Section 9: Risk Acceptance Framework

The Trust recognises that it is impossible, and not always desirable, to eliminate all risks especially in the delivery of care to patients/clients. A mark of good risk management is the innovative and imaginative use of resources in finding ways to avoid or reduce risks whenever possible.

Fine and balanced judgments will be necessary regarding the health and welfare of individuals especially within a person centred approach to patient/client care. It is sometimes the case that a higher level of risk may be accepted to facilitate a new and innovative service, which increases the quality of life for patients/clients.

The risk management process should identify the hazard and apply appropriate risk assessment and management action plans. Regardless of the level of risk assessed, all risk assessments must be recorded in the risk register, monitored and reviewed when necessary, determined by the risk rating, to ensure desirable outcomes.

Despite thorough risk assessment and management action plans, things can still go wrong and it is therefore essential that there are controls in place to deal with this situation.

It is crucial that Business Continuity Plans/local emergency plans are in place for the management of situations in which control failure leads to material realisation of risk.

Definition of Risk Appetite and Tolerance

Definition of Risk Appetite
According to ISO 31000, a risk appetite definition is “the amount and type of risk that an organization is prepared to pursue, retain or take.”

Tolerance Is related to risk appetite. It is the level of variation the organisation is willing to accept around ***specific*** objectives. (Institute of Risk Management)

Risk Appetite General Statement

The Trust must take risks in order to achieve its aims and deliver beneficial outcomes to stakeholders. Risks will be taken in a considered and controlled manner. Exposure to risks will be kept to a level deemed acceptable by the Board

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, risk appetite should address several dimensions:

- The nature of the risks to be assumed;
- The amount of risk to be taken;
- The desired balance of risk versus reward;

The overarching areas of:

- Risk to patients / service users

- Organisational risk
- Reputational risk
- Opportunistic risk
- Financial risk

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk."

Appetite Level	Described as
None	**Avoid** the avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Moderate	**Cautious** the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
High	**Open** and be willing to consider all potential delivery options and choose while also providing an acceptable level or reward (and VfM)
Significant	**Seek** and to be eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature** being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety.
However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust's greatest appetite to pursue innovation and challenge current working practices in terms of taking opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Risk Acceptance Framework Categorisations

The Risk Acceptance Framework for the Southern Trust applies a 'traffic light' system with regard to the categorisation of risks against the scale of very low, low, moderate and high. The categorisation of risk against these scales determines if a risk is acceptable or not, and the level and urgency of intervention required. The Risk Acceptance categorisation process should be applied as a guide. Individual managers are encouraged to consider the acceptance of risk on an individual case by case basis. This judgement should be used to inform the level and urgency of action required. The 'traffic light' system applied to the Risk Acceptance Framework is as follows:

Green Risks (Low)

Identified risks which fall in the green area are deemed as low (acceptable) risks and may require no immediate action, but must be monitored regularly to assess if and when action is required. These risks must be entered onto the local Risk Register.

Yellow Risks (Medium)

Identified risks which fall in the yellow area are deemed medium risk to the Trust but require action to reduce the risk. Responsibility for taking action would normally remain at a local level within the appropriate Directorates / Service Areas and be entered on the Team / Service Risk Register.

Where these risks cannot be managed locally they should be forwarded to the appropriate Directorate Governance Fora for consideration for further local action, resourcing or acceptance by the Directorate Governance Fora for the Directorate Risk Register.

These risks must be entered on the local risk register and where appropriate the Directorate Risk Register for information and monitoring purposes.

Amber Risks (High)

Identified risks which fall in the amber area are deemed high risk to the Trust and require prompt action to reduce the risk to an acceptable level. When risks cannot be reduced locally they should be submitted to the Directorate Governance Fora for consideration and recommended action, i.e. further local action, resourcing or acceptance.

Where these risks cannot be managed within the Directorate they should be referred to the Senior Management Team for consideration and/or addition to the Corporate Risk Register.

These risks must be entered on the local risk register and where appropriate the Directorate Risk Register.

Red Risks (Extreme)

Identified risks which fall in the red area are deemed extreme risk to the Trust and must be reported to the appropriate Director and Chief Executive. Immediate action is required to reduce the level of risks to an acceptable level. The appropriate Director will ensure the implementation of a time monitored action plan with regular reports to the Chief Executive and Governance Committee.

SMT will be the gate keepers of the Corporate Risk Register and will use the following criteria to inform their decision making in escalating risks to the Corporate Risk Register.

- The risk represents an issue that has the potential to hinder achievement of one or more of the corporate objectives
- The risk cannot be addressed at directorate level
- It requires further control measures to reduce or eliminate the risk
- It is likely to require considerable input of resources to resolve the risk (finance, people, time, etc)

These risks will be entered onto the Directorate, and if appropriate the Corporate Risk

Register(s) for monitoring by the SMT.

Where the identified risks have the potential to threaten the achievement of the Trust's corporate objectives, they will be escalated by the SMT to the Board Assurance Framework.

Any definition of risk must be pragmatic and time dependent as the passage of time will reduce the tolerance of risk once deemed acceptable. In an attempt to help prioritise all risks the following definitions should be applied as a guide to the management of risks by the Trust:

Definition of Acceptable Risk

As a guide the Trust considers green (low and medium) risks to be acceptable (as defined by the risk rating matrix, Figure 6).

This definition is to be used as a guide only and managers are encouraged to take action on green and yellow (low and very low) risks identified particularly when these risks can be easily eliminated or reduced.

Definition of Unacceptable Risk

The Trust considers all amber (high) and red (extreme) risks to be unacceptable (as defined by the risk rating matrix, Figure 6). Managers are expected to take immediate action on amber (high) and red (extreme) risks identified and document action taken.

Definition of Significant Risk

Those red (extreme) risks, which have been identified as potentially threatening the achievement of the Trust's objectives or represent significant gaps in controls / assurances, are escalated by the SMT Governance to the Board Assurance Framework.

In addition to these guidance notes, Directors, Directorates, Service Areas etc. should consider notifying the Governance Committee and Trust Board of frequently occurring lower graded risks via SMT.

The Corporate Risk Register will be reviewed monthly by the SMT. Trust Board review the Board Assurance Framework bi-annually in conjunction with a high level summary of the Corporate Risk Register.

The Corporate Risk Register is also shared with the Department of Health mid-year and year end as part of the accountability process.

Where the resolution of a risk includes funding implications that cannot be contained within the available budgets, a business case should be developed as part of the Trust's business planning process.

Risk Treatment / Action Planning

A risk action plan should be developed to document the management actions and controls to be adopted. The plans should involve:

- Formulating and selecting risk treatment options;
- Planning and implementing risk treatment;
- Assessing the effectiveness of that treatment;
- Deciding whether the remaining risk is acceptable;
- If not acceptable, take further treatment/action.

It is the responsibility of the Clinical and Social Care Governance Coordinators for the Directors of Acute, Children and Young People, Older People and Primary Care and Mental Health and Disability in conjunction with relevant Directors/Senior Managers/Heads of Service to develop and maintain risk action plans for Directorate/Departmental risk registers.

On the delegated authority of the Chair (the Chief Executive) of SMT Governance, the Board Secretary, is responsible for maintaining risk action plans for the Corporate Risk Register.

Risk action plans should be developed using the proforma (and maintained in a suitable electronic format) incorporating the following information:

- Risk ID Number
- The action to be taken and the risks such actions address.
- Identified individual(s) responsible for implementing the plan.
- Budgetary allocation (where appropriate)
- Timetable for implementation
- Details of mechanism and frequency or review of action plan

Risk Registers

Each Directorate maintains a risk register. Each Directorate has a forum in which these Risk Registers are monitored. Each Directorate Risk Register is owned by the Director for that Directorate. It is the responsibility of Clinical and Social Care Governance Coordinators for the Acute, Children and Young People, Older People and Primary Care and Mental Health and Disability Directorates to maintain Directorate level risk registers in conjunction with relevant Directors/Senior Managers/Heads of Service.

Risks identified at a corporate level will be recorded on the Corporate Risk Register which is managed by the Senior Management Team. It is reviewed by SMT review on a monthly basis and reported to the Governance Committee who review it on a quarterly basis providing challenge and advice. Based on the knowledge of risks identified, Directors will determine the level of assurance that should be available to them with regard to those risks.

With regard to both Directorate/Departmental and Corporate Risk Registers risks will be

entered in accordance with the risk rating and action guidance. Risk registers should be developed using the proforma attached in Appendix 1.

- Risk ID Number
- Source
- Risk title and description (including location and local details)
- Potential for harm
- Summary of current control measures
- Initial risk rating
- Action plan
- Nominated person responsible for each action
- Review date
- Monitoring arrangements
- Lead individual

Board Assurance Framework

The Board Assurance Framework is the tool used by the Board to identify high level risks to the delivery of the Trust's corporate objectives and provide assurances for the control and management of those risks. The Board Assurance Framework works 'top down' from the Trust's corporate objectives determining proactively, the high level risks and what controls and assurance processes are in place. As part of the process, the Trust Board is committed to discussing and making the connections between the corporate objectives, the high level risks that could affect achievement of those objectives and the range and effectiveness of existing assurance reporting. The Trust Board own the Board Assurance Framework and review it on a six-monthly basis.

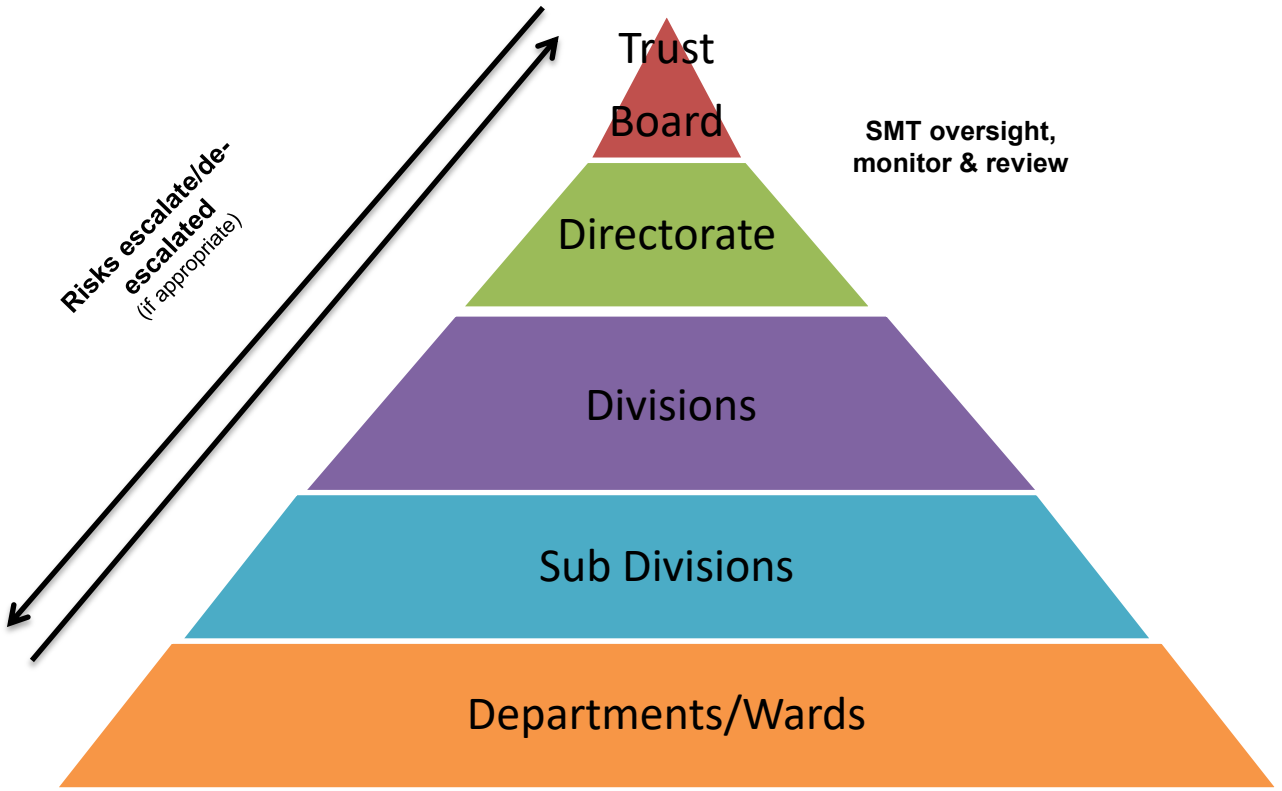
Risk Monitoring and Review

Monitoring and review should take place in all stages of the process. Monitoring and review includes planning, gathering and analysing information, recording results and providing feedback. The results of monitoring and review should be incorporated throughout the organisation's performance management, measurement and reporting activities.

Risk Escalation and De-Escalation

The grade of each risk not only determines who is responsible for managing the risk but also where it should be escalated to – Division, Directorate or Trust level. The timescale in which risks are escalated varies or assurance on the management of a risk varies according to the significance of the risk. This may be through routine monitoring systems or fast tracked. Senior Managers and Directors use judgement to determine the timescale for escalation, influenced by the impact the issue has on the delivery of safe, high quality care or organisational reputation.

It is the responsibility of the Chair of each group or committee to escalated risks, to ensure each escalated risk is reconsidered in the context of other risks already included in the Risk Register at that level. Each Risk Register should be reviewed to identify and understand themes in risks on the register, how this impacts on each other and the Trust and whether this identifies new risks or affects the grade of existing risks.
When actions to reduce a risk have been completed and the risk score is lowered to a level that no longer requires inclusion on a risk register, the risk can be de-escalated.



Assurance and Escalation Pyramid

Risk Owners

Each risk that is identified in a risk register will have a risk owner who will:-

- Ensure adequate and effective controls are implemented
- Review and update individual records regularly

Risk Recording and Reporting

The risk management process and its outcomes should be documented and reported through appropriate mechanisms

Risk Strategy Education and Training

The Trust is committed to the education and training of all staff which ensures the welfare and health and safety of patients, clients and the public.

Risk management training will be assessed and delivered by the Directorate Governance Teams based on organisational/staff needs. Directorates are required to maintain risk management training records, monitor attendance of staff at training, and report on risk management training to SMT Governance as required. Trust induction programmes will include standardised risk management training.

Appendix 1 – Trust Risk Assessment Form for Risk Register

<table>
<tr><td colspan="4">SOUTHERN HEALTH & SOCIAL CARE TRUST</td></tr>
<tr><td colspan="3">RISK ASSESSMENT FORM</td><td>Risk ID No</td></tr>
<tr><td>Directorate:</td><td colspan="2">Facility/Department/Team:</td><td>Date:</td></tr>
<tr><td colspan="2">Where is this being carried out?
(e.g. Trust premises/home of client/staff/ private nursing home etc)</td><td colspan="2">Objective(s) i.e. Corporate, Legislative requirements etc.</td></tr>
<tr><td colspan="4">Risk Title: (Threat to achievement of objective)

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)

Outline the potential for harm: (Consider injury to client, staff, litigation, etc.)</td></tr>
</table>

Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).

Are these controls: (a) Effective or (b) Require Further Action *(if [b], complete Action Plan)*

Please list control measures considered but discounted and why (where appropriate):

Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating L and C = RR e.g. Likely and Moderate = YELLOW

ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):

Action/Treatment	Action Lead	Start Date	Target Date	Progress/Review Date
Date of first review (to be determined by risk rating)				

Predicted Risk Assessment once all control measures are implemented	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating L and C =RR e.g. Likely and Moderate = YELLOW

Carroll, Ronan

From: Corrigan, Martina
Sent: 09 May 2022 17:48
To: Carroll, Ronan
Subject: FW: Patients to be added to Urgent Bookable List
Attachments: [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg; [redacted].jpg

From: Haynes, Mark [redacted]
Sent: 11 June 2020 12:47
To: OKane, Maria [redacted]; Carroll, Ronan [redacted]; Corrigan, Martina [redacted]; McClements, Melanie [redacted]
Subject: FW: Patients to be added to Urgent Bookable List

Afternoon

Attached are the green forms as mentioned and highlighted are cases in particular that should have been added to the waiting list at the date indicated. Also attached (in addition to the WL forms) is a copy of the full urology WL as of 11/5/20. 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.

Mark

[redacted]				
	18/07/2019	Malignant	URO	Replacement of
	05/11/2019	? Malignant	URO	Bilateral Ureterol
	01/06/2020	Malignant	URO	TURP
	04/06/2020	Malignant	URO	Bilateral Ureterogr
	15/09/2019	Benign	URO	Right Rigid & Flex
	11/09/2019	Benign	URO	Removal / Replac Lithotripsy
	11/02/2020	Benign	URO	Removal / Replac Lithotripsy
	13/05/2020	Benign	URO	Right Ureterosco
	14/05/2020	Benign	URO	Removal / Replac
	15/05/2020	Benign	URO	Removal of Bilate

From: O'Brien, Aidan
Sent: 07 June 2020 22:25
To: Neville, Linda; McIlveen, Jacquleine
Cc: Sector, Independent; Glackin, Anthony; Haynes, Mark; Elliott, Noleen
Subject: Patients to be added to Urgent Bookable List

Dear Linda and Jacquleine,

I added a list of ten patients to the existing list of patients for urgent admission and submitted it to Tony Glackin on Thursday 04 June 2020.
Mark Haynes has already arranged to have the first of those patients, Patient 113 , admitted to Kingsbridge Private Hospital on Wednesday 10 June 2020.
I have scanned and attached completed Green Forms for the remaining nine patients.
I have copied them to Noleen, my secretary, who will return to work on Tuesday 09 June 2020.
Please let me know if I can be of any further assistance.
I hope the above will facilitate their admissions.

Thank you,

Aidan.

UROLOGY ASSURANCE GROUP (UAG)

Monday 1 November 2021 at 2.00pm, by Zoom

Draft Minutes

FOI Implications: May not be disclosed Section 22 Information intended for future publication, Section 33 audit functions, Section 35 formulation of Government policy refers.

Jim Wilkinson, DoH (Chair)	Aidan Dawson, PHA
Lourda Geoghegan, DoH	Brid Farrell, PHA
Robbie Davis, DoH	Shane Devlin, Southern Trust
Anne-Marie Bovill, DoH	Stephen Wallace, Southern Trust
Sharon Gallagher, DoH	Maria O'Kane, Southern Trust
Ryan Wilson, DoH	Heather Trouton, Southern Trust
Paula Ferguson, DoH	Martina Corrigan, Southern Trust
Paul Cavanagh, HSCB	Melanie McClements, Southern Trust
Caroline Cullen, HSCB	

Apologies: Richard Pengelly, DoH, Michael McBride, DoH, David Gordon, DoH,

Welcome and apologies

1. The group was welcomed and apologies noted.

Minutes of previous meeting

2. The draft minutes of the previous meeting were agreed.

Actions from previous meeting

3. Action: Southern Trust (Shane Devlin / Stephen Wallace) to continue to engage with RQIA regarding possible assistance in gaining accessing Mr O'Brien's Private patients.

   Action: Southern Trust agreed to liaise further with DLS, to provide clarity on presentational concerns and to ensure that the letter to Mr O'Brien issues in early course.

Update: Shane Devlin advised this work is still ongoing. The Trust has no right to gain access to the information on private patients. There is potential the USI may be able to access this through law. The group noted a paper has been prepared by the Department and sent to DSO to seek advice.

4. Action: DoH to arrange a meeting with Trust Staff in October 2021.

   Update: Jim Wilkinson advised a meeting will be arranged between Richard Pengelly and the SHSCT staff.

5. Action: DoH to meet with HSCB and the Trust to agree urology recall/lookback review terminology and revise future UAG agenda items accordingly.

   Update: Robbie Davis advised this meeting took place and the agreed terminology is “lookback”.

6. Any other actions arising from the previous meeting were addressed during the course of the meeting.

Trust Update (Southern Trust)

7. The update report provided by the Southern Trust and circulated to UAG members prior to the meeting was noted by the group. This paper included a summary of progress relating to the Patient Record Scoping Exercise, SAIs, Structured Clinical Record Reviews and Private Sector issues. The following matters were discussed by the group:

<u>USI</u>

8. Heather Trouton advised that the Trust had received the Section 21 notice from the USI and had commenced collating the information requested. The group noted the reference to “recall” being used and it was agreed to confirm the terminology as “lookback” with the USI team.

Action: DoH to confirm terminology with USI team.

9. Heather confirmed that the USI are intending to make contact with all patients involved in the lookback. The group discussed, noting the Trusts intention to minimise any distress to patients. Heather confirmed the Trust will commence making contact with those patients involved in the lookback.

Action: SHSCT to contact all patients involved in the lookback

Lookback Review

10. Heather informed the group that the lookback review was progressing slowly. It was noted that the Trust have completed the Risk Assessment from the Lookback Guidance and have formally written to HSCB to request that the other Urology Teams help out with their current new patients until they have reviewed all of the patients in the current cohort of patients. The group noted this is a regional priority and best endeavours must be given to resolve.

11. Melanie McClements advised that interviews will be held on 8th December for 2 urologist vacancies. The group noted should they be successful it will still be a couple of months before they would be in place.

Private Practice

12. The group noted the Trust discussed mechanisms for obtaining private practice records with RQIA and the DoH on the 28th September. A revised correspondence has been drafted in collaboration with DoH, RQIA and the Trust, and DoH have sent to DSO for comment.

Cohort 1 Outcomes Report

13. A paper on the Outcomes Report was provided by Paul Cavanagh and shared with the group prior to the meeting. Paul advised that as this is recognised as a “lookback” that will determine the structure of the report.

14. Paul advised that nine questions are being asked as part of the lookback and each question will be reported on within the Outcomes Report. The report will focus on the cohort of patients who had been under the care of the Consultant for the period January 2019 to June 2020. Paul advised the intention is that an outcomes report will be completed for the Cohort by May 2022.

15. The group noted concerns that nine questions was a large number and may not be feasible to report on. The group noted:

    - Qualitative questions can become complicated when reporting;
    - Learnings from Neurology – use of 3 questions;
    - Time it may take for larger number of questions given current pressures; and;
    - Recommended consideration be given to streamlining questions.

    It was agreed the Trust and HSCB should reconsider questions.

Action: HSCB and SHSCT to reconsider lookback questions and agree final methodology.

Preparations for extending the Urology Review

16. The group noted there is no intention to extend the lookback at this point in time.

17. Heather informed the group that the Royal College of Surgeons are continuing to look at 100 patient records, this exercise will inform any extension.

Public Inquiry

18. The group noted the USI was now live and the evidence gathering process underway. The DoH are currently aligning staff structures to ensure a separation between review staff and inquiry liaison staff. Shane Devlin advised they are trying to mirror this structure within the Trust with a separate team for the Inquiry, Lookback and Improvements.

19. The group agreed as the Inquiry is now live, it should be removed as an agenda item from the UAG meetings.

Action: Public Inquiry to be removed as agenda item

Communications

20. No communication issues.

Any other business

21. The Trust noted the use of the SJR process for aspects not falling under SAI was non-routine practice, and suggested quality assurance of its use would be appropriate.

Action: Shane Devlin to ask the Permanent Secretary to request RQIA quality assure the Trust SJR process.

Date of next meeting

22. The next UAG meeting will be held mid December. Date to be confirmed in due course.

Annex 1

Action Log

Action	Date of Meeting	Owner	Actioned
DoH to confirm terminology with USI team.	1/11/2021	DoH (Robbie Davis)	
SHSCT to contact all patients involved in the lookback.	1/11/2021	Southern Trust	
HSCB and SHSCT to reconsider lookback questions and agree final methodology.	1/11/2021	HSCB / Southern Trust	
Public Inquiry to be removed as agenda item.	1/11/2021	DoH	
Shane Devlin to ask the Permanent Secretary to request RQIA quality assure the Trust SJR process.	1/11/2021	Southern Trust (Shane Devlin)	
To continue to engage with RQIA regarding possible assistance in gaining accessing Mr O'Brien's Private patients.	6/9/2021	Southern Trust (Shane Devlin / Stephen Wallace)	Ongoing

To liaise further with DLS, to provide clarity on presentational concerns and to ensure that the letter to Mr O'Brien issues in early course.	6/9/2021	Southern Trust	Closed
To meet with HSCB and the Trust to agree urology recall/lookback review terminology and revise future UAG agenda items accordingly.	6/9/2021	DoH (Robbie Davis)	Completed
To prepare a paper to present Urology Outcomes Report options for UAG consideration at the next meeting.	6/9/2021	Paul Cavanagh	Completed
To liaise with Christine Smith to discuss issuing a communique to SHSCT staff on the USI Terms of Reference.	6/9/2021	DoH (Jim Wilkinson and Robbie Davis)	Ongoing
To approach Belfast and Western Trusts to accept the repatriation of Urology patients as a formal request from the Urology Assurance Group.	18/6/2021	Southern Trust	Completed

To consider Outcomes Report learnings.	18/6/2021	DoH (Michael O'Neill) and Paul Cavanagh (HSCB)	Ongoing
Outcomes Report to become standing agenda item.	18/6/2021	DoH	Completed
To amend UAG agenda to reflect changes agreed.	18/6/2021	DoH	Completed
To consider other relevant reports (NI Audit Office, Patterson Inquiry Report and RQIA Report) in conjunction with the SAI recommendations.	14/5/2021	DoH (Michael O'Neill/Anne-Marie Bovill) and Southern Trust (Shane Devlin)	Ongoing
To explore if GDPR exemptions can be applied in order to gain direct access to Mr O'Brien's private patients.	14/5/2021	Southern Trust (Shane Devlin)	Ongoing
To consider the letters of apology being issued to SAI families and the potential for further wider media communications with private patients and GPs.	14/5/2021	DoH (David Gordon) and Southern Trust (Shane Devlin)	Ongoing

To provide an outline of the overarching themes within the draft Inquiry ToR.	14/5/2021	DoH (Michael O'Neill) and Southern Trust (Shane Devlin)	Completed
To consider the Patient Review form going forward and retrospectively to ensure a comprehensive and consistent review.	16/4/2021	Southern Trust (Melanie / Maria)	Ongoing
To consider the MDM issues raised at a system level and on a Trust wide basis.	16/4/2021	HSCB (Paul Cavanagh / Sharon Gallagher)	Ongoing
To establish a suitable date for Trust staff engagement meeting with Mr Pengelly and Dr McBride.	16/4/2021	Southern Trust (Shane Devlin)	Ongoing
Prepare the Trust to support and service a full Public Inquiry in adherence to the Inquiry Rules 2006.	19/3/2021	Southern Trust (Shane Devlin)	Ongoing

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Co-Ordination Group
Minutes

Thursday 25th November 2021, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Melanie McClements (Chair) Martina Corrigan — Stephen Wallace Heather Trouton — Jane McKimm Mark Haynes — Sarah Ward Caroline Cullen — Ronan Carroll Sylvia Irwin — Damian Gormley **Apologies** Dr Maria O'Kane Paul Cavanagh Dr Brid Farrell	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Melanie welcomed everyone to the meeting Melanie explained that going forward the Urology Inquiry would consist of 3 separate sections, (i) Urology Inquiry - led by Heather (ii) Lookback Exercise - led by Melanie (iii) Service Improvement - led by Dr O'Kane. Melanie noted that the Service Improvement section would be further divided into Cancer Clinical Services, (Ronan, Sarah & Dr Tariq's remit) and the Medical Director's Office, (Dr O'Kane/Stephen Wallace). The purpose of this meeting will be to bring together updates from the various strands identified above with HSCB/PHA colleagues. Caroline agreed with this analysis and suggested that going forward the agenda would be based around these separate areas.	

