1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance for 2013/2014 against:

- Health and Social Care Commissioning Plan Standards/Targets

A significant number of Indicators of Performance (IoP) have also been identified in year to complement the Commissioning Plan Standards and Targets. These IoPs whilst not identified as specific targets will be monitored in year to assess broader performance.

Detailed in the attached report are the Indicators of Performance that are currently reported on a monthly basis.

2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers;
- To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community;
- To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services;

The level of performance on a monthly basis will be assessed as follows:

Green (G)	Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track
Yellow (Y)	Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track
Amber (A)	Standard partially achieved/limited progress towards achievement of target – Management actions required
Red (R)	Standard/target not achieved/not on track to achieve – Management actions/intervention required
	Not assessed (due to lack of baseline; target; or robust data)

The performance trend will be assessed as follows and represent the typical performance profile for the identified standard/target over the period assessed and will not reflect month on month shifts in performance.

↑	Performance improving	↓	Performance decreasing	⇔	Performance static

3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF SAFE, RESILIENT AND SUSTAINABLE SERVICES

CP 3: HIP FRACTURES: Lead Director Mrs Deborah Burns, Director of Acute Services

From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip fractures. (No change envisaged in 2014/2015 CP draft targets)

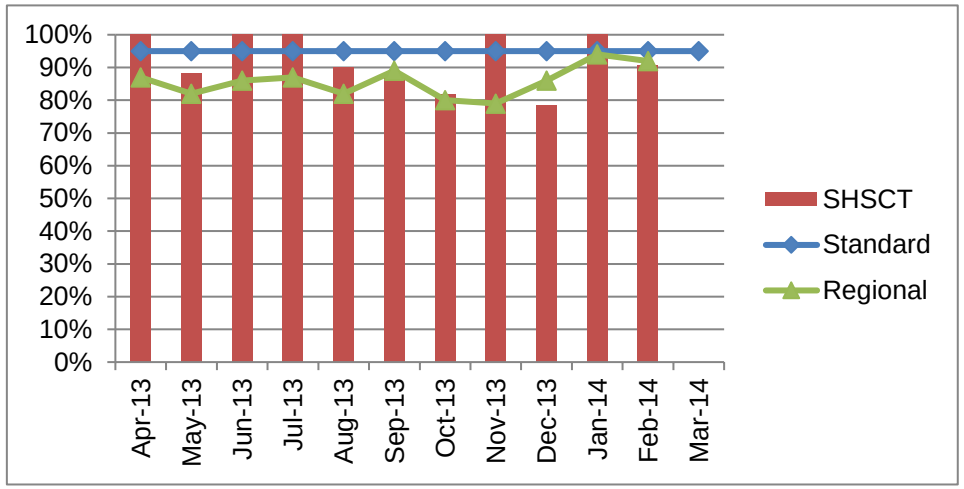
Baseline: 92.7% (cumulative April 2012 – March 2013)
TDP Assessment: Likely to be achieved with some delay/partially achieved

Standard: 95%

Comments:
As anticipated performance in February dropped to 90.5% in comparison to 100% in January due to on-going trauma pressures which are continuing to impact performance in March. This is only the third time in 2013/2014 that the Trust's monthly performance has fallen below the Regional average. The Trust's cumulative performance from April to February 2014 is 91% which remains significantly above the regional average at 86%.

Action to address:

- On-going daily bed management to ensure flow of trauma admissions, utilising orthopaedic bed capacity as required.
- Trauma & Orthopaedics IPT now agreed and implementation plan being progressed



Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	100% (30 out of 30)	88% (21 out of 24)	100% (16 out of 16)	100% (18 out of 18)	90% (26 out of 29)	87% (20 out of 23)	81.8% (18 out of 22)	100% (20 out of 20)	78.6% (22 out of 28)	100% (18 out of 18)	90.5% (19 out of 21)		Y	↓
Regional	87%	82%	86%	87%	83%	89%	80%	79%	86%	94%	92%			

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

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

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

Standard: 95%

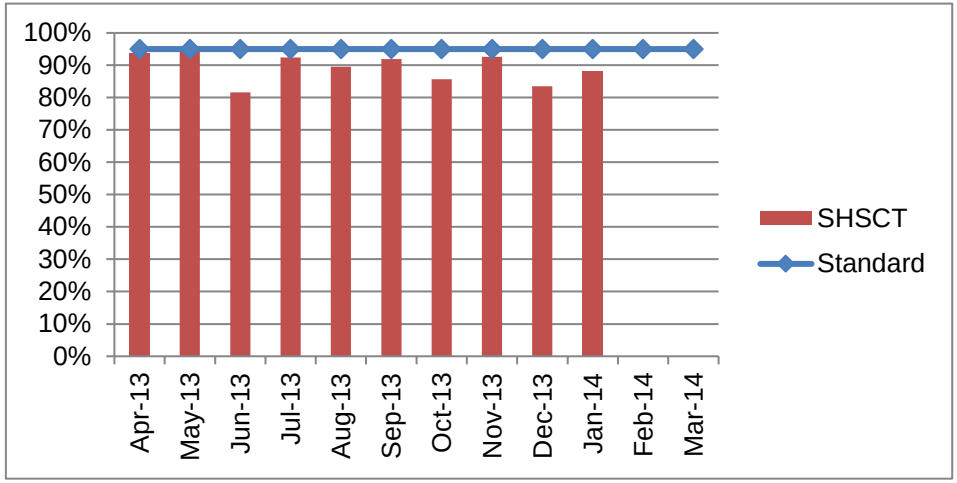
Comments: Reporting two months in arrears against the 62-day standard.

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

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

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

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



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

14-Day Breast Cancer (Indicator of Performance)

The 14-day breast cancer is an IoP standard not a commissioning plan target, however, this standard has demonstrated a significant fall in performance over the last 4-months and as such will be included in this main Trust Board performance report in order to maintain focus whilst performance is unsatisfactory. Whilst performance in December demonstrated an improved position (83%), performance has again fallen in January to 54%.

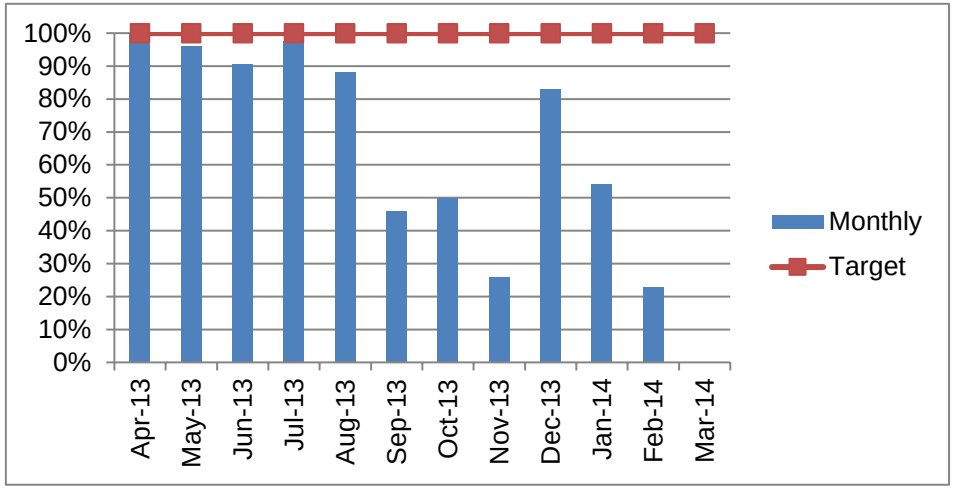
Cumulative performance at the end of January demonstrates a Regional position of 88% with the SHSCT performance at 72%. Performance across the 5 Trusts ranges from 72% (SHSCT) to 98% (BHSCT).

In February 2014 there were a total of 169 red flag referrals seen – 39 of these were seen within the 14-day standard with 130 not seen within 14-days. For those patients not seen within 14-days the longest waiting patient was 21-days with an average waiting time of 18-days. Detailed below is a breakdown of the waiting times for those referrals in excess of 14-days:

Days Waiting	Number of Referrals	Days Waiting	Number of Referrals
15-days	12	19-days	17
16-days	22	20-days	26
17-days	18	21-days	7
18-days	28		

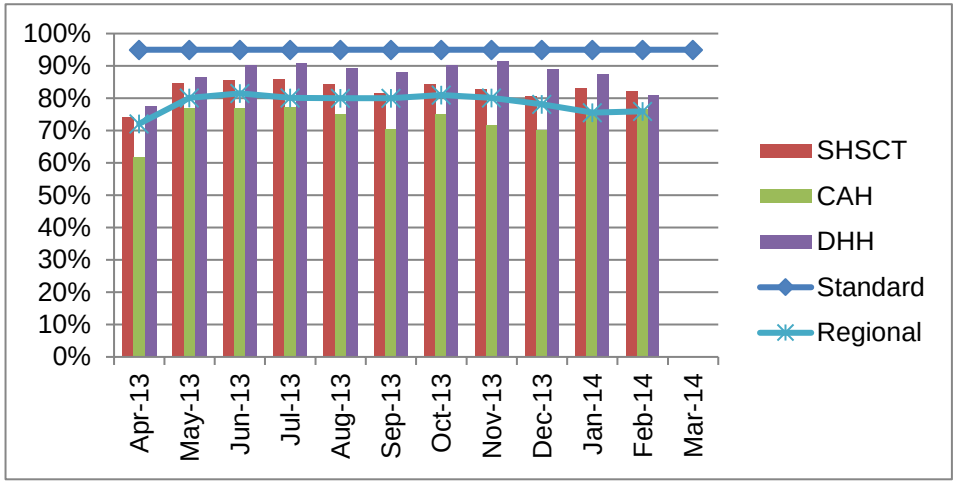
Actions to address:

- 3 additional daytime waiting list initiative clinics have been undertaken to create additional capacity for red-flag referrals which will contribute to an improvement in performance against the 14-day standard.
- The Trust has revised the Symptomatic Breast Clinic referral form and this has been circulated to all GPs. It is anticipated that this revised form may assist in the appropriate downgrading of referrals. The service has also reviewed the appointment classifications in conjunction with the demand analysis and appropriate adjustments have been made to the clinic templates.



Whilst these actions will assist in improving the performance, the Service will be faced with the loss of one of its consultants in mid-March, with an anticipated 3-month gap between the consultant's leaving date and the commencement of the new consultant. However, it is anticipated that a sustained improvement in performance may not be evidenced until August 2014.	

Monthly Position:												Monthly Assess	Trend
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
100%	96%	90.7%	97.7%	88%	46%	50%	26%	83%	54%	23%		**R**	↓

CP 5: ACCIDENT AND EMERGENCY: Lead Director Mrs Deborah Burns, Director of Acute Services	
From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Departments are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; (No change envisaged in 2014/2015 CP draft targets)	
Baseline: Trust – 86% (Position March 2013) CAH – 77% DHH – 92% **TDP Assessment:** Likely to be achieved with some delay/partially achieved	**Standard:** 95%
Comments: Performance continues to be challenging and a range of initiatives have been implemented to improve this position. All actions and outcomes are being reviewed to constantly monitor and evaluate the impact of changes made. Key actions being undertaken are: • Interim senior management changes to enable a dedicated focus to ED and patient flow processes until March 2014; • CAH ED Quality Improvement Group established – co-chaired by AMD for Emergency Medicine and the AD for Medicine and Unscheduled Care. • Early evaluation of the majors streaming pilot, which commenced in November 2013, has demonstrated a positive impact on improving the streaming and management of majors' patients through the Emergency Department. Following the evaluation outcomes it has been agreed to continue on with this pilot until the end of March 2013. • Patient flow processes and role of patient flow coordinators has been refocused to support early admissions from ED to admission ward and from mid-January ED has refocused daily patient flow processes, working to create 'ready' beds in the system throughout the day. This will enable improved outflow from ED for admissions thus improving flows. These new processes have worked thus far improving daily performance against 4 hours. • Medical rotas are being revised which provides extended senior doctor cover to 2am on Friday, Saturday and Sunday. This is running as a pilot for February and March, in the first instance. A new Middle Grade rota has been established at weekends with shifts staggered up to 2am. An additional ED Consultant on duty between 9pm to 1am is being piloted in February and March, in the first instance. These	

initiatives have helped support performance at the weekends.

- A range of other improvements are planned as follows:
  - Continuing to promote full use of NIRAES functionality – additional PCs and touch screen being installed to provide improved access which are all to be in place by the end of March. The plan will then be to move to UDDA clinical coding in real-time from May 2014.
  - Majors 2 (ambulatory majors) is continuing to function in pilot form.
  - The 'See and Treat' for minors is not yet consistently operational until nurse staffing is enhanced and reliance on 'As & When' is reduced.

The Trust has submitted an IPT to the SLCG for the re-designed Acute Medicine model for CAH and awaits SLCG response.

Cumulative performance at the end of January demonstrates a Regional position of 79% with SHSCT achieving 83%. Performance across the 5 Trusts ranges from 73% (BHSCT) to 83% (SHSCT).

Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	74% (8943 out of 12080)	84.5% (10483 out of 12409	85.5% (10256 out of 11994)	85.8% (10840 out of 12640)	84.2% (10107 out of 12002)	81.6% (9753 out of 11956)	84.4% (10074 out of 11937	82.6% (9118 out of 11043)	80.5% (9145 out of 11362)	83.1% (9326 out of 11229)	82.1% (8802 out of 10719)		R	⇔
CAH	61.6% (3776 out of 6126)	76.9% (4801 out of 6247)	76.8% (4663 out of 6071)	77% (4893 out of 6352)	75% (4523 out of 6031)	70.4% (4230 out of 6012)	75.1% (4629 out of 6166)	71.7% (4198 out of 5854)	70.1% (4331 out of 6176)	75% (4390 out of 5856)	76.5% (4244 out of 5549)		R	⇔
DHH	77.5% (2702 out of 3489)	86.5% (3071 out of 3551)	90.2% (3037 out of 3367)	90.7% (3334 out of 3674)	89.2% (3182 out of 3569)	87.8% (3038 out of 3459)	90.2% (2997 out of 3323)	91.3% (2834 out of 3103)	88.8% (2935 out of 3307)	87.2% (2977 out of 3414)	81.0% (2615 out of 3227)		A	↓
Regional Ave (Peer)	72.1%	80.1%	81.5%	80.1%	80%	80%	81%	80.1%	78.1%	75.6%	76%			

CP 5: ACCIDENT AND EMERGENCY: Lead Director Mrs Deborah Burns, Director of Acute Services

From April 2013, no patient attending any emergency department should wait longer than 12 hours. (No change envisaged in 2014/2015 CP draft targets)

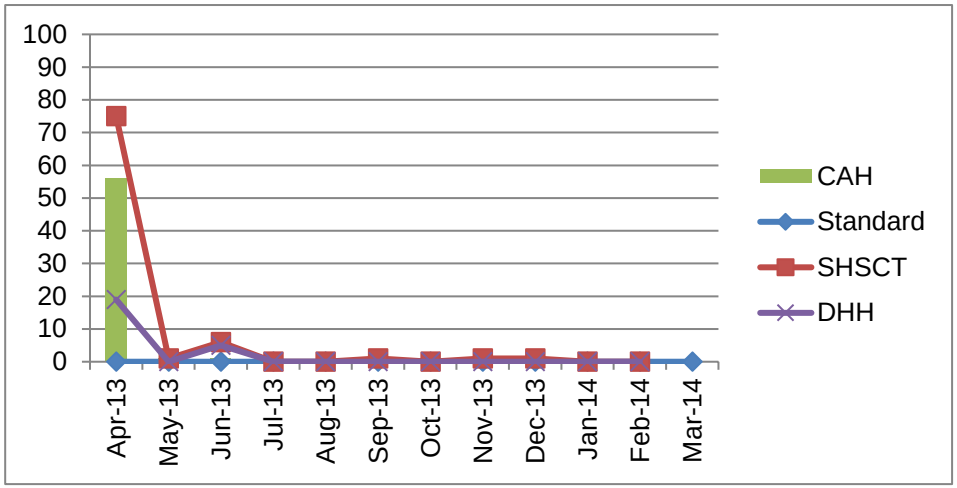
Baseline: 41 (cumulative April 2012 – March 2013)
TDP Assessment: Likely to be achieved with some delay/partially achieved

Standard: 0

Comments:

The month end February shows no breaches of the 12-hour standard, but there have already been 2 confirmed breaches reported in March.

