head in December 2016 when Mr O'Brien brought in 307 hospital notes back from his home. For the purpose of this response I have included samples of escalation emails regarding patient notes at home.

The documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan

20130905-email charts to consultants home

20131028-email chart with AOB

20140205-email chart at home

20150123- email missing charts Personal Information redacted by the USI

20150123- email missing charts MY
20130512-email chart removed from Trust DB
20150123- email missing charts
20160316 - email attachment Confidential letter - updated March 2016

Documents attached namely;
334. 20131112 - E Mr O'Brien and charts
335. 20131112 - E Mr O'Brien and charts DB
336. 20131112 - E Mr O'Brien and charts AC
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

iv. Not dictating on patients after clinics or day procedures

This first came to my attention in 2014 when the consultants Mr Haynes, Mr Glackin, and Mr O'Donoghue were doing some extra sessions to help address the review backlogs. Whilst doing this exercise they raised informally that there appeared to be a number of patients who didn't have a clinic letter on the Patient Centre system which meant they needed to see the patient face to face to make a decision on their follow-up care. Whilst I was informed about this, and discussed it with Mrs Trouton and Mr Mackle during 2015, it was very difficult to quantify how many patients didn't have a clinic letter as there was no electronic system to capture this information and therefore there was nothing further formally done on this issue until Mrs Trouton and Mr Mackle included this in their letter of March 2016. It became apparent that, despite it being raised with Mr O'Brien formally in March 2016, this didn't improve and, in January 2017 before his return to work, Mr O'Brien revealed to me that there were 668 patients who had not had a dictation dating back to 2014, which is in line of when this was brought to my attention.

v. Not conforming to booking of patients – doing his own thing

Mr O'Brien was asked on numerous occasions not to do his own scheduling of patients for theatre lists. However, he continued to do this. This entailed him ringing each patient and detailing what they needed to do or not do. Whilst this practice was good for the individual patient, no other consultant did this and, whilst he was doing this, he wasn't triaging, dictating or looking at results and was therefore doing a task that wasn't necessary. I know that, over the years, clinical managers (especially those doing his job plan/appraisal) asked him to stop this practice and explained to him the reasons why he should stop. This issue arose in this context because I understand that Mr O'Brien always requested more admin time and it was felt that, if he ceased the individual scheduling of patients, then he would have that additional time. This was always Mr O'Brien's practice which led to him not having time to do other admin but also meant that, as he scheduled his own patients, he was not conforming to chronological management and therefore, whilst he insisted it was in the patient's interest that he did the scheduling, other patients were disadvantaged.

Practice of patients receiving regular doses of Intravenous Antibiotics and Fluids

vi. I was made aware of this concern by Mr Mackle in 2010 when I was given a list of patients to arrange case discussions on and then to monitor them to ensure that they didn't come into the ward for any more IV antibiotics and fluids. From my recollection this practice had been on-going for at least 5 years before I took up post.

Benign Cystectomies

vii. I was made aware by Mr Mackle that there may have been an issue/concern that Mr O'Brien appeared to have performed more benign cystectomy operations than any other consultant urologist and it was felt that it needed to be investigated to see if there were valid reasons for those patients to have had this procedure performed. I was not directly involved, apart from facilitating the external reviewer (Mr M Drake) with 11 sets of notes. It would appear that this practice had been ongoing since 2005, but it was only raised as a concern in 2010.

Notes in the bin

viii. In June 2011 it was brought to my attention by Sr S Tedford, Ward Manager of Ward 3 South, that the ward clerk had advised her that she had found hospital notes in the bin on the ward and, on further investigation, we discovered that Mr O'Brien was responsible. I brought this to the attention of Mrs Trouton and Mrs Helen Walker, Assistant Director of Human Resources, and I am aware that Mr Brown and Mrs Parkes did a formal investigation into this.

Booking Private Patients for a procedure ahead of NHS patients

ix. Mr Haynes raised this issue with me towards the end of 2015 and advised myself and Mr Young of some specific patients who were private patients being brought onto NHS lists and significantly jumping the Waiting List. I advised Mr Haynes to speak with Mr Young on this issue and it is my recollection that, at this time, nothing was followed through on this but I have since learned that this was a common practice of Mr O'Brien's for a quite a number of years. However, I am not able to be more specific with timeframes due to this being verbal conversations with other members of staff who worked in theatres, on 3 South ward or in the Elective Admissions ward.

Not providing oncology patients with access to a Key Worker (Clinical Nurse Specialist)

x. I became aware that Mr O'Brien did not permit the Clinical Nurse Specialists to provide support as key worker to his oncology patients. I only became aware of this in November 2020 from the outcome of the investigations into the most recent SAI patients. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these.

Not following up upon results

xi. In June 2020 when the Directors Mrs McClements and Dr O'Kane asked me to do an admin look at Mr O'Brien's patients who had gone to theatre both as an emergency and electively, I discovered that some of these patients had had investigations and it appeared that they had not had their results reviewed by Mr O'Brien. It was as a result of this that Professor Sethia (external consultant) was asked to review all the records of patients who had had a test requested by Mr O'Brien and it was apparent that some of these patients had not had follow-up. Some of these patients were part of the recent SAI and some have been subject to a Structured Clinic Record Review (SCRR). The lookback review was from January 2019-June 2020 so this issue goes back to at least January 2019 as far as I am aware.

Prescribing unlicensed drug bicalutamide

xii. I only became aware that Mr O'Brien had been prescribing the unlicensed drug bicalutamide when Mr Haynes brought this to Dr O'Kane's and my attention whilst we were undertaking the clinical aspect of the initial lookback in October 2020. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these and none of the clinical staff

that attend these meetings had raised this as being a concern. To the best of my knowledge, Mr O'Brien has been prescribing this for at least 10 years.

Not adding patients to the Patient Administrative System

xiii. I became aware of this issue in June 2010 when Mr Haynes advised via email that he had discovered that, out of 10 patients that Mr O'Brien had requested be added to the Urgent Bookable list, two had not been added to a waiting list on the Patient Administrative System. It was because of this issue that I was requested by Mrs McClements and Dr O'Kane to carry out an admin lookback of Mr O'Brien's patients who had been operated on electively and as an emergency in order to ensure that they had been added to a waiting list if required. I am unable to say how long that this practice had been going on but, in my opinion, the issue that came to light in 2016/17 of Mr O'Brien not having recorded outcomes for outpatients from 2014 leads me to believe that this issue had been ongoing for quite a number of years as well; and whilst the Trust monitored the outpatients, I do believe that there was a failing in 2017 not to ensure monitoring of Mr O'Brien's inpatient and daycase outcomes as well.

Delay in responding to complaints/MLA Inquiries/FOI requests/Patient support inquiries

xiv. From the start of my tenure this was a concern for me with Mr O'Brien not responding to patient complaints/queries/MLA inquiries etc. . I spent a good proportion of time 'chasing' him for his comments on / responses to these and, after escalating to my assistant directors Mrs Trouton and Mr Carroll on numerous occasions, I would have had to go to speak with him directly. This, I believe, had been an ongoing issue with Mr O'Brien long before I took up post. From my observation and experience, it had never been addressed properly.

Documents attached namely;

337. 20191101 - Email [redacted] RIP

338. 201912015 - email complaint [redacted]

339. 20190929 - email complaint [redacted] RIP

340. 20190319 [redacted] complaint

341. 20140922 - [redacted] enquiries

342. 20190716 – complaint [redacted]

343. 20151201 - email query AC

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1 During my tenure I can confirm that I was involved in numerous discussions regarding the concerns about Mr O'Brien. I can also advise that the majority of these discussions were verbal and took place with the below staff either individually or collectively.

2009 - 2013

Mr Mackle, Mrs Trouton, Dr Rankin

55.2 Issues discussed were non-conforming with triage, not adhering to the process for scheduling patients, not pooling patients, not complying with performance targets (such as waiting lists and patient flow 4-hour and 12-hour targets), benign cystectomies, and IV antibiotics and Fluids. These meetings would have taken place in Dr Rankin's office, Mrs Trouton's office or in the Associate Medical Director's office, all on the Admin Floor in Craigavon Area Hospital (CAH). There were also telephone conversations

and some email conversations. All of these meetings were informal and no minutes were recorded for them and, from my recollection, Mr O'Brien never attended any of these meetings and I can confirm that I was never at any meeting with any of the above in this time period at which Mr O'Brien was in attendance.

Mr Brown and Mr Young

55.3 Issues relating to triage and notes at home were discussed. Meetings with Mr Young would have normally taken place in his office or via email and with Mr Brown mostly by telephone, as he was based in Daisy Hill Hospital. All of these meetings were informal and no minutes were recorded for them and, from my recollection, Mr O'Brien never attended any of these meetings.

2013 - 2015

Mr Mackle, Mrs Trouton and Mrs Burns

55.4 These meetings were mainly concerning triage, notes at home and review backlogs. They would have taken place in Mrs Burn's office, Mrs Trouton's office or in the Associate Medical Director's office, all on the Admin Floor. All of these meetings were informal and no minutes were recorded for them and, from my recollection for the majority of these meetings, Mr O'Brien was not in attendance. An exception was one meeting that I attended with Mrs Burns and Mr O'Brien in Mrs Burn's office where we discussed triage and what we could do to assist him with his admin work. I can confirm that there were no formal notes of the meeting but Mrs Burns sent an email to Mr Young the next day advising him of the discussions and asking him for his help.

Document is located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77 – Martina Corrigan - 20140224-email yesterday MC

Mrs Burns, Mrs Anita Carroll, Mrs Trouton

55.5 These meetings were informal and they were to discuss how we could ensure that patients whom Mr O'Brien was failing to triage were not

disadvantaged and it was at these meetings that a 'work around' was agreed that patients would be added to the outpatient waiting list according to the clinical priority the GP had assigned to them and, when the letter was returned (following triage), if this clinical priority then changed a similar change would accordingly be made on the waiting list. It was also from these meetings that Mrs Trouton and Mrs Carroll developed the escalation for triage.

Documents attached namely:

344. 20140416 – triage

345. 20140417 - email new triage process

346. 20140417 - email new triage process att1

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

Mr Young

55.6 Informal meetings took place with Mr Young to discuss triage and notes at home and Mr O'Brien was never in attendance.

August 2015 - April 2016

Mr Mackle and Mrs Trouton

55.7 Meetings took place with Mr Mackle and Mrs Trouton to discuss the issues of review backlog, no letters on Patient Centre, notes at home, and non-conforming with triage. This led to the 23 March 2016 letter that was signed by Mrs Trouton and Mr Mackle and given to Mr O'Brien when Mr Mackle and I met with him in March 2016.

Mr Haynes

55.8 Informal meetings took place between Mr Haynes and myself to discuss private patients on theatre lists and no letters for outpatient appointments on Patient Centre. No notes were kept of these informal meetings and Mr O'Brien was not present for any of these.

December 2016 - February 2017

Mr Carroll and Mrs Hynds

55.9 I had informal meetings with Mr Carroll and Mrs Hynds. There were no notes kept of these when we discussed all the issues that had come to our attention due to the letter raised by Mr Glackin on 15 December 2016 and shared with me by Mr Carroll on 20 December 2016. The purpose of these meetings were to provide Mr Carroll with updated information on the untriaged letters in the drawer, the notes returned from Mr O'Brien's home, the undictated clinics and information on private patients.

Documents attached namely;
347. 20161220 email concerns raised by an SAI Panel
348. 20161220 email concerns raised by an SAI Panel att
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

March 2017

Mr Weir and Mr O'Brien

55.10 There was a meeting with Mr Weir, Mr O'Brien and myself to discuss Mr O'Brien's return to work.

The documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20170313- email meeting with AOB and CW 9 March 17
20170313- email meeting with AOB and CW 9 march 17 – attachment
20170313-email meeting with AOB and CW 9 march 17
20170318-email update of meeting AOB and CW 9 March 2017V2 – attachment

June 2020 – June 2022

55.11 I can confirm that, after Mr Haynes had raised the issue with respect to the two patients not having been recorded on the Patient Administrative System, I was involved in numerous meetings to discuss all the concerns

raised. I can confirm that, since Mr O'Brien had retired at this stage, he was not in attendance at any of these meetings.

55.12 Minutes were taken of these meetings and attendees were normally, Dr O'Kane, Mrs McClements, Mr Carroll, Mr Wallace, Mrs Toal, Mrs Hynds, Dr Gormley, Mr Haynes and myself.

These minutes are located in folder - *Martina Corrigan - no 24 of 2022 –349. attachments Document 69 PIT*

55.13 In July 2020 I can confirm that I met with Mr O'Brien and accompanied him to his office on the 2nd floor of the main block of CAH with the purpose of Mr O'Brien removing any personal items from there and to return his keys and swipe passes.

Other Meetings

55.14 I can confirm that I was aware of other meetings which I didn't attend but for which I would have had to provide information, for example, meetings regarding IV Antibiotics and Fluids, meetings regarding benign cystectomies, and oversight meetings in 2016/2017 in respect of Mr O'Brien's return to work in February 2017.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

56.1 Below I will attempt to summarise all of the actions taken in respect of the xiii classes of concern identified in my answer to Question 54 above.

i. not returning GP letters from triage

a. Continuous escalations from the Booking Centre to Operational Service Lead, to Head of Service, to Assistant Director, to Director of Acute Services. The rationale was, I believe, to address this issue every time it was highlighted and to show Mr O'Brien that it was being monitored.

Sample of escalation emails - the documents are located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan

20110406-email re meeting with AOB

20110406-email attachment of note for meeting AOB Urology Triage

20110224-email RF triage escalation

20130417-email untriaged

20130921-email untriaged referrals

20130513-email urgent action triage

20130513-email urgent action triage att 1

20130513-email urgent action triage att 2

20130513-email urgent action triage att 3

20130513-email urgent action triage att 4

20130513-email urgent action triage att 5

20130513-email urgent action triage att 6

20130513-email urgent action triage att 7

20130513-email urgent action triage

20131008-email outstanding triage HT

20131126-email missing triage - AOB response

20140328-email confidential

20140319-email missing triage to AOB

20140319-email attachment 1 missing triage

20140319-email attachment 2 missing triage

20140318-email missing triage to KR

20150420-email outstanding triage
20120213-email about late triage

b. Mr O'Brien was spoken to by Directors of Acute Services (Dr Rankin and Mrs Burns) and, for example, Dr Rankin advised him he would not be allowed to attend the British Association of Urological Surgeons conference in Barcelona if he didn't get his triage up-to-date and keep it updated. Mr O'Brien worked on this for three days and got it all completed but actually didn't get to the conference due to the ash cloud. Mrs Burns met with Mr O'Brien and as a result of this meeting wrote to Mr Young and asked him to get the team to take over Mr O'Brien's triage to allow him time to concentrate on catching up on his other admin. Mrs Burns also instructed in the commencement of the default mechanism of all patients being added to the waiting list according to the clinical priority of the GP. I understand that the rationale for this by both Directors was to support him in not allowing him to keep falling behind in this task. Dr Rankin's intervention was in 2010 and Mrs Burns in 2015.
Document is located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77 – Martina Corrigan - 20140224-email yesterday MC

c. Mr Mackle and Mrs Trouton formally wrote to him in March 2016 asking him to address the triage. The rationale for this was to highlight the issues and work with him to get an action plan in place to address the problem.
The document is located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20160316 - email attachment Confidential letter - updated March 2016

d. When the issue of the 783 letters in the drawer was discovered in late 2016, the urology specialty was the first specialty to pilot and adapt the electronic triage which is much more visible and easy to monitor. The rationale for this was to make the monitoring of the triage much easier and it was successful in the monitoring of triage following Mr O'Brien's return to work in February 2017.

Documents attached namely:
350. 20200401-quick guide on NIECR for consultants
227. 20161230 - e-referrals management
228. 20171117 - new referrals paperless
351. 20170329 - E-Triage
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

ii. Patient notes at home

a. Escalation emails were sent from Health Records to when there was particular problems with obtaining hospital notes. The rationale was to highlight the problem of the amount of missing patient notes belonging to Mr O'Brien.
b. Health Records staff were instructed by their manager, Helen Forde, to complete IR1s on the Datix system to see if this would escalate and resolve the problem.
c. Mr Mackle and Mrs Trouton formally wrote to Mr O'Brien in March 2016 asking him to bring the patient notes in from his home. The rationale for this was to highlight the issues and work with him to get an action plan in place to address.
The document is located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20160316 - email attachment Confidential letter - updated March 2016
20130905-email charts to consultants home

20131028-email chart with AOB
20140205-email chart at home
20150123- email missing charts Personal Information redacted
20150123- email missing charts MY
20130512-email chart removed from Trust DB
20150123- email missing charts
20160316 - email attachment Confidential letter - updated March 2016

Documents attached namely;
334. 20131112 - E Mr O'Brien and charts
335. 20131112 - E Mr O'Brien and charts DB
336. 20131112 - E Mr O'Brien and charts AC
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

d. After the 307 sets of patient notes were left back in by Mr O'Brien this became part of his weekly monitoring plan, following his return to work in 2017, to ensure that there were no missing notes that were last with Mr O'Brien. For all of the monitoring period he did conform to this aspect of the Return to Work Plan.

iii. *Not dictating on patients after clinics or day procedures.*

a. Mr Mackle and Mrs Trouton formally wrote to Mr O'Brien in March 2016 asking him to address missing letters on Patient Centre. The rationale for this was to highlight the issues and work with him to get an action plan in place to address them.
The document is located in Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan
20160316 - email attachment Confidential letter - updated March 2016

b. In 2017, when it was highlighted that there were 668 outpatients that had no letter dictated after their attendance, this became a part of his Return To Work Action Plan and was monitored weekly to ensure that he complied.

iv. *Not conforming to booking of patients – doing his own thing*

a. I am not aware if there was any action taken in respect of this. I was present during conversations with Mr O'Brien and various others (Mr Young, Mr Haynes, Mr Mackle, Mr Weir), when they advised him to cease this practice as it was taking up too much of his time doing this task and taking him away from the admin that he needed to be doing (triage, results, dictation etc.). I have no dates for, nor any notes of, these conversations.

v. Practice of patients receiving regular doses of Intravenous Antibiotics and Fluids

a. I have limited knowledge of the actions taken on this concern as I was not involved directly with the discussions. I am aware from Mr Young that Dr Loughran, Medical Director, met with both him and Mr O'Brien to discuss and advise that this practice had to cease. I am also aware that Dr Damani and Dr O'Driscoll, Microbiologists, were contacted for advice. I am also aware that Ms Samantha Sloan, Clinical Director, was asked to lead and monitor on this and, as previously stated, my only involvement was in respect of monitoring that Mr O'Brien didn't bring any of the regular patients in for this treatment and also didn't commence any new patients on this treatment without a discussion with microbiology and pharmacy.

vi. Benign Cystectomies

a. I have limited knowledge of the actions taken on this concern as I was not involved directly with the discussions and, as previously stated, my only involvement was to support Mr M Drake on the gathering of information, so I am unable to comment on the actions taken and the rationale for them.

Document attached – 352. 20110301 - urology governance issue and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

vii. Notes in the bin

a. When this concern was raised with me, I escalated it to Mrs Trouton and Mrs Walker Assistant Director of Human Resources (Acute). My rationale for this escalation was that I deemed it to be serious as these were a legal record of a patient and may have been required at any stage in the future. I am aware that there was, but had no involvement in, a disciplinary process in respect of Mr O'Brien in respect of this incident.
This report can be found in folder Relevant to HR reference no 63 0110600 Ref 63 Disciplinary Report Mr AOBrien

viii. Booking Private Patients for a procedure ahead of NHS patients

a. To the best of my knowledge, until Mr O'Brien's return to work in 2017 this concern was never addressed. This was despite it being known and highlighted by others. I am not aware of any reason why this was not addressed nor actions taken.

ix. Not providing oncology patients with access to a Key Worker (Clinical Nurse Specialist).

a. This issue has been highlighted through the recent 9 SAIs and is an action on the Trust*'s* SAI recommendation group.
Documents attached namely:
353. 20210913-SAI recommendations first draft working plan
354. 20220509 - notes SAI Recommendation Implementation Super Group Meeting
355. 20220509 - notes SAI Recommendation Implementation Super Group Meeting att 1
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

x. Not following up on results

a. This issue had been highlighted through the recent 9 SAIs and is an action on the Trust*'s* SAI recommendation group.

xi. Prescribing unlicensed drug bicalutamide

a. As soon as this issue was highlighted, a request was made to the Department of Health's Pharmacy Department and a database provided and an audit completed, with patients who were affected contacted and a new management plan put in place. Mr Haynes carried out this snap audit and his rationale for this was to identify the patients and ensure they were on the correct management plan as soon as possible.

xii. Not adding patients to the Patient Administrative System

a. Action regarding this concern was to do an admin lookback of all patients who had been taken to theatre both as an emergency and electively under the care of Mr O'Brien. The rationale for this was to ensure that all patients who had been to theatre had been

added to a waiting list. This exercise was undertaken by myself under the direction of Dr O'Kane and Mrs McClements.

xiii. Delay in responding to complaints/MLA Inquiries/FOI requests/Patient support inquiries

a. In the course of my tenure when I was getting no response from Mr O'Brien I would have escalated this issue to my Assistant Directors and to the Directors of Acute Services. The rationale for this was that, as I was not obtaining the information myself, I needed their support in getting the matter resolved.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

i. what risk assessment did you undertake, and

ii. what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.1 I believe that all of the concerns listed above at Questions 54 and 56 (i)-(xiii) may have impacted on patient care and safety. I believe that I and the others involved recognised this and we therefore instigated the various responses described in my answers to questions 54, 55 and 56, because we perceived them to be appropriate actions to address the risks that Mr O'Brien had created. I am not, however, aware of any formal risk assessments having been undertaken in this regard.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and

others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1 In respect of concern (i) *not returning GP letters from triage*, it is my understanding that, during the 11 years that I worked with Mr O'Brien, he was afforded many opportunities and support to comply with normal practice. In terms of agreed ways forward:

a. On at least two occasions (2012 and 2014) Mr Young did his triage for him to allow him to get caught up on his admin. Whilst he agreed to this for a short period of time, on both occasions I was led to believe by Mr Young that Mr O'Brien asked to have triage given back to him. In addition, on 19 September 2014 I received an email from the booking centre advising that Mr Young was no longer doing Mr O'Brien's triage On both occasions this had been done without mine or any of the senior managers' knowledge.
   Documents attached namely:
   356. 20140919-email urology triage
   357. 20140919-email urology triage
   and can be located in folder - Martina Corrigan - no 24 of 2022 – attachments

b. Mrs Burns agreed the default mechanism of adding patients to the waiting list I line with the GP's clinical priority so that pressure would be taken off Mr O'Brien and the patient would not be disadvantaged.

58.2 In my opinion, the letter that Mrs Trouton and Mr Mackle gave to Mr O'Brien in March 2016 in respect of review backlog, notes at home, triage, and non-dictation was an opportunity afforded to him to address these concerns which had been ongoing for quite some time. However, it was an opportunity to agree a way forward which Mr O'Brien didn't accept.

58.3 In 2017, the agreed way forward between Mr O'Brien, Dr Khan (as MHPS Case Manager) and Mr Weir (as MHPS Case Investigator) (which I now understand had the approval of the Oversight Committee comprising the Medical Director, Director of Acute Services, and Director of HR), was to put in place a Return To Work Action Plan which was to address the four concerns that had been identified at the end of 2016 and ensure strict compliance with Trust procedures and policies in relation to:

a. Triaging of referrals;
b. Contemporaneous note keeping;
c. Storage of medical records;
d. Private practice.

To the best of my knowledge, Mr O'Brien was in agreement with the Plan and was aware that he would be monitored on his compliance at adhering to it, something which he largely appears to have done.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

59.1 I can confirm that, prior to Mr O'Brien's return to work agreement in February 2017, there was (to the best of my knowledge) no formal system in place for monitoring. Prior to February 2017, the two areas that were escalated were:

a. the non-conformance with triage of referrals – this was raised through escalation emails from Booking Centre staff or the Red Flag Office which I would then have brought to Mr O'Brien's attention and requested that he address;

b. patient notes at home - for the majority of the time this was raised directly with Mr O'Brien by the Health Records staff or his secretary, requesting that he bring the notes in from his home.

59.2 The metrics used after Mr O'Brien's return to work agreement in February 2017, and how they differed from any previous relevant metrics, are set out in the following table.

Concern	Metrics used for monitoring	Difference
IV Antibiotics and Fluid practice	To monitor compliance (no patients were admitted to the ward for regular IV antibiotics and fluids) I had a list of patient names that had been discussed as part of the multi-disciplinary teams that were no longer to receive this form of treatment. I checked off these names with the patients 'to come in' lists from Patient Centre and I made sure that none of the aforementioned names were on the list. The ward sister (Sr Tedford), also ensured that none of the patients were admitted to Ward 3 South.	I can confirm that, pre this issue being highlighted and discussed, there was no monitoring in place and the patients just continued to be admitted without challenge.
Benign Cystectomies	No Cystectomies, either for oncology or benign, could be performed in the Southern Trust after September 2009 as the recommendation from Review of Urology Services was that all radical pelvic surgery was to be carried out in Belfast. So, to ensure compliance I monitored the patients 'to come in' lists from Patient Centre and I also checked theatre lists to ensure there were no cystectomies listed.	As the decision was only made as a result of the Review of Urology Services in 2009, there was no prior requirement to monitor this aspect of care.
Triaging of referrals	E-Triage from NIECR, so this was easily monitored. All GP referrals are uploaded onto the NIECR system. So, it is easy to log-in and see what referrals are still waiting to be triaged, the date they are waiting from, and the consultant responsible.	Prior to 2015, all GP referrals were printed off from the CCG system and left with the Consultant Urologist who was on for the week. Therefore, these were all paper-based so, once they were with the consultant, it was more difficult to monitor in that reports had to be requested

		and then cross-checked with what had or had not been returned.
Contemporaneous note keeping	Digital Dictation – G2 system - which was introduced in the Trust in June 2014 and is a system which is linked to the computer in the clinic room/ward and allows the consultant to generate a letter from the patient's episode. The secretary, using a password, can then view these letters and the consultant will highlight the red flag and priority letters so that they can be typed first. A report can be generated from this system to advise on how many letters have been dictated per clinic, however, it must be noted that the limitation is that it simply records speech and generates a letter. However, G2 is unable to correlate the letter dictated against the outpatient attendance, so spot checks were required to ensure that all patients actually had a letter dictated.	Prior to the introduction of Digital Dictation, all consultants relied on the hand-held Dictaphone where they dictated their letters and then this tape was given to the secretary to type. Issues included tapes getting lost or damaged. For monitoring, there was no way of knowing what was on the tape until the letter was typed. This system was reliant on the secretary escalating if there was no tape for the clinic etc.
Storage of medical records	Physical check of office along with using PAS for borrower code for Mr O'Brien to check were notes in his office.	The same system was available prior to Mr O'Brien's return to work agreement except that I checked the borrower code on PAS and, after 2016, I had to go to Mr O'Brien's office but prior to 2017 I didn't check the office to see if notes were stored there.
Private practice	The metric used was a manual system in that I checked all patients on Theatre lists to ensure that they were not previously seen as a private patient (none were for the period of monitoring post 2017),	Prior to 2017, there was no monitoring in place at all for this aspect of Mr O'Brien's return to work agreement.

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

60.1 As per my response to question 59, I can confirm that, prior to 2017 and Mr O'Brien's return to work agreement, the monitoring for the IV antibiotics and the cystectomies was robust to the best of my knowledge.

60.2 However, for non-conformance with triage of referrals and hospital notes at home my observation for the period pre-2017 is that there were no robust systems nor agreements in place to address the concerns, as this was solely reliant on the escalations from the Booking Centre/Red Flag Team/Health Records to me and then reliant on me always to act on these escalations.

60.3 It was agreed that, as Head of Service, and because I had the knowledge of the systems and processes, that I would be responsible for the monitoring of the four areas within Mr O'Brien's Return To Work Plan from February 2017. I did this on a weekly basis every Friday (apart from those Fridays when I was on annual leave and also for the 18 weeks when I was off Personal Information redacted by USI Irrelevant information redacted by USI .

60.4 In my opinion, the systems I used were the best that I had available to me and my observation is that, whilst dependent on my input, the systems proved that they worked because, whilst I was monitoring Mr O'Brien, he complied in each of the four areas and I was able to pick up when he had any deviation so that it was resolved quickly. All of this was up until the point when I went on Personal information redacted by USI Personal information redacted by USI . I was only due to be off for 6 weeks Personal information redacted by USI I ended up having to be off on extended leave unexpectedly. During this time (as I was only

meant to be off for a short period) I was not replaced and I didn't hand over the monitoring, nor (I understand) was it picked up in my absence. During this period, when I wasn't monitoring and keeping in contact with Mr O'Brien, I know he deviated from dictation and notes at home (I only became aware of this on 4 October 2018 whilst I was still off [redacted] and I was contacted by phone by Ms Wendy Clayton and Mrs Brigeen Kelly to talk through how I monitored Mr O'Brien's return to work. After the conversation, I logged into my work computer and checked the deviations and I detailed this along with how I did this and forwarded to Mr Carroll. And whilst he got back on track and I began to monitor him again on my return [redacted], he did deviate again in September 2019 which again I confirm that it was through my monitoring that this was picked up and I escalated and I can confirm by end of September 2019 he had got back on track. So, in my opinion the methods that I was using worked and also the fact that I did this on a weekly basis meant that the monitoring was constantly under review. (add in the other escalation emails around this period that are in discovery)

Documents attached namely:

20181004-email return to work action plan

20181004-email return to work action plan – attachment

And can be located in folder: Relevant to PIT – Evidence after 4 November 2021 PIT – Reference 77 – Martina Corrigan

60.5 The two areas that in my opinion were weak were as follows:

a. The method I had to use in respect of the storage of patients' records issue - This was difficult to monitor as it was dependent on manual checks. Whilst I was doing this, I found no issues. However, if a set of patient notes had been 'Casenote tracked' to Mr O'Brien's borrower's code but they were not in his office I had no way of knowing where they were as any member of staff could have picked them up from his office and not changed the borrower's code and this would have led to issues of trying to locate those notes.

b. Digital dictation – This was the second area of weakness. Whilst this showed electronically how many letters there were, it didn't show if there was a letter for each patient. So, for example, if there were 8 patients who attended the clinic then I would have received a report from the Service Administrator to say there were 8 letters on the G2 system and, as part of my monitoring, I would have had to spot-check these clinics to ensure all 8 patients each had a letter. I did this spot-check every 3 months as I was assured that all patients were having a letter dictated on their attendance. However, in September 2019 I discovered during my spot-check that, whilst there were 8 patients and 8 letters on the G2 system, one patient had 3 letters (one letter to their GP, one letter to the patient with instructions, and one letter to the Clinical Nurse Specialist to review for lower urinary tract symptoms), one patient had 2 letters (one letter to the GP and then a specific one to patient with instructions), 3 patients had 1 letter each, and (unfortunately) 3 patients didn't have any letter dictated. I duly highlighted this to Mr Carroll. My observation on this is that I suspect Mr O'Brien realised this feature of the system, realised that this check was not done for every clinic, and slipped back into his old ways. I had organised a meeting about this on 8 November 2019 with Mr McNaboe and Mr O'Brien. Mr O'Brien sent me a letter dated 7 November 2019 in which he stated, '*It is evident that the issues that you wish to discuss, cannot be considered deviations from a Return to Work Plan which expired in September 2018.'* This, in my opinion, amounted to evidence that he had decided that, when he thought he was no longer being monitored, he could start to do his own thing again.

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

61.1 In my opinion the systems that were in place pre-2017 remedied the concerns in respect to the IV antibiotics and the cystectomies (as described

in my answer to question 59). As also described in my response to question 59 there were no robust systems put in place for other issues prior to 2017.

61.2 As outlined in question 60, in my opinion the agreements and systems put in place from 2017, whilst Mr O'Brien was being monitored weekly and whilst he knew that he was being monitored, *did* remedy the concerns that they were set in place to address. Whether other concerns (then unknown to me and, I assume, the others involved in monitoring Mr O'Brien) ought also to have been addressed at this time is a matter that I consider at question 70 below.

61.3 As also stated in response to question 60, it appears that as soon as Mr O'Brien thought that the monitoring was over, the concerns that the monitoring was designed to address emerged again - in 2018, when I was off sick, and again in 2019.

61.4 In my opinion, I think that there was over-reliance on one individual (me) who had a demanding operational day job. This should have been more fully considered and appreciated as a risk. Whilst I believe I am a very diligent and hardworking member of staff, the system failed when I went off [redacted], revealing this weakness in the system. The storage of patients' notes was always a concern of mine. Whilst, in principle, the Trust supported the move to electronic tagging, there was never the funding made available to implement this so I had to use the work around of physically visiting Mr O'Brien's office at 6:30am on a Friday morning to perform a check, something which also didn't happen when I was off.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if

anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

62.1 As stated above, I worked with Mr O'Brien for 11 years and, during this tenure, Mr O'Brien's main issue of concern would have been not having enough time for the emergency inpatients on the ward. He would have raised this at our Thursday Departmental meetings on a regular basis (this meeting was attended by the other urologists and Clinical Nurse Specialists along with myself). This was a recognised concern and, to address this, we agreed as a team to move to a 'Urologist of the Week' model which meant that one urologist would have no other clinical duties except dealing with emergencies, being available for emergency theatre, and doing the triage of GP referrals. This proposal, known as 'The Vision/Blue-sky thinking', was agreed by the whole team including Mr O'Brien and it was presented to Mr Dean Sullivan from the Department of Health who supported it and agreed to fund an additional consultant and Clinical Nurse Specialists. So, in my opinion this concern that Mr O'Brien had raised was listened to and a solution put in place. This was put in place in January 2015 and it appeared to satisfy Mr O'Brien.

62.2 However, he did raise with me about the time being spent on advanced triage and the need to increase his admin time to do this. When Mr O'Brien was triaging a GP referral, instead of just looking at the referral and using information available on NIECR (e.g., diagnostic results such as bloods or radiology results) and then deciding if it was routine, urgent or red flag, Mr O'Brien would spend a lot of his time (usually on a Sunday) and do a more detailed triage which could have involved him speaking directly to the patient, writing to the GP to request further information, organising diagnostics such as bloods, ultrasound, MRI, etc. So, what Mr O'Brien decided needed done with the patient was dependent on how much time he spent triaging the patient's referral. The other consultants, when triaging, may have ordered some tests (due to waiting times for diagnostics) but they did always advise that they would not go into this depth when triaging a

patient. It was after one of those occasions when he talked to me about advanced triage that I spoke with Mrs Burns and she met with him to discuss. After this meeting I understand that she asked Mr Young to assist by talking to his colleagues and share out Mr O'Brien's triage to allow him more time on his other admin work, particularly the chairing of the NICAN group. Mr Young actually took this additional triage on himself (he didn't discuss this with the other consultants) and this took place for a few months before Mr O'Brien requested that he start back to triaging. Mr O'Brien would, in our departmental meetings, raise the issue that it was taking quite a lot of time to do his advanced triage and I recall conversations where he was challenged as to why he should be doing this advanced triage as he was the only consultant doing it. However, Mr O'Brien would always have defended why he did this and he appeared not to take notice of his colleagues' contrary views. And to the best of my knowledge this was never raised any further.

62.3 Mr O'Brien would also have raised, during the Departmental meetings, the time he spent speaking with patients and how it was impacting upon his other work. Again, this was challenged by his colleagues but he argued back that in his opinion that the way that he contacted the patients was the right way to do things and that the other consultants who contacted the patient by just writing letters were not carrying out their jobs fully. To the best of my knowledge, this same issue would have been discussed at his job planning meetings when he would have asked for additional admin time rather than give up his practice of personally contacting patients.

62.4 In 2009/2010, I believe Mr O'Brien formally raised concerns about the impact on patient care and safety with the implementation of the recommendations of the Review of (Adult) Urology Services, particularly in respect of the centralisation of radical pelvic surgery to Belfast. I am not aware of the outcome of these conversations but I do know that he was extremely annoyed about these recommendations as he openly voiced his anger about this recommendation.

Documents attached namely:

358. 20090202- Email correspondence regarding the Urology Review

359. 20090202- Email correspondence regarding the Urology Review att1

360. 20090202- Email correspondence regarding the Urology Review att2

361. 20100928 - Email from Patient about pelvic surgery

and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

62.5 I do not recall Mr O'Brien formally raising any other concerns with regard to patient care and safety, risk, clinical governance or administrative issues. However, I have recently been made aware from an email from Mr Glackin sent to me and Ms E Stinson for inclusion in discovery, that Mr O'Brien tabled a document on 24 September 2018 when I was off Personal Information redacted by USI Personal Information redacted by USI, whilst I was aware of the meeting as I had the minutes shared with me, I was not aware of the paper that Mr O'Brien had presented until I received this from Mr Glackin on 29 March 2022. In this paper Mr O'Brien presented a patient entitled 'Issues of Concern for discussion' and the paper contained the following sections:

- Urologist of the Week
- Triage
- Waiting times for elective inpatient surgery
- Summary which I quote;

  '*I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, or even a Policy and Procedure, from the Trust of our practice obligations.'*

  Name at the bottom of document:

  AIDAN O'BRIEN

  24 SEPTEMBER 2018.

Documents attached namely;

362. 20220329 - Email Urology Service Development meeting 20180924

363. 20220329 - Email Urology Service Development meeting 20180924 att1

and can be located in folder – Martina Corrigan – no 24 of 2022 – attachments

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised

63.1 During my tenure working with Mr O'Brien the main concerns that I escalated were in respect to his non-triage, patients' notes at his home, and his lack of engagement with respect to performance - both elective and emergency (e.g., not doing a ward round to help with patient flow). I would also have raised concerns regarding Mr O'Brien bringing patients in from home on the week that he was consultant urologist of the week, thereby adding more pressure to an already pressured system.

(b) who did you raise it with and when?

63.2 These concerns were raised throughout my tenure and, in particular, from 2010-2015. I mainly raised these with Mrs Trouton/Mr Mackle and Mr Young.

(c) what action was taken by you and others, if any, after the issue was raised

63.3 With respect to non-triage there was further escalation to the Director of Acute Services (Dr Rankin/Mrs Burns), who both met with and spoke to him about this.

(d) what was the outcome of raising the issue?

63.4 Mr O'Brien would conform for a short period and then slip back to his old ways of not complying.

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.5 Whilst I did raise some concerns about Mr O'Brien, on reflection, I believe that I should have continued to raise these every time that there was an issue. Looking back, I believe the reason why I didn't always raise them was because 'it was just Aidan' and he had 'gotten away with' bad behaviour from before my time, everyone in a senior position past and present knew what he was like, and the sad thing for me is that he got away with it. It is my belief that, whenever a manager nearly got to address his issues, he seemed to suddenly get away with what he had done, for example, Mr Mackle appeared to be managing issues such as the triage and IV fluids practice and then he was advised to take a 'step back' as it was deemed that Mr Mackle was bullying and harassing Mr O'Brien. I believe that I felt in part that, if Medical Directors, Chief Executives, Directors of Acute Services, Assistant Directors, Associate Medical Directors, and so on were unable to manage him or get him to conform, then there was little or no chance for me as his Head of Service. Mr O'Brien could be quite intimidating in that he was so strong in personality that he did things his way and I never could win the debate with him; he wore me down and, for that, I am sorry as it appears that patients have come to harm as a result. I am also aggrieved, on reflection, regarding the amount of time I spent chasing and trying to get Mr O'Brien to do what he needed to do, which meant that I never got to spend the time with my other consultants (who never gave me any bother) in further developing the services.

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you

engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 My recollection is that there was no support outside of the Urology Team provided for Mr O'Brien as he didn't request or appear to need this. When he raised the issue about workload during his tenure of chair of NiCAN, Mrs Burns agreed that she would get the other consultants to support him with triage, however, as previously stated he had requested that the triage return back to him and I was not aware that this had happened for about 6 months after it had reverted back.

64.2 After his return to work in February 2017, Mr Weir and I met with him in March 2017 and the purpose of this meeting was to put in place any support that he felt he needed. So, for example, we agreed that on a Tuesday morning after he had been in Enniskillen doing a clinic that he would have no clinical session so that he could complete any admin work from the previous clinics. We also agreed that he could have reduced clinics to allow for travel time.

64.3 I believe that I provided a lot of support to Mr O'Brien during my time working with him. This would have been in the form of being available to listen to him, asking about his health and, indeed, asking after his family, volunteering to assist him with support with his workload, and sometimes attempting to work with him when he failed to adhere to deadlines, normal practice etc. rather than escalating the matters. I would have had conversations with Mr Young to try to do a 'work around' to support Mr O'Brien (getting his triage done for him, e.g., a list of letters not triaged would sometimes have been divided out between others and sorted, rather than annoy Mr O'Brien or put him under more pressure).

64.4 Mr O'Brien had a tendency, when asked a question, to take quite a bit of time to respond and go into a lot of detail. For example, in 2011-2013

when I would have had to speak with him regarding his chronological management, he would have gone into great detail about why he didn't agree with the clinical prioritisation of the patients as being 2 (urgent) and 4 (routine) and explained to me his system of 1-4. I believe that me taking the time to listen to him (even though this could have taken up to an hour at a time) showed that I was supporting him by listening and I would have explained to him in detail the reasons why we couldn't adopt his approach to prioritising. I was always courteous to Mr O'Brien, even when he was angry with me and, in my opinion, this also showed my level of support towards him.

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

65.1 I refer to my answer to Question 62. Any other risks are contained within the risk registers which can be found in

The documents attached namely;
174. Divisional SEC risk register - urology access waiting times
175. acute directorate risk register - urology access waiting times
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1 I can confirm that I am now aware of governance concerns arising out of the provision of urology services, which I was not aware of during my tenure. These are namely:

a. Actions not being followed through from the oncology multi-disciplinary meetings;
b. Whilst monitoring took place on Mr O'Brien's outpatient clinic dictation, there was no monitoring for day case admissions and follow-up letters from oncology multi-disciplinary meetings; therefore this was a governance risk;
c. Mr O'Brien did not follow the recommended process of having a Clinical Nurse Specialist for his oncology patients and, had affected patients had such a key worker, this may have reduced or prevented harm;
d. Mr O'Brien didn't followed recommended guidance on the prescribing of bicalutamide;
e. Sign-off of results was not carried through and, had Mr O'Brien agreed with the 'Discharge Awaiting Results' function on the Patient Administrative System and had his secretary followed this process, these results would have been monitored and the patients affected as a result of no follow-up might have been captured sooner.

66.2 During my tenure, I can confirm that I worked very closely with the urology team and we had a good system in place to allow for concerns/issues to be raised that would have impacted on patient safety. I was also the responsible manager for the monitoring of Mr O'Brien after he returned to work in February 2017. However, I can confirm that, whilst I was aware of Mr O'Brien's administrative short-falls from the aforementioned monitoring, I was never made aware of the clinical issues arising that I have mentioned at paragraph 66.1 above. I think that, through my good working relationship and track record of working with the team to resolve issues, I should have been made aware and the only reason that I can think of as to

why this wasn't the case was due either to (i) the other members of the team trying to resolve these issues among themselves rather than escalate them or (ii) the others in the team not being aware of an issue (e.g., for some issues such as the bicalutamide prescribing). A personal observation is that the Urology Team are a close-knit team and, whilst they considered that I was one of that team, some of them recognised that I was also a senior manager so that, once they escalated issues to me, I would always have acted on them. This may have inhibited them in raising some concerns with me as they still tried to 'protect' Mr O'Brien.

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

67.1 I have reflected on the response to this question and the explanation that I will give is based on my own opinion as to what went wrong within the urology services. I will also acknowledge from the outset that there have been failings on my part which contributed to the Mr O'Brien problems during my tenure but also in my opinion I believe that there are others who have worked with me over the course of my tenure who also contributed to these mistakes. I have provided more detail on these mistakes, both by me and others, in my response to question 70 below.

67.2 Mr O'Brien was a well-established consultant urologist who took up his role in 1992 as a single consultant urologist. I understand that this came about with the splitting of the retired consultant surgeon's post into a consultant general surgeon (Mr Eamon Mackle) and a consultant urologist (Mr Aidan O'Brien). I have been advised by others (such as: Mr Mackle; Mrs L Devlin, Head of Service; Ward Sisters who are since retired, for example, Mrs Dorothy Sharpe; nursing staff, for example, Paula McKay, now lead nurse; other consultants such as Mr Young, Mr Akhtar, and so on) that, from the outset, Mr O'Brien had strong opinions and it would always have been his way or no way. He undoubtedly had a strong personality and it would appear that, right through to his retirement in 2020, this came out in

his dealings with others; so much so that I believe that others (including myself) didn't challenge him enough because, when we did, he always challenged back and he wore people down to the extent that, in my opinion, he was able to continue to do his own thing (whether that was the correct way to do things or not). Mr O'Brien's response to me on numerous of occasions was, 'are you, as a non-clinical person, questioning my decisions?'. Examples of when he would have said this would have been when he was admitting patients straight from home a few days before they were going to theatre for work-up and the hospital system was struggling with bed pressures and trying to get the emergency department freed up to see other patients. When I took advice from other clinicians on this issue (as I always did first), they would have told me there was no need for them to be admitted so early in advance of their surgery and they would have detailed what needed to be done and what could be done in the community or via a visit to hospital outpatients in advance of being admitted. I always would have advised Mr O'Brien of this but he would then get cross, as he considered that I was going 'behind his back', and maintain that what the others were saying was incorrect.

67.3 From other consultants, I have heard some of them saying that Mr O'Brien was their mentor, either during training or when they came to work in Craigavon Area Hospital, and therefore I believe this made it more difficult for his colleagues to challenge his practice as they respected him too much.

67.4 Urology are a close-knit team with the majority of the team having been together for a long number of years and I think Mr O'Brien's practice became accepted, that there was a view that, when issues have been raised, nothing was done to him, and that people (including myself) became complacent. People would have said, 'it is just Aidan and, sure, that is the way he has done things for years'.

67.5 It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr O'Brien's practices and Mr O'Brien

using his connection to the Chair to his advantage, were other features or causes of what went wrong within Urology services. On occasions, Mr O'Brien in conversations with me and other members of the team would advise that he had spoken with the Chair directly to advise her of the capacity issues within Urology Services and he would have told us that she had assured him that she would sort this out, for example, that she would work on getting the urologists more theatre time. He would have advised of the times that he had met and spoken with Mrs Brownlee at social functions and that he had made her fully aware of what was happening in Urology. He also mentioned on a number of occasions that she was involved and supported the work of CURE (Craigavon Urological Research and Education), which is a limited company set up by a number of urological staff to provide funding (raised through fundraising) to allow for urology staff to do research and training and attend courses, and of which Mrs Brownlee had been a Director and she had also been actively involved in fund raising. As previously mentioned, I believe she was involved in asking at least two members of Trust staff who were actively trying to manage and address concerns regarding Mr O'Brien to step back (Mr Mackle and Mrs Gishkori). Although I am not aware of any other incidents, this outside influence always concerned me because, like the mentioning of his legal connections, Mr O'Brien also referenced this connection in his conversations and, in my opinion, the purpose may have been to make others feel intimidated by the knowledge that he was influential with someone who held a senior position in the Trust's senior management.