	Melanie noted that in discussions at earlier meetings it had been suggested that the Lookback Guidance recommended this meeting would be chaired by her as Director of Acute Services. However, she noted that having read the guidance in great detail, she was unable to find this reference to responsibility for chair of these meetings as Director of Acute Services. Melanie also noted the governance aspect of the meeting being chaired by Trust staff. Caroline agreed to follow this up with Paul and get back to Melanie.	**Caroline to discuss Chair of future meetings with Paul & update Melanie**
	• **Minutes of the Previous Meeting 28th October** - The minutes of the meeting held on 28th October were agreed.	
	• **Matters Arising from Meeting 28th October** Melanie gave an overview of the Matters Arising and the following points were noted. Action 1 - UAG update - The Trust agreed to forward the Trust update reports to Caroline prior to the next UAG meeting mid-December.	**Sarah to forward update reports to Caroline by mid-December**
	Action 53 - Stephen/Caroline to liaise re SAI Learning/Recommendations - This is ongoing.	
	Action 64 - Melanie to provide update to Paul once Internal Audit report has been reviewed internally - Melanie confirmed the Internal Audit report had been shared with the confidential Trust Audit Committee and the Trust Governance Committee. She confirmed that she will forward the Governance Committee update to Paul for information. Action now complete??	**Melanie to forward Governance Committee update on Internal Audit report to Paul??**
	Action 85 - Martina - To share 3 patient requests received about sharing their experiences, with P Ferguson, DoH - Action completed October 2021	
	Action 88 - Heather to share Trust proposal for Urology Group Structure going forward - Heather agreed to forward proposal to Caroline as soon as possible.	**Heather to share Trust proposal for Urology structures going forward with Caroline**
	Action 89 - Martina to share final draft of Lookback Risk Assessment by Friday 29th October - Martina confirmed this action is now null and void as the Trust is now going to write out to all patients.	
3	**Terms of Reference for Southern Urology Oversight Group**	
	Melanie noted this draft was based on the Regional Group and the Trust document should mirror the external group. Sarah shared the draft document and discussed each of the main points with the group. The main points of the discussion were:	

	• Risk Assessment will be an agenda item at each of the Trust future weekly meetings going forward. • The Trust is now in Stage 2 of the process. The Terms of Reference will be revised to make it specific to Stage 3, once this commences. • Heather noted the reference to 'recall' should be removed and replaced with 'Lookback' • Scope for each element (Point 4) - This should be used as a checklist to ensure the Trust continues to meet all its requirements. • Action/Work Plan (Point 6) - The Trust will detail the methodology used to date and to be used going forward. • Database of patients - Martina is progressing this and it is near completion. Reports will be provided at the fortnightly meetings • Securing Additional Resources (Point 11) - The need to secure additional resources as required by the team • Communication (Point 12) - The Trust will agree on the information to be provided to service providers included in the Lookback. Melanie noted these Terms of Reference were only specific to the Lookback Review section of the Inquiry and the meeting was more than Lookback. She questioned if a broader Terms of Reference would also be required for all 3 strands of the Inquiry. Caroline suggested that an overarching Terms of Reference for all 3 strands would be appropriate. She agreed to discuss this with Paul. Heather confirmed that she has drafted Terms of Reference for her element of the Inquiry, and she will share with Caroline as soon as they have been finalised. Ronan confirmed there was also a Terms of Reference available for the Service Improvement side of the Inquiry. From the Medical Directorate side of the Inquiry, Stephen confirmed they will begin to develop a Terms of Reference within the next few weeks and this will be included in the Service Improvement Terms of Reference.	**'Recall' to be replaced by 'Lookback' in Terms of Reference document** **Caroline to discuss with Paul the need for an overarching Terms of Reference for all 3 strands of the Oversight Group** **Heather/Ronan to share their draft Terms of References for Inquiry element and Service Improvement element with Caroline**
4	**Public Inquiry Update**	
	Heather noted the Terms of Reference for the Public Inquiry had been received in September and this was followed by the Section 21 request in October with a deadline for a response by 4th November. She confirmed the Trust had managed to reply to 90% of the Section 21 request by the deadline date. In respect of the final outstanding requests (no. 77), Heather noted that she had requested clarification on some of the information requested and an extension had been granted to 10th December. There were also some areas in respect of witness statements and an extension had been granted for these also to 10th December. In respect of Point 58, the release of patient names to the Inquiry, Heather noted the Inquiry team had been made aware of the dilemma this has caused the Trust. The response received from the panel was that it was the Trust's decision whether or not they contact individual members of the public, but the Inquiry team would be making	

	contact soon. Heather confirmed Trust colleagues are in agreement that they will contact all patients within the next few weeks, prior to being contacted by the Inquiry team, in order to prevent causing unnecessary distress to patients. Heather also noted that a second Section 21 request has now been received and this includes a further 27 additional requests for information. This second request is focussing more on the why, how, wherefore timeline of all events that escalated to a Public Inquiry. This would be a breakdown of the decision making process from June 2020 to date and has a deadline for response by 3rd December. Heather also referred to a separate information request which detailed a list of staff members, retired, due to retire and thinking of retiring who will be required to partake in the Inquiry process, if necessary. Heather also advised that the solicitor for the Public Inquiry had contacted DLS to record their appreciation and gratitude to the Trust staff involved for their commitment and efficiency to date and for their openness and transparency. Martina noted this had been approx. 2,500 pieces of information provided to the Inquiry. Caroline on behalf of HSCB/PHA colleagues also acknowledged the commitment of all the Trust staff involved in the process to date. Heather also acknowledged Martina's contribution to the whole process to date and acknowledged that she has been pivotal to the whole process.	
5	**Medical Directorate Update**	
	Melanie noted this section of the meeting would be broken up into the following sections, detailing what the ask is, what the data tells us and the way forward. The summary of patients update table was shared with the group and it was noted that the original starting position of 2,346 patients had been reduced to 2,176 patients. This was due to the fact that 237 patients who had been originally included as patients of Mr AOB had never been under his care and had therefore have been removed from the overall total, leaving a balance of 2,176. Of the 2,176 total patients, 503 are yet to be reviewed; however this could change due to decisions at weekly SCRR meetings. The report also identifies those patients who need to be prioritised (287 patients) and their records will be sent to Professor Sethia for review. The remaining 63 will then be reviewed following this. The SCRR and information line patients will be managed in-house. Sarah talked through the second table which detailed the number of patients reviewed to date and the different types of review undertaken. The remaining 238 patients have had a desktop review carried out by Professor Sethia and will now go through the SCRR process. These patients may then be followed up with a face to face or telephone review.	

Melanie acknowledged the achievement in 1,673 patients already being seen. She also noted the plan to deal with future patients would be discussed at the Trust internal meeting later today.

Caroline raised the issue of a GANTT chart to display the different elements of the process to date but it was felt this would not be suitable. It was felt the patient update table was more appropriate

Damien questioned if the patients with concerns were mostly historical issues regarding the right treatment path. Mark noted the majority of concerns were historic with some relating to patients on Bicalutamide. The patients with concerns are highlighted in the top 2 lines of the patient update report and consist mostly of patients who have contacted the helpline requesting clarification if they are at risk and who will see them.

Damian also questioned the removal of the some patients, previously recorded as under the care of Mr AOB, although seen by another doctor. Mark clarified that these 238 patients had been under the care of 2 different consultants and not Mr AOB. Martina noted that only a very small number of patients fell into this category.

Ronan noted that in summary, 503 patients remain to be seen and 238 patients already seen with concerns, but yet to be reviewed.

Caroline asked if additional causes for concern were identified in 238 patients to be seen would the process be SAI or SJR. Stephen noted that to add more caseload to the SJR process was unlikely to add any additional value and Dr O'Kane has agreed to seek advice from Dr L Geoghegan.

Mark added that as patients are identified they go through a screening process. If the issue has already been addressed, the patients will be put into ?? However, if the process is not already addressed, the cases will go to SJR process.

- IS Capacity - Sarah confirmed the draft specification is with DLS. Ten sets of redacted notes have now been passed to 3FiveTwo Medical and 10 consultants have piloted the Patient Review Form to be used. Feedback on this has been very positive. The Patient Review Form has been reduced from 9 to 4 questions and has been well received. The process will commence once the go ahead is received from the Trust.

- Support from Other Trusts - Melanie referred to a letter received from HSCB Chief Executive earlier today acknowledging current challenges faced by the Trust. It highlighted additionality from Kingsbridge, Hermitage and 3FiveTwo. Additional capacity from SEHSCT was also referenced in the letter and it was acknowledged that the Board will continue to work with the Trust to support them during this challenging time.

Caroline to discuss

	In respect of the additional help from WHSCT, Caroline noted that she had hoped to discuss with David McCormick. Caroline agreed to update Melanie once she had discussed with David. ➢ Core Capacity - Ronan confirmed core capacity contracts had also been agreed with 3FiveTwo. Urology waiting lists are starting to go down. ➢ Continued SJR Process - Of the 77 screened, Sarah confirmed that 37 have been completed and a further 20 will go for screening on Monday. Of the 37 screened to date 7 didn't need an SJR, although there may have been other concerns. In the 30 to go through SJR, Mark highlighted the 2 main issues as delayed referral for radical radiotherapy and management of unlicensed treatment?? Mark requested clarification if the records could be reviewed as two batches or if a sample from each batch could be taken for screening purposes. Stephen suggested that for this first batch the records could be screened as batches but questioned what the response to individual patients would reflect. Damian suggested that clarification should be sought from DoH. Ronan noted that in terms of SAIs they had been looked at collectively but each family received a separate individual response. It was noted that this may not simplify the process and it was agreed that Stephen will discuss further with Dr O'Kane to agree the way forward. Stephen noted the number of SJRs could increase tenfold and therefore the Trust would require an exit strategy to be in place. Melanie noted that if reviews were undertaken as groups, this would free up Urologist's time. It was also noted this process would not affect NI core capacity. Mark noted that it was likely that only 2 issues had been identified as these SJRs were as a result of his first review of prostate cancer patients in November 2020. ➢ Task & Finish Group - Ronan advised the Task & Finish Group continues to meet weekly with the close working group to discuss progress of implementing the 11 recommendations. Meetings are also continuing with the larger group monthly and the family representatives group monthly. He noted that tangible evidence of implementation should begin to be apparent within the next few weeks. Ronan also advised that Dr Tariq is working with MDM chairs on the operational side and Jacqueline Morton, Quality Improvement will commence process mapping. Ronan also advised of an offer from an external body for assistance in processing mapping and QA of the Trust process. The Trust would be keen to avail of this offer. Ronan noted the majority of recommendations should be implemented by Spring 2022. A further update will also be provided to families in January 2022. Caroline noted that her assumption was this process would not be cost neutral. Ronan noted some resources would be required specifically for additional consultant PAs for MDMs and also for tracking the 62 day pathway.	**repatriation of WHSCT patients with D McCormick, PMSI and report back to Melanie**

	Melanie noted the issues currently facing the Trust in relation to job plans etc. were not specific to Southern Trust but were Regional issues. Caroline highlighted the upcoming interviews for the 7th Consultant post and the anticipated additional capacity. Melanie noted that an IPT had been submitted for approx. £2.1m but no funding had yet been received. HSCB and Trust finance colleagues are in discussion regarding the costs associated with the IPT. Heather noted that if the IPT was not funded the Trust would be in an overspend position. Mark noted that any slippage from the 7th consultant post would be required to fund locums. Martina agreed to forward a copy of the IPT to Caroline and Caroline agreed to follow up with HSCB finance. ➢ <u>Service Improvement</u> - Stephen advised that one key piece of work would be around the Private Practice work based on the internal audit report and looking at how it works off-site and on-site. An 8b post is to be appointed to look at patient revalidation and this is also part of the IPT costs. Enhanced medical appraisal is also being progressed along with quantitative audits for appraisals. Damian noted the ongoing issue of performance review and the focus on divisional medical director jobs. Stephen noted that next year will focus on performance management of medical staff and performance support and this would be system wide. The three areas of focus would be job plans, appraisal revalidations and performance management support. ➢ <u>Communication</u> - Jane advised that since the Public Inquiry had commenced external requests had been reasonably quiet. Two documents have been drafted and will be shared internally within the next 2 weeks, explaining the Inquiry process and staff obligations to the process. Jane agreed to share with Caroline. The Trust is meeting next week to discuss communication processes going forward. It was also noted that once the patient letter is sent out next week the patient line will likely see an increase in calls and the patient information line details will be included in the letter to patients.	**Martina to forward a copy of IPT to Caroline & Caroline to discuss with HSCB finance** **Jane to share internal communications documents with Caroline**
6	**Outcomes Report**	
	Melanie noted there was nothing further to report but once the Trust started to work through the remaining 503 patients, a summary outcomes report will be produced by May 2022. The issue of the Patient Referral form was discussed and Caroline highlighted if 9 or 4 questions were to be used. Meanie noted the Trust had a series of discussions over the last few weeks regarding the format of the form to try and resolve this. Melanie referred to the different drafts, one with 3 questions, one with 4 questions and one with 9 questions. It was agreed internally that it was better to limit the form to 3 or 4	

	questions. Damian noted that if the Trust sticks with 9 questions, the number of people willing to undertake a review would be narrowed down. If limited to the first 4 questions then the process could confirm whether or not the patient is on the right current treatment pathway. Melanie noted the 4 questions have been used by Professor Sethia to date. The 4 questions are: (i) Is present diagnosis reasonable (ii) Was the correct pathway adhered to (iii) Was the medication correct (iv) Management Plan?? Damian also noted that although the 9 question format was preferable, the 4 question format was more aligned to the requirements. Melanie noted this was still a work in progress but would have to be concluded soon and she would update Caroline accordingly.	**Melanie to advise Caroline on final format of Patient Review Form (4 or 9 questions)**
7	**AOB**	
	Nothing further to discuss.	
8	**Date of Next Meeting**	
	The general agreement was that monthly meetings were now more appropriate. The date of the next meeting will be **Thursday 6th January 2022, 3.30pm**.	
9	**Action Log**	
	➢ **Caroline** to discuss Chair of future meetings with Paul & update Melanie ➢ **Sarah** to forward update reports to Caroline by mid-December ➢ **Melanie** to forward Governance Committee update on Internal Audit report to Paul?? ➢ **Heather** to share Trust proposal for Urology structures going forward with Caroline ➢ 'Recall' to be replaced by 'Lookback' in Terms of Reference document ➢ **Caroline** to discuss with Paul the need for an overarching Terms of Reference for all 3 strands of the Oversight Group ➢ **Heather/Ronan** to share their draft Terms of References for Inquiry element and Service Improvement element with Caroline ➢ **Caroline** to discuss repatriation of WHSCT patients with D McCormick, PMSI and report back to Melanie ➢ **Martina** to forward a copy of IPT to Caroline & Caroline to discuss with HSCB finance ➢ **Jane** to share internal communications documents with Caroline ➢ **Melanie** to advise Caroline on final format of Patient Review Form (4 or 9 questions)	

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Oversight Steering Group Minutes

Thursday 6th January 11, 2022, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Heather Trouton Martina Corrigan Jane McKimm Damian Gormley Sarah Ward Caroline Cullen Sylvia Irwin **Apologies** Melanie McClements Ronan Carroll Stephen Wallace Dr Helen Rogers	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Paul welcomed everyone to the meeting and apologies were noted. **Minutes of the Previous Meeting 6th January** - The minutes of the meeting held on 6th January were agreed. • **Matters Arising from the Meeting on 25th November** ➢ Trust Update Report to Paul - Paul noted that this had been received. Caroline advised that the report has been re-titled Urology Update Report so as to avoid confusion with the Outcomes Report due by May 2022. Paul referred to the different format of the report and noted that to date he had not received any comments back from DoH colleagues on the revised format. Caroline confirmed that she had also shared the revised report with NICaN colleagues, Cara and Naomi. Paul noted that next UAG meeting was due to take	

	place at the beginning of March and he suggested an update on MDMs would be helpful before the next UAG meeting. **(Is this an action??)** Caroline noted that she would also ask for clarification on Patient Pathways and re-admission of patients from Denise Boulter, DRO. ➢ Repatriation of WHSCT patients - Caroline advised that a further meeting is due to take place the following day at 9.30am. She noted that WHSCT colleagues were reluctant in getting involved; however she was still hopeful to have a plan involving WHSCT and SET in place soon. Caroline also confirmed that funding is available, if required.	
3	**Public Inquiry Update**	
	Heather advised the group that congratulations were due to Jane as her successor as Programme Director for the Public Inquiry. Paul congratulated Jane on her appointment and noted that her involvement to date as Communications Manager would prove invaluable. He also acknowledged Heather's involvement in the group and thanked her for her invaluable contribution. Heather provided an update on progress since the last meeting and highlighted the vast amount of documents submitted to the Inquiry team as part of the first Section 21 notification. In particular she highlighted that copies of the Trust Board minutes had been submitted as requested. These had included many topics of discussions unrelated to the Urology Inquiry. However, Heather noted that the Inquiry team had now requested copies of all associated documents, whether related to the Public Inquiry or not. Heather advised that the Trust had only received this further notification this week and the deadline for this additional information was 28th January. This would involve the download of hundreds of additional documents, within a very tight timeframe. Martina also highlighted the issue of attachments within attachments and noted that all of these attachments had to be copied and submitted to the Inquiry Team by the deadline. Heather confirmed that other Section 21 notices to individuals are also due to be issued within the next few weeks. She noted that this would be a huge amount of work for the Trust to pull this together within the tight timeframe.	
4	**Medical Directorate Update**	
	Trust Update Report - Sarah shared the refreshed report with the group. She noted that since the last update, 19 letters had been sent out and there are now only 358 letters left to be issued. In respect of SCRR reviews, Sarah advised that there are only 8 remaining to be reviewed, however Mr Haynes needed more time to go through these in detail. All other SCRR patients have been contacted by telephone.	

	Clinical activity is continuing to progress as planned and is being dealt with in-house. A Did Not Attend (DNA) alert system is in place and also a text reminder system which should help to reduce further potential DNAs. <u>Task and Finish Group update</u> - Sarah advised that some additional pieces are still being progressed. The 2016 recommendations are also being matched and mapped across with the 2020 recommendations. Sarah also referred to discussions with Cara Anderson regarding the tracking system. Sarah also highlighted the BHSCT system and suggested that Southern Trust was hoping to get something similar. This would be progressed once Dr Tariq returns Personal Information redacted by the USI in February. Sarah also noted that the Trust Cancer Improvement team had met with Clinical Nurse Specialists (CNS) on cancer tumour documents. She advised that the feedback survey should be open within the next few weeks. Job plans for CNS and a CNS database are currently being developed. Sarah noted that the last meeting with service users had been cancelled and the next meeting was due to take place in 2 weeks' time. A template on information sharing has been shared with the group for comments. Sarah confirmed that the structure of a Pathology report for cross-referencing purposes has been agreed. Paul thanked Sarah for the comprehensive update and noted the importance of sharing this at the next UAG meeting in March. Paul requested that an updated report is forwarded to him before the next meeting on 3rd February and a more detailed update on 17th February, as this will be the meeting prior to the next UAG meeting in March.	**Sarah** **To forward update report to Paul by Friday 28th January**
5	**Terms of Reference Urology Oversight Steering Group**	
	Caroline advised that Version 4 of the Terms of Reference for the newly named Urology Oversight Group had been circulated for comments and she would finalise within the next few days. Once this has been finalised, a copy will be circulated to all members.	
7	**AOB**	
	Nothing further to discuss.	
8	**Date of Next Meeting**	
	The date of the next meeting will be **Thursday 3rd February 2022, 3.30pm**	
9	**Action Log**	
	➢ **Sarah** to forward update reports to Paul by Friday 28th January	

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Oversight Steering Group Minutes

Thursday 17th February, 2022, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Martina Corrigan Jane McKimm Dr Maria O'Kane Sarah Ward Caroline Cullen Ronan Carroll Stephen Wallace Dr Helen Rogers Sylvia Irwin **Apologies** Melanie McClements Sophie Lusby Dr Shahid Tariq	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Caroline welcomed everyone to the meeting and apologies were noted. She congratulated Dr O'Kane on her appointment as interim Chief Executive of the Trust. **Minutes of the Previous Meeting 3rd February** - The minutes of the meeting held on 3rd February were agreed. • **Matters Arising from the Meeting on 3rd February** ➢ Trust Update Report to Paul - Caroline noted that this had been received. She referred to the internal meeting that had taken place last week and thanked Sarah for the update report on MDMs, which gave assurance not only in Southern Trust, but across the region. ➢ All other matters arising will be discussed as agenda items.	
3	**Public Inquiry Update**	
	Martina gave an update in respect of the Public Inquiry. ➢ A further tranche of patients to be seen by 31st January. ➢ Section 21 request in respect of former Chief Executive, Shane Devlin was	

	submitted to the Inquiry team on 4th February. ➢ Further Section 21 requests are expected by the first week in March'22. ➢ Witness statements will also be required and Martina noted that any meetings going forward will be discoverable and the Trust is obliged to submit this information. ➢ It is anticipated the Chair of the Inquiry will start speaking to patients April/May. All witness statements are to be submitted by the end of June and the Inquiry is due to commence by September. ➢ Jane noted that when the Section 21 request is received by the Urology clinical team, this will have an impact on clinical capacity. This has been raised with DLS and USI. ➢ It was suggested that this should be re-emphasised at the UAG meeting next week.	
4	**Medical Directorate Update**	
	Sarah talked thorough the UAG update 14th February 2022: ➢ All letters had been sent out, apart from approx. 7 letters which required more investigation. ➢ SCRR screening completed apart from 2 complex cases which require further screening. ➢ Additional clinics had been set up to see patients; however clinician has since caught Covid. ➢ MDM Administrator has now been appointed and some audits on MDM attendance have been commenced. ➢ Task & Finish Group met last Monday and reports have been received from various tumour sites. ➢ The service user group met earlier today. ➢ CNS workshop to be held in March and KPI framework for CNS has been developed. ➢ Macmillan Peer review project being scoped within Trust involving dedicated peer facilitators to support patients through their journey. ➢ Internal process for Advanced Communication Training being reviewed. 2 Options currently for Clinical Education Centre and also Internal Training Package involving cascade training model. ➢ Raised regionally discussion 26.1.22 regarding recording of keyworker on CaPPS. Establishing if a field can be made specific for this, and possibility of mandatory fields with MDM section. ➢ HNA (Historic Needs Assessment) clinics in progress across all CNS. Moving all to the electronic method, with Urology and Head and Neck Cancer operational and Breast and Colorectal next. HNA reflected in job plans across all CNS ➢ Commencing review of "breaking bad news clinics" and how this is recorded, what format these take, are the MDT involved, CNS etc. ➢ Our rescheduled CNS workshop now first week of March will be focused on the KPI framework and HNA clinics. Updates will follow on this. ➢ Urology CNS have revised and updated all Nurse Lead Policies/ Procedures and these are now signed off. This has led to discussions regarding a sign off	

	tracking system to ensure timely sign off and if any issues these is directed promptly to the right person. This process and revision of policies will be rolled out across all CNS. ➢ Job description for MDT Chairs has been circulated and is still under review with specific elements surrounding governance arrangements still being discussed. These will be shared regionally. ➢ Recognised significant deficit within Audit team in SHSCT. Proceeded with process to recruit an MDT auditor role which BHSCT has in place and allows continuous ongoing audit of MDT outcomes and allows for those who have not followed recommended plans to be brought back to MDT for discussion. Scoping JD from BHSCT and will be further discussed within Trust. ➢ Reestablishment of Waiting Time Guidance working group, looking at review and update of 2008 guidelines in keeping with process in England. Group meets next month. ➢ Pathology lab report now operational, allows report to be generated for all positive pathology results for cross checking at MDM. Currently reviewing the content/ format and will be developing SOP for use to ensure robust process and reduce missed results. ➢ 2016 recommendations note input from HSCB- need to set up meeting to review these. Includes Electronic e-referral and e-triage processes, triage target times and Consultant only Triage, CCG system, NICE Guideline 12 implementation. Paul thanked Sarah for the comprehensive update and acknowledged the progress made by the Trust to date. Paul noted the update would be shared with UAG prior to the meeting next week.	
5	**Oversight Steering Group Meeting – 23rd February 2022, 3pm**	
	Paul discussed the items on the UAG agenda with the group and noted that DoH colleagues had requested an update on progress on the Outcomes Report due April/May 22. It was agreed that an update would be provided to Paul for discussion at next UAG meeting on 23rd February. <u>Private Patients</u> - Stephen referred to a meeting he had with Anne-Marie and Robbie last week to discuss the letter to Private Patients. Several options had been discussed and he noted the possibility of using RQIA as a broker. This would be discussed further at UAG meeting next Wednesday. <u>Review of SCRR</u> - Stephen noted that this was being progressed with RQIA and he had also discussed with Dr Lourda Geoghegan. It was agreed that if further SAIs were not an option then SCRR was the best way forward. Paul requested that this was referenced in the updated UAG report to be forwarded next week.	**Sarah to provide update on progress made on Outcomes Report to Paul before UAG 23/2/22**
7	**AOB**	
	➢ Additional Activity outside Trust - Caroline requested a progress update from the Trust.	**Trust to provide update on additional IS activity**

8	**Date of Next Meeting**	
	Paul advised the fortnightly meetings would continue as necessary and the date of the next meeting would be **Thursday 3rd March 2022, 3.30pm**	
9	**Action Log**	
	➢ **Sarah** to provide update on progress made on Outcomes Report to Paul before next UAG 23/2/22. ➢ **Trust** to provide update on additional IS activity	

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Oversight Steering Group Minutes

Thursday 3rd March 2022, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Martina Corrigan Jane McKimm Sophie Lusby Sarah Ward Ronan Carroll Stephen Wallace Damian Gormley Sylvia Irwin **Apologies** Melanie McClements	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Paul welcomed everyone to the meeting and apologies were noted. **Minutes of the Previous Meeting 17th February** - Jane to forward amendments to the minutes of the meeting held on 17th February and the minutes are to be finalised following this. • **Matters Arising from the Meeting on 17th February** ➢ Meeting to discuss 2016 SAI Recommendations - Sophie confirmed that as she is now replacing Caroline on the urology Oversight Steering Group she will follow this up with Caroline and arrange to meet with Trust colleagues to discuss further. ➢ Trust feedback on 20 SCRR cases discussed with Dr Farrell - It was noted that this had been discussed at UAG. Jane noted that there had been no conclusion as to what would flow from these cases. Paul noted that UAG discussions had recommended that the Trust should not undertake any further cases and it was agreed that clinical discussions regarding this matter would be required at the next UAG meeting.	**Sophie - to follow up meeting to discuss 2016 SAI recommendations with Caroline and then meet with Trust colleagues**

	Jane questioned how proper restitution for all patients could be secured if this process was stopped and where the decision to stop this process would lie. It was agreed that Jane and Sophie would discuss this matter further outside these meetings and possibly involve DoH colleagues in these discussions. Stephen noted that from discussions at the previous UAG meeting it was not clear what the next steps would be regarding SCRRs and he referred to recent discussions with Bernie Owens, BHSCT regarding Neurology Inquiry. Paul noted that the Neurology Inquiry process was not comparable and agreed that although the advice from UAG was to cease any further SCRRs, it was not clear what the next steps would be in place of SCRR. Damian advised that his understanding was the Trust was to proceed with the current 57 cases and produce a report highlighting learning and not proceed beyond that. However he was unclear if this was the final decision. Sophie noted that families would have the option to secure restitution by going down the legal route, if necessary. Paul suggested that Sophie, Jane and Stephen discuss the matter further offline and Trust to produce the requested report. Further discussions to be had with DoH colleagues, if it was felt this was necessary. Damian noted that it may not be a good use of resources to undertake more SCRR cases. ➢ <u>Update on Activity from other Trusts</u> - Ongoing.	**Jane/Sophie/Stephen to discuss decision to cease further SCRR cases, Trust to produce report and liaise with DoH if necessary.**
3	**Public Inquiry Update**	
	➢ <u>Section 21 requests</u> - Jane confirmed that the Section 21 work is ongoing and Dr O'Kane is now the Accounting Officer. Jane noted the Trust had still not received a significant tranche of Section 21 requests that are expected and there was still no indication when these would be received by the Trust. Some form of the Public Inquiry hearing is expected to start in July, but no information on that is available yet. Martina noted the Trust was still receiving additional queries from the first tranche of Section 21 requests and these queries were taking a lot of time to respond to. Paul noted that HSCB had not received any Section 21 requests to date. Jane also advised the Trust was trying to work on pre-empting what further requests would entail. Jane confirmed that DLS were also in contact with the Inquiry team on a daily basis.	