Cumulative performance at the end of January demonstrates Regionally 2450 breaches of the 12-hour standard with the SHSCT accounting for 85 (3.5%) of these. Breaches of the 12-hour standard across the 5 Trusts ranges from 85 (SHSCT) to 1100 (SEHSCT).



Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	75	1	6	0	0	1	0	1	1	0	0		G	⇔
CAH	56	1	1	0	0	1	0	1	1	0	0		G	⇔
DHH	19	0	5	0	0	0	0	0	0	0	0		G	⇔

CP 6: HOSPITAL RE-ADMISSIONS: Lead Director Mrs Deborah Burns, Director of Acute Services

By March 2014, secure a 10% reduction in the number of emergency re-admissions within 30 days. (Same target proposed in 2014/2015 CP draft targets but percentage not defined)

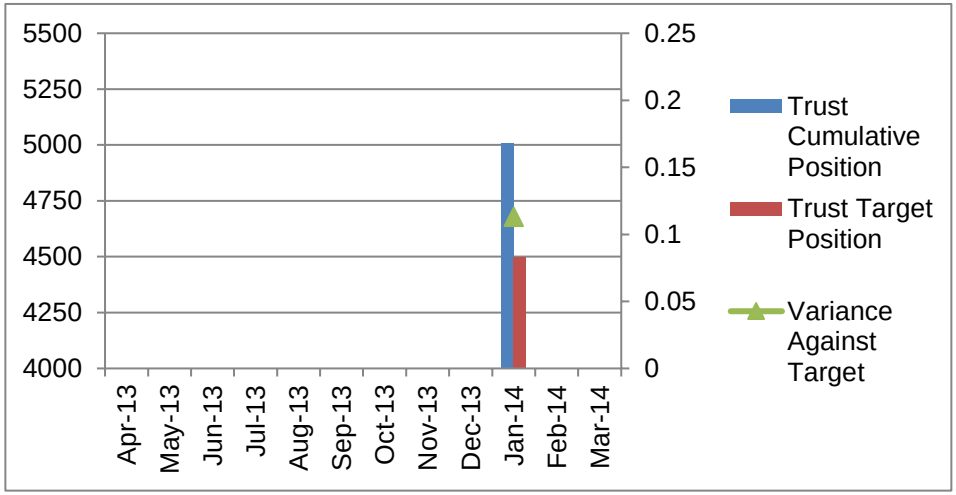
Baseline: 4498
TDP Assessment: Achievable dependent upon additional funding

Target: 10% reduction (4048)

Comment/Actions:

Based on April to January 2014 performance the Trust is demonstrating a re-admission rate of +11.3% (+510) against the baseline position of 2011/2012.

It should be noted that this re-admission information only includes patients discharged from and re-admitted to a SHSCT hospital. This does not include re-admission of a patient previously in a SHSCT hospital into a hospital in another Trust area as this data is not available to the Trust. Work is on-going a regional level to develop this information. Regionally all Trusts are showing increasing re-admissions linked to the fact that total admissions are also increasing. The Trust will seek a review of how this indicator is assessed to consider re-admissions as a percentage of total admissions.



Monthly Position:													Monthly Assess	Trend
Target – Not to exceed 4048	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
Trust Cumulative Position	5008													
Baseline Position	4498													
Variance Against the Baseline	+11.3%												**R**	

CP 7: ELECTIVE CARE OUT-PATIENTS: Lead Director Mrs Deborah Burns, Director of Acute Services	
From April 2013, at least 70% of patients wait no longer than 9-weeks for their first out-patient appointment with no-one waiting longer than 18-weeks, increasing to 80% by March 2014 and no-one waits longer than 15-weeks. (Proposed to maintain at 80% within 9 and 15 weeks maximum wait in 2014/2015 CP draft targets)	
Baseline: 87.9% (<9-weeks @ 31 March 2013) 83 (>18-weeks @ 31 March 2013) **TDP Assessment:** Achievable dependent upon additional funding	**Standard:** 70% <9-weeks and 0 >18-weeks; rising to 80% <9-weeks and 0 >16-weeks

Comment/Actions:

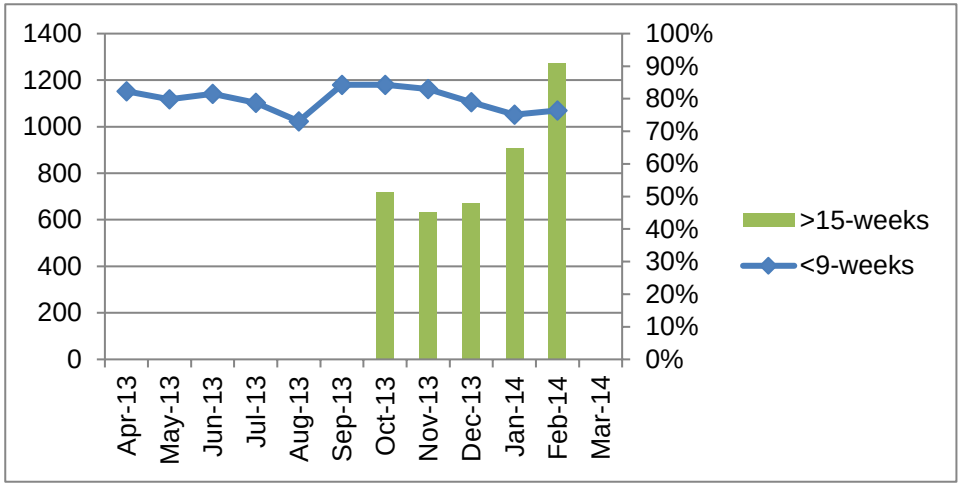
Performance in January has remained fairly static with 76.4% of patients waiting less than 9-weeks in comparison compared to 75.1% in January. The number of patients waiting over 15-weeks has further increased to 1272 in February from 908 in January. This cohort of patients waiting in excess of 15-weeks now relates to 7% of the total OP waiting list compared to 5% in January.

Performance at the end of January demonstrates a Regional position of 60% of patients waiting less than 9-weeks. Regionally the total number of patients waiting in excess of 9-weeks was 47,782 with the SHSCT equating to 4,334 (9%) of this. The volume of patients in excess of 9-weeks ranges across the 5 Trusts from 3,969 (WHSCT) to 27,068 (BHSCT).

Regionally the total number of patients waiting in excess of 15-weeks was 20,325 with the SHSCT equating to 907 (4%) of this. The volume of patients in excess of 15-weeks ranges across the 5 Trusts from 839 (SEHSCT) to 13,882 (BHSCT).

At the end of February the following specialties were in excess of a maximum wait of 15 weeks:

- Dermatology (inc ICATS) – 276 patients – longest wait 28-weeks;
- Urology (inc ICATS) – 201 patients – longest wait 33-weeks;
- Paediatrics – 4 patients – longest wait 17-weeks – Division have escalated risk of some breaches, but are still working towards achievement of 9-weeks at end of March;
- Cardiology ICATS – 8 patients – longest wait 32-weeks
- Ortho-Geriatrics – 22 patients – longest wait 33-weeks
- Neurology – 80 patients – longest wait 19-weeks



- Orthopaedic ICATS – 4 patients – longest wait 16-weeks – Division have confirmed return to 9-weeks at the end of March.
- General Surgery – 1 patient – waiting 18-weeks (late return from IS)
- Respiratory – 1 patient – waiting 19-weeks (late referral from Other Consultant)
- Geriatric Assessment – 1 patient – waiting 16-weeks (under validation)
- Paediatric Dentistry – 2 patients – longest wait 39-weeks – Division report that both patients have attended appointments in March

Three external (visiting specialties) in excess of 15 weeks were Ophthalmology – 664 patients, longest wait 28-weeks; Oral Surgery – 265 patients, longest wait 31-weeks; and Paediatric Cardiology – 25 patients, longest wait 29-weeks. It should be noted that the full waiting list management of the Oral Surgery service transferred to its core Trust ie. SEHSCT in mid-February. And discussions are on-going with the Commissioner in respect of the future management of the Ophthalmology Visiting Services from 1 April 2014.

In respect of patients waiting in excess of 9-weeks there are a total of 4826 patients (4274 consultant-led and 552 ICATS). 2276 (2059 consultant-led and 217 ICATS of these relate to specialty areas that require to achieve 9-weeks.

Specialties that did not achieve 9 weeks at the end of February but did achieve the 15-week backstop include: Symptomatic Breast; Cardiology (Consultant-Led); Gastroenterology; General Medicine; Gynaecology; Haematology; Pain Management; Rheumatology; Nephrology. Orthopaedics achieved 13-weeks.

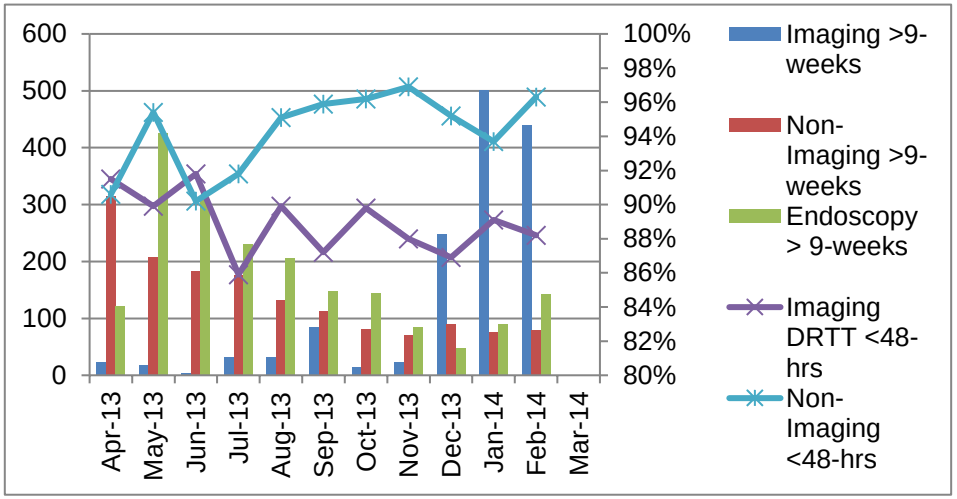
Whilst non-recurrent funding for additional capacity in Q3/4 has been confirmed by HSCB it is not sufficient to meet the totality of the capacity gap.

A projected year end position on access standards and SBA performance is detailed in Appendix 2.

Actions to address:

- The CYPS Directorate to review their plans in paediatrics to return to 9-week position
- Demand and capacity analysis to be undertaken for discussion with the Commissioner in respect of Ortho-Geriatrics as demand continues to be in excess of capacity, which is a 1-Consultant service.
- Director level bi-weekly performance meetings are in place within the Acute Services Divisions to review and challenge the performance position and agree areas of remedial action to improve areas of underperformance. Focus is also on the ability to deliver the agreed high levels of additional capacity where spend has been committed against non-recurrent funding allocated by the HSCB to minimise financial risk.
- Where performance is not improving Director level meetings are being held with respective specialty teams, including clinicians, to provide an oversight of the performance issues and to work to develop and implement solutions to improve performance;

	Monthly Position:												**Monthly Assess**	**Trend**
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
<9-weeks	82.3% (12954)	79.8% (13220)	81.5% (13896)	78.8% (13574)	73.1% (12495)	84.3% (13377)	84.3% (13355)	83% (13483)	79% (12947)	75.1% (13083)	76.4% (13864)		**Y**	⇔
>18 weeks	195	180	336	439	713	191	Monitoring against >15-weeks (October 2013 to March 2014)							
>15-weeks	Monitoring against >18-weeks (April to September 2013)						719	631	674	908	1272		**R**	↓

CP 8: ELECTIVE CARE DIAGNOSTICS: Lead Director Mrs Deborah Burns, Director of Acute Services	
From April 2013, no patient waits longer than 9-weeks for a diagnostic test including endoscopy and all urgent diagnostic tests are reported on within 2 days of the test being undertaken. (No change envisaged in 2014/2015 CP draft targets, although endoscopy not specifically mentioned)	
Baseline: Diagnostic Testing – 254 > 9 weeks (@ 31 March 2013) Endoscopy – 11> 9 weeks (@ 31 March 2013) Imaging DRTT – 90.9% < 2 days(@ 31 March 2013) Non-Imaging DRTT – 88%< 2 days (@ 31 March 2013) **TDP Assessment:** Likely to be achieved with some delay/partially achieved.	**Standard:** Diagnostic Testing – 9-weeks Endoscopy – 9-weeks DRTT – 2 days
Comment/Actions: **Diagnostic Testing –** • **Imaging** – The number of patients in excess of 9-weeks for Imaging has reduced slightly to 440 patients at the end of February, compared to 501 at the end of January. Whilst HSCB provided a level of non-recurrent funding for Imaging it was insufficient to achieve and maintain the 9-week access standard. • **Urodynamics** –There are 79 patients waiting in excess of 9-weeks within Urodynamics (Urology). The longest waiter at end of February is 54-weeks with an anticipated position for end of March of 52-weeks. • **Endoscopy** – The number of patients waiting in excess of 9-weeks for Endoscopy has further increased to 143 patients at the end of February, compared to 89 patients at the end of January. **Actions to address:** ○ The Trust has submitted an IPT to the Commissioner in January 2014 for expansion in Nurse Endoscopist capacity to deal with the capacity gap on a recurrent basis, as requested by HSCB. A response is awaited. ○ The Trust continues to utilise additional capacity both within in-house additionality and with IS provision ensuring an appropriate balance is achieved between new and planned patients. Cumulative performance at the end of January demonstrates Regionally	

8,831 patients breached 9-weeks with SHSCT equating to 577 (6.5%) of this. The volume of Diagnostic patients (Imaging and Non-Imaging) in excess of 9-weeks across the 5 Trusts ranges from 353 (WHSCT) to 6,736 (BHSCT). A projected year end position on access standards and SBA performance is detailed in Appendix 2. • **Diagnostic Reporting** – **Imaging** – Performance in February (88.2%) has remained relatively static from the end of January position (89.1%). Within Imaging the challenges in turnaround time for reporting remain within the modalities of MRI and Barium Enema. These challenges have been exacerbated by consultant manpower issues. Performance against the 48-hour standard is affected by the timing of the examinations with timing of examination based on the clinical need of the patient and not the ability to report within the 48-hour standard. It should be noted that in-patient and A&E urgent examinations will be 'verbally' reported ie. handwritten into the patient's medical note to minimise any delay in the patient pathway. **Actions to address** ○ Division to analyse the impact of 7-day working on performance against this target • Diagnostic Reporting – Non-Imaging – Performance in February (96.3%) has increased from the end of January position (93.7%). Cumulative performance at the end of January demonstrates Regional position of 92% with SHSCT performance at 89%. Performance across the 5 Trusts ranges from 87% (BHSCT) to 99% (NHSCT).	