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

68.1 In my opinion, there has been a lot of learning from a governance perspective and in this paragraph of my answer I confirm that I would agree

with the lessons highlighted in Dr Dermot Hughes' overarching Serious Adverse Incident report as follows:

a. The Trust must promote and encourage a culture that allows all staff to raise concerns openly and safely.
b. Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collaborative and equal culture.
c. The Trust must take action if it thinks that patient safety, dignity or comfort is or may be compromised and mechanisms should be put in place to allow this to happen.
d. The Trust have commenced strengthening its governance structure and there has been a lot of work on improvement being developed and led by our previous Medical Director, Dr O'Kane, and this needs to continue into all Directorates and Divisions within the Trust.

68.2 In my opinion, there has also been the following learning from a governance perspective:

a. A key learning for me is the failure of staff to formally raise concerns that they had about Mr O'Brien's practice. So, whilst we were aware of non-conformance with triage, patient notes at home, IV antibiotics and cystectomies, I think that there were a lot of missed opportunities to become aware of issues such as medication practice (bicalutamide), not having a key worker present with him during oncology consultations, not acting on results, and not being available for the morning ward rounds. Whilst I could monitor the aspects of his job that I was aware of, I do believe that, if others had raised these other concerns, we would have been in a position to address these much sooner than when they came to the fore in 2020.

b. Whilst it has greatly improved in recent years, particularly under the leadership of our previous Medical Director, Dr O'Kane, I do feel there needs to be a better inclusion of the non-clinical managers with the clinical managers. This will help to highlight clinical issues as well as the non-clinical issues and, whilst I had a very good working relationship with my clinical managers, I know that this is not necessarily the case for other specialties. Whilst this Public Inquiry is focused on the Urology Service, I think it is obviously important that any lessons or improvements of broader relevance to the Health Service here are captured and implemented.

c. Learning from Serious Adverse Incidents/complaints should not be done in isolation of each individual event and trends should have been picked up earlier, for example, not reading results, delays in contact with patient/family, and lack of correspondence after patient attendance. Also, delay in completing the SAIs and complaints sometimes meant, or at least ran the risk, that another event had occurred before the recommendations could be implemented. The Patient 16 case, *which can be located in Folder – Relevant to Acute, Document Number 51, 51L with or between any patient or family member of a patient,* Patient 16 *- 20200203 Final Report* Personal information redacted by USI happened in 2016 but the report was not signed off until 2020, so the learning of this was not available and some of the points were then raised in the SAIs of 2020

Document attached namely;
364. 20210421 - overarching report to HSCB on 9 SAI's
and can be located in folder - Martina Corrigan - no 24 of 2022 - attachments

d. In my opinion, the governance departments do not have enough human resources. Therefore, more resources should be aligned to governance, particularly support to operational managers who

have demanding day jobs, ensuring the flow of patients both electively and as emergencies, and the day to day running of their services. It would benefit those managers if they had more input and support in responding to complaints and queries, and had the time to identify trends and patterns in areas such as complaints/SAI/queries coming in from, e.g., MLAs and MPs, which could then be discussed with the Divisional teams. I think that the accountability should still lie with the Divisional team but it would assist greatly if there was someone who could gather information for complaints and meet with consultants, organise patient meetings, etc. and if this member of staff could be part of the Divisional team.

e. In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff they need to know who this is and what authority they have as their accountable manage. It is my observation that there wasn't a clear line of accountability/management whilst I was in post. So, whilst the consultants were directly accountable to their Responsible Officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a Clinical Lead (Mr Young), and whilst I believe it was understood that he should be managing the rest of the Urological consultants, Mr Young never had an actual job description outlining what this should entail and (from my recollection) only got 0.5 PA to be the Clinical Lead, so I don't believe that he ever felt that this was his role (although this would be a matter best addressed with him). I do feel that it was unfair in any event to have peers attempting to manage peers as these were their colleagues and it was hard to hold them to account when they were of the same grade. Equally, it was difficult for a non-urologist clinician to manage them as they were not familiar with the way the service worked, hence the reliance on the Head

of Service. However, as a non-clinical person I felt that issues slipped between a number of people, as one group felt the others were managing the concerns and, unfortunately, I do believe that Mr O'Brien was aware of this and used it to his advantage when he continued not conforming to systems and processes.

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

69.1 In my opinion, I think that whilst issues were addressed over the years by myself and others (mainly triage) that there was a failure to engage fully with the problems within the urology services. The main reason for this was that, when the issue with triage was raised with Mr O'Brien, it would resolve for a short-time before re-emerging and the cycle would repeat before it eventually did come to a head in 2016/17. From when I commenced in 2009 until 2016 the issue with triage kept re-emerging and, whilst I would have escalated and worked with Mr Mackle and Mrs Trouton (who I understand escalated in turn to their respective directors, Acute and Medical), it is my understanding that nothing further ever happened with these escalations. I am not in a position to say why this was but I believe that this was a failing which, if sorted in those earlier years, may have prevented patients coming to harm later. It is my understanding that Mr Mackle and Mrs Trouton met with Dr Richard Wright in January 2016 after he took up post as the new Medical Director and it was after this meeting that he asked them to address the issues with Mr O'Brien in writing, which happened in March 2016. Whilst I was aware of the contents of the letter (as I had provided the data for it and also accompanied Mr Mackle when he gave the letter to Mr O'Brien), I didn't follow up on this as it was my understanding that Mr O'Brien would come back to us with a plan. Also in April 2016, Mrs Gishkori reorganised her

Assistant Directors and Mrs Trouton was moved to Women and Children's and Cancer and Clinical Services Division and Mr Carroll was moved to Surgery and Elective Care. Mr Mackle also resigned in April 2016. I believe Mr Carroll was alerted by Mrs Trouton to the content and issues in the letter and I know that Mr Carroll did have conversations with Dr McAlister, who was interim AMD, and Mr Weir as Clinical Director (both didn't take up post until June 2016 – so medical management was absent for 2 months). I was not aware of, or involved in, these discussions but I acknowledge that I failed in that I didn't follow up on any aspect raised in the letter that was given to Mr O'Brien in March 2016 because I wrongly assumed that it was being addressed by others (Assistant Directors/Director of Acute/Medical Director).

69.2 As stated previously, I took up my post as Head of Service in September 2009 and, whilst as outlined above, there have been problems in respect to recruitment, long waiting lists (performance in general), accommodation and equipment, I believe that we as a senior management team addressed those of the problems that were within our control to the best of our ability. This belief includes how we addressed the issues that arose in 2016/17 when Mr O'Brien failed to comply with good practice by not triaging, by having large volumes of patient notes at home, by not dictating on outpatient attendances, and by adding private patients inappropriately to the theatre lists ahead of NHS patients. We put a return to work plan in place to monitor Mr O'Brien and we moved the triage from paper to electronic (urology services were one of the pilot specialties in this regard).

69.3 Leading on from my statement in answer to question 68 above, that there needs to be more inclusion between non-clinical and clinical managers, in my opinion there was, in respect of Mr O'Brien's Medical Management (up until 2018), a failure to engage fully with these problems. It is my belief that Mr O'Brien was simply unable to be managed by his clinical managers. To quantify this, I refer to the issues that I am aware of

over the years of my tenure and, in my opinion, whilst they were isolated and he appeared to conform, he would then do something else in its place that needed addressed, and I feel that he used the change in personnel to avoid conforming. I have outlined examples below:

a. 2009/2010 - the regular administration of intravenous antibiotics and fluids, in which I was not directly involved but did have to monitor his 'regular' patients to ensure that he didn't admit them for this procedure.

   i. I am aware that this was raised with the Medical Director (Dr P Loughran) and that the Health and Social Services Board, through Dr Diane Corrigan, was involved with this issue. I am also aware that Mr Young followed the same practice, but I know that Mr O'Brien was Mr Young's mentor when he started in Craigavon Area Hospital in 1998 and, as it was Mr O'Brien's practice and hadn't before been challenged, then I can understand why this may have led to Mr Young following the same practice. I confirm that, when this practice was challenged, Mr Young was much more receptive and conformed more with the meetings to discuss this issue than Mr O'Brien, who strongly felt that this practice was in the best interest of his patients.

b. 2010-2016 – non-conforming with triage of GP/other consultant referral letters.

   i. There is evidence that this was dealt with operationally but I am not aware if this was escalated to the Medical Directors (Dr Loughran/Dr Simpson) until it came to a head in 2016/2017, and, in my opinion, I do think this should have been addressed by the Directors of Acute Services to the Medical Directors as it would appear to me that it was escalated no further that the Directors of Acute.

c. 2011 – the practice of benign cystectomies, in which I was (again) not directly involved, apart from facilitating the notes for the external consultant, Mr Marcus Drake.

i. Whilst I agree that I, as the non-clinical manager, didn't need to see the report, I think the Terms of Reference and the outcome of the report may have been useful. I also believe that this report was shared with Dr Corrigan in the Health and Social Care Board and often wonder if there should have been something further done by the Health and Social Care Board with this information that may have prevented the issues that arose with clinical practice in 2020 and I also am not aware of whether Mr O'Brien knew of this lookback or whether a copy of the report had been shared with him.

d. 2011 – issue of throwing patients notes in the bin on the ward.

i. Whilst this was escalated to me from the Ward Manager and I had forwarded the email on to the Associate Medical Director (Mr Mackle), Assistant Director (Mrs Trouton), and Assistant Director of Human Resources (Mrs Helen Walker), I never heard the outcome, apart from that there would have to be a formal investigation into this. And whilst this would appear to have been an isolated incident, again it was part of the overall issue with Mr O'Brien in respect of his attitude in that he appeared not to think anything of throwing these notes in the bin and I was aware, from speaking with Sr Tedford, that he was adamant that he hadn't done anything wrong.

e. March 2016 – issue of letter to Mr O'Brien regarding untriaged letters, review backlog, no patient letters and notes at home.

i. Whilst I provided the data for the letter to Mr Mackle and Mrs Trouton and was present with Mr Mackle when he gave Mr O'Brien the letter, I was not involved in the reasoning or decision-making as to why the issues were being addressed in this way on this occasion (as stated previously, they had been happening since I took up post in 2009 and attempts had been made to address them previously). Nor was I involved in any follow-up and I am aware only very recently (since the start of this Public Inquiry) that there had been an oversight meeting in September 2016 but the detail of this was not shared with me at the time. I believe that this was led by the Director of Acute Services (Mrs Gishkori) and the Medical Director (Dr Wright), but my next involvement was in December 2016 after a letter from Mr Glackin (Consultant Urologist) had been shared with Mr Carroll, my Assistant Director, from Dr Tracey Boyce (Director of Pharmacy, with responsibility for Governance), and Mr Carroll had asked me for information on Mr O'Brien's review backlog. In my opinion, as Head of Service I could have assisted from March 2016 on the monitoring (just as I did after he returned to work in February 2017).

69.4 To conclude, I believe that there were attempts to engage fully with the problems and each time they arose they were addressed and worked through to what appeared to be a satisfactory conclusion. However, I do think that there was a failure to address the fact that Mr O'Brien was set in his ways and continued to deviate from processes and systems and particularly when there was a change of personnel. However, this failure was more to do with Mr O'Brien himself who I feel, on reflection, was very difficult to manage and, in my opinion, he appeared to feel that he should be allowed to do his own thing and not conform.

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

70.1 Overall, I do believe that mistakes were made, both by me and others, in handling the concerns that I have mentioned previously in my statement.

70.2 Firstly, by way of both explanation and/or mitigation of my mistakes I offer the following:

a. We all had busy operational roles which meant that, during our 9-5 hours, we would have spent a large amount of times away from our desks and managing issues from a patient flow perspective, talking to staff on wards or departments such as Thorndale or outpatients. We were dealing with managing performance issues and, at a time from 2010-2016, we as an operational team were responsible for ensuring that no patients waited longer than 12 hours to be admitted to a ward, and this involved constant management of patient flow through the hospitals. I also worked on the out of hours on-call emergency rota and, whilst the main purpose of this is to be available and manage a major incident, it also means that we work with the patient flow teams out of hours to manage the flow of patients from the Emergency Department. This is a very demanding aspect of our roles and, sometimes, it meant staying on to work with patient flow and two examples that show the extent of the pressure are the following:
    i. On a Friday night during the winter months of 2014, when I was on call with Mrs Trouton, we had

to make 23 moves of patients in beds in order to clear the Emergency Department to allow patients to be off-loaded from ambulances as there was no room left (not even on the corridors). We had both had been in work from before 8am that day but neither of us left until 2:30am and I still had to drive back home to Fermanagh (60 miles).

ii. On a Monday night during the winter of 2015, I was on call with Mr Carroll and (having been in work that day from 07:30am and having just arrived home at 9:00pm) I got a phone call at 10:30pm from the Emergency Department Consultant to advise that, if we didn't get space to treat patients, he was going to have to declare a Major Incident. I advised that I would return to work to help assess the situation, I rang Mr Carroll and he agreed to meet me at the hospital and, when we arrived, the only option for us was to open and staff the day ward and, as there was no overnight staff in this ward, Mr Carroll and I staffed the ward until the day staff came on duty, at which point he and I went back to our respective offices and worked until 5:30pm as neither of us could get home again due to winter bed pressures.

b. Whilst I have explained both of these examples in detail, there are many other times when I either didn't get home at all or when would have put in 15-hour days to meet the demands of the day job or where I spent most of the night on the phone sorting issues.

c. Therefore, I admit that during the first part of my tenure (up to approximately 2017) when I probably should have been watching or monitoring what Mr O'Brien should or should not have been

doing and escalating more, I didn't do this and, on reflection, this was a mistake on my part.

d. As Mr O'Brien was very poor at responding to emails I would often have gone to speak with him directly. I would have gone directly to Thorndale to his clinic and waited until he was free (between patients) to ask him to triage/ bring notes in from home/schedule patients etc. If he wasn't in Thorndale, I would have gone to his office on the second floor at CAH and, if not there, I would have called to the ward to find him. Once located, I would have raised the issue re triage/notes/scheduling etc. On reflection, this less formal, verbal approach was perhaps a mistake as it was not evidenced – i.e., I have nothing in writing to back it up. At most I have some emails where I indicated, in terms, that I was going to find him to speak to him.

e. On reflection, I should have kept more notes of meetings that I had with the urology teams and of discussions we had. However, being part of the team and part of the discussions, it was very difficult to take a record of the meetings and also be involved in the discussions. I recognise that this is a failing now and that I should have had an admin person with me at meetings. As we had only one such person between five of us, however, I am not sure that this would have been possible.

f. There were times when I did try to cajole Mr O'Brien by advising him that I was going to get into trouble if he didn't conform and, during these times, I didn't escalate the issues. On reflection, this was a mistake on my behalf because, whilst there were occasions when he did improve and conform, more often he did not do so and I let him away with it. However, I will say that, whilst this was on reflection a mistake on my behalf, I also feel that it should not have been my role to 'babysit' everything Mr O'Brien did or didn't

do. I had two teams, Urology (at one stage comprising 6 consultants, 2 registrars and 1 staff grade) and ENT (comprising 7 consultants, 3 staff grades, 2 registrars, and 3 junior doctors), and whilst monitoring was required across both teams to ensure everything was on track, the other members of my two teams conformed with proper practice and I never had cause to speak to or escalate issues in respect of them as I did with Mr O'Brien. So, I do feel aggrieved that I had to so often chase and monitor Mr O'Brien as this prevented me having more time to work on service improvement, and this was particularly the case from 2017 until Mr O'Brien retired in 2020.

70.3 In my opinion, I do think that there were also mistakes made by the senior medical personnel responsible for managing Mr O'Brien. As detailed previously, his strong personality came through when managers tried to address concerns with him in that (in my view) he managed to influence senior managers to persuade those staff to leave him alone (e.g., in respect of Mr Mackle). I believe that this was a mistake with the Senior Management Teams effectively letting Mr O'Brien away with threatening behaviour in order to stop being micro-managed. When issues were highlighted and he was spoken to, he often chose to ignore these interventions and nothing was done. I believe that this too was a mistake and that he should have been disciplined for this, just like any other member of staff, who is deemed not to be conforming and/or making mistakes, would have been.

70.4 An example of this is when he was asked on numerous occasions not to do his own scheduling of patients for theatre lists yet he continued to do it his own way. This entailed him ringing each patient and detailing what they needed to do or not do. Whilst this practice was good for the individual patient, no other consultant did this and, during the time when he was doing this, he wasn't doing important tasks such as triaging, dictating or looking at results. He

was, therefore, doing a task that it wasn't necessary for him to do. I know that, over the years, clinical managers (especially those doing his job plan/appraisal) asked him to stop this unnecessary practice and explained the reasons why he should stop as he always requested more admin time and it was felt that, if he ceased the individual scheduling of patients, then he would have that additional time. But he chose to ignore this directive and continued this practice right up until he retired.

70.5 Mr O'Brien always dictated his own workload, right from the time of the Regional Review when he would not agree to the numbers of patients being booked to his clinic. The (then) Director of Acute Services (Dr Rankin) overturned this and asked that we booked the agreed number of 14 patients to his clinics (8 New and 6 Review), which we did and we ended up having to reduce this to 8 patients as Mr O'Brien wasn't finishing his clinics until 8pm at night, which was unfair on patients waiting and on the staff as this was every Tuesday evening. Mr O'Brien, when challenged about this, said he would not rush appointments, yet the rest of his peers were able to see the required number of patients without any complaints from patients that the consultations were rushed. So, once again, Mr O'Brien got to do his own thing and, in my opinion, this was a mistake by his clinical managers as to me it appeared as if he was being rewarded for his bad behaviour.

70.6 I also think that a mistake was made in the first Maintaining High Professional Standards investigation. I do feel that, in February 2017, Mr O'Brien should not have been allowed back to work so soon and particularly he should not have been able to come back until after the investigation was fully completed. There were too many issues and I think that, by allowing him back so soon, there was not a proper plan in place to manage him. For example, I now think it was a mistake that the monitoring only took place for outpatient dictation

and outcomes, which was agreed by the case managers through the oversight group as this is where the issue had been identified in December/January 2016/17. However, as I discovered when doing the admin lookback in June 2020 (prompted due to two patients not being added after emergency surgery to the waiting list) there were patients who had been in under Mr O'Brien's care as an emergency patient or as a daycase that had either no letter dictated (36 patients) or had a delay in dictation (120 patients, with the longest delay 41 weeks from their episode). So, whilst he changed his practice for outpatient attendances (because he was being monitored), he didn't for the rest of his practice including the oncology multi-disciplinary meetings. In my opinion, had all of his practice that required a follow-up letter or instruction been included in 2017, then maybe the issues that arose in 2020 could have been avoided.

70.7 In my opinion, the 'work around' of adding patients to the outpatient waiting list on the clinical priority given to them by the GP was a mistake. I think that, whilst the intention was good in that all patients were getting on to a waiting list without delay, it meant that we didn't have the clear visibility regarding non-triage / triage delays that we would have had previously. So for example, under the old system I could have looked at the waiting list and seen where a patient wasn't triaged as they had no waiting list code against them. However, the new system didn't have these 'blanks' and therefore it was appearing as if every patient had been triaged. Although the Booking Centre kept outcome triage sheets and filed these with the letters when they were returned, this was not visible to the Operational Support Leads (Sharon Glenny and Wendy Clayton) nor to myself as Head of Service. However, it would have been expected that the issue of no triage would have been escalated but this didn't happen after the 'work around' system was put in place.

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

71.1 My observation is that, whilst everyone tried to make governance top of the agenda, I do feel that it didn't get the time that it required given its importance. My concerns for the governance arrangements were that there were not enough resources put in place within the Governance Departments.

71.2 In my opinion, both of my Assistant Directors (Mrs Trouton and Mr Carroll) took governance very seriously and they would have had a monthly team meeting to discuss issues such as responses to complaints, Datix, serious adverse incidents, staffing issues on the wards, patient safety issues such as falls, central lines, VTE risk assessments etc. Both Assistant Directors also discussed the Risk Registers with respect to our own Divisions and we all would have updated these at the meetings so as to feed into the Directorate and Corporate Risk Registers if relevant.

71.3 My main concern with regard to the governance arrangements (shared by other Heads of Service in the Surgery and Elective Care Division) was the lack of dedicated time that we had to spend on governance. So, for example, when we received a complaint from the Governance Department we had a short period of time to respond and get this returned for approval. If the complaint was straightforward, for example, a query with respect to what the waiting times were for certain procedures, then we would have turned this around quickly. However, if the complaint required input from a number of areas (such as the ward staff, consultant staff, outpatient staff etc.), this took much longer as we didn't have the time to keep chasing the consultants and other staff. The result of this was that the response times would slip, the Governance Department would send escalation emails, and

we as Heads of Service (whilst we would have sent the escalation emails on) didn't have the dedicated time we would have liked and required to concentrate on getting the outstanding responses. I also admit that I didn't have the time to look for trends in Datix, complaints and SAIs. This had always been a concern of mine as, whilst I took governance very seriously, I didn't have time to commit to this as much as I wanted due to the day-to-day pressure in my role. In fact, for much of my time as Head of Service, the responses to these complaints were done by me out of working hours and or at weekends.

71.4 I can confirm that I raised this concern regularly at meetings with my Assistant Directors, both one-to-one and at the Divisional team meeting. In particular, when I would have been asked to account for why I hadn't met the deadline for a response to a complaint, I would have advised them that I didn't have the time that I would have liked to respond properly as I was operationally busy doing the day to day firefighting (to ensure there was a proper patient flow, that clinics were booked to capacity, that my wards were staffed safely, etc.) and I always expressed the opinion that there were not enough resources and that we needed a dedicated governance member of staff to work on the team. I do know that both Mrs Trouton and Mr Carroll were of the same opinion as they would have shared conversations that they had at their Acute Governance meetings.

71.5 During my tenure there were changes in the personnel within Acute Governance and I understood that each of the Heads of Governance did try to embed changes to ensure that governance was fit for purpose and I do know this was always through ensuring that there were more resources and that there were proposals put forward to help strengthen this governance. However, during my tenure this never got embedded and therefore I feel that this did lead to the governance arrangements not being fit for purpose. All this was raised and discussed at our Divisional team meetings.

Urology Services Inquiry

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 Having read through my responses to all of the above questions, and based on the knowledge I have of matters at present, I can confirm that I have nothing further to add.

NOTE:

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

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 06/07/2022

Section 21 Notice Number 24 of 2022

Witness Statement: Martina Corrigan

Index

Attachment	Document Name
1	Head of Urology and ENT Job Description
2	Public Inquiry AD JD
3	202001- SEC Organisational Chart
4	Stone Treatment Centre Improvement Project
4a	20140902 The Vision
5	20150925- E Learning from medication incidents June 2015
6	20150925- E Learning from medication incidents June 2015 A1
7	20150925- E Learning from medication incidents June 2015 A2
8	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY
9	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A1
10	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A2
11	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A3
12	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A4
13	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A5
14	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL

	POST-MORTEM EXAMINATION HSC REGIONAL POLICY A6
15	20151016 - E HSS(MD)172015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY A7
16	20151025 - E Management and advice for patients-clients with swallow-dysphagia problems
17	20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A1
18	20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A2
19	20151025 - E Management and advice for patients-clients with swallow-dysphagia problems A3
20	20151029-E Whistleblowing Policy
21	20151029-E Whistleblowing Policy A1
22	20120930-E - Management of Seasonal Flu
23	20120930-E - Management of Seasonal Flu A1
24	20120930-E - Management of Seasonal Flu A2
25	121125-E-TYC Presentation
26	121125-E-TYC Presentation A1
27	121125-E-TYC Presentation A2
28	Public Inquiry JD Programme Director 8d
29	20091022-urology away day
30	20160922 - mins urology departmental meeting
31	20150618 agenda urology dept meeting
32	20150403-meeting MC and CNS
33	minutes of meeting re urology 17 june 2010
34	20111102- leadership walk
35	20180305 - leadership walk
36	20120523 - leadership walk

37	20130123 - E Patients requiring to be seen by the end of March
38	20130123 - E Patients requiring to be seen by the end of March A1
39	20130123 - E Patients requiring to be seen by the end of March A2
40	20130123 - E Patients requiring to be seen by the end of March A3
41	20130123 - E Patients requiring to be seen by the end of March A4
42	20130123 - E Patients requiring to be seen by the end of March A5
43	20130123 - E Patients requiring to be seen by the end of March A6
44	20130123 - E Patients requiring to be seen by the end of March A7
45	20130123 - E Patients requiring to be seen by the end of March A8
46	20130123 - E Patients requiring to be seen by the end of March A9
47	20180202 – Stone Presentation
48	20150626- Urology PIG Actions
49	20190911 - E invite to PIG meeting
50	20190911 - E invite to PIG meeting a1
51	20190911 - E invite to PIG meeting a2
52	20201207 - E agenda PIG meeting
53	20201207 - E agenda PIG meeting a1
54	20190227-PIG presentation M Haynes-M Corrigan
55	20090909- consultation response questionnaire for review of urology
56	20090909- consultation response questionnaire for review of urology letter

57	21010306 - Summary of consutlation responses
58	20090101-summary of consultation responses
59	20100513 - notes of urology steering group
60	20100521- Project Initiation Document
61	20100519- E clarity on urology meetings
62	20100519- E clarity on urology meetings a1
63	202100517-Urology Action Plan
64	201005245 E Action note of urology meeting
65	201005245 E Action note of urology meeting a1
66	20120214- Investment Proposal Template Urology
67	2010-blank template for job planning exercise
68	20111101- Job Plan AOB
69	20111101- Job Plan MA and MY
69a	20100104- proposed urology job plans - 5 consultants model
70	20121218- consultant 4 and 5
71	20100310-E uro consultant JP
72	20100310-E uro consultant JP a1
73	20130306 job planning meeting notes
74	20120812-E Team South visit
75	20100622 - E Enniskillen
76	20100622 - E Enniskillen a1
77	20100623 E from D McLaughlin Enniskillen
78	20130218- E OP Referrral Fermanagh
79	20130218- E OP Referrral Fermanagh a1
80	20130218- E OP Referrral Fermanagh a2
81	20130514 - CCG Enniskillen
82	20130916- E clinics in SWAH
83	20100614--Team South Implementation Plan V1
84	20101101- Team South Implementation plan v2

85	20101105-Team South Implementation Plan V3
86	20100401- update recommendations of Urology review
87	20130801-update on urology review recommendations
88	20140401-draft update of recommendations
89	20140401-Urology review stocktake
90	20140425-update on nursing recommendations for review
91	20111211- Job description – urologist
92	20131001-job description consultant urologist
93	20131112- specialty doctor urology advert
94	20131106- advert consultant
95	20120106- spec advisor email about job
96	20120111- replacement post Med HR
97	20120106 - email EM to MY
98	20040804 -clinton review of urology CAH
99	20001001-BAUS Guidelines
100	20020201-BAUS Guidelines
101	20100603 – Urology Benchmarking
102	20090526- E response of department of urology
103	20090526- E response of department of urology a1
104	20140311- E copy of IEAP
105	20140311- E copy of IEAP a1
106	20121018-cutting plans for urology
107	20121018-cutting plans for urology a1
108	20121018-cutting plans for urology a2
109	20121018-cutting plans for urology a3
110	20121018-cutting plans for urology a4
111	20121010 - E performance update report

112	20121010 - E performance update report a1
113	20090930-month end final position IP-DC's- 13 weeks +
114	20090930-month end final position OP 9 weeks +
115	20130524- E update from performance meeting
116	20130524- E update from performance meeting a1
117	20130524- E update from performance meeting a2
118	20130524- E update from performance meeting a3
119	20130524- E update from performance meeting a4
120	20130524- E update from performance meeting a5
121	20130909-notes from urology meeting - performance
122	20130320-performance
123	20130508 - E performance update for the board
124	20140620 - availability of performance reports on SharePoint ICATs
125	20140620 - availability of performance reports on SharePoint ICATs a1
126	20140307-availability of sharepoint reports outpatient ptl
127	20140307-availability of sharepoint reports outpatient ptl a1
128	20140307-availability of sharepoint reports in's and days
129	20140307-availability of sharepoint reports in's and days a1
130	20140306 - availabilty of Actual IP and Daycase waiting lists on sharepoint
131	20140306 - availabilty of Actual IP and Daycase waiting lists on sharepoint a1
132	20140303- availability of performance reports - diagnostic physiological measurement PTL a1

133	20140303- availability of performance reports - diagnostic physiological measurement PTL
134	20140407 - month end IP-DC position reports
135	20140407 - month end IP-DC position reports a1
136	20140407 - month end IP-DC position reports a2
137	20090930 - month end IP-DC position reports
138	20130719-E demand capacity for access target
139	20130719-E demand capacity for access target a1
140	20130719-E demand capacity for access target a2
141	20130719-E demand capacity for access target a3
142	20130719-E demand capacity for access target a4
143	20120312-E Demand Capacity Triage Urgents
144	20120312-E Demand Capacity Triage Urgents a1
145	20120312-E Demand Capacity Triage Urgents a2
146	20120312-E Demand Capacity Triage Urgents a3
147	20120312-E Demand Capacity Triage Urgents a4
148	20111211 ACTIONS-ISSUES - operational Performance Meeting
149	20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog
150	20101230- E MINUTES OF MEETING RE UROLOGY 17TH JUNE review backlog a1
151	20101230- E-action plan from urology primary care meeting
152	20101230- E-action plan from urology primary care meeting a1
153	20100614-Team South Implementation plan Appendix 2
154	20111221- E Additional Urology

155	20101221 - E - review backlog
156	20111216- E - Review Backlog Clinics
157	20101220- E Mr O'Brien's backlog reviews
158	20111230- E OP REVIEW BACKLOG UPDATE
159	20091009 - urology meeting
160	20111230- E OP REVIEW BACKLOG UPDATE
161	20150618- update review backlog urology
162	20150813- update review backlog urology
163	20150520- update review backlog and performance urology
164	20101230- E-action plan from urology primary care meeting
165	20101230- E-action plan from urology primary care meeting a1
166	20110407- GP pathways presentation
167	20111211- Pathways for Erne and DHH
168	20110901-Retention of Urine pathway
169	20110911-vasectomy pathway
170	20180701- urology performance
171	20190219- urology performance
172	20210416- urology performance
173	20220608- urology performance
174	Divisional SEC risk register - urology access waiting times
175	acute directorate risk register - urology access waiting times
176	20121019-OP Review Backlog Update
177	20121019-OP Review Backlog Update a1
178	20151012- update urology RBL
179	20151012- update urology RBL a1
180	20151012- update urology RBL a2

181	20151123 - review patients to be booked
182	20151123 - review patients to be booked a1
183	20170704 - E-Urology Trust Performance Actions 16-17
184	20170704 - E-Urology Trust Performance Actions 16-17a1
185	20091221-ACUTE DIRECTORATE PERFORMANCE RISKS TEMPLATE
186	2009-2022 – Consultants in post
187	20141002- paper re 6 and 7 urologist
188	20141002- paper re 6 and 7 urologist a1
189	20140915 costs for urology new model
190	2009-2022 – non-consultant grades in post
191	20130821 - urology plan - staff gaps
192	20140614 - activity
193	20190919 Personal Information redacted theatres
194	20190719- Personal Information ext of contract
195	20210521 - E re Personal Information redacted by the USI
196	20210521 - E re Personal Information redacted by the USI
197	20210521 - E re Personal Information redacted by the USI
198	20210521 - E re Personal Information redacted by the USI
199	20210521 - E re Personal Information redacted by the USI
200	20130123 - letter Personal Information redacted by the USI
201	job description ward manager support Thorndale and Outpatients
202	20190419 – KSF Gemma Robinson
203	20190601-MC KSF
204	20170817-MC KSF
205	20091022- urology away day
206	20100427- HM700-ltr to Trust Dir Acute re Urology review implementation
207	urology review report 2009
208	20110411-GP Pathway presentation
209	20131017 - notice of thorndale move
210	20130921 - New Urology accommodation

211	20130923-E Thorndale Unit
212	20131013- E Thorndale Urology Move
213	20131017- E Thorndale Urology move
214	20140901- The vision for urology services
215	20140901- the vision for urology services presentation
216	20190701 - Urology Team Schedule July 2019
217	20170101 - Urology Team Schedule January 2017
218	20151201 - Urology Team Schedule December 2015
219	20151210 - Paed ESWL list
220	20141212 - Theatre list monday 29 December 2014
221	20141229 - E start times monday theatres in January
222	20190219 - urology performance paper
223	20150520- urology performance paper
224	20181109 - Urology performance paper
225	20130930-email - theatre scheduling
226	20190601 - Specialty induction for urology
227	20161230 - e-referrals management
228	20171117 - new referrals paperless
229	20160304-Proposal for ADEPT Management Project
230	20180214-Stone Centre Quality Improvement Project
231	20171227- MC to JMCM
232	20170204 E IPT stent for BenignProstatic Hyperplasia
233	20170204 E IPT stent for BenignProstatic Hyperplasia att1
234	20170204 E IPT stent for BenignProstatic Hyperplasia att2
235	20171117 - E Personal Information redacted by the USI
236	20171114- funding for Trust Doctors

237	20171028 - E complaints spreadsheet
238	20171028 - E complaints spreadsheet a1
239	20171028 - E complaints spreadsheet a2
240	20171028 - E complaints spreadsheet a3
241	20171028 - E complaints spreadsheet a4
242	20171028 - E complaints spreadsheet a5
243	20171028 - E complaints spreadsheet a6
244	20171028 - E complaints spreadsheet a7
245	20171028 - E complaints spreadsheet a8
246	20171028 - E complaints spreadsheet a9
247	20171028 - E complaints spreadsheet a10
248	20140321 E staffing in Thorndale Unit
249	20140328-EUrology BC
250	20140328-EUrology BC a1
251	20140407 - E Mr O'Brien Triage
252	20140407 - E Mr O'Brien Triage a1
253	20140407 - E Mr O'Brien Triage a2
254	20140414 - BP Monitor for Thorndale Unit
255	20150325 - urology PTL's
256	20150325 - urology PTL's a1
257	20190602 - E AFC KoN
258	20190602 - E AFC KoN a1
259	20190602 - E AFC KoN a2
260	20190602 - E AFC KoN a3
261	20190602 - E AFC KoN a4
262	20190602 - E AFC KoN a5
263	20190602 - E AFC JMcM
264	20190602 - E AFC JMcM a1
265	20190602 - E AFC JMcM a2
266	20190602 - E AFC JMcM a3
267	20190602 - E AFC JMcM a4
268	20170310 green light laser
269	20191212 - Urology Elective Care Meeting

270	20191212 - Urology Elective Care Meeting a1
271	20150415- Urology Regional Workshop presentation
272	20160922 - Urology Departmental meeting
273	20150723 - Urology Departmental meeting agenda
274	20151008- urology departmental meeting agenda
275	20191219 quarterly sisters meeting
276	20191219 quarterly sisters meeting a1
277	20150626 - Urology Planning and Implementation Group
278	20151111 - Urology Planning and Implementation Group
279	20150714 - urology and implementation planning group
280	20190724 - 1 to1 sarah ward
281	20180418 1to 1 josie Matthews
282	20180418 1to 1 josie matthews a1
283	20180418 1to 1 josie matthews a2
284	20190206 - patients awaiting results aob
285	20190207 - patients awaiting results MH KR
286	20151015 - datix concern
287	20160701 - datix investigation
288	20160701 - datix investigation att1
289	20160526 datix investigation
290	20160518 datix follow-up
291	20160207 - results follow-up
292	20160720 - follow-up from a datix
293	20160720 - follow-up from a datix att1
294	20160720 - follow-up from a datix att2
295	20160720 - follow-up from a datix att3
296	20160720 - follow-up from a datix att4

297	20160720 - follow-up from a datix att5
298	20160720 - follow-up from a datix att6
299	20190502 - Backlog report
300	20190502 - Backlog report a1
301	2008 to 2021 Acute Directorate Risk Register
302	2008-2022 - Divisional SEC Risk Register
303	20120911 corporate risk register
304	20151217 - Confidential Meeting [redacted]
305	20120315 E Staff grade urology
306	20120322 E statement [redacted]
307	20120322 E statement [redacted]
308	20120621 - E [redacted]
309	20120621 - E [redacted] ZP
310	20120621 - E [redacted]
311	20120618 - E [redacted]
312	20130126 - my ltr re [redacted]
313	20160418-E [redacted] action plan
314	20160417 [redacted] courses
315	2016 mar and apr [redacted] theatres
316	20160311 - nomination for excellence awards
316a	20190829 [redacted] resign
317	20190818 - [redacted] timesheet
318	20190818 - [redacted] different booking confirmations
319	20220706- section 21 Notice 24 response to Question 47
320	20130515 - IS Service Specification for provision of urodynamics
321	20120504 - IS Urology Specification
322	20130701 Email pt returned from IS
323	20130227 pt complaint from IS
324	20100201 Lone Working Policy and Procedure
325	20120901 – CAH Urology Outpatients Business case
326	20140428- TDU Timetable
327	20190128 - TDU compliment

328	20160608- email trust excellence
329	TRF1819-03 - Mr M Young - Allocation of Funding - 18.09.18
330	TRF1819-03 - Mr M Young
331	20191204 E - Job Plan
332	20191204 E - Job Plan reply
333	20130302 – Email – Urology Job Plans
334	20131112 - E Mr O'Brien and charts
335	20131112 - E Mr O'Brien and charts DB
336	20131112 - E Mr O'Brien and charts AC
337	20191101 - Email [redacted] RIP
338	201912015 - email complaint [redacted]
339	20190929 - email complaint [redacted] RIP
340	20190319 [redacted] complaint
341	20140922 - [redacted] enquiries
342	20190716 – complaint [redacted]
343	20151201 - email query AC
344	20140416 – triage
345	20140417 - email new triage process
346	20140417 - email new triage process att1
347	20161220 email concerns raised by an SAI Panel
348	20161220 email concerns raised by an SAI Panel att
349	attachments Document 69 PIT
350	20200401-quick guide on NIECR for consultants
351	20170329 - E-Triage
352	20110301 - urology governance issue
353	20210913-SAI recommendations first draft working plan
354	20220509 - notes SAI Recommendation Implementation Super Group Meeting
355	20220509 - notes SAI Recommendation

	Implementation Super Group Meeting att 1
356	20140919-email urology triage
357	20140919-email urology triage
358	20090202- Email correspondence regarding the Urology Review
359	20090202- Email correspondence regarding the Urology Review att1
360	20090202- Email correspondence regarding the Urology Review att2
361	20100928 - Email from Patient about pelvic surgery
362	20220329 - Email Urology Service Development meeting 20180924
363	20220329 - Email Urology Service Development meeting 20180924 att1
364	20210421 - overarching report to HSCB on 9 SAI's

73209161

Southern Health and Social Care Trust

JOB DESCRIPTION

JOB TITLE Head of Urology and ENT

BAND 8B

DIRECTORATE Acute

INITIAL LOCATION To Be Confirmed

REPORTS TO Assistant Director of Surgery & Elective Care

ACCOUNTABLE TO

JOB SUMMARY

- To be responsible for the operational management and strategic development of Urology and ENT services across the Southern Trust.
- To be responsible for leadership, service provision and service development of Urology and ENT services and ensuring high quality patient centred services.
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.
- As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY DUTIES / RESPONSIBILITIES

1. Quality & Governance

1.1 Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

1.2 Be committed to supporting honest, open communication and effective multi-disciplinary working.

1.3 Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

1.4 Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

2.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.

2.2 Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

2.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.

2.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

2.5 Ensure the division implements and adheres to Trust HR policies and procedures.

2.6 Work in partnership with Trade Unions and staff representatives

in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

3.1 Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

3.2 Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.

3.3 Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.

3.4 Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

3.5 Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.

3.6 Make sure that all recommendations arising from RQIA inspections are implemented in a timely manner.

3.7 Act as a member of the division's senior management team and contribute to its policy development processes.

3.8 Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

3.9 Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

4.1 Assist with the development of the strategic plan for the delivery

of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.

4.2 Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.

4.3 Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

5.1 Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

5.2 Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

5.3 Participate in contract and service level negotiations with commissioners.

5.4 Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

5.5 Update and monitor the operational policies of the Division and take account of risk management needs.

5.6 Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

5.7 Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

6.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.

6.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

7.1 Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Elective Services.

7.2 Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

7.3 Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.

7.4 Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

7.5 Participate in and comply with requirements in the production of performance reports.

7.6 Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.

7.7 Lead by example in practising the highest standards of conduct in

accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered

and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

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

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

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE	Head of Urology and ENT Band 8B
DIRECTORATE	Acute Services
SALARY	£44,258 – £54,714 per annum pro rata
HOURS	37.5 per week (Job share may be considered)
Ref No:	73209161

June 2009

Notes to applicants:

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

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

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

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Hold a relevant[1], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years experience in a Senior Role[2] **OR** have at least 5 years experience in a Senior Role[2].

[1] *'relevant' will be defined as a business or health related field*
[2] *'Senior Role' is defined as Band 7 or equivalent or above.*

2. Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant[3] improvement in service.

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[3] change initiative.

4. Have a minimum of 2 years experience in staff management.

5. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4].

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

KNOWLDEGE / SKILLS / ABILITIES

6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.

8. Have an ability to provide effective leadership.

9. Demonstrate evidence of highly effective planning and organisational skills.

10. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

[3] *'Significant' is defined as contributing directly to key Directorate objectives*
[4] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipqualities.nhs.uk Particular attention will be given to the following competencies:

- *Self Belief*
- *Self Management*
- *Drive for results*
- *Holding to account*
- *Seizing the future*
- *Leading change through people*
- *Effective and strategic influencing*

Informal enquiries to: Email: Personal Information redacted by USI

Tel: Personal Information redacted by USI

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Quality Care - for you, with you

Assistant Director for Public Inquiry and Trust Liaison Band 8C

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Assistant Director for Public Inquiry and Trust Liaison
BAND	8C
DIRECTORATE	Executive Director of Nursing and AHPs
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Executive Director of Nursing and AHPs
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

In the first instance, the post holder will be responsible through the Executive Director of Nursing and Allied Health Professionals for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the Statutory Public Inquiry regarding the Practice of a Southern Trust Consultant Urologist. The post holder will also act as the Trust's Liaison Officer for the Inquiry Panel, the Directorate of Legal Services and other external stakeholders, for example, the Department of Health.

KEY DUTIES / RESPONSIBILITIES

For each of the following, the post holder will;

1. On behalf of the Executive Director of Nursing, lead on the coordination, administration and project management of work streams relating to the Public Inquiry.
2. In conjunction with the Executive Director of Nursing, develop, quality assure and manage processes that ensure information requested by the Public Inquiry is reviewed, accurate, complete prior to issue.

3. Lead on the administrative, systems and process management to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include overseeing the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
4. Be responsible for ensuring the preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings are completed and available as required.
5. Oversee the collation, cataloguing, storage and maintenance of evidence anticipated to be required for the Public Inquiry, and evidence subsequently submitted to the Inquiry.
6. Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
7. Be responsible for briefing and supporting staff who are required to participate in the Inquiry and for providing guidance on best practice throughout the Inquiry process.
8. Respond to any queries of the Inquiry Panel and the Director of Legal Services and to ensure the timely provision of witness evidence, and other evidence, as stipulated by the Inquiry Panel.
9. Be responsible for developing and maintaining governance processes associated with implementation of agreed recommendations, actions and learning from SAI's, Structured Clinical reviews, NICE and other Best practice guidance related to the inquiry.

Look back Exercise and Public Inquiry Management

10. Provide effective leadership in the co-ordination of the Trust's response to the Statutory Public Inquiry ensuring that the Trust meets its statutory duties with regard to open and transparent production of relevant and requested information and records.
11. Oversee the co-ordination, collation and provision of evidence, including witness evidence, as required by the Inquiry Panel and/or Directorate of Legal Services, in line with Trust Policy and Regional Guidance on the Provision of Witness Statements.

12. Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
13. Ensure that there are systems and processes in place to optimise the timeliness and responsiveness to the Inquiry Panel requests including the provision and use of an electronic system of record / data / information storage platform.
14. Provide timely information to employees in the requesting of reports and statements required by the Inquiry Panel.
15. Ensure that the relevant line manager is aware that a member of staff is being asked to attend the Inquiry.
16. Ensure that staff who are required to participate in the Public Inquiry receive adequate support throughout the entire Inquiry process, keeping the team informed of developments in the case and dates and times of any consultations. This will include supporting the relevant directorate management team to guide them through the process and ensure their preparedness to enable them to support staff.
17. Escalate any concerns in relation to potential delays in the provision of information to the Inquiry Panel through the Trust's assurance/accountability framework to the Executive Team.
18. Provide administrative support to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
19. Be responsible for preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings as required.
20. Oversee and ensure that the lookback into the care of all relevant patients is undertaken in a clear and coordinated way to ensure that patient care is reviewed to ensure patient safety and that the outcome of patient reviews is recorded .
21. Ensure that patients and families are fully communicated with and involved in any area of concern identified as part of the care provided.

22. Oversee the range of quality improvement actions that are required in response to a range of recommendations that have arisen from a number of service Serious Adverse Incidents.
23. Oversee the production of Structured Clinical Record reviews emanating from the look back exercise.
24. Oversee the review of a range of Best Practice Guidance relating to both Urology and Cancer pathways to ensure that such practice is implemented in the service.
25. Work with other stakeholders and Trust services to share the learning derived from this Public Inquiry process to ensure that best practice is implemented across relevant services.
26. Lead on the provision of Corporate Learning from the Public Inquiry process across the organisation for the improvement of patient quality and safety .

Corporate Management

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

Collaborative Working and Communication

28. Establish collaborative relationships and networks with internal and external stakeholders.
29. Engage with stakeholders across the organisation including the Risk and Governance Team and the Medical Directors Office to ensure the provision of accurate and timely information to the Inquiry Panel.
30. Work collaboratively with external stakeholders including the Directorate of Legal Services and other third party agencies as required.
31. Be responsible for developing and maintaining sound internal and external communications systems.
32. Represent the Trust, as appropriate, on external groups and to represent the Director where appropriate and as required in respect of the Trust's approach to the Public Inquiry.