4	**Directorate Update**	
	Sarah shared the update report dated 3rd March and noted the following points:- ➢ A further 20 patients have been identified and added to the total 2,115 cohort. ➢ Professor Sethia has reviewed a further batch of patients. ➢ Internal screening clinics continue on Mondays and every patient has now received a letter. A cycle of letters will continue as required. ➢ 57 SCRR patients have now received their letters, 2 patients with more complex requirements will require more time. ➢ 317 additional reviews completed to date. The Trust will not meet the end of March deadline due to DNAs, additional patient line activity etc. but reviews should be completed by mid-April. ➢ An additional flurry of activity in January via the Information Line - 5 still to be responded to. ➢ SAI recommendations update - Sarah noted that 3 recommendations are coded green as complete and 8 recommendations coded amber are being progressed. The process is yet to be finalised. ➢ Task & Finish Group meetings on Monday past and good progress being made. ➢ 2016 SAI Recommendations - Sophie to check with Caroline and report back to Sarah. ➢ Outcomes Report - Paul advised the Neurology Outcomes Report, 3rd cohort would be issued next week. He agreed to share with colleagues.	**Sophie - To check position re 2016 recommendations and report back to Sarah** **Neurology Outcomes Report - 3rd cohort Paul to share with Trust**
5	**Outcomes Report**	
	Sophie noted the report was not due until May 2022 and she agreed to pick this up with Stephen.	**Sophie/Stephen to liaise re Outcomes Report**
6	**UAG Meeting 23rd February**	
	Private Patients - Stephen noted the request for him to contact GMC regarding Private Patients of Mr AOB and he had done this. He noted the issue that Mr AOB was now retired but DoH would take the necessary action when a response is received.	
7	**AOB**	
	Nothing further to discuss.	
8	**Date of Next Meeting**	
	Paul advised due to the St Patrick's Day bank holiday, the next meeting would take place on **Thursday 31st March 2022, 3.30pm**	
9	**Action Log**	
	➢ **Sophie -** to follow up meeting to discuss 2016 SAI recommendations with Caroline and then meet with Trust colleagues ➢ **Jane/Sophie/Stephen** - to discuss decision to cease further SCRR cases, produce report and liaise with DoH if necessary. ➢ **Sophie -** to check position re 2016 recommendations and report back to Sarah ➢ **Paul** - to share Neurology Outcomes Report 3rd cohort with Trust ➢ **Sophie/Stephen** - to liaise re Outcomes Report	

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Oversight Steering Group Minutes

Thursday 31st March 2022, 3pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Martina Corrigan Jane McKimm Sophie Lusby Sarah Ward Ronan Carroll Sylvia Irwin **Apologies** Melanie McClements Dr Tariq Dr O'Kane Stephen Wallace Damian Gormley	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Paul welcomed everyone to the meeting and apologies were noted. **Minutes of the Previous Meeting 3rd March** - The minutes of the meeting held on 3rd March were agreed. • **Matters Arising from the Meeting on 3rd March** ➢ Meeting to discuss 2016 SAI Recommendations - Sophie confirmed that she has met with Caroline to discuss. She will now follow this up with Denise Boulter and Dr Louise Herron, PHA. ➢ Decision to cease further SCRR cases - Sophie confirmed that she has discussed this matter with Sarah but a further meeting with Jane, Stephen Sarah and herself will take place within the next few weeks. Paul noted the need for this meeting to happen before the next UAG meeting, as an outcome would be required by then. ➢ Neurology Outcomes Report 3rd Cohort - Paul advised that the report in respect of the Neurology 3rd Cohort had not been published yet. Sophie agreed to contact Emma McKee, HSCB regarding a copy of the 2nd cohort report and share with Trust colleagues.	**Sophie - to follow up meeting to discuss 2016 SAI recommendations with D Boulter/Dr L Herron** **Sophie to coordinate meeting with Jane/Sarah/Stephen to discuss decision to cease further SCRR cases,** **Sophie to contact Emma McKee and share copy of Neurology 2nd cohort report with Trust colleagues**

	Sophie advised that she has arranged a meeting with Stephen Wallace to discuss the Neurology Outcomes report with Paul Cunningham and Deborah McCord, HSCB. Paul noted that as the first draft of the Outcomes report was due by May'22, it was important to keep an eye on the timeframe of these planned meetings.	
3	**Public Inquiry Update**	
	➢ Section 21 requests - Jane confirmed that the Section 21 work is ongoing and she noted the high volume of Section 21 requests that have now been received by individual Trust colleagues. She also highlighted the extraordinary level of detail included in these individual requests. This pressure has led the Trust to assess the original discovery process document. Jane noted that once a Section 21 request is received, the individual staff members are taken out of the loop of normal day to day activities, in order to address the Inquiry request. Jane confirmed that DLS were also in contact with the relevant colleagues and the Inquiry team on a daily basis. Ronan noted that he had received his individual Section 21 request the previous day and this contained 70 questions with sub sections. The deadline for submission is 11th May. It was also noted the response time for these requests has now increased from 4 to 6 weeks. Jane added that the questions within these requests are so detailed and specific to the individual, they will likely have to be addressed solely by the individual. It was also noted that when individual clinicians receive their Section 21 requests, the day to day Urology service will be severely impacted. Martina also highlighted the pressure felt by the clinical team due to these impending requests. The impact of the Hyponatraemia case on clinicians, AMDs and Clinical Directors was also noted. Jane referred to the statement released by the Public Inquiry team dated 22nd March 2022, which confirmed that the Inquiry will start in week commencing 7th November 22. Individual patient and family hearings will commence from June'22 onwards and will be closed to members of the public. However, all discovery submitted within the Inquiry will eventually be made public. This will therefore require significant timeout for clinicians in order to prepare for this start date. Paul requested Jane to forward a link to this statement.	**Jane to forward link to the latest statement made by the Public Inquiry team to Paul**
4	**Directorate Update**	
	Sarah shared the update report dated 30th March and noted the following points:- ➢ Lookback Exercise Letters - Sarah noted that an error had been discovered in the lookback letters previously sent out and 355 letters due to go out had	

	been recalled and redrafted. The revised draft is currently with DLS for comments and these should go out within the next few weeks. Patients who have received the original letter containing the error will be sent an apology letter. ➢ SCRR Patients - A further 4 patients additional to the original 77 have now been identified. ➢ Urology Information Line Calls - Sarah advised there had been a flurry of activity in January and February but this had now eased off again. ➢ SAI Recommendations - It was noted that of the 11 recommendations, 3 are complete (coded green) and 8 are in progress (coded amber). The Task & Finish Super Group met on 8th March and the key priorities of the amber recommendations were shared with the group. Further meetings have already happened and others are planned for the coming weeks. ➢ Trust requires input from HSCB re 2016 recommendations and Sarah noted that this is in hand. Paul requested the Trust update dated 30th March is shared with DoH colleagues and Sophie agreed to forward. The format of the report was discussed and Paul noted this version, previously shared with DoH colleagues had been acceptable. However, he requested that a more detailed report would be required prior to the next UAG meeting, date to be confirmed.	**Sophie to forward Trust update report of 30th March with DoH colleagues**
5	**Outcomes Report**	
	Sophie advised that she would work on this over the next few weeks, once she has had a chance to review the Neurology Cohort 2 Outcomes Report.	
6	**Date for Next UAG Meeting**	
	Paul noted that this had not yet been agreed but it was likely the next meeting would take place before the end of April.	
7	**AOB**	
	Nothing further to discuss.	
8	**Date of Next Meeting**	
	The next meeting will take place on **Thursday 14th April 2022**	
9	**Action Log**	
	➢ **Sophie** - to follow up meeting to discuss 2016 SAI recommendations with D Boulter/Dr L Herron ➢ **Sophie** - to coordinate meeting with Jane/Sarah/Stephen to discuss decision to cease further SCRR cases ➢ **Sophie** - to contact Emma McKee and share copy of Neurology 2nd cohort report with Trust colleagues ➢ **Jane -** to forward link to the latest statement made by the Public Inquiry team to Paul ➢ **Sophie** - to forward Trust update report of 30th March with DoH colleagues	

Southern Health and Social Care Trust

Health and Social Care Board

Southern Urology Oversight Steering Group Minutes

Thursday 14th April 2022, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Martina Corrigan Jane McKimm Dr Shahid Tariq Sarah Ward Ronan Carroll Melanie McClements Stephen Wallace Dr Damian Gormley Sylvia Irwin **Apologies** Sophie Lusby	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Paul welcomed everyone to the meeting and apologies were noted. **Minutes of the Previous Meeting 31st March** - The minutes of the meeting held on 31st March were agreed. • **Matters Arising from the Meeting on 31st March -** Paul referred to Sophie's update e-mail in respect of the Matters Arising, circulated to the group and noted the following points:- ➢ Meeting to discuss 2016 SAI Recommendations - Sophie noted in her e-mail 2016 SAI had been closed by PHA in April 2021 with no regional learning and at that stage advised the Trust that the first 4 recommendations on their action plan should be taken forward by themselves in conjunction with NICaN re: NG12. There was some correspondence with NICaN who outlined that this was complicated as NG12 was not fully implemented. The acute SAI group and the DRO are responsible for identification of regional learning but not for	

monitoring of action plans if no learning is identified. It had been discussed on many occasions with the Trust that they should not make recommendations for any other organisation (including HSCB now SPPG) before discussing with them first and these discussions were had with them regarding this particular SAI.

Mark Haynes has confirmed that, regarding the recommendation the current guidance doesn't align with updated NG12 PSA normal ranges but this raised this at the recent CRG for amendment and follow through.

The UOG should therefore consider this action as closed, albeit the residual effect of NG12 will be worked through appropriate NICaN processes.

Paul questioned if the Trust would accept this action as closed. Sarah agreed to have a further discussion with Sophie as AG12 had been specifically mentioned. Sylvia agreed to advise Sophie of this discussion.

Sarah
to have further discussions with Sophie regarding closure of 2016 SAI
Sylvia
To advise Sophie of today's discussions

Martina noted the importance of closing and signing off these 2016 SAI recommendations, as this was an area the Inquiry Team was very keen to focus on.

- Decision to cease further SCRR cases - Sarah referred to the update provided to the group and confirmed that of the 77 SCRR cases, 55 had been screened in and 20 had been screened out, with 2 queries. Paul noted the agreement to suspend further SCRRs after the initial 77 had been screened.

Stephen advised that he had started an options appraisal for SCRR to be shared with UAG. He agreed to share in draft form with the Steering Group, once this was available.

Stephen
To share draft SCRR options appraisal with group

Melanie noted the importance of highlighting further elements of risk. Stephen stated that if any further specific issues were raised outside those already highlighted, these cases would still need to be screened.

Paul noted the earlier agreement to pause further SCRRs and noted that only significant new differences should be included.

- Neurology Outcomes Report 2nd Cohort - Sarah confirmed that a meeting had taken place with Emma McKee and Deborah McCord in relation to the Neurology Outcomes report, 2nd Cohort. Sarah noted that this had been a very useful meeting and had provided guidance as to the Urology Outcomes report. She also noted that a further meeting with Emma and Deborah is due to take place on 25th April.

Paul reminded that the deadline for submission of the Outcomes Report was

	May 2022.	
3	**Public Inquiry Update**	
	➢ Section 21 requests - Jane advised that the Trust is concluding the overarching Section 21 requests and now starting to focus on the individual Section 21 requests. She noted the significant amount of time and work involved in responding to these. Jane also noted that the Inquiry team have been in contact with a number of individual staff. The Trust had been able to alert staff in advance of these requests. There however was still a degree of uncertainty and anxiety amongst staff affected as to what was to be expected. The Trust is also answering case specific queries in the build up to the commencement of individual patient hearings and Martina added that the Trust is being asked for details on specific patients relating to the 2016 SAI recommendations and also some SCRR patients. Paul questioned if there was appropriate support in place to support Trust staff affected by the ongoing Inquiry. Jane noted the various strands of support in place, e.g. psychological, occupational health, Inspire etc. RCN have also been briefed in regards to current processes around the Inquiry. Jane advised that the Trust had tried to reflect these concerns back to USI team and she acknowledged the concerns for staff caught up in the Inquiry process. Melanie highlighted the need to keep staff on board and keep communication lines open.	
4	**Directorate Update**	
	Sarah gave a brief overview of the 3 reports circulated to the group:- ➢ Lookback Exercise Letters - Sarah advised the Trust was working on how to get the apology letter agreed and issued. She advised the 1st batch of letters would be processed soon. Paul asked if a deadline for all letters of 30th April was viable. Sarah agreed that this should be an achievable deadline for letters to be finalised. ➢ SCRR Patients - Work on identifying SCRR recommendations continues and Sarah confirmed that the questionnaire is near completion. Mary Haughey continues to meet with MDMs to hopefully finalise this piece of work. Sarah noted that of the 77 SCRRs initially identified, 22 had been screened out, leaving a balance of 55 SCRRs. Anything else identified would be over and above the original 55 SCRRs.	

Martina advised that Professor Sethia will be brought in on 9th May to review the 22 SCRR records which have been screened out by the Trust. This process is to verify the 22 records have been correctly screened out. Professor Sethia will also review Orthoderm patients and this work will be ongoing.

- Orthoderm Discoveries Report - Sarah gave an overview of the report and advised that 323 patient records had been sent for review to Mr King and 233 of these patients were Mr AOB's patients. 89 patients had been returned to the Trust and there are plans in place to address these. To date 33 patients have yet to be actioned.

  Paul asked if it was reasonable that these 33 patients would be reviewed by 30th April. Sarah agreed that this could be achieved if the issue of getting clinics in place was addressed. Sarah noted it was likely that some of these clinics may run into May, but the Trust would endeavour to get all 33 patients reviewed by end of April.

  Martina noted the Trust had now reverted back to using the 9 question Patient Review Form, as opposed to the 4 question form previously agreed with DoH and used at earlier reviews. She explained that this was due to the fact that current care was found to be acceptable but issues seemed to be arising in the review of historical care. The 9 question Patient Review form is better suited for recording evidence and adds value from a safety point of view. Sarah agreed to discuss this further with Sophie outside this meeting.

  Paul noted that in terms of the above discussions, the Outcomes Report may take longer to produce. He suggested that a separate meeting involving Sophie, Dr Farrell, Dr Gormley and Stephen would be helpful.

  Ronan highlighted the effect of USI letters on nursing staff and noted the Trust would need to meet with ward sisters and clinic sisters to support them through this process.

  Dr Tariq advised that his role in service development was to clarify responsibility lines for clinics, MDMs, OP managers and create Job Descriptions (JDs). Clinical and Medical Directors will also have a paragraph in their JDs regarding their role in MDMs.

  Dr Tariq also noted that a Urology Lead Job Description had now been drafted and he will continue to develop JDs for the remaining roles. He highlighted that this would be a significant piece of work.

  Ronan confirmed that 5 MDMs are still to be reviewed and meetings are to be arranged. This will reclassify the SAI recommendations for MDMs from amber to green. Ronan also noted that a Band 5 auditor post has been established to

Sarah/Sophie
To discuss use of 9 question Patient Review form as opposed to 4 question form

Sophie
To set up a separate meeting to discuss timeline of Outcomes Report involving, Dr Farrell, Dr Gormley and Stephen Wallace

	progress this work within the next few months. Paul requested a presentation on progress made is given to the group by mid to end of May.	**Ronan** To arrange a presentation on progress to the group by mid to end of May
5	**Outcomes Report**	
	Previously covered.	
6	**Date for Next UAG Meeting**	
	Paul noted that this had not yet been agreed.	
7	**AOB**	
	Dr Rogers questioned if the Trust was also looking at areas outside of SAIs such as missed opportunities to identify the consultant's under-performance and dealing with other issues such as whistle blowers, complaints etc. Stephen confirmed that this is currently being addressed by the Trust and he noted the same themes were present in this case as had been in other high profile NHS inquiry cases. He agreed to share the draft report once it was available in a few months' time. Paul suggested a separate meeting may be appropriate when the report is produced.	
8	**Date of Next Meeting**	
	The next meeting will take place on **Thursday 28th April 2022**	
9	**Action Log**	
	➢ **Sarah/Sophie** - To have further discussions regarding closure of 2016 SAIs ➢ **Sylvia** - To advise Sophie of actions arising from the above discussion ➢ **Stephen** - To share draft SCRR options appraisal with group ➢ **Sarah/Sophie** - To discuss use of 9 question Patient Review form as opposed to 4 question form previously agreed with DoH ➢ **Sophie** - To set up a separate meeting to discuss timeline of Outcomes Report involving, Dr Farrell, Dr Gormley and Stephen Wallace ➢ **Ronan** - To arrange a presentation on Trust progress to the group by mid to end of May	

Southern Health and Social Care Trust

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Department of Health
An Roinn Sláinte
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Southern Urology Oversight Steering Group Minutes

Thursday 28th April 2022, 3.30pm

Via Zoom

	Item	Actions
1		
	In Attendance Paul Cavanagh (Chair) Martina Corrigan Jane McKimm Dr Damian Gormley Sarah Ward Ronan Carroll Melanie McClements Stephen Wallace Dr Helen Rogers Dr Maria O'Kane Sylvia Irwin **Apologies** Sophie Lusby Mr Mark Haynes	
2	**Actions from Previous Meeting**	
	• **Welcome & Apologies** - Paul welcomed everyone to the meeting and apologies were noted. **Minutes of the Previous Meeting 14th April** - The minutes of the meeting held on 14th April were agreed. • **Matters Arising from the Meeting on 14th April -** ➢ Closure of 2016 SAI Recommendations - Sarah noted that she had no further update since the last meeting and this matter was still outstanding. ➢ Draft SCRR Options Appraisal document - Stephen noted that he had discussed this matter with Sophie following the last meeting and Stephen agreed to send draft to SPPG colleagues by the end of the week.	B/f for update at next meeting **Stephen** To forward draft SCRR Options Appraisal document to SPPG colleagues by Friday 29th April

	➢ Trust use of 9 question Patient Review form as opposed to 4 question form previously agreed with DoH - Stephen advised that he had discussed the Trust's rationale for using the 9 patient review form with Sophie outside of the meeting and this had been accepted. ➢ Sophie to set up a separate meeting to discuss timeline of Outcomes Report involving, Dr Farrell, Dr Gormley and Stephen Wallace - Stephen advised the Trust had met with Sophie on two occasions and also met with BHSCT colleagues. These meetings had been productive. ➢ Ronan - To arrange a presentation on Trust progress on SAI recommendations to the group by mid to end of May - Ronan advised the presentation will take place by the end of May.	**Ronan** To give presentation to group on SAI Recommendations by end of May 2022
3	**Public Inquiry Update**	
	➢ Section 21 requests - Jane advised the Trust is still finalising the tail end of the previous Section 21 requests and a further tranche is expected next week. She also highlighted the questionnaire that has been sent to 160 Urology staff. Jane noted her concerns in regard to how this process has been managed by the USI team. Dr O'Kane noted that GMC have spoken to Urology medical staff and before the Trust could stand down any necessary compulsory work, a risk assessment on the impact to patients would be required. Melanie noted that this would be necessary right across ward-based staff and CNS and also included retirees. It is likely that retirees could reply independently, without consulting the Trust. The questionnaire included 51 in-depth questions with no support for completion, unless requested. Jane noted that due to the USI process, the Trust was restricted in what support they could offer to staff. She noted her concerns that although the Trust had made representation through every available route, they had not received any guidance from USI. Paul highlighted the possibility of involving DLS and DoH colleagues and questioned if it would be worth having a separate meeting outside of the regular meetings. Ronan noted that separate to Section 21 requests, the questionnaires were sent to staff inviting them to respond. The Trust is not in a position to advise staff whether or not to respond and some staff are extremely anxious about what to do. It was agreed that Trust would contact Paul if further discussions	

	were required.	
4	**Directorate Update**	
	Apology Letters - Sarah advised the current focus is to get the apology letters issued to patients, but before this can take place the Trust has to ensure that every patient is safe. A plan should be forthcoming by the end of the week but it would be difficult to quantify a timeframe for this. SAI Recommendations - Sarah noted this area is making good progress and is currently focusing on MDM elements. The team is due to meet again in 2 weeks' time and a meeting will take place this Friday with the service users group. Sarah is hopeful that all recommendations will be re-classified as green category by end of June at the latest. Melanie noted the importance of no further misinformation and advised the lack of available capacity was slowing down the process. Paul acknowledged the comments and noted the importance of getting it right this time. The Trust agreed to forward an updated Trust Summary Report to Paul for DoH colleagues by the end of the following week, 6th May.	**Sarah** To forward updated Trust Summary Report to Paul by 6th May
5	**Outcomes Report**	
	Sarah referred to the Outcomes Brainstorm Chart which had been developed and shared with the group. She noted this had been drafted following discussions with Sophie and SPPG staff involved in the development of the Neurology Outcomes Report. She added that the process is ongoing and the document was an outline draft of what could potentially be included in the final report. Paul noted that he would like the report to be based on the format of the Neurology Outcomes Report. Paul enquired if the brainstorm chart was too inclusive and should focus only on patient data and patient outcomes, rather than processes. Melanie advised the chart had been developed merely as a tool to understand the overall process and a lot of the topics included may be discounted in the final draft report. Paul noted that he would be happy to go with 9 questions currently being used or a sub-set of the 9 questions, whatever the Trust felt was more appropriate. Paul asked that a draft Outcomes report be shared as soon as possible, as it would likely be required by UAG for the next meeting. Sarah agreed to forward a copy of the 9 question review form to Dr Rogers and Dr Farrell for further comments. Melanie enquired if the 3 questions used in the Neurology Review were published in the Neurology Outcomes Report. Paul confirmed this was the case and again noted that the Neurology report presented patient data only.	**Sarah** To forward copy of the 9 question review form to Dr Rogers & Dr Farrell for comments

	Dr Gormley noted the reason the Trust had come to the decision to use 9 questions was that the 3 question format did not cover all the answers. Paul acknowledged these comments and noted that he had no issues with this decision.	
6	**Date for Next UAG Meeting**	
	Paul noted that this had not yet been agreed but should be sometime in May/June.	
7	**AOB**	
	Nothing further to discuss.	
8	**Date of Next Meeting**	
	The next meeting will take place on **Thursday 19th May 2022** due to other commitments on 12th May.	
9	**Action Log**	
	➢ **Sarah** - To provide further update on closure of 2016 SAI Recommendations at meeting on 19th May ➢ **Stephen** - To forward draft SCRR Options Appraisal document to SPPG colleagues by Friday 29th April ➢ **Ronan** - To give presentation to group on SAI Recommendations by end of May 2022 ➢ **Sarah** - To forward updated Trust Summary Report to Paul by 6th May ➢ **Sarah** - To forward copy of the 9 question review form to Dr Rogers & Dr Farrell for comments	

Lookback Steering Group Meeting
11th April 2022 @ 8.30am Via Zoom

Present:

Melanie McClements
Wendy Clayton
Sarah Ward
Damien Gormley
Martina Corrigan
Maria O'Kane
Mark Haynes
Ronan Carroll

Apologies
None

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
Minutes of last meeting shared**. NO comments**

Matters Arising

- Melanie asked if we can be assured that those patients removed off the list originally are meant to be off. Martina advised the original 2346 patients once screened produced approx. 400 that were not AOB patients. This took total to 2095.