	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Imaging >9-wks	23	17	3	32	32	84	15	22	248	501	440		R	↑
Non-Imaging >9-wks	315	207	183	176	112	139	81	70	89	76	79		R	⇔
Endos. >9-wks	121	425	309	231	205	147	145	85	48	89	143		R	↓
Imaging DRTT Urgents <48-hrs	91.5% (2238 out of 2441)	89.9% (2330 out of 2592)	91.8% (2331 out of 2539)	85.9% (2390 out of 2782)	89.9% (2243 out of 2499)	87.2% (2212 out of 2537)	89.8% (2444 out of 2721)	88% (2326 out of 2654)	86.9% (2239 out of 2576)	89.1% (2637 out of 2960)	88.2% (2450 out of 2779)		A	⇔
Non-Imaging DRTT Urgent <48-hrs	90.6% (126 out of 139)	95.4% (145 out of 152)	90.2% (120 out of 133)	91.8% (134 out of 146)	95.1% (116 out of 122)	95.9% (141 out of 147)	96.2% (150 out of 156)	96.9% (126 out of 130)	95.2% (119 out of 125)	93.7% (134 out of 143)	96.3% (129 out of 134)		Y	↑

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

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

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

TDP Assessment: Achievable dependent upon additional funding

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

Comment/Actions:

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

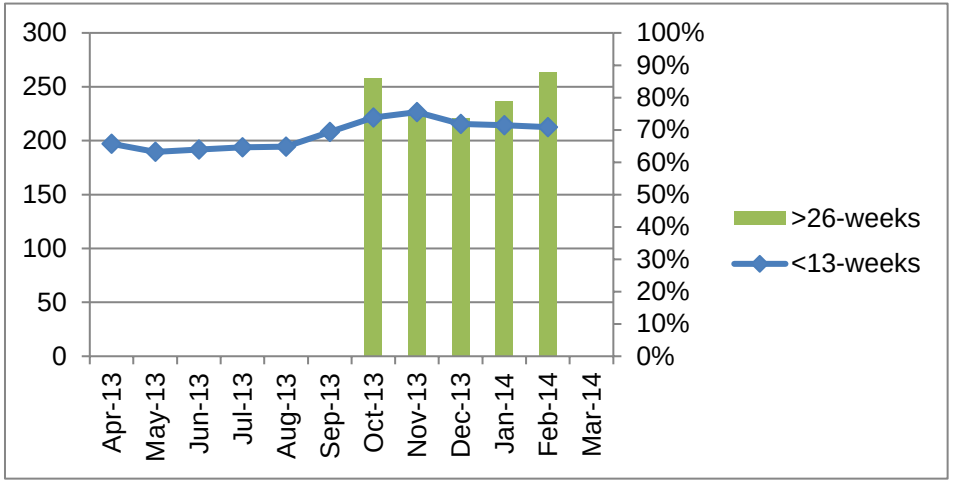
Performance at the end of January demonstrates a Regional position of 64% of patients waiting less than 13-weeks. Regionally the total number of patients waiting in excess of 13-weeks was 17,391 with the SHSCT equating to 1,765 (10%) of this. The volume of patients in excess of 13-weeks ranges across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

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

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

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

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



1 external (visiting specialty) in excess of 26-weeks was Oral Surgery – 5 patients – longest wait 29-weeks.

Whilst additional funding for additional capacity in Q3/4 has been confirmed by HSCB it is not sufficient to meet the totality of the capacity gap.

A projected year end position on access standards and SBA performance is detailed in Appendix 2.

Actions to address:

- Director level bi-weekly performance meetings are in place within the Acute Services Divisions to review and challenge the performance position and agree areas of remedial action to improve areas of underperformance. Focus is also on the ability to deliver the agreed high levels of additional capacity where spend has been committed against non-recurrent funding allocated by the HSCB to minimise financial risk.
- To maximise theatre utilisation and to ensure maintenance / improvement of SBA activity specialties, for example Breast Surgery and Gynaecology, are flowing patients between CAH and DHH sites. This not only allows for maintenance / improvement of SBA performance but also ensures equalisation of waiting times across the sites / specialties.
- Where a significant improvement is required within an IP/DC SBA specialty Director level meeting with the Specialty's Clinical Directors have been held to discuss the underperformance and to facilitate the clinicians to identify and implement options for improvement. This has included the addition of an extra DC patient onto all IP theatre lists; scrutiny of all theatre lists to ensure maximum number of patients booked; facilitation of additional patients on the STH lists.

<table>
<tr><th rowspan="2"></th><th colspan="12">Monthly Position (Excluding Scopes):</th><th rowspan="2">Monthly Assess</th><th rowspan="2">Trend</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td><13-Weeks</td><td>65.7% (4443)</td><td>63.2% (4241)</td><td>63.9% (4230)</td><td>64.6% (4087)</td><td>64.8% (3886)</td><td>69.4% (4286)</td><td>73.8% (4618)</td><td>75.5% (4650)</td><td>71.8%</td><td>71.4%</td><td>70.9%</td><td></td><td>A</td><td>⇔</td></tr>
<tr><td>>30-weeks</td><td>327</td><td>410</td><td>406</td><td>404</td><td>407</td><td>288</td><td colspan="6">Monitoring against >26-weeks (October 2013 to March 2014)</td><td></td><td></td></tr>
<tr><td>>26-weeks</td><td colspan="6">Monitoring against >30-weeks (April to September 2013)</td><td>258</td><td>223</td><td>221</td><td>237</td><td>263</td><td></td><td>R</td><td>↓</td></tr>
</table>

CP 10: HEALTHCARE ACQUIRED INFECTIONS: Lead Director Mr John Simpson, Medical Director

By March 2014, secure a reduction of 29% in MRSA and Clostridium Difficile infections compared to 2011/2012. (Proposed target changes baseline to 2013/2014 year but % reduction not yet defined - ? Trust specific)

Baseline: MRSA – 1
C Diff – 42

TDP Assessment: Awaiting confirmation of targets for 2013/2014

Target: MRSA – <3
MRSA Case Reduction Required – -1 - +2
C Diff – 33
C Diff Case Reduction Required – -9

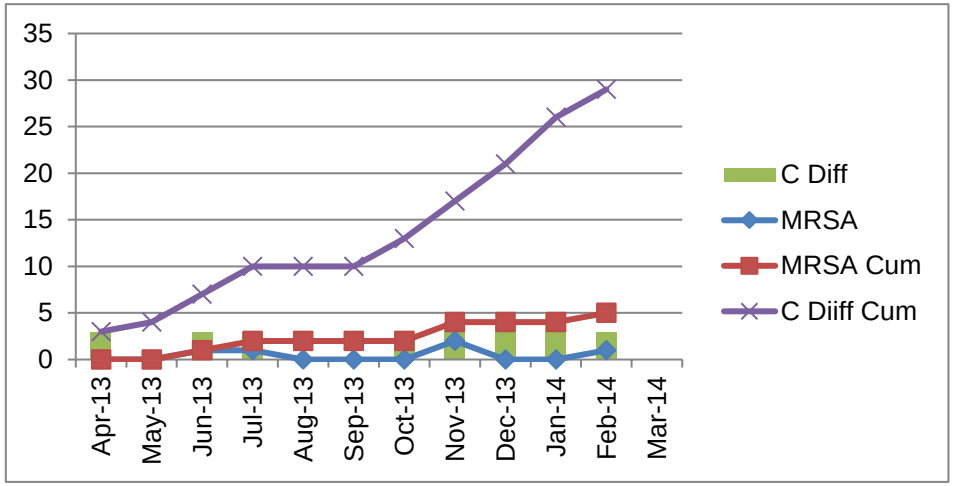
Comment/Actions:

MRSA – 1 further case of MRSA reported in February. The total number of reported cases between April 2013 and February 2014 is in excess of the Trust's target for 2013/2014.

With the exception of BHSCT all Trusts have reported cases of MRSA in excess of their target for 2013/2014.

C Diff – 3 further cases of C Diff have been reported in February. The total number of reported cases between April 2013 and February 2014 remains below the Trust's target for 2013/2014.

Further information on the HCAI rates is provided within the Medical Director's Trust Board Report.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MRSA Actual	0	0	1	1	0	0	0	2	0	0	1		R	↓
MRSA Cum	0	0	1	2	2	2	2	4	4	4	5		R	↓
C Diff Actual	3	1	3	3	0	0	3	4	4	5	3		G	↑
C Diff Cum	3	4	7	10	10	10	13	17	21	26	29		G	↓

CP 12: SPECIALIST DRUGS: Lead Director Mrs Deborah Burns, Director of Acute Services	
From April 2013, no patient should wait longer than 3-months commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, and no patient should wait longer than 9-months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013. (No change envisaged in 2014/2015 CP draft targets - hold at 3-months all therapies)	
Baseline: 0 Rheumatology (>3-months @ 31 March 2013) 8 Dermatology (>9-months @ 31 December 2012) **TDP Assessment:** Achievable dependent on additional funding	**Target:** 0 >3-months Rheumatology 0 >9-months Dermatology; changing to 0 >3-months by September 2013

Comment/Actions:

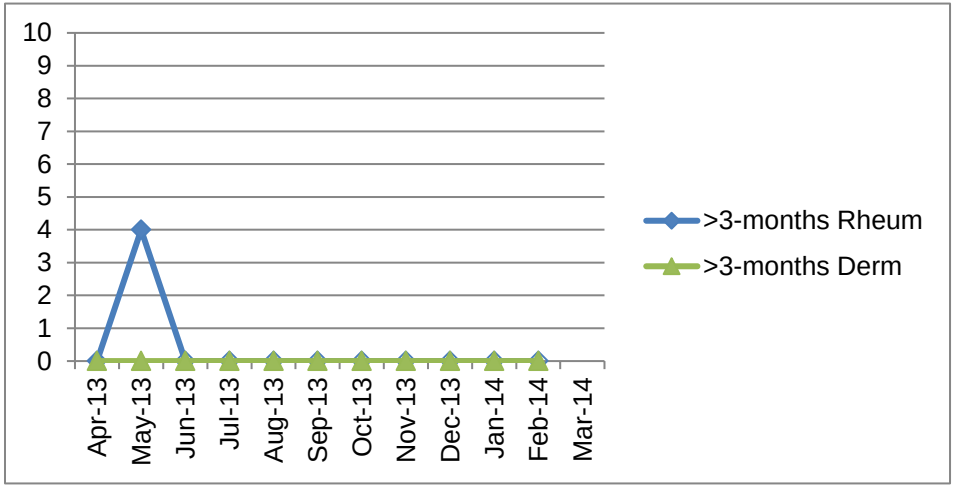
The Trust continues to have 0 patients waiting more than 3-months for the commencement of NICE approved specialist therapies for rheumatoid arthritis; psoriatic arthritis; or ankylosing spondylitis or for the commencement of NICE approved specialist therapies for psoriasis.

A response has recently been received from HSCB regarding the Trust's Rheumatology IPT (Rheumatology elective gap element), however, this will require further discussion as is significantly lower than the Trust bid. Until this is resolved the Trust is not in a position to formally respond to PHA/HSCB on the anti-TNF therapies.

HSCB has confirmed the funding for additional drug costs to facilitate maintenance of the target however infrastructural issues, including pressures in pharmacy may affect the ability to implement new drug treatment and achieve targets.

Actions to address:

- Service to review recent HSCB offer against the Rheumatology IPT and escalate as required.
- Critical pharmacy pressures have been highlighted to HSCB/SLCG and have the potential to impact on the delivery of the specialist drugs standard. A short briefing paper has been submitted to the SLCG and shared with DHSSPS Pharmacy Lead.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
>3-months Rheum	0	4	0	0	0	0	0	0	0	0	0		**G**	⇔
>9-months Derm	8	6	0	0	0	0	Monitoring against >3-months (October 2013 to March 2014)							
>3-months Derm	Monitoring against >9-months (April to September 2013)						0	0	0	0	0		**G**	⇔

CP 13: SPECIALIST DRUGS: Lead Director Mrs Deborah Burns, Director of Acute Services

By March 2014, ensure that at least 10% of patients with confirmed Ischaemic stroke receive thrombolysis. (Suggested target moved to IoP)

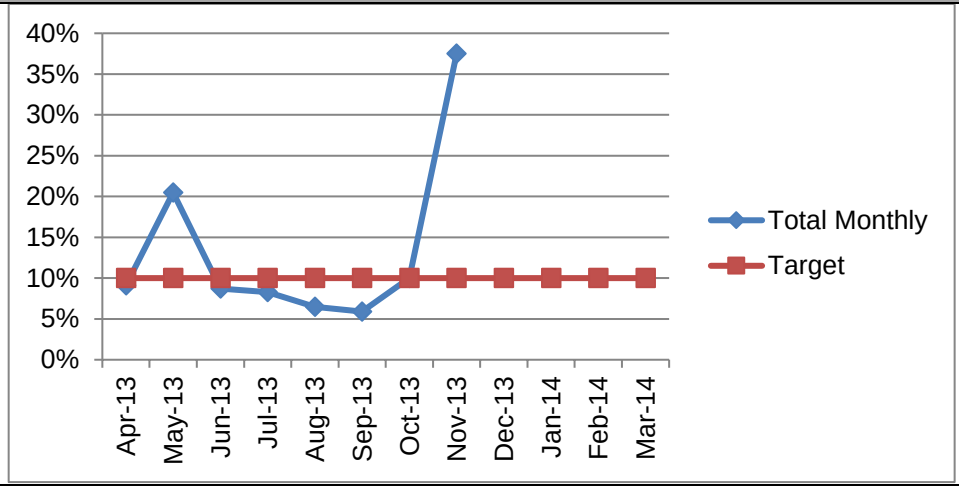
Baseline: 9.7% (cumulative April 2012 – December 2012)
TDP Assessment: Achievable

Target: 10%

Comment/Actions:

In November the Trust achieved a greater than 10% of patients with confirmed ischaemic stroke having received thrombolysis (37.5%), with a cumulative performance of 11.5%.