Financial and Resource Management

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

People Management and Development

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

1. Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and

the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND	**Assistant Director for Public Inquiry and Trust Liaison Band 8c**
DIRECTORATE	**Nursing, Midwifery and AHP Directorate**
SALARY	**£63,751 - £73,664 per annum**
HOURS	**37.5 per Week**

May 2021

Notes to applicants:

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

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience / Qualifications	1. Have a university degree or relevant professional qualification at graduate or diploma level **AND** worked for at least 2 years in a *senior management role in a major complex organisation **OR** Have worked for at least 3 years in a *senior management role in a major complex organisation. ***Note *senior management role will be considered to be at Band 8A or equivalent or above.***	Shortlisting by Application Form

	2. Delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. 3. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years. 4. Successfully demonstrate high level people management, leadership and organisational skills for a minimum of 2 years.	
Other	5. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criterion will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	6. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff within the Trust, and outside the organisation. 7. Have the ability to collate and critically analyse statistical and qualitative information and the ability to make and take decisions after analysis of options and implications. 8. Ability to multi-task and continue to function to a high standard when under pressure. 9. Determination, drive to succeed, perseverance, and resilience. 10. IT literacy -proficient in MS Word, Excel, PowerPoint, etc.	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Knowledge	1. Knowledge / Experience of Legal Processes 2. Knowledge / Experience of Clinical Services	Shortlisting by Application Form

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

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

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

ue	What does this mean?	What does this look like in practice? - Behaviours
W king Together	ether for me for people we upport. We work across Health and Social ith other external organisations and ecognising that leadership is the ty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
ompassion	itive, caring, respectful and understanding se we care for and support and our We listen carefully to others to better and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	o being the best we can be in our work, prove and develop services to achieve nges. We deliver safe, high-quality, te care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
ness & Honest	nd honest with each other and act with ndour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

Quality Care - for you, with you

ORGANISATIONAL CHART

January 2020

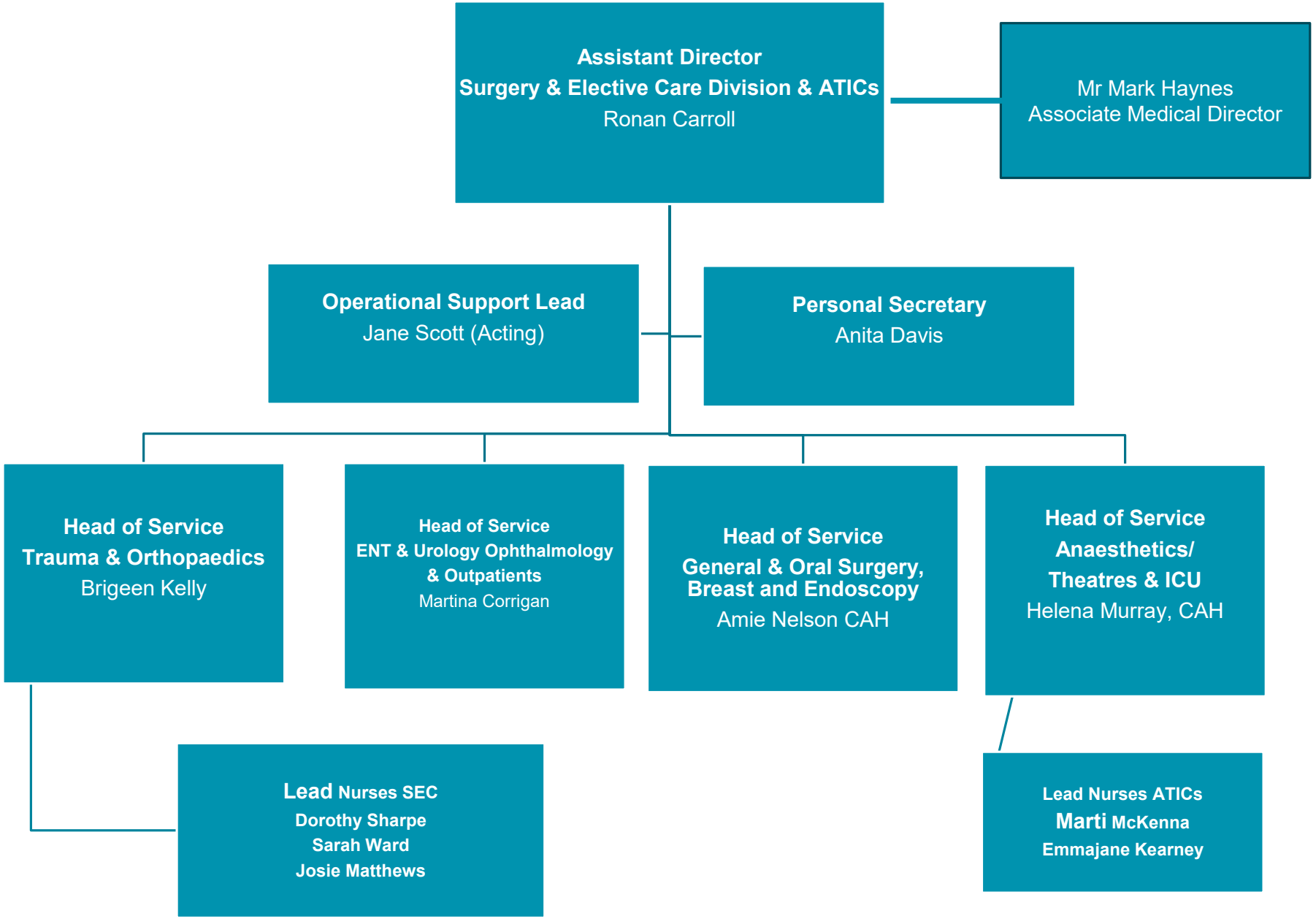
Southern Health and Social Care Trust

Quality Care - for you, with you

Surgery & Elective Care Division and ATICS

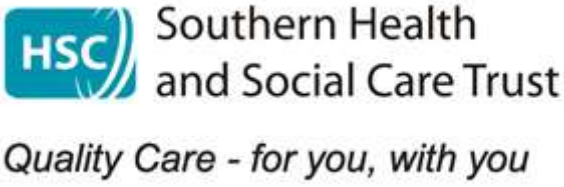
SEC and ATICS

WIT-26360



Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Stone Treatment Centre Improvement Project



Contents

1. Extracorporeal Shockwave Lithotripsy (ESWL)

ESWL is a method of using shockwaves applied to the back of a patient to treat kidney stones and ureteric stones (ureter is the pipe which drains urine from the kidney to the bladder). ESWL is undertaken with pain relief and no anaesthetic is needed unless the patient is a child, and is most commonly conducted as a day case. The alternative for stone treatment is ureteroscopy and percutaneous nephrolithotomy (PCNL), both of which require general anaesthetic and are conducted in a theatre setting.

2. Rationale

The overall lifetime risk of renal or ureteric calculi is 10-15%, the male to female ratio is 2:1 and the peak age of presentation is 30-50 years. The recurrence rate can be high, with up to 30% of cases recurring at 10 years and 90% of cases recurring at 30 years.

The Southern Trust has an on-site lithotripter providing a maximum of 3 ESWL sessions a week, with each session treating a maximum of 3 patients, giving a total of only 9 patients per week. There is currently no capacity or model for emergency ESWL. Occasional Paediatric list in conjunction with Belfast and adult patients from the Northern and South Eastern Trusts are also accommodated. The lithotripter is therefore not used for 11 out of a possible 14 daytime clinical sessions.

The average waiting time for first elective ESWL session was 9 weeks, with the longest single wait at 55 weeks as of October 2016, but the waiting time was rapidly increasing as demand increased.

Currently all emergency stones needing treatment are operated on via the emergency list. For patients who are suitable, emergency ESWL may be a more cost effective and potentially less morbid modality for treatment. Ureteric stone patients who are admitted as an emergency have been recommended to be treated within 48 hours from the decision to treat (Wiseman, 2017).

Selected patients could be removed from overburdened inpatient elective Ureteroscopy waiting lists if ESWL capacity was increased. This could potentially provide a more cost effective modality compared to use of the operating theatre and requirement of a general anaesthetic.

3. Project aim

1. To meet the demand for the Extra Corporal Shockwave Lithotripsy (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust.
2. Provide stone treatments recommended by NICE, BAUS and EAU
3. Provide patients with informed choice

In order to meet the demand for ESWL the waiting list needs to be reduced and then maintained at a reasonable wait. Imaging of patient's stone must be recent to avoid re-imaging or difficulty in identifying stone location for treatment, which can only be achieved with a short wait for treatment. The desired wait time will be set following the service evaluation and visit to a 'Gold Standard' service centre.

4. Hypothesis

Patient numbers per session can be increased by reviewing and improving the process currently in place. Extra sessions per week can decrease the overall cost of the patients treated for renal and ureteric stones by decreasing the number treated by the more costly emergency theatre and elective theatre sessions.

5. Objectives

1. Review and appraise current service set-up for ESWL. Including equipment, clinical area, staff, referral, follow-up and discharge of patients. Recording of treatments and any further investigations and stone prevention.
2. Identify current funding parameters for ESWL and potential funding
3. NICE and EAU guidelines for stone treatments in relation to current practice and application to any changes
4. Obtain costs of ESWL vs Emergency ureteroscopy surgery vs Elective ureteroscopy surgery in the Southern Trust
5. Review emergency surgery conducted over 9 month period that could have received ESWL had it been available
6. Evaluate 'Gold standard service'. How do other NHS hospital work regarding onsite ESWL including follow-up and prevention. How do the top European centres implement their ESWL service.

7. Project Scope

The project will encompass the patient pathway of stone diagnosis to treatment and discharge for those patients suitable for ESWL in the Southern Trust. It is outside the scope of this project to provide a service for stone prevention and follow-up of recurrent or high risk stone formers. The theatre practise of alternative treatments for stones, ureteroscopy and PCNL, will not be part of the project, although recommendation for type of stone treatment patients receive will be reviewed as part of the service evaluation on how patients are selected for ESWL.

8. Project Sponsor

The overarching sponsor is the Medical Director and his Executive Team. Keeping the Medical Director Richard Wright copied into important e-mails to drive the project forward is fundamental, as well as regular face to face meetings with project update presentations. The project heavily involves the Urology team especially Mr Michael Young as clinical lead and Martina Corrigan as Urology Manager and daily/weekly engagement is crucial. It is a necessity for the project sustainability and eventual outcomes to be supported that the groups of people mentioned thus far are kept regularly up to date and are in agreement with actions.

9. Project Team

In order to fulfil our aims for the Southern Trust the team will have a constant core team of staff who work at the Craigavon Stone Centre. Team members who are going to deliver the service are vital for inclusion, as they will drive the improvement, sustain the improvement, and hopefully continue future improvement. The team can learn together the methodology of improvement science, the need for improvement and not just change. There will be interaction required from other departments in order to fulfil the aims and objectives and the need for the team to be flexible to incorporate other personnel when required. The team in fundamental for success, especially in a National Health Service setting, where the varied skill sets and experience can be utilised, but without a team effort no project in the NHS can succeed as barriers will occur. The Medical Director and executive team will be kept informed and utilised as the project requires. In order to meet certain objectives input will be required from Estates, Trust architects, Pharmacy, IT, Radiology, Accident and Emergency and the remainder of the Urology Consultant Team.

The Core Team:

Mr Michael Young : Urology Clinical Lead and Project Lead

Mr Matthew Tyson: Project lead

Mr John O'Donoghue: Urology Consultant

Martina Corrigan: Manager for Urology

Saba Husnain: Staff Grade Urology Doctor

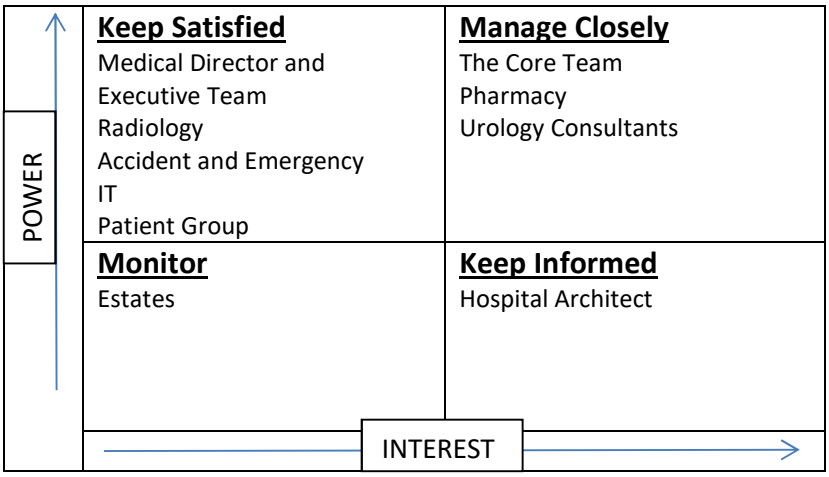
Laura McAuley: Staff Grade Urology Doctor

Paulette Dignam: Secretary and Administration

Hazel McBurney, Bronagh OShea, Bernadette Mohan, Wayne Heatrick: Radiographers

Nuala Mulholland, Mairead Leonard, Justin McCormick, Kate McCreesh, Martina O'Neil: Nursing Staff

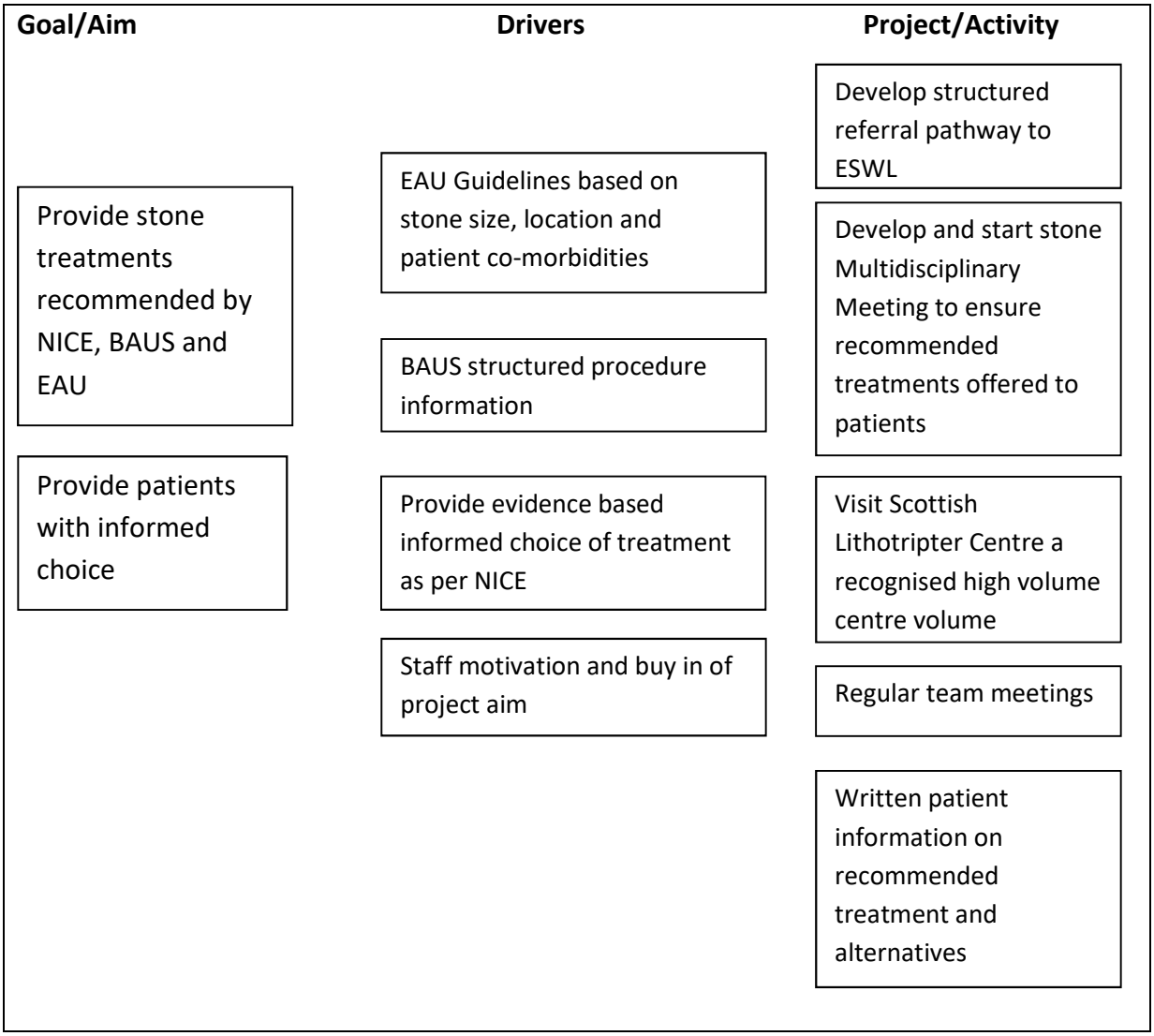
Stakeholder Evaluation



10. Approaches and Measures (Method)

To help plan the project improvement and due to the complexity of the task, driver diagrams were constructed. (Royal College of Physicians Ireland, 2012)

Goal/Aim	Drivers	Project/Activity
To meet the demand for (ESWL) service for elective and emergency renal and ureteric stone treatment for the Southern Trust	More ESWL to reduce the demand on main theatre for Ureteroscopy and Laser to Stone	Prove ESWL treatment is more cost effective then main theatre Ureteroscopy
	Reduce the waiting list for ESWL by increasing activity	Time and Motion study of ESWL treatment session
	Increase number of patient treated per day with ESWL, allowing for emergency ESWL	Evaluation of current service
	Reduce the demand for outpatient appointments	Visit Scottish Lithotripter Centre a recognised high volume centre volume
	Staff motivation and buy in of project aim	Regular team meetings
	Identify method to stop patients having outpatient appointment prior to ESWL treatment, to reduce patient wait for ESWL	Patients booked directly for ESWL treatment from diagnosis of stone



As highlighted by the driver diagram a **service evaluation** is a must and was the first step, this included the **patient pathway**, **time and motion study** of ESWL treatment session and infrastructure of the Stone Treatment Centre. This was followed by **a visit to the Scottish Lithotripter Centre** to see first-hand the processes of a high volume ESWL centre, and to determine what lessons could be relayed to the Southern Trust.

A 2 hour **Team Meeting** every Thursday morning was an opportunity for planning and review of **PDSA cycles**, keeping the team up to date, role and responsibility setting as well as motivating team members to the aim and learning.

Patient questionnaire following receiving ESWL treatment, as well as **patient and staff interview** of ESWL treatment sessions.

Data Collection and Review of Patient notes to record how many patients who received Emergency Treatment for Kidney Stones could have undergone ESWL. An analysis of the

cost implication of Emergency ESWL vs Emergency Ureteroscopy and Elective ESWL vs Elective Ureteroscopy.

Process measures will reflect the steps involved in the patient being identified and referred to the Stone Treatment Centre, such as the referral pathway, including the structured referral form, as well as the process and number of the patient(s) on the day of treatment.

Structure measures will reflect the staffing and equipment required for the Stone Multidisciplinary Meeting (MDM), and the ESWL treatment sessions.

Outcome measures will be assessed on proving the changes are improvements, these will be in keeping with the ethos of 'High Quality Health Care' (Southern Health and Social Care Trust). In relation to the overall aims quantitative outcomes will be measured as a reduction in the waiting times for patient to receive ESWL and the provision of Emergency ESWL. Quantitative review of Stone Meeting outcomes in relation to guidelines as per European Urology and quantitative patient questionnaire on 'informed choice on treatment of their stone'. Finally there is a chance to prove an economic benefit from the project, with quantitative outcome evidence that increasing funding of ESWL stone treatments saves money to the Trust overall. As noted by Donabedian outcome measures will be the 'ultimate validators' of the effectiveness and quality of this project (Donabedian, 2005)

Balances are important, so that no change or improvement has a direct or indirect negative consequence. An example for this project would be ensuring that by increasing the number of ESWL sessions that patients are successfully treated with ESWL for their stone, and only a minimal number require further treatment by Ureteroscopy in main theatre. This will be determined largely by the correct, guideline orientated selection of patients for the most recommended treatment for their stone.

11. Data Collection (Results)

1. Service Evaluation

The service evaluation looked at the patient journey from diagnosis of a ureteric or renal stone to an end point of completion of treatment of the stone. The evaluation was conducted using observation of patient pathway, interview of staff and patients and questionnaire of patients receiving ESWL treatment.

Summary of evaluation findings:

Summary of Service Evaluation August 2016

1. **Patients were most commonly diagnosed with kidney or ureteric stone in Accident and Emergency using NCCTKUB.**
2. **There was no Trust guideline policy on who, how or when to image when presenting with possible renal colic.**
3. **Referral of patients from Accident and Emergency was either by telephone call to registrar on-call or hand written free hand referral to consultant on call for outpatient follow-up.**
4. **Only 56% of patients had serum calcium checked (within the previous year) for referral of emergency treatment (Ureteroscopy and Laser in main theatre as emergency ESWL was not available). Serum calcium needed for potential risk of developing stones, and if raised a rare cause of morbidity and mortality (World Health Organisation , 2015). Only 37% of patients had their serum Uric acid checked, if elevated another possible cause of kidney stones.**
5. **Patients referred for outpatient review were seen in Outpatient Appointment prior to any stone treatment commencing**
6. **NO Emergency ESWL was available**
7. **The wait for ESWL was 9 weeks (and increasing)**
8. **Day of treatment for ESWL Stone Treatment Centre consisted of:**
    a. **3 patients treated per session (half day), 9 patients per week. Staff present for treatment X1 Staff Nurse, X1 Health Care Assistant, X1 Radiographer, On-call Doctor called to prescribe medications.**
    b. **Dedicated Stone Treatment Centre for ESWL, with modern Lithotripter**
    c. **Data from the staff interview indicated they were enthusiastic, dedicated, and eager to improve service, they had a good knowledge base and were eager for further learning and to share learning so far. Themed comments were 'need to reduce waiting list', 'imaging need to be up to date for day of treatment, images of stone diagnosis were often out of date due to the long wait for treatment', 'medications prescribed in advance of treatment as delays were being caused by waiting for doctor to prescribe'.**
    d. **The themed responses from the patient interviews were 'difficulty in finding the Stone Treatment Centre', 'long wait for treatment', 'nowhere to safely store personal items, no lockers', 'no dedicated changing room', they did also comment on 'excellent staff', 'kind staff', 'tea and scone post treatment' was most appreciated.**

e. The Post ESWL pain questionnaire highlighted the need to provide breakthrough pain medication for those who had pain during treatment, so effective treatments could be given. Pain medication was based on Piroxicam 20mg and Paracetamol 1g pre-treatment, with no breakthrough medication.
f. The Time and Motion study highlighted long period of time needed by nurses in the current method of working to consent and prep patient for ESWL, with some reaching 45 minutes. There was down-time of the Lithotripter whilst the nurse undertook the consent and checks. There was no dedicated room to consent patient and do pre-ESWL checks, the patient was in the same room as the patient who was being recovered from previous treatment, separated by a curtain, and thus confidentiality was an issue.
g. The discharge letter from ESWL treatment was a handwritten note, with a further formal dictated and typed letter weeks to months later.

9. Follow-up of treatment was a further outpatient appointment for patient.

2. **Visit to Scottish Stone Centre Edinburgh**

Summary of Visit to Scottish Stone Centre, Edinburgh, 14-15 November 2016

1. Patient Journey followed
   a. Structured referral to Stone Centre was viewed
   b. All referrals were reviewed and stone treatment recommended at Stone MDM. Urology Stone Consultants and Treating Radiographer were present at the meeting. Dictation was used to instruct which pre-formed letter to send to patient. Patients were booked direct to treatment as required by radiographer present.
   c. Letter for recommendation for stone treatment was sent to patient
   d. Patient arrives within a 2 week wait for ESWL treatment
2. Day of ESWL treatment
   a. Treatment staff included x2 staff nurses and x1 radiographer
   b. Medication was pre-prescribed (Diclofenac 100mg PR and Oral 1g Paracetamol)
   c. Breakthrough medication was available (IV Opiate)
   d. Discharge information was sheet given to patient
   e. Follow-up imaging was booked on completion of treatment by radiographer, to be viewed by Urology Consultant and further or alternative treatment planned as required.
3. Number of Patients treated
   a. 2 week max wait
   b. Capacity for emergency patient to be treated daily
   c. 3-4 patients were treated per session, and all sessions were filled.
   d. Centre ran 5 days a week (Monday to Friday)
4. Staff Interviews noted radiographers are dedicated to work only at the Stone

Treatment centre and have 'developed large skill and knowledge base', 'multiple publications have evolved from the centre', feel working full time at Stone Centre 'provides a dedicated, skilled team' to providing patient treatments, the model allows for 'minimal wait from diagnosis to treatment, thus reducing the possible re-presentation to Accident and Emergency'.

3. **Recommendations following Service Evaluation of Southern Trust Stone Treatment Centre and Visit to Scottish Stone Centre**

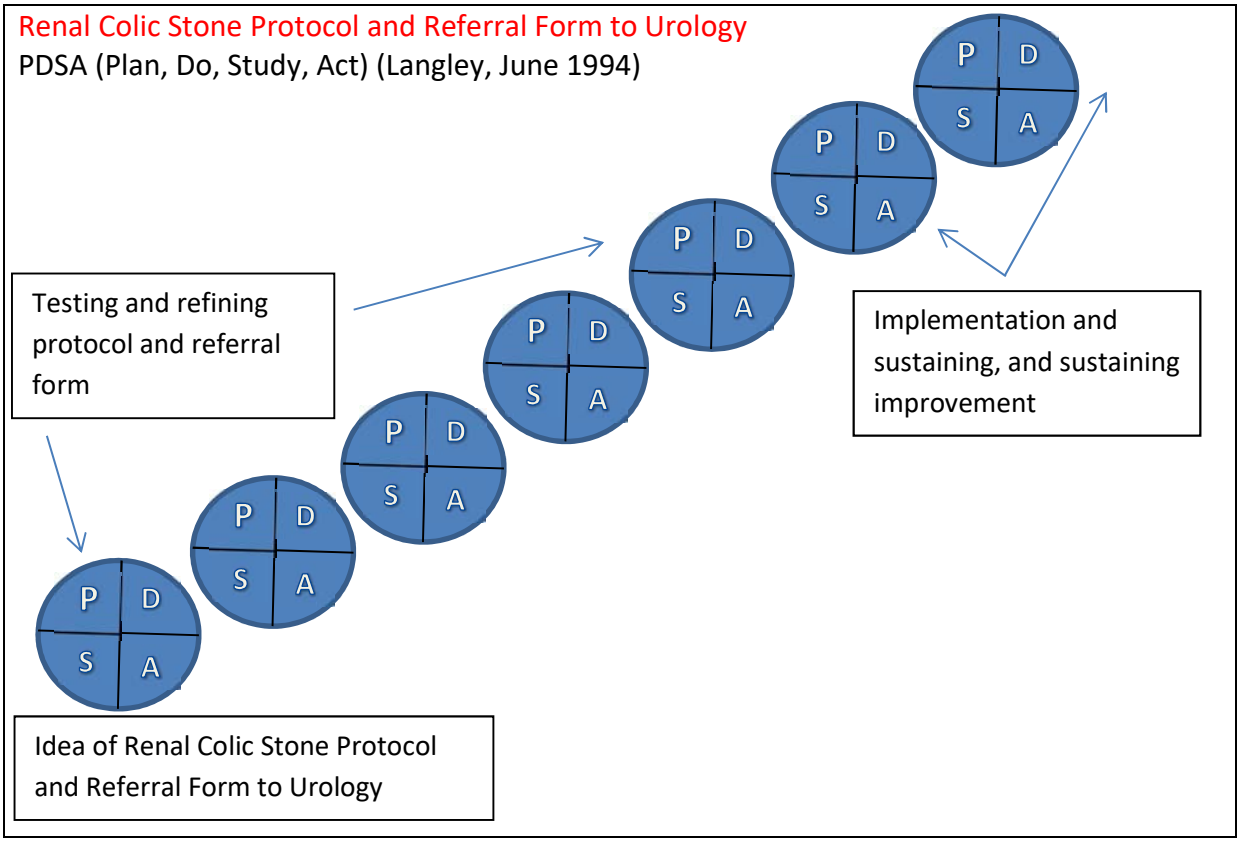
Recommendations for Craigavon Stone Treatment Centre

1. Need for Southern Trust Protocol on whom and how to image possible renal colic (Stone presentation) patients in Accident and Emergency.
2. Need for structured referral to stone treatment centre, including all information needed to recommend stone treatment at a Urology Stone MDM.
3. Need weekly Stone MDT meeting, with administrative support and dedicated meeting space with imaging available and Electronic Care Records. Pre-prescribe medication for ESWL treatment.
4. Information pack to patient on outcome of Stone MDM for recommendation of treatment of their stone, informed choice, consent form, map to ESWL Stone Treatment Centre, ability to see Doctor in Outpatient if patient doesn't want to proceed to treatment or ask further questions.
5. Decrease the wait for ESWL treatment to 2 weeks, so imaging is not out of date and prevent re-presentations to Accident and Emergency.
6. Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment
7. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
8. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
9. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.

4. **Renal Colic Protocol and Stone Referral Form for Southern Trust (pdsa cycles)**

The service evaluation and visit to the Scottish Stone Centre highlighted the need to provide the Southern Trust with a Renal Colic Stone Protocol to help Doctors in Accident and Emergency decide on when to image, how to image, blood tests required and how and when to refer to Urology. The referring doctor should complete a structured Stone Referral Form so all information that is a necessity is provided, so a treatment option can be recommended to a patient from Stone MDM. The Thursday Morning team meeting was utilised as a platform for ideas (plan), invited speakers from other specialities and distribution of work (do) and review (study), to eventual implementation (act).

The Renal Colic protocol and Urology Stone Referral Form needed input and agreement from Urology, Accident and Emergency and Radiology departments. Background work was required to ensure all recommendations were evidence based and fitted with current guidelines for all specialities involved (C. Türk (Chair), 2016). Numerous PDSA cycles (X7) (Langley, June 1994) were required in order to agree on the current forms which are now in active use. The current forms can be viewed in the appendix.



5. **Stone Multidisciplinary Team Meeting (MDT) benefits**

The Thursday morning team meeting evolved in to the Stone MDT.

The Stone MDT model allows a much greater through put of patients then a single doctor seeing a patient in clinic. It benefits the patient as they are discussed amongst a group of healthcare professionals, with an evidence based treatment of their stone recommended. It means the time from diagnosis to treatments is reduced. The MDT model was based on the Scottish Lithotripsy Centre model, and relies on organisation for the weekly meeting.

The weekly Thursday MDT has discussed up to 30 patients in a meeting so far. The meeting will eventually incorporate new patient referral in the first part, then review of follow-up imaging in the second part of patients who have completed their ESWL treatment to ensure their stone(s) have been successfully treated, then a template letter confirming this could be sent.

Patients have already been given their diagnosis of a stone and location when they presented, usually to Accident and Emergency. The outcome of MDT, if conservative treatment or ESWL then patient information pack can be sent so they can proceed directly to treatment or further imaging. All the information needed to make a decision on a patient in included in the Urology Stone Referral. There is always the option to see the patient in Outpatient Clinic if the option needs further discussion, such as Percutaneous Nephrolithotomy, or significant co-morbidities, although these are the minority.

Urology Stone MDT

Benefits:

1. **Platform for discussion of complex patients, what is their most suitable management and by whom. The full range of therapeutic options can be discussed**
2. **A+E referrals can be reviewed and patients placed for appropriate treatment with only complex patients or high risk patients having outpatient's appointments. (All patients could be offered an outpatient appointment if wish to discuss their MDT outcome further, prior to any treatment).**
3. **Shorten delay to treatment with direct booking.**
4. **Decrease number needing outpatient appointments, thus saving money.**
5. **Patients may be happier not to see doctor in outpatients if their case has been discussed with the experience of multiple healthcare professionals then just one in clinic.**
6. **Education platform for staff.**
7. **Time to disseminate any quality improvements cycles, audits or concerns and compliments.**
8. **Any clinical trials, allow suitable discussion and allocation.**

9. **Potentially greater continuity of care.**
10. **Improved and more efficient coordination of the stone service.**
11. **Improve communication between care providers and develop clear lines of responsibility.**
12. **Improve resource management and efficacy, such as on site lithotripter (minimises paper work on treatment days, allowing increased capacity).**

Disadvantages:

1. **Some may see discussion of straight forward cases as unnecessary, (if patients are booked direct without discussion at MDT, then data capture is required for audit purposes)**
2. **Meeting only held once a week, some patients will need treating prior and not go through MDT.**

Potential Cost Savings of Patients being booked directly to treatment for ESWL

Cost of New Outpatient Appointments = £250
Cost of Follow-up Outpatient Appointment = £170
Combined total of = £420 per patient

Number on waiting list for ESWL = 233

- Potential cost saving of £97,860 in appointments if directly booked and followed up with imaging and letter
- On average 31 new patients booked for ESWL per month (average June to December)
- The number of ESWL patients increases year on year as stones become more common due to diet factors, increases in obesity and aging population, as well as potentially global warming (stones are more common in warmer climates)
- The potential savings will therefore increase year on year by utilising the MDM model.

6. **Patient Information Pack** (see appendix)

Following an MDM discussion, the patient is placed on the correct, guideline recommend pathway for treatment of their stone. The outcome of MDM is communicated to the patient in a letter, with the majority of letter a standard template to save administrative time, see appendix. Those patients selected for ESWL treatment of their stone are also sent an information pack on the treatment.

The information pack was developed from first reviewing the Scottish Stone Centre patient information, an internet search of other centres patient information on ESWL and the British Association of Urology consent for ESWL (British Association of Urological Surgeons , 2016).

From listening to the patients we included a map, and a plan set in place to review patient's satisfaction on ease of use to arrive at their destination.

The documentation went through a number of PDSA cycles, taking around 6 months to reach agreement with the MDM Stone Treatment Group, until a version was ready for sending to patients. The next PDSA cycle will be to study the evaluations of the information from the patient group.

From the time and motion study the information pack was designed to decrease the time taken to pre-admit a patient before they commence their ESWL on the day of treatment. **This would help in time saving on day of treatment and allow an extra patient to be added to the treatment session, such as an emergency patient.**

The information pack includes: a. MDM letter outcome (template letter)

b.Information and consent on ESWL

c. Map on how to find Craigavon Stone Treatment Centre

d. Advice on discontinuation of medication pre-treatment and when to re-start

The Next PDSA cycles

The patient information pack sees a number of PDSA cycles running simultaneously (Langley, June 1994).

a. **Patient feedback questionnaire on contents on patient information pack (Study), all separate, yet linked PDSA cycles.**

b. **A repeat time and motion study to review if the patient information has decreased administration time for admission of patient prior to treatment.**

c. **Though MDM and pharmacy involvement to ensure medication advice sheet stays up to-date. Periodic review date set, and awareness of pharmacy to notify of updates.**

7. **Extracorporeal Shockwave Lithotripsy treatment session**

Recommendations were made following the service evaluation, patient and staff interviews, and patient post-treatment questionnaire

Recommendations and outcomes for Craigavon Stone Treatment Centre

1. **Decrease the time for Nurse to check-in patient and consent patient for ESWL treatment on day of treatment**
   Patient information pack and pre-prescription of pain medications. Follow-up time and motion study to be conducted.

2. Have typed discharge for patient ready upon discharge from ESWL treatment day. Have discharge uploaded on day of treatment to Electronic care records so can be viewed at any time by Doctors, especially in the event of an emergency admission to Accident and Emergency.
   Reviewing the data needed for inclusion into a discharge letter, for immediate discharge and follow-up, the letter went through a number of PDSA cycles through the stone MDM and day of treatment.
   We moved from a hand printed discharge letter to an electronic generated letter, allowing a standard letter to be generated, with all necessary information required for completion.
   The letter had to be quick (less than 5 minutes) and easy for the author to complete. Following meetings and successful lobbying of the Electronic Care Records team (Northern Ireland regional Electronic notes) we achieved access and upload of the discharge letter. The letter can now be uploaded to Electronic Care Records straight after its generation, and allows a printed copy to the patient.
   The patients General Practitioner (GP) had previously received a typed discharge letter some 6 weeks following the patient's treatment. The standard electronic uploaded discharge summery immediately following treatment meant the additional letter to the GP was no longer required**.** The electronic generated discharge therefore prevented any further secretarial input, and thus saving money.

3. Review on pain medication given to patients at Southern Trust Stone Treatment Centre, and recommendation for breakthrough medication during ESWL treatment.
   A literature review was conducted on the Stone Treatment Centre long standing use of Piroxicam prior to ESWL treatment. The data suggested that the NSAID diclofenac may provide a more successful pain relief than Piroxicam 20mg.

Prospective data on treatment parameters and pain scores were collected on the pre-ESWL medication Piroxicam and paracetamol given to patients on the day of treatment. From reviewing patients receiving 20mg Piroxicam and 1g paracetamol, compared to those who could only receive paracetamol due to Piroxicam contraindication there was no benefit of receiving the addition of Piroxicam compared to paracetamol alone.

Following the evidence collected and literature review, the pain medication was changed to pre-ESWL Diclofenac Potassium 100mg oral and paracetamol. The work included the input from the pharmacy team, who also consulted the literature and evidence available. The Stone Treatment Centre will now collect data on the pain medication change to Diclofenac Potassium 100mg oral and paracetamol, to ensure a change has been an improvement.

Patients contraindicated to NSAIDS could receive codeine phosphate or tramadol.

A breakthrough pain medication was highlighted in the review. Following investigation work, Penthrox (3mg Methoxyflurane**)** was identified as a possible solution. The medication required for breakthrough pain relief had to be administered by a staff nurse only, with no doctor present. The Scottish Stone Centre used an opiate based breakthrough medication to achieve adequate stone treatments for patients requiring additional pain relief. The Craigavon Stone Treatment centre is staffed by a radiographer, staff nurse and health care assistant, and thus not suitable for opiate administration, which requires x2 staff nurse to check the medication. Options were explored for the provision of a second staff nurse, but were restricted by cost and availability of a second staff nurse. Penthrox is a recognised pain relief and used widely in Australia, especially by Emergency Departments and Paramedics, and is safe to be administered by a single staff nurse, with very few contraindications. A medication New Product Application was successfully passed by the Hospital Drugs and Therapeutics board, which included a literature review of the current evidence (see appendix). The board required evidence of the effective use of Penthrox as a breakthrough pain relief for ESWL, for 50 patients, data collection currently ongoing.

4. Have architectural drawing proposal on how to alter Stone Treatment Centre to also provide private consultation room for patients, and area to change and keep personal items secure.
   The Stone MDM team and hospital architect reviewed the recommendation and official hospital architectural plans were drawn. We were unable to expand the floor print of the centre, but in moving several plasterboard walls, a changing room for patients and suitably sized consultation room could be constructed. This left a recovery room, which doubles as the Stone MDM room on a Thursday morning, and the treatment room for ESWL. See Appendix for the plans, which have been approved and are on the Hospital waiting list to be undertaken.

   We involved the hospital estates team to ensure the ventilation to the room was suitable. Calculations for the use of Penthrox for air changes were undertaken and

the number of air-changes was easily improved by re-calibrating the system.

11. Leadership Approach

The NHS Healthcare Leadership Model provided a structured road map for leadership with a view to Improvement of a service, through the nine dimensions of Leadership Behaviour (NHS, 2013). Using the model we started by Inspiring a Shared Purpose with the Stone Treatment Team on a vision of where the centre could improve for the benefit of the patient. It was also important to listen to each member of staff in helping to develop and reach their individual goals, such as the request to be involved in research and development of the centre (Research Nurse/Radiographer funding application), the aim of a radiographer to learn treatment of distal ureteric stones with ESWL (Staff sent to Edinburgh Stone Treatment Centre to observe and learn).

Data collection was important, so changes could be made following the evaluation of the information gained, and improvement could be measured in a quantitative method where possible, such as the improvement to the pain medication. It was important though to collect the data as a team and through the weekly team meeting, analyse and act through improvement science methodology, such as the numerous PDSA cycles, time and motion studies, patient questionnaires.

It was important to work collaboratively with other teams, such as Accident and Emergency and Radiology when it came to initiating the improvements to the diagnostic and referral pathway for renal and ureteric stones. The Stone Service is intrinsically connected to the wider Health Care Service and so important to build strong, workable, strategic relationships with other departments involved in the patient journey of stone diagnosis through to treatment. We took time to understand the issues affecting other departments and addressed any concerns of the new referral pathway. With the interconnectivity of the other departments involved, we had to share the vision early, and highlight the benefits this would produce for the Stone Service, for the patient and for their own departments.

It was important to keep the team united, focused and motivated on the task in hand. The weekly meeting helped bring the team together and allowed a platform for staff to air their views on aspects of the project. The provision of the meeting with tea/coffee and croissants in a room away from any active clinical duties, helped staff to openly discuss the issues in play and feel part of the team and want to contribute. Setting the right environment to succeed is fundamental for team working and achieving the aim, and there is much we can learn from how the commercial world interact and achieve the best from their staff (Deloitte, 2016).

Developing and encouraging progression of staff enabled the project to achieve the improvement aims. Developing the staff, developed the service, developed the teams skills in improvement science, giving evidence based results.

Presenting our results to the Hospital Senior Team allowed the request for further funding to develop the Stone Treatment Centre and to be on the waiting list for structural layout improvement to the Centre. By demonstrating our results on how we could decrease waiting times for stone treatments, decrease the need for outpatient appointments, cut the cost of emergency stone treatments, decrease the waiting time and cost of discharge summery from Stone Treatment Centre we hope to highlight to the Senior Team to the need and importance of the Stone Treatment Centre.

Eric Dishmans TED talk on 'health care as a team sport', a personal view through his own renal disease, and the need to be pro-active on healthcare, take the patient on the journey with you and empower them to understand and prevent their disease or disease progression (Dishman, 2014). In a stone context, treat the stone and prevent recurrence, but the patient needs to understand their stone disease. The Stone Treatment Centre improvement model will progress in the future to prevention strategies by utilising patient groups along with a Stone Treatment Centre dietician to prevent recurrence of their stone disease.

Many different staff groups were involved or impacted by the project, including Urology, Radiology, Pharmacy, Accident and Emergency, Estates, IT, Administration and Management. Leadership of the project was based on the 'Developing Collective Leadership for Health Care' Kings Fund paper (Michael West, 2014). The project needed a 'post-heroic' model of leadership, and so we undertook collaborative leadership, to create a positive environment where ownership of the implementation and success or failure of the project is a shared responsibility and mission. Using a collaborative leadership model and the inherent aims of the project a 'high concern for people and high concern for productivity', the most work with content staff was achieved (Blake R R, 1991).

The work of Parish (C, 2006) identified that a broad range of leadership styles (directive, visionary, affiliative, participative, pace-setting and coaching leadership) are demonstrated by a successful leader. The range of leadership styles still needs to be relevant to a modern Health Care Setting, with an overarching theme of collaboration…. 'Coming together is a beginning, staying together is progress and working together is success' (Ford)

12. Outcome and improvement measures

The improvement project is a continuum and not a single finish point. Much was achieved and improved, and the more success will follow.

Aim	Result Outcome	Quality Improvement method and evidence	Future
1. Emergency ESWL	Ability to provide a forth treatment on ESWL treatment session	• Time and motion study • Weekly team meeting • Cost analysis vs Main theatre (Potential saving of £874500 over 5 years)	• Funding application for further sessions
2. Meet demand for ESWL elective sessions	Funding application with evidence submitted for extra sessions	• Cost analysis vs Main Theatre (ESWL saves potential £1248 and £2235 per patient when compared to day case and inpatient Theatre Ureteroscopy) • Ability to book patient directly from Urology MDM • Reducing Outpatient appointments	• Await outcome of funding • Provide sessions for other trusts in Northern Ireland/ Cross boarder
3. Provide stone	• Urology	• PDSA cycles	• Patient

treatments recommended by NICE, BAUS and EAU 4. Provide patient with informed choice	Stone MDM • Evidence based stone pathway • Patient information leaflets • Chance to discuss in person	on paperwork and Stone MDM • Patient interviews	questionnaire • Further PDSA cycles
As a result of original aims			
a. Patient discharge summery	• Electronic and printed paper version on day of treatment	• Decreased discharge summery time from weeks to immediately following treatment • Saved administration and medical cost and time	• Improvements planned to the electronic discharge sheet for 2019
b. Improvement to Stone Treatment Centre Building layout	• Architectural plans and successful buildings work submission	• Time and motion study • Patient interviews • Staff walk around	• Await building works
c. Stone diagnostic and referral pathway	• Currently in use • Evidence based	• Patient now having calcium and uric acid checked and point of care • Appropriate information now gained for decision of treatment of stone	• Currently paper version • **Should aim for electronic referral on Electronic Care Records**
d. Stone MDM	• Patients discussed	• Evidence based	• Needs administrative

	weekly via A+E referral pathway • Faster decision and review of patients stone disease then waiting for outpatient appointment	treatments • Staff education • Patient information and education • Saves on Outpatient appointments (saves £420 per patient booked for ESWL)	personal dedicated to Stone Treatment Centre
e. Pain medication for ESWL	• Changed to Diclofenac Potassium • Trial of Penthrox breakthrough medication	• Study on Piroxicam ESWL pain medication, led to change to Diclofenac	• **Patient pain questionnaire on diclofenac and Penthrox for evidence of effectiveness of use, results awaited**
f. Application for Stone Treatment Centre Research post	• Application accepted for research funding	• Ability for collecting and analysing Stone Treatment and medications	• Await and plan for start of research project, including staff recruitment

13. Project sustainability

The continuation of the project is through the collaborative team model established, and will be steered in the correct direction by Urology Clinical Lead Mr Young , Staff Grade Ms Laura McCauley and Martina Corrigan, with help from all of the Stone Treatment Team. The project is and will always be team approach.

The increasing obesity epidemic, ageing population, sedentary lifestyle and potentially global warming (increasing temperature with poor fluid intake) highlights the importance of this project, not only to meet the demand for current stone patients, but to build capacity for the future increase. It is a project therefore that cannot be ignored.

14. Bibliography

A.N.Argyropoulos, D. T. (2010). SWL is more cost-effective than ureteroscopy and Holmium:YAG laser lithotripsy for ureteric stones: A comparative analysis for a tertiary referral centre. *British Journal of Medical and Surgical Urology,*, Volume 3, Issue 2, Pages 65-71.

Better OS, A. A. (1973). Studies on renal function after relief of complete unilateral ureteral obstruction of three months' duration in man. *The American Journal of Medicine* , 234-240.

Blake R R, M. A. (1991). *LEADERSHIP DILEMMAS- GRID SOLUTIONS.* Houston : Gulf Publising .

British Association of Urological Surgeons . (2016, March). *Lithotripsy, Procedure Specific Information* . Retrieved September 10, 2017, from http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/ESWL.pdf

C, P. (2006). Being nice is not enough for good leadership on the wards. *Nursing Standard* , 20 (41):6.

C. Türk (Chair), T. K.-c. (2016). Urolithiasis. *European Urology Guidelines* , 3.4.2.3.3.-3.4.3.3.

Campbell, D. (2015, January 19). *NHS cannot cope with ageing population, warns top doctor*. Retrieved January 06, 2017, from The Gaurdian : https://www.theguardian.com/society/2015/jan/19/nhs-we-have-not-fit-for-future-warns-top-doctor-bruce-keogh

Deloitte. (2016). *Ingedients for Success, Striking the Right Balance.* Deloitte.

Dishman, E. (2014, March 04). *Healthcare should be a team sport* . Retrieved November 01, 2016, from TED@Intel: https://www.ted.vom/talks/eric_dishman_health_care_should_be_a_team_sport/up-next#532964

Donabedian, A. (2005). Evaluating the Quality of Medical Care. *The Millbank Quarterly*, 83(4):691-729.