ACTION: Melanie requests Sarah and Wendy check the approx. 400 patients that were removed for a 2nd check of assurance

- Melanie asked about the checks of the Urology Codes where patients were found on. Sarah & Wendy advised these were all checked last week and no further AOB patients were located.
- Maria advised the outcomes from the work on letter errors that Margaret O'Hagan and Grace Hamilton completed have been extremely useful. Maria is intending to ask Margaret & Grace to do another piece of work on patients removed from the list, including the Orthoderm outcomes.
- Melanie asked about the Personal Information redacted by the USI issue. Mark explained when his care was reviewed for the time period (Jan 19- June 20) there were no clinical issues. It was only when a look at his historical care identified he was on unlicensed dose of Bicalutimide many years ago. Demonstrates the restriction of the 4 question review.
- Discussed the continued reviews using the 4 vs 9 questions

ACTION: Maria, Jane and Stephen to discuss and go back to the Board to advise of the issues we have discovered with 4 questions.

- Mark highlighted the need for 9 questions to ensure historical care was reviewed.
- Martina advised Orthoderm patients may not have been picked up either as not using 9 questions.
- Melanie asked how the Orthoderm outcomes were not actioned. Martina explained this was a result of a report from the IS team which lead to belief that all patients had been seen. Melanie has asked if our IS contract process is robust. Mark explained that Wendy and him have spent a lot of time reviewing the IS contracts process. Wendy explained there is a monitoring process in place which includes the Finance team and checking of letters against numbers in and out. This didn't happen with other IS contracts.

Activity to Date

- Sarah had 3 documents to share.
    1. Orthoderm Updates
    2. Letter Updates
    3. SCRR updates
- Orthoderm- This demonstrated a breakdown of all patients sent to Orthoderm. Of those 89 were returned to Trust and not noted as this. Mark reviewed these patients and of this 8 patients were not seen (5 required to be seen & appointments requested by Sarah) and a further 4 patients were noted to have been on Bicalutimide which now required screening for potential SCRR (added to screening list) These patients have all received Letter A (NO ISSUES) as were coded on master as "Oncology Review" and no concerns/ comments/ issues. Maria raised we need to consider what we tell patients.
  - 33 patients sent to Orthoderm did not have outcomes actioned. These have been forwarded to Mark (8.4.22) as 6 patients have not been seen (since Orthoderm). 1 Patient RIP & Orthoderm advised review and scans, 1 patient RIP and was on WL for TURP & not seen. 2 patients already on our WL for review & awaiting appointment. 1 is not an AOB patient. 20 seen in Trust since Orthoderm review. 1 patient was sent to 3Five2 as part of Urology WLI but DNA and sent back to GP. 1 Patient not on Master Spreadsheet & NIECR shows AOB episode in 2019 & Gp letter and scans completed under AOB. 2 patients on WL to se see received Letter B. 1 Patient not on Master has received no letters to date. Other patients received Letter A as were coded as "Onoclogy Review" and no comments/ issues
  - Detailed the additional patients requiring reviews at clinics (now at 53 with ? 24). Sarah asked about potential to have patients seen as part of the Urology 3five2 WLI contract. This would be a quick solution for getting patients seen, however would require Clinical Review Form to be completed in advance in Trust prior to sending to IS. Mark advised he felt it best to have these patients seen in Trust. This equates to roughly 7 clinics and could be completed potentially by the end of May. Mark also raised that some of our own consultants may end up doing the IS work and other Consultants may not have access to NIECR. Decision made by group to keep these patients in Trust & contract will be for the next cohorts of the 5 year lookback.
  - Suggestion that Prof Sethia could potentially complete a 9 questions review on these patients identified from Orthoderm above whilst awaiting review clinic and details of review passed to Consultant who will see them.

ACTION: Mark to review these patients that did not have outcomes actioned. The review the 21 patients seen by Orthoderm to ascertain if need for any further review. 9 Questions to be completed.
ACTION: Prof to be asked if he can support these clinical record reviews- Sarah.

- Letters- Sarah shared the update on outstanding letters (currently 598) and includes the details of what groups require what apology letter.
  - Patient [redacted] still requires apology for inaccurate info on SCRR letter.
  - Sarah identified all the letter templates we now require:
    1. Letter A
    2. - Letter B (new in light of above)
    3. - Apology for completely wrong letter (in light of above)
    4. - SCRR
    5. - SAI 2nd Update Letter & apology for missing signature
    6. - Post Clinic Review
    7. - Apology for inaccurate dates/ PI intention
  - Sarah raised concern that this is becoming very complex. Gave example that patients are now coming to reviews and have not had any indication why they are there- and will get letter detailing clinic update, reason for PI, apology for not communicating sooner. And those coming to clinic who received Letter B will need clinic update and apology for inaccurate dates in original letter B combined into 1 letter rather than 2 separate. Needs careful planning and support to get this done.
  - Maria advised the Covid SAI work is coming to an end so there may be scope for support from Liaison Team to assist in getting these completed.
  - Importance of getting these correct is recognised.
- SCRR- 4 inconsistencies remain with 2 no decision made as yet. Advised that our last screening the group felt it important to get a steer on the continued SCRR and the potential of Prof joining the screening group to provide that independence for those screened out of SCRR. Martina had went back to Mr Lunny to ask about the SCRR and we await response. Group wished for a legal opinion on Prof joining the group as felt Mark was identifying patients and Mark was involved in screening- need independence.
- Maria advised that we continue with the process whilst awaiting response and suggests we bring Prof in now in absence of guidance.
- **ACTION: Melanie requests that 4 inconsistent patients are discussed at todays screening meeting.**
- **ACTION: Martina will contact Prof to see if he can join the SCRR screening meetings.**

Other Discussion

- Mark raised that issues in care has been noted as far back as 2007 with patients receiving care for Prostate Cancer. Mark feels its important to look at all Prostate Cancer patients, as AOB didn't do biopsies and Mr Glackin and Mr Haynes both done biopsies for him there could be other issues.
- Mark has suggested a histology report be obtained for all Prostate Cancer diagnosis. Mark has started the data submission request for this.
- Mark advises this will create some challenges as what we do if the patient is RIP and harm is noted/ RIP & no harm

- Maria advised we would need to consider having discussions with relatives if concerns and the patient is RIP.

Next Meeting

- Leave pending
- Next meeting will be 4 weeks but can call meeting by exception if felt required.

Next Meeting Scheduled for 8.30am Monday 9th May 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
9th May 2022 @ 8.30am Via Zoom

Present:

Melanie McClements
Wendy Clayton
Sarah Ward
Ronan Carroll
Mark Haynes
Damien Gormley
Margaret O'Hagan
Maria O'Kane

Apologies

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
Minutes of last meeting shared**. No amendments required.**

Matters Arising

Action Plan for Steering Group

Melanie asked if the 400 patients removed at the start of the list had been cleansed to ensure they were accurately removed. Sarah advised this still needed review and this also required some clinical assurance. Margaret asked if it would be possible to create a timeline for removals and a narrative for each. The group agreed this would be useful.
ACTION: Sarah to look at the removals from the original list and create a timeline and narrative around this.

Melanie recognised that there is two question 4's in the 9 question review form therefore 10 questions in total. Group agreed that we need to move to 10 question review form terminology going forward to be consistent.

Sarah shared the Letter/ Apology/ Clinical Review Form template. Identified the following:
1) 2113 patient total- 1 patient on list twice.
2) Adding up the letters sent/ those to be sent there is 69 unaccounted for. Sarah advised she needs to review this but expects these to be Original Letter A & B. Advised Maria Siahhan from Validation Team had generated a report with IT to review the number of letters generated through the system.
ACTION: Sarah to look at the remaining 69 patients and establish where they sit in the letter process.

Sarah talked through the table shared from Fridays meeting- this one has been updated with the recent activity. The Orthderm patients have been added onto this. Sarah explained the requests forwarded to Prof Sethia for a 10 Question clinical review form to be completed:
1) Orthoderm patients identified by Mark Haynes as needing review and meeting threshold for SCRR (5 for review & 4 for SCRR) as well as the 33 patients who did not have outcomes actioned on return to Trust which have not had a review form completed. Prof will have these completed within a week.
2) The patients that had a 4 question review form completed at clinics in Trust to have 9 Questions completed (124 patients). Prof will have these completed by end of May.
3) Patients on incorrect clinic codes (19 patients) who will not have been seen or reviews completed will also be completed by end of May.
Sarah explained that the outcomes of the review forms would determine if the patient needed to be seen at clinic.

Sarah advised the New SCRR patients remain to be a concern. We have 2 patients who received Letter A and are now for SCRR. These patients were agreed to be brought to clinic but prior to that Liaison was to contact and advise so they were not coming to clinic unprepared. Sarah advised the script has been drafted with Beverly (Liaison Support aligned to SCRR) and has been forwarded to Jane McKimm for review and discussion with DLS. Sarah advised the supporting SCRR info leaflet also needs revised. Sarah highlighted that these patients will be coming in the next few weeks and the agreement was to advise them before coming and in the absence of guidance to continue with new SCRR (as same themes) what are we advising the patients of? We need a letter template. Mark has agreed to see the patients at clinic but needs a form of words for an apology.
ACTION: Jane to review the SCRR script for Liaison & discuss a letter Template for communicating this to the patients & direction for Mark for clinic reviews.

Mark Haynes advised this should be potentially an apology from the Trust that they may have come to harm instead of advising of a SCRR process that may not happen. Group agreed this would be a reasonable option but this needed discussed with UAG.
ACTION: Maria to take this back to advise UAG we will be discussing this with them at the next meeting on 23rd May and we need a direction due to the complexities we are facing with this.

Sarah advised 10 records had been returned from BAUS with completed SCRR. Advised that there was not a process agreed for how we check the information on return and how we communicate the findings to the patients (another letter template). 49 Records were sent to BAUS with 5 still to go. 39 awaiting to be returned. Melanie asked if there was in house capacity to review these outcomes. Mark advised the Urology Team was losing a Consultant in 3 weeks and lots of things need reviewed and there is simply not enough time. Mark also raised the section 21 work. Melanie has asked if Mark & Damien Gormley can review the 10 completed SCRR and determine if there is any learning to come from these.
ACTION: Mark Haynes and Damien Gormley to review the 10 returned SCRR from BAUS.

Sarah advised a meeting with Chris Wamsley and Dawn King happened last week to discuss and draft an SOP for the continued record upload and SCRR process. Dawn

is currently scoping the number of patients that would be included in the next lookback so we get a steer for the volumes we may be looking at.

Maria advised that we need to start looking at a stratified approach to the next batches of patients. Mark raised that the risk of patients being on the wrong pathway is lower as the patients at most risk as demonstrated by the current lookback is Prostate Cancer patients. Mark suggests we pull patients with Prostate Cancer diagnosis as review in timeline format to ascertain prostate cancer care is ok. Mark advised a Pathology report could be run of all prostate biopsies completed, if we were to extract those that were negative results this would require a resource from Pathology labs so would be best to pull all biopsies and complete timeline for all as those that are negative would be quick to do.

Maria asked how we would capture those diagnosed outside of biopsy pathway. Mark advised those diagnosed clinically would be low in numbers. The next cohort we could pull are those patients that had a TURP & biopsy with positive diagnosis which would potentially be a small number. Maria advised this seemed a reasonable option and this would be discussed as felt it was important to start looking at these next patients.

Sarah asked about the Outcomes report and what each streams intention was to submit this. Martina advised she believed this to only be related to the lookback element and also advised Caroline Cullen previously advised that the Trust was to provide the data and the HSCB would collate the report. Maria also confirmed this was the discussion when the outcomes report was first discussed. Melanie and Sarah advised this was not the direction from the last HSCB meeting and the expectation was that we collate the entire report. Melanie asked if any other stream needed to be involved and Sarah advised to allow her some time to review her process thinking and if anything required from another stream she would raise this. The group asked to see the Neurology report for comparison. Melanie advised Sarah would require support to get this completed and we may need to consider a task and finish group for Outcomes report. Agreed that we would have some shape of a report for the 19th May for the next HSCB meeting **ACTION: Sarah to contact Sophie Lusby and ask to meet to discuss outcomes report advising that we would provide the data for them to collate their report and Sarah to forward a copy of the Neurology Report to the group for review.**

Next Meeting Scheduled for 8.30am Monday 23rd May 2022 via Zoom

Lookback Steering Group Meeting
28 March 2022 @ 8.30am Via Zoom

Present:

Melanie McClements
Wendy Clayton
Sarah Ward
Damien Gormley
Martina Corrigan
Margaret O'Hagan
Maria O'Kane

Apologies
Mark Haynes

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
Minutes of last meeting shared**. Agreed**

Matters Arising

Action Plan for Steering Group

- Melanie asked about the process for checking the outcomes from Orthoderm contract. Martina advised the outcomes were checked by Mark and advised Mr Keane copied in "superintendent Radiographer" into communication.
- Melanie asked about the checking of the Waiting list codes we had found patients on a few weeks back. Sarah advised that Wendy and her were nearly finished.

ACTION: Melanie requests Sarah and Wendy complete this today.

- Melanie asked if we were sure that the original patients (2500 approx) have all been accounted for and if removed was it correct. Martina provided detail of why patient number reduced for eg if patient was referred in to AOB but never actually seen by him then they were removed.

ACTION: Melanie has asked Martina to provide the original list of patients and those screened out and reasons why – cross reference will aid assurance

- Melanie asked Martina if Mr Keanes patients went onto a DARO list. Martina advised that Mark had to order scans so yes this was the care. There was one situation where Mr Keane ordered himself and this was MRI as these could be done quicker in Independent sector.
- Sarah shared the summary table of the letter activity and detailed as requested what cohorts of patients required original first letters, apology letters and clinic

updates plus apology letters. Dr O'Kane asked that full names be included on the reports

ACTION: Sarah to ensure full names on reports as requested by the USI for uploading to section 21.

- The total number of patients included in the cohort is fluctuating. To ensure numbers match on reports

ACTION: Sarah to ensure total number of patients is accurate on all reports.

- Melanie asked about Personal Information redacted by the USI - this was the patient identified by Mark as being seen by Orthoderm and outcome not recorded on return to Trust. Patient was on Bicalutimide at unlicensed dose and now needs referred to internal screening team for SCRR. Patient was identified as having Oncology review and no concerns noted on master. Patient now has metastases. Sarah advised this is concerning as letters were issued based on detail in master and patient had no concerns identified in the timeframe.
- Discussed the continued SCRR process. Currently no guidance that we continue. New permanent secretary in post will have to guide us and we await outcome of this.

Next Meeting Scheduled for 8.30am Monday 11th April 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
14 March 2022 @ 8.30am Via Zoom

Present:

Melanie McClements
Wendy Clayton
Sarah Ward
Emma Stinson

Apologies
Ronan Carroll
Damien Gormley
Maria O'Kane

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
Minutes of last meeting shared**.**
ACTION: Sarah to amend minutes based on Martina comments in email this am

Matters Arising

Action Plan for Steering Group

Melanie wished to take time to review the Lookback work. Sarah advised this is what she wished to do as there had been **new patients identified in past 2 weeks**.

Sarah shared "action to date" document. Detailed the **new total of 2114** patients. Sarah explained the newly found patients (**19 patients**) that were located as a result of 3 things:

1) **Patient** rang Dr Khan secretary asking for results of scan in Sept 21. Patient identified as being sent to Mr Keane in Orthoderm (on RV BL code). Outcomes not actioned on return to Trust so results not known to be chased/ reported. Coding error and remained on GUROL code. **All patients sent from Orthoderm are being reviewed by OSL team to ensure all outcomes actioned.**

2) PTL ran on GURO/ GUROL WL code- **3 patients found under AOB**. Added to master, review appointments requested and will require letters.

3) PTL ran on GURO RBL code- **14 patients found under AOB**. Added to master and review appointments requested and will require letters.

4) OP REG code ran and **2 patients found under AOB** code however there were not episodes or letters. Notes pulled and confirmed 1 patient who should have had CT CAP not actioned in 2014. Urgent review requested. Other patient DNA on 2016 and

recorded by AOB not for further allocation of appointment. Both added to spreadsheet and require letters.

ACTION: Sarah & Wendy to have RBC run report of patients under OP Reg Codes GURO/ GUROL codes to ensure no other patients

Melanie advised this needs checked across other services also as this could well result in patients being missed.

5) **1 patient reviewed by Prof Sethia (record review) missing off master**. Established had been identified in initial "pull down" but missed inadvertently off master spreadsheet. Added and review appointment requested and requires letter.

Of the initial 33 patients Sarah couldn't locate episodes for, all apart from 6 have been sorted. These 27 still need letters. The remaining 6 are being looked at by Martina ([redacted] emailed to advise will complete this week on return).

Sarah shared the spreadsheets for SCRR and those screened out for SCRR. There are 55 screened in and 20 screened out. However **discrepancy identified with 2** patients (Sarah & Governance have different outcomes recorded) Discussed with Mark and **for discussion on 21.3.22**.

8 New SCRR identified in progress of review clinics and continued screening of remaining 247 patients initially screened out at start of process (following prof Sethia record reviews). **1 of these patients was screened initially as having no concerns but on ringing info line advised seeking legal action and was brought to clinic. Now needs SCRR letter and phonecall.**

247 patient screening commenced 2 weeks ago- 28 screened and **1 identified as threshold for SCRR.** Separate spreadsheet maintained for the **"new" SCRR outside the original 77**. Melanie asked regarding timescales and Sarah advised this is slow due to availability of Mark/ annual leave etc. and could potentially take 10 weeks to complete the rest.
Patients screened out will have already received a letter as previously identified at initial stages as no concerns.
Patient identified for SCRR received Letter B that care being looked at and will be part of review backlog reviews. Needs SCRR letter and to be contacted.

Info Line update- limited activity past 2 weeks. Patricia Thompson assisting and approx. 5 to have calls returned. Patricia working on this and updates provided.

Clinic reviews- Sarah advised each time she filters spreadsheet various numbers of patients still to be seen is produced. Advised PAS needs reviewed but Sarah advises she believes the number to be below 100.
ACTION: Sarah & Wendy to confirm number of appointments still required and timescale for completion.
Melanie has also asked that all patients seen by consultants are coded correctly to them

Sarah updated on the Personal Information redacted by the USI Patient we hadn't been able to identify NOK [redacted] Personal Information redacted by the USI. Records had a friend listed but number not active. To discuss with "patients who pay" team to see if Embassy can be contacted**. ACTION: Sarah to liaise with Team to find family**

Sarah advised there are approx. 60 patients seen at clinic that require update letters. Awaiting feedback from Jane regarding letter template.
ACTION: Sarah to draft template with Clinic updates and share (whilst awaiting approval from Urology Inquiry) to be ready once go ahead is given

Letter templates have been revised by Janes team and Sarah was advised last week these have gone to Christine Smith for review. Melanie has asked these to be shared with her**. ACTION: Emma to ask Jane to share templates**

Sarah also advised she was still awaiting feedback from Janes team with regards to the SAI apology (lack of signature) and the redraft of update 2. Sarah shared the feedback from the service users with the group. **ACTION: Emma to ask Jane regarding the SAI letter update**

Melanie discussed the outcomes report for UAG. Sarah advised Sophie Lusby had been in contact to set up a meeting to discuss this. Also noted next UAG meeting falls on 17th March. **ACTION: Sarah to email both Sophie and Caroline to establish re next meeting. ACTION: Melanie to speak to Maria regarding the HSCB Outcomes report**

Continued SCRR process was discussed at UAG last meeting. Sarah advised anyone identified outside the original 77 have been recorded separately. Melanie advised we need the **details of the outcomes report to steer the direction** for further lookback, perhaps up to 5 years, as per decision @ UAG.

Melanie advised Sarah needs dedicated admin support for this continued work. Wendy advised Maria who has been assisting Sarah could be released to work soley with Sarah**. ACTION: Wendy to speak to Jane to confirm**

Wendy advised Melanie she had received notification that Avril Frizzell and Emmett from Legal Team joining the Urology Departmental meetings. Melanie informed for information but does not need to attend.

Role of the CNS discussed. Advised they are supporting this lookback by attending clinics with AOB review patients where able but sickness has hindered this in recent weeks. CNS also supporting Info Line and allocated as Key Workers. CNS focused within SAI recommendations actions and work plan. Melanie asked about membership of the group as per TOR. Noted that CNS were invited but due to surgery they haven't been able to attend.
ACTION: Sarah to send invite to Leanne McCourt & ensure TOR are updated and circulated.

Next Meeting Scheduled for 8.30am Monday 28th March 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
28~~14~~th February @ 8.30am Via Zoom

Present:

Ronan Carroll
Dr Maria O'Kane
Martina Corrigan
Sarah Ward
Mark Haynes
Dr Damien Gormley
Emma Stinson
Lynne Metcalfe

Apologies
Wendy Clayton
Melanie McClements

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared.

Matters Arising

Action Plan for Steering Group

- SW shared the report 'Action Plan Internal Lookback Steering Group.
- RC asked if the attendance has improved for the clinics and if they were running to maximum capacity. MH advised that the clinics had been filled and there had been an odd cancellation due to illness or covid.
- RC asked if we were any further on with the Royal College of Surgeons. Mc replied that Dr O'Kane had sent correspondence to them but as of yet we had no reply. RC commented that nearly a year had passed and wanted to know if we would be critised for not doing more. DG advised that they operated within a schedule of works and it was out of our control. MC commented that the Inquiry Team were aware of the situation and that we had a paper trail to show that we were keeping on top of it.
- SW said that she previously spoke about the 2 patients whos cases were much more complex and needed records reviewing. SW advised that she had now made contact with the lady patient and both patients were awre their cases would take additional time due to complexities.
- SW advised that she would be starting to go through the remaining 247 patients internal screening process today. Chris is aware of this. Melanie had asked in the last meeting how long it would take for this to be done and Sarah hopes to

be in a position to update when she has completed the first batch. **ACTION: After first batch completed Sarah to update.**

- SW advised at the last meeting that there was an additional 33 patients who's records couldn't be located. SW advised that Martina assisted with this and there is now only 6 patients remaining. **ACTION**: update when completed.
- SW asked MC about AOB annual leave. MC said that his leave was all over the place as sometimes he had requested leave and then not taken it. MC said her records and Mr Youngs didn't match.
- RC asked about the source of the initial set of screening bt MC and MH. MC said patients were screened in or out. If they were just on waiting list they were screened out and not sent through for SCRR. DG asked what was an adverse incident and MC replied that they weren't treating a case as an adverse incident if it was something like a delay in a scan as opposed to if a scan had not been requested. MH commented that anything Prof Sethia had cause for concern with was being treated as an adverse incident.
- MO'K asked if we had a master spreadsheet and SW shared same and advised the further 247 patients screening was starting today and governance were aware. MO'K asked if it highlighted the areas Prof Sethia had concerns about and SW advised that it did. SW advised that the spreadsheet was all cross referenced with Prof Sethias. RC wanted to know the totality of patients on the spreadsheet and SW said 3012. MO'K asked if that helped in terms of information? DG yes.
- MC said that she had 6 she was still looking into that were not coming up as AOB. MC said she ran a PTL~~PTC~~ with clinic codes and found 17 under the wrong codes. RC asked what triggered the search and SW said that the patient had phoned Mr Keanes secretary. MC said an MRI had been ordered under a different code and the patient had phoned for an update. 17 recorded under the wrong code. MO'K asked how many patients Dr Keane had saw and MH said 236 and it was not clear why the scan required a different code. It didn't go through the normal request process. MC said she was going through all again to make sure all has been done as it wasn't on the letter that a scan had been requested. MO'K asked was he right to request a scan in first place and MH said different consultants would have different answers. SW said there is a problem with OP reg codes and MC said a report is ran every 6 months to see if there are any patients that haven't been seen. 2 patients under AOB clinic in 2013 & 2014 didn't seem to have any except for 2 patients who DNA.
- MH advised that he has 36 codes assigned to him, even though he only has one clinic. He said the whole system was very complicated and as it was manual was open to individual error. He suspects there are other open OP REG codes in other specialities throughout the Trust. RC said that we need to be absolutely sure that every patient of AOB has been identified and reviewed.

Lookback Exercise

Letter update to patients

- SW shared the activity to date report.

- SW advised that all letter A & B sorted.
- Professor Sethia has reviewed 411 Cases, 29 with concerns, 27 to be added on to the list and 355 had no issues.
- SW advised letter C is now finished except for the two patients still under review who are aware of the situation.
- SW advised that there had been a few issues with the letter contents. The letters were sent without signatures and Susanna from the Service User Group though the content of the letters was cold. MH asked if we had people checking the content of the letters to make sure that they were in simple and understandable language. MO'K said it would be useful go get input from the service User Group. MH advised that there was a group called 'plain English Group' who checked things like this. ACTION: SW to search and source this.
- SW advised that of the letters sent out 7 did not respond and some said they did not want to be involved or contacted. SW shared this list with MC.

SCRR

- SW advised 3 Consultants are on board and 30 patient records have been sent across to them. MMc enquired if the 3 consultants would then take the further 30 cases between them after the initial 30 were reviewed and SW confirmed that she expected this to happen.
- MMc said a clear timeline was needed for the outcome of the screening from these consultants. SW advised that she believed the findings would be sent across as soon as they were completed and that no deadline had been set for this, however, she would touch base with Stephen for an update. **ACTION:** sarah to get update from Stephen on SCRR feedback
- SW advised that she had a conversation with Raymond from 352 Healthcare last week. He confirmed that he believed he had consultants who would be willing to screen the cases, SW advised that these are potential cases of possibly 300 but she is planning for the unknown.