In respect of CAH the target was achieved in 2 out of 8 months, with a cumulative performance of 11.2%; whilst at DHH the target was achieved in 6 out of 8 months with a cumulative performance of 12.3%.



Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	9.1%	20.5%	8.7%	8.3%	6.5%	5.9%	10%	37.5%					G	↑
Trust Admissions	A 55 T 5	A 44 T 9	A 46 T 4	A 48 T 4	A 46 T 3	A 52 T 3	A 40 T 4	A 24 T 9						
Trust Cumulative	-	-	-	-	-	-	-	11.5%						
CAH	5.4%	24%	8.3%	6.3%	8.8%	5.7%	7.1%	50%					G	↑
CAH Admissions	A 37 T 2	A 25 T 6	A 36 T 3	A 32 T 2	A 34 T 3	A 35 T 2	A 28 T 2	A 14 T 7						
CAH Cumulative	-	-	-	-	-	-	-	11.2%						

Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
DHH	16.7%	15.8%	10%	12.5%	0%	5.9%	16.7%	20%					G	↑
DHH Admissions	A 18 T 3	A 19 T 3	A 10 T 1	A 16 T 2	A 12 T 0	A 17 T 1	A 12 T 2	A 10 T 2						
DHH Cumulative	-	-	-	-	-	-	-	12.3%						

Note: Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

CP 14: MEDICINES FORMULARY: Lead Director Mrs Deborah Burns, Director of Acute Services	
From April 2013, ensure that HSCB achieve 70% concordance with the published Medicines Formulary. (No change envisaged in 2014/2015 CP draft targets)	
Baseline: To be confirmed **TDP Assessment:** HSCB to respond	**Target:** 70%

Comment/Actions:

Resources and systems are not available to permit a full audit of compliance however Trust is complying with the Regional Formulary and PCE guidance and by way of assurance has undertaken inpatient prescribing audits on six key areas between April – October 2013 and provided a report on the position to HSCB

The Trust is willing to carrying out a wider audit should be this required subject to the availability of additional resources from the Region.

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Not Available													

CP 15: ALLIED HEALTH PROFESSIONALS: Lead Director Mrs Angela McVeigh, Director of Older People and Primary Care Services

From April 2013, no patient waits longer than 9-weeks for referral to commencement of AHP treatment. (No change envisaged in 2014/2015 CP draft targets)

Baseline: 27 Paediatric OT (>9-weeks @ 31 March 2013)
TDP Assessment: Achievable

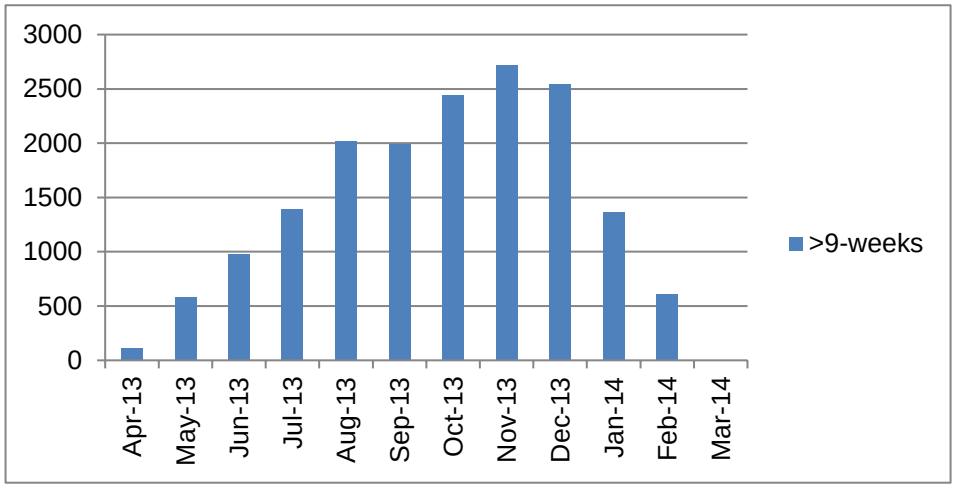
Standard: 0

Comments:
The number of waiters in excess of 9-weeks further decreased to 612 at the end of February compared to 1365 at the end January. The breakdown and longest waiters are as follows: Dietetics 80 (17-weeks); Occupational Therapy 168 (35-weeks); Physiotherapy 255 (18-weeks); Podiatry 109 (13-weeks). Speech & Language Therapy have no patients waiting in excess of 9-weeks and confirm that will hold the 9-week target at end March 2014.

Regionally performance at the end of January demonstrated a total of 5,971 breachers of the 9-week standard with SHSCT accounting for 1,364 (23%) of these. The volume of breachers across the 5 Trusts ranges from 125 (SEHSCT) to 2,128 (NHSCT).

Actions to address:

- Additional temporary staff and additional hours have been fully implemented utilising the non-recurrent allocation.
- Cutting plans have been submitted by all Professions and collective fortnightly Performance meetings are held (Chaired by Head of Performance) to monitor progress against same and challenge of areas where performance is not as anticipated per the cutting plans.
- The internal review implemented by SMT continues with recommendations needing to align with/be informed by the outcome of the regional HSCB / PHA exercise. A timescale for the report of the regional process is awaited



Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
108	584	979	1396	2020	1993	2440	2718	2542	1365	612		Y	↑

CP 16: TELEHEALTH: Lead Director Mrs Angela McVeigh, Director of Older People and Primary Care

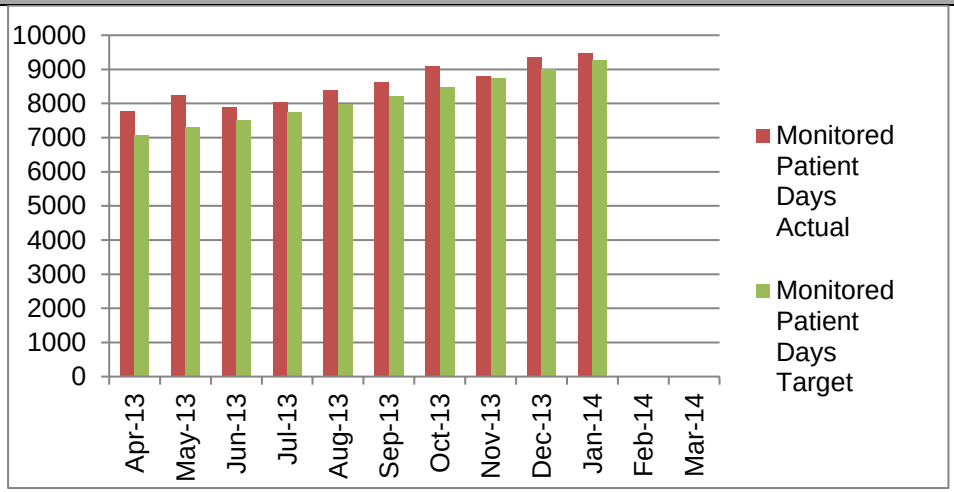
By March 2014, deliver 500,000 Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract. (Target is under review in 2014/2015 CP draft targets and may be subject to change)

Baseline: To be confirmed
TDP Assessment: To be confirmed

Target: To be confirmed

Comment/Actions: Reported one-month in arrears

Performance detailed below demonstrates that the target for monitored patients' days has continually been achieved, and over performed for 10-months.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Actual Monitored Patient Days	7780	8243	7887	8050	8407	8634	9114	8803	9362	9477			G	⇔
Target Monitored Patient Days	7085	7299	7513	7744	7974	8222	8487	8753	9018	9283				

CP 19: UNPLANNED ADMISSIONS: Lead Director Mrs Angela McVeigh, Director of Older People and Primary Care	
By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long-term conditions. (No change envisaged in 2014/2015 CP draft targets although 10% reduction not defined)	
Baseline: -5.7% (cumulative April 2012 to December 2012) **TDP Assessment:** Achievable	**Target:** Reduce by 10%

Comment/Actions: Reported 3-months in arrears –

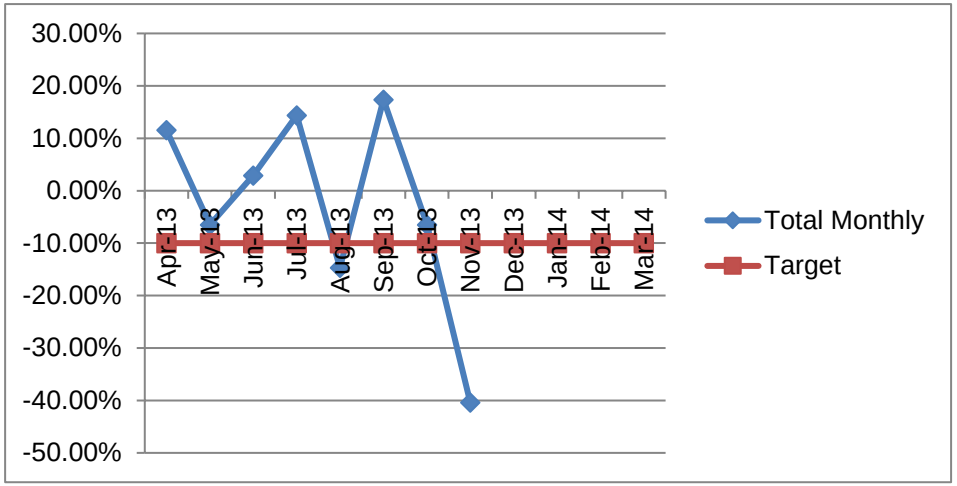
The total* conditions specified within this target are:

- COPD;
- Diabetes;
- Heart Failure; and
- Asthma.

November activity shows that 3 out of 4 of the specified long-term conditions (COPD; Diabetes; and Heart Failure) have achieved a higher reduction than the target of a reduction in admissions by 10%.

The baseline admissions for the 4 specified long-term conditions is listed below with the corresponding activity for the 8 months of 2013/2014:

- Total – Baseline 838 versus 810 actual admissions
- COPD – Baseline 443 versus 423 actual admissions
- Diabetes – Baseline 78 versus 67 actual admissions
- Heart Failure – Baseline 257 versus 234 actual admissions
- Asthma – Baseline 60 versus 86 actual admissions



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Total* Monthly	11.6%	-6.5%	2.9%	14.4%	-14.7%	17.4%	6.5%	-40.4%					G	↑
Total Admissions*	B 121 A 135	B 107 A 100	B 102 A 105	B 90 A 103	B 109 A 93	B 92 A 108	B 108 A 101	B 109 A 65						
Total* Cumulative	-	-	-	-	-	-	-	-3.3%						
COPD	14.3%	-19.4%	15.4%	6%	-26.4%	14%	21.7%	-53.3%					G	↑
COPD Admissions	B 63 A 72	B 62 A 50	B 52 A 60	B 50 A 53	B 53 A 39	B 57 A 65	B 46 A 56	B 60 A 28						
COPD Cumulative	-	-	-	-	-	-	-	-4.5%						
Diabetes	10%	44.4%	-36.4%	60.0%	-8.3%	-28.6%	-46.2%	-54.5%					G	↑
Diabetes Admissions	B 10 A 11	B 9 A 13	B 11 A 7	B 5 A 8	B 12 A 11	B 7 A 5	B 13 A 7	B 11 A 5						
Diabetes Cumulative	-	-	-	-	-	-	-	-14.1%						
Heart Failure	-13.2%	-6.9%	-9.4%	-8.6%	-14.6%	40%	-12.1%	-27.6%					G	↑
Heart Failure Admissions	B 38 A 33	B 29 A 27	B 32 A 29	B 35 A 32	B 41 A 35	B 20 A 28	B 33 A 29	B 29 A 21						
Heart Failure Cum	-	-	-	-	-	-	-	-8.9%						
Asthma	90%	42.9%	28.6%	1000%	166.7%	25%	-43.8%	22.2%					R	↓
Asthma Admissions	B 10 A 19	B 7 A 10	B 7 A 9	B 0 A 10	B 3 A 8	B 8 A 10	B 16 A 9	B 9 A 11						
Asthma Cumulative	-	-	-	-	-	-	-	43.3%						

Note: Long-term conditions admissions figures: B = Baseline / A = Actual In-Year

Note: July-Oct figures updated due to link with completion of clinical coding.

CP 21: UNNECESSARY HOSPITAL STAYS: Lead Director Mrs Deborah Burns, Director of Acute Services	
By March 2014, reduce the number of excess beddays for the Acute Programme of Care by 10%. (No change envisaged in 2014/2015 CP draft targets although % reduction not yet defined)	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Target:** Reduce by 10%

Comment/Actions:

Based on the HSCB February Performance Report (for January performance) Regional performance against this target is +22.2% based on April to October 2013. The Southern Trust is reported as having a +41.1% performance against this target with only 1 (NHSCT) out of 5 Trusts achieving the required 10% reduction in excess beddays. Performance against this target, across the 5 Trusts, ranges from -40.8% (NHSCT) to +73.3% (WHSCT). Of note is the fact that SHSCT had the lowest opportunity for reduction of excess beddays in the region being only 14% of the total opportunity.