Fink RL, C. D. (1980). Renal impairment and its reversibility following variable periods of complete ureteric obstruction. *The Australian and New Zealand Journal of Surgery* , 77-83.

Ford, H. (n.d.).

Langley, G. N. (June 1994). *The Foundation of Improvement, Quality.*

Michael West, K. S. (2014, May 21). *Developing collective leadership for health care*. Retrieved January 6, 2016, from Kings Fund : https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care

NHS. (2013). *Healthcare Leadership Model Version 1.0.* NHS.

NICE. (2015). *Renal or ureteric colic - acute*. Retrieved Febuary 08, 2018, from https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!backgroundsub:2

O'Neill, M. (2016). *Health and Wellbeing 2026: Delivering Together' .* Northern Irish Assembly.

Professor Rafael Bengoa (Chair), D. A. (2016). *Systems not structures, changing health and social care.* Northern Irish Assembly .

Royal College of Physicians Ireland. (2012, October 05). *Driver Diagrams.* Retrieved September 01, 2016, from Leadership in Quality in Healthcare : publichealth.hscni.net/sites/default/files/directorates/files/CAW%20Day%20

Southern Health and Social Care Trust. (n.d.). *Southern Health and Social Care Trust*. Retrieved January Friday, 2017, from Corporate Information : http://www.southerntrust.hscni.net/about/1594.htm

TED Talks. (n.d.). *TED Talks*. Retrieved from www.ted.com>talks

Vaughan, E. J. (1971). Mechanism of acute hemodynamic response to ureteral occlusion. *Investigative Urology*, 109-118.

World Health Organisation . (2015, October). *Patient Advocates use past experience to change the future .* Retrieved December 03, 2016, from WHO: www.WHO.INT

15. Appendix

a. **Ureteric and Renal Stone Pathway (guidance and referral form)**
b. **Urology Stone Multidisciplinary Meeting**
    - **i. Patient Pathway Stone MDM**
    - **ii. Patient Information Pack**
        - **iia. Template Letters**
        - **iic. Patient Information and Consent Form**
        - **iib. Anticoagulation Pathway**
c. **ESWL Treatment Day Protocols**
d. **ESWL Medications**
e. **Craigavon Area Hospital ESWL TMS i-sys Sonolith lithotripter Adult Protocol**
f. **Business Case Proposal**
g. **Research funding proposal**

a. Ureteric and Renal Stone Pathway

Including guidance for pathway and referral form

Ureteric and Renal Stone Pathway

Southern Trust Hospitals

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

Note: Male >50yrs, no history of renal stones, then consider AAA pathway

History Suggestive of Renal Colic? THEN DO THE FOLLOWING

- Urine dipstick including pH
- Pregnancy test (12 to 55 years)
- Patient observations
- FBC, U&Es, CRP, Calcium and uric acid

(Same day imaging if single kidney, infection, AKI)

Not Pregnant and >18 years old

Non Contrast CT Urinary Tract

Ureteric stone or obstructing kidney stone

Is there any:
1. Infection (? SEPSIS 6)
2. Acute Kidney Injury
3. Uncontrolled pain
4. Ureteric stone >6mm
5. Diabetes
6. Immunosuppression

Yes → Discuss with Urology

No → Complete Outpatient Stone Referral Form

Non-obstructing Stone in Kidney, not ureter

Evidence of Pyelonephritis

Yes → Consider admission if necessary (See Hospital/ NICE guidelines)

No → Consider alternate cause for pain

AND

For the stone finding, complete Stone Referral Form

<18 years old

USS RENAL TRACTS

Hydronephrosis OR highly suspicious of stone, OR Urological abnormality, Discuss with Urology.

Pregnant

Discuss with Obstetrics

USS RENAL TRACTS

Discuss with Urology
Consider NC MRI Renal Tracts

Negative Imaging

Consider alternative cause of pain

(Non-visible haematuria on urine dipstick: Notify GP to re-check and refer if needed as per NICE guidance)

Pathway next due for REVIEW July 2018 Stone MDM

Completed form send to Urology Consultant on-call, Craigavon Area Hospital

WIT-26389

Ureteric and Renal Stone Referral

Urology, Craigavon Area Hospital

Southern Health and Social Care Trust

Quality Care - for you, with you

Please refer to A+E protocol for referral guidance:

Uncompleted forms will be returned to referring Doctors

Patient identification (sticker)

Referring Doctor: _____

Referring unit: _____

Date of referral**:** ___ / ___ / 20___

Patient Phone number:_____

Physical or mental disability? **Yes** **No**

Presenting symptoms: (circle)

Side of stone: Left Right

Side of Pain: Left Right No pain

Visible haematuria Yes No

Acute Medication given from A+E:

Imaging modality: (circle)

NCCTKUB* **USS KUB/ NC MRI**

(*CT Urinary tract) **(If <18 yrs or pregnant)**

Findings:

X ray KUB done: Yes No

(Indication: if stone not visible on CT scout)

Past medical History: (circle)

Solitary Kidney **yes** **no**

Abdominal Aneurysm: **yes** **no**

Pacemaker: **yes** **no**

If yes, type_____

ASTHMA: **yes** **no**

Cardiac Stent: **yes** **no**

Date of stents_____

CKD Stage IV or V: **yes** **no**

Current Gastric Ulcer **yes** **no**

Malignant hyperthermia **yes** **no**

Symptomatic heart failure **yes** **no**

Other past medical history:

-

-

ALLERGIES: (circle) YES NO

Drug:

Anticoagulants:

Immunosuppressive agents:_____

BLOODS

Creatinine:_____ eGFR:_____

Corrected Calcium:_____ Uric acid:_____

Haemoglobin:_____ Platelets:_____

White Cell Count:_____ CRP:_____

Urine dip stick:

pH:_____ Blood:_____

Leucocytes:_____ Nitrites:_____

Pregnancy test Positive Negative (circle)

Completed form send to Urology Consultant on-call, Craigavon Area Hospital

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

Radiology:#

It would aid stone management if the radiologist were to record

1. Stone size
2. Stone location
3. Stone attenuation
4. Skin to stone distance
5. Hydronephrosis
6. Congenital anomalies
7. Extravasation
8. Stranding

Based on AUA guidance http://www.auanet.org/guidelines/imaging-for-ureteral-calculous-disease accessed August 2017.

b. Urology Stone Multidisciplinary Meeting

Time: 09:00 Thursday mornings

Location: Stone Treatment Centre, Craigavon Area Hospital

Urology Consultants, Staff grade, STC Sister, Radiologist, Radiographer, Secretary

Stone meeting agenda to be produced by the Urology Staff Grade or Fellow attached to the unit. Urology referrals to be reviewed and checked for accuracy, then work list generated on ECR. Any forms missing vital information to be returned to sender unless delay may impact upon safety of a patient, in which case organise to see patient urgently.

Patient Details	**Imaging modality and stone details**	**Meeting outcome**	**Specific Tasks**
Example 343234321	NC CTKUB 01/01/17. 7MM upper ureteric stone	ESWL	Stop rivaroxaban 2 days prior

The imaging modality and stone details can be cut and pasted into the diagnosis part of a **letter template**, pending on meeting outcome decision.

Patient pathway to be determined at meeting, see table 1.

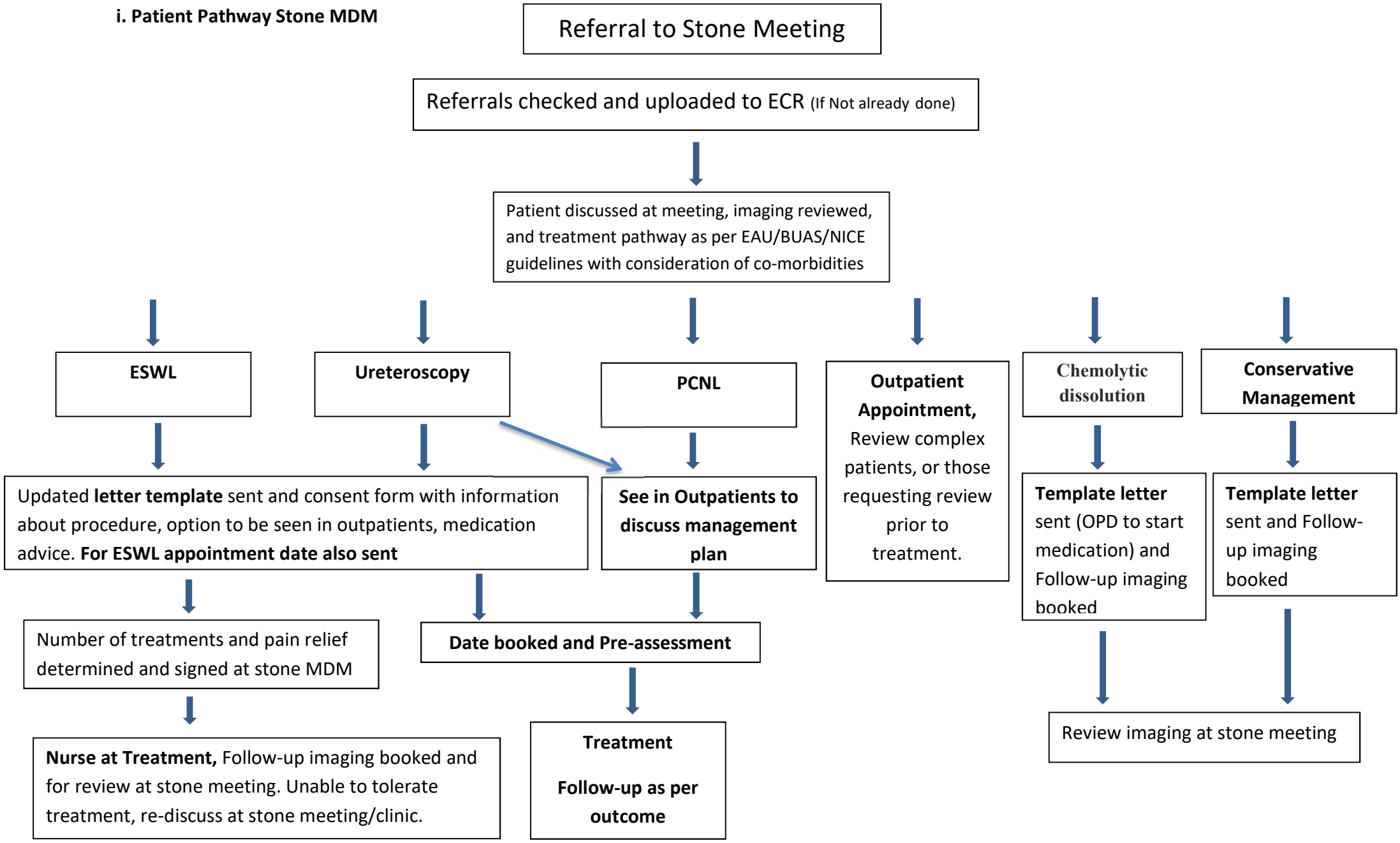
ESWL booking is organised at meeting. Appointment date, meeting letter (template as above), consent form, patient information, and **anticoagulation medications advice** sent out following meeting. The secretary can organise letter at time of meeting, since only the imaging modality and stone details need added to template. Alternatively the meeting outcomes can be forwarded to the secretary following meeting conclusion.

ESWL Radiology request completed at meeting containing: 1. Stone side and location
2. Number of ESWL sessions
3. Follow-up imaging planned

Dictation for complex patient may be needed and should be ready for use.

Medications for ESWL can be signed for each patient, Pharmacy to provide pre-printed drug cards to save time on prescribing and ensure clarity of prescription. Pre-printed outpatient script for take home medication. Allergies and contraindications are checked on referral, ECR and again on day of treatment by nursing staff prior to administration.

i. Patient Pathway Stone MDM



ii. Patient Information Pack

Patient Letter and Information Pack

The Urology MDM allows for direct template letter to be sent to the patient, explaining they have been discussed by the multidisciplinary panel and which treatment pathway has been advised.

Patients who are not suitable for direct treatment pathway will be called to clinic to discuss management, these will include all PCNL and ureteroscopy (at present) patients and those deemed the highest risk for any treatment.

The aim of the pack is to decrease the number of patients seen in clinic, yet providing the patient with reassurance they have been reviewed by the stone MDM and provided with a fully informative pack containing,

1. Letter explaining MDM OUTCOME and Imaging findings
2. Modified BAUS information leaflet and consent form (to bring on day of treatment sign last page)
3. Anticoagulation schedule for those on anticoagulants
4. Map for Blood room and Stone Treatment Centre

Pre-assessment: All patients listed for ureteroscopy and PCNL. ESWL patients deemed high risk on anticoagulation should undergo pre-assessment so clexane cover can be organised as per guidelines.

Patient Hospital Contact: The letter will contain the contact number of Stone Centre secretary, for which the patient will contact if:

1. Request OPD instead of direct to treatment
2. If date received is not suitable
3. If stone has passed (patient advised to present to GP for stone to be sent for analysis), so can be re-discussed at meeting for follow-up

Font size

The font size can be increased for any patient who has difficulty in reading and sent out accordingly by the secretary

Language

The patient information is set as English. A further copy could be provided using patient language services to translate the information before being sent. A template letter and consent form could be created for common other languages that are not English, with translator provided on day of treatment.

Dear iia.Template letter for Conservative Treatment

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

There is a very good chance this stone will pass and not need surgery/intervention.

We have organised repeat imaging in 6 to 8 weeks' time to check for stone passage, the x-ray department will contact you with a date. However, if you are unwell in the interim, especially with a high temperature, please attend your GP or A+E.

Dietary Advice

• Specific types of stone can be managed by measures aimed at the cause of your stone formation

• Generally, keeping your urine dilute & colourless reduces your risk of forming a further stone by almost one third (30 to 40%)

• In addition, a normal calcium, low-salt, low-protein dietary intake can reduce your risk of stone formation even further

If you pass the stone, please call **Paulette on** Personal information redacted by USI or **Gemma on** Personal information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

If you have any further questions please call number above.

Your repeat imaging in 6 to 8 weeks will be discussed at the Stone Centre Meeting and we will contact you with the outcome.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Dear

Template Letter for ESWL Stone Treatment

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

The stone we are going to treat first is

We have organised for you, **Extra Corporeal Shockwave Lithotripsy (ESWL)** in order to treat your stone at the **Craigavon Stone Treatment Centre**

Date of ESWL is: (if no date given, then await appointment letter).

Please call **Paulette on** [redacted] or **Gemma on** [redacted] **to confirm the treatment date is suitable**

Please find enclosed with this letter:

1. *Information* on Extra Corporeal Shockwave Lithotripsy (**ESWL**)
2. ***Consent form*** **-** Following reading and understanding the information on ESWL provided, please sign consent form and **bring along to the day of treatment.**
3. ***Advice sheet*** for patients who take anticoagulation medication (BLOOD THINNERS), on when to stop before treatment and when to restart following treatment.
4. *Dietary advice* sheet to help decrease risk of further stones
5. *Map* of how to get to **Craigavon Stone Treatment Centre**

If you pass the stone before your ESWL treatment, please call **Paulette on** [redacted] first, otherwise call **Gemma on** [redacted] and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

On your treatment day please bring your consent form and all your medications (including over the counter medications). Report to check in desk on day of treatment (see map).

If however you would like to discuss the treatment on offer or possible alternatives then please call the number above to make an appointment.

We look forward to meeting you at Stone Treatment Centre for your treatment.

Many thanks

Mr Young FRCS(Urol)
Urology Consultant

Dear Template Letter for Ureteroscopy and Laser

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

We have recommended for you, **Ureteroscopy and laser, under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Ureteroscopy and laser to stone**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette on** Personal Information redacted by USI or **Gemma on** Personal Information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Dear

Template Letter PCNL

Patient Details: Insert here

Your recent x-ray/scan demonstrated a kidney stone. This was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging report demonstrated: Insert here

We have recommended, **Percutaneous Nephrolithotomy (PCNL), under general anaesthetic** in order to treat your stone.

We shall see you in our outpatient clinic to discuss your stone management further.

Enclosed with this letter:

1. Information sheet on **Percutaneous Nephrolithotomy (PCNL)**, under general anaesthetic
2. Dietary advice sheet to help decrease risk of further stones

If you pass the stone, please call **Paulette on** Personal Information redacted by USI or **Gemma on** Personal Information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

We look forward to meeting you at Craigavon Area Hospital.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

Chemolytic Therapy

Dear

Patient Details: Insert here

Your kidney stone was discussed at the Southern Trust Stone Meeting, Craigavon Area Hospital.

Your imaging demonstrated: Insert here

We have organised for you, **specialised dissolution therapy, this is medication to dissolve your stone.**

Enclosed in letter:

1. Information sheet on Chemolytic dissolution of kidney stones
2. Dietary advice sheet to help decrease risk of further stones

We shall see you in Stone Treatment Clinic to discuss starting the treatment medication in the near future.

When your outpatient appointment letter arrives, please phone to confirm.

If you pass the stone, please call **Paulette on** Personal Information redacted by USI or **Gemma on** Personal Information redacted by USI, and then please take your kidney stone to your GP, so it can be sent for analysis of stone type.

Many thanks

Mr Young FRCS(Urol)

Urology Consultant

iib Patient information and consent form

Procedure specific information should be sent to each patient when directly booked for a procedure from Urology Stone MDM. This should provide information on the treatment selected and alternatives, as well as a clear presentation of contraindications and risks so the patient can make a balanced decision themselves if they wish to proceed or not.

Further to the procedure specific information, a consent form is attached to be signed by the patient once they understand and agree to go ahead with the treatment proposed. This consent form should be brought to the day of treatment with the patient and countersigned by the nurse.

What if the patient doesn't wish to go ahead with the proposed treatment or wish to ask further questions?

A telephone number for **Stone Treatment Centre** secretary is provided on the letter template from Urology Stone MDT. The patient may contact this number and arrange an outpatient appointment or phone-call appointment for further discussion as required, prior to any treatment going ahead.

Next Page is ESWL patient information and consent form

Extracorporeal Shockwave Lithotripsy (ESWL)

What does the procedure involve?

Delivering shockwaves through the skin to break kidney stones into small enough fragments to pass naturally. This involves either x-ray or ultrasound to target your stone.

What are the alternatives to this procedure?

Telescopic surgery, keyhole, open surgery and observation to allow stones to pass on their own.

What should I do on the day of ESWL treatment?

1. Please take all prescribed medications, except blood thinners (anticoagulants), which you should have already stopped as per anticoagulant advice sheet.
2. You can have a light meal on the morning of your treatment (or light lunch if an afternoon appointment), but you should drink only water in the two hours before the treatment.
3. **Please bring your consent form and your medications on the day of treatment.** It is helpful if you bring your own dressing gown to wear.
4. We advise you bring someone with you and not to drive yourself home following your treatment, especially if you have received any medication with a sedative effect. In the absence of a chaperone we may have to restrict your medication and treatment.
5. Please leave enough time to park at the hospital if driving; it can take up to 30 minutes to find a parking space.
6. On arrival:
   a. Book into A+E reception for your ESWL treatment (see map)
   b. (If on Warfarin proceed to blood room, see map)
   c. Proceed to Stone Treatment Centre for ESWL Treatment

On arrival to stone treatment centre

1. Ring the bell, take a seat and the nurse will be with you shortly.
2. **Please tell your Health Care Provider before your treatment** if you have any of the following:
   A. Usually take blood thinning medication such as warfarin, aspirin, clopidogrel (Plavix®), rivaroxaban, prasugrel or dabigatran.
   B. Heart pacemaker or defibrillator
   C. Artificial joint
   D. A history of abdominal aneurysm
   E. A neurosurgical shunt
   F. Any other implanted foreign body
   G. An artificial heart valve
   H. PREGNANT
   J. <u>Tell Your Nurse on Arrival</u> if you have <u>ANY ALLERGIES</u>

3. You may need to pass a urine sample on arrival for analysis

4. Pain relief will be given at least 30 minutes before, and additional pain relief might be needed during the treatment

What happens during the procedure?

You do not need an anaesthetic and you will be awake throughout the procedure. We usually only use general anaesthetic for children.

You will be asked to lie on the treatment bed and your stone will be located by Ultrasound and/or X-ray. Gel will be applied to the skin over your kidney and the treatment head, which generates the shockwaves to treat your stone, will be placed comfortably against this part of your back (as per picture).

You will have a sensation like being flicked in the back by an elastic band. You will hear a clicking noise of the machine during the treatment.

Your treatment will be monitored by a Nurse and Radiographer.

You may also feel a deeper discomfort in the kidney. If this proves too painful, we can usually give you an additional painkiller.

Your treatment will normally last up to 60 minutes, with an average total stay of 2 hours in the Stone Treatment Centre.

Following the Procedure

Please feel free to ask how the procedure went and ask any questions.

Patients usually stay with us for up to 30 minutes, to be monitored by the nurse and light refreshments will be offered.

You will be given pain relief medication and a discharge letter from the nurse, which will include your follow-up plan.

At Home following procedure

1. Rest for 24 hours
2. Drink 6 pints of water a day (unless told to fluid restrict by your doctor)
3. Some pain may be expected, please take your pain relief medication when needed.
4. Expect to see blood in the urine for 3 to 4 days. Restart blood thinning medication 2 days after treatment, unless heavy bleeding.
5. If any blistering or bruising appears on your treatment side, use a soothing skin cream to ease discomfort.
6. Any stone fragments passed, please collect and take to your GP for testing.

What else should I look out for?

If you develop a fever (above 38ºC or 100.4 F), severe pain on passing urine or you cannot pass urine then attend your GP or A+E department immediately.

Driving after ESWL

We advise not to drive for 24 hours after the procedure. It is the patient's responsibility to know when they are pain free and feel well enough to drive following ESWL treatment.

Are there any side-effects?

Most procedures have possible side‑effects. But, although the complications listed below are well recognised, most patients do not suffer any problems.

Common (greater than1 in 10)

- Blood in your urine for up to 72 hours after the procedure.
- Pain in your kidney as small fragments of stone pass.
- Urinary infection due to bacteria released as the stone breaks.
- Bruising or blistering of the skin.
- Need for further ESWL treatment.
- Failure to break stone(s) which may need additional or alternative treatment, especially for very hard stones.
- Recurrence of stones.

Occasional (between 1 in 10 and 1 in 50)

- Stone fragments may get stuck in the tube between the kidney and the bladder and require surgery to remove the fragments.

Rare (less than 1 in 50)

- Severe infection requiring intravenous antibiotics (less than 1%) and the need for drainage of the kidney by a small tube placed into it.
- Kidney damage (bruising) or infection needing further treatment.
- Damage to the pancreas or lungs by the shockwaves requiring further treatment.

Information based on British Association of Urology Surgeons, Patient information, Lithotripsy for stones, Published 2016.

Further Information can be viewed at:

https://www.baus.org.uk/patients/conditions/6/kidney_stones

http://patients.uroweb.org/i-am-a-urology-patient/kidney-ureteral-stones/treatment-kidney-ureteral-stones/

Extracorporeal Shockwave Lithotripsy Consent Form

Patient Sticker

Please bring on day of ESWL

I have read, understood and agree to go ahead with extracorporeal lithotripsy (ESWL) treatment(s) for my renal/ureteric stone

……. …… …….

Patient name Patient signature Date

…… …….. ……

Radiographer name Radiographer Signature Date

To be placed in patients notes

iiic Anticoagulation (Please also refer to patient anticoagulation pathway, Stone MDM)

Patients on anticoagulation medication will be identified by the structured referral form and checked on Electronic Care Record at Stone MDT (or prior by Doctor organising the list for Stone MDM). A further check for ESWL is on treatment day by the nurse, otherwise for theatre cases by the pre-assessment team.

For ESWL, patients taking Aspirin 75mg regularly there is controversy if this should be stopped or not. The BAUS patient information leaflet would appear to lean towards stopping the medication (British Association of Urological Surgeons , 2016); the team visit to the Scottish Lithotripter Centre in October 2016 noted their current practise is to stop Aspirin 75mg, 7 days prior to ESWL. Other centres are noted to continue their patients on Aspirin 75mg, but state to stop all other NSAIDs 7 days prior (Colchester Hospital University Foundation Trust , 2016).

A PubMed Search for continued daily patient use of Aspirin 75mg and ESWL was conducted. The search terms included 'ESWL' OR 'Extracorporeal Shockwave Lithotripsy' OR Shockwave lithotripsy' and Aspirin.

A retrospective study could be undertaken in Craigavon as patients who were on 75mg Aspirin, previous to this report patients were not told to stop the medication. Has there been any clinical presentation of renal haematoma or prolonged or heavy haematuria necessitating admission. Since Urology Stone MDT August 2017 the decision was made to stop Aspirin 5 days prior ESWL (Based high bleeding procedures, Southern Trust)

Information sheet on how long before any treatment a patient should discontinue their anticoagulation medication is part of the information pack and produced as part of the Stone MDM. ESWL patients should not restart anticoagulation until 48 hours after the treatment and only when urine is no longer haematuria (European Association of Urology , 2017).

Patients who require bridging low molecular weight heparin should attend pre-assessment so this is safely facilitated for ESWL, as with main theatre procedures.

Pharmacy and Haematology

Before the information is to be disseminated to patients the clinical information should also be reviewed by Pharmacy and Haematology teams. When new anticoagulants are introduced to the market, a trigger should be in place to inform the stone MDM so the anticoagulation advice sheet can be updated accordingly. Alternatively this could fall as part of a periodic review of the information pack.

List position for ESWL and Patients needing an INR

Patients who are on Warfarin therapy will require an INR prior to treatment with ESWL. Therefore they should not be placed at the start of the morning list, this is to allow their INR blood test to be taken and processed. The haematology laboratory should therefore be contacted once the INR has been sent so to be processed promptly and reduce the chance of a patient delay in treatment whilst the result is awaited.

Blood sample for INR can be collected from the phlebotomy service located next to the Thorndale Unit. The patient could either be sent to the service direct from registering their visit to the hospital at the main reception next by A+E, with the blood form left in preparation with the phlebotomy service. Alternatively the form could be collected by the patient from the Stone Treatment Centre, but this would add on much time for the patient and potential delay in INR result and thus treatment.

Process for Anticoagulation plan at Stone MDT

- If patient determined low risk for CVD then anticoagulation protocol followed and patient informed by letter from MDT when to discontinue their medication, given a blood form for pre-ESWL INR check and with instruction to ensure first INR check 5-7days after treatment restarted
- If patient determined high risk for CVD then consider postponing procedure or offering alternative treatment e.g. URS or observation
- If patient determined high risk for CVD but requires ESWL then green form completed at MDT and patient referred to Pre-operative assessment:
    - For bridging with low molecular weight heparin (LMWH), the Pre-Operative Assessment Nurse and Pharmacist will ensure the prescription is written and the LMWH is dispensed by the hospital pharmacy.
    - The pre-operative assessment nurse will inform the patient in writing of the dates of administration of enoxaparin and inform their GP about the pre-operative management of warfarin by sending them a copy of the green form.
    - Where possible, the patient / carer should be instructed on self-administration of LMWH by the pre-operative assessment nurse.
    - The post-op management must be documented on green form so that LMWH can be prescribed and dispensed by pre-op assessment in preparation for discharge with appointment made for INR check 5-7days post ESWL

On day of ESWL:

• INR should be checked to ensure it is <1.4. If INR is above this target, ESWL does not proceed and patient rescheduled

Determination of CVD risk for patient

Low Risk:

- AF with no prior stroke or TIA
- VTE more than 3months ago
- 6months after MI/ PCI/ BMS/ CABG/ stroke (12months if with complications)

High Risk: (consider ureteroscopy/ observation/ postponing of treatment instead of ESWL)

- Mechanical heart valve
- 12 months after drug eluting stent
- Target INR >3
- AF with previous stroke or TIA
- VTE in last 3months (post pone surgery)
- Antiphospholipid syndrome
- 6weeks after MI/ PCI/ BMS/ CABG (6months if complications)
- 2weeks after stroke

(MI – myocardial infarction, PCI – percutaneous coronary intervention, BMS – bare metal stent, CABG – coronary artery bypass grafting)

References:

- Sharepoint: http://sharepoint/as/clinical/Anticoagulant%20Documents/Forms/AllItems.aspx
- Alsaikhan, B., & Andonian, S. (2011). Shock wave lithotripsy in patients requiring anticoagulation or antiplatelet agents. *Canadian Urological Association Journal*, *5*(1), 53–57. http://doi.org/10.5489/cuaj.09140
- https://uroweb.org/guideline/urolithiasis/#3

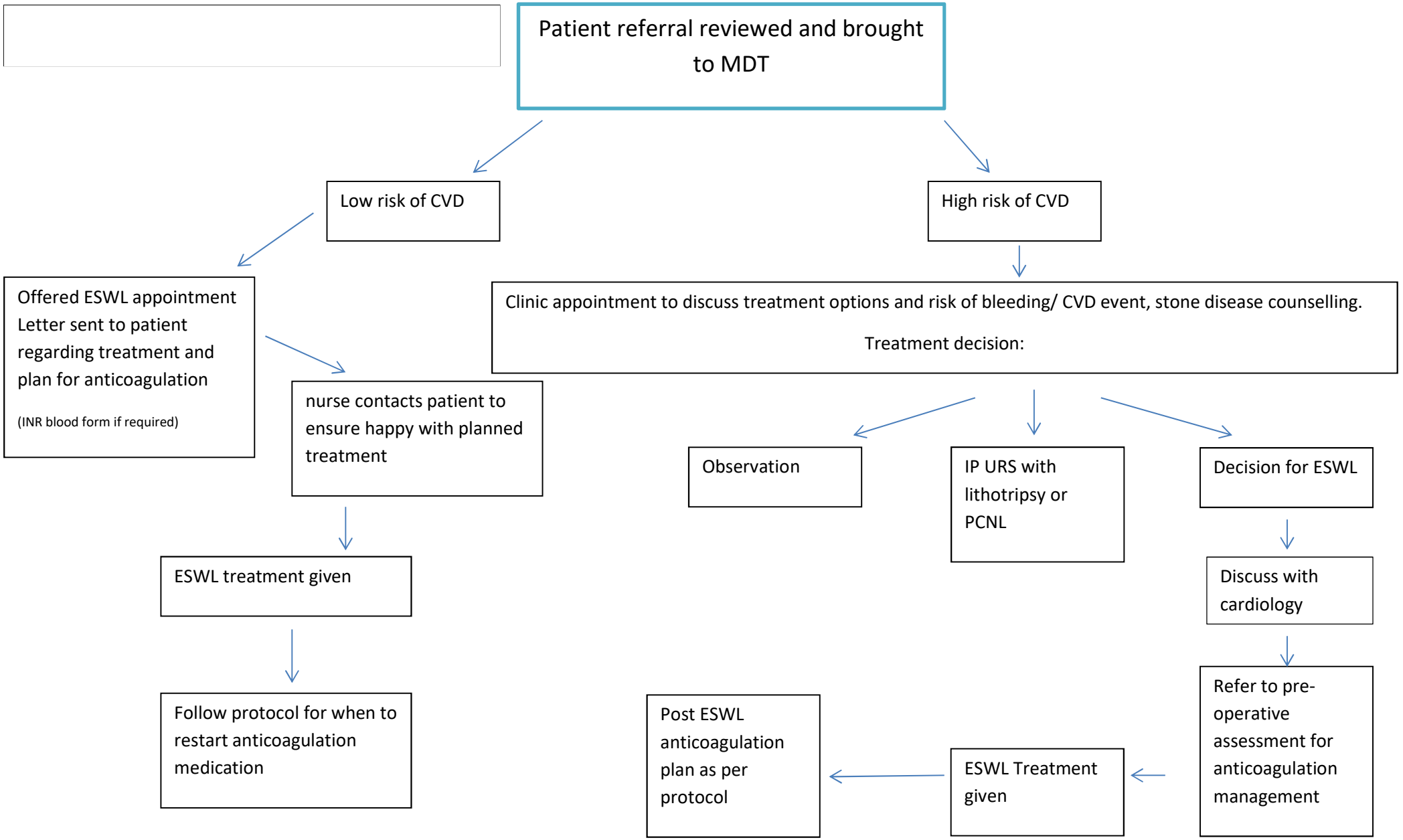
Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

~ CrCl ≥80 stop 48hours, CrCL 50-80 stop 72hours, CrCl 30-50 stop 96hours

CVD risk	ASA (e.g. Aspirin)		Thienopyridine agents (e.g. clopidogrel)		Warfarin		Dabigatran		Rivaroxaban/ Apixaban/ Edoxaban	
	Pre op	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*	*Pre op*	*Post op*
Low Risk	Stop 5 days	Restart 2days	Stop 5 days	Restart 2days	Stop 5 days	Restart evening (normal dose)	Stop – rv CrCl~	Restart 2days	Stop 2days#	Restart 2 days
High Risk	Continue	Continue	Stop 5days Bridge treatment dose LMWH	Restart clopidogrel 2days Discontinue LMWH	Stop 5 days Bridge LMWH: - treatment dose (day 3 and 2 pre op) - 50% of dose day 1 pre op	Restart evening Prophylactic dose LMWH 48hours then resume treatment dose until INR therapeutic	Stop – rv CrCl~ Prophylactic dose LMWH	Restart 2days Continue LMWH 2days then stop*	Stop 2 days# Prophylactic dose LMWH	Restart 2days Continue LMWH 2days then stop*

*Do not give DOAC and LMWH together

Stop 3 days if Cr Cl <30



Patient Advice Prior to ESWL Treatment for Stones

Plan for your anticoagulation (blood thinning) medications: Page 1 of 2

(Please see circled which is relevant to you)

Warfarin	Please stop 5 days before ESWL Please bring the attached blood form and attend the blood (phlebotomy) room at the Thorndale Unit, Craigavon Hospital, for INR at 08:30am on the day of your treatment Then proceed to the Stone treatment centre for result review and ESWL treatment Please restart your normal dose of warfarin the evening of your treatment. **Please ensure you have an appointment to get an INR check 5-7days after your warfarin is restarted.**

Aspirin **Dipyridamole** **Clopidogrel**	**Please stop 5 days before ESWL and restart your normal dose 2 days after your treatment**

Rivaroxaban (Xarelto) **Apixaban (Eliquis)** **Edoxaban (Lixiana)**	**Please stop 2 days/ 3days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment**

Dabigatran (Pradaxa)	**Please stop 2 days/ 3 days/ 4 days (depends on creatinine clearance) before ESWL and restart your normal dose 2 days after your treatment**

Ticagrelor **Prasurgel**	**Please stop 7 days before ESWL and restart your normal dose 2 days after your treatment**

Patient Advice Prior to ESWL Treatment for Stones

If you have recently undergone a cardiology procedure and are on medication following this procedure, please contact **Paulette on** Personal information redacted by USI **Gemma on** Personal information redacted by USI before you accept the appointment.

Medications/ Supplements

Unless you are informed otherwise, please continue all medications that are prescribed by your doctor.

Many herbs, vitamins and diet supplements may increase the risk bleeding during ESWL.

Certain over the counter medications may also increase your risk of bleeding.

Please stop taking all over the counter medications, vitamins, herbs and diet supplements 7 days before ESWL. You may resume taking these supplements 2 days after your treatment.

Examples of herbal remedies to be stopped[1]:

- Garlic[2]
- Ginseng
- St John's Wort
- Ginkgo biloba
- Danshen

Common over the counter medication to be stopped[3]:

- Naproxen
- Aspirin (e.g. Anadin, Anadin extra)

1. Cordier W., Steenkamp V. Herbal remedies affecting coagulation: A review. *Pharmaceutical Biology* Vol. 50 , Iss. 4,**2012**
2. Gravas S, Tzortzis V, Rountas C, Melekos MD. Extracorporeal shock-wave lithotripsy and garlic consumption: a lesson to learn. *Urol Res*. **2010** Feb;38(1):61-3. doi: 10.1007/s00240-009-0242-0. Epub 2009 Dec 15.
3. Dickman A. Choosing over-the-counter analgesics. The Pharmaceutical Journal, Vol. 281, p631 | URI: 10040592

C. Proposed Protocols for ESWL

Craigavon Stone Treatment Centre

Agreed method of working at Urology Stone MDT on

For review 3 months after start date of working at stone MDT.

1. **Staff Nurse checking in and out of Patient**
    1. Patient to Arrive 45 minutes prior to treatment and hand in patient consent and contraindications signed form (Sent by post prior to appointment)
    2. On arrival patient is asked to produce a Urine sample (and pregnancy test for child baring age 12 -55 years of age IRMA guidelines. QUOTE)
    3. In the patient consultation room, consent form checked signed. Contraindications to ESWL form checked with patient again and nurse signs check list to confirm.
    4. Medications given as per protocol (30 minutes before ESWL , ref evidence meds onset of action)
    5. Following completion of ESWL, patient to remain in waiting room, given light refreshments and observed for 30 minutes.
    6. Bloods pressure, Heart rate, respiratory rate and oxygen saturation checked prior to discharge.
    7. Radiologist books patient for either;
        1. Follow-up imaging as indicated by stone meeting or
        2. Re-book slot for ESWL and inform patient of date and time, included in discharge letter (add to hospital W/L)
    8. Upon discharge copy of discharge and medications given and explained, ESWL post procedure advice sheet given.

2. **Medication Protocols**

    1. Patient to receive medication pathway set and prescribed at Thursday morning stone meeting
    2. Nurse to check with patient allergies/ check contraindication
    3. Pathway 1,2,3,4 Nurse led, Pathway 5 Doctor led

	Pathway 1	Pathway 2	Pathway 3	Pathway 4	Pathway 5
30mins prior to ESWL, oral medications	Paracetamol 1g	Paracetamol 1g, Diclofenac Potassium 50mg oral	Paracetamol 1g, Diclofenac potassium 50mg oral	Paracetamol 1g	Doctors led, meds advised
Breakthrough pain relief during ESWL	Not suitable	Not suitable	Penthrox 3ml inhaler	Penthrox 3ml inhaler	Penthrox or Alfentinal

3. i. **Radiographer ESWL treatment and discharge letter**
    A. Patient consent form counter signed by radiographer
    B. Stone to be treated as per Stone meeting outcome letter or as per stone clinic outpatient letter.
    C. Stone localised using USS and/or fluoroscopy
    D. Ramping as per protocol

E. Following completion of patients dedicated treatment hour please fill **lithotripter e-discharge to state**

1. Patient full name, date of birth, address
2. Radiographer and nurse full name
3. Urologist responsible for patient
4. Blood pressure before/ during/after
5. Medication given prior, during and discharge from treatment
6. Number of shocks, energy and power
7. Stone location
8. Pain encountered during treatment
9. Fragmentation
10. **Until the software changes below have been made, please use the free text comment box to fill out <u>either</u>** a. Rebooked for second treatment to same stone
    b. Rebooked for third treatment to same stone
    c. Rebooked for fourth treatment to same stone
    d. Rebooked for treatment to concurrent stone
    e. Follow-up imaging 6weeks (option x-ray, USS, both or CTKUB)
    f. Re-discuss at MDT meeting due to treatment failure or complication
    g. Stone clinic review

Software changes proposed;

i. Hounsfield units of stone being treated
ii. Validated Pain score 0-10
iii. Treatment limited due to: drop down box
    a) Pain
    b) Nausea and vomiting
    c) Other patient factors
    d) Time constraints
iv. Stone to skin distance (cm)
v. Accurate stone size from original CT (mm)
vi. Number of treatments to stone
vii. Record of other stones present (green colour on diagram, red treated stone)
viii. Allergies (free text)
ix. Free text comments
x. Drop down selection of follow-up
    a) Rebooked for second treatment to same stone
    b) Rebooked for third treatment to same stone
    c) Rebooked for fourth treatment to same stone
    d) Rebooked for treatment to concurrent stone
    e) Follow-up imaging 6weeks (option x-ray, USS, both or CTKUB)
    f) Re-discuss at MDT meeting due to treatment failure or complication
    g) Stone clinic review

<u>e-discharge is then uploaded to ECR (copy to patient/GP/patients notes)</u>

ii. **Auxiliary Nurse during treatment**

A. Ensure patient comfort on table; supervise patients to prevent moving off the table during a treatment. Allow patient to play music they have brought in and use the earphones if patient has brought their own with them.

B. Undertake continuous observations of **heart rate** and **oxygen saturation** during Penthrox use, and ask radiologist to stop treatment and retrieve staff nurse from adjoining room if patient concerns raised, such as increased MEWS.

C. **Blood pressure** check every 15 minutes during Penthrox treatment, or more regular if required.

iii. **Staff nurse**

A. To provide Penthrox medication as breakthrough pain relief to suitable patients.

4. When Help is needed

1. **Treatment Query;**
   - Urgent advice needed then contact Mr Young on Mobile [redacted]
   - Call Urology Registrar on call if Mr Young unavailable
   - If unable to contact then call consultant on-call via switch board (0)

2. **Unwell patient;**
   - Contact the Registrar on Call for Urology on bleep [redacted] or mobile through switch board. If unable to contact call the Consultant on-call.

Cardiac Arrest or Peri-arrest Dial 6666 and state 'cardiac arrest, stone treatment centre' Then call Urology Doctors.

Nurse Checklist for Stone Treatment centre

Admission: Date: _____ **Patient Label:**

Time: _____

Signed: _____

Print Name: _____

Prior to treatment	YES	No	Comment if required
Confirm patient details			
Confirm patient understands treatment and any questions			
Chaperone present			
Review medication list			
Allergies (incl latex)			
Medications stopped as advised			
Able to take NSAIDs			
Urinalysis (POCT urine if symptomatic of UTI, Immunosuppressed)			(See flow chart)
Pregnancy test (12 to 55 years of age)			
Safety checklist from patient:			
Anticoagulation stopped as per protocol			List medication held:
Artificial heart valve			If yes give antibiotic prophylaxis Check anticoagulation protocol
Pacemaker or defibrillator			Electrophysiologist check/programme pre and post ESWL **YES/NO**
Artificial joint or mobility concern			
Abdominal aneurysm			Proceed only if aneurysm discussed at MDT and ESWL recommended. **YES/NO** Otherwise, cancel ESWL and discuss at Stone MDT
Neurosurgical Abdominal shunt			Cancel treatment and discuss at Stone MDT
Neurostimulator or other abdominal implant			If aware at MDT and ESWL to proceed **YES/NO** Implant not to be in focal zone of treatment
Pregnancy test positive			Cancel if positive and discuss at Urology Stone MDT
Pre ESWL Medications given and signed for			
Counsel on use of Penthrox (if indicated)			
Consent form check – radiographer countersigned			

During treatment	YES	No	Comment if required
Penthrox used			
Comments			

Observations

Admission

BP: **Pulse:** **Sats on air**: **Temperature:**

During Treatment

Time	BP	Pulse	Sats on air	Other (if required)

After treatment and on discharge

BP: **Pulse:** **Sats on air**: **Temperature:**

After treatment	YES	No	Comment if required
Post ESWL information given			
Medications for discharge			
Chaperone			
Anticoagulation to restart			Restart date as per protocol/ warfarin clinic organised **YES/NO**
e-Discharge letter for GP and patient			
Follow up arrangements made by radiographer			

Discharge: Date: _____

Time: _____

Signed: _____

Print Name: _____

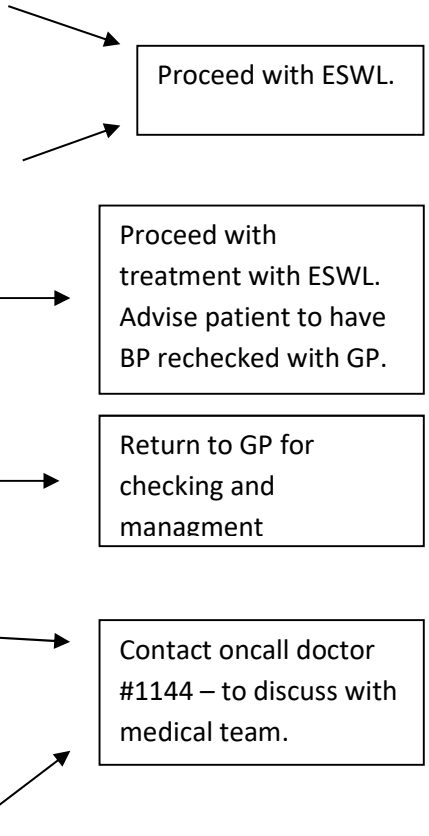
Management of blood pressure Prior to ESWL Treatment

Acute episodes of hypertension may arise in a variety of clinical settings due to the exacerbation of a pre-existing chronic hypertensive condition or as *de novo*. Emergency, intensive care, anaesthesia, and surgery are among the clinical settings where prompt recognition and treatment of acute hypertensive episodes (AHE) is of paramount importance. A variety of surgical and medical events may trigger intense sympathetic activity, resulting in sudden elevations in blood pressure (BP).

Table 1

Classification of Blood Pressure for Adults Aged ≥18. **(Pre-ESWL)**

Category	Systolic Blood Pressure	Diastolic Blood Pressure
Normal	<120	<80
Pre-hypertension	120–139	80–89
Hypertension-Stage I	140–159	90–99
Hypertension-Stage II	≥160	≥100
Hypertensive Urgency	>180	>120
Hypertensive Emergency	>180	>120 and target organ damage



Adapted from Chobanian, 2003.

Tulman DB, Stawicki SPA, Papadimos TJ, Murphy CV, Bergese SD. Advances in Management of Acute Hypertension: A Concise Review. *Discovery medicine*. 2012;13(72):375-383.

d. ESWL Medications

(Pain Relief and Antibiotics)

PATHOGENESIS OF PAIN DURING ESWL

The pain experienced by a patient receiving ESWL is multifactorial, but broadly speaking can be split into patient factors and lithotripter factors.

Patient Factors	Lithotripter Factors
Cutaneous superficial skin nociceptors*	Lithotriptor type^
Visceral nociceptors such as periosteal, pleural, peritoneal*	Size and site of stone burden^
Musculoskeletal pain receptors*	Location of shockwave focal stone^
Pain tolerance	Size of focal zone^
Pre-existing injury	Cavitation effects^
	Shockwave peak pressure^
* (Weber A, 1998)	Entry of shockwaves at skin^
	Coupling
	(Basar H, 2003)

To achieve the desired number of shockwaves delivered to a stone, at a suitable power, to generate a reasonable level of energy delivery to treat the stone requires the practitioner to limit the pain experienced by the patient.

Although many papers have been written on ESWL and pain relief, to date a consensus on what to prescribe has not been reached. The search for the ideal pain medication regime therefore continues.