- **ANY OTHER BUSINESS**

- WC said that SW and herself had gone through Mr O'Briens job plan rota to see what was done, however, they could not see if he had been on ward rounds. SW and WC were both confident he was on the rota to do clinical success, MDT and ward rounds. MC advised that he did work in the clinics although he would have seen less patients than the other consultants. MC further advised that junior doctors raised concerns that they had to do the ward rounds without Mr O'Brien and just with the Reg as he was never there to join them. Sometimes he would arrive for ward rounds at Midday but never actually looked at the patients he was just there to chat. Mr O'Brien would also have been noted on the wards at 1 and 2am. MC further advised that Mr O'Brien would have phoned patients on a Sunday to book them on for the following weeks clinics

and he definitely would have been in these clinics. SW said that she had looked at annual leave for Mr O'Brien from January 19 – March 20 and it looked like he didn't take annual leave and Mr Young would have recorded this. MC advised AOB would request leave and not take it or else take it and not tell MC therefore the leave recorded by MY and MC didn't match ~~that he actually did take all of his annual leave and more and was renowned for saying on a Friday that he didn't have anything on and would take that day as annual leave. MC is to send SW a copy of Mr O'Briens Annual Leave for these periods. **ACTION:** Martina to send Wendy & Sarah a copy of AOB annual leave for this time period to cross check~~

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Next Meeting Scheduled for 8.30am Monday 28th Feb 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
14th February @ 8.30am Via Zoom

Present:

Melanie McClements
Ronan Carroll
Dr Maria O'Kane
Martina Corrigan
Wendy Clayton
Sarah Ward
Emma Stinson
Lynne Metcalfe

Apologies

Mark Haynes
Dr Damien Gormley

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome

- Minutes of last meeting shared. MMcC asked if there were any actions from the last meeting to which SW replied the main issues from the last meeting was the capacity in the review clinics and the fact that they had not been running at capacity mostly due to DNAs. This seems to have been mostly resolved and the clinics going forward are maxed out.

Matters Arising

Action Plan for Steering Group

- SW shared the report 'Action Plan Internal Lookback Steering Group.
- MO'K commented that RC had mentioned if we should be looking further back as we were a public body, MO'K said that for the time being we had to stay within the terms of the public inquiry.
- SW said the TOR had been agreed.
- MC advised that Dr O'Donaghy had 2 DNAs at his clinic who had confirmed but then didn't arrive for appointment. RC asked what happened to patients that DNA SW advised that they would be contacted to find reason of non-attendance and then another appointment would be sent out to them. SW said that last Mondays clinic had to be cancelled because of sickness in the urology department, WC commented that Johns clinic had to be cancelled today and Marks clinic on Wednesday would also have to be cancelled as he currently has covid. Sarah advised that because of cancelled clinics this may exceed the end

of March timeline. **ACTION:** All clinics to be maximised and RBC to advise if slots unfilled to allow for patients to be allocated

- RW commented that we had previously discussed the Royal College of Surgeons and they now come June would have had the charts for a year. MC advised Dr O'Kane would be writing to the Royal College of Surgeons regarding this and she would chase up, MC said this letter needed to come from the Medical Director. **ACTION**: Dr O'Kane to write to RCS to ascertain the progress of 100 charts review

Lookback Exercise

Letter update to patients

- SW said that MMc had asked for descriptors for letters A-C which were sent to patients. Melanie asked for this to be elaborated on. **ACTION**: Sarah to update the template to include descriptors
- SW explained anyone who received a letter A had been screened by Prof Sethia and Mark Haynes and the vast majority of the 295 reviewed had all received a letter A.
- Letter B was sent to patients whose files are currently being reviewed by the 3 consultants at the additional clinic and any who have been seen and deemed to be ok have now received their letter A. MMC asked from letter B did we know how many had been done and SW said that she was uploading them currently onto a spreadsheet, MMc asked if there was any new themes being picked up SW replied no that most who were being seen were then receiving the letter A.
- Prof Sethia update was shared by SW 425 patients were screened and 29 were identified as having concerns, 27 patients need to be seen at the clinic and added onto the review and 355 were identified as having no issue and were sent letter A.
- Letter C was sent to 174 patients who are on review waiting list and they have all received letters now.
- SCRR patients – of the original 77 patients 57 have been confirmed for SCRR and 2 remain a male and female as they are complex cases and have had over 20 procedures each. One is a [redacted] who has made contact with the information line and has spoken at length to Martina and Mark, he is aware that as his case is complex it is taking longer to screen and the other is a female who has not received a letter yet. SW said that MH has advised that he cannot determine if the procedures the patient received were warranted as there are so many different specialties involved so the case will need to be looked at by other doctors in those specialties. MMC said that the patient needs to receive a call first to advise her that her case is being looked at and because of the mixed specialties it will take a while longer. She then needs to receive a follow-up letter confirming this. SW confirmed that Fiona Sloan was the liaison with the SCRR and a phone call was necessary and a detailed letter. SW further advised that 7 patients have not responded at all and this has been detailed in the correspondence sent to them. **ACTION**: Sarah to link with Liaison to make

phonecall to the female patient advising of complexities in review and potential for SCRR

Patients in each cohort

- RC asked about the 300 patients and MO'K said 29 or 25 have been forwarded for SJR and wanted to know if there was any new themes. SW advised vast majority were the same themes and are waiting time related which was out of our control. MO'K said we couldn't take waiting time themes at face value and these still needed to be properly reviewed. **ACTION:** Sarah advised the internal screening team were continuing to meet on Mondays (none next week due to Consultant AL) and will screen each patient and record the reasons they were not screened in.
- MC advised that out of the patients Prof Sethia reviewed 77 were identified as having cancer and 247 were screened out as they didn't meet the threshold. MC advised that she and MH looked at the waiting times on the cases and that Chris had advised that we need to be robust and open to the same screening procedures in the internal screening process that was done initially. MH further advised that Chris said that to keep things above board the same screening process must be used on the other 247. **ACTION:** Sarah has emailed Chris to advise of the intention to continue screening and recording the outcomes. Datix to be completed on those screened in and minutes will reflect the reasons for screening out
- MMc asked what was the difference between Martina and Mark reviewing the cases on their own compared to the other team and MC advised that Chris had said Mark and Martina needed to be under the larger team. MO'K said that it added an extra layer of protection as we may be challenged on it. MMc asked SW for a timescale for completing the 247 reviews and SW advised that she is currently working through 22 a week so it may take a few months, however, some are clear-cut and can be removed from the list as they don't meet the threshold. **ACTION:** To ascertain after next screening meeting how quickly these can be done and establish a timeline for completion
- SW shared the Themes with the meeting which are Bicalutimide, Radiotherapy, MDM, Surgery, Results, and Procedure. SW advised that she did cleansed and crosschecked the master spreadsheet and shared same for the purposes of DLS. MC advised the DLS needed the information for the USI and SW advised that some of the patients who were contacted or relatives of patients who had passed did not want to be contacted again by the inquiry and did not wish to take part. MMc said that this needed to be made very clear on the sheets so that we had a trail as well. **ACTION:** Sarah to share this with Martina. Advised this is clear on the spreadsheet also and the emails/ phone calls are saved in email folders from Fiona Sloan/ Info Line Call Handlers
- SW commented that she had 33 other cases which she believed had no connection with Mr O'Brien. MC said she also checked these and on quick glance had found 7 cases but would need to look in more detail as she believed that these were cases Mr O'Brien had possibly seen privately. **ACTION:** Martina advised these will be looked at closer with Sarah. Unlikely there is 33

as some are known to have PP encounters. Will likely require records to be pulled.

SCRR

- SW advised 3 Consultants are on board and 30 patient records have been sent across to them. MMc enquired if the 3 consultants would then take the further 30 cases between them after the initial 30 were reviewed and SW confirmed that she expected this to happen.
- MMc said a clear timeline was needed for the outcome of the screening from these consultants. SW advised that she believed the findings would be sent across as soon as they were completed and that no deadline had been set for this, however, she would touch base with Stephen for an update. **ACTION:** sarah to get update from Stephen on SCRR feedback
- SW advised that she had a conversation with Raymond from 352 Healthcare last week. He confirmed that he believed he had consultants who would be willing to screen the cases, SW advised that these are potential cases of possibly 300 but she is planning for the unknown.

- **ANY OTHER BUSINESS**

- WC said that SW and herself had gone through Mr O'Briens job plan rota to see what was done, however, they could not see if he had been on ward rounds. SW and WC were both confident he was on the rota to do clinical success, MDT and ward rounds. MC advised that he did work in the clinics although he would have seen less patients than the other consultants. MC further advised that junior doctors raised concerns that they had to do the ward rounds without Mr O'Brien and just with the Reg as he was never there to join them. Sometimes he would arrive for ward rounds at Midday but never actually looked at the patients he was just there to chat. Mr O'Brien would also have been noted on the wards at 1 and 2am. MC further advised that Mr O'Brien would have phoned patients on a Sunday to book them on for the following weeks clinics and he definitely would have been in these clinics. SW said that she had looked at annual leave for Mr O'Brien from January 19 – March 20 and it looked like he didn't take annual leave and Mr Young would have recorded this. MC advised that he actually did take all of his annual leave and more and was renowned for saying on a Friday that he didn't have anything on and would take that day as annual leave. MC is to send SW a copy of Mr O'Briens Annual Leave for these periods. **ACTION:** Martina to send Wendy & Sarah a copy of AOB annual leave for this time period to cross check

Next Meeting Scheduled for 8.30am Monday 28th Feb 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
31st January @ 8.30am Via Zoom

Present:
Ronan Carroll
Martina Corrigan
Mark Haynes
Dr Damien Gormley
Wendy Clayton
Sarah Ward
Emma Stinson
Lynne Metcalfe

Apologies
Melanie McClements

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared.

Matters Arising

Action Plan for Steering Group

- Sarah shared the report 'Action Plan Internal Lookback Steering Group.'
- Ronan asked if there were any actions arising from last meeting to which Sarah replied the main thing completed was the SOP for the booking centre. The filtered master spreadsheet has been sent through and the booking centre have been told to pull off the list in order to fill the slots for appointments at the clinic, Sarah believes there should be no further issues.
- Ronan enquired if we have had any further clinics and mark advised that he had a clinic on 19th January which 9 patients were booked into and only 7 attended the remaining 2 cancelled. Ronan said he would like to know what the DNA figures were for Tony and John's clinics.
- Sarah advised that Professor Sethia had completed a review of 411 clinical records. Out of these 355 had no issues and would be sent a letter A, 27 have to be reviewed and 29 had concerns
- Ronan asked the group what they thought should be done with the additional 29 patients that Prof Sethia identified as having concerns. Should they be added to the list of patients already identified and screened and brought in for review? He added that advice should be taken from a higher authority as to how to proceed. Mark commented that without screening we can't make the assumption that they have the same concerns as the previous patients. Martina added that the concerns of the new 29 identified needed to be looked at and then it has to be decided if they are to be added on to the list as additional

names. Martina commented that Maria was to come back and let us know if there were new cases with additional issues did we open a new SAI or add to the list. Mark commented that whether we screen or not the files still need to be reviewed. Dr Gormley commented that we have to follow all of the processes and if there is a problem flagged with a patient then it has to be made sure that the patient is currently on the proper treatment. He further commented that out of the 77 only 14 had been screened out. Martina advised that Chris Walmsley had said we have to follow the same processes for all, we would be criticised if the same process was not followed and we will be asked what process was used. Ronan asked why the initial 77 were screened and Martina advised it was because of serious concerns. Mark added that it was concerns regarding clinical management and Ronan commented that we as a Trust do not want to be found wanting. Mark said that the decision making needs to be clearly documented and filled in. Dr Gormley said if you came across a case like this that wasn't related to AOB you have to ask would you take any action.

- Ronan advised that there needs to be very clear decision making and records kept and also it would be helpful to know what is in the additional 29 cases. Is it a case of anything clinical is kept in and anything not clinical is out? Mark advised that there had been an incident with a man who had penile cancer and was not on the waiting list, this was a SAI.
- Ronan asked how we were going to process the 130. Mark replied there needs to be an excel spreadsheet with a summary of concerns and why some are not on SAI process and this needs to be signed off.
- Martina commented that it would be helpful if Chris Walmsley was at the lookback meetings going forward.
- Sarah is to link in with Chris to collate the spreadsheet and then add the further 29 to it.
- Martina advised that the solicitors from DLS have asked that they be updated in relation to the fortnightly meetings in the lookback group. Ronan said he was happy with this and Martina said that she would provide an update along with updated spreadsheet and everything else needed to update on meeting.

Lookback Exercise

- Sarah shared the report 'Activity to Date as of 27th January 2022'. Melanie had asked for the meaning of each letter A, B, C to be elaborated on and Sarah has provided this in the report.
- Sarah advised in the last meeting we had talked about themes. Six themes have now been agreed going from most common to the least common.
- Sarah advised that she is in the process of cleansing the master spreadsheet and believes she has approximately one hundred letters still to send out.
- Sarah updated the meeting that Professor Sethia had completed a review of 411 clinical records. Out of these 355 had no issues and would be sent a letter A, 27 have to be reviewed and 29 had concerns.

- Sarah commented that patients who had initially received the letter B however, were subsequently found to have no concerns have now been cleared and are receiving the letter A.
- Sarah commented that the urology information phone line has taken off and 36 calls have come through, a lot of them are from patients who received letter A and it is very time consuming.
- Sarah further advised that every patient who has been screened to date has now received a letter and phone call.

CAPACITY

- Sarah commented that there are 100 slots still to fill for the end of March. Wendy said she was waiting on the March availability for the consultants. The additional 29 patients may push us over the deadline of end of March.
  Ronan asked if a patient DNA were they invited back. Wendy said yes but they might not be seen until the end of March. Every patient will be offered an appointment by the end of March.

SCRR

- 2 Consultants are on board and 20 patient records have been already sent across to them. One other consultant is about to come on board and hopefully by next week another 10 records will be sent across.

- Sarah advised that the independent sector are looking at taking on some of the cases under contract. Originally 352 Healthcare were looking at taking on the contract however there were issues with their insurance. Ronan commented that the contract would have to go out to the private market for tender so that all companies had a fair chance to take on the contract. Sarah said that the 3 consultants on board might only take on about 60 of the cases, Dr Gormley said he believed each consultant would only take on 10-12 cases each. Ronan asked Sarah to speak to the contracts team and she replied that she was in the process of getting everything prepared and ready to go but there was quite a bit off work involved.

- Ronan asked if the Royal College of Surgeons had been in touch and Martina replied, no, a lot of the staff had bowed out and this is a conversation that needed to be escalated to Maria as the matter had been ongoing from July. The Inquiry had also contacted them and had been told the same. Ronan commented as a public body he thought they should be looking beyond the first lookback. Martina said that she would be happy to go back to Dr O'Kane but if the Royal College came back in a few weeks and said we had to go back to 2015 it would be a huge piece of work.

- **NO OTHER BUSINESS**

Next Meeting Scheduled for 8.30am Monday 14th February 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
17th January @ 8.30am Via Zoom

Present:
Ronan Carroll
Martina Corrigan
Mark Haynes
Dr Damien Gormley
Wendy Clayton
Sarah Ward
Emma Stinson
Lynne Metcalfe

Apologies
Melanie McClements
Dr O'Kane

Purpose of Meeting
Internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared.

Matters Arising

- (Dr Gormley confirmed that one person had completely engaged and there was a meeting tomorrow with another.)
- Sarah gave update that Melanie was to meet with Chris for an update of SCRR patients. Dawn has most uploaded and will be ready to start transferring notes.
- Update on letters – No further action required.
- Wendy confirmed the Clinics for the month of January have been set up and she is waiting for Februarys theatre list so she can set up Februarys Clinic.
- There are text alerts going out to patients with appointments.
- Mark advised that patients are not turning up for appointments and it is not known until the day of appointment. Anyone who is a DNA needs followed up. There needs to be a clear list of patients and that as a last stop they should be able to contact the Consultants secretary.
- Mark advises that patients are contacting the information line and not getting through. There is then a subsequent number of emails being sent in relation to who to send for next, which is time consuming. An SOP needs to be put in place for which patient is to go to next. Wendy advised she would speak with Sarah regarding this.
- Ronan commented that we have to make sure that the clinics are booked. DNAs will be inevitable. Mark commented that the clinics need to be filled. The matter has been left with Wendy and Sarah.

- Sarah advises that she was off and is only back into the office today. She needs to catch up and see what has been done whilst she was off.
- Ronan asked if anyone wanted to raise concerns or queries and asked for a summary of what stage we are at.
- Sarah confirmed that the position as of last Thursday was that 582 patients were still to be got through, although the figures would have changed by now. Martina advised that she needed updated figures today as she had to update the Trust Board. Sarah confirmed that this would be provided and the table updated.

Action Plan For Steering Group

- Sarah asked was there anything in the action plan that anyone was concerned about.
- Mark asked if all patients had now been through screening and was advised that there was a small number (6) left who needed a comprehensive notes review. Mark enquired regarding the patients who needed a comprehensive notes review if he was expected to do this or add it to the review. Dr Gormley advised that the normal processes for a serious adverse incident should be applied and the cases would need to meet the threshold. Mark advised that this was a phenomenal piece of work and there was no time available to him at present to review the cases. He cautioned that it will take him a lot of time to get through 6 patients who have had multiple procedures.
- Ronan said he was comfortable that we were making progress and there were a lot of greens which was positive.

SCRR

- Sarah advised SCRR is down to a handful and a meeting is taking place today at 11am. It was agreed if Mark hasn't reviewed the remaining 6 patients that there was no point in continuing with the meeting and it should be deferred to another date. Mark advised that he would let everyone know when this was done so the meeting could be rescheduled.

AOB

- Ronan commented that everything was going the right way.
- Concerns were raised over the clinical subject review and the amount of patients available to us. Sarah advised that out of 77 patients that were to be screened 14 had been screened out and 63 remained. Out of the 63 patients remaining 57 were identified for a clinical subject review and 6 were still to be screened by Mark.
- There has been an additional 2 patients added to the review and Dr Gormley believes that these should be kept separate from the original 77 patients.

- There is difficulty getting patients to confirm. Patients are being selected by a random selector which will choose patients from the same theme. We need to alter the way in which this is done and Sarah is to draft this.
- The process needs to be made clean and clear in order to get patients to engage.
- Mark commented that themes outside of normal practice should be highlighted to the individuals conducting the reviews who in turn can highlight back. It is necessary to give as much information as is possible in order for them to give quality feedback.
- Mark enquired if our learning to date had been shared and in particular if the SAIs have been shared. Martina advised that only the drafts had been shared to date. Mark advised that anyone conducting the reviews should have this information available to them and Martina advised that this would be done.
- Mark stated a conversation needed to be had in relation to the clinical reviews. That a contract needed to be built in to give clarity and certainty as to what the processes should be for clinicians seeing patients and they need to be given a full briefing of what they should be aware of.

Next Meeting Scheduled for 8.00am Monday 31st Jan 2022 via Zoom

Notes from Urology Lookback Steering Group Meeting
6 January 2022 @ 8am Via Zoom

Present:
Melanie McClements
Mark Haynes
Dr Damien Gormley
Wendy Clayton
Sarah Ward
Ronan Carroll

Apologies
Martina Corrigan
Kate O'Neill

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.
-

Terms of Reference
- Internal TOR for Steering Group accepted.
- External Assurance Group TOR on agenda for todays HSCB meeting.

Matter arising
- Melanie asked if there was final agreement re using the 4 questions on clinical review form or 9 questions that Prof Sethia has been using. Sarah advised Mark Haynes has been using the 9 questions as he had done so previously when reviewing the patients at his additional clinics. Michael Young and John O'Donoghue using the 4 questions as the 4 questions are non-biased and capture what we need. The 9 was an issue as felt too time consuming and concerns about commenting on another consultants practice. Focus to be on safe patient management.
- Melanie asked with regards to Section 21 notice - had all uploads been completed. Wendy advised Leanne McCourt was completing today and then we are compliant.
- With regards to the SCRR process Melanie asked how this was progressing with the team in England. Dr Gormley advised he has met with 1 of the consultants and there is more discussions pending. We are keen to get the patients screened internally to them to begin the SCRR process. Melanie advised she is meeting with Chris Wamsley today and believes a large volume is already uploaded for review. She will ascertain if we are ready from records/ notes upload perspective. **Action:** Melanie to check with Chris regarding record upload.
-

Update re Capacity to See Outstanding Patients

- Sarah shared the table of the 428 patients left to be seen. By end of Jan 22 our predicted activity is 2330 patients. However Mark advised at yesterday's clinics there were 4 DNA's despite them confirming and staff attempting to ring from clinic. Melanie has asked that a text reminder be sent to patients in advance as reminder. **Action:** Wendy to ask booking centre to ensure reminders sent.
- Melanie asked about overbooking clinic to allow for DNA, Mark advised he tried this previously and clinic ran over extensively. A discussion ensued re the process for DNA and agreed that this is more sensitive than regular appointments therefore agreed patients who DNA will be offered another appointment.
- Sarah advised we are waiting on Feb/ Mar on call rota which may affect our planned completion date of end of March. However Wendy advised we are maximising the theatre slots we cannot use for reviews so we hope to still meet this timeframe. Also accounting for DNA patients this may also affect end date.

Update on Letters to Patients

- Sarah advised we have a total of 1513 (plus some more completed yesterday afternoon) completed with approx. 580 still to send. All Letter A (no issues with care) group have received their letters. All Letter B (awaiting review of care) group have been sent also. The final group Letter C which is care reviewed and needs follow up is ongoing. The challenge has been we are booking the patients into clinics and Sarah advised it felt inappropriate to send Letter C then patient be seen the following week. On discussion with Ronan agreed to hold on letters for patients booked into first few weeks of January and then send letter post review clinic. Group agreed this was reasonable approach. Sarah currently working through who is booked onto clinics and getting letters out to those who are not.
- Sarah advised of the patients already seen at clinics in Dec - they have been sent a personalised letter following their review. Clinic yesterday - will have the same completed once clinic notes available.
- Of Original 77 SCRR patients we have screened out 14. They have received Letter A (No issues) following the screening process. We have 17 left to screen. Sarah has letters prepped for these. All patients screened to date have received a call from Liaison Team and letters sent.
  1 Patient who is RIP and NOK is now RIP who we cannot get a contact for. Sarah has advised she is currently requesting notes for this and other patients in similar circumstances.
  Of all patients called by Liaison, 6 have not responded to multiple calls and messages left. This has been included in the letters sent to them also and encouraged them to make contact.
- Master Spreadsheet is being kept up to date of all activity including type of letter sent, date of sending, datix numbers, calls from Liaison and any

feedback, dates of review clinic appointments and completions of clinical record review forms.

- Little contacts on Info line but Sarah advised this may increase now Christmas is over. Currently supported by Matthew McAlinden's PS team and database kept for these patient calls.

Other Matters

- Discussion regarding Service User Group. Sarah explained that we had a meeting with the Liaison staff as it was felt that their expectations of the group was not what a service user group should be. One Service User in particular has caused anxiety re role and function for staff. We are waiting feedback from Liaison team as they were going to meet with the service user.

Next Meeting Scheduled for 8.30am Monday 17th January via Zoom (renewed link sent) and will be fortnightly after that.

Melanie Personal Information redacted by the USI so Rona agreed to Chair..

Notes from Urology Lookback Steering Group Meeting
20 December @ 8.30am Via Zoom

Present:
Melanie McClements
Ronan Carroll
Martina Corrigan
Mark Haynes
Dr Damien Gormley
Wendy Clayton
Sarah Ward
Dr O'Kane

Apologies
Kate O'Neill

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.

Terms of Reference
- Internal TOR agreed after last meeting on 6.12.21
- External Assurance Group TOR discussed at last meeting and Caroline Cullen going to add to. These are to be shared at next meeting in Jan 2022

Matter arising
- Melanie asked if there was final agreement re using the 4 questions on clinical review form or 9 questions
- Martina advised that Prof Sethia is using the 9 questions as he is looking at historical care and these are appropriate for this. 4 questions was discussed in meeting with Caroline Cullen, Ronan & Sarah on Friday and aware we are going with 4 questions based on following:
  1. CMO questioned use of 9 when 4 deemed reasonable
  2. Buy in from Consultants in house and in IS for use of 4 rather than 9. 9 felt to be too tedious
  3. Allows in house Consultants to remain neutral and not comment on past. Focus on current care pathway
  4. The process is quicker- means we can get more patients seen in shorter timeframe.
- Prof Sethia to continue his process on the 9 questions.
- All members of group asked if in agreement to use 4 questions. All in agreement but recognised that Prof Sethia to continue with the 9 as he has been using this process and is very comfortable with it.

- June Turkington in DLS aware of 4 questions as these were shared with her with the draft specification for IS contract. Comments on spec but not on questions. Melanie asked that June is updated on the decision to use 4 questions to ensure clarity. **Action:** Sarah to email June and cc members of group in to advise of the decision to proceed with 4 questions
- Melanie asked regarding Section 21 notice upload. Martina advised all completed apart from MH which is being completed and then we are complete. All CNS have uploaded.
- Martina advised she has raised with PI team the challenges coming in January 22 with the next surge and the high likelihood of redeployment to support teams. Martina has asked for acknowledgement that there will be a need to extend timescales for potential next section notices in light of this situation.
- Dr Gormley also advised that for the SCRR team with Hugh Gilbert. Of the 8 originally identified medical staff, 1 has withdrawn and a further 2 have not responded to the request. Dr Gormley advised they are planning to meet with them to reassure and ensure they are aware this is being done for the Trust and not for the PI team.
- Next UAG scheduled for today has been cancelled. We submitted update anyway.

Update re Capacity to See Outstanding Patients

- Wendy and Sarah updated on the Urology Consultants and x3 (including MH) accommodating WLI to address the 503 patients waiting to be reviewed. Initially the 114 patients on waiting list were identified as those to go to IS. Wendy explained with down turn in theatre capacity in Jan 22 these sessions can be used to accommodate these patients. Communication going out today with the sessions available and the allocation. Aim to have these completed by Feb therefore still on track to have all patients reviewed by March 22.
- A 2nd CNS (Cancer) has had to go off sick due to knee injury and is unable to drive therefore with this gap there will be no resource to have CNS present at each of the AOB review clinics. CNS remaining will do the best they can.
- Wendy detailed the clinics completed so far from JOD and MY with MH starting this week
- Sarah shared the table we submitted to UAG detailing the volumes and dates.

Letters/ SCRR

- Sarah shared the table detailing that just over 100 letters (Letter A-record review and no issues) have all been completed and posted from last week.
- Sarah advised that the letters for RIP patients were 2nd checked by her to ensure correct NOK, H&C etc etc. Few issues but all rechecked after amendments and sent.