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Not Available													

MINISTERIAL PRIORITY: TO IMPROVE PRODUCTIVITY BY ENSURING EFFECTIVE AND EFFICIENT ALLOCATION AND UTILISATION OF ALL AVAILABLE RESOURCES, IN LINE WITH PRIORITIES

CP 22: PATIENT DISCHARGE: Lead Director Mr Francis Rice, Director of Mental Health & Disability

From April 2013, ensure that all learning disability and mental health discharges take place within 7-days of the patient being assessed as medically fit for discharge. (Proposed target seeks 99% of discharged within 7-days and backstop of 28–days)

Baseline: LD 84% (cumulative April 2012 – March 2013)
MH 98% (cumulative April 2012 – March 2013)

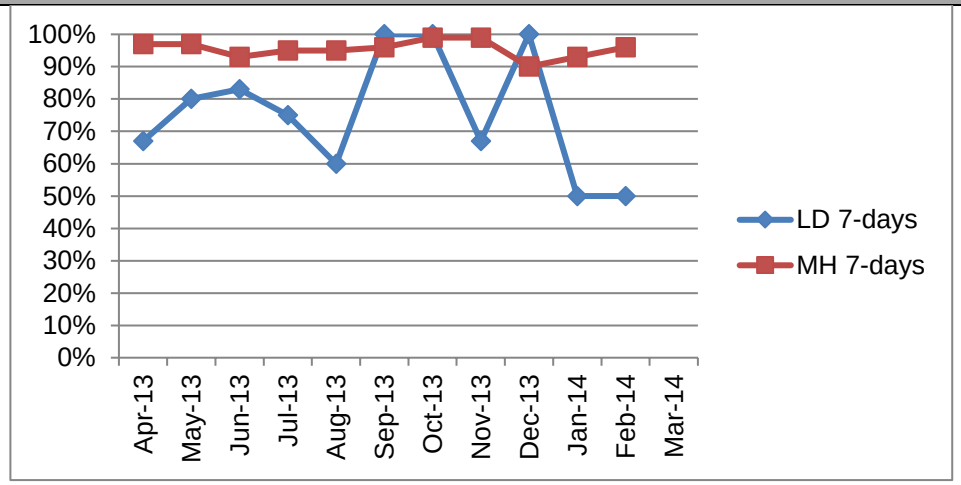
Standard: 100% all discharges 7-days

TDP Assessment: Achievable

Comment/Actions:

In Learning Disability 3 out of 6 (50%) Learning Disability patients were discharged, in February, within 7-days which continues to show variable performance associated with the small cohort of patients discharged. Cumulative performance at the end of January demonstrates Regional position of 88% with SHSCT performance at 74%. Performance across the 5 Trusts ranges from 74% (SEHSCT) to 95% (NHSCT).

In Mental Health 93 out of 97 (96%) were discharged in February, within 7-days showing an increase in performance in comparison with January (93%). Performance within Mental Health is impacted upon by a lack of suitable facilities for patients to be discharged to. Cumulative performance at the end of January demonstrates Regional position of 96% with SHSCT performance at 96%. Performance across the 5 Trusts ranges from 93% (NHSCT) to 100% (BHSCT).



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD 7-days	67% (2 out of 3)	80% (4 out of 5)	83% (5 out of 6)	75% (3 out of 4)	60% (3 out of 5)	100% (1 out of 1)	100% (4 out of 4)	67% (2 out of 3)	100% (2 out of 2)	50% (2 out of 4)	50% (3 out of 6)		A	↔
MH 7-days	97% (112 out of 115)	97% (133 out of 137)	93% (115 out of 123)	95% (131 out of 138)	95% (123 out of 129)	96% (128 out of 134)	99% (134 out of 135)	99% (128 out of 129)	90% (93 out of 103)	93% (126 out of 135)	96% (93 out of 97)		Y	↑

CP 22: PATIENT DISCHARGE: Lead Directors Mrs Deborah Burns, Director of Acute Services and Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2013, ensure that all non-complex discharges from an Acute hospital take place within 6 hours; 90% of all complex discharges take place within 48-hours; and that all complex discharges, take place within 7-days. (No change envisaged in 2014/2015 CP draft targets)

Baseline: 93.9% non-complex 6-hours (cum April 2012 – March 2013)
97.7% complex 48-hours (cum April 2012 – March 2013)
99.6% all discharges 7-days (cum April 2012 – March 2013)
TDP Assessment: Achievable

Standard: 100% non-complex 6-hours
90% complex 48-hours
100% all discharges 7-days

Comment/Actions:

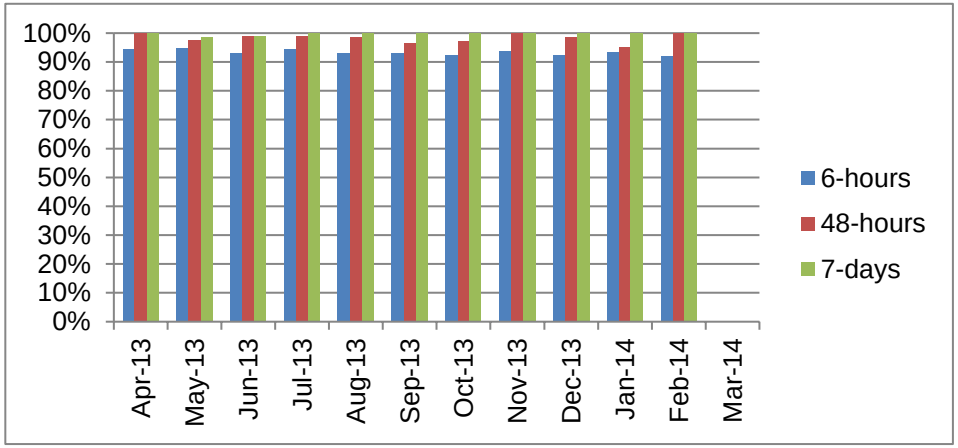
Non-Complex Discharges – Performance against the 6-hour discharge standard has declined slightly in February (92%) compared to 93.4% in January. This equates to 1917 out of 2083 non-complex discharges being completed within 6-hours with 166 not being completed within 6-hours.

Regional cumulative performance at the end of January demonstrates performance of 96%. Performance across the 5 Trusts ranges from 93% (SHSCT & SEHSCT) to 98% (BHSCT).

Complex Discharges – 41 out of 41 complex discharges were completed within 48-hours with no patients waiting longer than 7-days.

Cumulative performance at the end of January, against the 48-hour standard, demonstrates a Regional position of 85% with SHSCT performance at 96%. Performance across the 5 Trusts ranges from 66% (BHSCT) to 96% (SHSCT).

Cumulative performance at the end of January, against the 7-day standard, demonstrates 819 discharges in excess of 7-days with SHSCT accounting for 14 of these (2%). Breaches across the 5 Trusts ranges from 14 (SHSCT) to 294 (BHSCT).



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
6-hrs	94.5% (2280 out of 2413)	94.65% (2330 out of 2462)	92.9% (2197 out of 2365)	94.4% (2240 out of 2372)	93.1% (2157 out of 2317)	93.1% (2207 out of 2370)	92.2% (2309 out of 2503)	93.8% (2143 out of 2285)	92.2% (2071 out of 2246)	93.4% (2070 out of 2217)	92% (1917 out of 2083)		A	↓
48-hrs	100% (84 out of 84)	97.5% (79 out of 81)	98.9% (86 out of 87)	98.8% (81 out of 82)	98.4% (61 out of 62)	96.3% (52 out of 54)	97.2% (70 out of 72)	100% (60 out of 60)	98.4% (60 out of 61)	95.2% (79 out of 83)	100% (41 out of 41)		G	↑
7-days	100% (84 out of 84)	98.7% (80 out of 81)	98.8% (86 out of 87)	100% (82 out of 82)	100% (62 out of 62)	100% (54 out of 54)	100% (72 out of 72)	100% (60 out of 60)	100% (61 out of 61)	100% (83 out of 83)	100% (41 out of 41)		G	↔

CP 23: LEARNING DISABILITY / MENTAL HEALTH: Lead Director Mr Francis Rice, Director of Mental Health & Disability

By March 2014, 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015. (New 2014/2015 CP draft target defines all long stay to be resettled)

Baseline: Learning Disability 11 (@ 31 March 2013)
Mental Health 3 (@ 31 March 2013)

TDP Assessment: Learning Disability – Achievable
Mental Health – Not Achievable 2013 – 2014 – Achievable 2015

Target: Learning Disability – 12
Mental Health – 17

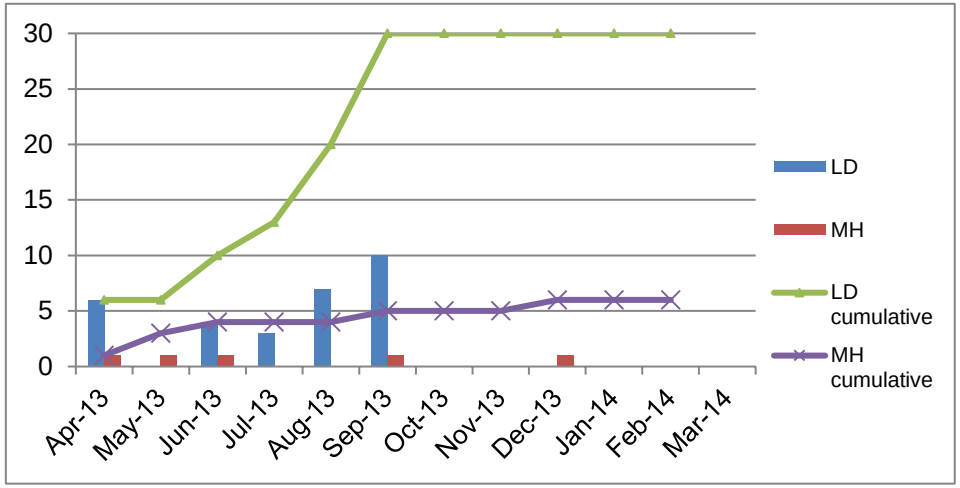
Comment/Actions:

Mental Health – Resettlement plans for the remaining long stay population in St Luke's remain dependent upon a number of Supported Living schemes which should be available providing sufficient places to resettle the remaining population by 2015. In the interim the Division is exploring all other potential opportunities for resettlement in year within existing facilities as well new places in the Independent Sector. Discussion is underway with Commissioner regarding an in-year target versus a final target for all patients to be resettled by no later than March 2015.

Whilst the Regional cumulative performance at the end of January demonstrates a total of 11 resettlements with SHSCT accounting for 5 of these (45%), the SHSCT information details 6 resettlements.

Learning Disability – 30 patients have been resettled achieving the in-year target.

Regional cumulative performance at the end of January demonstrates a total of 59 resettlements with SHSCT accounting for 30 of these (51%).



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD	6	0	4	3	7	10	0	0	0	0	0		G	⇔
LD Cumulative	6	6	10	13	20	30	30	30	30	30	30			
MH	2	1	1	0	0	1	0	0	1	0	0		A	⇔
MH Cumulative	2	3	4	4	4	5	5	5	6	6	6			

CP 24: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services														
From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%. (No change envisaged in 2014/2015 CP draft targets)														
Baseline: To be confirmed **TDP Assessment:** To be confirmed												**Standard:** Increase to 85%		
Comment/Actions: Performance against this standard is to be reported annually. Therefore, monitoring information will not be available until early 2014/2015.														
Monthly Position:													**Monthly Assess**	**Trend**
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**			
Not Available														

CP 25: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services														
From April 2013, ensure a 3-year time frame for 90% of all children to be adopted from care. (No change envisaged in 2014/2015 CP draft targets)														
Baseline: To be confirmed **TDP Assessment:** To be confirmed												**Standard:** 3-year time frame for 90%		
Comment/Actions: Performance against this standard is to be reported annually. Therefore, monitoring information will not be available until early 2014/2015.														
Monthly Position:													**Monthly Assess**	**Trend**
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**			
Not Available														

CP 26: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

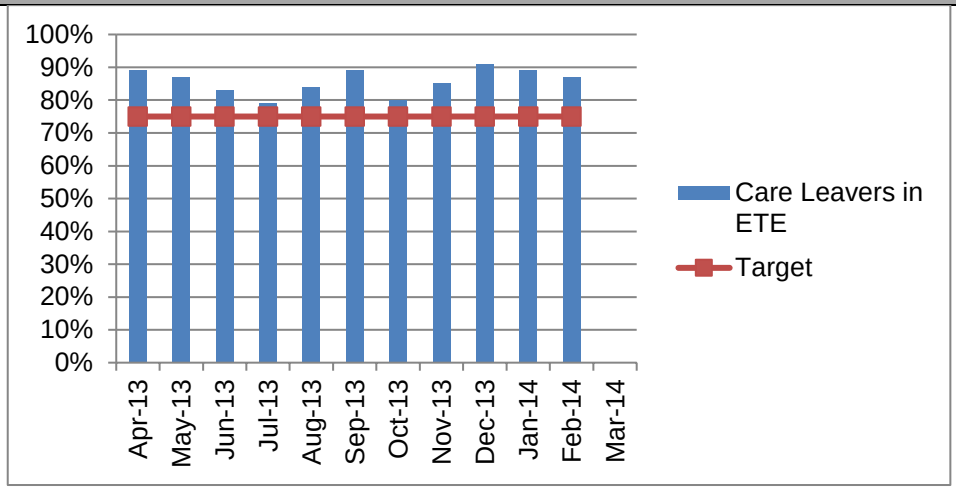
By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%. (Proposed move to IoP target in 2014/2015 CP draft targets)

Baseline: 76% (@ 31 March 2013)
TDP Assessment: Partially Achievable

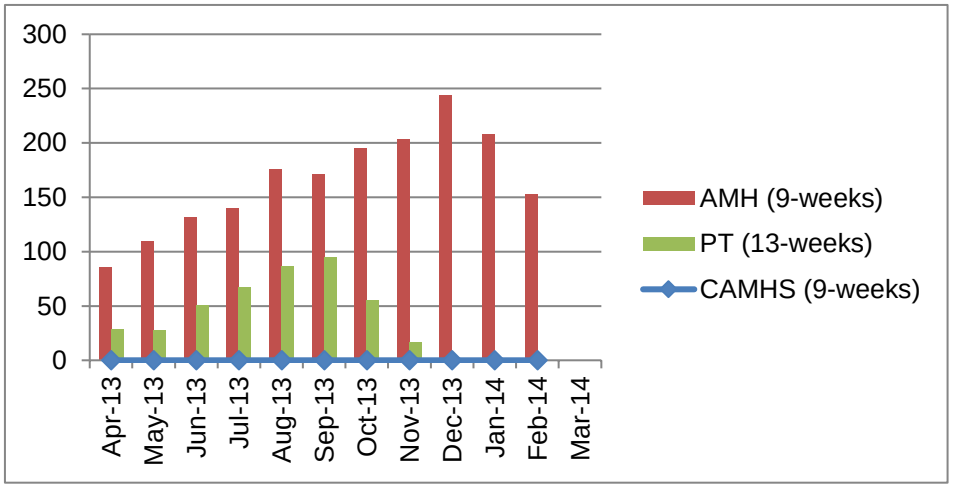
Target: 75%

Comment/Actions:
Whilst performance in February has fallen (87%) in comparison to the end of January position (89%) performance continues to be in excess of the target with 87% of care leavers in education, training or employment at the end of January. This equates to 33 out of 38 care leavers.

Cumulative performance at the end of January demonstrates a Regional position of 76% with SHSCT performance at 89%. Performance across the 5 Trusts ranges from72% (BHSCT) to 89% (SHSCT).



Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
89% (25 out of 28)	87% (26 out of 30)	83% (25 out of 30)	79% (26 out of 33)	84% (26 out of 31)	89% (25 out of 28)	80% (24 out of 30)	85% (28 out of 33)	91% (29 out of 32)	89% (32 out of 36)	87% (33 out of 38)		G	↓

CP 27: MENTAL HEALTH: Lead Director Mr Francis Rice, Director of Mental Health & Disability	
From April 2013, no patient waits longer than 9-weeks to assess child and adolescent services (CAMHS) or adult mental health (AMH) services, and 13-weeks for psychological therapies (PT) (any age). (No change envisaged in 2014/2015 CP draft targets)	
Baseline: 0 CAMHS (@ 31 March 2013) 72 Adult Mental Health (30 PMHC & 42 Memory) (@ 31 March 2013) 67 Psychological Therapies (@ 31 March 2013) **TDP Assessment:** CAMHS – Achievable Adult Mental Health and Psychological Therapies – Achievable but remains at risk 2013/2014	**Standard:** 0 >9-weeks – CAMHS and Adult Mental Health 0 >13-weeks – Psychological Therapies
Comment/Actions: **Adult Mental Health Services** – The number of patients waiting in excess of 9-weeks in February has decreased to 153 compared to 208 at end January. Breakdown as follows: Primary Mental Health Care 12 and Memory 141. • **Primary Mental Health Care –** The service has through its implementation of the additional in-house capacity rolled forward with its recovery plan to return to 9-weeks. At the end of February there were 12 breachers of the 9-week access standard, but these have been validated and either booked in March or discharged. No risk has been identified to achievement of the 9-week standard at the end of March 2014. • **Memory/Dementia Services** – The total number of patients waiting in excess of 9-weeks has further decreased in February (141) with longest wait 46-weeks. Cumulative performance at the end of January demonstrates that the SHSCT is a significant outlier in this area, however, it is understood that the Trust reporting methodology differs across the Trusts and therefore, the Regional comparison is not effective. The reporting differential will be rectified from 1 April 2014.	

Actions to address:

- Divisional recovery plan in place – Division anticipate will achieve 20-weeks by end March
- The Trust has secured non-recurrent funding from HSCB to assist in the backlog clearance of those patients in excess of 9-weeks. However, the funding available will not facilitate a return and maintenance of the 9-week access standard by the end of March 2014. Additional capacity associated with the non-recurrent funding is now in place.
- The Directorate is to review the demand and capacity gap and identify what element of this gap could be addressed through service improvement / productivity and what gap remains to be closed off through potential recurrent investment.

- **Psychological Therapies** – There were no patients waiting in excess of 13-weeks at end February. The return to 13-weeks has been achieved through a combination of a critical review of the patient pathway and referral criteria/acceptance along with additional resources through non-recurrent funding from HSCB.

  Performance at the end of January demonstrates Regionally 511 breaches of the 13-week standard with the SHSCT accounting for 0 (0%) of these.

	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
CAMHS	0	0	0	0	0	0	0	0	0	0	0		G	⇔
AMH Including Memory/ Dementia	86	110	132	140	176	171	195	203	244	208	153		R	↑
PT	29	28	51	67	87	95	55	17	1	0	0		G	⇔

CP 28: COMMUNITY CARE: Lead Director Mrs Angela McVeigh, Director of Older People and Primary Care

From April 2013, people with continuing care needs wait no longer than 5-weeks for assessment to be completed, and have the main components of their care needs met within a further 8-weeks. (No change envisaged in 2014/2015 CP draft targets)

Baseline: 96% 5-weeks (@ 31 December 2012)
100% 8-weeks (@ 31 March 2013)
TDP Assessment: Achievable

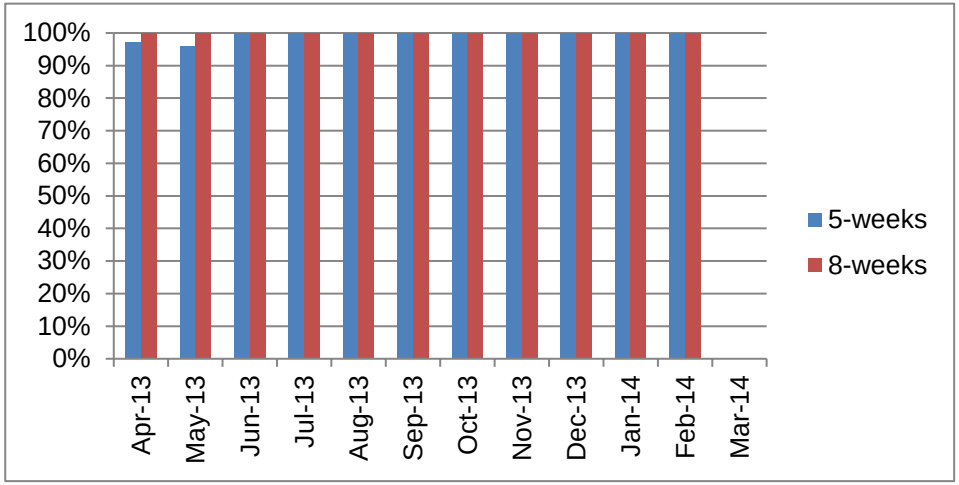
Standard: 100% 5-weeks
100% 8-weeks

Comment/Actions:

The Trust has continually met the target for assessment and delivery of care needs within 5 and 8-weeks for a period of 9-months from June 2013 to February 2014.

Cumulative performance at the end of January, against the 5-weeks, demonstrates a Regional position of 98% with SHSCT performance at 100%. Performance across the 5 Trusts ranges from 90% (WHSCT) to 100% (NHSCT, SEHSCT and SHSCT).

Cumulative performance at the end of January, against the 8-weeks, demonstrates a Regional position of 100% with SHSCT performance at 100%. Performance across the 5 Trusts ranges from 99% (NHSCT and WHSCT) to 100% (BHSCT, SEHSCT and SHSCT).



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
5-weeks	97% (74 out of 76)	96% (82 out of 85)	100% (75 out of 75)	100% (62 out of 62)	100% (52 out of 52)	100% (43 out of 43)	100% (57 out of 57)	100% (71 out of 71)	100% (43 out of 43)	100% (92 out of (92)	100% (72 out of 72)		G	↔
8-Weeks	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)	100% (0 out of 0)		G	↔

MINISTERIAL PRIORITY: TO IMPROVE AND PROTECT HEALTH AND WELL-BEING AND REDUCE INEQUALITIES; THROUGH A FOCUS ON PREVENTION, HEALTH PROMOTION AND EARLIER INTERVENTION

CP 1: BOWEL SCREENING: Lead Director Mrs Deborah Burns, Director of Acute Services		
The HSC will extend the bowel cancer screening programme to invite in 2013/2014 50% of all eligible men and women aged 60 – 71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60 – 74 from April 2014. (No change envisaged in 2014/2015 CP draft targets)		
Update Position	**Monthly Assess**	**Trend**
Comment: • Bowel cancer screening sessions are now being provided – 1.5 sessions weekly, however, with the age extension and increased funded SBA there is now a requirement to undertake 2 sessions weekly. • Age extension to 74 years of age commencing April 2014; therefore 2.5 sessions would be required weekly which the Trust is working towards securing. • The Specialist Screening Practitioner (SSP) sessions are now seeing 8 patients weekly. • The scheduled visit on 20 February 2014 from JAG to the DHH site was a positive one and the unit will be applying for accreditation after the Summer.	**G**	⇔

MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF SAFE, RESILIENT AND SUSTAINABLE SERVICES

CP 18: LONG-TERM CONDITIONS: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care		
By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively. (No change envisaged in 2014/2015 CP draft targets)		
Update Position:	**Monthly Assess**	**Trend**
Comment: The Trust has a number of programmes in place for patients to manage their long-term conditions effectively. It has commissioned a series of "Challenging Your Condition" generic self-management programmes for people with long-term conditions and these are provided by Arthritis Care and CHS. A service level agreement is in place and programmes are being delivered as per the specification. In addition to the core programmes a one day refresher programme for people who previously attended the course has commenced. It is planned that there will be 3 programmes delivered in Feb 2014. A 3 day programme for Carer's called 'Managing Caring' is being piloted in SHSCT. A number of education programmes are available for people with both Type 1 and Type 2 Diabetes: SHAIRE, SET 2, BERTIE, X-PERT, CHOICE and DAY. All of these programmes are delivered by the Diabetes Team across all Trust localities throughout the year The Trust provides a targeted smoking cessation service for people with a Long Term Condition including COPD, Diabetes and heart disease, and will be promoting support for patients with Rheumatoid Arthritis from January 2014. Education is provided at pulmonary rehabilitation and maintenance programmes provided by the COPD team and is also an integral part of the Cardiac Rehabilitation programme. Pulmonary Rehabilitation and Maintenance programmes are delivered three times yearly in each Trust locality by the COPD team. Cardiac Rehabilitation programmes are delivered by the Community Cardiac Rehab Team in the Armagh & Dungannon locality with the Acute Teams covering the Craigavon & Banbridge and Newry & Mourne localities.	**G**	**N/A**

The Trust is funded by Macmillan Cancer Support to provide a cancer information project to ensure that people affected by cancer within the SHSCT area have access to quality and timely cancer information and support. As a result of this project, 40% of GP practices in the SHSCT area now have a dedicated Macmillan Information Point. Within Craigavon Area Hospital, 17 Macmillan information Points have been installed across wards, outpatient, and cancer unit settings increasing access to cancer information for patients, staff and the public. Funding has been approved for a Macmillan Information Centre which will be situated in the main foyer of Craigavon Area Hospital with a daily foot fall of 300 – 400 people. It is anticipated that the information centre will be operational by early Spring 2014.		

CP 20: INTEGRATED CARE PARTNERSHIPS		
During 2013/2014, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care. (Intention in 2014/2015 CP draft targets to change this target to focus on service delivery in ICP - target not yet defined)		
Update Position:	**Monthly Assess**	**Trend**
Comment: HSCB Target – Trust update on contribution to the process: Responsibility and leadership for implementing Integrated Care Partnerships across NI sits with the Integrated Care Director in HSCB. A regional project structure is in place and staff have been appointed to support the establishments of 3 ICPs in the southern area. This includes a lead GP (not yet appointed in the south) and 3 locality lead GPs. The intention is to have an initial meeting of these 3 partnership committees before the end of June 2013. The Trust, as one provider partner within the structures, has nominated senior staff to be representatives on these 3 local ICPs. These Trust representatives will ensure that a 2 way communication process is in place to bring updates into the Trust on ICP plans and to represent the Trust objectives at the ICP meetings. An initial area of discussion within the ICPs will be how the collective partners/providers intend to work together to deliver against regionally issued commissioning specifications for a range of long-term conditions and what associated investment of transitional funding will be required to support this delivery. The Trust has signalled the criticality of the ICPs and the development of alternative primary and community care based services to the achievement of its TYC and QICR plans. The Trust had worked with the Southern LCG and 9 local GP practices during 2012/13 to develop a pilot phase of integrated care working. HSCB recently advised that as at the end of June 2013, this pilot would cease to be funded and the learning and approaches would be merged into the new ICP structures and processes. **As the pilot has now ceased the responsibility for reporting on this target has moved from the Trust to the ICP.**	**N/A**	**N/A**

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Appendix 1 – AHP Waiting Times by Programme of Care as at 28/2/14

Profession	Programme of Care	No of patients waiting >9-weeks	Longest Wait
Dietetics	02 Maternity and Child Health	79	17-weeks
	04 Elderly Care	0	8-weeks
	09 Primary Health and Adult Community	1	10-weeks
Occupational Therapy	02 Maternity and Child Health	150	35-weeks
	04 Elderly Care	10	12-weeks
	06 Learning Disability	4	11-weeks
	07 Physical & Sensory Disability	0	9-weeks
	09 Primary Health and Adult Community	4	19-weeks
Physiotherapy	02 Maternity and Child Health	10	12-weeks
	04 Elderly Care	19	15-weeks
	09 Primary Health and Adult Community	226	18-weeks
Podiatry	02 Maternity and Child Health	22	12-weeks
	04 Elderly Care	34	13-weeks
	06 Learning Disability	0	4-weeks
	09 Primary Health and Adult Community	53	13-weeks
Speech & Language Therapy	02 Maternity and Child Health	0	8-weeks

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Appendix 2 – End of March 2014 Projected SBA Performance and Access Times

Out-Patients

Specialty (Required Access Standard / Backstop)	SBA Projected Performance @ March 2014	Estimated Access Time @ March 2014
Breast Surgery (9-weeks)	**G (+2% = 65)**	13-weeks (26 patients in excess of 9-weeks)
Cardiology (9-weeks)	**G (+7% = 155)**	15-weeks (277 patients in excess of 9-weeks)
Dermatology (15-weeks)	**A (-7% = 618)** **SBA underperformance on-going in 2013/2014 associated with significant loss of medical staff capacity associated with sick leave / maternity leave**	Consultant-Led 18 weeks – risk to 41 ICATS patients – if not seen longest wait 21-weeks (239 in excess of 15-weeks)
Endocrinology (9-weeks)	**G (+7% = 41)**	12-weeks (6 patients in excess of 9-weeks)
ENT (9-weeks)	**G (+1%= 85)**	15-weeks (692 in excess of 9-weeks)
General Surgery (9-weeks)	**G (+1% = 87)**	13-weeks (425 patients in excess of 9-weeks) – emergent risk associated with 10 patients cancelled for 13/3/14 due to Consultant absence – patients being offered alternative March dates but lack of reasonable notice
Neurology (9-weeks)	**G (+5% = 140)**	20-weeks (358 patients in excess of 9-weeks – 113 of which are in excess of 15-weeks)
Gynaecology (9-weeks)	**G (+6% = 323)**	15-weeks (78 patients in excess of 9-weeks)

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

Specialty (Required Access Standard / Backstop)	SBA Projected Performance @ March 2014	Estimated Access Time @ March 2014
Ortho-Geriatrics (9-weeks)	**G (+18% = 8)**	34-weeks (39 patients in excess of 9-weeks)
Nephrology (9-weeks)	**G (+24% = 39)**	9-weeks
General Medicine / Gastro-enterology (9-weeks)	**G (-4% = 119)**	9-weeks General Medicine and 15-weeks Gastro (162 patients in excess of 9-weeks)
Chemical Pathology (9-weeks)	**R (-12% = 17)** **SBA is set higher than the demand, therefore, SBA not achievable**	<9-weeks
Anti-Coagulant (9-weeks)	**G (+37% = 119)**	2-weeks
Breast Family History (9-weeks)	**G (+3% = 7)**	13-weeks (10 patients in excess of 9-weeks)

Mental Health

Specialty (Required Access Standard / Backstop)	Estimated Access Time @ March 2014
PMHC (9-weeks)	9-weeks
Memory/Dementia (9-weeks)	20-weeks (80 patients in excess of 9-weeks)
Psychiatry of Old Age (9-weeks) *	>9-weeks <15-weeks (to be confirmed)
Psychological Therapies (13-weeks)	13-weeks

* It should be noted that whilst this service is currently reported as Consultant-Led it actually operates within as Multi-Disciplinary and therefore, from 1 April 2014 the service will be reported as Multi-Disciplinary (this relates to the Memory Service not the Functionally Mentally Ill – FMI should be 9-weeks.