Pain Medication ESWL pathway Craigavon Stone Treatment Centre (still active October 2017)

Current Medication:

a. Prior to treatment: **1 gram oral Paracetamol**
20mg Piroxicam oral (FELADINE MELT)

These are both given as long as there are no contraindications prior to procedure. Currently there is no set time prior to treatment for when given, hence a patient may take the medication and proceed straight to ESWL treatment.

b. Post Procedure : **Paracetamol 1 gram oral, QDS, 3 days**
Diclofenac 50mg, oral, tds, PRN, 3 days
(Alternative to diclofenac is codeine phosphate 30-60mg, oral, QDS, PRN, 3 days)

Pre-medication Onset of action

Paracetamol:

Paracetamol is readily absorbed from the gastrointestinal tract with peak plasma concentrations occurring about 30 minutes to 2 hours after ingestion. It is metabolised in the liver (90-95%) and excreted in the urine mainly as the glucuronide and sulphate conjugates. Less than 5% is excreted as unchanged paracetamol. The elimination half-life

varies from about 1 to 4 hours (emc+, 2016)

Piroxicam:

Piroxicam is a Non-steroidal Anti-inflammatory, with a half-life of 3-4 hours, and duration of action of up to 2 days, with some effect being reported up to 7-10 days (British Medical Association , Fourth edition, 2012). The Piroxicam Melt has a fast absorption and is not influenced by the fasting state (Gorham, 2013).

The FDA gives two explicit warnings on the use of NSAIDS (Not Aspirin) (DRUGS.COM , 2017)

WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS

Cardiovascular Thrombotic Events

- Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic events, including myocardial infarction and stroke, which can be fatal. This risk may occur early in treatment and may increase with duration of use. *[see Warnings and Precautions (5.1)]* .
- Piroxicam Capsules USP is contraindicated in the setting of coronary artery bypass graft (CABG) surgery *[see Contraindications (4) and Warnings and Precautions (5.1)]*.

Gastrointestinal Bleeding, Ulceration, and Perforation

- NSAIDs cause an increased risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events *[see Warnings and Precautions (5.2)]* .

Pubmed Search for Piroxicam use for ESWL

Search terms included ‘ESWL’, ‘SWL’, ‘Extracorporeal shockwave lithotripsy’ and ‘Piroxicam’

9 papers were returned

7 papers were discarded as they did not directly compare piroxicam in a trial or present study evidence for its use.

The remaining 2 papers were clinical trials, a randomized placebo-controlled study and a randomised comparison trial.

Andreou et al undertook a Randomized study comparing piroxicam analgesia and tramadol analgesia during outpatient electromagnetic extracorporeal lithotripsy, 2006. They randomised 171 patients into 2 groups of 40mg IM Piroxicam and 100mg IV tramadol. The tramadol group had more side effects, but both forms of medication were deemed suitable pain relief for ESWL according to the visual pain score and researches analysis (Andréou A, 2006).

Aybek et al undertook a randomized, placebo-controlled study, comparing 30 patients receiving IM Piroxicam 40mg

vs 30 patients receiving IM saline as the placebo control. Medications were given as IM injection to the gluteal muscle 45 minutes before ESWL. Medication vs no medication demonstrated a significant difference on a verbal rating pain scale (Aybek Z, 1998).

The 2 papers which looked at piroxicam and ESWL did not look at the oral route and were not using the current generation or modality of shock generation used at Craigavon Area Hospital.

Outcome:

Data is therefore required for oral Piroxicam use as a pre-medication for ESWL. We conducted a prospective study in Craigavon, comparing 100 patients in relation to energy received to stone and premedication given.

Comparison Study of Piroxicam and Paracetamol vs Paracetamol

for ESWL pain relief medication.

Craigavon Stone Treatment Centre

Aim

Does the combination of oral Piroxicam and Paracetamol premedication for ESWL increase the power and energy delivered to renal and ureteric stones when compared to Paracetamol alone?

Background

The Craigavon Area Hospital Stone Treatment Centre generally follows the recommendations for ESWL based on the European Urology guidelines for Urolithiasis (European Association of Urology , 2017). It was noted the most common reason for limitation of ESWL treatment was pain experienced by the patient. The department had been traditionally using the NSAID piroxicam 20mg oral fast tab and 1 gram of oral paracetamol as pre-medication for ESWL. This had been given to the patient on average 30 minutes before their ESWL treatment.

Piroxicam is non-selective non-steroidal anti-inflammatory drug (NSAID), meaning it has action on COX-1 (Cyclo-oxygenase-1) and COX-2 enzyme inhibition. The COX-1 and COX-2 enzyme catalyzes the synthesis of cyclic endoperoxides from arachidonic acid to form prostaglandins. Prostaglandins mediate the inflammatory, fever and pain sensation (Day RO, 2013). COX-1 is distributed throughout the body, with higher concentration in kidney, stomach, endothelium and platelets. Prostaglandins produced via this pathway control renal perfusion, promote platelet aggregation and gastric protection. Whilst COX-2 is found in macropharges, leukocytes, fibroblasts and synovial cells, with the prostaglandins produced mediate inflammation, fever, and pain and inhibit platelet aggregation (Longo D, 2012).

There are several non-prostaglandin pathways NSAIDS may act upon, but further study in required to explain the mechanism of action and the importance (Soloman, 2017). The combination of paracetamol and the NSAID

Ibuprofen has been proved to be of benefit in a Cochrane review, for the treatment of post-operative pain (Derry CJ, 2013). There is however clear variation in the individual patient response to NSAIDs in both therapeutics and adverse effects, and some patients seem to respond better to one drug than to others, and responses differ between patients. These differences have been attributed to variations in mechanism of action to COX enzyme inhibition different capacities for altering non-prostaglandin-mediated biologic events; and differences in pharmacodynamics, pharmacokinetics, and drug metabolism, including pharmacogenetic factors (Soloman, 2017).

The pain experienced by a patient receiving ESWL is multifactorial, but broadly speaking can be split into patient factors and lithotripter factors.

Table 1.

PATHOGENESIS OF PAIN DURING ESWL

Patient Factors	Lithotripter Factors
Cutaneous superficial skin nociceptors*	Lithotriptor type^
Visceral nociceptors such as periosteal, pleural, peritoneal*	Size and site of stone burden^
Musculoskeletal pain receptors*	Location of shockwave focal stone^
Pain tolerance	Size of focal zone^
Pre-existing injury	Cavitation effects^
	Shockwave peak pressure^
* (Weber A, 1998)	Entry of shockwaves at skin^
	Coupling
	(Basar H, 2003)

To achieve the desired number of shockwaves delivered to a stone, at a suitable power, to generate a reasonable level of energy delivery to treat the stone requires the practitioner to limit the pain experienced by the patient.

Although many papers have been written on ESWL and pain relief, to date a consensus on what to prescribe has not been reached. The search for the ideal pain medication regime therefore continues.

A Pubmed search for the use of oral Piroxicam as pre-treatment medication for ESWL returned no studies. Search terms included 'ESWL', 'SWL', 'Extracorporeal shockwave lithotripsy' and 'Piroxicam', 9 papers were returned, 7 papers were discarded as they did not directly compare piroxicam in a trial or present study evidence for its use. The remaining 2 papers were clinical trials, a randomized placebo-controlled study and a randomised comparison trial, but neither studied the use of Piroxicam as an oral medication (Andréou A, 2006) (Aybek Z, 1998). Data is therefore required for oral Piroxicam use as a pre-medication for ESWL.

Method,

Data on a prospective 150 patients receiving ESWL for renal and upper ureteric stones was collected in2017. The departments guidelines for pain relief was followed, offering all patient pre-medication with paracetamol and piroxicam, with those contraindicated to piroxicam due to allergy, previous stomach ulcer, NSAID ingestion that day or personal choice only receiving Paracetamol or nothing. Oral medication was given on average 30 minutes prior to treatment by the staff nurse, in a separate room to the lithotripter and blinding radiographer who delivers the ESWL treatment.

All patients were treated by the same EDAP TMS Sonolith i-sys, which is a new generation electroconductive lithotripter. All patients were aimed to have 1000J delivered to a renal and 1400J to a ureteric calculi, with a frequency of 1.2Hz as standard. The power to the calculi was aimed at reaching 100%, requiring 3000 maximum shocks up to a one hour treatment session. Treatment can be stopped if stone successfully treated at a lower energy.

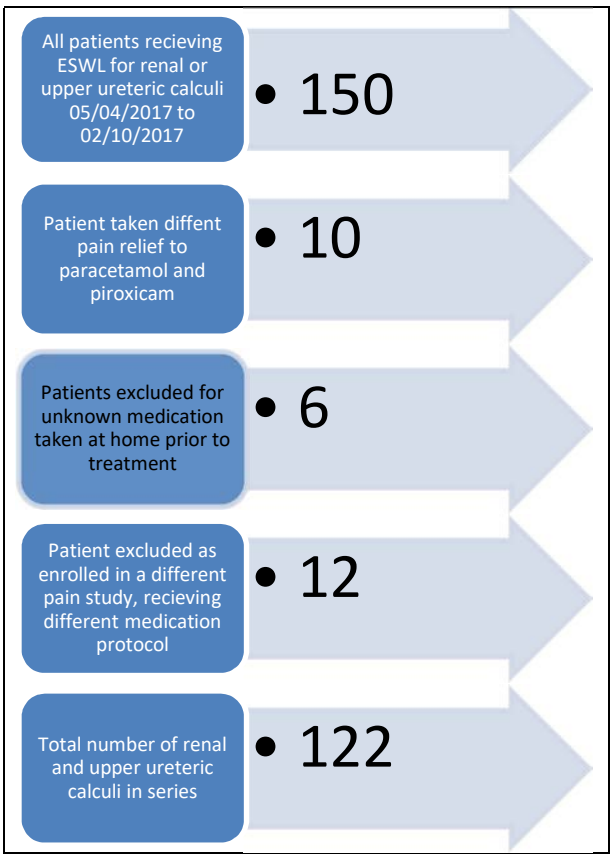


Table 2. Patients excluded from study

Results,

Table 3. Renal and upper ureteric calculi

Medication	Number of Patients	Average age and (range)	Power (%) average and (range)	Energy average and (range)
20mg Piroxicam and 1g Paracetamol	62	50.3 (24-80)	59.4 (16-100)	689.6 (55-1000)
1g Paracetamol	56	54.4 (28-81)	60.8 (12-99)	788.8 (145-1000)
No Medication	4	65.5 (60-74)	51 (38-59)	899.25 (713-1000)

The statistical analysis of prioxicam and paracetamol vs paracetamol alone demonstrated no significant difference for the power or energy delivered to renal or ureteric calculi.

Discussion

The medication groups were well matched for age and number, 62 patients received piroxicam and paracetamol with an average age of 50.3 years and, 56 patients with an average age of 54.4 years received paracetamol only. The average power and energy was less in the joint paracetamol and piroxicam group then the paracetamol group alone. There is no significant difference between the two pain reliefs it would appear based on the treatment parameters.

There were too few patients in the no medication group to really comment, with only 4 patients, who received less power to the calculi on average then the medication groups, but received more energy due to a higher number of shockwaves.

The reason for no difference between the two medicated groups is probably due to the time of onset of the piroxicam. Although the 20mg piroxicam melt used and has a fast absorption rate (Gorham, 2013) it has a variable action of onset and take up to 2 days for a steady state with a half-life of 3 -4 hours (British Medical Association , Fourth edition, 2012). The medication may have greater benefit therefore if it was started the day before or even two days before treatment, and then possibly continued as part of the post procedure pain relief for a number of days. This however would increase cost and the complexity of prescribing the medication prior to attendance at the Stone Treatment Centre for ESWL. Further limitations of the study would include the small numbers in each group and the lack of a validated pain score. Since piroxicam activity can last up to 7-10 days a pain score once the patient had returned home may have been of benefit.

The current use of Piroxicam 20mg 30 minutes prior to ESWL should therefore be discontinued. If an NSAID is to be continued as a pre ESWL pain relief medication then an intramuscular NSIAD or Per Rectum NSAID may be of greater effect (ref). Other fast acting oral NSIAD medications would warrant further evidence for their use with ESWL, as more practical and acceptable form of medication for the patient.

ESWL Treatment Breakthrough Medication:

Currently no breakthrough pain medication is given during ESWL treatment at Craigavon Stone Treatment Centre. Thus patient's treatments can be limited due to pain. A Prospective study was conducted looking at patient who did not receive any break though medication and the average power able to be achieved, if treatment was limited due to pain as per radiographer and a visual analogue scoring system for pain experienced during by the patient during treatment.

Results

A break though pain medication was sought. Since the ESWL treatments are Nurse and radiographer led, then type and route of drug is limited. IV morphine is currently not allowed to be given by a nurse, and the nurses also do not have prescribing rights.

A novel solution is therefore required, and so following consultation with A+E, Penthrox 3ml Inhaler as a

breakthrough medication is a consideration. The alternative pathway would be to include a Doctor with treatment session so IV morphine could be given as and when required, however this would increase the cost of the service and impact negatively to another aspect of the urological activity. Could the numbers requiring breakthrough pain medication be reduced further by altering or adding to the current regime, this is a further topic for research and is an ongoing topic of research in the sphere of ESWL.

In order to trial the use of Penthrox as breakthrough medication the drug had to be first approved at the drug and therapeutic committee at Craigavon Area Hospital. A review of the drug, including current use and safety was conducted, as well as the environment for its use.

Penthrox was given approval for use from the Craigavon Hospital Drug and Therapeutics Committee (DTC) in February 2017. An initial 50 units (Penthrox 3ml inhaler) were to be purchased by the hospital and a further 20 units were to be provided by Galan free of charge. There were all then registered to the pharmacy department and requested for use at the Stone Treatment Centre when required.

Southern Health and Social Care Trust

New Product Application Form

This form must be completed to provide the SHSCT Drug and Therapeutics Committee (DTC) with information about the proposed product. Applications may only be made by Trust Consultants.

Requests must be sent to Dr Tracey Boyce c/o DTC Secretary, CAH Pharmacy Dept., at least **2 weeks** prior to the Drug and Therapeutics Committee meeting.

*** * Please note that incomplete forms will be returned to the consultant concerned ****

Section 1: Background information

Generic name of medicine: Methoxyflurane

Brand name/ manufacturer: Penthrox

Formulation: 3ml Methoxyflurane (99.9%), liquid to be used in an inhaler

Route of administration: Inhaler with carbon filters for exhaled gases.

Proposed indication: Breakthrough pain relief for extracorpeal shockwave lithotripsy (ESWL) of renal and ureteric stones

Dose information: 3ml Penthrox, not to exceed 6ml on single administration, not to exceed 15ml in a week.

Section 2: Place in treatment algorithm

Please specify the criteria for patient selection:

Patients have 1g Paracetamol and NSAIDS (currently oral piroxicam 20mg, may change to PR Diclofenac 75mg) 40 minutes prior to starting ESWL treatment of stone.

If treatment limited due to pain, then breakthough pain relief to be given in the form of 3ml Penthrox as inhaler under supervision by a staff nurse. **Only one inhaler of 3ml to be given to each patient over their treatment hour as needed, and no more than one per hour to be used in the treatment room**. Currently no breakthrough pain relief is available and so some treatments are limited or require more treatments. No breakthrough pain relief potentially increases the need for more costly treatment in main theatre, such as Flexible Ureterenoscopy, which also carries greater risk of patient complication compared with ESWL.

Penthrox **would not be given** to patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

Section 3: Summary of evidence on clinical effectiveness issues

What are the principal trials supporting the indication(s) described above and the overall results regarding efficacy? Please provide copies of up to 3 (maximum) relevant references, preferably including comparative data trials.

http://www.sciencedirect.com/science/article/pii/S027323001630126X

Derivation of an occupational exposure limit for an inhalation analgesic methoxyflurane (Penthrox®)

John Frangos, , Antti Mikkonen, Christin Down
Golder Associates, 570 – 588 Swan Street, Richmond, Victoria, 3121, Australia
Received 4 March 2016, Revised 9 May 2016, Accepted 11 May 2016, Available online 13 May 2016

Highlights
• Dose response analysis using clinical toxicity data is exemplified.
• Exposure limit for methoxyflurane of 15 ppm (8 h TWA) was derived.
• Occupational exposure estimates are well below the proposed MEL.

The peak is always less than 15 ppm in a treatment room under the following conditions:

1 vial per hour at an air change per hour (ACH) OF 1.15; and
2 vial per hour at ACH of 1.95.

Abstract
Methoxyflurane (MOF) a haloether, is an inhalation analgesic agent for emergency relief of pain by self administration in conscious patients with trauma and associated pain. It is administered under supervision of personnel trained in its use. As a consequence of supervised use, intermittent occupational exposure can occur. An occupational exposure limit has not been established for methoxyflurane. Human clinical and toxicity data have been reviewed and used to derive an occupational exposure limit (referred to as a maximum exposure level, MEL) according to modern principles. The data set for methoxyflurane is complex given its historical use as anaesthetic. Distinguishing clinical investigations of adverse health effects following high and prolonged exposure during anaesthesia to assess relatively low and intermittent exposure during occupational exposure requires an evidence based approach to the toxicity assessment and determination of a critical effect and point of departure. The principal target organs are the kidney and the central nervous system and there have been rare reports of hepatotoxicity, too. Methoxyflurane is not genotoxic based on in vitro bacterial mutation and in vivo micronucleus tests and it is not classifiable (IARC) as a carcinogenic hazard to humans. The critical effect chosen for development of a MEL is kidney toxicity. The point of departure (POD) was derived from the concentration response relationship for kidney toxicity using the benchmark dose method. A MEL of 15 ppm (expressed as an 8 h time weighted average

(TWA)) was derived. The derived MEL is at least 50 times higher than the mean observed TWA (0.23 ppm) for ambulance workers and medical staff involved in supervising use of Penthrox. In typical treatment environments (ambulances and treatment rooms) that meet ventilation requirements the derived MEL is at least 10 times higher than the modelled TWA (1.5 ppm or less) and the estimated short term peak concentrations are within the MEL. The odour threshold for MOF of 0.13–0.19 ppm indicates that the odour is detectable well below the MEL. Given the above considerations the proposed MEL is health protective.

Emergency Medicine Journal

Emerg Med J 2014;**31**:613-618 doi:10.1136/emermed-2013-202909

- Original article

STOP!: a randomised, double-blind, placebo-controlled study of the efficacy and safety of methoxyflurane for the treatment of acute pain

OPEN ACCESS

Frank Coffey[1], John Wright[2], Stuart Hartshorn[3], Paul Hunt[4], Thomas Locker[5],Kazim Mirza[6], Patrick Dissmann[4]

Abstract

Objective To evaluate the short-term efficacy and safety of methoxyflurane for the treatment of acute pain in patients presenting to an emergency department (ED) with minor trauma.

Methods STOP! was a randomised, double-blind, multicentre, placebo-controlled study conducted at six sites in the UK. A total of 300 patients, 90 of whom were adolescent patients (age 12–17 years), were randomised 150:150 to receive either methoxyflurane via a Penthrox inhaler or placebo. The primary end point of the study was the change in pain intensity as measured using the visual analogue scale (VAS) from baseline to 5, 10, 15 and 20 min after the start of study drug inhalation. Patients were supplied with one inhaler containing 3 mL methoxyflurane or 5 mL placebo after enrolment and initial assessments. Age group (adolescent/adult) and baseline VAS score were controlled for in the statistical analyses.

Results A total of 149 patients received methoxyflurane, and 149 patients received placebo. Demographic and baseline characteristics were comparable between the groups. Methoxyflurane reduced pain severity significantly more than placebo ($p<0.0001$) at all time points tested, with the greatest estimated treatment effect of −18.5 mm (adjusted change from baseline) seen at 15 min after the start of treatment. Methoxyflurane was well tolerated, with the majority of adverse reactions being mild, transient and in line with anticipated pharmacological action.

Conclusion The results of this study suggest that methoxyflurane administered via the Penthrox inhaler is an efficacious, safe, and rapidly acting analgesic.

Trial registration number: NCT01420159.

Anaesthesia
Journal of the Association of Anaesthetists of Great Britain and Ireland

Self-administered methoxyflurane for procedural analgesia: experience in a tertiary Australasian centre

1. A. L. Gaskell Research Fellow[1,*],
2. C. G. Jephcott Consultant[2],
3. J. R. Smithells Consultant[2] and
4. J. W. Sleigh Consultant, Professor[2,3]

Version of Record online: 15 FEB 2016

DOI: 10.1111/anae.13377

Summary

Methoxyflurane, an agent formerly used as a volatile anaesthetic but that has strong analgesic properties, will soon become available again in the UK and Europe in the form of a small hand-held inhaler. We describe our experience in the use of inhaled methoxyflurane for procedural analgesia within a large tertiary hospital. In a small pilot crossover study of patients undergoing burns-dressing procedures, self-administered methoxyflurane inhalation was preferred to ketamine-midazolam patient-controlled analgesia by five of eight patients. Patient and proceduralist outcomes and satisfaction were recorded from a subsequent case series of 173 minor surgical and radiological procedures in 123 patients performed using inhaled methoxyflurane. The procedures included change of dressing, minor debridement, colonoscopy and incision-and-drainage of abscess. There was a 97% success rate of methoxyflurane analgesia to facilitate these procedures. Limitations of methoxyflurane include maximal daily and weekly doses, and uncertainty regarding its safety in patients with pre-existing renal disease.

Section 4: Summary of evidence on comparative efficacy

What are the advantages of this medicine compared to other treatments? Consider medicines already recommended in the Regional Formulary or in the same therapeutic class.

Rapid onset

Patient controlled

Compared with the opiate alternatives there would be no need for a second staff nurse present. The stone centre is run by x1 staff nurse, x1 HCA, X1 radiographer.

Section 5: Summary of evidence on comparative safety

What are the advantages/disadvantages of this medicine in relation to patient safety compared to other treatments?

Self-administered by patient in the form of an inhaler

Rapid onset of analgesia (6 – 10 breaths)

Shorter recovery time then traditional opiate based medication

After 30 minutes of observation can be discharged and can safely return to highly skilled psychomotor skills tasks such as driving and daily work the same day.

Not for use in patients with clinically evident cardiovascular or respiratory instability, any history of anaesthetic allergy, alcohol abuse, isoniazid, phenobarbital, rifampicin, clinically significant renal impairment (e.g. CKD stage IV, V).

NOTE: The cardiovascular and respiratory caution may well be historic to its use as an anaesthetic agent as no clinically significant changes were observed for vital signs (heart rate, respiratory rate, BP or temperature).

H F Oxer, 'Effects of Penthrox® (methoxyflurane) as an analgesic on cardiovascular and respiratory functions in the pre-hospital setting, Volume 24 Number 2; April 2016, Journal of Military and Veterans' Health'.

Regarding potential occupational exposure the number of air changes per hour has been calculated by the estates department. Only one 3ml vial per patient may be used and not more than one vial per hour to be used in the treatment room. To achieve a peak of always less than 15 ppm in the treatment room then 1 vial per hour at an air change per hour of 1.15 needs to be achieved (Frangos et al, see Section 3, Summery of Evidence)

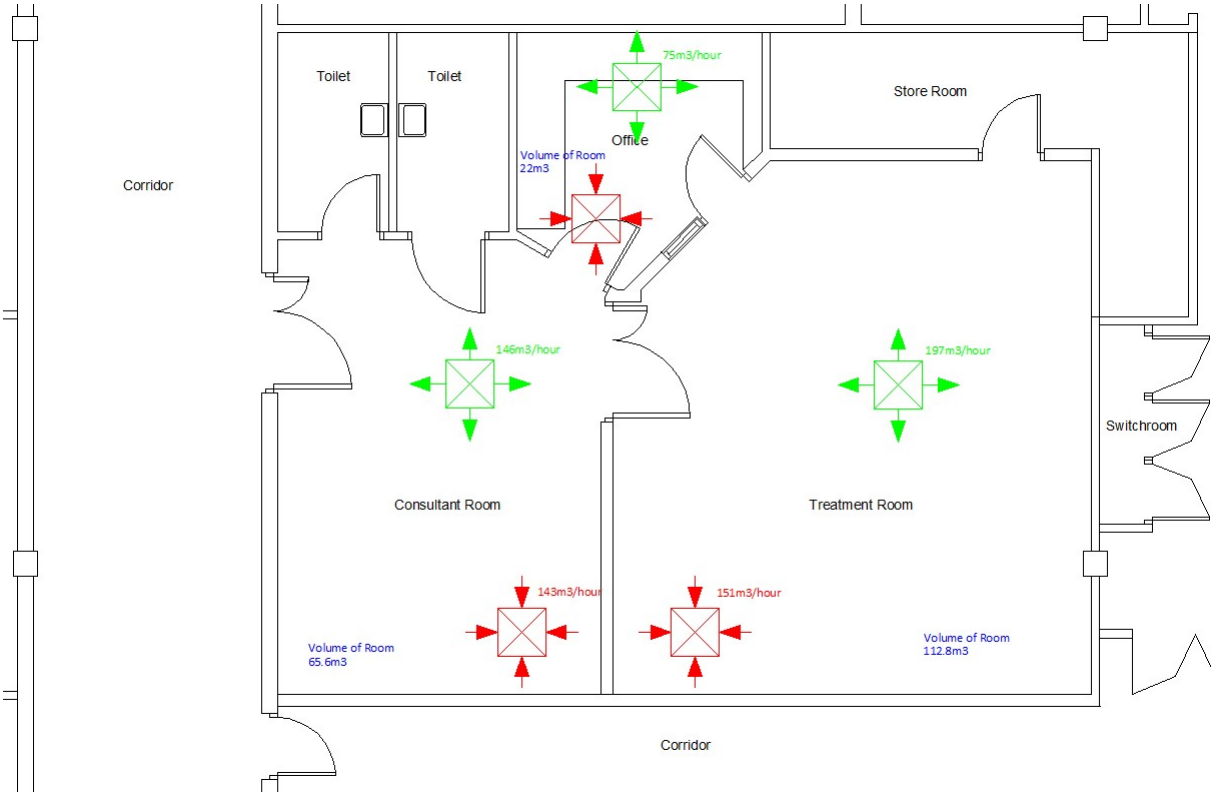
The room was tested on the 09/02/2017 by the Estates department and the treatment room meets the standard required, with an air change per hour of 1.75.

Craigavon Area Hospital – Stone Treatment Centre Ventilation Report

Measured on 9th February 2017 by Ruairi King, Estates Department

Survey conducted to measure the number of air changes per hour within each room. This information is required to determine the use of a new inhaler type pain relief at the centre.

Stone Treatment Centre Plan showing supply and extract grilles with corresponding air flows.



$$Air\ changes/hour = \frac{Volume\ of\ air\ supplied/hour}{Volume\ of\ room}$$

Treatment room:

$$Air\ changes/hour = \frac{197}{112.8} = 1.75$$

Consultant room:

$$Air\ changes/hour = \frac{146}{65.6} = 2.23$$

Office:

$$Air\ changes/hour = \frac{75}{22} = 3.41$$

The ventilation system supplying air to the Stone Treatment Centre is not connected to the Hospitals Building Management System (BMS); therefore its status cannot be monitored by the Estates Department.

It is necessary to install airflow sensors which connect to the BMS so that the status of the ventilation system can be monitored and logged in case of faults etc.

An indicator should also be installed within the treatment centre showing the status of the system and alarm when

there is a fault or when there is no air flowing. This is needed to safeguard staff and patients when using the new inhaler type of pain relief.

Section 6: NICE and Scottish Medicines Consortium (SMC) Adjudications

Has NICE considered this product: Yes / No
If yes – what was the outcome? If No – is NICE currently considering the item?

Nice contacted Galen in 2016 as they are considering reviewing the medication as per Dr Sarah Dolan 06/02/2017.

Penthrox was highlighted on a NIHR horizon scanning document in February 2016: http://www.hsric.nihr.ac.uk/topics/methoxyflurane-penthrox-for-emergency-relief-of-moderate-to-severe-pain/

Has the NICE guidance been endorsed in Northern Ireland: Yes / No

Has SMC considered this product: Yes / No
If yes – what was the outcome?
All Wales Medicines Strategy Group concluded that Penthrox was exempt from review as it is a medicinal gas: http://www.awmsg.org/docsnoindex/awmsg/June%202016.pdf

Penthrox is classed as a medicinal gas, and therefore exempt from review by SMC as per Dr Sarah Dolan from Galen 06/02/2017 – see exclusion criteria no. 7 in SMC publication: Guidance for medicines out with SMC remit.

Section 7: Financial Information

	No. of patients in SHSCT eligible for treatment per annum	Cost per annum (£) per patient	Total annual cost (£)

Secondary Care		Current ESWL capacity is 9 patients per week. At present 9 x52 = 468 potential stone treatments per year. (not taking into account public holidays)	£17.89 + VAT	£61138 + VAT Used as Breakthrough pain, 73% would require Penthrox, therefore 73% of 468 = 342 patients). Based on ESWL questionnaire of pain during treatment 10/02/17, currently on-going.
Primary Care				
Cost of the therapy to be 'replaced' if applicable	Secondary Care	**<u>Potential cost savings</u>** if further treatments of ESWL prevented by use of the pain relief, or potential failure of treatment requiring more expensive ureteroscopy or PCNL.		
	Primary Care			
TOTAL NET COST:				£8372.52
Other Cost Implications e.g. Additional Medicine Therapy, X-rays, Lab Tests, etc.	Please state:			

If additional funding is required to purchase this product within the Trust please give details of how this will be found (e.g. current approved business case, agreed reduction in bed-days /beds, stopping use of another product)

Increased funding is likely to be required to fund the medication, but it will have a **knock on effect to save money** from the reduction in further procedures and waiting list. The aim would also to provide emergency treatment, so reduce the cost and burden on the emergency operating theatre.

The use of Penthrox as breakthrough pain relief could increase the number of patients receiving a full treatment of ESWL and therefore reduce the need for secondary procedures such as Ureteroscopy or PCNL, both of which are more costly.

Koo and Young from Craigavon Area Hospital, published in the British Journal of Urology in November 2010 calculated the overall cost of Flexible ureteroscopy (FURS) to be £2602, compared to £426 for ESWL. If each patient had one treatment of ESWL instead of FURS, then £2176 could be saved, or to use the operating time for a different case and possibly decrease the waiting list.

Only 2.8 patients would need to be prevented from having a further surgical procedure (FURS) **by having successful ESWL to match the cost of 342 patients receiving Penthrox**. (Based on 342 patients x £17.89 Penthrox cost).

Many patients may have reduced number of ESWL treatments, as a greater energy can be delivered to the stone on initial treatment then the current average.

From the 4th Jan 2017 to 6th Feb 2017, 22 patients out 31patients treated by ESWL had limited treatment received, with the most common reason being pain.

Section 8: Declaration of Interests

SHSCT Gifts and Hospitality and Standards of Conduct Policy/ Declaration of interest (Procurement)

The lead consultant(s) responsible for completing this application to the Drug and Therapeutics Committee are asked to declare and describe to the Chairman, any involvement that they may have with the relevant pharmaceutical company, or with the manufacturers of any comparator products.

This includes direct or indirect financial gain that they have received from the pharmaceutical company where this amounts to *greater than £500 p.a. within the last 2 years*. Such interests may be direct (e.g. lecture or consultancy fees, sponsorship for postgraduate educational activity) or indirect (egg. departmental donations, research contracts, funded staff support).

Do you have an interest in the pharmaceutical industry as described above? **No** (please delete as necessary)
If Yes, name of Pharmaceutical Company(ies):
Nature of involvement or assistance: Direct and/or indirect – specify (the amount of money involved does not have to be declared):

Signatures **(please note all must be complete before application accepted by DTC)**

Name of Consultant: Mr Michael Young Date: 10/02/2017
(please print name)

Signature of Consultant: _____

Associate Medical Director

Name: _____ Date: 10/02/2017
(please print name)

Signature of AMD: _____

Assistant Director/Director

Name: _____ Date: 10/02/2017
(please print name)

Signature of AMD: _____

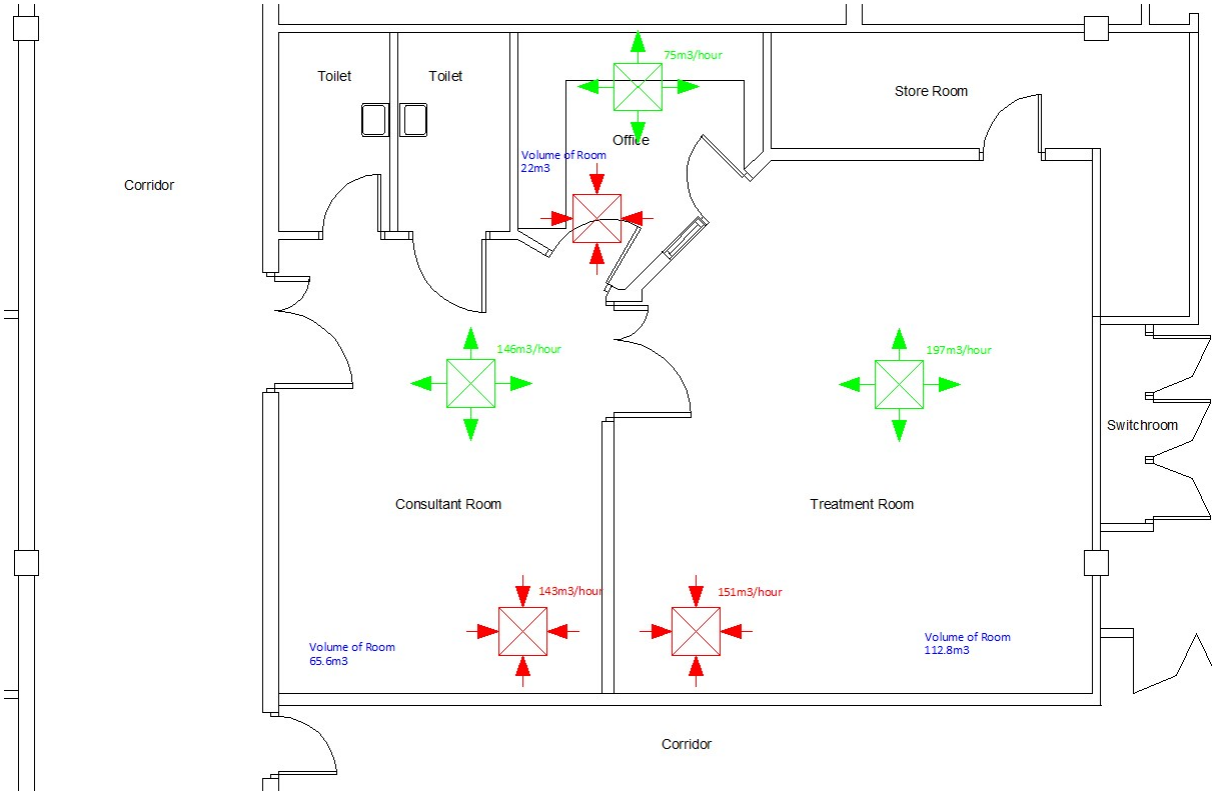
Outcome of DTC

Craigavon Area Hospital – Stone Treatment Centre Ventilation Report

Measured on 9th February 2017 by Ruairi King, Estates Department

Survey conducted to measure the number of air changes per hour within each room. This information is required to determine the use of a new inhaler type pain relief at the centre.

Stone Treatment Centre Plan showing supply and extract grilles with corresponding air flows.



$$Air\ changes/hour = \frac{Volume\ of\ air\ supplied/hour}{Volume\ of\ room}$$

Treatment room:

$$Air\ changes/hour = \frac{197}{112.8} = 1.75$$

Consultant room:

$$Air\ changes/hour = \frac{146}{65.6} = 2.23$$

Office:

$$Air\ changes/hour = \frac{75}{22} = 3.41$$

The ventilation system supplying air to the Stone Treatment Centre is not connected to the Hospitals Building Management System (BMS); therefore its status cannot be monitored by the Estates Department.

It is necessary to install airflow sensors which connect to the BMS so that the status of the ventilation system can be monitored and logged in case of faults etc.

An indicator should also be installed within the treatment centre showing the status of the system and alarm when there is a fault or when there is no air flowing. This is needed to safeguard staff and patients when using the new inhaler type of pain relief.

The DTC required further evidence to be produced following the use of Penthrox for ESWL break through pain relief. Data was prospectively collected on the standard pre-medication given (paracetamol, piroxicam), a pain visual rating index, if breakthrough Penthrox was received, power and energy delivered to the stone and if pain limited treatment (this could be decreased power or energy delivered compared to standard expected, e.g. 1000j to renal and 1400j to ureteric stones).

Prior to use of the Penthrox the medical prescribing doctor has to check for contraindications to its use. Prior to use of Penthrox each patient is given an information sheet containing action, contraindication and side effects, as well as how to use the device. This was developed in conjunction with Galan the manufacturer. All patients were advised to attend with a chaperone. This is more from a safety standpoint that ESWL can produce small fragments and potential colic and may well be best not to drive themselves home.

To standardise the information given to the patients a standard script was developed by the nurses to explain how to use the drug. On average the script take 75 seconds to run and demonstrate how to use the Penthrox device.

Observations during Penthrox use were discussed and agreed at a Urology Stone Meeting MDM August 2017 to include continuous saturation and heart rate monitor and BP every 15 minutes.

Following ESWL treatment patients receive a minimum of 30 minute observation, including re-checking of observations prior to discharge. A Penthrox advice card is given to the patient as part of their discharge pack.

Pain Intensity Score During ESWL Questionnaire (To be completed by Staff Nurse following ESWL)

Patient to give score immediately following completion of ESWL.

Patient Age

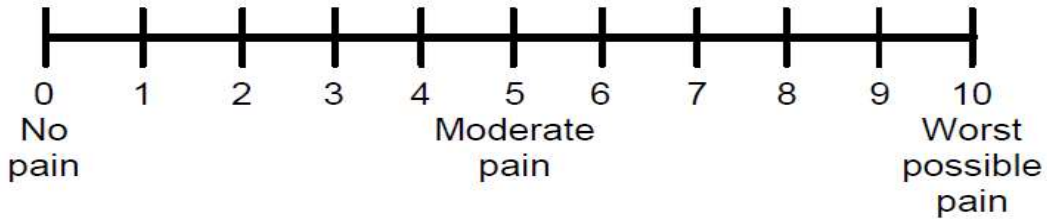
Patient gender Male Female (circle answer)

Type of pain relief given,

Paracetamol Piroxicam Diclofenac Codeine Phosphate Penthrox (circle answer)

1. **How would you rate your pain DURING your ESWL treatment (show to patient)**

0–10 Numeric Pain Rating Scale



2. **Any nausea/ sickness experienced during treatment? Yes No (circle answer)**

3. **Renal or Ureteric stone (circle answer)**

4. **Mean Power achieved …… Total energy delivered……**

5. **Did pain limit treatment Yes No (circle answer)**

Many thanks

PENTHROX 3ML Inhaler Breakthrough Pain Relief

1. Patient unable to Tolerate ESWL treatment, STOP TREATMENT

2. Check no contraindications (Table 1) to Penthrox (ideally checked before ESWL started)

Table 1.

Penthrox Contraindications: (Galen Ltd)

Contraindications

- Clinically significant renal impairment , (e.g. eGFR <30, Stone Treatment Centre)
- Patients who have a history of showing signs of liver damage after previous methoxyflurane use or halogenated hydrocarbon anaesthesia
- Malignant hyperthermia: patients with known or genetically susceptible to malignant hyperthermia or a history of severe adverse reactions in either patient or relatives
- Use as an anaesthetic agent
- Hypersensitivity to PENTHROX or any fluorinated anaesthetic
- Altered level of consciousness due to any cause including head injury, drugs or alcohol
- Clinically evident cardiovascular instability
- Clinically evident respiratory depression

Galen Ltd . (n.d.). *Penthrox, Methoxyflurane*. Retrieved March 21, 2017, from Penthrox: https://www.penthrox.co.uk/hp/information/safety/contraindications/

3. If no contraindication give 3ml Penthrox inhaler as per instruction 8-10 breaths (see table 2)
4. Radiographer to resume ESWL and begin power ramping
5. Patient to self-administer further Penthrox, 2-3 breaths as required.
6. Once Penthrox treatment complete inhaler, carbon filter and drug bottle to be placed in sealed plastic bag provided and placed in clinical waste.
7. Clinical waste to be disposed of from Stone Treatment Centre every day Penthrox is in use.

Only use with the air exchange ventilation system operating. Periodic assessment of air exchange ventilation system required by Estates Department to ensure air changes/hours of >1.15

Nurse Administration protocol:

- Patient informed of possible Penthrox use prior to entering ESWL treatment room (patient information leaflet in pre-procedural pack and in waiting room) and demonstration given by nurse using a training pack.
- Script for explaining PENTHROX usage to patient (takes 75seconds to explain):
    - **'Hold the green inhaler in the opposite hand to the side of your treatment**
    - **Place the inhaler into your mouth and create a tight seal with your lips**
    - **Take 3 gentle breaths in AND out through the inhaler**
    - **Keep inhaler in your mouth and breath normally in AND out for 5 more loading breaths then remove it from your mouth**

- **If you experience pain during the procedure then reinsert the inhaler into your mouth and resume normal breathing in AND out through the inhaler device until you feel more comfortable.**
- **If you need a stronger dose you can place your finger over the clear plastic hole and continue your normal breathing in AND out through the inhaler.**
- **Please take your Penthrox throughout the procedure as you need it.**
- **It is normal to experience some discomfort during this procedure. It has been described as a similar sensation to being flicked with an elastic band.**
- **Do you have any questions about using the Penthrox inhaler'?**

- See Penthrox package for explanation of assembly of delivery device.
- ESWL treatment to stop if patient not tolerating treatment.
- Give the inhaler to the patient and use the directional script above to aid use.
- Radiographer should restart treatment 60seconds after first Penthrox inhalation breath.
- See flowchart for example of use.
- Encourage patient to continue using inhaler as required, including covering the dilution hole to deliver a stronger dose during treatment.
- If patient not tolerating treatment despite optimal use of inhaler then pause treatment and deliver a further five loading breaths, repeat this step to a maximum of x3 as required.
- Discontinue treatment if not tolerated/ patient requested

Patient who are unable to tolerate ESWL treatment, pause treatment, and if no contraindications use Penthrox

Initial loading with Penthrox (3 inhalation breaths and 5 loading breaths in and out of the inhaler).

Radiographer restarts ESWL treatment 60 seconds after first inhalation breath of Penthrox .

Throughout Penthrox treatment monitor

1. Heart Rate and Saturation using continuous monitor
2. Blood pressure every 15 minutes

Patient to continue taking normal breaths in and out through the inhaler **as required** for pain relief.

If stronger dose required, instruct patient to cover dilution hole whilst continuing normal breathing in and out through inhaler.

Patient not tolerating treatment despite optimal use of inhaler:

If after 3 cycles patient not tolerating treatment then abandon treatment.

Stop treatment and reload with 5 breaths in and out of inhaler.

Radiographer to restart ESWL 60seconds after first breath taken.

Patient tolerating treatment:

Continue same usage as required until treatment completed

Note: stop treatment at any point if patient requests.

Pain Relief Future Considerations

It is important to optimise the pain relief so ESWL treatments are not limited by this factor. Pain from ESWL is multifactorial, as seen in the section on 'Pathogenesis of pain during ESWL'. Such is the case therefore any changes which are made to the delivery of the treatment should be made in isolation and proved the change to be an improvement (e.g. change in medication only and then study, not change in medication and coupling medium).

	Patient Factors	Nurse Factors
Premedication:	• Pain relief to act within 1 hour or 30 minutes of pre-ESWL procedure. • Medication to give adequate pain relief during ESWL for a 1 hour session. • Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL	• The ideal medication should be able to administered by a single staff nurse • If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights
Breakthrough Medication	• Pain relief to act within a short time to allow ESWL treatment to resume. • Medication to give adequate pain relief during ESWL for a 1 hour session. • Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL	• Can be given with only one staff nurse present • Allows a discharge following procedure of 45 minutes maximum • If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights
Discharge Medications	• Provides adequate pain relief for renal colic • Have limited side effect profile and able to be prescribed for the majority of patients who attend for ESWL	• Able to be dispensed the day of ESWL • If nurse prescribing is started then medications able to be prescribed by a nurse with prescribing rights

Urology Stone MDM: Recommendations for changes in Pain Relief Medication or Delivery of ESWL

Medication or change in delivery of ESWL	Reason for Change	Method of action	Evidence (Such as Pubmed search or review article or guidelines)	Method to study change	Result and Outcome
Penthrox 3ml Inhalor (Methoxyflurane)	Introduced as a trail for breakthrough medication during ESWL. No breakthrough medication used prior to this.	Methoxyflurane can cause dose-related nephrotoxicity a clinical study identified that nephrotoxicity occurred at doses in excess of 2.5 MAC-hours These doses were reached when methoxyflurane was used for anaesthesia. As a result of this clinical study a safe upper limit for methoxyflurane exposure was determined to be 2 MAC-hours – doses below 2 MAC-hours have not been associated with nephrotoxicity. Methoxyflurane administered via the PENTHROX inhaler (3 mL dose) equates to approximately 0.3 MAC-hours.[3] PENTHROX was approved by the regulatory	Please refer to the Penthrox Drugs and Therapeutics Committee (DTC) submission	Keeping Paracetamol 1g oral and Piroxicam 20mg oral fast tab as premedication for ESWL. Penthrox used for breakthrough pain relief. When used as a breakthrough medication during ESWL, does it allow completion of treatment and provide adequate pain relief?	Results to be submitted to the Craigavon DTC and disseminated at the Urology Stone MDM.

		authorities for use in the UK and Ireland in late 2015			

Antibiotic Prophylaxis ESWL

In keeping with European Association of Urology (EAU) Guidelines, prophylactic antibiotics are given to patients,

1. Infection stones
2. Bacteriuria (European Association of Urology , 2017)
3. Stone Treatment Centre Guidelines also includes patients who are relatively immunocompromised, such as steroids, immune modifying drugs.

- The standard at CAH STC is 500mg oral Ciprofloxacin prior to ESWL.

Recommendation for future practice would be to modify antibiotic prophylactic to urine sensitivities. This would require those patients needing antibiotic prophylaxis to have a urine culture one or two weeks prior to treatment.

A Pubmed search of 'ESWL' or Shockwave Lithotripsy' and 'Antibiotic', Prophylaxis', Urine Culture'

Returned 10 papers

Excluded was 1 case report

e. Craigavon Area Hospital ESWL TMS i-sys Sonolith lithotripter Adult Protocol

(In addition to the TMS i-sys Sonolith manual, EDAP TMS 2012)

Stone and side for treatment	As per MDT indication, check ESWL request for stone and laterality. Recommended number of treatments and follow-up plan included
Pain Relief	As pre-prescribed by Stone MDT (nurse to check allergies prior to administration)
Breakthrough pain relief	As per pre-prescribed MDT (nurse to check allergies prior to administration)_ Stop ESWL to initialise break through medication and restart at last tolerated power level
Imaging	USS or Fluoroscopy or both. Regular imaging (constant if USS) to check stone position for treatment. **Stop treatment if satisfactory stone treatment achieved.**
Ramping protocol	**First 250 shocks at 25% (See 1.8.1 Power level reference chart for kV** (EDAP TMS, 2012)**)** **Second 250 shocks at 50%** **Third 250 shocks at 75%** **Following the first 750 Shocks, aim to reach 100% power as tolerated before 1000 shocks** **Average treatment power will therefore be around 80%.**
Energy levels	**Maximum 1000J to renal stone** **Maximum 1400J to ureteric stone**
Shockwaves	**Maximum of 3000 shockwaves delivered per treatment session**
Frequency	**1.2Hz**
Treatment session	1 hour
Interval between treatments	4 weeks (EDAP TMS 2012)
Discharge letter	Radiographer to populate template and copy for ECR, Patient notes and GP.