- Letters B & C (needs records reviewed & reviewed but need further review) have been in progress from last week. Some of these will have been posted as Matthews team have been working through these. Sarah to get update from Matthew from weekends activity as staff doing additional to get letters completed.
- SCRR letters completed for all patients we have screened (55 in total). Remaining 23 to be screened today. Sarah has prepped letters for some of the remaining 23 in advance of meeting to try and get ahead.
- The 55 patients screened have been contacted by Liaison (some have not responded) received call from daughter Friday asking as they know the plans for SCRR can they not receive the letter prior to xmas and get this after. Sarah asked for consensus on this as also noted Fiona Sloan the SCRR liason link is not available to ring remaining SCRR patients until this Wednesday (22nd Dec) and felt it too close to xmas for this. Also conscious that letters going out this week in Letter B & C groups may not get these until end of the week and therefore no one will be available on Info Line to support. Would like to delay ringing further SCRR patients and sending out remaining Letter B & C until next week.
- Group all asked individually of thoughts and all agreed that this was the most sensitive thing to do as these patients are all being told their care needs looked at. The patients who have received Letter A are assured there are no issues and therefore this would provide relief for xmas.
- Agreed that next wed 29th Dec we would start ringing the remaining SCRR patients as we finish screening today and aim to post letters to SCRR, Letter B & C groups on Friday 31st for them to arrive Monday 2nd and then have Info Line support available from 3rd after bank holiday.
- Aware inquiry team have written to the SAI patients at this time. No indication that any SCRR patients or any other patient has been contacted.
- Sarah advised that we have not yet had a steer on the continuation of the SCRR process. Dr O'Kane advised she has written to Lourdes and is awaiting guidance. As themes have been identified in current SCRR process felt we do not need to continue however aware that Governance HOS has asked about the screening of the previous patients. **Action:** Await feedback regarding continued SCRR screening process.
- Sarah advised all datix have been completed for the 77 SCRR Patients that have went through screening.
- Master spreadsheet has been updated to reflect datix number, patients seen at WLI clinics, outcomes, info line contact, letter type and date sent etc.

Next Meeting Scheduled for 8.00am Thursday 6th Jan 2022 via Zoom: Sarah will send out link for this one only and then continue with already scheduled 2 weekly Monday meetings.

Notes from Urology Lookback Steering Group Meeting
6 December @ 8.30am Via Zoom

Present:
Melanie McClements
Martina Corrigan
Mark Haynes
Dr Damien Gormley
Kate O'Neill
Wendy Clayton
Sarah Ward
Dr O'Kane

Apologies
Ronan Carroll (on leave)

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.
- Calendar invite (zoom) appears to be not appearing in some members calendar.
  Action: Sarah to cancel all other versions of this meeting and resend link to all starting from 20th December on fortnightly occurrence.

Terms of Reference
- Internal TOR for Steering Group sent out for comment. Nil returned and group happy to accept these.
- External Assurance Group TOR discussed at last meeting and Caroline Cullen going to add to. This will be shared at next meeting in Jan 2022. **Action:** Sarah to finalise TOR and circulate.

Matter arising
- Melanie asked if there was final agreement re using the 4 questions on clinical review form or 9 questions that Prof Sethia has been using. Sarah advised no further feedback has come to her but group following discussion agreed there needs to be final clarity on this. Melanie advised this to be added to the agenda for the Jan 22 HSCB meeting. **Action:** Sarah to add to agenda for Jan meeting.

Update re Capacity to See Outstanding Patients

- Wendy and Sarah updated on the conversation with the Urology Consultants and x4 (including MH) happy to undertake WLI to address the 503 patients waiting to be reviewed. Explained MY has expressed initial desire to see the waiting list patients, with MH wanting to address

the Info line patients. Discussed that priority was for review backlog patients to be seen. Dr Gormley advised that we need to be sure that correctable harm is addressed as a priority as we may find that historical care cannot be reviewed if records destroyed after patient RIP over 7 years.
Action: Wendy to speak to Consultants and advise that priority to be given to the review backlog patients.
Wendy to detail for Melanie which Consultant will do what, in core commitment and in additionality. Wendy has raised that Consultants want the agreement in writing as there may need to be flexibility with WLI rules. For consideration once clearer picture of what additionality is required.

- Mark explained that working over 48 hrs per week exceeds European working time directive and requires explicit approval from Trust / HR. Mark detailed potential to displace admin into own time. Mark also expressed collective feeling that stopping clinics to complete this backlog would be a big step back in the work done to address Urology waiting times.

Discussion/ Actions

- Melanie asked about CNS role in addressing 503 patients and advised that it would be desirable if CNS could be present at reviews, but Kate advised clinical activity already planned for Dec 21 and asked is the request to displace planned clinics and reviewing potential cancer patients? Melanie advised it is not ideal for cancer patients to be stood down and queried the option of additionality to be explored within CNS team and prioritisation of backlog patients.
  Action: Wendy to discuss with CNS what additionality can be provided to support the clinics to see outstanding patients.
- Mark expressed pressures with trying to read lots of letters going out to patients (SCRR). Melanie advised Sarah to ascertain what we need Mark to review and if any other Consultant can assist so as not to stall actions.
  Action: Sarah to complete SCRR letters to patients and establish who needs to review these for checking prior to sending.
- Sarah shared the action plan devised following last meeting. Follows framework within the policy for Lookback exercise and collated to update on work done to date. Discussed that:
  - approx. 880 patients have been identified as being clinically reviewed, have no issues with care and are still alive. These letters have been generated via PAS and are completed with support Information Line details included. Shane Devlin has reviewed this letter template and is happy to have electronic signature added.
  - Next batch of patients is the same cohort only RIP and this involves establishing NOK. Sarah advised this is time consuming and group advised utilising OSL and PA staff to support this.
  - Sarah advised she wished to have all letters completed in next 2 weeks. Melanie asked if this can be expedited as so close to Christmas and need for patients to have this info in advance of PI team starting to make contact.

- Sarah also advised she would have to complete the letters for SCRR patients as they needed to have more specific information relating to the reviews/ actions completed to ensure they are on the right treatment plan now. There are approx. 50 so far with 29 still to screen so this is time consuming.
  Action: Sarah to collate RIP patients list and have OSL/ PA staff assist in collating the NOK details.
  Note all letters will need to be second checked to ensure addressed to the right person, and right letter in envelope. Advised 1st batch of letters were PAS generated and team of 2 worked on these over weekend.

- Sarah detailed the actions taken for the Information Line. We require 2
  - one for SCRR patients who are being contacted prior to letter being sent and is completed by the Liaison Team. A script has been done for this previously.
  - The 2nd line is the general urology Information line which Matthew McAlinden's team can provide 2 staff to cover the line from 10-2pm mon to Fri starting next week. There needs to be a script completed and a database formulated to collect information from those calling in with queries/concerns.
    Action: Sarah to work with Matthew to devise script and database.

- Next UAG meeting scheduled for 20th Dec. Melanie requests the reports for this by 15th Dec.
  Actions: Martina and Sarah to discuss and complete
- Terms SJR and SCRR are unclear to some of group. Sarah believed this was 2 processes but advised that the terms are essentially the same but the preferred SCRR is basically an SAI review to ensure patient is on the right treatment plan initially and secondly is a record review for learning purposes. Group agreed to draft descriptor/ explanation of the process and methodology and evolution form SJR process.
- Kate advised the agenda and previous minutes were sent very late to meeting. Melanie advised this was valid point and as Sarah just into post this can be addressed going forward
- **Action:** Sarah to ensure agenda and minutes sent in advance of the meeting to allow time to read.
- Kate also raised the issue re role of CNS
  Action: Wendy agreed to discuss outside meeting and inform re any issues.

Next Meeting Scheduled for 8.30am Monday 20th December via Zoom (renewed link sent) and will be fortnightly after that.

Notes from Urology Lookback Steering Group Meeting
22 November @ 8.30am

Present:
Melanie McClements
Martina Corrigan
Mark Haynes
Ronan Carroll
Damien Gormley
Kate O'Neill

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance and inform agenda/communication on regional meetings.

Terms of Reference

- **Regional TOR shared and briefly discussed.**
  It is intended that this group mirrors the objectives of the regional group to ensure dovetailing with the fortnightly Thursday meeting.
  ACTION: All to confirm if happy with objectives or any amendments. Agreed membership to be refreshed for local group (Sarah)

Where We Are

- Martina provided update on patients still outstanding to be seen and summary document shared. Discussed range of review types to date, desktop, ftf etc.

Discussion/ Actions

- Discussion of the clinical review form and 9 questions vs 3 questions. Consensus - 3 was preferred at meeting last Thursday, however Mark felt it gave a more comprehensive picture using the 9. Maria had thought that for expediency we could proceed with 3.
  ACTION: Ronan will follow up with Mark to agree 3 or 9

- Can Dr Sethia carry out any further clinical reviews (desktop) for us?
  ACTION: Martina to ask Dr Sethia if capacity to do this.

- Discussions regarding in house additionality for Urology Consultants to review the outstanding patients from Mark. Requested that formal communication goes out to request this.

  ACTION: Ronan to send out email to request in house additionality

Next Meeting Scheduled for 8.30am Monday 22nd November via Zoom (link sent) and will be fortnightly after that.

Notes from Urology Lookback Steering Group Meeting
15 November @ 8.30am

Present:
Melanie McClements
Martina Corrigan
Mark Haynes
Ronan Carroll
Damien Gormley
Kate O'Neill

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance and inform agenda/communication on regional meetings.

Terms of Reference

- **Regional TOR shared and briefly discussed.**
  It is intended that this group mirrors the objectives of the regional group to ensure dovetailing with the fortnightly Thursday meeting.
  ACTION: All to confirm if happy with objectives or any amendments. Agreed membership to be refreshed for local group (Sarah)

Where We Are

- Martina provided update on patients still outstanding to be seen and summary document shared. Discussed range of review types to date, desktop, ftf etc.

Discussion/ Actions

- Discussion of the clinical review form and 9 questions vs 3 questions. Consensus - 3 was preferred at meeting last Thursday, however Mark felt it gave a more comprehensive picture using the 9. Maria had thought that for expediency we could proceed with 3.
  ACTION: Ronan will follow up with Mark to agree 3 or 9

- Can Dr Sethia carry out any further clinical reviews (desktop) for us?
  ACTION: Martina to ask Dr Sethia if capacity to do this.

- Discussions regarding in house additionality for Urology Consultants to review the outstanding patients from Mark. Requested that formal communication goes out to request this.

  ACTION: Ronan to send out email to request in house additionality

Next Meeting Scheduled for 8.30am Monday 22nd November via Zoom (link sent) and will be fortnightly after that.

Notes from Urology Lookback Steering Group Meeting
11 November 2021 : 17.00pm via Zoom

Present:
Melanie McClements
Dr Maria O'Kane
Mark Haynes
Ronan Carroll
Ted McNaboe
Michael Young
Wendy Clayton
Sarah Ward

Purpose of Meeting
Establishment of Monday morning 8.30am meeting to review the progress of Urology lookback exercise.

Where We Are
- We have 770 patients that haven't been reviewed at all.
- Need to consider separate management for patients on general waiting list- potentially to IS
- And these 770 patients once screened are managed "in house"
- 77 SJR's as a result of Martina and Mark reviewing 385 cases screened by Dr Zethia. This was not a formalised screening process and Mark advises that there needs to be an external screening process. Advised that Mark could not be the final point for the decision making and all agreed.
- Consideration for these to be reviewed by additionality or part of the IS contract.
- Themes within SJR noted for eg Bicalutamide- does SJR need completed for every single one or can this be condensed into a theme.
- Sarah has commenced completion of Datix for the screening for SAI. Approx 15 done today.
- Ronan has set up pilot of review and SJR starting Monday and will provides further updates on this ongoing process.

Discussion
- Sarah provided update on IS contract for the review of the patients records (completion of clinical review form) and subsequent F2F/ investigations/ Follow up that may be required. Currently the direction is for a "mock" of 4 sets of redacted notes to go to 3five2 for Consultants to use the form. Advised that issues predominately with complexity of form, and potential time taken to complete and to enable costing of contract. **Group Agreed:** that clinical review form would be amended to reflect the 3/4 questions asked for in the Outcomes report- rather than the 9. **Action:** Sarah to revise the form for 3/4 questions only and proceed with "mock" exercise to enable pricing and progression.
- Can CNS assist in any aspect of the backlog. Advised that they are working through Urodynamics waiting list and as a result they may well have already

seen some of these without knowing they are part of the patient load outstanding. **Action:** Agreed that cross reference of who has had completed urodynamics that is included on the 770 patients waiting. Wendy agreed to do this and collate a list of names and DOB

- Can BAUS assist further with the desktop review of the outstanding patients?

Meeting Scheduled for 8.30am Monday 15th November via Zoom (link sent)
Apologies from Sarah Ward [redacted]

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 20:36
To: Carroll, Ronan
Subject: FW: Proof read / comments / sadditions

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 13 June 2017 11:04
To: Carroll, Ronan Personal Information redacted by the USI
Subject: Proof read / comments / sadditions

Morning Ronan

Could you read through this email which I intend to send to Ronan, Damian, you, Brigeen and Amie.

Are you about this morning to discuss through? Also need to discuss Mr Yousaf.

Mark

Dear Damian / Ronan

I plan to start the job planning process for the coming year shortly. In order to do this I would like to meet with you both, alongside me, Ronan, Brigeen and Amie to discuss the process and needs for the departments of the coming year. I would be grateful if you could both confirm your availability over the next 4 weeks to Brigeen / Amie so that we can set this meeting up.

As you are aware, all consultants are employed on a 10PA contract (with the exception of those on the old contract) and each has an additional PA contract for their PA's over this standard 10PA.

As starting point for all consultants I will be looking to agree a core 10 PA job plan. It is intended that all consultants core job plans will be 'fixed' in terms of timing of clinical commitments but I would hope to have agreement with the whole consultant body to work flexibly in regards the nature of activity where required so that theatres do not stand empty. Due to the nature of the non-elective component of the job plans this will form a standard part of all consultants job plans and will be the same for all consultants. I would be grateful if you could give some thoughts to your current work patterns during the respective TSOW and SOW periods. In particular in regards any developments / changes to the current work patterns that you wish to bring in for the coming year and discuss these with your teams.

Governance activity as per the trusts job plan principles (rolling M&M cycle) takes place on half day sessions and as per the trusts principles, where this activity replaces DCC activity, the DCC activity is supposed to be paid back flexibly (this is not extra activity). Could you confirm if this is practical and workable within the team. If pay back of the lost activity is not practical, the SPA element within the job plans which includes this rolling programme will be adjusted so that it reflects the replacement of DCC activity.

In addition to this rolling programme I am aware that within T&O (for example) there is a weekly meeting which also serves a clinical governance function. I would be grateful if any such mandatory governance related activity which needs to be recognised in all job plans within the speciality could also be identified so that it can be included.

Where consultants wish to undertake private practice and/or WLI work for the trust they are require as per their terms and conditions of service to offer an 11th PA of activity to the trust. For all consultants the trust will wish to take up this options of additional activity. In order to make the most of our finite resources, any activity above 10 PA's will be recognised flexibly within the job plan. Where consultants have sessions during the week where they are not able to work flexible clinical activity (eg regular private practice sessions) these will be identified within the job plan and they would not be expected to undertake flexible activity at this time. However, all Admin and SPA activity will be scheduled during normal working time during the week such that at times where consultants are scheduled to be undertaking one of these activities, flexible activity can be worked into this session. The displaced activity can then be conducted outside of the job planned time.

In order to maximise the use of our finite resources we need to agree a leave process and rule across the two departments which are consistent with other staff groups within the department and avoid situations which have arisen in the past where we have almost all of an individual department on leave. Across the teams we need a standardised leave request process which must be documented, an agreed and adhered to request period (eg from 1 year before to minimum 6 weeks before the planned leave) and a maximum number of consultants on leave at any one time which must enable an agreed minimum service to continue (and this minimum service includes elective activity).

Finally I would like to agree a pattern for regular meetings with you both alongside Ronan/Brigeen/Amie to be worked into your job plans. I would like a monthly meeting of all of us and a separate monthly meeting (staggered by 2 weeks with the whole group meeting) with you individually alongside the respective HoS. Could you give some thought as to the timing of this within your own job plans?

Thanks

Mark

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 20:39
To: Carroll, Ronan
Subject: FW: 100%

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 15 June 2017 10:54
To: Carroll, Ronan Personal Information redacted by the USI; Weir, Colin Personal Information redacted by the USI
Subject: RE: 100%

100%

From: Carroll, Ronan
Sent: 15 June 2017 10:52
To: Haynes, Mark; Weir, Colin
Subject: FW: 100%
Importance: High

FYI – suggesting point 1, 2 & 3 apply to all surgical specialties?

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 15 June 2017 10:43
To: Gishkori, Esther; McVey, Anne
Cc: Kelly, Brigeen
Subject: FW: 100%
Importance: High

FYI and some thoughts & views to guide decision making today and for ever more!!!

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI

From: McKeown, Ronan
Sent: 15 June 2017 10:40
To: Bunn, Jonathon; Doyle, Timothy; McMurray, David; Murnaghan, Mark; Patton, Sean; Rajkumar, Shan; Roberts, Veronica; Watson, Bruce; Wilson, Lynn; Kelly, Brigeen; Carroll, Ronan; Burke, Mary; Hampton, Gareth
Cc: Ward, Sarah
Subject: 100%
Importance: High

Brigeen,

I hope you can allay some fears.
There is a lot of concern from the trauma ward that patients will be wheeled around from ED today, even if we don't have a bed for them and left on a trolley in the middle of the ward.

I have a number of concerns about this, if it is true

1. Until these patients have a bedspace they remain the responsibility of the ED team both for their medical and nursing care. They are not accepted for admission by the T&O team.
   All this is simply doing is storing an ED patient on our ward, with no resource to care for them.
   To be very clear - We are not accepting any medical or legal responsibility for the care of these patients.

2. It is undignified to leave these ED patients in a corridor or middle of a nursing area.
3. The physical storage of these ED patients in this manner is dangerous for the T&O patients that our under our care
   It will put our patients at risk in the event of Fire / cardiac arrest / medical emergency by blocking fire corridors and rapid access to our patients and equipment.

Ronan

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 20:51
To: Carroll, Ronan
Subject: FW: Letter of Concern
Attachments: Letter of Professional Concern.pdf

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 13 April 2018 15:05
To: Carroll, Ronan Personal Information redacted by the USI
Subject: Fw: Letter of Concern

This is just unmanageable.

I suggest we invite a review of services externally from the college of surgeons and commit to accepting all recommendation that come out of this review.

Any thoughts?

Mark

Sent from my BlackBerry 10 smartphone.

From: Gilpin, David Personal Information redacted by the USI
Sent: Friday, 13 April 2018 14:29
To: Haynes, Mark; Khan, Ahmed; Gishkori, Esther; Weir, Colin; Carroll, Ronan; Gibson, Simon
Cc: Aljarad, Bassam; Sim, David; Moan, Shane (Michael-John); Hillemand, Christophe; Gudyma, Jaroslaw; McArdle, Gerarde; Thompson, Richard; Hampton, Gareth
Subject: Letter of Concern

Dear Mark,
The surgical team in DHH were very distressed to learn that elective re-sectional surgery is leaving DHH. Unfortunately, there has been no consultation about how it will influence the hospital generally and surgery in particular. A letter of concern is enclosed requesting a formal meeting with senior managerial staff, and copied to those with an interest who may also like to attend.
Regards, David G

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 21:08
To: Carroll, Ronan
Subject: FW: Update on CW

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 24 October 2018 11:28
To: Carroll, Ronan Personal Information redacted by the USI
Subject: RE: Update on CW

I am – just busy (UoW)

Have had to send my likely apologies for the paeds meeting today as I am just about to start a case in emergency theatre that will be around 2 hours.

Mark

From: Carroll, Ronan
Sent: 24 October 2018 11:27
To: Haynes, Mark
Subject: RE: Update on CW

Good morning
How are you. You are not about these days
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Information

From: Haynes, Mark
Sent: 24 October 2018 06:00
To: Clayton, Wendy; Carroll, Ronan
Subject: RE: Update on CW

Yes

From: Clayton, Wendy
Sent: 23 October 2018 20:39
To: Haynes, Mark; Carroll, Ronan
Subject: Update on CW

Mark

Ronan and I met with Colin Weir today.

[redacted]

herefore, Colin will not be in work from Mon 26 November until approx March 19

On this basis, can I go out for Consultant locum cover from Mon 26 November?

Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: [redacted]
External number: [redacted]
Mob: [redacted]

EXT [redacted] ***if dialling from Avaya phone.***
If dialling from old phone please dial [redacted]

External No [redacted]

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 21:18
To: Carroll, Ronan
Subject: FW: An idea

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 17 January 2019 05:54
To: Carroll, Ronan Personal Information redacted by the USI
Subject: An idea

Morning

I have had a thought re paeds surgery.

Would we be able to get approval for funding for a part time consultant general surgeon do general surgery of childhood if Mr Mackle was interested in taking on a part time post?

Could be very positive offering general paediatric surgery, training for SPRs etc

Obviously would need to ask Eamon if he would do it first!

Was thinking maybe 2 clinical sessions per week – 1 theatre, 1 OP in DHH seeing children only (obviously a PT job would also need time for a small amount of admin and SPA s would likely come to a 5PA job).

What do you think?

Mark

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 21:33
To: Carroll, Ronan
Subject: FW: My Job Plan

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 09 June 2019 06:07
To: Carroll, Ronan Personal Information redacted by the USI
Subject: RE: My Job Plan

Yes that is my preference.

From: Carroll, Ronan
Sent: 08 June 2019 09:07
To: Haynes, Mark; Corrigan, Martina
Subject: RE: My Job Plan
Importance: High

Good morning,
I will speak with Melanie at my 1:1 Monday week.
I am assuming (correct me if wrong) your preference is 1
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by the USI

From: Haynes, Mark
Sent: 04 June 2019 07:50
To: Carroll, Ronan; Corrigan, Martina
Subject: My Job Plan

Morning

I know I have briefly discussed with you previously (Ronan you are first sign off), I need my job plan sorting as I cannot continue trying to do everything. In terms of my view I am unwilling to stop doing the BCH activity due to the impact this would have on delivery of renal cancer services in NI (and from a personal clinical perspective this is the work I enjoy). From my perspective the 2 options going forward are;

1) Remain as AMD, bring BCH activity into standard job plan and charge BCH for this clinical time and half of my MDM, SPA and admin time. Use back charged 5PA's (approx.) and AMD PA time (as this is funded by the trust and so is separate to the funded consultant urologist time)to put towards a 7th consultant urologist post which would give a total of 8 PA's to put in a case for a 7th urologist if the trust would go at risk for the remaining 2 PA's. In this situation my working week would be (this may need some minor changes as may well be >12PA when put into Zircadian);

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	CAH SPA and Admin	AMD	CAH flexible DCC session	BCH Theatre / clinic alt weeks	BCH Theatre
Afternoon	CAH flexible DCC session	AMD	AMD	MDM (CAH / BCH Alt weeks)	BCH SPA and Admin

In the interim period while we look to appoint the 7th and to ensure no loss of activity I would be agreeable to continue to do a DCC session on Monday morning (displace SPA/admin to own time) and Wednesday pm (displace AMD email / admin work to own time) with these two sessions paid as WLI activity.

2) Resign as AMD, bring BCH activity into standard job plan and charge BCH for this clinical time and half of my MDM, SPA and admin time. Given demand pressures would be ideal to use back charged 5PA's (approx.) to put towards a 7th consultant urologist post if the trust would go at risk for the remaining 5 PA's. In this situation my working week would be (this may need some minor changes as may well be >12PA when put into Zircadian);

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	CAH OP (or flexible DCC session)	CAH OP (or flexible DCC session)	CAH Theatre (or flexible DCC session)	BCH Theatre / clinic alt weeks	BCH Theatre
Afternoon	CAH Theatre (or flexible DCC session)	ACH Admin (finish mid pm)	CAH SPA (finish mid pm)	MDM (CAH / BCH Alt weeks)	BCH SPA and Admin

Again in the interim period while a new AMD is appointed I would be agreeable to continue to do AMD activity by displacing my CAH SPA and admin time and working on my afternoon off with two of the DCC sessions paid as WLI activity.

Can we discuss at some point soon? Or if you have a clear preference, let me know and I will update Zircadian with the proposed detail.

As my primary employing trust obviously there are other options (ie not accepting my proposal to do BCH work) which, if you were to decide were the preferred way forward I would need to consider further.

Thanks

Mark

Carroll, Ronan

From: Carroll, Ronan
Sent: 19 April 2022 21:37
To: Carroll, Ronan
Subject: FW: GP concerns regading red flag referral

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Haynes, Mark Personal Information redacted by the USI
Sent: 12 June 2019 06:57
To: OKane, Maria Personal Information redacted by the USI
Cc: Carroll, Ronan Personal Information redacted by the USI; Reid, Trudy Personal Information redacted by the USI; Connolly, Carly Personal Information redacted by the USI
Subject: RE: GP concerns regading red flag referral

How long have you got?!

In short, no we are not working at elective capacity or at maximum efficiency. Simply because we do not have the resource to do so.

Regarding efficiency in what we deliver, one aspect that is eternally frustrated is equipment investment. Within Acute services and from my perspective SEC/ATICS we have multiple items requiring investment sitting on a long list (attached). In total there are 54 items of equipment, totalling approximately £2.6 million. Each round of CAG allocations funds a tiny proportion of these items, while the list continues to grow. The net impact is that without equipment in OP and theatres our delivery of patient care is inefficient and delayed. For example, without available endoscopes for ENT outpatients, patients need to be brought back for second visits to have the endoscopy, without the equipment for delivery of transperineal biopsies for prostate cancer diagnosis we utilise a trans rectal route resulting in a 3-5% acute admission rate and using inpatient theatres to deliver what should be an outpatient procedure for the 5% of patients that require a transperineal biopsy procedure (this frustrates me more than anything as I have driven the move in NI away from TRUS as NICAN CRG chair, and the only trust that hasn't invested in delivering this is the trust I work in. It is just embarrassing).

I don't believe there is any transparency or objectivity in the allocation of monies to purchase medical equipment, certainly I have never seen any evidence of an objective system being used to decide which items of equipment from different directorates gets funded, nor have I seen any minutes or commentary on any meeting where decisions are made as to what equipment to purchase outlining how the decisions were made. I contrast this to my experience in England where medical equipment requirements were outlined in a business case, scored on paper against multiple factors (eg impact on ongoing delivery, impact on delivery against standards of care, impact on staff, impact on patient outcomes, cost and income), and higher ticket items subjected to additional scrutiny and board level presentation and decision making.

Every item that is on the list as a replacement (because the existing equipment is past it's usuable life span), or new (in order to deliver current standards of care) requires investment immediately.