In-Patients / Day Cases

Specialty (Required Access Standard / Backstop)	SBA Projected Performance @ March 2014	End of March 2014 Estimated Access Time
Breast Surgery (26-weeks)	**A (-9% = 36)**	26-weeks
Cardiology (13-weeks)	**G**	13-weeks
Dermatology (13-weeks)	**A (-5% = 55)**	13-weeks
ENT (13-weeks)	**G (+1% = 25)**	22-weeks (135 in excess of 13-weeks)
General Surgery (26-weeks)	**G (-2.5% = 123)**	26-weeks
Gynaecology (13-weeks)	**A (-5% = 131)**	22-weeks (96 patients in excess of 13-weeks)
Ophthalmology (13-weeks)	**VISITING SERVICE R (-19% = 188)**	**VISITING SERVICE** - 13-weeks
Pain Management (26-weeks)	**G (+11% = 61)**	26-weeks
Rheumatology (26-weeks)	**G (+6% = 161)**	26-weeks
T&O (26-weeks)	**G (+2% = 23)**	26-weeks 12/3/14: 26-weeks
Urology (26-weeks)	**R (-16% = 793)** **(SBA under-performance on-going in 2013/2014 associated with significant loss of medical staff capacity associated with sick leave and vacancies at Middle Grade; GPwSI; and Consultant levels)**	69-weeks (250 patients in excess of 26-weeks and 54 patients in excess of 52-weeks)
Endoscopy (9-weeks)	**G (-4.7% = 380)**	12-weeks (133 patients in excess of 9-weeks)

Diagnostics

Specialty (Required Access Standard / Backstop)	SBA Projected Performance @ March 2014	End of March 2014 Estimated Access Time
MRI (9-weeks)	**G (+11% = 748)**	13-weeks
Non-Obstetric Ultrasound (9-weeks)	**G (+4% = 1353)**	13-weeks (25 patients in excess of 9-weeks)
Urodynamics (9-weeks)	N/A	52-weeks (72 patients in excess of 9-weeks)
Dexa (9-weeks)	**G (=0%)**	13-weeks (220 patients in excess of 9-weeks)
CT (9-weeks)	**G (+3% = 364)**	13-weeks
Cardiac Investigations (9-weeks)	N/A	Risk to achievement of 9-weeks due to short-term medical sick leave – risk to be confirmed
Audiology (9-weeks)	N/A	9-weeks

Allied Health Professionals

Specialty (Required Access Standard / Backstop)	End of March 2014 Estimated Access Time
Dietetics	15-weeks (95 patients in excess of 9-weeks)
Occupational Therapy	26-weeks (TBC patients in excess of 9-weeks)
Orthoptics	9-weeks
Physiotherapy	12-weeks (<500 patients in excess of 9-weeks)
Podiatry	11-weeks (164 Patients in excess of 9-weeks)
Speech and Language Therapy	9-weeks

RAG Status as per Dean Sullivan:
G = 0% to -4.9%
A = -5% to -9.9%
R = -10% and over

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COMMISSIONING PLAN STANDARDS/TARGETS FOR 2013/2014

INDICATORS OF PERFORMANCE

March 2014 for February 2014 Performance

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A5. Note – Performance reported 1-month in arrears Admissions for Venous Thromboembolism. **Note: Reporting format amended – Reporting now against Monthly Compliance with Use of Risk Assessment and Monthly Compliance with Appropriate VTE Prophylaxis –* *RA = Risk Assessment* *P = Prophylaxis*	RA 79% P 97%	RA 89% P 98%	RA 83% P 97%	RA 81% P 98%	RA 86% P 97%	RA 88% P 96%	RA 79% P 92%	RA 86% P 98%	RA 95% P 100%	RA 87% P 100%		
A10. Number of A & E presentations due to deliberate self-harm (self-harm/suicide attempt/ideation)	193	233	177	165	164	207	205	185	203	160	183	
A22. Uptake of seasonal flu vaccine by front-line health and social care workers.	Vaccination programme not yet commenced – commencing 1 October 2013						1277	103	17	2	0	
A24. Level of activity in maternity and child health programme of care including average length of stay.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against A24											
A25. Percentage of babies born by caesarean section and number of babies born* in midwife-led units, either freestanding or alongside.	C-S 37.33% MLU 61	C-S 38.3% MLU 66	C-S 34.99% MLU 55	C-S 36.16% MLU 67	C-S 28.81% MLU 74	C-S 34.4% MLU 69	C-S 34.29% MLU 61	C-S 32.44% MLU 68	C-S 33.27% MLU 75	C-S 33.33% MLU 94	C-S 32.15% MLU 74	
A26. Breastfeeding rate at discharge from hospital. * *Note: Breast = Breast Feeding and B&Comp = Breast Feeding & Complementary Methods*	Breast 39% B&Comp 11%	Breast 39% B&Comp 8%	Breast 41% B&Comp 7%	Breast 40% B&Comp 6%	Breast 44% B&Comp 8%	Breast 41% B&Comp 5%	Breast 39% B&Comp 7%	Breast 41% B&Comp 10%	Breast 41% B&Comp 7%	Breast 44% B&Comp 7%	Breast 42% B&Comp 7%	

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A28.	Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against A28											
B1.	**Note – Performance reported 1-month in arrears** Percentage of patients receiving first definitive treatment within 31-days of a cancer diagnosis (decision to treat). **Note: Reported 1-month in arrears*	100%	100%	99%	99%	98%	99%	96%	100%	100%	98.33%		
B2.	Number of red flag cancer referrals **Note: GP Suspect Cancer Referral Source*	528	557	575	631	557	617	658	633	606	761	654	
B3.	Percentage of patients seen within 14-days of an urgent referral for breast cancer.	100%	96%	90.7%	97.7%	88%	46%	50%	26%	83%	54%	23%	
B5.	Number of new and unplanned attendances at emergency departments Types 1 and 2. **Note: Data currently available only for type 1 & type 3 EDs*	12,080	12,409	11,994	12,640	12,002	11,956	11,937	11,043	11,362	11,229	10,719	

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
B6.	Percentage of new and unplanned review attendances at emergency care departments waiting: <30 minutes; 30 minutes – 1 hour; 1 – 2 hours; - 2 – 3 hours; 3 – 4 hours; 4 – 6 hours; 6 – 8 hours; 8 – 10 hours; 10 – 12 hours; and 12 hours or more, before being treated and discharged or admitted	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B6											
B8.	Rate of Review outpatient appointments where the patient did not attend. **Note: Cons-Led OP Only*	7.4%	7.1%	7.6%	7.6%	7.3%	7.1%	7.5%	7.1%	7.7%	7.7%	6.9%	
B9.	Rate of new outpatient appointments cancelled by the hospital.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B9											
B10.	Number of GP referrals to consultant-led outpatient services.	7020	7675	7336	7017	7015	7290	8004	7317	6229	8073	7521	
B11.	Number of out-patient appointments with procedures for selected specialties.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B11											

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
B12.	Number of radiology tests (for discrete list of tests). **Note: Tests undertaken in core SBA sessions* *BE – Barium Enema* *CT* *MRI* *US – Non-obstetric* *Plain – Plain Film*	BE 83 CT 1420 MRI 610 US 2654 Plain 15468	BE 87 CT 1476 MRI 607 US 2768 Plain 15824	BE 85 CT 1696 MRI 613 US 3012 Plain 15313	BE 87 CT 1622 MRI 683 US 3220 Plain 15342	BE 71 CT 1552 MRI 622 US 2919 Plain 14549	BE 76 CT 1474 MRI 634 US 3207 Plain 15698	BE 67 CT 1639 MRI 611 US 2905 Plain 15775	BE 71 CT 1610 MRI 686 US 3133 Plain 14848	BE 70 CT 1535 MRI 609 US 2741 Plain 14173	BE 72 CT 1893 MRI 699 US 3308 Plain 16197	BE 40 CT 1598 MRI 605 US 2958 Plain 14712	
B13.	**Note – Performance reported 3-months in arrears.** Number of patients admitted with stroke.	55	44	46	48	46	52	40	24				
B15.	Incidents of pressure ulcers occurring in hospital medical and surgical care settings.	8 (acquired in hospital setting)			18 (acquired in hospital setting)			19 (acquired in hospital setting)					
B16.	Number of falls in hospital settings.	317			258			291					
B17.	Number of hearing aids fitted within 3 months as a percentage of completed waits.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
B18.	Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).	14%	13%	6%	4%	14%	9%	11%	6%	4%	5%	4%	

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
B19. Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the OT assessment and options appraisal.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
B20. Level of attainment of prescribing targets set out in the Regional Board pharmacy efficiency programme.	Resources and systems are not available to permit a full audit of compliance, however, Trust is complying with the Regional Formulary and PCE guidance and by way of assurance has undertaken inpatient prescribing audits on six key areas between April – October 2013 and provided a report on the position to HSCB The Trust is willing to carrying out a wider audit should be this required subject to the availability of additional resources from the Region.											
B24. Percentage increase in access to cardiac catheterisation.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B24											
B25. Percentage of patients, where clinically appropriate, waiting less than 7 days for in-patient fracture treatment.	96.2%	86.8%	96.7%	95.3%	96.2%	91.1%	89.3%	97.7%	100%	98.5%	87.6%	
B26. Emergency admissions for acute conditions which should not usually require hospital admissions.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B26											
B27. Number and proportion of emergency admissions and readmissions for people aged 0 – 64 and 65+, (i) with and (ii) without a recorded long-term condition, in which medicines were considered to have been the primary or contributory factor.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B27											

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
C1b.	For Health and Care Centres, the number and proportion in each Trust with (i) active pharmaceutical services provision and (ii) plans for active pharmaceutical services provision.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against C1b											
C5.	**Note – Performance reported 1-month in arrears.** Number of patients benefiting from remote telemonitoring (cumulative).	22	13	17	16	22	32	17	19	15	23		
C6.	Number of patients benefiting from the provision of telecare services.	Information being sourced to facilitate reporting against C6											
C7.	Number of patients waiting longer than 9-weeks from referral to commencement of Occupational Therapy treatment.	27	74	137	194	305	274	256	202	176	171	168	
C8.	Number of patients waiting longer than 9-weeks from referral to commencement of Speech and Language Therapy treatment.	0	2	72	113	152	202	260	313	326	44	0	
C9.	Number of patients waiting longer than 9-weeks to access dementia services. **Note: MDT Dementia/Memory Clinic*	71	103	129	136	170	171	194	202	242	207	141	
D2.	Numbers of direct payment cases.	623	601	615	607	631	626	623	633	640	626	633	

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
E1.	**Note – Performance reported 3-months in arrears.** Elective average pre-operative stay. **Note: Beddays used by elective admissions not on day of surgery – Reported 3-months in arrears*	61	55	83	48	51	115	56	14				
E2.	Average length of stay in acute programme of care.	Elect N/A Non-Elect N/A	Elect N/A Non-Elect N/A	Elect 2.5 Non-Elect 3.7	Elect 2.4 Non-Elect 3.6	Elect 2.35 Non-Elect 3.2	Elect 2.33 Non-Elect 3.7	Elect 2.35 Non-Elect 3.7	Elect 2.28 Non-Elect 3.7	Elect 2.3 Non-Elect 3.73	Elect 2.3 Non-Elect 3.8	Elect 2.28 Non-Elect 3.8	
E3.	**Note – Performance reported 3-months in arrears.** Average length of stay for stroke patients within the acute programme of care. **Note: Reported 3-months in arrears*	8.8	16	9.1	9.4	8.9	11.7	7.6	8.7				
E4.	**Note – Performance reported 3-months in arrears.** Day surgery rate for each of a basket of 24 elective procedures. **Note: Reported 3-months in arrears*	63%	65%	63%	63%	63%	69%	67%	77%				
E5.	Percentage of operations cancelled for non-clinical reasons.	3.0%	1.5%	1.0%	1.4%	1.8%	1.4%	2.2%	1.5%	1.4%	1.2%	0.8%	

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
E6.	**Note – Performance reported 3-months in arrears.** Percentage of patients admitted electively who have their surgery on the same day as admission. **Note: Reported 3-months in arrears*	91.26%	93.16%	90.06%	93.82%	93.04%	90.72%	92.64%	92.51%				
E7.	Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.	Imag. 96.3% Non-Imag. 93.5%	Imag. 96.7% Non-Imag. 97.5%	Imag. 96.7% Non-Imag. 95%	Imag. 93.4% Non-Imag. 98.7%	Imag. 96.5% Non-Imag. 96.8%	Imag. 97.9% Non-Imag. 97.6%	Imag. 96.1% Non-Imag. 99%	Imag. 96.8% Non-Imag. 99.7%	Imag. 95.3% Non-Imag. 98.8%	Imag. 95.9% Non-Imag. 97%	Imag. 87.0% Non-Imag. 97.7%	
E8.	Percentage of routine diagnostic tests reported within 4 weeks of the test being undertaken.	Imag. 99.8% Non-Imag. 99.4%	Imag. 99.8% Non-Imag. 99.6%	Imag. 99.9% Non-Imag. 97.9%	Imag. 98.5% Non-Imag. 100%	Imag. 99.6% Non-Imag. 100%	Imag. 99.9% Non-Imag. 97.9%	Imag. 99.5% Non-Imag. 100%	Imag. 99.9% Non-Imag. 99.8%	Imag. 99.4% Non-Imag. 99.3%	Imag. 99.9% Non-Imag. 97.1%	Imag. 99% Non-Imag. 99.6%	
E9a.	Nurse/bed ratios with Normative Staffing Ranges in the use across general and specialist areas to delivery on safety, quality and patient experience outcomes.	Information being sourced to facilitate reporting against E9a											
E10.	Ratio of new to review outpatient appointments scheduled by speciality and Trust. **Note: N:R based on actual activity – not scheduled*	1:1.92	1:1.73	1:1.77	1:1.77	1:2	1:1.72	1:2	1:2	1:2	1:2		
E11.	GP Out of Hours Attendance	Information being sourced to facilitate reporting against E11											
F1.	Percentage of all foster care	31%	33%	35%	32%	34%	34%	35%	34%	34%	36%	35%	

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	placements that are kinship care placements. **Note: Data reflects kinship foster carers panel and field work approved*												
F2.	Number of residential care leavers in education, training and employment. **Note: Data relates to over 19 years care leavers*	25 out of 28	26 out of 30	25 out of 30	26 out of 33	26 out of 31	25 out of 28	24 out of 30	28 out of 33	29 out of 32	32 out of 36	33 out of 38	
F3.	Numbers of children with an adoption best-interests decision notified to the Regional Adoption Information system (RAIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. – *Reported 3 months in arrears*	3 out of 3			4 out of 5			3 out of 3					
F4.	The number of school-age children in care for 12 months or longer who have missed 25 or more school days.	Information being sourced to facilitate reporting against F4											
F5.	Length of time for Best Interest Decision to be reached in the adoption process.	Information being sourced to facilitate reporting against F5											
F6.	Children in Adult Mental Health wards.	2	0	0	1	0	0	0	0	0	0	0	

Note: Only those IoPs applicable to the Trust have been included in this report.