Time between treatments

There is little evidence on the time between ESWL treatments; there is evidence to show that a patient can be retreated after 24 hours. A safe regime would leave the **interval between elective treatments as 4 weeks** (EDAP TMS, 2012).

European Urology 2017 Guidelines for ESWL Treatment

3.4.2.1.3.2 Best clinical practice

Summary of evidence - Number of shock waves, energy setting and repeat treatment sessions	LE
Stepwise power ramping prevents renal injury.	1b
Clinical experience has shown that repeat sessions are feasible (within one day for ureteral stones).	4
Optimal shock wave frequency is 1.0 to 1.5Hz.	1a

(European Association of Urology , 2017)

e. REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

To be tabled at SMT Meeting TBC

Name of Organisation	Southern Health & Social Care Trust
Project Title	Extra Corporeal Shockwave Lithotripsy (ESWL) & Generalised Stone Services at Southern Health & Social Care Trust Draft V.03
Total Cost	**£TBC**
Start Date	**£TBC**
Completion Date	**Recurrent funding requested from 2018/19 onwards £TBC**

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	**Yes**
How much total funding required?	**£TBC**
How much funding required per year?	**£TBC**
Is this funding to be made recurrent?	**Yes**

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	**No**
Total cost of proposal	**N/A**
Cost of proposal per year	**N/A**
Is this cost within recurrent allocation?	**N/A**

Is this business case	***Y/N***
(a) Standard	***Yes***
(b) Novel	***-***
© Contentious	***-***
(d) Setting a precedent	***-***
If yes to (b) or (c) or (d) , requires Departmental & DFP approval Is Departmental / DFP approval required	

Approvals & submissions

Prepared by:		
Name Printed	**NICKY HAYES**	**(signed)**
Grade/Title	**Planning Officer Band 5**	
Date	**APRIL 2018**	

Approved by:		
Name printed	**ESTHER GISHKORI**	**(signed)**
Grade /Title	**Director of Acute Services**	
Date	**APRIL 2018**	

Approved by:		
Name printed	**HELEN O'NEILL**	**(signed)**
Grade /Title	**Director of Finance**	
Date	**APRIL 2018**	

Approved by:		
Name printed	**SHANE DEVLIN**	**(signed)**
Grade /Title	**Chief Executive**	
Date	**APRIL 2018**	

Complete this section if Department / DFP approval required

Date submitted to Department
Department/ DFP approval (y/n)
Date approved

BUSINESS CASE TEMPLATE **REVENUE FUNDING £50k - £250k**

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Introduction
This paper outlines a proposal associated with enhancing the Extra Corporeal Shockwave Lithotripsy & Generalised Stone Service within the Southern Health & Social Care Trust.

Associated costs of **£TBC** have been identified from **TBC** funding stream and approval is now being sought from Senior Management Team for the progression of this proposal.

The Trust's Senior Management Team confirmed at its meeting on 24 January 2018 that it was supportive of a proposal being developed.

Background
The Southern Health & Social Care Trust (SHSCT) was established on 1st April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon & Banbridge Community, Newry & Mourne and Armagh & Dungannon Health and Social Services Trusts. It is one of six organisations that provide a wide range of health and social care services in Northern Ireland.

The Trust provides acute hospital and community services to council areas of Armagh, Banbridge and Craigavon; Newry, Mourne and Down; and Mid Ulster – a population of some 369,000. The acute hospital services provided by the Trust are also used by people from outside the Southern area including Fermanagh, Down and Lisburn, Antrim, Cookstown, Magherafelt and the Republic of Ireland.

The Trust's hospital network comprises two acute hospitals (Craigavon Area Hospital and Daisy Hill Hospital) with a range of local services provided at South Tyrone Hospital. The hospitals work together to co-ordinate and deliver a broad range of services to the community.

Both acute hospitals provide inpatient, out-patient and day case services across a range of specialties. These include a 24-hour Emergency Department and unscheduled medical and surgical services.

The Trust is responsible for the delivery of high quality health and social care to its resident population and employs 13,000 staff.

Extra Corporeal Shockwave Lithotripsy (ESWL)
This is a non-invasive procedure which is used in the treatment of kidney stones that are too large to pass through the urinary tract. The procedure is carried out by Consultant Urologists who have experience in urinary tract stone disease. In the first instance, kidney stones will be detected via the use of x-rays/scans which will determine their presence and location.

Patients within the Southern Trust area suitable for this specific treatment regime may attend on an

elective basis or in the case of patients referred for urgent admission, ESWL may be carried out during the inpatient stay. The procedure entails breaking down the stones in the kidney, bladder or ureter (tube that carries urine from the kidneys to the bladder) by sending high-frequency ultrasound shock waves directly to the stone once located with fluoroscopy (a type of x-ray) or ultrasound. The shock waves cause large stones to be broken down into smaller pieces to enable these to pass through the urinary system. Treatment sessions last for approximately an hour.

Strategic Context
Guidelines for the management of renal colic/renal and ureteric stones are documented in:-

- British Association of Urological Surgeons "**Standards for the Management of Acute Ureteric Colic" September 2017**
- National Institute for Health & Care Excellence guideline **"Renal & Ureteric Stones: Assessment and Management (consultation 20 January to 17 February 2017)"**

"Stone removal is recommended in the instance of persistent obstruction, failure of stone progression or increasing or unremitting colic. The choice of treatment to remove a stone depends on the size, site and shape of the stone. Options include extra corporeal shockwave lithotripsy (ESWL) ureteroscopy with laser, percutaneous nephrolithotomy or open surgery".

"Where suitable, ESWL offers a non-invasive treatment with lower complication rates and a shorter hospital stay".

In addition, the current standards associated with care for acute stone pain and use of ESWL (British Association of Urological Surgeons "***Standards for the Management of Acute Ureteric Colic" September 2017)*** states that "for symptomatic ureteric stones, primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" – is this the text to be referred to???

Local Context
"Improving Together" the Trust's Corporate Plan 2017/18 – 2020/21 sets out the strategic direction for the next four year period and includes challenges and opportunities to create better health outcomes for the population within the Southern area.

The Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment in line with the financial and workforce resources available to us.

The key objectives which the Trust will strive to achieve are:-

- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

Demographic Growth:

- The Trust has the second largest population in NI 369,000. The Trust population is projected to increase by over 20% between 2016 and 2039 (compared to the NI projected growth of 8.5%) including more significant growth in our ageing population

Current Service Provision
At the present time, there are a total of two Lithotripsy machines across Northern Ireland, a mobile machine sited in Belfast and a machine located within the Stone Treatment Centre (STC) at Craigavon Area Hospital.

Lithotripsy treatments are delivered to the Southern Trust's resident population in addition to patients residing outside of the Trust's catchment area (from January 2017 South Eastern Trust patients have undergone stone treatment procedures at CAH).

Current Capacity
The STC facilitates a total of three weekly ESWL sessions which take place on Monday, Wednesday and Friday mornings. The first treatment commences at 9.00 am with the session ending at 1.00 pm. A total of **9** patients undergo ESWL treatments every week.

Patients' referrals for stone treatment regimes are received via a number of channels including:-

1. Emergency Departments at Craigavon Area, Daisy Hill and South West Acute (Enniskillen) Hospitals
2. General Practitioners within the Southern Trust region and the South West Acute Hospital's local population
3. Wards in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital
4. Consultant Urologists from Southern and South-Eastern Health & Social Care Trusts
5. Letterkenny Hospital, Republic of Ireland
6. Altnagelvin Hospital

Although emergency ESWL treatments can be made available if there is a cancellation, predominantly emergency treatments are performed on Mondays, Wednesdays and Fridays - TBC

The current staffing establishment per session consists of:-

- 0.30 wte Consultant
- 0.30 wte Radiographer
- 0.30 wte Band 5 Nurse
- 0.30 Band 3 Healthcare Assistant

Key Issues/Assessment of Need
The growing demands being placed upon the Trust's ESWL & Generalised Stone Service understandably proves challenging when taking into consideration the number of issues in terms of:-

1. Demand & Capacity
Since the introduction of the Extra Corporal Shockwave Lithotripsy (ESWL) service on 11 September 1998, there has been a steady increase in the number of patients being offered this treatment regime.

In January 2017, there were a total of 108 adult patients awaiting treatment, however by January 2018 the figure has dramatically increased to a total of 233 adult patients showing a staggering 116% rise.

This figure equates to an average of 31 patients being added to the waiting list per month.

The waiting time for treatment (as of January 2018) is presently 8 months.

2. Emergency ESWL Provision for Upper & Distal Ureteric Stones

In addition to the number of adult patients awaiting outpatient (elective) ESWL treatment, on average approximately 10 patients will have a ureteroscopy performed each week at Craigavon Area Hospital.

Some of these patients could be suitable to undergo "emergency ESWL" treatment, however due to the restricted use of the Lithotripser machine at the present time, this cohort of patients have to undergo their treatment within Main Theatres at Craigavon Area Hospital as there are only ESWL sessions 3 days per week.

Understandably, this practice is counter-productive as it hinders the Trust's ability to adhere with the respective guidelines associated with the assessment and treatment of ureteric stones[1] which states that "primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene" – is this the relevant text to use TBC. More non-invasive procedures and extended availability across the week would support the Trust to comply with guidelines.

3. Service Model

The Lithotripser machine has been in operational use since the late 1990s (circa 20 years). At that time, the working practices put in place adequately met the needs of the service. Inevitably changes in medical practice have evolved in recent years however no modifications or adaptions to the working practices within the STC have been implemented. As a consequence, it has not been possible to optimise the potential to develop the Southern Trust's ESWL & Generalised Stone Service.

Given the existing service model, provision of a service which represents value for money whilst making best use of the facilities available is not achievable. The insufficiencies are particularly prevalent within the following areas:-

- Increased number of patients being **referred** into the Service
- As the majority of patients initially opt for treatment to be given without the need for a general anaesthetic, the number of patients awaiting elective ESWL treatment inevitably causes a rise in **waiting times**
- As a consequence of current waiting lists, patients' **x-ray/scan images** become out-of-date often emanating in the loss of a treatment 'slot' as the patient cannot undergo their planned ESWL procedure if there is a possibility that their renal stones have become dislodged
- A significant amount of nursing **administration** associated with patient documentation which is undertaken on the day of treatment impinges on the allocated treatment time

4. "Time & Motion" Study

In an effort to address the inefficiencies with the current service model, a "Time & Motion" study was conducted in December 2017. This involved a group of multi-disciplinary staff reviewing and 'process mapping' the "Renal & Ureteric Stone" pathway in order to streamline the processes, improve treatments/safety and patient follow-up reviews.

On conclusion of the "Time & Motion" study, a number of recommendations were identified which included:-

- The need for a Stone Multi-Disciplinary Team (MDT) to be established
- With the introduction of an MDT this would facilitate:-
  - a platform for discussion of complex patients

- referrals received from Emergency Departments, Wards and GPs to be reviewed giving due consideration to each individual patient's condition
- a review of patients' imaging
- an informed decision to be made in relation to the most appropriate treatment pathway for each patient for example ESWL, Ureteroscopy etc which would be in line with guidelines (eg British Association of Urologists, NICE etc)

- New documentation to be developed such as:-
  - Ureteric & Renal Stone Referral
  - Patient Information Pack

5. Staffing Resources

In view of the recommendations emanating from the "Time & Motion" study, a change in practice was introduced in December 2017 which enabled a Stone Multi-Disciplinary Team to be established together with an agreed Referral Pathway to be developed.

At that time, the potential to increase capacity was identified if changes associated with the nursing administration process could be introduced.

It highlighted that if the requisite administration could be performed prior to a patient attending for their treatment, this could permit an additional patient per session to be treated (eg a total of 4 patients would undergo an ESWL procedure per session).

However, with insufficient staffing resources presently available, the delivery of an efficient and effective ESWL & Generalised Stone Service is compromised.

- **Administrative & Clerical**

With the weekly MDT meeting taking the form of a "virtual clinic" there is a significant amount of administration to be progressed in advance of the weekly meetings which encompasses:-

- ensuring all the requisite paperwork is available for the meeting (eg referral forms, prescription sheets, diagnostic results etc) which require populating during the MDT meeting when outcomes are discussed/agreed
- preparation of MDT lists
- population of worklist on NIECR for ease of access during the MDT meeting
- taking notes of the MDT meetings, completing the electronic MDT outcome form, populating patient templates with agreed outcomes from MDT in order to send to patients
- ensuring follow-up arrangements are made
- tracking follow-up arrangements/results

In addition to the duties associated with the weekly MDT meetings, there are a number of administrative tasks in respect of the elective ESWL process which are detailed below:-

- Population of appointments and preparation of lists
- Ensuring all ESWL related treatment paperwork is available (eg prescriptions, nursing checklist, post-treatment advice)
- Creating and printing of booklets and distribution of patient documentation (to negate the need for this to be undertaken on the day of treatment TBC)
- Sending for list and confirming patients' attendances
- Ordering notes for ESWL treatment day
- Arrangement/tracking of follow-up

A patient letter template was created on Patient Centre to enable Consultant Urologists' secretaries to type up the weekly patient letters. However, the increased workload is unsustainable given the

other duties assigned to Consultant secretaries. As a consequence, delays associated with the typing up of the MDT letters are regularly experienced TBC

- **Medical, Nursing & Radiology**

In view of the volume of administrative tasks associated with both the MDT meetings in conjunction with the ESWL processes, this can often result with the Specialty Doctor in Urology providing a degree of administrative support to the Stone Treatment Centre.

In terms of ESWL Sonographer training, there is a detailed protocol which must be adhered to in order for Sonographers to become competent in ESWL. This involves a period of supervised targeting and treatment of renal calculi in both adults and paediatrics which must encompass both ultrasound and fluoroscopic control. In addition, a minimum of 50 treatments must be achieved and in the event of a trainee being absent for a prolonged period of time (eg maternity leave), there may be a requirement for part of the process to be repeated. On completion of the requisite training and to allow progression, it will necessitate a Sonographer participating in ultrasound audit programmes and undertaking future training updates to ensure continuing professional development and assessment of accuracy.

Reference 1 *– British Association of Urological Surgeons Standards for the Management of Acute Ureteric Colic September 2017*

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Improve access to ESWL Service by 31 March 2019	• Increase access across the week ➢ Baseline – 3 sessions per week (as of April 2018) ➢ Target – 7 sessions per week
2. To improve compliance with Commissioning Plan Objective 4.12 ➢ No patient waits longer than 13 weeks for inpatient/daycase ESWL treatment by September 2019	• Facilitation of appropriate ESWL provision which meets the demand for elective treatment:- ➢ Baseline – as of January 2018, a total of 148 patients are awaiting more than 13 weeks for elective ESWL treatment ➢ Target – minimum of 30% reduction in waiting time for routine treatment ** a non-recurrent exercise will be required to reduce routine waiting times in the first instance*
3. Improve the efficiency of the current ESWL Service by 31 March 2019	• Increase number of patients treated per session:- ➢ Baseline – a total of 3 patients per session (as of April 2018) ➢ Target – a total of 4 patients per session (on appointment of additional staffing resources)

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability to appoint additional staffing resources	The Trust will ensure that robust recruitment processes are in place, maintaining close

	links with BSO and Human Resources to ensure that any issues which may arise are promptly addressed
2. Recurrent revenue funding not secured	The Trust will maintain close links with the HSCB in order to proactively seek financial support for the service

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO	BRIEF DESCRIPTION OF OPTION
1	**Do Nothing/Status Quo - continue with existing arrangements** This option will entail the continuation of the existing service model of 3 ESWL sessions per week permitting a total of 9 patients to be treated. Although this option will not meet the project objectives, it has been shortlisted as a base case comparator.
2	**Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital** This option will entail the appointment of additional staffing resources and permit the current 3 ESWL weekly sessions to be extended to 7 ESWL sessions per week. It will accommodate a total of 4 patients per session to be treated, emanating in additional capacity to facilitate a further 19 patients per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC) in comparison to the 9 patients that are presently seen each week.
3	**Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital** Similar to Option 2, this option will consist of a significant number of staffing appointments being made enabling the number of weekly ESWL sessions to be extended from 3 to 7 sessions. It will permit a total of 4 patients per session to be treated, facilitating an additional 19 patients to be seen per week (eg 4 patients per session x 7 sessions equates to 28 patients TBC). With provision of a dedicated team of multi-disciplinary staff aligned to the Stone Treatment Centre at Craigavon Area Hospital it will enable all ESWL treatments, weekly MDT meetings, the complete outpatient journey (from investigation to review) to be effectively managed. Provision of a dedicated ESWL session for patients residing within South Eastern Trust area will also be deliverable. Is there any additional information as to what this option will deliver that needs incorporated?

SECTION 4: PROJECT COSTS

Option	Year 1 (£'000)	Year 2 (£'000)	Year 3 (£'000)	Total (£'000)
1				
2				
3				

COST ASSUMPTIONS:

Option 2
There will be a requirement for the following additional **posts to be appointed**
Can you please confirm exact staffing requirements please

- XX wte Band 5 Staff Nurse
- XX Band 3 Health Care Assistant
- XX wte Radiographer
- Xx wte Band 4 Admin & Clerical

Option 3
There will be a requirement for the following additional **posts to be appointed**

Can you please confirm exact staffing requirements please

- XX wte Band 5 Staff Nurse
- XX wte Band 3 Health Care Assistant
- XX wte Band Radiographer
- XX wte Consultant Urologist
- XX wte Registrar
- XX wte Band 4 Admin & Clerical

Goods & Services
- Are there any additional consumables that would be required for the no of sessions proposed TBC
- The anticipated life span of Lithotripter equipment is 10 years however it is not dependent upon the number of shocks/treatments/patients
- The current equipment has been in operational use since 1998 and is on the capital equipment list for Acute Directorate for replacement

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with the project are detailed below:-

Non-Monetary Benefit	Option 1 Status Quo/Do Nothing	Option 2 Increase Sessions within the Stone	Option 3 Provision of a Dedicated Team for

		Treatment Centre	Stone Treatment Centre
Provision of additional sessions per week	• With no improved access to the service, enhanced utilisation of Hospital facilities will be untenable	• Facilitation of an additional 4 weekly sessions will enable higher volumes of patients to undergo their treatment resulting in a total of 28 patients being seen on a weekly basis.	• Similar to Option 2, this option will facilitate a further 4 weekly sessions to take place thus enabling a higher percentage of patients to undergo treatment each week (circa 28 patients).
Reduced Waiting Times for Treatment	• As the number of patients being referred into the Service will continue to grow, it will result in a rise in waiting times. Therefore, patients will continue to experience lengthy waiting times for their treatment	• The patients' experience will be greatly enhanced as they will receive treatment for their conditions within an appropriate timeframe	• Similar to Option 2, the patients' experience will be significantly enhanced as the patient journey (from investigation to review) will be managed within an appropriate timeframe by a dedicated service team
Improved efficiency	• With the volume of administrative tasks associated with both MDT meetings and the ESWL processes, the degree of administrative support from the Specialty Doctor will still be prevalent (understandably, a situation which does not make best use of skills). • With no improved service provision, the use of Main Theatres at CAH for some patients' procedures will continue.	• As administrative tasks will be progressed prior to the day of treatment, a reduction in nurse administration on the day of treatment will be deliverable. This will increase capacity for treatment of an additional patient per session (total of 4 patients as opposed to 3 patients per session). • The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date. • As more non-invasive treatment will be deliverable, fewer patients will require treatment within Main Theatres	• As with Option 2, there will be a reduction of nurse administration on the day of treatment as administrative tasks will be progressed prior to the day of treatment. This will increase capacity for treatment of an additional patient per session (total of 4 patients). • The potential loss/delay of treatment sessions will significantly reduce as x-ray scans will be up-to-date. • This option will provide dedicated ESWL sessions for South Eastern

		at CAH. Therefore, permitting patients to be managed within an appropriate environment. • Delivery of a more streamlined service will be achievable.	patients • With dedicated staffing within the Stone Treatment Centre this will optimise the facilities available within the Stone Treatment Centre at CAH and enhance the patient's journey.

SECTION 6: PROJECT RISKS & UNCERTAINITIES

The project risks associated with this scheme are detailed in the table below:-

	H/M/L			risk management/mitigation measures
1. Inability to Appoint Staff	**N/A**	**L**	**L**	**Option 1** – N/A **Options 2&3** - there is the potential that no applicants may apply for the new posts, however this is deemed to be a 'low' risk. • **Mitigation Measure** - the Trust will ensure that robust recruitment processes are in place and any issues raised by BSO are promptly addressed
2. Recurrent revenue funding not secured	**N/A**	**M**	**M**	**Option 1** – N/A **Options 2&3** – this is a possibility that recurrent funding may not be secured and therefore this is considered a 'medium' risk • **Mitigation Measure** – the Trust will maintain close links with the HSCB/continue to seek financial support from the HSCB
Overall Risk (H/M/L):	**N/A**	**L/M**	**L/M**	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 - Status Quo/Do Nothing

- With no modifications being made to existing service model, there will be no enhanced utilisation of Hospital facilities
- The waiting times associated with ESWL treatment will continue to grow, therefore patients will continue to experience lengthy delays for treatment
- There will still be a requirement for the Specialty Doctor to provide a degree of administrative support which does not make best use of medical staffing resources
- The number of ureteroscopies will steadily increase as no additional capacity for elective ESWL treatments will be attainable
- No improvements to the efficiency of the ESWL & Generalised Stone Service within the Southern

Trust will be achievable

Option 2 - Increase ESWL Sessions from 3 to 7 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital

- This option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be greatly enhanced as waiting times for treatment will reduce therefore patients will receive treatment for their conditions within an appropriate timeframe
- The potential loss/delay of treatment sessions will significantly reduce as x-rays/imaging scans will be up-to-date
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH
- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- An improved skill mix of staff will be attainable

Option 3 - Provision of a Dedicated Team for Stone Treatment Centre at Craigavon Area Hospital

- Similar to Option 2 above, this option will enable the weekly Extra Corporeal Shockwave Lithotripsy (ESWL) sessions to be extended from 3 to 7 sessions per week.
- It will provide increased capacity as a total of 4 patients per session will be treated, equating to a total of 28 patients receiving treatment per week (in comparison to 9 patients treated at the present time).
- The patient's experience will be significantly enhanced as the patient journey (from investigation to review) will be effectively managed within an appropriate timeframe
- As some patients may no longer require invasive treatment, fewer patients will require treatment within Main Theatres at CAH

- With more non-invasive procedures and extended availability being attainable, this will support the Trust to improve compliance with the requisite guidelines/recommendations (British Association of Urologist, National Institute for Clinical Excellence) as delivery of an enhanced ESWL Service to patients requiring treatment of renal stones will be achievable.
- This option will make provision for a dedicated team of staffing to be aligned to the Stone Treatment Centre at Craigavon Area Hospital which will enable all ESWL treatments, weekly MDT meetings and the complete patient journey (from investigation to review) to be efficiently and effectively managed.
- An improved skill mix of staff will be achievable.

Is there any additional information that needs to be incorporated?

The preferred option is Option 2 – Increase ESWL Sessions from 3 to 7 Sessions per week within the Stone Treatment Centre at Craigavon Area Hospital as this will enable a further 4 weekly sessions to be delivered giving the Trust additional capacity to treat a total of 28 patients per week. Therefore, the patient's experience will be greatly enhanced as the current waiting times for treatment will reduce.

As more non-invasive treatment regimes will be achievable this will improve the Trust's compliance with British Association of Urologists and NICE guidelines/recommendations whilst permitting patients to be managed within an appropriate environment.

Any potential loss or delay of treatment sessions due to x-rays/imaging scans being out-of-date will reduce.

With an increase in capacity, the Trust will be able to deliver a more streamlined and efficient ESWL & Generalised Stone Service to its resident population.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required					
Capital required					
Revenue required					
Existing budget :					
Capital					
Revenue					
Additional Allocation Required:					
Capital					
Revenue					

AFFORDABILITY ASSUMPTIONS

SECTION 9: MANAGEMENT ARRANGEMENTS

The following project management roles have been agreed:-

- Project Owner – Mrs Esther Gishkori (Director of Acute Services)
- Project Director – Mrs Heather Trouton (Interim Executive of Nursing & Allied Health Professionals (with responsibility for Cancer & Clinical Services)
- Project Manager – Mrs Martina Corrigan, Head of ENT & Urology

The project timescales associated with this proposal are detailed in the table below:-

Project Timescales	
Business Case Approval	May/June 2018
Submission of Business Case to HSCB	May/June 2018
Confirmation of Funding	June/July 2018
Recruitment Process Commenced	July/August 2018
Staff in Post	October 2018

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation?	Mrs Martina Corrigan - TBC Head of Service – ENT & Urology
Who will monitor and evaluate the outcomes?	A Head of Service independent to the project - TBC
What other factors will be monitored and evaluated?	
When will this take place?	April 2019

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

	Specifiy activity, e.g. IP, DC OPN, OPR, Contacts etc					
	IP	**DC**	**OPN**	**OPR**		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

HSC TRUST RESEARCH & DEVELOPMENT FUND

APPLICATION FORM 2018 – 2019

N.B. Applications should only be submitted for research which can be completed by 31 March 2019 as funding cannot be carried forward to the next Financial Year

	Mr Michael Young
	Urology Consultant
Work Address:	Craigavon Stone Treatment Centre, Craigavon Hospital
	Tel: Mobile: Personal Information redacted by USI
	Email: Personal Information redacted by USI
	Kidney and Ureteric Stones Treated With Extracorporeal Shockwave Lithotripsy Using the EDAP i-sys Sonolith Lithotripter: Successful stone clearance and complications
	Context/Background – why it is important to do the research, Kidney Stones have afflicted the human population for thousands of years, having been identified in Egyptian mummies, and even make up part of the classical Hippocratic Oath from the 4th century BC (Tefekil A, 2013). Kidney Stones can be identified in 8% of the population (BAUS). In the United Kingdom renal colic (pain from kidney stone) is common, with 12% of men and 6% of women having at least one episode of renal colic in their lifetime, with the incidence peaking at 40-60 years of age for men and late 20's for women (Bultitude M, 2012), (NZ, 2014). The difference between male and female risk in decreasing, this is likely due to the increase in obesity and western diet in women (NICE, 2015). **The overall incidence of kidney stones is rising.** In America the 1994 incidence rate of 1 in 20 has almost doubled to 1 in 11 when compared to year 2007-2010 data (Hitt, 2012). The risk of further stones

development is high, with 30% to 40% chance of recurring at 5 years (NICE, 2015).

The Craigavon Urological Stone Treatment Centre (CAH STC) looks after an area greater than the geographical Southern Trust boundaries, caring for a population of 420000. In addition the CAH STC receives regular referrals from the other trusts, namely the South Eastern Trust.

How the Urologist treats a kidney stone is dependent on location and size of the stone, as well as patient comorbidities. The majority of stone can be treated by Extracorporeal Shockwave Lithotripsy (ESWL), available onsite at Craigavon Area Hospital, and is the only fixed site ESWL in Northern Ireland, or in fact the North of the Ireland!

In order to fulfil the demand of ESWL stone treatments, the CAH STC must provide 1100 treatment per year. ESWL is a well-recognised treatment modality for Kidney stones, and is recommended by the European Association of Urology guidelines (C Turk 2017) and NICE (NICE 2015).

Since the invention of ESWL in 1980 we are now on the 4th Generations of Lithotripter. The Southern Trust invested around £430000 in a new EDAP TMS i-sys lithotripter to replace an older model. It has its own dedicated centre, with the treatment sessions run by a radiographer and nursing staff. The patients are awake for their treatments, with oral pain relief. ESWL has less risk of complication and is safer when compared to more invasive Urological stone procedure of Ureteroscopy and Percutaneous Nephrolithotomy.

A PubMed search using various combinations of search terms of ‘ESWL’, ‘SWL’, ‘EDAP TMS’, i-sys sonolith did not generate any clinical papers on the success outcomes of the i-sys sonolith lithotripter.

As technology progresses, evidence is required to demonstrate that the Lithotripter in use is still providing effective kidney stone clearance rates, at a low complication rate.

Aim – broad statement about what the research will entail

To assess the outcomes of stone clearance rates for kidney and ureteric stones using the i-sys sonolith lithotripter. To

provide complication rates and patient satisfaction with receiving the treatment modality for their stones.

Objectives – the actions required to meet the aim of the research

1. **Patient demographics** (age, sex, BMI)
2. **Kidney stone factors pre-treatment** (Size, location, Hounsfield units, stone to skin distance)
3. **ESWL treatment parameters** (Ramping protocol, average power delivered, total energy delivered, type of pain relief)
4. **Patient satisfaction** with treatment, including pain score)
5. **Outcome of treatment**: (stone clearance, fragmentation, no change, other procedures needed)

Sample/Participants – the people/data who will be the focus of the research and how you will gain access

All patients undergoing ESWL for treatment of kidney or ureteric stones. The above data required in objectives is already recorded in the patient's clinical notes.

Data Collection Method – Qualitative/Quantitative/Mixed Methods e.g. interviews, questionnaires, focus groups – provide some information about the proposed method(s)

Prospective study for the outcome of ESWL using the i-sys sonolith. A data collection excel spreadsheet would be created to record the objective setting data. The data (objectives 1-4) would be best inputted at time of treatment, and outcome data (objective 5) at the Stone Multidisciplinary Meeting (MDT). The Stone MDT is the platform where patients are currently listed for ESWL and also their follow-up imaging discussed at 4-6 weeks following treatment to assess treatment success.

Objective 4, patient satisfaction would be assessed via a questionnaire, the same day of treatment completion.

Ethical Considerations – ethical issues relating to the research e.g. Consent

ESWL is already a recognised and recommended treatment

	for kidney and ureteric stones by EAU and NICE. Consideration to alternate treatment modalities or change in treatment parameters if data was to demonstrate unsatisfactory stone clearance rates or complications from the use of the i-sys sonolith lithotripter. **Potential outputs – what will be the impact on patient care** Provide data to support the on-going funding of the ESWL service. Provide data to patients on the percentage success for stone clearance using the i-sys sonolith and complication rate. This will aid patients to make a fully informed choice on their treatment options. Provides data to the wider clinical and scientific community on use of the i-sys sonolith lithotripter and treatment of kidney and ureteric stones. **Data Analysis method – dependent on whether data is numerical or text based e.g. SPSS, thematic analysis** There will be a mixed data analysis method. Stone clearance rates will be numerical, and could be statistically compared against older lithotripter data sets of clearance, as well as statistical comparison against the more invasive surgical treatment of ureteroscopy for stone clearance. Patient satisfaction and complication rates can also be numerically processed, analysed and compared against similar studies for other lithotripters or surgical modalities. **Proposed start date** October 2018 **Proposed end date** October 2019 (although it would be of benefit for data collection to continue for a 4 or 5 year period to potential give around 5000 treatments, and so provide robust data and one of the largest ESWL evidence bases, future funding could be discussed with the Trust) **Specify how the time required to undertake the Study will be incorporated into your work and other personal**

	commitments Study data will be collected by the proposed funding for a research radiographer or nurse, they will be aided in their write up and analysis of the data. Time to oversee and support the project will be dedicated on a weekly bases by Mr Young Urology Consultant, including time following the weekly Thursday morning MDT **References** BAUS. (n.d.). *Kidney Stones*. Retrieved Febuary 02, 2018, from British Association of Urology: https://www.baus.org.uk/patients/conditions/6/kidney_stones Bultitude M, R. J. (2012). Management of renal colic. *BMJ*, 345. C. Türk, A. N. (2017). *Urolithiasis*. Retrieved Febuary 08, 2018, from European Association of Urology Guidelines : http://uroweb.org/guideline/urolithiasis/#3 Hitt, E. (2012, May 24). *Incidence of Stone Disease Has Doubled Since 1994*. Retrieved November 2016, from Medscape : http://www.medscape.com/viewarticle/764518 NICE. (2015). *Renal or ureteric colic - acute*. Retrieved Febuary 08, 2018, from https://cks.nice.org.uk/renal-or-ureteric-colic-acute#!backgroundsub:2 NZ, B. (2014). Managing patients with renal colic in primary care: know when to hold them. *Best Practice Journal New Zealand*. Tefekil A, C. F. (2013). The History of Urinary Stones: In Parallel with Civilization. *Scientific World Journal* .
Outline how the Project relates to the Trust's Corporate Objectives:	The project aims to deliver evidence behind the use of the i-sys sonolith lithotripter in the treatment of kidney and ureteric stones. And…. • Provides safe, high quality care • Maximize independence and choice for our patients and clients • Support people and communities to live healthy lives and improve their health and wellbeing • Make the best use of resources • Be a great place to work, with staff being actively involved in providing evidence based medicine in the form of ESWL

	• Learning opportunity for a member of staff to enhance a service, share the learning, benefit patients.
Outline the potential to develop into a larger research Project:	The data could be continued to be collected every year to provide one of the largest data sets and evidence for ESWL using the i-sys sonolith. The data collected would aid the development of regional, national (NICE and BAUS) and international guidelines (e.g EAU) for the use of ESWL in treatment of kidney and ureteric stone using the i-sys sonolith lithotripter.
Financial Support Required:	**Please provide a full breakdown of the costs required**: • Salary costs – The costs should support either a radiographer or nurse (band 5). • Goods and Services costs – The cost wold be for the time of radiographer or nurse to collect the data, data analysis, presentation of data. • Cost Centre to which any funding awarded should be credited (To be provided by your Line Manager) • Outline how you would take forward the proposal if only a percentage of the funding requested is awarded to your application: a) We would scale the project down if funding did not allow for complete collection and analysis of every patient. b) The project is achievable with a day a week, although 2 or more days a week would produce more robust data collection, evidence and impact to any potential publication and information for patients.
Line Manager Support:	**Please provide the name and job title of your Line Manager whose agreement you have sought to submit this application:**

	Martina Corrigan
Line Manager	**Line Manager to provide a short statement to confirm support of this application**
Line Manager's Signature and Date	

Completed Forms should be returned by email to Irene Knox, Research Manager [redacted] **no later than Friday, 13 July 2018**

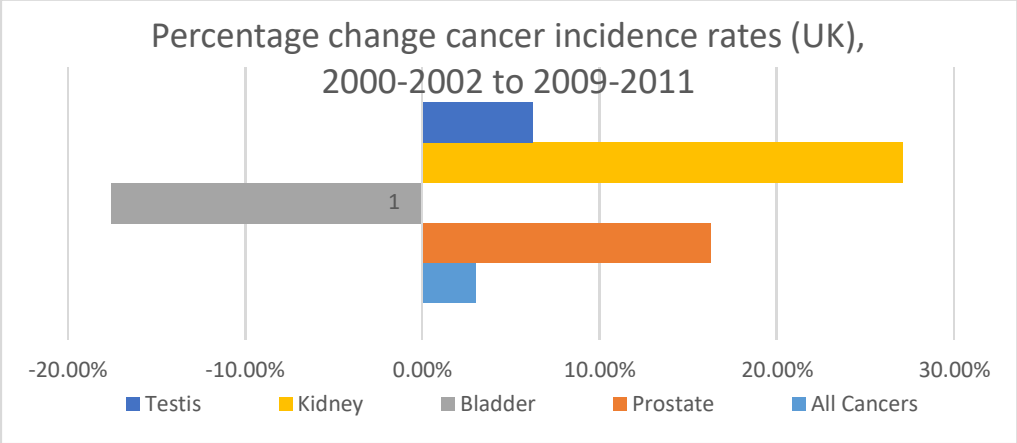
Personal Information redacted by USI

The Vision for Urology Services
Southern Health and Social Care Trust

Background

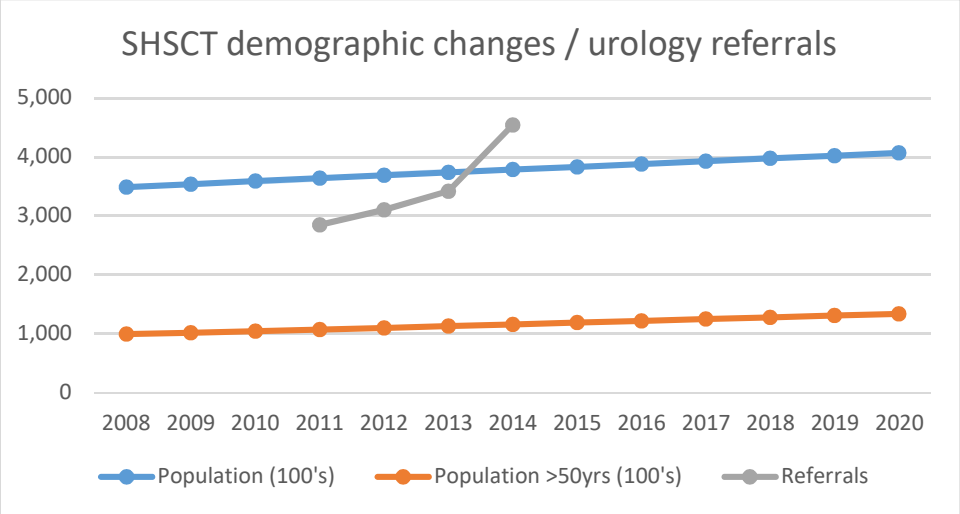
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015.

Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team).

For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question 'what can be done differently to reduce our consultant capacity requirement?'. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway currently provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively, as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals have been delayed

rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral.

All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be ‘what speciality do you wish to refer the patient to?’ which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral.

These systems are used in other areas of the NHS and to a limited extent in specific conditions within NI (e.g. post-menopausal bleed clinic referral). Unfortunately we are advised that this ideal is a considerable distance from being available within the NI ‘gateway’. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms).

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move immediately to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use considerable consultant time and in order to maximise efficiency of consultant time we would

envisage this as a ‘stop gap’ measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non-consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the Trust and wider NHS is that whilst they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects.

In order to deliver a sustainable service there is recognition that the number of Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. It was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of

patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on Craigavon Area Hospital site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.

- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations so as to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12 months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of

a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379
June	395

July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10 min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres.

As discussed in the service plan, utilisation of offsite theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously, work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work.

We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation Trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this demand. However, it is noted that in order to get to the benchmark timings, the

Benchmark Trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new outpatient consultations the haematuria and diagnostic / Lower Urinary Tract Symptoms (LUTS) assessment patients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Extracorporeal shock wave lithotripsy (ESWL- Stones)

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within Trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requirement for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. Follow-up demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been performed prior to the first outpatients attendance. Where investigations are arranged, writing with results and if required telephone follow-up. Those patients who do need to attend for follow-up will be seen either by CNS or consultant. A significant proportion of this required follow-up will be consultant led and nurse delivered (in particular oncology follow-up), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led

service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood.

A separate plan is required for reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing follow-up while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requirements are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the Trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session	Weekly sessions required	Weekly Hours	Weekly PA's

	(including admin time)			
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service within Southern Health and Social Care Board and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and reduce this consultant input but presently we believe this aspiration is some considerable time away.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 25 September 2015 10:13
To: Burns, Sandra; Campbell, Dolores; Henry, Gillian; Holloway, Janice; McMahon, Jenny; ONeill, Kate; McClenaghan, Nichola; McNeilly, Julie; Sharpe, Dorothy; Hunter, Catherine; McElvanna, Ciara; Sheridan, Patrick; McAlinden, Jacinta; Moorcroft, Caroline; Mulligan, Marilyn; Rocks, Cathy
Subject: FW: Learning from Medication Incidents June 2015
Attachments: Learning from Medication Incidents June 2015.doc; Guidelines for patient involvement in the administration of insulin in hospital SHSCT July 2015.pdf

For information and sharing

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: Trouton, Heather
Sent: 09 September 2015 13:07
To: Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: Learning from Medication Incidents June 2015

Dear All

Can you please share with all your ward sisters and discuss at the next sisters meeting

Thanks
Heather

From: Redpath, Jillian
Sent: 09 September 2015 11:03
To: Gibson, Simon; Conway, Barry; Trouton, Heather; McVey, Anne; Carroll, Ronan
Subject: Learning from Medication Incidents June 2015

Dear all
Please find attached the learning bulletin for distribution to staff. I have also attached the guidelines for patient involvement in the administration of insulin.
Regards
Jilly

Learning from Medication Incidents

Acute Services/Non-acute Hospitals

June 2015

43 medication incidents were reported in June 2015. There was one incident with major impact and all other incidents had a minor or insignificant impact on a patient. There were two incidents with an extreme risk rating. The following incidents are highlighted with learning points for staff.

Omitted/delayed medicines

Patient prescribed clozapine at 06.00 and dose overlooked and not administered.

- ✓ Clozapine is a critical medicine where timeliness of administration is crucial.
- ✓ Prescriptions for morning doses of non-injectable medicines should be prescribed at 10.00 unless there is a specific clinical reason for a different time.

Oncology patient admitted for observation as an outlier to another medical ward with neutropenia and pain day 6 post chemotherapy. Observations checked at 23.30 which met criteria for commencement of neutropenic sepsis treatment however medical staff not contacted. Observations checked again at 03.30 and 07.10 which also met criteria. Patient encouraged to drink water however no escalation to medical staff. Incident detected on morning ward round.

- ✓ All staff should be familiar with the neutropenic sepsis guidelines if caring for a patient who has received chemotherapy. The guidelines are available on the intranet or via the following link http://www.southernguidelines.hscni.net/?wpfb_dl=40

Patient's blood glucose had been erratic therefore Lantus® insulin was not administered at prescribed time of 22.00. Blood glucose was 16.2 mmol/l the following morning and Lantus® 6 units was administered then. Lantus® was also administered later that day at 22.00 as usual and patient became hypoglycaemic.

- ✓ Lantus® or other long-acting insulin is usually administered once a day and is usually always continued. If the patient is hypoglycaemic, the dose should be reduced and/or advice sought from the diabetes team.
- ✓ If a dose has to be omitted, do not administer later in the 24 hour period as the dose will still be effective by the time the next dose is due.
- ✓ The high blood glucose the following morning should have been treated with rapid-acting insulin using the correction dose guidelines available on the SC insulin/blood glucose monitoring chart.

Wrong dose

Patient weighing 31.9kg was prescribed and administered two dose of gentamicin 320mg instead of 5mg/kg (160mg). Patient had not been weighed on admission and a previous weight recorded in notes used.

- ✓ All patients should be weighed on admission to hospital wherever possible. Hoist scales should be used where needed.
- ✓ Check that a patient weight looks reasonable for the appearance of the patient.

Wrong medicine

Codeine was being dispensed for a patient however the codeine box was found to contain a strip of cyclizine tablets with two tablets already punched out.

- ✓ Do not amalgamate stock from different boxes.

Patient with chronic renal failure who had been treated for acute hyperkalaemia was prescribed and administered Hartmann's fluid pre-operatively instead of sodium chloride.

- ✓ Review patient's U&Es before prescribing intravenous fluids.

Patient admitted and prescribed bisoprolol and atenolol. These were both administered for one week before the medication history was reviewed and it was noted that atenolol had been discontinued on the last admission and bisoprolol commenced.

- ✓ Check the dates on NIECR to confirm when a prescription was last issued and confirm current medication with the patient or carer.
- ✓ A patient would not usually be taking two beta-blockers and if a patient has been prescribed both, review with cardiology.

Incorrect self-administration

Patient admitted with abdominal pain and required analgesia. IV paracetamol administered with little effect. Hyoscine-n-butylbromide and codeine also administered. Patient later found drowsy; airway protected and flumazenil and naloxone administered with good effect. Patient later advised that they had taken their own medication.

- ✓ All patients must be asked on admission if they have brought any medication into hospital with them. This must be recorded and any medication stored securely.

Patient demanded dose of Lantus® insulin and was unhappy for staff nurse to administer this, took the pen from the staff nurse and injected a dose however staff nurse was unable to determine dose.

- ✓ All patients on insulin should be assessed on admission if they are to be involved in the administration of their insulin in hospital and where possible then involved.
- ✓ Where patients are to be involved, the procedure should be explained to them and a patient information leaflet provided, available by clicking on the icon below

Guidelines for patient involvement in the ad

Wrong frequency

Patient administered gentamicin at 18.00 as prescribed and then a further dose at 22.00. Staff had looked at the chart, saw the following day's dose prescribed but didn't note the day or date and thought it had been missed at 18.00 that day.

- ✓ Check the day of the week and date on gentamicin prescriptions to confirm administration is due.

Contra-indicated medicine

Patient on apixaban, prescribed enoxaparin on admission and dose administered.

- ✓ Check for concurrent anticoagulants before prescribing enoxaparin.

Patient commenced on rivaroxaban with calculate GFR of 28ml/min. Discontinued and patient commenced on warfarin.

- ✓ SHSCT guidelines advise that rivaroxaban should be avoided if GFR <30ml/min.

Southern Health and Social Care Trust

CLINICAL GUIDELINES ID TAG	
Title:	Guidelines for patient involvement in the administration of insulin under supervision in hospital
Author:	Safe use of insulin group
Speciality / Division:	All
Directorate:	Acute/OPPC/MHD
Date Uploaded:	
Review Date	July 2017
Clinical Guideline ID	

Guidelines for patient involvement in the administration of insulin under supervision in hospital (Adult patients)

Introduction

This guideline is designed to provide a framework for patients to administer their insulin dose while in hospital, ensuring appropriate supervision and accountability of hospital practitioners.

This guideline describes patient involvement in the administration of insulin under direct supervision of nursing/midwifery staff and should not be confused with self-administration or self-management of insulin in hospital where the patient is not directly supervised.

Medicines are usually administered to inpatients by hospital practitioners. However for patients who administer or intend to administer their own insulin outside hospital, it is important to facilitate their involvement in the administration of insulin in hospital when it is safe to do so. This will maintain pre-admission independence, provide opportunities to reinforce education and detect compliance issues for existing patients. It also enables newly diagnosed patients to learn to administer insulin themselves in preparation for discharge.

Evaluation of a patient for involvement in insulin administration in hospital

All adult patients on insulin should be evaluated on admission to hospital by a registered nurse/midwife for involvement in the administration of insulin using Appendix 1. The completed evaluation should be filed in the patient's nursing/midwifery notes. This evaluation should be reviewed at any stage following admission where changes occur that could affect patient involvement in insulin administration or where there are concerns about a patient's involvement in insulin administration.

Storage

All insulin must be stored securely in a locked fridge, locked medicine trolley or locked bedside medicine locker and access is restricted to nursing/midwifery/pharmacy staff. Opened insulin can be stored at room temperature for up to 28 days from the date of opening.

Labelling

All insulin products are single patient use only. The date of first opening should be entered at the time of first use.