As you know, bed capacity is a major issue. In order for secondary care to deliver elective care at maximum capacity and maximum efficiency we need to fix the unscheduled care issues. Fundamentally this means an increase in bed capacity. No trust can manage elective care while bed occupancy runs in the high 80's to 90+%. Ideally we need an expansion in beds to get to a point where on the acute sites bed occupancy is 85% (or ideally 80%). There is no quick

fix to this but a first step is acknowledging that this is a major issue that requires primary focus is essential. All LOS reduction strategies are contingent on this being in place. Continued focus on strategies which are needed, but deliver small impacts on unscheduled care requirements misses this essential problem. There has never been a proposal floated that fixes the problem of 40+ medical outliers on surgical wards in the trust. Without fixing this by increasing the bed capacity, all other attempts to deliver care become stifled, our wards become unspecialised, extra patients are bedded in environments which are not suited to patient care, and staff leave, deepening our problems. A first step in moving towards this is a corporate recognition that the primary issue affecting the trust is a lack of capacity for unscheduled care. Once this is accepted and recognised I believe we can start to make progress towards identifying how this can be addressed, but as with equipment, solutions will require investment.

Regarding increasing demand for trust services, I believe the underlying issue comes down to how services are commissioned and delivered within primary / secondary care. The NI model does not place any onus or requirement on primary care to manage demand. This is in stark contrast to England where demand management is a key component of primary care CCG's functions. Secondary care commissioning is to meet a projected service baseline. This baseline is based on previous years activity and not meeting demand meaning that the demand:capacity mismatches within our services grow.

What we have (when manpower etc get factored in) is a stretched primary care service, with no capacity to, or requirement to pre-investigate or pre-treat patients, and no penalty for referring patients who don't need seeing referring ever increasing numbers of patients, managing progressively longer routine waiting lists by 'upgrading' referrals (Urology referrals have increased each year but if you look at each clinical category, routine has reduced and both urgent and red flag have increased significantly). Meanwhile in secondary care, capacity is based upon delivery of the service based activity figures. This does not match demand, is based upon 'bean counting' (that was what Dean Sullivan always called it, not me!) and can be 'cheated' by 'imaginative' coding (from urology DECC work it appears that one trust has a waiting list for insertion of a urethral catheter with near 1000 elective admissions for this a year, but none in the other 3 trusts! Nb almost no one is put on an elective waiting list for urethral catheterisation). Performance meetings focus on delivery against said service based delivery figures, but not on meeting referral demand, and waiting times for services spiral upwards. There is also a perverse negative incentive whereby, if secondary care start delivering over and above their SBA, the SBA expectation is changed to meet this, without any increase in service funding. Decisions to create new permanent posts are made centrally and do not always match where demand for services is highest but can be influenced by other factors.

Again to contrast with England, if secondary care demand goes up, additional money comes into secondary care from CCG's as money follows the patient, this enables secondary care to react to and pre-empt increasing demand by planning development and expansion of services, with money coming into the system to fund this. Decisions for new permanent staff appointments are made by the trust, not reliant on central 'commissioning' of new posts, and infrastructure and equipment investment by the trust drives increased income into trusts as it increases services delivered.

To be delivered demand management needs to be led by primary care. There is some hope that through the federations this may start to happen, but I fear that in order to deliver what GPs consider to be enhanced primary care services, they will want in increase in investment in their services. I am constantly told there is no additional money (in my interactions through the PIG and through the DECC work), so I am concerned that this will become a barrier to successful demand management. Secondary care needs to be commissioned to deliver demand.

(Climbs down from soapbox).

Happy to discuss further.

Mark

From: OKane, Maria
Sent: 11 June 2019 21:05
To: Haynes, Mark

Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

Thanks for this. Outside of what you suggest Mark – are there any other changes we can make to increase capacity that you feel are being frustrated or do we think we are working at capacity and as effectively as possible? Regards, Maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 11 June 2019 20:37
To: OKane, Maria
Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

I'm happy to follow up on this myself 1st thing tomorrow morning as it is an issue that cuts across all surgical specialities, and is something that as a NICAN CRG chair I can feed into NICAN if required. As you are aware there has been considerable lag in the region adopting NICE guidance from 2015 regarding suspected cancer referrals, with concern regarding direct access to MRI scanning being the main reason behind this regional delay (from my understanding). This means that the RF criteria applied to NI patients are not those that are applied to patients in England, Wales and Scotland. Additional targets timelines and real world timelines for patient being seen in NI lags far behind the situation in England (English Referral to treatment target timeline is 18 weeks for all referral categories, in NI we only meet this for RF referrals, we have no 2 week rule for any speciality other than breast, I can continue on my soapbox of why the situation here is as it is!).

The difficulty here is that there are clear RF criteria that apply to NI (NICAN referral guidance 2014). If a patient doesn't meet them then they can and should be downgraded. This is one of the purposes of triage. However, not meeting RF criteria does not mean no possibility of a malignant diagnosis, just a lower likelihood. The real problem here is that a clinically urgent patient (non RF) is not seen within an acceptable period of time due the waiting time pressures (and in some specialities routine referrals are almost not seen). The fact that these criteria are not current NICE criteria is not down to clinicians.

If we cannot downgrade referral that do not meet the RF referral criteria currently applied to NI patients, we will never be able to provide RF OP appointments within a reasonable time as patients are referred in without RF symptoms because in some specialities this is the only way they are likely to be seen. If we do, appropriately downgrade referrals, when one receives a malignant diagnosis, we are criticised for applying nationally agreed criteria. We know , for instance, that in urology up to 20% of GP referrals are either upgraded or downgraded (in both Southern and western trusts). If all were left at the original referral category, some would be seen without meeting RF criteria, with an approximately 3% risk of cancer diagnosis, while many others would wait longer, who do meet RF criteria, and have a 9% risk of a malignant diagnosis.

As an aside and as an example of how arbitrary RF criteria are, the risk of a malignant diagnosis in patients with severe storage urinary symptoms in the absence of infection is around 2-3% but this is not a red flag criteria, and a urine dipstick screening study (done in Leeds) demonstrated an equal risk of bladder cancer in patients with dipstick haematuria and patients without dipstick haematuria, yet dipstick haematuria has constituted a RF criteria for referral for many years for urology, with a risk of a malignant diagnosis of 2-3%.

The only real solution to this problem is to match demand with capacity, but that requires investment in manpower (nursing, medical and administrative, primary and secondary care) and infrastructure (both physical (eg Wards, OP facilities, theatres), technological (eg scanners, endoscopy equipment) and supporting diagnostic services (labs, cytology, histopathology)).

Carly – if you get anything on email from Dr McCollum could you forward to me please?

Mark

From: OKane, Maria
Sent: 11 June 2019 18:50
To: Carroll, Ronan; Haynes, Mark
Subject: FW: GP concerns regading red flag referral

Mark could you ask on of the CDs to ring the GP please as vi to understand clinically what has happened and to let me know. Thanks Maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Reid, Trudy
Sent: 11 June 2019 17:18
To: Connolly, Carly; Carroll, Ronan
Cc: OKane, Maria
Subject: Re: GP concerns regading red flag referral

Carly than you, these will need screening
Ronan please see below for investigation, action and contact with the GP
Regards,
Trudy

On Jun 11, 2019 3:49 PM, "Connolly, Carly" Personal Information redacted by the USI wrote:
Dear Trudy

I received a phone call today from Dr McCollum Willow Bank surgery Keady. I advised Dr McCollum Patricia was off at present and not due back for a couple of weeks. Dr McCollum expressed his concerns about the red flag referral system. Dr McCollum reports he referred one of his patients via red flag surgical referral in Dec 2017, however this was downgraded and his patient was not seen until February 2019. This patient has subsequently being diagnosed with a tumour. Dr McCollum also said another situation happened again recently, he referred a patient via red flag ENT , but the patient was not seen for a number of weeks later. This is 2 incidents within months. Dr McCollum expressed his concerns about the red flag referral process and reports GPs need confidence that patients will be followed up as per red flag procedure. Dr McCollum has asked to speak to you specifically regarding his concerns. Telephone Personal Information redacted by the USI. I have advised Dr McCollum to email me his concerns . Can you return his call please.

Many Thanks

Regards

Carly

Mrs Carly Connolly
Clinical Governance Manager
Governance Office
Administration Floor
CAH

Personal Information redacted by the USI

Davis, Anita

From: Carroll, Ronan
Sent: 15 December 2021 23:46
To: Davis, Anita
Subject: FW: For Response - Meeting Request - AOB

Follow Up Flag: Follow up
Flag Status: Flagged

Section 21

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by the USI

From: Gibson, Simor Personal Information redacted by the USI
Sent: 24 January 2020 12:57
To: OKane, Maria; Weir, Lauren
Cc: Carroll, Ronan; Haynes, Mark; Corrigan, Martina; Hynds, Siobhan; McNaboe, Ted; Khan, Ahmed; Carroll, Anita; McClements, Melanie; Toal, Vivienne
Subject: FW: For Response - Meeting Request - AOB

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

The Backlog Report was commenced in approximately 2016, (it existed before though detail and format may have been different) to quantify workload between secretarial and audio-typist staff and allow movement of work where necessary. Information was gathered by completion of a template by secretaries themselves on a monthly basis, when they were asked to quantify the level of work awaiting to be done either by their consultant or themselves.

This information was compiled into a report and circulated to consultant staff, and copied to relevant Heads of Service and Assistant Directors. It was not forwarded to medical staff acting in their capacity as CD or AMD. There appears to be variable consideration of this report by specialties within either patient safety meetings or specialty meetings. It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with individuals own recollection of behaviour or workload of colleagues. In essence, it was felt that there may have been inaccuracies in the data provided by staff. This data was never independently verified, and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology, and was not regularly discussed at the Urology specialty meeting.

Expectation re compliance

None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a gauge against reported performance.

Escalation

As there was some cynicism in relation to the validity of the data, combined with a lack of standards to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.

It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr O'Brien

In concluding the discussion, those present felt that the best way to move this topic forward was for a group of interested staff to:

1. *Agree and describe why this information is being collated: for example, is it largely for resource / secretarial workload*
2. *Disaggregate into two areas those indicators for which clinicians are responsible and those indicators for which administrative staff are available*
3. *Agree and describe a consistent process for how this information is collated, and the method by which the information can be independently verified*
4. *Provide a Trust wide standard of performance in relation to these performance indicators which all clinical staff should be expected to adhere to*
5. *Agree the process for escalation for when monthly information indicates a deviation from this Trust wide standard of performance*

Considering the processes outlined above in the wider sense of supporting medical staff who have had issues identified, I feel there would be benefits in an urgent discussion regarding the day-to-day management of Mr O'Brien by his operational line management team to ensure that supervision of his administrative duties are being carried out as expected. This would allow an opportunity to identify if there are any concerns starting to emerge, so that appropriate supports can be offered to Mr O'Brien, to ensure that concerns do not continue.

Happy to discuss.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI

From: OKane, Maria
Sent: 17 November 2019 12:11
To: Hynds, Siobhan; Khan, Ahmed; Haynes, Mark; Carroll, Ronan; Gibson, Simon
Cc: Weir, Lauren
Subject: RE: FW: Backlog Report - October 2019

Thanks Siobhan.

Simon can I ask that you coordinate a meeting which I am asking you to minute please asap to

1. describe in detail the management plan around this ,
2. the expectation re compliance
3. and the escalation.

It will be important before all of you meet with Mr O'Brien that you have this process well described and documented – process mapping this might be the most useful approach.
While I appreciate that there is a divergence in views about the process we have in place to manage referrals, he is being asked to comply with this as is until it is collectively agreed that the system should be changed.

Lauren bf 2 weeks please

Thanks Maria

From: Hynds, Siobhan
Sent: 08 November 2019 10:10
To: OKane, Maria; Khan, Ahmed; Haynes, Mark; Carroll, Ronan
Subject: RE: FW: Backlog Report - October 2019
Importance: High

Maria

Mr O'Brien is clearly deviating from the action plan that was put in place as a safeguard to avoid this type of backlog and he is also an outlier in terms of his other Urology colleagues by some way.

Has there been any direct discussion with Mr O'Brien about this? Could I suggest a meeting of the case manager(Dr Khan) with Ronan and Mark to discuss the data and decide on the necessary next steps. As a matter of urgency there needs to be a clear plan in terms of clearing any outstanding work. Given some dictation is now going back to June 18 we need to understand if there is any impact on patients and we need to discuss the process for monitoring as this hasn't flagged.

Siobhan

From: OKane, Maria
Sent: 05 November 2019 08:33
To: Khan, Ahmed; Hynds, Siobhan; Haynes, Mark; Carroll, Ronan
Subject: Fwd: FW: Backlog Report - October 2019

Dear Ahmed / Siobhan you will have a view about this please ?

Ronan can you describe the systematic process in place please to capture the relevant information agreed with case managers please? Thanks Maria

---------- Forwarded message ----------
From: "Haynes, Mark" Personal Information redacted by the USI
Date: Nov 5, 2019 6:37 AM
Subject: FW: Backlog Report - October 2019
To: "Khan, Ahmed" Personal Information redacted by the USI, "OKane, Maria" Personal Information redacted by the USI, "McClements, Melanie" Personal Information redacted by the USI, "Carroll, Ronan" Personal Information redacted by the USI
Cc:

FYI re oversight.

Relevant info for oversight is highlighted below for October;

UROLOGY	Backlog - Number of charts with oldest date in brackets											
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	oldest date	Results to be dictated	oldest date	Results to be typed	old da
Mr Tyson/ solt												
Mr Glackin	1	Aug-19	16	28.10.19	1	22.10.19	3	29.10.19	13	07.10.19	21	23.1
Mr Haynes	0	-	0	-	0	-	17	24.10.19	11	21.10.19	15	30.1
Mr O'Brien	35	27.06.17	0	-	45	23.09.19	11	20.09.19	21		0	-
Mr O'Donoghue	0	-	0	-	0	-	43	15.10.19	19	16.08.19	78	15.1
Mr Young	8	-	0	-	0	-	29	24.10.19	32	-	0	-
Sub Speciality Totals	44		16		46		103		96		114	

From: Evans, Marie
Sent: 04 November 2019 22:03
To: Carroll, Ronan; Robinson, Katherine; Carroll, Anita; Corrigan, Martina
Cc: Tyson, Matthew; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Backlog Report - October 2019

Dear All,

Please find attached Backlog Report for October 2019.

If you have any queries please don't hesitate to contact me.

(Mr Tyson/Solt blank due to Personal Information)

Kind Regards

Marie Evans

Service Administrator (SEC)

Ground Floor

Ramone Building

T: Personal Information redacted by the USI

E: Personal Information redacted by the USI

CANCER AND CLINICAL SERVICES DIRECTORATE

Clinical Governance Meeting

Boardroom, Craigavon Area Hospital

Thursday, 7th April 2011

Present: Dr Hall **R Carroll** **Brian Magee** **Dr Fawzy** **Alexis Davidson** **Dr Convery** **Alison Porter** **Dr Rankin**	**Apologies: David Cardwell** **Marian Fitzsimons** **Dr Damani** **Dr McCusker**

AGENDA	Comments.	Actions
• Apologies • Update	Brian Magee gave an update from the labs re the new Datix system – Laboratories have bid in for IT for software to electronically link Q-Pulse and Datix. Although this has not been tried and tested a reduced price has been offered to allow for testing the interface. Dr Rankin gave a brief update on the implementation of Datix in the 2 labour wards and the Bluestone Unit – Feedback positive.	
• Governance Update	Ronan gave an update on the new Governance Structure – Appointment of Assistant Director of Governance – Debbie Burns. Appointments for assistants at Band 8B have also been made, though not for acute sector – these will go back out to interview.	
• IR1 Pathways	Laboratory – completed. Radiology – To be presented in a more simplified form as a flow chart. Cancer – Alison Porter presented the cancer services flow chart and gave a brief explanation of the cancer pathway. Dr Rankin expressed concern that Medical Director was informed on	

	Level 5 issues and advised that it should be the Acute Director informed only and not the Medical Director.	
• RCA'S	Ronan gave a brief update and overall summary – No active RCAs at present. Progressing any ongoing. Plain film reporting update given by Dr Hall – Escalation Policy with regard to 19 day target in place at present.	
Complaints	As David was unavailable, Ronan gave an update. Most of C&CS complaints were regarding neurophysiology and the delay in appointments. This is being addressed at present. Dr Hall expressed concerns over an oncology complaint and the link with the oncologists. Alison replied that there had been some difficulty in setting up an acute oncology management team. Dr Rankin added that there was no funding available as yet as monies had not been aligned.	
• Litigation	Marian not present. Dr Rankin gave a brief update. There has been a recent review of litigation processes in the Trust, which is almost finished. Dr Hall commented that it was important that clinicians know they are supported by the Trust.	
• NPSA/NICE Guidelines	Caroline Beattie introduced herself and gave a brief outline of her job. There have been 98 new standards and issues from Caroline was appointed to her post in May 2010, 17 of which were applicable to C&CS. Dr Hall was hopeful that Caroline would be available to update at further meetings.	
• RQIA	Radiology Issues – Have gone through first phase. Feedback has not yet been finalised. IRMER status progressing through the clinicians. Dr Rankin will obtain some feedback from clinicians at next Acute Governance meeting.	
• AOB	Risk Register – Divisional register was updated 2 weeks ago. Main item was plain film reporting in radiology. It was generally agreed that the urology cancer	

	performance would go on to the risk register.	

Dates of Next Meeting:

Thursday, 9th June 2011 – 8.00am
Thursday, 11th August 2011 – 8.00am
Thursday, 13th October 2011 – 8.00am
Thursday, 15th December 2011 – 8.00am

CANCER AND CLINICAL SERVICES DIVISION

Clinical Governance Meeting

Boardroom, Craigavon Area Hospital

Thursday, 16th February 2012

Present: Dr Hall **Brian Magee** **Dr McCusker** **Dr Fawzy** **Alexis Davidson** **Dr Convery** **Alison Porter** **Caroline Beattie**	**Apologies: Ronan Carroll** **Wendy Clayton** **Karen Wasson**

AGENDA	Comments.	Actions
• Apologies • Minutes of Previous Meeting	Agreed	
• SAIs	Dr Hall gave a brief outline of document produced by Margaret Marshall for the Management of Serious Adverse Incident Review. Dr McCusker was unsure of how to access the "definition " of a Serious Adverse Incident and it was suggested that the definition may be accessible on the Departmental website.	
• IR1 Pathways	All divisions within C&CS have produced pathways but it was generally agreed that these would now need updated with the introduction of electronic Datix. After a general discussion on how the Datix system operated and how IR1 proceeded through the system it was agreed that this process would need tidied. Alexis agreed to contact Joanne McEvoy, who seemed to be the general contact for Datix. Laboratory is at present operating Q-Pulse and Datix, with no connection between the 2 systems. A trial of software to allow integration of both systems was unsuccessful and therefore not progressed. It	

	was agreed that the laboratory would need to decide the best way forward for their pathway. Dr McCusker and Brian Magee to progress. Dr Hall asked Dr McCusker to speak to Joanne McEvoy to see if cross-over of 2 systems can be progressed and to then bring this to the Acute Governance meeting for agreement. Dr Hall proceeded by giving a run down of stats recorded within C&CS – No new recorded incidents, 3 ongoing incidents and 1 closed incident. Actions from IR1 Process: 1. Rolling Education programme. 2. Joanne McEvoy to speak on Datix and also to train clinicians within C&CS. 3. Need new updated IR1 pathways Learning from Radiation incident which was recently closed will be tabled a next CD meeting.	
• Complaints	Vivienne Kerr was not in attendance at the meeting and therefore no update was available. Dr Hall gave a brief outline of 2 ongoing complaints within the Division. Brian Magee also added that the lack of timely results was also an issue.	
• Litigation	Karen Wasson was unavailable for the meeting but an update will be emailed to all members when received from Karen.	
• NPSA Guidelines/Standards	Caroline presented an accountability report at the last Acute governance meeting and provided a summary report for the meeting today, for the period October to December 2011. Dr Hall commented on the fact that 23 new standards and guidelines produced in this period of time was unusual. Ongoing workstreams – Caroline gave brief outline and update of these. Dr Convery gave update on chest drain insertion – some training has been received by 2 clinicians – auditing is progressing. Mannequin in place but never used. Dr Briggs has been approached by Dr Convery re mentoring. Dr Hall was concerned that the Radiology Department was still asking for marking of patients, which was not part of the process. This item has now been tabled for the next M&M meeting. Caroline will circulate up-to-date information from the Safety Forum after the meeting.	

	Brian Magee presented a query re MDA Device Alerts but Caroline informed Brian that these were managed separately by Nigel McClelland and not at this forum.	
• RQIA	Dr Hall gave an update – Phase 1 document, due out in November has still not been issued. Dr Hall commented that a significant amount of examinations are still not reported with this being highlighted to Dr Rankin and the dangers associated. Clinicians are still not signing up to take responsibility for reporting on films.	
• AOB	Neutropenic sepsis query from Alison was answered by Dr Hall. Dr Hall gave support in progressing towards full accreditation for laboratories and assured Dr McCusker that Dr Rankin would also support this and any funding required to progress. Dr McCusker – i) There are 22 haemovigilance items which she feels should be on the Acute Risk Register and has concerns that these are not. This will be discussed on Monday at the laboratory CD meeting. Ii) Backlog issues – Dr McCusker is concerned re backlog and turnabout time sitting now at 3 weeks as opposed to 10 days. Biochemistry also has a backlog. Dr McCusker suggested that this would need to be highlighted globally. Dr Hall suggested clearing backlog with WLI's. Dr McCusker commented that this would not be feasible to keep up. Iii) Laboratory User Handbook – problems with web-base at present. Dr McCusker would like to know who to contact on how to fix and also better support for the handbook. Brian Magee suggested that a higher level of access would be needed. Dr Hall suggested speaking to Dr Rankin. – Solution to fix – abandon handbook in that solution – It was agreed that this was a division issue and needed addressed internally.	
Date of Next Meetings: **Thursday 19th April 2012** **Thursday 21st June 2012** **Thursday 6th September 2012** **Thursday 22nd November 2012**		

CANCER AND CLINICAL SERVICES DIVISION

Clinical Governance Meeting

Boardroom, Craigavon Area Hospital

Thursday, 13th October 2011

Present: Dr Hall **Ronan Carroll** **Brian Magee** **Dr McCusker** **Margaret Marshall** **Alexis Davidson** **Dr Convery** **Alison Porter**	**Apologies: David Cardwell** **Marian Fitzsimons** **Dr Damani** **Dr Rankin** **Dr Fawzy**

AGENDA	Comments.	Actions
• Apologies • Welcome	Dr Hall welcomed Margaret Marshall to the group. Margaret is the new governance co-ordinator for Cancer and Clinical Services and she gave an outline of her role under Debbie Burns. Margaret is on secondment for 6 months and will lead and support improvement in governance for cancer and clinical services. David Cardwell and Vivienne Kerr will also assist Margaret in risk management and incident reporting. Dr Hall asked if there was any remit within Margaret's new role for audit, but Margaret replied that at this stage unfortunately there was not.	
• IR1 Pathways	Cancer – Dr Hall queried from Alison who would score the pathway, and it was noted that the IR1 would have already been scored at this stage. Margaret Marshall was able to give information on the next Datix system at this stage but it was highlighted that Dr Rankin should be made aware that all divisions would need to be linked to Datix as soon as possible. Labs – Brian Magee gave an update on the	

	laboratory system. At present Datix and Q-Pulse are not being interfaced as there is a problem, but a meeting has been arranged to try and look at what will be required for the interface. Dr McCusker pointed out that with the laboratories own incidents, they can only informal central reporting at present. Margaret clarified that within the new Datix system there are 2 separate fields: 1. What the actual consequence of the incident would be – 2. Score and potential consequence Dr Convery queried that our IT infrastructure would be able to support this system.	
• RCA'S	Radiology – No 3, 4 or 5 incidents at present. All level 1, which are reviewed weekly. Cancer – No 3,4 or 5's at present. Labs – No 3, 4 or 5's at present. All low level incidents. Ronan informed the meeting that the risk register has been cleansed recently for C&CS and only 3 were present: 1. Decontamination issue in STH 2. Plain film reporting issue 3. Cancer performance – 62 day pathway not conforming. Dr McCusker highlighted concern over haemovigilance and the risks involved. Dr Hall asked Dr McCusker to escalate this and take to her meeting this afternoon. Margaret took everyone through the pathway for major risks – how they are reported and the process around this. She also highlighted guidance on the intranet.	
• Complaints	As David Cardwell was unavailable to attend the meeting Ronan gave a breakdown of complaints for C&CS. Margaret commented that a lot of complaints are complex and are taking considerable time to be explored properly, and that feedback is	

	also required. Dr Hall highlighted that if a complaint involved a clinician then the clinician concerned should be given sight of the reply before response was released.	
• Litigation	Marian Fitzsimons was unable to attend the meeting. Dr Hall suggested that he would highlight at the next AMD meeting, lessons learnt from medical negligence cases and how they were cascaded to people involved.	
• NPSA/NICE Guidelines	Caroline Beattie gave a brief update on where we are at present with NPSA guidelines. Caroline has a summary report ready to go out. Dr Hall did point out the lack of progress in getting a training scheme in place for chest drains, and left this with Ronal to follow up.	
• RQIA	Action Plan in place.	
• AOB	Radiology and Laboratory user groups now taking place regularly. To be tabled at next meeting: - 1. Summary of radiology discrepancy meeting 2. Summary of laboratory discrepancies 3. Summary of audits with the system.	
Date of Next Meeting: **Thursday 15th December 20112**		

Cancer and Clinical Services Directorate

Clinical Governance Meeting

Boardroom, Craigavon Area Hospital

Thursday, 10th February 2011

Present: Dr Hall **R Carroll** **Dr McCusker** **Brian Magee** **Dr Fawzy** **Alexis Davidson** **Dr Convery** **Alison Porter** **Beatrice Moonan** **David Cardwell** **Marian Fitzsimons**	**Apologies: Edel Corr** **Dr Damani**

AGENDA	Comments.	Actions
• Apologies • Update	New Governance Structure – General opinion – still needs some structure. Unsure of where the Cancer and Clinical Services Governance group fits into the structure.	
• Cancer Governance Update	As the meeting was deferred and a new date was yet to be given Alison was unable to given an update.	
• IR1	Beatrice Moonan commented that all IR1 were on track. Haematology (medication) incident did not go through the IR1 process. Dr Convery gave an update on the incident and actions taken with continuing practice and support around the process. Pathways for IR1 for radiology and laboratories in place. Cancer pathway has not yet been updated.	