- Ward stock – each insulin should be labelled with the patient's name, H&CN/hospital number and date of birth by attaching a 'laboratory addressograph' at the time of first use.
- Non-stock supply – each insulin should be labeled with the patient name at the time of dispensing.
- Patient's own supplies – check that the insulin is within expiry date, has not been removed from the fridge for more than 28 days, is labelled with the patient's name, Health &Care/Hospital Number and date of birth by attaching a 'laboratory addressograph' to the vial, cartridge or pre-filled device.

Prescription

Insulin must be prescribed by a prescriber having confirmed the patient's insulin regimen. Where a patient adjusts their insulin dose appropriate to their food intake and/or their blood glucose measurement, a range should be prescribed instead of a specific dose.

Blood glucose monitoring

Blood glucose monitoring must be conducted by a registered nurse/midwife using hospital glucose meters to ensure quality control of monitoring and a link to the laboratory results system. Blood glucose results must be recorded on the appropriate blood glucose monitoring chart. The patient should be informed of the result and encouraged to record the result in their own patient held record.

Procedure for patient involvement in insulin administration in hospital

When a patient has been evaluated for involvement in the administration of their insulin in hospital, the registered nurse/midwife should:

- Ensure that the ward has an adequate supply of the patient's insulin.
- Instruct the patient to alert the nurse/midwife 15 minutes before their insulin dose is due. Note that for patients who adjust their bolus dose of insulin according to their food intake and/or blood glucose measurement, the patient will not be able to determine the appropriate insulin dose until the meal has been delivered to the patient.
- Encourage the patient to continue recording their insulin dose in their own patient held record.
- Provide the patient with a patient information leaflet, in either standard or large print format (Appendix 2).

When the patient alerts a registered nurse/midwife that a dose of insulin is due, the nurse/midwife should:

- Conduct measurement of blood glucose using the hospital glucose meter, inform the patient of the result and record blood glucose readings.

Two nurses/midwives should:

- Make the insulin available to the correct patient and confirm this corresponds to the insulin prescription and the patient's current insulin regime. Encourage the patient to check it is the correct insulin. If this is incorrect, contact a prescriber.
- Check the patient's intended dose of insulin and confirm this corresponds to the prescribed dose or is within the prescribed dose range and relevant blood glucose reading. If a patient indicates that the prescribed dose or dose range is incorrect, contact a prescriber to review the prescription and amend if appropriate before a dose can be administered.
- Observe the patient measuring the dose and confirm this is correct prior to administration.
- Observe the patient administering the measured dose.
- Record administration on the prescription.
- Provide any necessary education and training required by the patient. Contact your Diabetes Link Nurse or the Diabetes Specialist Nurse if you require additional input for education and training of the patient.
- Ensure any sharps have been correctly disposed.

- Return the patient's insulin to the locked medicine trolley or locked bedside medicine locker.

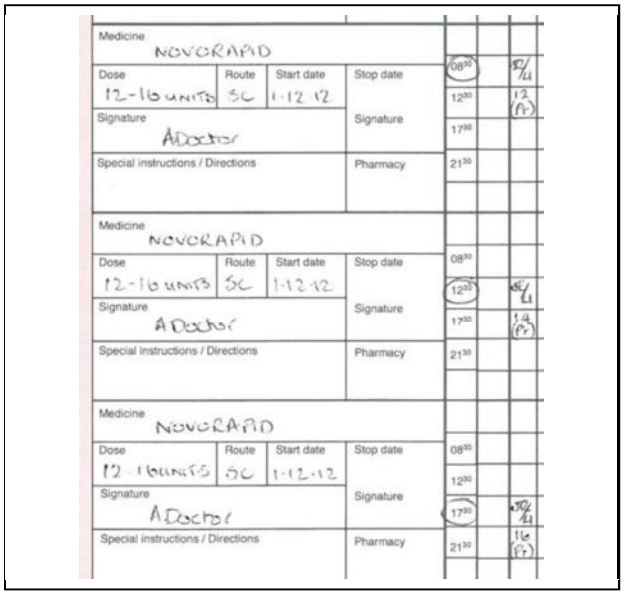
Record of administration

The supervising nurse/midwife's initials should be recorded together with '(Self)' to indicate that the patient has administered the dose. Where the patient is adjusting the dose of insulin according to food intake and/or blood glucose measurement, record the actual dose administered beside the administration signatures. Examples of recording are shown on the next page for insulin prescriptions chart and long stay Kardex [delete as appropriate].

Insulin prescription chart: nurse/midwife 'LW' and nurse/midwife 'AD' supervised a patient administering 12 units NovoRapid® from a prescribed dose range of 12-16 units.

Date	Time	Capillary blood glucose (mmol/L)	Prescription			Administration (Mandatory second check)			
			Insulin (use brand name)	Dose	Prescriber's signature	Sig1	Sig2	Dose	Time
1/7/15				units				units	
				units				units	
	Pre-breakfast 08.00	7·6	NOVORAPID	12-16 units	ADoctor	LW(Self)	AD	12 units	08·10

Long stay Kardex: nurse 'JR' and nurse 'LI' supervised a patient administering 12 units, 14 units and 16 units NovoRapid® respectively at 08.30, 12.30 and 17.30.



Southern Health and Social Care Trust

Write in CAPITAL LETTERS or use addressograph

Surname:……

First Names:……

Hospital number:……

DoB:……

Hospital:……Ward:……

Consultant:……

Evaluation of an adult patient for involvement in the administration of insulin under supervision in hospital

Date of evaluation						
1. Does the patient self-administer or intend to self-administer their insulin at home?	Yes	No	Yes	No	Yes	No
2. Does the patient wish to be involved in the administration of their insulin while in hospital?	Yes	No	Yes	No	Yes	No
If the answer to 1 and 2 is no, the patient will not be involved in the administration of insulin and no further evaluation is required.						
3. Does the patient have a clear understanding of the insulin type, dose, timing and use of the insulin device?	Yes	No	Yes	No	Yes	No
4. Is the patient at risk of known self harm?	Yes	No	Yes	No	Yes	No
5. Has the patient any physical difficulties that would prevent them being involved in the supervised administration of insulin e.g. manual dexterity?	Yes	No	Yes	No	Yes	No
6. Are there any other reasons why the patient should not be involved in the supervised administration of insulin? Specify:	Yes	No	Yes	No	Yes	No
Patient to be involved in administration of insulin under supervision*	Yes	No	Yes	No	Yes	No
Signature of registered nurse/midwife						

*If any answer is in a shaded box, the patient should not be involved in the administration of insulin in hospital. If a patient is not to be involved in the administration of insulin, consider referral to [Diabetes Link Nurse or Diabetes Specialist Team].

This evaluation should be reviewed at any stage following admission where changes occur that could affect patient involvement in insulin administration or where there are concerns about a patient's involvement in insulin administration.

This form must be filed in the patient's nursing/midwifery notes.

Southern Health and Social Care Trust

Involvement in the administration of my insulin in hospital under supervision

(Adult patients)

Information for patients

Introduction

You are a patient who requires insulin. Either you usually give (administer) your own insulin at home or you will be giving your own insulin after you go home. Your nurse/midwife has discussed your insulin with you and you will be involved in giving your insulin in hospital under the supervision of nursing or midwifery staff.

Why should you be involved in the administration of your insulin?

If you have been already been taking insulin before, it is important that you continue to give your own insulin in hospital so you are able to continue to do this when you leave hospital. If you have not taken insulin before, it is very important for you to be involved so you know exactly how to administer insulin after you leave hospital.

What if you don't want to be involved in the administration of your insulin?

If at any stage, you do not wish to be involved in giving your insulin in hospital, please tell your nurse or midwife and they will give you your insulin. If your condition or treatment changes during your hospital stay, for example you become very unwell or require a period of fasting (not eating or drinking any food or drink), it may be necessary for staff to manage your insulin treatment and give your insulin until it is considered safe for you to be involved in giving your insulin again.

How is your insulin stored?

In hospital, all medicines must be stored securely for the safety of all patients, visitors and staff. Your nurse/midwife will store your own insulin securely for you in a locked fridge, medicine trolley or locked bedside medicine locker. A label will be attached to your insulin with your name, date of birth and Health and Care/Hospital Number. Your nurse/midwife will check when you started using any opened insulin and that you have stored any unopened insulin in the fridge. If you need any more supplies of insulin while you are in hospital, these will usually be supplied from the hospital pharmacy.

How is your blood glucose monitored?

It is important that your blood glucose is monitored regularly in hospital. The nurse/midwife looking after you will use the hospital meter to monitor your blood glucose. The results will be recorded in your hospital record. You should record the results in your own blood glucose records. You can continue to use your own blood glucose meter if you wish but these results will not entered in your hospital record. The hospital meter must be used by staff as it is regularly checked to ensure it is giving correct blood glucose readings and it is also linked to the laboratory results system.

How is your insulin dose recorded?

A doctor or other prescriber will check your insulin and dosage regimen with you on admission. Your insulin and dose will be prescribed for you in hospital. If you usually vary your insulin dose based on what you are eating, your dose will be prescribed as a range to accommodate this. If your insulin or dose is changed from what you were taking before, your doctor/nurse/midwife will tell you. Your dose will be checked by nursing/midwifery staff each time a dose is due. If you think that the insulin and dose on the prescription is not correct, tell the nurse or midwife and they will contact a doctor or other prescriber.

What will happen when my insulin dose is due?

You should tell a nurse/midwife 15 minutes before you are due to give your insulin so they can bring your insulin to you.

Nursing/midwifery staff need to know exactly how much insulin you are giving yourself so they will check your insulin and dose with you, watch you give this and then sign a record that you have received it.

How can I dispose of my sharps safely?

All sharps need to be disposed of carefully. A nurse/midwife will provide you with a sharps bin for this.

What if I have more questions?

If you have any questions about your insulin or your diabetes, please ask your nurse/midwife.

Southern Health and Social Care Trust

Involvement in the administration of my insulin in hospital under supervision

(Adult Patients)

Information for Patients

Contents

July 2015

Introduction

You are a patient who requires insulin. Either you usually give (administer) your own insulin at home or you will be giving your own insulin after you go home. Your nurse/midwife has discussed your insulin with you and you will be involved in giving your insulin in hospital under the supervision of nursing or midwifery staff.

Why should you be involved in the administration of your insulin?

If you have been already been taking insulin before, it is important that you continue to give your own insulin in hospital so you are able to continue to do this when you leave hospital. If you have not taken insulin before, it is very important for you to be involved so you know exactly how to administer insulin after you leave hospital.

What if you don't want to be involved in the administration of your insulin?

If at any stage, you do not wish to be involved in giving your insulin in hospital, please tell your nurse or midwife and they will give you your insulin. If your condition or treatment changes during your hospital stay, for example you become very unwell or require a period of fasting (not eating or drinking any food or drink), it may be necessary for staff to manage your insulin treatment and give your insulin until it is considered safe for you to be involved in giving your insulin again.

Back to Top

How is your insulin stored?

In hospital, all medicines must be stored securely for the safety of all patients, visitors and staff. Your nurse/midwife will store your own insulin securely for you in a locked fridge, medicine

trolley or locked bedside medicine locker. A label will be attached to your insulin with your name, date of birth and Health and Care/Hospital Number. Your nurse/midwife will check when you started using any opened insulin and that you have stored any unopened insulin in the fridge. If you need any more supplies of insulin while you are in hospital, these will usually be supplied from the hospital pharmacy.

How is your blood glucose monitored?

It is important that your blood glucose is monitored regularly in hospital. The nurse/midwife looking after you will use the hospital meter to monitor your blood glucose. The results will be recorded in your hospital record. You should record the results in your own blood glucose records. You can continue to use your own blood glucose meter if you wish but these results will not entered in your hospital record. The hospital meter must be used by staff as it is

regularly checked to ensure it is giving correct blood glucose readings and it is also linked to the laboratory results system.

Back to Top

How is your insulin dose recorded?

A doctor or other prescriber will check your insulin and dosage regimen with you on admission. Your insulin and dose will be prescribed for you in hospital. If you usually vary your insulin dose based on what you are eating, your dose will be prescribed as a range to accommodate this. If your insulin or dose is changed from what you were taking before, your doctor/nurse/midwife will tell you. Your dose will be checked by nursing/midwifery staff each time a dose is due. If you think that the insulin and dose on the prescription is not correct, tell the nurse or midwife and they will contact a doctor or other prescriber.

What will happen when my insulin dose is due?

You should tell a nurse/midwife 15 minutes before you are due to give your insulin so they can bring your insulin to you.

Nursing/midwifery staff need to know exactly how much insulin you are giving yourself so they will check your insulin and dose with you, watch you give this and then sign a record that you have received it.

How can I dispose of my sharps safely?

All sharps need to be disposed of carefully. A nurse/midwife will provide you with a sharps bin for this.

What if I have more questions?

If you have any questions about your insulin or your diabetes, please ask your nurse/midwife.

Back to Contents

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 16 October 2015 17:49
To: Donnelly, Jonathan; Lesay, Michal; McCartan, Donna; McGreevy, Angela; Moran, Michael; Taggart, Andrew; Wauchope, Jessica; Williams, Matthew; Farnan, Turlough; Korda, Marian; Leyden, Peter; McCaul, David; Reddy, Ekambar; Hall, Sam; Ted McNaboe [redacted] Martin, Jennifer; Mukhtar, Bashir; Tyson, Matthew; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY
Attachments: HSS MD 17 2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY.pdf; image001.jpg; image003.jpg; image005.jpg; image002.jpg; image004.jpg; image006.jpg

Importance: High

FYI

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: Trouton, Heather
Sent: 12 October 2015 11:29
To: Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY
Importance: High

Dear all

Can you please share with your clinical (medical) teams?

Thanks
Heather

From: Griffin, Tracy
Sent: 08 October 2015 12:22
To: Hamilton, Alberta; McVeigh, Angela; McVey, Anne; McMurray, Bryce; Burke, Mary; Campbell, Catriona; Clarke, Wendy; Clarke, Colin; Conlon, Noeleen; Ferguson, Dawn; Wright, Fiona; Rice, Francis; Maguire, Geraldine; McClure, Irene; Gillen, Patricia; Trouton, Heather; Lappin, Aideen; Stafford-Barton, Laura; Fee, Lynn; Magill, Dympna; McClements, Melanie; Toner, Roisin; Carroll, Ronan; McShane, Wendy
Subject: HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY
Importance: High

Dear All

Please see attached for action as appropriate.

Regards,
T

Mrs Tracy Griffin
Personal Assistant to
MR FRANCIS RICE
Director of Mental Health & Disability Services /
Executive Director of Nursing & AHPs
Southern Health and Social Care Trust

Personal information redacted by USI

'You can follow us on Facebook and Twitter'

From: Henderson, Elizabeth Personal Information redacted by USI
Sent: 08 October 2015 11:14
To: Mary Hinds; Alan Finn; Angela Young (PA to Brenda Creaney); Brenda Creaney; Debbie Cousins (PA to Nicki Patterson); Rice, Francis; Katrina Quinn (PA to Alan Finn); Lorna Bates (PA to Olive Macleod); Nicki Patterson; Olive MacLeod; Griffin, Tracy
Cc: ElizabethJ Thompson; Gordon, Lesley
Subject: FW: HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY

Executive Director of Nursing, PHA
Executive Directors of Nursing HSC Trusts

Please see attached letter from Dr P Woods, DCMO.

Elizabeth Henderson
PS/Professor Charlotte McArdle
Office of the Chief Nursing Officer
DHSSPS
Tel. Personal Information redacted by USI

From: Gordon, Lesley
Sent: 08 October 2015 10:49
To: Boyle, Margaret (DHSSPS); Chada, Naresh; McBride, Michael; Addley, Ken; Kilgallen, Anne; McMaster, Ian; Mulligan, Gerry; McMahon, Nigel; Woods, Paddy
Cc: Henderson, Elizabeth; Perkins, Roisin (DHSSPS); Dillon, Edmond; Anderson, Sonya; Gordon, Lesley; Carson, Jane; McGonigal, Lynn
Subject: HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY

PLEASE SEE ATTACHED FROM DR PADDY WOODS, DEPUTY CHIEF MEDICAL OFFICER FOR INFORMATION

HSS(MD)17/2015 - CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY

From the Deputy Chief Medical Officer
Dr Paddy Woods

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

HSS Personal Information redacted by USI

For Action:

Chief Executives, HSC Trusts

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI
Email: Personal Information redacted by USI

Your Ref:
Our Ref: Personal Information redacted by USI

Date: 8 October 2015

Dear Colleagues

CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION HSC REGIONAL POLICY

In November 2012, the Consent for Hospital Post Mortem Examination HSC regional policy was introduced across Northern Ireland **http://www.dhsspsni.gov.uk/hss-md-48-2012.pdf**. This was developed to standardise policy and practice regarding consent for hospital post mortem examinations and to ensure that all HSC Trusts meet their responsibilities for obtaining valid consent in compliance with the Human Tissue Act.

Since then, the policy has been reviewed by the HSC Bereavement Network and some changes have been necessary to reflect:

- the new training programme introduced in January 2014 on seeking and obtaining consent for hospital post mortem examination **http://www.dhsspsni.gov.uk/hss-md-3-2014.pdf** and;
-
- Departmental guidance issued on death, stillbirth and cremation certification following the Court of Appeal decision on the death of a fetus in utero **http://www.dhsspsni.gov.uk/hss-md-38-2014.pdf** .

The revised HSC regional policy can be accessed at:
http://www.dhsspsni.gov.uk/index/phealth/professional/professional_good_practice_guidelines/postmortem.htm

I would ask you to ensure that it is adopted by your Trust and circulated to relevant staff.

Yours sincerely

DR PADDY WOODS
Deputy Chief Medical Officer

For Information:

Chief Executive, Health and Social Care Board
Chief Executive, Public Health Agency
Executive Medical Director/Director Public Health, Public Health Agency
Director of Integrated Care, Health and Social Care Board
Director of Nursing, Public Health Agency
Medical Directors of HSC Trusts
Directors of Nursing, HSC Trusts
Family Practitioner Service Leads, HSC Board
Professor Stuart Elborn, Dean, School of Medicine, Dentistry & Bio-medical Sciences, QUB
Mr Keith Gardiner, NIMDTA
Professor Sam Porter, Head of School of Nursing & Midwifery, QUB
Dr Owen Barr, Head of School of Nursing, University of Ulster
Dr Gemma Andrews, Coroners Service NI
Dr Tony Stevens, Chair Bereavement Network (for cascade to HSC Trust Bereavement Co-ordinators)
Angela McLernon, NIPEC
Dr Glynis Henry, Clinical Education Centre

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 25 October 2015 14:32
To: Burns, Sandra; Campbell, Dolores; Henry, Gillian; Holloway, Janice; McMahon, Jenny; ONeill, Kate; McClenaghan, Nichola; McNeilly, Julie; Sharpe, Dorothy; Hunter, Catherine; McElvanna, Ciara; Sheridan, Patrick; McAlinden, Jacinta; Moorcroft, Caroline; Mulligan, Marilyn; Rocks, Cathy
Subject: FW: Learning Reminder SQR/SAI/2015/015 (OPS/MH/LD/AS) - Management and advice for patients/clients with swallow/dysphagia problems
Attachments: SQR-SAI-2015-015 - Management and advice for patients clients with swallow dysphagia problems.pdf; image001.png; image002.png

For sharing

Thanks

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: Stinson, Emma M
Sent: 19 October 2015 12:14
To: McVey, Anne; Conway, Barry; Trouton, Heather; Carroll, Ronan; Gibson, Simon; Devlin, Louise; Burke, Mary; Carroll, Kay; Kavanagh, Catriona; McGoldrick, Kathleen; Clarke, Wendy; Nelson, Amie; Reid, Trudy; Corrigan, Martina; McGeough, Mary; McIlroy, Cathie; Reddick, Fiona
Cc: Beattie, Caroline; Quinn, AnneM; Conlon, Noeleen; Lappin, Aideen; Livingston, Laura
Subject: Learning Reminder SQR/SAI/2015/015 (OPS/MH/LD/AS) - Management and advice for patients/clients with swallow/dysphagia problems

Dear all

Please see attached for your information and circulation as appropriate through your teams.

Many Thanks
Emma

Emma Stinson
PA to Mrs Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]

EmmaM.Stinson Personal Information redacted by USI
P Please consider the environment before printing this email

Click on the link to access the Acute Services Page

'You can follow us on Facebook and Twitter'

From: Safety and Quality Alerts HSCB Personal Information redacted by USI
Sent: 01 October 2015 17:05
To: Michael Mcbride; Tony Stevens; Hugh McCaughey SE Trust; Clarke, Paula; Elaine Way Western Trust; Glenn Houston RQIA
Cc: Pauline McCabe SE Trust; Emma Taylor Northern Trust; Personal Information redacted by USI ; Personal Information redacted by USI ; Personal Information redacted by USI ; Wright, Richard; Personal Information redacted by USI Personal Information redacted by USI ; Patterson, Nicki (South Eastern Trust); Rice, Francis; Personal Information redacted by USI ; Personal Information redacted by USI Personal Information redacted by USI ; Personal Information redacted by USI Morgan, Paul; Personal Information redacted by USI ; Personal Information redacted by USI Personal Information redacted by USI ; Personal Information redacted by USI ; Marshall, Margaret; Personal Information redacted by USI ; Personal Information redacted by USI ; Personal Information redacted by USI ; Personal Information redacted by USI ; Seamus.McGoran setrust; Personal Information redacted by USI Gishkori, Esther; Stinson, Emma M; Personal Information redacted by USI ; Personal Information redacted by USI ; Personal Information redacted by USI ; McVeigh, Angela; Personal Information redacted by USI ; Jill Bradley; Personal Information redacted by USI ; Harney, Carmel; Personal Information redacted by USI ; Personal Information redacted by USI ; Personal Information redacted by USI ; David McManus (niecr); Tom McGarey; David Stewart RQIA; Fodey, Kathy (RQIA); Personal Information redacted by USI ; Keith Gardiner; Pauline Dardis; Personal Information redacted by USI '; Porter, Prof. Sam (QUB); Personal Information redacted by USI ; Traynor, Dr Marion (QUB); Personal Information redacted by USI ; Barr, Owen (UU); Lorainne Brownlie; Personal Information redacted by USI ; Personal Information redacted by USI ; Glynis Henry; Angela McLernon; Personal Information redacted by USI ; Eddie Rooney; Carolyn Harper; Mary Hinds; Pat Cullen; Lynne Charlton; Michelle Tennyson; Gavin Lavery; Valerie Watts; Sloan Harper; Brenda Bradley; Fionnuala McAndrew; Michael Bloomfield; Safety and Quality Alerts HSCB; Personal Information redacted by USI ; Personal Information redacted by USI ; McArdle, Charlotte (DHSSPS); Personal Information redacted by USI ; Personal Information redacted by USI '; Colum Conway; Sarah Graham; Personal Information redacted by USI Personal Information redacted by USI ; Personal Information redacted by USI
Subject: Learning Reminder SQR/SAI/2015/015 (OPS/MH/LD/AS) - Management and advice for patients/clients with swallow/dysphagia problems

"This email is covered by the disclaimer found at the end of the message."

Please find attached Safety and Quality Reminder of Best Practice Guidance Letter from Dr C Harper, Mrs M Hinds and Mrs F McAndrew.

Regards

Alerts Office
on behalf of Dr C Harper, Mrs M Hinds and Mrs F McAndrew

Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Management and advice for patients/clients with swallow/dysphagia problems
HSCB reference number	SQR/SAI/2015/015 (OPS/MH/LD/AS)
Programme of care	Older People Services/Adult Mental Health/Learning Disability/Acute Services

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

There have been a number of serious adverse incidents related to choking on food. In one such incident, a resident in a residential care home had been resettled from a long stay hospital with active involvement from hospital and community services during and following resettlement.

Speech and Language Therapy (SLT) had assessed the resident as being at risk of choking and made detailed recommendations.

The SLT recommendations included:

- Soft mashed food;
- Full supervision at mealtimes; and
- Use of a personalised placemat as a visual reminder of the above.

Recommendations were documented in the resident's care plan prior to discharge from the long stay hospital, and following assessment whilst in the residential care home. The recommendations, however, were not followed and the resident subsequently choked on food and despite prompt administration of first aid, they very sadly died.

The contributory factors to this incident were:

- Staff caring for the resident where not fully aware of the SLT recommendations. Food of a hard consistency was served to the resident;
- At the time of the incident, only one member of staff was supervising a group of residents;
- The recommendation regarding use of a personal placemat was not put in place following the resident's transfer to the residential care home.

Health and Social Care Board

Public Health Agency

REQUIREMENTS UNDER CURRENT GUIDANCE

Managers of Residential Care and Nursing Homes:

- You should have robust systems in place, and working, to ensure that all staff involved in delivering care are fully aware, and reminded of, each resident's individual needs and care plans.

- You should ensure that relevant staff under your management are aware of the DHSSPSNI Care Standards for Nursing Homes (April 2015) - Standard 12, (Nutrition, Meals & Mealtimes)
  http://www.dhsspsni.gov.uk/nursing_homes_standards_-_april_2015.pdf - and the
  Residential Care Home Standards – Minimum Standards (August 2011) – Standard 12 (Meals & Mealtimes)
  http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

For staff involved in the delivery of individual care plans:

- You need to make sure you know the detail of individual care plans of each resident under your care during a shift and you should adhere to each plan. This should include any speech and language therapy recommendations.

ACTION REQUIRED

HSC Trusts should:

1. Share this Reminder of Best Practice Letter with relevant staff.

RQIA should:

1. RQIA should disseminate this letter to relevant independent sector providers.

Date issued	1 October 2015		
Signed:	Personal information redacted by USI	Personal information redacted by USI	Personal information redacted by USI
Issued by	Dr Carolyn Harper Medical Director/ Director of Public Health	Mrs Mary Hinds Director of Nursing, Midwifery and Allied Health Professionals	Mrs Fionnuala McAndrew, Director of Social Care and Children

Health and Social Care Board

Public Health Agency

RE: Management and advice for patients/clients with swallow/dysphagia problems – Distribution List

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
Medical Director		✓	Medical Director/Director of Public Health		✓
Directors of Nursing		✓	Director of Nursing/AHPs		✓
Directors of Social Services		✓	PHA Duty Room		
Governance Leads		✓	AD Health Protection		
Directors of Acute Services		✓	AD Service Development/Screening		
Directors of Community/Elderly Services		✓	AD Health Improvement		
Heads of Pharmacy			AD Nursing		✓
Allied Health Professional Leads		✓	AD Allied Health Professionals		✓
NIAS			Clinical Director Safety Forum		✓
CEX		✓	**HSCB**		
Medical Director		✓	CEX		✓
RQIA			Director of Integrated Care		✓
CEX	✓		Director of Social Services		✓
Medical Director		✓	Director of Commissioning		
Director of Nursing		✓	Alerts Office		✓
Director for Social Care		✓	Dir PMSI & Corporate Services		✓
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean		✓	GPs		
QUB			Community Pharmacists		
Dean of Medical School		✓	Dentists		
Head of Nursing School		✓	**Open University**		
Head of Social Work School		✓	Head of Nursing Branch		✓
Head of Pharmacy School			**DHSSPS**		
Head of Dentistry School			CMO office		✓
UU			CNO office		✓
Head of Nursing School		✓	CPO office		
Head of Social Work School		✓	CSSO office		✓
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)		✓	Safety, Quality & Standards Office		✓
Clinical Education Centre		✓	**NI Social Care Council**		✓
NIPEC		✓	**Safeguarding Board NI**		✓
GAIN Office		✓	**NICE Implementation Facilitator**		✓
NICPLD			**Coroners Service for Northern Ireland**		✓

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 29 October 2015 09:24
To: Donnelly, Jonathan; Lesay, Michal; McCartan, Donna; McGreevy, Angela; Moran, Michael; Taggart, Andrew; Wauchope, Jessica; Williams, Matthew; Martin, Jennifer; Mukhtar, Bashir; Tyson, Matthew; Burns, Sandra; Campbell, Dolores; Henry, Gillian; Holloway, Janice; McMahon, Jenny; ONeill, Kate; McClenaghan, Nichola; McNeilly, Julie; Sharpe, Dorothy; Hunter, Catherine; McElvanna, Ciara; Sheridan, Patrick; McAlinden, Jacinta; Moorcroft, Caroline; Mulligan, Marilyn; Rocks, Cathy
Subject: FW: WHISTLEBLOWING POLICY
Attachments: WhistleblowingPolicyMarch2015-RevisedandFinal.pdf

Importance: High

FYI

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: Trouton, Heather
Sent: 29 October 2015 09:18
To: Brown, Robin; Gilpin, David; Hurreiz, Hisham; McKay, Damian; Neill, Adrian; Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; Reddy, Ekambar; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; Mallon, Peter; Weir, Colin; Yousaf, Muhammad; Bunn, Jonathon; McKeown, Ronan; McMurray, David; Murnaghan, Mark; Patton, Sean; Wilson, Lynn; Glackin, Anthony; O'Brien, Aidan; Young, Michael; McArdle, Gerarde; Gudyma, Jaroslaw; McCaul, David; Mathers, Helen; Doyle, Timothy; Alam, Ahsan; Watson, Bruce; Rajkumar, Shan; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: WHISTLEBLOWING POLICY
Importance: High

Dear All

Following a recent Trust survey of staffs' understanding of Whistle Blowing, please see attached a re issue of the Whistle Blowing policy for your attention.
The Policy is also available on the Intranet in the Human Resources section.

Can you please ensure this is shared with your medical team.

Thanks
Heather

Southern Health and Social Care Trust

WHISTLEBLOWING POLICY

Policy Checklist

Name of Policy:	Whistleblowing Policy and Procedure for Raising Concerns at Work
Purpose of Policy:	The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to safeguard anyone who raises concerns, and this policy encompasses the requirements of that Order. The policy provides a mechanism for staff to raise concerns about a range of matters at an early stage and in the right way thereby developing a culture of responsible openness and constructive criticism regarding all aspects of the Trust's activities including clinical care.
Directorate responsible for Policy	Directorate of Human Resources & Organisational Development
Name & Title of Author:	Vivienne Toal - Head of Employee Engagement & Relations
Does this meet criteria of a Policy?	Yes
Staff side consultation?	Yes
Equality Screened by:	Vivienne Toal – Head of Employee Engagement & Relations
Date Policy submitted to Policy Scrutiny Committee:	30th March 2015
Policy Approved/Rejected/ Amended	Approved subject to amendments
Communication / Implementation Plan required?	Yes
Any other comments:	
Date presented to SMT	April 2015
Director Responsible	Mr Kieran Donaghy
SMT / Trust Board Approved/Rejected/Amended	Approved
Date returned to Directorate Lead for implementation (DHR& OD)	30th March 2015
Date received by Employee Engagement & Relations for database/Intranet/Internet	30th March 2015
Date for further review	March 2017

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Whistleblowing Policy Version: 2_0 Reference number/document name:
Supersedes	Supersedes: Whistleblowing Policy version 1
Originator	Name of Author: Vivienne Toal Title: Head of Employee Engagement & Relations
Policy Scrutiny Committee & SMT approval	Referred for approval by: Vivienne Toal Date of Referral: Policy Scrutiny Committee Approval SMT approval: As Above
Circulation	Issue Date: September 2017 Circulated By: Vivienne Toal Issued To: Directors, Assistant Directors, Heads of Service for onward distribution to staff.
Review	Review Date: March 2017 Responsibility of (Name): Vivienne Toal Title: Head of Employee Engagement & Relations

Southern Health and Social Care Trust

Quality Care - for you, with you

WHISTLEBLOWING POLICY

AND

PROCEDURE FOR RAISING ISSUES OF CONCERN AT WORK

Author	Vivienne Toal, Head of Employee Engagement & Relations
Directorate responsible	Human Resources & Organisational Development
Date	March 2015
Review date	March 2017

	Contents	***Page No.***

Appendices

1.0 INTRODUCTION TO POLICY

The Southern Health & Social Care Trust is committed to promoting a culture of openness in which staff are encouraged to raise concerns without fear of reprisal and victimisation; and to ensuring that health and social care services are provided with the highest standards of integrity and honesty. The Trust expects all employees to maintain high standards in all areas of practice. All employees are therefore strongly encouraged to report any perceived wrongdoing by the organisation, its employees or workers that fall short of these principles.

Each of us at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about dangers to or ill treatment of service users, staff or the public, issues relating to the quality of care provided, patient safety, professional misconduct, unlawful conduct, financial malpractice, fraud, health and safety, or dangers to the environment, it can be difficult to know what to do.

You may be worried about raising such issues. You may want to keep the concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or the organisation. You may decide to say something but find you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also not be clear how your own professional code of conduct relates to Trust procedures.

2.0 PUBLIC INTEREST DISCLOSURE (NORTHERN IRELAND) ORDER 1998

The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to protect anyone who raises concerns from detriment and / or dismissal, and this policy encompasses the requirements of that Order. The Order protects employees or workers who make "protected disclosures", i.e. who reports wrongdoing within the workplace. This policy provides a process to enable employees or workers to inform the organisation about any wrongdoing in the workplace which they believe has occurred, or is likely to occur. Protection is against victimisation, disciplinary action or dismissal for employees who raise genuine concerns.

The Order 1998 has a tiered approach to disclosures which most easily gives workers protection for raising a concern internally. It is intended that this policy and associated procedure provide reassurance to staff who wish to raise such matters internally. Guidance from a range of regulatory / professional bodies encourages registrants to raise their concerns internally to ensure maximum level of protection under the Public Interest Disclosure Act.

Further details of the Order can be found using the following web address: http://www.pcaw.co.uk/law/pida.htm.

3.0 PURPOSE AND AIMS

Purpose

The Senior Management Team of the Trust is committed to running the organisation in the best way possible and to do so we need the help of those who work for us. We have this policy is place to reassure those who work for us that it is safe and acceptable to speak up and to enable all workers to raise any concerns that they may have at an early stage and in the right way.

There may be times when, after staff have raised a concern under this policy, it is deemed to be more appropriate to be dealt with differently. However this should not stop staff raising concerns under this Policy.

This policy aims to:

- Provide an avenue for you to raise a concern internally as a matter of course, and receive feedback on any action taken;
- Provide for matters to be dealt with quickly and appropriately and ensure that they are taken seriously;
- Reassure you that you will be protected from reprisals or victimisation for raising the concern in good faith;
- Allow you to take the matter further if you are dissatisfied with the Trust's response.

4.0 POLICY STATEMENT

The Trust would rather that you raised the matter when it is just a concern rather than waiting for proof. It is important to raise any concerns at an early stage, on the basis of any level of concern or relevant information. Indeed, if you have serious suspicions that an offence has been committed, you have a responsibility to report them as soon as possible. We all have a responsibility to protect the Trust, its service users, staff and public. **If in doubt – raise it!**

If something is troubling you that you think the Trust should know about or look into, please use the Procedure for Raising Concerns at Work – see section 10.0. You should never accuse individuals directly, and telling the wrong persons may jeopardise an investigation.

What we do ask is that in order to qualify for protection under this policy, you must:

- Act in good faith (effectively this means honestly) and

- Genuinely believe the information you are going to impart is accurate and
- Not act maliciously.

Our assurances to you

Your safety

The Chair, Chief Executive & Trust Board are committed to this Policy. If you raise a genuine concern under this Policy, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this same assurance is not extended to someone who maliciously raises a matter they know is untrue, and in such cases disciplinary action will be considered.

Your confidence

Confidentiality

The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern under this Policy. However, we recognise that you may nonetheless want to raise a concern in confidence. If you ask us to protect your identity by keeping your confidence, we will respect your request and it will not be disclosed without your consent. However a situation may arise where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court, or the Trust has to act on the information), and this will be discussed with you in advance of any disclosure.

Anonymous allegations

Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. You are encouraged to put your name to any issue of concern you are raising. Allegations expressed anonymously and/or with little detail or information are much less powerful and more difficult to address but may be considered at the discretion of the Trust. Whilst we will give due consideration to anonymous reports, we cannot follow the procedure set out in Section 11.0 for any concerns raised anonymously. The Trust endeavours to promote a supportive environment in which you are able to express your concerns in confidence, thereby hopefully negating the need for raising concerns anonymously.

5.0 SCOPE OF POLICY

This Policy applies to you whether you are a permanent, temporary or bank employee. The Trust is also very dependent on a wide range of contractors, suppliers, and others not directly employed by the Trust such as agency staff, trainees, volunteers, secondees, or a student or anyone on a work experience placement – the policy applies to all individuals in these categories where there are concerns about the activities of the Trust.

6.0 HOW WE WILL HANDLE YOUR CONCERN

Members of staff, including students, can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or colleague where appropriate.

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal enquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her, the timescale for action and whether your further assistance may be needed.

All staff who raise a concern will be automatically allocated support from the Head of Employee Engagement & Relations or a nominated deputy throughout the investigation process in line with section 8.0.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can and confirm our response in writing. Please note that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

7.0 RESPONSIBILITIES

7.1 Your responsibilities

The Trust wishes to encourage you to highlight areas where you are aware of inadequacies in the provision of services. In doing so concerns can be addressed at the earliest opportunity thus ensuring an overall improvement in the level of services provided to service users.

In particular you have a responsibility to:

- report any genuine concern of wrongdoing or malpractice preferably to your line manager or alternatively via one of the other options set out in the procedure in section 10.0. Proof of wrongdoing is not required, merely a genuine and reasonable concern. At the same time, you have an equal responsibility not to raise issues maliciously, where no potential evidence or indication or malpractice or danger exists; and

- familiarise yourself with and to understand the procedure for raising concerns outlined in section 11.0.

- be aware that information given unjustifiably to the media may unreasonably undermine public confidence in the Trust and Health and Social Care generally.

7.2 Our Responsibilities

All **managers** contacted by a member of staff, are responsible for:

- ensuring at the earliest opportunity that the appropriate action is taken in line with section 10, considering the nature and seriousness of the concern raised, including informing others, responding to concerns quickly and in confidence, taking all concerns seriously. This action will include deciding how any person, against whom an allegation is made, is informed of the matter, ensuring that the investigation is not jeopardised by the disclosure.

- supporting and reassuring those raising concerns – it is recognised that raising concerns can be difficult and stressful

- responding to all concerns without pre-judging

- recording all concerns, including the date the concern was raised, dates of interviews with employees, who was present at each interview and the action agreed

- keeping all records safely and securely

The **Trust's Senior Management Team,** through the Director of Human Resources & Organisational Development is responsible for:

- ensuring that these procedures are explained to all new staff, as part of Trust Induction

- protecting the interests and confidentiality of staff, for treating any concerns raised seriously, and for investigating them fairly and thoroughly

- ensuring that an investigation report relating to each Whistleblowing concern raised is considered as part of the Trust's Corporate / Clincial & Social Care Governance arrangements.

8.0 SUPPORT FOR EMPLOYEES

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Head of Employee Engagement & Relations or a nominated deputy

throughout any investigation process. The Head of Employee Engagement & Relations will not undertake an investigation role in any whistleblowing case but will oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.

The Trust also provides Carecall services to all employees through its Employee Assistance Programme; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Head of Employee Engagement & Relations will arrange for you to receive advice about the process.

If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Head of Employee Engagement & Relations.

9.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

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

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

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

10.0 ALTERNATIVE FORMATS

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

11.0 COPYRIGHT

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe

copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

12.0 PROCEDURE FOR RAISING CONCERNS AT WORK

There are a range of options from which you can choose if you wish to raise a concern.

Concerns are best raised in writing. You should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

12.1 How to raise a concern <u>internally</u>

Staff should raise any concern internally using one of the options listed below:

➢ **Option 1**

Managers have a vital role to play in ensuring that you and your colleagues are able to make constructive contributions and to feel that your ideas are welcomed, appreciated and where appropriate, acted upon in a positive manner.

You are therefore encouraged in the first instance to raise concerns with your line manager. You may wish to involve a Trade Union representative or colleague to advise or assist you. As soon as you have a concern, you should make an immediate note of it. You should write down all the relevant details – what was said or done, date, time, names etc.

➢ **Option 2**

If, for any reason, you feel unable to raise the concern with your line manager, please raise the matter with another senior person you can trust. This might be another manager or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

➢ ***Option 3***

If you feel that the concern is so serious that it cannot be discussed with any of the above you can contact:-

- Director of Human Resources & OD direct line Personal Information redacted by USI
- Chief Executive direct line Personal Information redacted by USI
- Non –Executive Director contacted through the Chair's office
  (See Appendix 2 for names) direct line Personal Information redacted by USI

The contact address for any of the above is: -

Southern HSC Trust Headquarters, Craigavon Area Hospital, Lurgan Road, PORTADOWN, BT63 5QQ

12.2 Response required from internal managers / Director to whom concerns are reported

Stage 1

ALL whistleblowing concerns MUST be notified by internal managers to the Director of Human Resources & Organisational Development for logging and investigation. The Director of Human Resources & Organisational Development will ensure that the Head of Employee Engagement & Relations is notified of the concern to ensure support can be provided to the employee.

The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff). Advice from Employee Engagement & Relations may help to clarify this at any early stage.

Any internal manager / Director to whom a concern is raised must then arrange to meet with the employee to discuss the concern without delay along with a representative from the Employee Engagement & Relations team.

The manager / Director and HR representative should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter.

A record should be made of all discussions at this stage by the manager and Employee Engagement & Relations.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is

decided that further action cannot be justified, the reasons for this decision should be documented and retained by the Employee Engagement & Relations Department.

Stage 2

Once the preliminary facts / issues of concern have been established, the approach to investigating the concern must be discussed and agreed. A record should be made of the decisions and/or agreed actions which should be signed and dated.

Stage 3

Within 10 working days of the concern being received, the manager receiving the concern must write to the employee:

- Acknowledging that the concern has been received;
- Indicating how the matter will be dealt with;
- Providing an estimate as to how long it will take to provide a final response; and/or
- Telling the employee whether any initial enquiries have been made; and
- Telling the employee whether further investigations will take place and if not why not; and /or
- Letting the employee know when s/he will receive further details if the situation is not yet resolved; and
- Providing the employee with details of whom to contact should s/he be dissatisfied with this response (see 10.4 below)

Advice from Employee Engagement & Relations should be sought when drafting the letter of response.

11.3 How to raise a concern <u>externally</u>

If you are unable to raise the matter internally as outlined above in Options 1 to 3, or if you feel it has not been dealt with properly, we would rather you raise it with an appropriate external agency, detailed in Option 4 below, than not at all.

- **Option 4.**

Provided that you are acting in good faith and have evidence to back up the concern, your concern may also be raised with: -

- Relevant Professional / Regulatory Bodies (e.g. Nursing & Midwifery Council, General Medical Council, Northern Ireland Social Care Council, Health Care Professions Council etc.)

- Statutory Bodies (e.g., Mental Health Commission, Regulation & Quality Improvement Authority (RQIA))

- The Health and Safety Executive for N. Ireland

- Department of Health, Social Services and Public Safety.

Contact addresses and telephone numbers are included in Appendix 1.

11.4 If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in Section 10.3. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly. By using this procedure, you will help us to achieve this.

12.0 SOURCES OF INDEPENDENT ADVICE AND FURTHER INFORMATION

You may also wish to access independent advice for example,

- A Trust JNCF Trade Union representative or any other recognised Trade Union official*;*

  or

- The independent charity *Public Concern at Work*
  - telephone 0207 404 6609 where lawyers can give free confidential advice at any stage about how to raise a serious concern.

Appendix 1

Northern Ireland Social Care Council
7th Floor Millennium House
Great Victoria Street
BELFAST
BT2 7AQ
Personal Information redacted by the USI

Nursing & Midwifery Council
23 Portland Place
LONDON
W1B 1PZ
Personal Information redacted by the USI

Regulation & Quality Improvement Authority (RQIA)
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT
Personal Information redacted by the USI

General Medical Council
20 Adelaide Street
BELFAST
BT2 8GD
Personal Information redacted by the USI

Health Professions Council
184 Kennington Park Road
LONDON
SE11 4BU
Personal Information redacted by the USI

Department of Health, Social Services & Public Safety (DHSSPSNI)
Castle Buildings
Stormont
BELFAST
BT4 3SJ
Personal Information redacted by the USI

Health & Safety Executive for Northern Ireland
83 Ladas Drive
BELFAST
BT6 9FR
Personal Information redacted by the USI)

Mental Health Commission for Northern Ireland
4th Floor – Lombard House
10-20 Lombard Street
BELFAST
BT1 1RD

DHSSPS Fraud Hotline
Personal Information redacted by the USI

Appendix 2

List of Non-Executive Directors with whom a concern can be raised

Mrs Deirdre Blakely

Mr Edwin Graham

Mrs Siobhan Rooney

Mrs Hester Kelly

Mrs Elizabeth Mahood

Mr Raymond Mullan

Mr Roger Alexander

Contact can be made with any of the above Non-Executive Directors through the Office of the Chair on Personal Information redacted by USI **.**

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 30 September 2012 17:05
To: Connolly, David; Farnan, Turlough; Korda, Marian; Leyden, Peter; Reddy, Ekambar; Hall, Sam; McNaboe, Ted; Glackin, Anthony; O'Brien, Aidan; Young, Michael
Subject: FW: HSS MD 43/2012 - Management of Seasonal Flu 2012/13
Attachments: Attachment HSS MD 43 2012 - Management of Seasonal Flu in Northern Ireland 2012 - 2013.pdf.pdf; HSS MD 43 - 2012 - Letter Management of Seasonal flu 2012 - 2013.pdf.PDF

Dear all

FYI

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Reid, Trudy
Sent: 28 September 2012 14:01
To: Nelson, Amie; Corrigan, Martina; Henry, Gillian; Sharpe, Dorothy; Devlin, Louise; Connolly, Connie
Subject: FW: HSS MD 43/2012 - Management of Seasonal Flu 2012/13

For information and circulation as required

Trudy

From: Griffin, Tracy
Sent: 27 September 2012 08:36
To: Hamilton, Alberta; McVeigh, Angela; McVey, Anne; Murphy, Jane S; McMurray, Bryce; Burke, Mary; Campbell, Catriona; Clarke, Colin; Wright, Fiona; Rice, Francis; Maguire, Geraldine; Fleville, Michelle; Gillen, Patricia; Gordon, Christine; Trouton, Heather; Greene, Jane; Stafford-Barton, Laura; Fee, Lynn; McStay, Patricia; McClements, Melanie; Toner, Roisin; Carroll, Ronan; Reid, Trudy; Irwin, Laura J; McShane, Wendy
Subject: HSS MD 43/2012 - Management of Seasonal Flu 2012/13

Dear All

Please see attached for action as appropriate.

Regards,
T

Mrs Tracy Griffin
Personal Assistant to
MR FRANCIS RICE
Director of Mental Health & Disability Services / Executive Director of Nursing

(Personal Information redacted by USI

-----Original Message-----
From: Henderson, Elizabeth [mailto: Personal Information redacted by USI
Sent: 26 September 2012 14:17
To: Mary Hinds; Maxine White; Alan Finn; Angela Young (PA to Brenda Creaney); Brenda Creaney; Charlotte McArdle; Debbie Cousins (PA Charlotte McArdle); Rice, Francis; Katrina Quinn (PA to Alan Finn); Lorna Bates (PA to Olive Macleod); Olive MacLeod; Griffin, Tracy
Cc: 'rachel.o'reilly Personal information redacted by USI
Subject: FW: HSS MD 43/2012 - Management of Seasonal Flu 2012/13

Director of Nursing and AHPs PHA
Directors of Nursing HSC Trusts (for onward distribution to all Community Nurses, and Midwives)

Please see attached letter from CMO, CNO and CPO.