	Laboratories have altered their system to inform other individuals – Individuals have not yet been identified. As the pilot for the new datix is about to start it was agreed to look at the possible interface between Q-Pulse and Datix. It was generally agreed around the table that each directorate had regular meetings re IR1 forms and it was highlighted that individuals who fill in the IR1s are fed back to. The new Datix Pilot will only last for 2-3 weeks. Beatrice explained that she had no difficulty with the IR1 process at present but is unsure of the closure process on the new system. The implementation of the new datix system will be fed through trained Superusers in each area. Brian Magee brought to the table a query over an IR1 requesting clarity over responsibility. Dr Hall expressed concern that a communication pathway was not in place. He accepted the fact that a clear pathway between clinical areas needed to be in place and would put this in writing expressing his concerns re communication between Governance groups.	Brian Magee to look into.
• Trust Litigation	Marian Fitzsimons gave an update on the importance of the action plan in the Litigation process and it's connection when filling in IR1s properly. Marian also gave an update on the number of cases of litigation against the Trust at present. 365 are pending – with 4 pending at present for Cancer and Clinical Services. Marian took everyone through the litigation process and Dr Hall queried support for the individual concerned in the litigation. He also queried how the learning process was fed back from this. Marian assured that correspondence does go to the operational directors re lessons learnt but Dr Hall was unsure of how this was cascaded to all clinicians and expressed the wish for a general learning process to be cascaded to all staff. Unfortunately in the review of the litigation process which is ongoing at present, Marian stated the fact that this had	

	not been possible. It was also highlighted that clinical summaries for Coroner's cases were not yet going to litigation, but Marian has spoken to the mortuary and this should be coming now.	
• Complaints Process *Update David Cardwell*	David stated that there were no major issues with complaints. David highlighted that for appraisal purposes appraisees will now request a statement from complaints which can be documented for their appraisal.	
• NPSA/NICE Guidelines	As Caroline Beattie was not in attendance at the meeting it was agreed to invite her to the next meeting to clarify the Trust's policy on conformance with regard to the guidelines. Ronan expressed concern about the volume of guidelines produced.	Gail to write and ask Caroline to attend.
• Never Events List	For information only and comment.	
• AOB	Risk Register – Dr Hall highlighted the fact that the plain film reporting situation in radiology will now need to sit on the acute risk register. Minimum data Set – Laboratories have a set policy. It was generally accepted that if there was acknowledgement from SMT that a policy exists this could be enforced. Dr McCusker expressed the fact that she would like the SMT team within each Trust to support the policy and agree to enforce it. Dr Hall agreed to take this forward if the laboratories produced the policy.	

Dates of Next Meeting:

Thursday, 7th April 2011 – 8.00am
Thursday, 9th June 2011 – 8.00am
Thursday, 11th August 2011 – 8.00am
Thursday, 13th October 2011 – 8.00am
Thursday, 15th December 2011 – 8.00am

Cancer and Clinical Services Directorate

Clinical Governance Meeting

Boardroom, Trust HQ

Thursday, 7th October 2010

Present: Dr Hall **R Carroll** **Dr Damani** **Dr McCusker** **Brian Magee** **Dr Fawzy** **Alexis Davidson** **Dr Convery** **Alison Porter** **Beatrice Moonan** **David Cardwell** **Dr Rankin**	**Apologies: Edel Corr** **Marian Fitzsimons**

AGENDA	Comments.	Actions
• Apologies • Update	Trust Governance Update – Given by Dr Hall – draft documentation has been circulated to all AMD's and CD's. Responsible officer for Trust – Dr P Loughran, following this there will be the appointment of an operations director for each directorate. Dr Rankin informed the table that the implementation document for this should be ready by mid November.	
• IR1 Pathways	**Radiology** Alexis gave breakdown of IR1 pathway for radiology. Alexis will amend IR1 pathway to allow herself and Dr Fawzy, CD, to meet weekly.	Beatrice to add in 5th column for closure of incidents. Alexis to contact Beatrice with radiology info. Beatrice will collate and bring stats to next meeting.

	Ronan gave a brief rundown of the new Datix system demonstration carried out recently. This will be implemented within 3 months. Laboratories Brian Magee gave a breakdown of IR1 pathway for laboratories. Laboratories have committed to move to new Datix. Infection Control Dr Damani gave breakdown of how MRSA and C Diff issues are followed through. Cancer Services Alison Porter gave a breakdown of IR1 pathways for cancer services. She highlighted the fact that many of the incidents are closed at the time of reporting. Closing of incidents has not been agreed with Beatrice as yet. No time frame has been set. Dr Rankin highlighted the fact that although pathways for each directorate had been agreed, these would need finalised for the implementation of Datix. Dr Damani brought up the fact that there was some confusion on the wards as to who filled out the IR1 if there is an outbreak. Dr Rankin confirmed that the IR1s should be filled in at ward level. This item will be brought to the Acute Governance Meeting. It was generally agreed that someone from Datix should be invited to come and present at next C&CS governance	

	meeting.	
• Audit	Dr Hall congratulated Dr McCusker on recent visit of HTA Inspection, which highlighted the Southern Trust as an exemplary site. Dr McCusker gave brief outline of recent audit carried out on the process of how deaths are recorded within the Trust, the outcome of which was that checklists would need revised and perhaps merged with Life Extinct Forms. Dr Hall agreed to transfer the audit information from laboratories for discussion at the next AMD meeting.	Dr Hall to take forward to AMD meeting.
• Trust Litigation	As Marian Fitzsimons had sent apologies, it was agreed to leave to next meeting.	
• Complaints Process *Update David Cardwell*	There has been a slight change to pathway for clinicians. Complaints from MPs and MLAs will be dealt with within 10 working days instead of 20 working days (As agreed at SMT). It was generally agreed that this was not practical from clinicians point of view.	Dr Hall to write to Dr Loughran expressing concerns
• Never Events List	Documentation circulated and discussed briefly. It was highlighted that labelling as R and L should be set out in full as Right and left.	Alexis and Brian to write out to clinicians asking for Right and left to be written in full on all referrals.
• AOB	NPSA and NICE guidelines update were deferred to next meeting.	

	Caroline Beattie will be invited to speak re NPSA. Dr Hall highlighted he would like responses back from Table re Trust Governance document circulated.	

Dates of Next Meeting

It was generally agreed that the meetings would now take place every 2 months.

Date of next meeting to be forwarded.

Corrigan, Martina

From: Gibson, Simon [redacted]
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]
Mobile: [redacted]
DHH: [redacted] Ext [redacted]

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

Eamon Mackle	**Heather Trouton**
Associate Medical Director	**Assistant Director**

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: [redacted]

Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: [redacted]

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: [redacted]

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: [redacted]
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana Personal Information redacted by the USI
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Patient 93

From: Coleman, Alana
Sent: 31 August 2016 08:34
To: Haynes, Mark
Subject: RE: Patient 93
Importance: High

Ah I found Patient 93 !!

This referral went for triage to Mr O'Brien on the 05/05/2016 – and was not returned.
We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral – the GP originally referred Patient 93 as Routine.
I have attached what was sent for triage – Patient 93 referral is pg25-31.

Thanks
Alana

From: Coleman, Alana
Sent: 31 August 2016 08:14
To: Haynes, Mark
Subject: RE: Patient 93

Morning Mr Haynes,

The HCN is for a [Personal Information redacted by the USI] – referral we got yesterday from SWAH?

If it is definitely [Patient 93] your querying do you have a date of birth?

Thanks
Alana

From: Haynes, Mark
Sent: 31 August 2016 07:08
To: Coleman, Alana
Subject: [Patient 93]

Morning Alana

Could you find out what happened at triage to the referral from 4th May 2016 on this man and let me know please?

Mark

Corrigan, Martina

From: McAllister, Charlie [redacted]
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: [redacted]

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C
Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: [redacted]

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: [redacted]
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: [redacted]
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana [Personal Information redacted by the USI]
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: [Patient 93]

From: Coleman, Alana
Sent: 31 August 2016 08:34
To: Haynes, Mark
Subject: RE: [Patient 93]
Importance: High

Ah I found [Patient 93] !!

This referral went for triage to Mr O'Brien on the 05/05/2016 – and was not returned.
We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral – the GP originally referred [Patient 93] as Routine.
I have attached what was sent for triage – [Patient 93] referral is pg25-31.

Thanks
Alana

From: Coleman, Alana
Sent: 31 August 2016 08:14
To: Haynes, Mark
Subject: RE: [Patient 93]

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Mark

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 31 August 2016 15:40
To: McAllister, Charlie
Subject: FW: [redacted]
Attachments: aob 050516.pdf

Importance: High

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

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Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: [redacted]
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
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Craigavon Area Hospital
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Mobile : [redacted]

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Mark

Urology Outcome Sheet

(for face to face appointments and advice)

Consultant's name: MR O'BRIEN **Date: 05.05.16**

Patient Name	H & C or Hospital Number	DOB	Source of Referral	New or Review	Action: Add to op w/l list, add to inpt w/l, discharge etc	Type of Contact: Face to Face/Telephone/Email
[redacted] Personal Information redacted by the USI						

Patient Name	H & C or Hospital Number	DOB	Source of Referral	New or Review	Action: Add to op w/l list, add to inpt w/l, discharge etc	Type of Contact: Face to Face/Telephone/Email
[redacted]						

Personal Information redacted by the USI

Southern Health and Social Care Trust
Quality Care – for you with you

LURGAN HOSPITAL
SLOAN STREET
LURGAN
BT66 8NX

Secretary: Mrs Valerie Jackson
Tel: [redacted] Fax: [redacted]
Email: [redacted]

OLDER PEOPLE & PRIMARY CARE

REFERRAL LETTER

MR YOUNG
CONSULTANT UROLOGIST
CAH

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
05 MAY 2016
CAH

Dear DR MR YOUNG

Re: Patient Name: [redacted]
D.O.B.:
Address:
Hospital No: [redacted] **H&C No:** [redacted]

Thank you for assessing this [redacted] year old gentleman with Parkinson's disease, mild cognitive impairment, small AAA, gallstones, hiatus hernia and atrial fibrillation on Dabigatran who presents with macroscopic haematuria.

[redacted] has been attending our Parkinson's clinic for two years. On several occasions he has had macroscopic haematuria and an ultrasound scan in May 2014 revealed one or two right sided kidney stones but no other abnormality in the urinary tract. He now has one month of macroscopic haematuria but no other urinary symptoms.

I have referred this gentleman for repeat ultrasound scan and sent urine for organisms and culture. I would appreciate your evaluation, query other pathology.

Medications include Bisoprolol 1.25mg once daily, Citalopram 10mg once daily, Dabigatran 100mg once daily, Omeprazole 20mg once daily and Zopiclone 3.75mg once daily.

[redacted] remains independent of ADL's in spite of his mild cognitive impairment and Parkinson's disease.

Red Flag
Urgent
Routine
Other
Virtual

Yours sincerely

[redacted]

DR KARIN HOUSTON, SPECIALITY DOCTOR TO
DR P MC CAFFREY, CONSULTANT GERIATRICIAN

Date Dictated:7/4/16	Date Typed: 11/04/16 lh

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN
BT63 5QQ
TEL: Personal Information redacted by the USI
Secretary: Michelle Graham

REFERRAL LETTER

20/04/16

SOUTHERN TRUST BOOKING CENTRE RECEIVED 05 MAY 2016 CAH

CONSULTANT UROLOGIST
CRAIGAVON AREA HOSPITAL

Dear Colleague

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No: **H&C No:** Personal Information redacted by the USI

We would be grateful if you would see this gentleman. He was recently in hospital with minor stroke. He has had ongoing symptoms of frequency and nocturia. He would be grateful for assessment. PSA was normal.

Yours sincerely

Personal Information redacted by the USI

DR GRAINNE TALLON
ASSOCIATE SPECIALIST TO
DR P MCCAFFREY
CONSULTANT GERIATRICIAN/STROKE PHYSICIAN

Date Dictated:	Date Typed: 20/04/16 mg

Routine
Other
Virtual

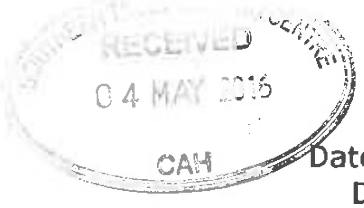
Personal Information redacted by the USI **DOB:** Personal Information redacted by the USI **H+C:** Personal Information redacted by the USI

HSC Southern Health and Social Care Trust

Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ
Tel: 028 3861 3674/2952

Ward Tel:

GP Copy



60 HIGH STREET
LURGAN
CRAIGAVON
CO ARMAGH
BT66 8BA

Date: 28/04/2016 18:58
Discharge Id: Personal Information redacted by the USI
Version: 41

462

Dear Dr CHAMBERS

DISCHARGE NOTIFICATION

The patient was admitted under the care of **DR A MCCLELLAND** (specialty: **CARDIOLOGY MEDICINE(C)**) into **1 NORTH CCU/CARDIOLOGY** Ward at **CRAIGAVON AREA HOSPITAL** on **23/04/2016 01:44:00** and discharged on **28/04/2016**.

Forenames: Personal Information redacted by the USI
Surname:
D.O.B:
Hospital No:
NHS No:
Gender: Male
Ward: 1 NORTH CCU/CARDIOLOGY

Address: Personal Information redacted by the USI

Initial Diagnosis
Heart failure

Method of Admission Emergency

Principle Discharge Diagnosis
Obstructing ureteric calculi

Additional Information for GP

Changes to Medications - Start/Stop
Start bisoprolol, tamsulosin and furosemide

Clinical Information/Comments

Personal Information redacted by the USI was admitted with new onset confusion, SoB, reduced ET and

lethargy. New diagnosis of dilated cardiomyopathy. BG chronic back pain. O/e dehydrated. Reduced eGFR noted on bloods. CT abdomen showed large obstructing ureteric calculi and AAA 5cm. He underwent emergency ureteroscopy with laser lithotripsy and stenting. He was admitted to ICU post for some inotropic support. He was successfully weaned from this and discharged to ward. He has been well post-procedure and will require urology follow up re definitive management of stones once fully recovered. He will also undergo Cardiac MRI and angiogram as OP. He is currently medically fit for discharge. He will require monitoring of his U&E and LFTs - could you please repeat on 05/05/2016. Many thanks for ongoing care,

Did the patient receive a blood transfusion?

No

Allergies:

Patient Has No Known Allergies

Details of Allergies:

Known Reactions to Allergies:

Additional Information:

Infection Status:

Follow Up Details

Arrangements for Follow Up:	Please cc Mr Glackin secretary re urology f/u. OP CMRI and angiogram.
Further Detailed Discharge Letter to Follow:	No
Awaiting Further Results:	No
Awaited Results:	
Patient Aware of Diagnosis:	Yes

Other Management Information For GP

Please monitor U&E and LFT 5/5/16

disp check completed by NMcA 28/4/16 @16.24
- perindopril and metformin on hold whilst in hosp but to recommence and be reviewed

Discharge Prescription: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?

Admission drugs (unamended)					
TEMAZEPAM 10 mg Tablets	10 mg	Each Night	-	Oral	Yes
ATORVASTATIN Tablets	20 mg	Each Night	-	Oral	Yes
LANSOPRAZOLE Capsules	30 mg	Each Morning	-	Oral	Yes
METFORMIN HYDROCHLORIDE Tablets	500 mg	Three Times Daily	-	Oral	Yes
BISOPROLOL Tablets *(Change Reason: .)*	3.75 mg	Each Morning	-	Oral	Yes
PERINDOPRIL ERBUMINE (TERT-BUTYLAMINE) 4 mg Tablets *(Additional Info: please review as dose was decreased in hosp due to poor renal function)* *(Change Reason: .)*	4 mg	Each Morning	-	Oral	Yes
Drugs prescribed since admission					
FUROSEMIDE Tablets	60 mg	Each Morning	-	Oral	Yes
TAMSULOSIN 400 micrograms MR Capsules	400 micrograms	Each Morning	-	Oral	Yes
SPIRONOLACTONE Tablets	25 mg	Each Morning	-	Oral	Yes
Admission drugs (amended)					

Stopped Medication: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				
p *(Change Reason: .)*	2 mg	Each Morning	-	Oral
PERINDOPRIL ERBUMINE (TERT-BUTYLAMINE) 2 mg Tablets *(Change Reason: .)*	2 mg	Each Morning	-	Oral

Authorised Forms	
Form	**Authorised By**
Adult Clinical Details (Emergency-CMPM)	JORDAN MCVEY

Prescribing Clinician: JORDAN MCVEY **Bleep No:** Personal Information redacted by the USI

WIT-14247

HCN [redacted]
AE Number [redacted]
GP B BEDWELL
GP TEL. [redacted]

Surname [redacted] Forename [redacted] Dob [redacted]

[redacted]

Diagnosis
1. Urinary retention
2. piles
3.

Investigations and Results

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

ED Discharge Plan
Patient to attend GP
U. catheter → catheter care pathway
TTO

Referred to Specialty
Time
GP to monitor BP in 2 weeks

Admission Agreed By:
DTA Time

Grade of Doctor
Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given by	Quantity
TTO Laxido Movicol	as needed	pr	prn	5/7	Dr. [illegible]		[redacted]		
Anusol supp	as per box	pr	prn	7/7					

FINAL PLACEMENT
Admit to ward — GP — other hospital OPD
CDU — ED Review — Did not wait/refuses Rx
TNF to OH — Fracture Clinic — Died in ED
Home — CBYL — Psych. Assess — CTMA
OPD Urology MR Kennedy — ED Physio — Absconded

Sig [redacted]
Grade Cons
Breach Time 21:38
Exam Finish Time 2140
Departure Time

Seen to Theatre Sanice O'Reilly

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
69	209/101	21	36.4	98	15		

Transport booked — Time booked — Ref if NIAS
IV Cannula removed — Advice leaflet given — UNOCINI complete
CBYL given — GP letter given — Patient property returned

Breach Time 21:38

Time left department 22:30
Signature Nurse [redacted]
Rechecked 19/5/16

Page 4

CRAIGAVON HOSPITAL EMERGENCY DEPARTMENT

Lurgan Road, Craigavon, BT6 3SQQ
Tel: [redacted] Fax: [redacted]

FBP ☑ Coag ☐ Amylase ☑
U&E ☑ D dimer ☐ Other:
CRP ☑ Troponin ☐ Time: 1840
LFT's ☑ VBG ☐ Sign: [illegible]
Cardiac ☐ Toxscreen ☐

AE Number [redacted]
HCN [redacted]
Priority Code 3
Surname [redacted]
Forename [redacted]
Dob [redacted] Age [redacted]
Sex M MS M
Occ. RETIRED
Casenote [redacted]
GP B BEDWELL
[redacted]
Tel [redacted]
Mobile/Other

Arrival Date/Time 03/05/2016 17:38
Arrival Mode PR Incident Type NT
Source of Referral Other
Accompanied By
Patient at risk of leaving Yes/No

Prev Episodes 03 / 01
Triage Date/Time 03/05/2016 18:06
Breach Time 21:38
Nurse: EJ
ELISSHA JONES
Tetanus Status:
Booster Given Yes/No

Adult Safeguarding Concerns Yes/No
Child Protection Concerns Yes/No
Special Needs

Presenting Complaint NIL OUTPUT OF URINE
Presentation URINARY PROBLEMS
Discriminator RETENTION OF URINE
Triage Text HAD HERNIA OPERATION UNDER DR HEWITT ON 28/4, NOW C/O URINARY RETENTION.

Medication

Allergies NKDA

Signature [redacted]

Pulse	B/P	RR	PFR	Temp	SaO2	GCS	CRT	BM	PERL	AVPU
75	194/99	17		36.7	99					A

Visual Acuity — Right Eye — Left Eye — Urine — Pregnancy Test — Weight

ECG required yes/no (< 10 minutes cardiac)
History
MRSA
CDIFF
Patient Location MAJORS 1
Pain Score
Time 18:06
Category 3 Infection

Commenced on NEWS/CNS/PEWS chart Yes No Signature

Nursing Assessment

MENTAL STATE	Yes	No	WASHING AND DRESSING	Yes	No	SOCIAL HISTORY	Yes	No
Alert and Orientated			Independent			Lives Alone		
Confused			Help Required			Lives With		
Agitated			Full Assistance Required			Relatives Present		
Aggressive			Pressure Areas Checked			Aware		
Drowsy			Commode required			Contacted by		
Trolley Sides in Situ			Pad Changed					
MOBILITY			FEEDING AND DIET			Relative Contact Number		
Independent			Dietary Requirements					
Walk with Help			Dentures top			Patient updated at regular intervals		
Walk with Aids			bottom			Yes	No	

Version - 10.9.1

WIT-14248

HCN Personal Information redacted by the USI Surname Personal Information redacted by the USI Forename Personal Information Dob Personal Information
AE Number [redacted]

Assessment Seen By Personal Information redacted by the USI Time 20.36

History and Examination

PC Urinary Retention

H/O Inguinal Hernia Repair 28/6

Unable to PU 1/7

Catheterized at the [illegible]
Abdo soft, [illegible] enlarged bladder

14FG Cath Insertion

22/6/20 ± 550 ml urine drained → Pt is comfortable

Request medication for piles (painful)

Rx < Catheter care pathway
TTO - [illegible] (prn)
L Anusol supp (prn) discharge

PTFE AquaFlate REF P310114
PTFE Coated Latex LOT 15HE35
Shortfilled long-term (up to 4 weeks use) 2020-07
Standard, 2-way Foley
SIZE Ch. 14 (4.7mm) / 10ml

Indication ______
Residual Volume (ml) ______
Colour of Urine ______
Easy Insertion? Y N If No, why? ______
Name ______
Signed ______
Date ______

"Case discussed with ED consultant" yes ☐ ______

HCN Personal Information redacted by the USI Surname Personal Information redacted by the USI Forename Personal Information Dob Personal Information redacted by the USI
AE Number Personal Information redacted by the USI

Prescription (Medicines in Department) — Administration

Medicine	Dose	Route	Time to be given	Signature	Given by	Time

Nursing/care delivered in ED

Bloods
@ abn
amylase
FBC → Hb | WCC 24.69 ← (urinary retention) CLL
CRP 1.64 | lymph 52
LFT → bil 23.3 ↑
U&E

Signatue of Nurse ______

Admission checklist (please tick if completed)

Time Bed manager informed ______ Ward Ready at ______

Copy ED Flimsy	☐	MEWS/CNS	☐	IV Cannula Form	☐
Fluid Balance	☐	Relevant performa	☐	C diff completed	☐
Copy of NIAS notes stroke PTs	☐	Own Drugs	☐	Relatives aware admission	☐

Patient handover given to admitting nurse ______ (please record their name) Time ______

Patient has previous history of C Diff yes ☐ no ☐
Patient has vomiting and /or diarrhoea yes ☐ no ☐
Patient had contact with anyone with vomiting and /or diarrhoea in last 5 days yes ☐ no ☐
If yes to any of above refer to agreed guidance.

SOUTHERN TRUST BOOKING CENTRE
RECEIVED
04 MAY 2016
CAH

For Trust use only:
HCN: Personal Information redacted by the USI
Date Sent: 04-May-2016

Referral Date: 04-May-2016
Surname: Personal Information redacted by the USI

WYNNE HILL SURGERY Personal Information redacted by the USI

Practice address

Personal Information redacted by the USI

Practice code: Personal Information redacted by the USI

Contact number(s)
Telephone: Personal Information redacted by the USI
Fax:

Red Flag
Upgrade
Urgent
Routine
Other
Virtual

Practice Email:

Referral to:	Craigavon Area Hospital	**Referral Type:**	Out Patient
Specialty:	UROLOGY		
Urgency:	**ROUTINE**		
Urgency Reason:	no priority reason given		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Practice Code:	Personal Information redacted by the	**Registered GP:**	Dr Colin McDonald	**Registered GP Cypher:**	Personal Information redacted by the USI
Referring GP:	Dr kevin Hagan	**Referring GP Cypher:**			

HCN Number	Personal Information redacted by the USI	**Title:**	Miss
Surname:	Personal Information redacted by the USI	**Forenames:**	Personal Information redacted by the USI
Previous Surname:	-	**Known as:**	-
DOB:	Personal Information redacted by the USI	**Gender:**	Female
Registered Contact Details:	Personal Information redacted by the USI		
Tel No:	Personal Information redacted by the USI	**Mobile:**	Personal Information redacted by the USI
Patient Email:	-		
Preferred Contact Details if different from above:			

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint
Description: recurrent UTI's

Comment: I would be grateful if this [Personal] year old girl could be seen in your clinic. She presents with recurrent UTI's and also has a history of UTI in childhood. For investigation of this she had a renal ultrasound scan this showed minimal hydronephrosis measuring 9 mm in AP transverse diameter which persists post micturition. Her BP 120/68 and her renal function is normal. I would be grateful if she could be followed up in your clinic. Thank you.

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Date of onset	Date recorded
Urinary tract infection, site not specified	22-Nov-1995	22-Nov-1995
Eczema NOS	12-Jun-1995	12-Jun-1995

Past procedures (High and medium priority - all)

Description	Date recorded
Appendicectomy NEC	22-Sep-2009

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Nitrofurantoin Capsules 50 mg	0501130R0AAAAAA	28 capsule	TAKE ONE QDS	-	25-Feb-2016	42 Days
Co-Codamol 15/500 Tablets	-	50 tablet	TAKE ONE OR TWO QDS PRN	-	25-Feb-2016	42 Days
Ibuprofen Tablets 400 mg	1001010J0AAAEAE	24 tablet	ONE TO BE TAKEN THREE TIMES A DAY	-	03-Feb-2016	8 Days
Trimethoprim Tablets 200 mg	0501080W0AAAEAE	14 tablet	TAKE ONE TWICE DAILY	-	27-Jan-2016	42 Days
Fluconazole Capsules 150 mg	0502000G0AAABAB	1 capsule	TAKE ONE DAILY	-	25-Jan-2016	1 Days
Trimethoprim Tablets 200 mg	0501080W0AAAEAE	6 tablet	TAKE ONE TWICE DAILY	-	21-Jan-2016	47 Days
Co-Codamol 8/500 Tablets	0407010F0AAAAAA	100 tablet	TAKE ONE OR TWO UPTO FOUR TIMES A DAY IF NEEDED	-	18-Dec-2015	12 Days
Ovranette Tablets	0703010F0BFAAAC	63 tablet(s)	take one as directed	-	18-Nov-2015	42 Days

ALLERGIES & RISKS

Lifestyle risks

SMOKING STATUS

Description	Comment	Date Recorded
Never smoked tobacco		15-Feb-2013

ALCOHOL INTAKE

BMI

25

SOCIAL HISTORY

OTHER PATIENT DATA