Elizabeth Henderson
PS/Angela McLernon
Office of the Chief Nursing Officer
DHSSPS
Tel. Personal Information redacted by USI

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

MANAGEMENT OF SEASONAL FLU IN NORTHERN IRELAND 2012/13

MANAGEMENT OF SEASONAL FLU

September 2012

Introduction

1. Seasonal Influenza is an annual occurrence, although the exact timing, severity and extent of spread vary from year to year. For this reason, plans to manage seasonal flu should form part of wider planning for the winter months, rather than being regarded as a crisis each year.

2. This paper sets out the arrangements for management of seasonal flu in 2012/13. It builds on the experience of recent years. It is important to note that this paper refers to the broad policy issues. The Public Health Agency (PHA) and Health and Social Care Board (HSCB) will work with Trusts, Primary Care and other providers on more detailed operational aspects of the response to flu.

Background

3. The 2009 H1N1 (swine flu) pandemic changed public, media and political awareness and perception of flu. In addition, the extent and severity of seasonal flu in 2010/11 was greater than anticipated, further fuelling public interest. In contrast, the 2011/12 season was relatively quiet, illustrating the unpredictable nature of influenza viruses.

4. While it is impossible to predict what might happen in 2012/13, the aim of this paper is to ensure that we are as well prepared as possible and to avoid increasing pressure on health and social care services through public alarm.

5. The remainder of the paper considers different aspects of the response in turn.

Media and Communications

6. Good, consistent and open communication with the public, media, politicians and professionals is a key element of managing the response to seasonal flu as a whole society. By providing accurate, timely and balanced information, the public will be well informed and enabled to respond to help themselves and use health services appropriately.

Proactive engagement with the media

7. The Department, HSCB and PHA will be pro-active in engaging with the local media in advance of the flu season to:

- outline the preparations and expectations for the forthcoming flu season;
- clarify arrangements for how the Department and HSC organisations will be responding at each stage of the flu season;
- explain what data will be released by the Department/PHA and the limitations around comparison with other UK countries.

Public information campaigns

8. This year the PHA has again produced a multimedia campaign to include the following key messages:

- If you are pregnant, or have a serious medical condition like a heart, lung or neurological condition or are over 65 you need to get vaccinated against flu.
- It is important to get the vaccine early (October or November).
- The flu vaccine is needed every year - last year's vaccine won't protect you this year.

Engagement with politicians

9. Departmental officials will work, as determined by the Minister, to ensure that the Health Committee and other MLAs are fully briefed in advance of the flu season and that this information is updated as required.

Media briefings and press conferences

10. Seasonal flu is an annual event, in contrast to a pandemic which occurs infrequently. For this reason, it is necessary to manage seasonal flu as part of the overall work of the HSC.

11. The PHA has responsibility for monitoring infectious disease and protecting the health of the public. It also takes the lead in organising the flu vaccination programme;

developing the advertising campaign; and undertaking surveillance of flu. The HSCB takes the lead on coordinating the preparation and response of the HSC and related services to increased service pressures, including those due to flu. The PHA will lead on coordinating flu-related communications with the media and to the public, working very closely with the HSCB to ensure a single coherent approach.

12. In the event of a particularly widespread or severe flu causing pressure on other health services, a weekly press briefing may be held. The benefits of this approach include consistency of message and 'batching' of media bids, leading to a reduction in the demands on senior staff from all organisations at a time of intense activity and pressure. This format has worked well in previous years and has consisted of a panel of experts from the PHA, HSC Board, General Practice etc chaired by CMO to provide the latest update on flu activity and any service pressures; explain the flu policy; and respond to queries.

13. The decision to move to a weekly press briefing will be taken by the Chief Executive of the Public Health Agency in discussion with the HSCB and DHSSPS and following assessment of the public health and service pressures situation in Northern Ireland and nationally.

Online information

14. Information from all Government Departments in Northern Ireland is channelled through the nidirect website (www.nidirect.gov.uk). This website will provide high level information about seasonal flu, the vaccination programme, hygiene messages, and what to do if you are ill. It will signpost users to the Public Health Agency's dedicated flu website at www.fluawareni.info.This website will provide more detailed information and will be updated regularly as the flu season progresses. Communications staff from the DHSSPS and PHA will work together to ensure that any information which is contained on both websites uses the same wording to ensure consistency of message.

Seasonal flu vaccination programme

15. Vaccination policy in Northern Ireland and the rest of the UK is guided by the recommendations of the Joint Committee on Vaccination and Immunisation (JCVI), an independent expert advisory committee that advises the four UK Health Ministers on

matters relating to the provision of vaccination and immunisation services. JCVI consider all the available medical and scientific evidence before recommending which groups should be offered vaccination. For the 2012/13 vaccination programme JCVI have not extended their recommendation to any other group outside the clinical 'at risk' groups.

16. As in previous years, the seasonal flu vaccination programme will officially begin at the start of October. This year the PHA has procured over 480,000 doses of trivalent seasonal flu vaccine sufficient to vaccinate all eligible patients and staff, based on previous uptake rates.

17. The CMO letter announcing details of the vaccination programme was issued on 31 July and is available at http://www.dhsspsni.gov.uk/hss-md-34-2012.pdf

18. Occupational health staff in Trusts worked hard to achieve an overall uptake rate for seasonal flu vaccine of 20% in frontline health and social care workers in 2011/12, Every effort should be made to encourage and facilitate health and social care workers to take up the offer of vaccination to protect themselves and their vulnerable patients and clients and for this reason the target is being raised to 25% in 2012/13.

People with complex medical healthcare needs

19. Children with complex medical healthcare needs are particularly vulnerable to influenza viruses, particularly the H1N1 2009 strain. While there are no plans for a schools-based vaccination programme, the PHA plan to write to all parents of children in this group to encourage them to have their child vaccinated. Parents will be advised to contact their GP promptly if their child develops symptoms of flu. The PHA, in conjunction with Trusts, will work with GPs to identify all people with complex medical healthcare needs to ensure they are invited for vaccination.

Pregnant women

20. Pregnant women are at increased risk of complications from influenza infection, particularly with H1N1 2009 virus. All pregnant women should be strongly encouraged to accept the offer of vaccination. As with last year all pregnant women will be vaccinated by their own GP.

Severe egg allergy

21. Trivalent seasonal flu vaccines available in the UK have historically been egg based and this remains the case. However, this year the PHA has sourced a small amount of an egg free trivalent seasonal flu vaccine, licensed for use in people over 18 years of age with severe egg allergy. Guidance issued in the 'Green Book' sets out the advice on vaccination of people of all ages with varying degrees of egg allergy. Special arrangements will be put in place for vaccination of children with severe egg allergy. Demand for egg free vaccine will be closely monitored by the PHA to ensure that vaccine is reserved for those with the most severe egg allergy. More details are contained in the CMO letter (see paragraph 22, Annex 1 of HSS/MD 34/2012).

Live attenuated influenza vaccine

22. This year the PHA has also secured live attenuated influenza vaccine (Fluenz®) which has been shown to provide greater protection for children than inactivated influenza vaccine. The vaccine is licensed for those aged two years to less than 18 years of age. Given that this vaccine gives better protection for children GPs should administer Fluenz® vaccine to all children in clinical risk groups except those with contraindications such as immunodeficiency or severe asthma, active wheezing or egg allergy. More details are contained in the CMO letter (see paragraphs 19 to 21 in Annex 1 of HSS/MD 34/2012).

Healthy Under 5s

23. During the H1N1 2009 pandemic, vaccine was offered to healthy children aged 6 months to 5 years, once the offer of vaccination to those in risk groups was completed. This is not routine practice in seasonal flu.

Vaccination records

24. On occasions the PHA may need to contact GPs to get vaccination details of particular patients to better understand vaccine efficacy. GPs are requested to facilitate all requests for this type of information received from the PHA.

Infection control issues

25. As happens every autumn and winter, increased levels of respiratory viruses are likely to circulate in the community, resulting in large numbers of people presenting with respiratory symptoms. Therefore any infection control guidance should minimise the risk of influenza infection, particularly to vulnerable patients. Respiratory infection control guidance i.e. standard infection control and droplet precautions are recommended when caring for people with respiratory infections such as influenza.

26. FFP3 masks and associated precautions will still be required when performing aerosol generating procedures on patients with confirmed or suspected influenza or other severe respiratory illness of unknown type.

Laboratory Testing

27. Swab testing for influenza will depend on the location and clinical status of the patient.

▪**In the community:** routine swab testing of patients with flu or flu-like illness (FLI) will only be undertaken if it is considered to be clinically indicated or as part of existing surveillance schemes. The exception would be investigation of outbreaks of FLI in care homes and other settings in order to establish the causative organisms. GP spotter practices will continue to test as usual for surveillance purposes.

▪**Hospitals:** patients presenting to hospital with flu or FLI will be tested to determine their subsequent management in hospital and the duration of infection control measures. This is of particular relevance for critical care patients and those who are immunosuppressed.

28. Once influenza is circulating, arrangements for same day results, 7 days per week, will be put in place. In order to meet demand and manage workload in the Regional Virology Laboratory (RVL) it is necessary to specify a cut off time. RVL will process a specimen received by 12 noon for same day result, specimens arriving after 12 noon will be tested the next day. It is essential that Trusts put in place appropriate and timely transport arrangements to fit in with the 12 noon cut off for transfer of specimens to the Regional Virus Laboratory. The start date for 7 day/same day results will be

communicated to PHA, flu leads and microbiologists by RVL when this is about to commence.

29. As with any test or investigation being undertaken as part of diagnosis or treatment, the person who ordered the test is responsible for following up the result of that test. Recording of patient information on the laboratory request form is an essential part of the process, in particular when circumstances are unusual or cross the primary care/secondary care interface. The person who needs to be informed of the result should be clearly noted on the test request form. If there appears to be an unusual delay in receiving the result (eg within 48 hours), then responsibility for active follow-up rests with the person with clinical responsibility for the patient who has requested the test in the first place. The responsibility for informing the patient/carers and any other relevant health care professionals of the result of the test lies with the healthcare professional who is managing the patient and requested the test.

Antiviral prescribing for treating patients with flu-like illness and as prophylaxis

30. As in previous years, based on surveillance advice from the PHA that flu has begun to circulate in Northern Ireland, the Department will issue a letter advising that antivirals can be prescribed under the Health Service. A further letter will be issued when flu has ceased circulating.

Preparation of HSC Trusts, General Practitioners and Related Services

31. HSCB, supported by PHA, will oversee provider preparation for flu, other peaks in service demand, or interruptions to service continuity. The HSCB should identify a lead Director to oversee the preparation phase and response.

32. Trusts and primary care in-hours and out-of-hours providers should have detailed escalation plans which enable them to respond to increased service demands, including from flu-related activity.

Response and Escalation

33. Trusts and primary care providers should activate their escalation plans as necessary. The HSCB, supported by the PHA should have arrangements in place to coordinate

the response of the HSC and related services, and should activate those as required, including arrangements to collect and report data as described later.

34. The HSCB will keep DHSSPS informed of significant service pressures, as appropriate.

Critical Care

35. During the pandemic, plans were put in place to increase capacity in critical care. Although these escalation plans were not fully tested during the pandemic, they proved invaluable in the 2010/11 season and ensured that the HSC responded promptly to a rapid increase in the number of critical care patients.

36. The Critical Care Network of Northern Ireland (CCaNNI) has since updated these plans. These plans should be held in readiness for the 2012/13 season if required. CCaNNI will also assist with data collection relating to critical care.

National arrangements for surveillance and reporting

37. A UK working group was established in 2011 by the 4 Chief Medical Officers to agree unified surveillance and reporting arrangements for the four UK countries. Arrangements for surveillance of influenza have been agreed and are well developed in each of the UK countries. Information is now collected using agreed case definitions and this worked well in 2011/12, although it was not fully tested in such a quiet year.

38. Arrangements for surveillance and reporting are unchanged from last year. In 2012/13, all four countries will collect and report:

- Laboratory confirmed cases of all flu types (H1N1, other Flu A, Flu B etc). This will be reported weekly and cumulative totals from 1st October disaggregated by age band and sentinel/non sentinel sources.

- Information on admissions and deaths in intensive care units/ high dependency units (adult and paediatric) of patients with laboratory confirmed influenza infection.

Additional Reporting of Flu and its Impact in Northern Ireland

39. The PHA and HSCB should work together to ensure that arrangements are in place to enable collection and collation of the information outlined below. The organisational responsibilities for communication of this information to the media and public have been described earlier (para 12).

Flu bulletin

40. The Public Health Agency's regular flu bulletin is the definitive source of public health surveillance information on flu activity for Northern Ireland throughout the season. Data in the bulletin is collected and reported using definitions agreed by health protection services across the UK. It therefore enables comparison between UK countries and it will include the nationally agreed data items outlined in para 37. Publication starts fortnightly around the beginning of October, moving to weekly once flu begins to circulate more widely. The flu bulletins will be accessible online on the dedicated flu website at www.fluawareni.info.

41. Weekly mortality data is provided from Northern Ireland Statistics and Research Agency. The data relates to the number of deaths from selected respiratory infections (some of which may be attributable to influenza, and other respiratory infections or complications thereof) registered each week in Northern Ireland. This is not necessarily the same as the number of deaths occurring in that period. Searches of the medical certificates of the cause of death are performed using a number of keywords that could be associated with influenza (bronchiolitis, bronchitis, influenza and pneumonia). Death registrations containing these keywords are presented as a proportion of all registered deaths.

Other information on flu and its impact

42. In addition to the flu bulletin, and to further inform the public in Northern Ireland of the impact of flu, the following information will be collected and updated weekly by the Health and Social Care Board;

A. Information on deaths, in hospital but outside ICU (adult and paediatric), of patients with laboratory confirmed influenza infection (of all types). This will be reported as cumulative totals from 1 October.

B. Point prevalence at a set time each day once a week, of

a. The number and percentage of patients in adult critical care and separately, paediatric critical care with laboratory confirmed influenza infection (of all types);

b. The number of adults and the number of children in hospital but not in critical care, with laboratory confirmed influenza infection (of all types).

C. Cumulative total from 1 Oct, of the total number of elective inpatient admissions deferred as a result of flu-related increased demand.

D. Other information as appropriate to the circumstances at the time.

Reporting of small numbers

43. In Northern Ireland, the annual number of laboratory confirmed deaths with or from flu is small. If additional information about age or co-morbidity (underlying medical conditions) is included, this may lead to deductive disclosure whereby individuals may be identified. This can cause great distress to families of the deceased. For this reason, information on the numbers of patients with deaths from influenza will only be reported on a weekly basis.

44. To prevent deductive disclosure and in accordance with normal practice, PHA/HSCB will only share information such as age and presence of underlying conditions each time there is an accumulated total of 5 patients in the category (i.e. until a total of five is reached, the information will be reported as 'less than 5' or '<5'). Information on age of those who died will be categorised by age-band (0-14, 15-44, 45-64, and 65+).

Access to specialist public health advice and guidance

45. Clinicians who require detailed public health advice, especially about outbreak situations, should contact Public Health Agency health protection staff; in office hours through the duty room on Personal Information redacted by USI, or out-of-hours ask ambulance control to bleep the on-call public health doctor.

Outbreaks

46. Given the close social contact in care homes or between school-age children, local outbreaks in care homes or schools may occur as was noted during the 11/12 flu season. Anyone with flu or flu-like symptoms should not attend work or school until their symptoms have cleared. For expert public health advice about outbreaks please contact PHA health protection staff as above. The PHA when investigating such outbreaks will require some symptomatic individuals to be swabbed to confirm the diagnosis and will liaise the general practitioners regarding the use of antivirals for prophylaxis and/or treatment of residents/pupils and staff.

Conclusion

47. Information about a wide range of topics has been included in this paper, however it should be noted that this will be kept under review up to and during the flu season as circumstances dictate. Every effort will be made to ensure that all stakeholders are kept fully informed of any changes or updates, so that messages can be kept consistent.

From the Chief Medical Officer
Dr Michael McBride

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

HSS(MD) 43/2012

FOR ACTION

Chief Executives, Public Health Agency/Health & Social Care Board/HSCTrusts/NIAS

PLEASE SEE ATTACHED FULL CIRCULATION LIST

Castle Buildings
Stormont
BELFAST
BT4 3SQ

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI
Email: Personal Information redacted by USI

Your Ref:
Our Ref: HSS(MD) 43/2012
Date: 26 September 2012

Dear Colleague

MANAGEMENT OF SEASONAL FLU 2012/13

Action Required

Chief Executives must ensure that all those who are involved in the response to seasonal flu in Northern Ireland make themselves familiar with the contents of this paper and ensure that they are prepared to respond accordingly.

1. Seasonal Influenza is an annual occurrence, although the exact timing, severity and extent of spread vary from year to year. For this reason, plans to manage seasonal flu should form part of wider planning for the winter months, rather than being regarded as a crisis each year.

2. The attached paper sets out the arrangements for management of seasonal flu in 2012/13 and builds on previous experience and lessons learnt during past influenza seasons .

3. It is important to note that the paper refers to the broad policy issues and has been agreed with the Public Health Agency (PHA) and Health and Social Care Board (HSCB).

4. The PHA and HSCB will work with Trusts, Primary Care and other providers on more detailed operational aspects of the response to flu.

Conclusion

5. The 2009 H1N1 (swine flu) pandemic changed public, media and political awareness and perception of flu. In addition, the extent and severity of seasonal flu in 2010/11 was greater than anticipated, further fuelling public interest. However, despite these pressures, seasonal flu over the past two years has been managed well by the full range of health services in Northern Ireland. It is therefore important that we build on the lessons learnt over the last number of years and ensure the health service is fully prepared to deal with the effects of flu during 2012/13.

Yours sincerely

Dr Michael McBride
Chief Medical Officer

Mrs A McLernon
Chief Nursing Officer (Acting)

Dr Norman Morrow
Chief Pharmaceutical Officer

cc Dr Richard Smithson, Consultant in Health Protection, PHA
Dr Tom Black, Chair, NIGPC
Brenda Bradley *(for onward distribution to Pharmacists)*
Dr Jill Mairs, Regional Procurement Pharmacist
Dr Desie Bannon, SEHSCT (NI Prison Service)
Universities Student Health Services
Occupational Health Departments HSC Board/Trusts
NICS Occupational Health
Mr P Tiffney, Movianto Northern Ireland
Medical Director, RQIA
Prof C Johnston, QB
Prof H McKenna, UU
M Devlin, CEC

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

Circulation List - For Action:

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, Health & Social Care Board
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, HSCB
Family Practitioner Service Leads, Health & Social Care Board *(for cascade to GP Out of Hours services)*
GP Medical Advisers, Health & Social Care Board
All General Practitioners and GP Locums (*for onward distribution to practice staff)*
All Community Pharmacists
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians & School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and Midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Regional Medicines Information Service, Belfast HSC Trust Regional Pharmaceutical Procurement Service, Northern HSC Trust

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 25 November 2012 19:47
To: Farnan, Turlough; Korda, Marian; Leyden, Peter; Reddy, Ekambar; Hall, Sam; McNaboe, Ted; Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Subject: FW: *for action* TYC Presentation
Attachments: TYC General Questions.pptx; TYC presentation staff engagement Nov 2012 final.pptx

Dear all

Please see attached for your information

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: Reid, Trudy
Sent: 22 November 2012 18:51
To: Nelson, Amie; Devlin, Louise; Corrigan, Martina; Sharpe, Dorothy; Henry, Gillian; Connolly, Connie; Mackle, Eamon; Hall, Sam; Brown, Robin; McKeown, Ronan
Subject: FW: *for action* TYC Presentation

Dear all please see attached for information and discussion staff and specialty meetings

Regards,

Trudy

From: Stinson, Emma M
Sent: 22 November 2012 16:51
To: Boyce, Tracey; Burke, Mary; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Reid, Trudy; Trouton, Heather
Cc: Conlon, Noeleen; Livingston, Laura; Graham, Michelle; Irwin, Laura J; Lappin, Aideen; Ward, LauraAnne
Subject: *for action* TYC Presentation

Dear all

Please cascade this presentation through staff meetings internally and share with AMDs, CDs and discuss at specialty fora.

Gillian

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI

Email: Personal Information redacted by USI
P Please consider the environment before printing this email

From: Dalzell, Stacey
Sent: 19 November 2012 11:21
To: Clarke, Paula; Donaghy, Kieran; McNally, Stephen; McVeigh, Angela; Morgan, Paul; Rankin, Gillian; Rice, Francis; Simpson, John; McAlinden, Mairead
Cc: Gilmore, Sandra; Mallagh-Cassells, Heather; Radcliffe, Sharon; Stinson, Emma M; Taylor, Karen; White, Laura; Wright, Elaine; Joyce, Barbara; Griffin, Tracy; Wright, Elaine; Dalzell, Stacey
Subject: TYC Presentation

All

Please find attached the TYC presentation and information that is being used at the TYC Staff Engagement Events that commenced today.

I have also uploaded these to the homepage of the Intranet for staff information.

Regards

Stacey

Mrs Stacey Dalzell
Communications Assistant
Trust HQ
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ

Personal Information redacted by USI
Personal Information redacted by USI

TYC General Questions

17 Questions

Question 1

Do you agree that our health and social care services need to change in order to meet the needs of the community and promote health and well-being through prevention and early intervention so that as much acute illness as possible is avoided?

Question 2

Do you agree that people who need care and support should have control over how their assessed care and support needs should be met?

Question 3

Do you feel the provision of individualised budgets and self-directed support should be more widely promoted?

Question 4

Do you agree we should organise our services to enable people to stay at home for as long as possible and / or be cared for at home?

Question 5

Given the choice, who would you like to provide your care and support in your home?

1. Statutory bodies

2. Voluntary and community groups

3. Independent sector

4. A mixture of the above

5. You would prefer to receive the money yourself to choose

Delivering services at home and in the community: Integrated Care Partnerships

Question 6

Do you agree that Integrated Care Partnerships could make a positive contribution to the delivery of care closer to home rather than in hospitals?

If your response is 'disagree' or 'strongly disagree', do you think there are any alternative ways to deliver care closer to home?

Older People

Question 7

Do you agree with the proposals set out in respect of older people's services?

Do you believe there are better alternatives?

Long Term Conditions

Question 8

With regard to Long Term Conditions, would it be helpful to

a) Make more information and education available to help those with a long term condition to monitor and manage their own condition?

b) Enable those with long term conditions to make more use of technology in their home to help problems be identified earlier, and reduce the need for avoidable visits to hospital or the doctor?

Palliative and End of Life Care

Question 9

Do you agree that the proposals set out in respect of palliative and end of life care would support you to be cared for in a place of your choice?

Do you believe there are better alternatives?

Mental Health

Question 10

Do you agree with the proposals set out in respect of mental health services?

Do you believe there are better alternatives?

Learning Disability

Question 11

Do you agree with the proposals set out in respect of learning disability services?

Do you believe there are better alternatives?

Physical Disability and Sensory Impairment

Question 12

Do you agree with the proposals set out in respect of physical disability and sensory impairment services?

Do you believe there are better alternatives?

Family and Child Care

Question 13

Do you agree with the proposals set out in respect of Family and Child Care?

Do you believe there are better alternatives?

Maternity and Child Health

Question 14

Do you agree with the proposals we have set out in respect of maternity and child health services?

Do you believe there are better alternatives? Please provide details

Acute Care in Hospitals

Question 15

Do you agree with our proposals in respect of acute hospital services?

Do you believe there are better alternatives?

Question 16

Do you agree that the criteria set out in Appendix 1 against which acute services have been assessed remain the most appropriate criteria?

If you disagree or strongly disagree, please provide specific details on what you see are more appropriate criteria. Please give reasons for your comments.

Increasing our links with the Republic of Ireland and Great Britain

Question 17

To what extent do you agree we should develop closer working relationships with the Republic of Ireland and Great Britain?

Southern Health and Social Care Trust

changing... for a better future

Transforming Your Care

'Vision to Action'

November 2012

Staff Engagement Meetings

changing... for a better future

Background

❑ Transforming Your Care (TYC)

- **Review into the future for health and social care in Northern Ireland, endorsed by the Health Minister in December 2011.**

- **The Trust, with Locality Commissioning Group, developed the Southern Area Population Plan which set out our response to TYC. All the papers are on the Trust's intranet site.**

- **The Minister has now published a formal consultation document - 'Vision to Action'.**

changing... for a better future

TYC in the Southern Trust

- **Engagement with MLAs, MPs, Councils, voluntary and community groups**
- **Staff engagement in August**
- **November 2012 - Jan 2013**
  - **Regional consultation and local staff engagement**
- **The Minister is looking for views on the proposals in *Vision to Action*, and has posed a series of 17 questions in the document.**
- **The Trust will formally respond – we encourage you to respond through your line management arrangements, through dedicated TYC contact point and also as local citizens**

changing... for a better future

‘Vision to Action’

- You can view the document at www.tycconsultation.hscni.net

- TYC is on Facebook - TYC consultation- and Twitter @TYC Consultation

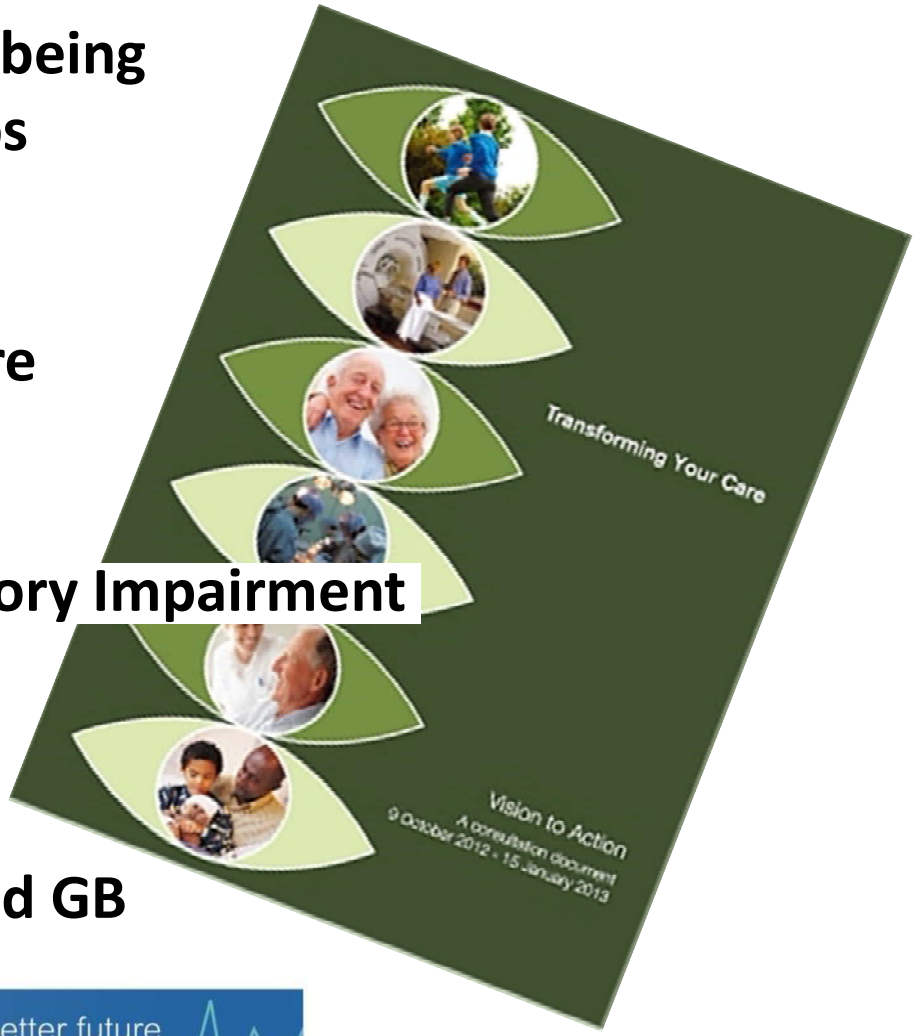
- Leaflet drop to all homes in Northern Ireland

changing... for a better future

‘Vision to Action’

Proposals for change under 12 headings

1. Population health and wellbeing
2. Integrated Care Partnerships
3. Older People
4. Long Term Conditions
5. Palliative and end of life care
6. Mental health
7. Learning disability
8. Physical disability and Sensory Impairment
9. Family and Child Care
10. Maternity and Child Health
11. Acute Care in hospitals
12. Increasing links with ROI and GB



changing... for a better future

Key areas for Trust response

Seek continued recognition of the need for regional action to support us locally in implementing change. These include:

- **Access to transitional funding:**
  - **to ensure new models of care in place before removing existing models**
  - **to support staff to re-skill where required**
- **Access to capital funding**
- **Policy decisions where required e.g. social enterprise**

External Environment

- **Outside our control:**
  - **Regional reviews**
  - **Financial climate**
  - **Emerging standards and guidelines**

‘Vision to Action’

General questions

Question 1

- ❑ **Do you agree that our HSC services need to change in order to meet the needs of the community and promote health and well-being through prevention and early intervention so that as much acute illness as possible is avoided?**

Question 2

- ❑ **Do you agree that people who need care and support should have control over how their assessed care and support needs should be met?**

Question 3

- ❑ **Do you feel the provision of individualised budgets and self-directed support should be more widely promoted?**

changing... for a better future

‘Vision to Action’

General questions

Question 4

- **Do you agree we should organise our services to enable people to stay at home for as long as possible and / or be cared for at home?**

Question 5

- **Given the choice, who would you like to provide your care and support in your home?**
  - **1. Statutory bodies**
  - **2. Voluntary and community groups**
  - **3. Independent sector**
  - **4. A mixture of the above**
  - **5. You would prefer to receive the money yourself to choose**

changing... for a better future

Southern Trust – Context for Change

- **The Southern Trust has an annual budget of about £500million.**
- **Trust employs over 13,000 staff**
- **Savings to be delivered this year**
  - **£11m cash releasing**
  - **£5m non-cash releasing**
- **Savings to be delivered by 2015**
  - **£27m cash releasing**
  - **£16m non-cash releasing**
- **Population of 358,600 – Fastest growing population in NI over the last 10 years with projected further growth of 13.5% by 2020 compared to NI average of 6.5%. This includes:**
- **Largest increase in births - 37% increase (2000-10) compared to NI average 17.7%**
- **Largest 0-17 years population – 12.6% growth by 2020 compared to NI average 2.5%**
- **Over 65 population – 33% growth by 2020 compared to NI average 27%**

What we want in our local health and social services

= Transforming Your Care

changing... for a better future

Impact of major change areas in the Southern Trust - Early intervention & prevention

Our priorities will be;

- A focus on prevention and early intervention across all service areas
- Specific focus on children and young people, older people and populations/areas of low uptake of health care
- *Family nurse partnership being developed*
- *Falls prevention services being further developed through partnership with NIAS*

- Improved access to early support and advice through information hubs/single points of access
- *Access and information centres being established for Older persons*
- *Family support hubs in place*

Which will result in;

- Reducing the need for health and social care support and intervention

- Improving health outcomes and addressing health inequalities

Impact of major change areas in the Southern Trust - Enable independent living, choice & care at home

Our priorities will be;

- Supporting skills and confidence for independent living by rolling out a reablement approach across the Trust area within services for older people, people with mental health needs and with disabilities
- Achieving clarity of expectation for individuals, families and care providers through individual care plans
- Increasing the numbers of people using personalised budgets and supporting access to a greater diversity of provision across the collective resources in the community and independent sectors with the specific development of social enterprises.
- Increasing supported living accommodation options and completing the resettlement of people with mental health and learning disability out of long-stay hospitals
- Developing a wider range of community based supports including rapid response community teams and increasing support for people with dementia

Which will result in;

- More domiciliary care being provided through partnerships with independent, voluntary and social enterprise providers
- Reduced provision of statutory residential care with proposed closure of a minimum of 2 homes by 2015 and potentially all homes by 2017.
- Reduced need for statutory day care by promoting day opportunities, respite and short breaks.
- Opportunities for new community based services.
- Completing the closure of long-stay hospital based care for people with mental health problems and learning disabilities
- Reconfigure local provision in line with the Regional Review of Addiction Services

Impact of major change areas in the Southern Trust -
Integrated working between primary, community & secondary care

Our priorities will be;

- Developing integrated care partnerships that support primary, community, independent, voluntary and acute teams to plan and deliver care for an individual in a coherent and joined-up way
- Focusing on populations aligned with GP practices and targeting support at those with greatest needs by assessing "risk" with an initial focus on those over 75 and with long term conditions
- Making effective use of technology to allow individuals to be monitored at home and allow a shared view of all the information needed to effectively plan care
- Increasing access to rapid response services
- Enabling specialist hospital based staff to be available to provide more care and advice within the community
- Improving infrastructure within primary and community care and access to diagnostic services to support team working

Which will result in;

- Moving care closer to home with less people needing to be admitted into hospital particularly for unscheduled or "urgent" care and reducing the number of inpatient beds needed
- Reducing the amount of duplication of information and diagnostic tests
- Increasing the number of people with palliative or end of life care needs supported to die at home
- Increasing the number of Community Treatment and Care Centres and facilities for providing integrated care services in the area by at least 2 by 2015

Impact of major change areas in the Southern Trust - Making best use of our hospital network

Our priorities will be;

- Providing safe, personal, effective care across our hospital network
- Re- balancing services across our hospital network to support growing demand and service developments
- Improving patient pathways outside and inside hospital
- Using innovative technology and the skills of clinical and professional generalists and specialists
- Increasing rapid access, day surgery, walk in/out care, use of virtual clinics and one-stop models and reducing the number of appointments where service users ‘Do not attend’ and the incidence of cancelled operations.
- Working with Primary Care to implement care pathways to manage referral demand and to ensure that where appropriate diagnostic, treatment and review procedures are moved from secondary to primary care

Which will result in;

- Continued delivery of major acute hospital services at both CAH and DHH for at least the next 3 years with some movement of service between sites
- Continuing provision of Consultant obstetric care at both Hospitals and MLU at CAH
- Reducing the numbers of inpatient beds needed in our acute and non acute hospitals allowing resources to be re-invested to enhance community and primary care ('shift- left')
- More outpatient care provided outside the hospital
- Further development of local access to sub-regional services such as orthopaedics, urology, and cardiology
- Ensuring patient/client quality and safety is maintained and patient/client experience and satisfaction is enhanced.

What does this mean for staff

- **We are already well on the way to "transforming your care"**
- **Trust has a good track record in the Management of Change, in supporting and protecting staff through major change process.**
- **There will be opportunities for staff in new services**

changing... for a better future

TYC already in action

- **Transforming Your Care is already in evidence across the Trust: e.g.**
  - **More efficient acute care with better outcomes**
  - **HDU in DHH and introduction of the first robot in the UK**
  - **Thousands of elderly patients supported to remain at home through re-ablement services**
  - **Successful resettlement programme already in action**
  - **Increased numbers of people availing of 'day opportunities'**
  - **Promoting choice through increased uptake of Direct payments/self directed support**
  - **Telehealth / Telecare**
  - **Launch of Family Nurse Partnerships and Family Support Hubs**
  - **Better links with community/voluntary sector e.g. Good Morning service**

changing... for a better future

TYC in action

'Telemedicine' getting vital clot-busting drugs to stroke patients

Clinics move out but mums-to-be won't lose out

Robo-Doc

Changing the world one baby at a time

Stroke victim Ellen recovers thanks to clot-busting drugs

changing... for a better future

Where next?

Regionally

Consultation ends January 15th, 2013

Three public meetings in the Southern Area, hosted by the SLCG:

- ❑ **November 20th, Banbridge**
- ❑ **November 21st, Armagh**
- ❑ **December 6th, Newry**

Locally

Trust response to consultation

Local public consultation on key proposals expected after the Minister closes the regional consultation on:

- ❑ **Statutory Residential Care**
- ❑ **Non-Acute Hospital Pathway**
- ❑ **Day Care- OP, MHD**

changing... for a better future

Questions?

- Now
- After today – through
  - [redacted]

Personal Information redacted by USI

changing... for a better future

Southern Health and Social Care Trust

Quality Care - for you, with you

Programme Director for Public Inquiry and Trust Liaison – Urology Services Inquiry
Band 8D
1 year initially

Working together Excellence Openness & Honesty Compassion

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Programme Director for Public Inquiry and Trust Liaison
BAND	8D
DIRECTORATE	Office of Chair & Chief Executive
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive

JOB SUMMARY

The post holder will be responsible for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the Statutory Public Inquiry into Urology Services. The post holder will also act as the Trust's Programme Director lead for the Inquiry Panel and will be the main link between the Trust and the Directorate of Legal Services and other external stakeholders, for example, the Department of Health.

The Trust's response programme to the Urology Services Public Inquiry will be coordinated through a Programme Board, chaired by the Chief Executive and reporting to Trust Board. It will focus on three key strands:

(1) **Inquiry Management** - directly managed through a Public Inquiry Steering Group chaired by the Programme Director
(2) **Look-back Programme** – directly managed through a Lookback Steering Group chaired by Director of Acute Services.
(3) **Quality Improvement** - Quality Improvement Oversight Group chaired by Medical Director.

The Programme Director will, on behalf of the Chief Executive, be the key lead Director responsible for the successful delivery of the Public Inquiry programme, and will directly manage the Inquiry Management response. The Programme Director will also be responsible for coordinating the successful delivery of all strands of the programme which will require providing strategic senior level leadership, programme management leadership and challenge to the Look-back and Quality Improvement Programmes to ensure all three strands of the programme are effectively discharged, whilst effectively

managing their interdependencies. The Urology Services Inquiry is at the forefront of the Southern Trust challenges and therefore the success of the programme is a key risk for the Trust Board and although the postholder will not be a formal member of Trust Board it is expected that the Programme Director will regularly attend and update the Board.

KEY RESPONSIBILITIES

1. To be the senior leadership face of the inquiry, to liaise professionally with all stakeholders and to ensure that the Trust is professionally presented at all times.
2. Lead the strategic planning and operational implementation of the Trust's preparations for the Public Inquiry in line with the Terms of Reference set by the Inquiry Team, creating and maintaining focus and momentum and proactively monitoring its progress, resolving issues and initiating corrective action.
3. Responsible for the overall integrity and coherence of the overall public inquiry Programme, developing and maintaining the Programme environment to support each Programme strand within it through an effective Public Inquiry Management Office.
4. Design, establish and then manage the Programme management structures and processes.
5. Define the Public Inquiry Programme's governance arrangements, including preparation of an initial risk log.
6. Ensure robust communication strategies internally and with external organisations / stakeholders to ensure compliance with all performance targets and deadlines associated with the Inquiry Programme. This may involve representing the Trust in various forms of media e.g. radio, TV, social media.
7. Research, develop and issue guidance on the capture, retention, disclosure, and management of records and documents likely to be required for the Inquiry, in collaboration with the information governance and IT teams and in accordance with all requirements of the Inquiries Act 2005.
8. Lead on the preparation of chronologies, decision logs, and position papers on all relevant aspects of the Public Inquiry response, working in collaboration with Executive Director colleagues.
9. Proactively manage the key risks and issues associated with the Inquiry response, ensuring appropriate actions are taken to mitigate or respond, reporting as necessary to the Chief Executive, Senior Management Team, Trust Board and

other key stakeholders.

10. Manage the relationship with the legal advisors appointed to support the Trust's response to the Inquiry.
11. Lead on briefing and correspondence related to the Public Inquiry, ensuring that the Senior Management Team and Trust Board are kept up to date with an appropriate level of detail in a fully open and transparent way.
12. Establish effective working relationships with senior stakeholders across the health system to ensure that the Inquiry preparations are appropriately managed.
13. Secure resources and expertise as required.
14. Establish, with the Assistant Director, a common approach to major issues that arise throughout the course of the Programme.
15. Lead on communication with and support of all employees, including former employees who will be required to provide evidence to the USI.
16. Establish and manage systems of working so that the Director of Acute Services and the Medical Director, as workstream leads, are supported to deliver to the workstream objectives.
17. Establish and manage systems of working that hold to account, on behalf of the Chief Executive, workstream leads for the delivery of all activities within the workstream, including establishing formal reporting arrangements on Programme progress.
18. Be responsible for the understanding and analysis of all information submitted to the USI.
19. Assume overall responsibility for briefing and supporting staff who are required to participate in the Inquiry and for providing guidance on best practice throughout the Inquiry process.
20. Respond to any queries of the Inquiry Panel and the Director of Legal Services and to ensure the timely provision of witness evidence, and other evidence, as stipulated by the Inquiry Panel.

Collaborative Working and Communication

21. Establish collaborative relationships and networks with internal and external stakeholders.
22. Be responsible for developing and maintaining sound internal and external communications systems.
23. Represent the Trust, as appropriate, on external groups and to represent the

Director where appropriate and as required in respect of the Trust's approach to the Public Inquiry.

Financial and Resource Management

24. Responsible for the management of the financial allocation/budget associated with the Trust's preparation and involvement in the Public Inquiry.

People Management and Development

25. Be responsible for the line management of the Public Inquiry administrative team
26. Promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.
27. Be responsible for his/her own performance and take action to address identified personal development areas.
28. Manage recruitment processes, to ensure staff are recruited in a timely and professional manner and vacancies are filled appropriately.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines

within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND **Programme Director for Public Inquiry and Trust Liaison Band 8D**

DIRECTORATE **Chief Executive's Office**

HOURS **37.5 per Week**

December 2021

Notes to applicants:

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

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience / Qualifications	1. Currently employed by the Southern HSC Trust. 2. Have a university degree or relevant professional qualification at graduate or diploma level **AND** worked for at least 2 years in a senior management role in a major complex organisation reporting to Director level or equivalent. 3. Worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a	Shortlisting by Application Form

	minimum of 3 years in the last 5years. 4. Successfully demonstrated high level people management, governance and organisational skills for a minimum of 3 years in the last 5 years, and; 5. Have a proven track record of running large, successful programmes or projects which have delivered business change.	
Other	6. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criterion will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	7. Have exceptional communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff within the Trust, and outside the organisation regarding highly sensitive and contentious matters. 8. Have the ability to collate and critically analyse statistical and qualitative information and the ability to make and take decisions after analysis of options and implications. 9. Astute. Strategic and broad perspective and awareness of how this relates to the Public Inquiry Programme. 10. Determination, drive to succeed, perseverance, and resilience. 11. IT literacy -proficient in MS Word, Excel, PowerPoint, etc.	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Knowledge	1. Knowledge / Experience of Legal Processes 2. Knowledge / Experience of Clinical Services	Shortlisting by Application Form

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

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

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

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

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

Quality Care - for you, with you

ISSUE	ACTIONS	WORKGROUP	TIMESCALE
EQUIPMENT Broken Equipment – letters to management over 1.5 years with virtually no response. 2 working rectoscopes by pulling all the instrumentation from two trays they could another two sets. Equipment too old, not on a service contract, pieces are vulnerable with a piece falling off intraop (Clinical incident completed – no response back) Same equipment, different suppliers STORZ and WOLF sets Can't tell the exact	Ownership of the problem Who actually owns the problem and who will take it forward? Service contract?? Guidelines on safety – does management agree with this Incident Reports – how are these brought back to the team. Does anything happen? Has there been any raised for this problem Baseline Audit required. Last one 4 – 5 years ago for urology initiative. Harvested the higher standard of equipment and investment made at that time for new equipment. Require a further audit Standardise equipment? Location of procedures – what site will procedures be carried out – what equipment needed for each site Service contracts for equipment Following eg 50 uses, should these be	Ronan Carroll Mary McGeough Martina Corrigan Mr Young Mr O'Brien Mr Akhtar Beatrice Moonan Theatre sister Sandra McLoughlin	Initial Meeting to take place by week ending 6 November. Audits etc to be completed by week ending 20 November Report back by end of end of November.

numbers of forceps for stents. Utererscopes – only have two – one is broken so only one available for procedures. Flexible uteroscope – only one 'old' scope. There should be 3-4 flexible and 4-6 rigid to meet urology service needs	serviced Decontamination of equipment and affects on equipment New technology for the future.		
WARD RECONFIGURATION	Where is the 3 month review What was to be gained from fragmenting the service between emergencies, longstay and shortstay? Would it have been better for urology to share as a specialty on one ward to bring the same number of bed reductions? Affects to patient care with patients have to move between wards so many times. Quality?? What do the urology team and nursing	Heather Trouton Martina Corrigan Noleen O'Donnell Catriona McGoldrick Nursing Staff Mr Young Mr O'Brien Mr Akhtar Sharon Glenny	3 Monthly review meeting organized for November 2009 Report of findings to Urologists by end of November

	staff see as the better “system” for caring for patients. Safety for patients Expectations on nursing staff, eg, emergency care ward and the movements of patients/patient flow. Are management aware of the concerns from clinical and nursing staff? Do they see the problem first hand? Emergency ward should be 100% emergency, not a mixture of elective and emergency. Patients could be moving 3 – 4 times during the course of their stay. Patients may only be staying on one ward for 6 hours! All wards should be equipped to deal with all types of patients, depending on where they will be staying. Was cutting beds to save money the most effective? What about clinical teams having to move around to see patients. Loss to patient care and quality of care		

	What is best for urology department? Need clear ideas and deadlines Having now sampled existing model		
Clinical Day Care Centre *IV Fluids and Antibiotics*	Business case to staff CDCC unit regularly for patients for IV fluids and antibiotics as admission avoidance to wards ??having junior anaesthetist to get peripheral venous access. Management keen for this to go ahead. Need to know which patients are suitable for this unit and how often they require treatment. Most days have access to beds and 2 side rooms. Side rooms used for intravesical chemotherapy. ??urology ambulatory day case	Shirley Tedford Martina Corrigan Sheila Mulligan In Liaison with three Urologists	Mid-December
Intravesical chemo	Janice has now moved across Cost centre required Supplies being order through 4 north	Shirley Tedford Martina Corrigan Janice	Mid- December
Trial Removal of	When in 2 south had bed capacity – now	Shirley Tedford	Mid-December

Catheter	don't Some done in the community if appropriate. Those that need brought back to CAH go to CDSW. Catheters removed, scanned, regs contacted and discharged home. Would like to move to ambulatory day area. Staff there qualified to do catheterization, bladder scans, etc. Patient who are going on end of urodynamics sessions for TRC/change of catheter could go to ambulatory area. Protocols to be written for this. Cant depend as much on community staff as have done in past. When patients attend A&E and sent out to community, this area will give a base to be referred on to.	Martina Corrigan Mairead Leonard Nicola McClenaghan In liaison with three Urologists	
Clean intermittent catheterization	There are some patients who need to come into hospital Propose that they come into ambulatory area rather than beds.	Shirley Tedford Martina Corrigan Martina (Community-based) Wendy(Community-based)	Mid-December