Stinson, Emma M

From: Corrigan, Martina [redacted]
Sent: 19 December 2014 12:20
To: Burns, Deborah
Subject: for todays Urology Meeting

Hi Debbie

As discussed last night, below are the areas that the urologists are happy to take on to allow for the Western/Belfast Trust's do the Northern Patients:

Omagh area – population 50,000
All of Moira = population 4,500
All of Cookstown = population 11,000

Thanks

Martina

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

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

Stinson, Emma M

From: Corrigan, Martina [redacted]
Sent: 30 December 2014 17:33
To: Burns, Deborah
Cc: Stinson, Emma M
Subject: FW: Urology Referrals
Attachments: image001.gif

Hi Debbie

Can we have a discussion about this when you return from leave?

Thanks

Martina

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

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

From: Doherty Paul D [redacted]
Sent: 30 December 2014 16:38
To: Corrigan, Martina
Cc: Lynne Charlton [redacted]
Subject: Urology Referrals

This e-mail is covered by the disclaimer found at the end of the message.

Hi Martina

As you are aware there is currently a medical staffing shortage in the NHSCT and subsequent to this there have been a number of meetings with the HSCB in relation to same.

At the last meeting, 19th December 2014, it was indicated that Mr Young had agreed with Mr Mulholland that all referrals from Cookstown (BT80) should be re-directed to Team South i.e. direct GP referrals and that this post code become part of the SHSCT Urology catchment population.

Can you advise if this has now been agreed within the Trust and we can begin the process of notifying GP's, updating CCG etc… just as we did with the transfer of Fermanagh patients to SHSCT in January 2012.

Many Thanks

Paul

Stinson, Emma M

From: Glackin, Anthony [Personal Information redacted by USI]
Sent: 09 February 2015 20:44
To: Burns, Deborah; Corrigan, Martina; Young, Michael; O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram
Cc: Stinson, Emma M
Subject: RE: URGENT FOR RESPONSE - urology follow up
Attachments: image001.jpg; image002.jpg

Debbie et al.
I agree with the redirection of BT80 to us until end of March 15 via PAS.
Importantly it is also deliverable.

Tony

From: Burns, Deborah
Sent: 09 February 2015 19:04
To: Corrigan, Martina; Young, Michael; O'Brien, Aidan; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram
Cc: Burns, Deborah; Stinson, Emma M
Subject: FW: URGENT FOR RESPONSE - urology follow up
Importance: High

Please see below. I believe we should accept below with the clarification that it is redirection from PAS not straight from primary care – until end of March – you happy with that as a team?
Thanks
D

Debbie Burns
Acting Director of Acute Services
SHSCT
[Debbie Burns' email address]
Tel: [Personal Information redacted by USI]

From: Dean SullivanPA [Personal Information redacted by the USI]
Sent: 09 February 2015 15:54
To: Burns, Deborah
Cc: Clarke, Paula; McAlinden, Mairead; Lynne Charlton; Sara Long; Dean Sullivan; [Emma Stinson's email address]
Subject: URGENT FOR RESPONSE - urology follow up
Importance: High

"This email is covered by the disclaimer found at the end of the message."

SENT OBO DEAN SULLIVAN

Debbie,

I refer to your email of 28 January in relation to the above.

Based on trend, total new referrals from the BT80 postcode will be around 21 per month. Currently Southern Trust receive around 16 referrals a month from this postcode so it accounts for approximately an additional 5 per month.

The existing waiting list for referrals has 12 outpatients from BT80.

In this context, grateful if you can confirm by return that you are content to take the 12 current patients and the additional 5 referrals per month in the interim (until end March).

Many thanks.

Dean

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Burns, Deborah Personal Information redacted by USI
Sent: 28 January 2015 14:28
To: Lynne Charlton; Dean Sullivan; Clarke, Paula; Stinson, Emma M
Cc: Mairead McAlinden's email address Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up
Importance: High

Thanks
To be honest this info is difficult to understand. As you will see from our email and discussion with Dean we need to know the size of the population of BT 80 – so you believe this is around 26k – so also what would obviously be useful is a rough idea of historical referral data from that population – I appreciate that might be difficult but would be very useful and should be easily captured from current waiting list.

We cannot accept a re direction as reiterated below. This cannot be a permanent shift at this time without the strategic plan for urology as per discussion with Dean. I cannot see the issue with waiting list transfer until the end of March as discussed – and we believed agreed.

Thanks
D

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

From: Lynne Charlton Personal Information redacted by USI
Sent: 28 January 2015 11:50

To: Dean Sullivan; Clarke, Paula
Cc: Burns, Deborah; McAlinden, Mairead; Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up

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Thanks everyone

Debbie I will call you secretary to determine the best time for you to take a call.

In the interim, for clarification, please see attached presentation which we tabled on Friday.

It shows that the entire Mid Ulster ICP is showing as having 15 practices (85,597). We have been working with BSO to obtain data regarding BT80. Initial information would suggest that the GP list size for patients residing in BT80 is in the region of 26,000, I am waiting further validation and confirmation.

The presentation also shows analysis of current referral patterns Jan – Nov 14 by PCP show that SHSCT have taken 15% referrals from MID Ulster PCP in that time period.

Total referrals Jan-Nov 14 (duplicates +/- 7 days and ICATs excluded)

Our initial proposals are not to transfer from NHSCT waiting list but rather prospectively re direct any new referrals coming into NHSCT to SHSCT where the patient lives in BT80 code.

Thanks

Lynne
Cardiac Network Co ordinator/Programme Manager
Health & Social Care Board
12-21 Linenhall Street
Belfast
BT2 8BS

Mobile Personal Information redacted by USI
Office Personal Information redacted by USI
Email Lynne Charlton's email address

From: Dean Sullivan
Sent: 28 January 2015 09:36
To: Paula Clarke's email address
Cc: Debbie Burns' email address; Mairead McAlinden's email address; Sara Long; Lynne Charlton; Lyn Donnelly

Subject: Re: URGENT FOR RESPONSE - urology follow up

Paula - yes, your understanding of the proposed way forward is correct. Sara and Lynne will be in touch with you-Debbie today-tomorro to finalise. Thanks again for your support with this. Dean

From: Clarke, Paula [redacted]
Sent: Tuesday, January 27, 2015 05:16 PM GMT Standard Time
To: Dean Sullivan
Cc: Burns, Deborah [redacted]
[redacted]
Subject: URGENT FOR RESPONSE - urology follow up

Dean just for sake of avoiding any confusion given the current pressures on us all here is what we understand the next steps are re urology:

- You are going to clarify what the population number for BT80 Cookstown town area is as we do not understand how it could be estimated at 80,000
- You also agreed to find out how many referrals are on NHSCT/WHSCT PAS from this postcode that would come to us and what more referrals we might expect to get based on elective outpatient urology referrals from this area historically
- If feasible when we see the numbers we would then try and accept this defined population - BUT only on a temporary basis to end of March and only after referral has been made into NHSCT/WHSCT (with onward transfer to us)
- There should be no letter to GPs redirecting referrals - as this is a temporary measure only
- The impact on SHSCT performance will be understood by commissioner

Can you come back to us asap so we can ensure clinical team kept informed and we avoid rumours!
Thanks

Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform
[redacted]
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Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: O'Brien, Aidan [redacted]
Sent: 09 February 2015 19:06
To: Burns, Deborah; Corrigan, Martina; Young, Michael; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram
Cc: Stinson, Emma M
Subject: RE: URGENT FOR RESPONSE - urology follow up
Attachments: image001.jpg; image002.jpg

I am,

Aidan.

From: Burns, Deborah
Sent: 09 February 2015 19:04
To: Corrigan, Martina; Young, Michael; O'Brien, Aidan; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram
Cc: Burns, Deborah; Stinson, Emma M
Subject: FW: URGENT FOR RESPONSE - urology follow up
Importance: High

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

From: Dean SullivanPA [redacted]
Sent: 09 February 2015 15:54
To: Burns, Deborah
Cc: Clarke, Paula; McAlinden, Mairead; Lynne Charlton; Sara Long; Dean Sullivan; [redacted]
Subject: URGENT FOR RESPONSE - urology follow up
Importance: High

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12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Burns, Deborah Personal Information redacted by the USI
Sent: 28 January 2015 14:28
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Cc: Mairead McAlinden's email address Sara Long; Lyn Donnelly
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SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Lynne Charlton Personal Information redacted by the USI
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Cc: Burns, Deborah; McAlinden, Mairead; Sara Long; Lyn Donnelly

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Cardiac Network Co ordinator/Programme Manager
Health & Social Care Board
12-21 Linenhall Street
Belfast
BT2 8BS

Mobile Personal Information redacted by the USI
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Email Personal Information redacted by the USI

From: Dean Sullivan
Sent: 28 January 2015 09:36
To: Paula Clarke's email address
Cc: Debbie Burns' email address Mairead McAlinden's email address Sara Long; Lynne Charlton; Lyn Donnelly
Subject: Re: URGENT FOR RESPONSE - urology follow up

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From: Clarke, Paula [redacted]
Sent: Tuesday, January 27, 2015 05:16 PM GMT Standard Time
To: Dean Sullivan
Cc: Burns, Deborah [redacted] [redacted]
Subject: URGENT FOR RESPONSE - urology follow up

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Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform
[redacted]
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Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: My [Michael Young's email address redacted]
Sent: 09 February 2015 23:17
To: Corrigan, Martina
Cc: Burns, Deborah
Subject: Re: URGENT FOR RESPONSE - urology follow up

Mundane amount.
Would be interested to know where the other 72,950 come from.
We do however need to think about this in round Two and this will be more important. It is important not to loss sight of end point and direction

Sent from M.Y. iPhone

On 9 Feb 2015, at 20:12, Corrigan, Martina [Personal Information redacted by the USI] wrote:

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile [Personal Information redacted by the USI]

From: Burns, Deborah
Sent: Monday, February 09, 2015 07:04 PM
To: Corrigan, Martina; Young, Michael; O'Brien, Aidan; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram
Cc: Burns, Deborah; Stinson, Emma M
Subject: FW: URGENT FOR RESPONSE - urology follow up

Please see below. I believe we should accept below with the clarification that it is redirection from PAS not straight from primary care – until end of March – you happy with that as a team?
Thanks
D

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

From: Dean SullivanPA [Personal Information redacted by the USI]
Sent: 09 February 2015 15:54
To: Burns, Deborah
Cc: Clarke, Paula; McAlinden, Mairead; Lynne Charlton; Sara Long; Dean Sullivan; [Emma Stinson's email address redacted]
Subject: URGENT FOR RESPONSE - urology follow up
Importance: High

"This email is covered by the disclaimer found at the end of the message."

SENT OBO DEAN SULLIVAN

Debbie,

I refer to your email of 28 January in relation to the above.

Based on trend, total new referrals from the BT80 postcode will be around 21 per month. Currently Southern Trust receive around 16 referrals a month from this postcode so it accounts for approximately an additional 5 per month.

The existing waiting list for referrals has 12 outpatients from BT80.

In this context, grateful if you can confirm by return that you are content to take the 12 current patients and the additional 5 referrals per month in the interim (until end March).

Many thanks.

Dean

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Burns, Deborah Personal Information redacted by the USI
Sent: 28 January 2015 14:28
To: Lynne Charlton; Dean Sullivan; Clarke, Paula; Stinson, Emma M
Cc: Mairead McAlinden's email address Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up
Importance: High

Thanks
To be honest this info is difficult to understand. As you will see from our email and discussion with Dean we need to know the size of the population of BT 80 – so you believe this is around 26k – so also what would obviously be useful is a rough idea of historical referral data from that population – I appreciate that might be difficult but would be very useful and should be easily captured from current waiting list.

We cannot accept a re direction as reiterated below. This cannot be a permanent shift at this time without the strategic plan for urology as per discussion with Dean. I cannot see the issue with waiting list transfer until the end of March as discussed – and we believed agreed.

Thanks
D

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

From: Lynne Charlton Personal Information redacted by the USI
Sent: 28 January 2015 11:50
To: Dean Sullivan; Clarke, Paula

Cc: Burns, Deborah; McAlinden, Mairead; Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up

"This email is covered by the disclaimer found at the end of the message."

Thanks everyone

Debbie I will call you secretary to determine the best time for you to take a call.

In the interim, for clarification, please see attached presentation which we tabled on Friday.

It shows that the entire Mid Ulster ICP is showing as having 15 practices (85,597). We have been working with BSO to obtain data regarding BT80. Initial information would suggest that the GP list size for patients residing in BT80 is in the region of 26,000, I am waiting further validation and confirmation.
<image001.jpg>

The presentation also shows analysis of current referral patterns Jan – Nov 14 by PCP show that SHSCT have taken 15% referrals from MID Ulster PCP in that time period.

Total referrals Jan-Nov 14 (duplicates +/- 7 days and ICATs excluded)
<image002.jpg>

Our initial proposals are not to transfer from NHSCT waiting list but rather prospectively re direct any new referrals coming into NHSCT to SHSCT where the patient lives in BT80 code.

Thanks

Lynne
Cardiac Network Co ordinator/Programme Manager
Health & Social Care Board
12-21 Linenhall Street
Belfast
BT2 8BS

Mobile Personal Information redacted by the USI
Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Dean Sullivan
Sent: 28 January 2015 09:36
To: Paula Clarke's email address
Cc: Debbie Burns' email address; Mairead McAlinden's email address; Sara Long; Lynne Charlton; Lyn Donnelly
Subject: Re: URGENT FOR RESPONSE - urology follow up

Paula - yes, your understanding of the proposed way forward is correct. Sara and Lynne will be in touch with you-Debbie today-tomorro to finalise. Thanks again for your support with this. Dean

From: Clarke, Paula [redacted]
Sent: Tuesday, January 27, 2015 05:16 PM GMT Standard Time
To: Dean Sullivan
Cc: Burns, Deborah [redacted]
[redacted]
Subject: URGENT FOR RESPONSE - urology follow up

Dean just for sake of avoiding any confusion given the current pressures on us all here is what we understand the next steps are re urology:

- You are going to clarify what the population number for BT80 Cookstown town area is as we do not understand how it could be estimated at 80,000
- You also agreed to find out how many referrals are on NHSCT/WHSCT PAS from this postcode that would come to us and what more referrals we might expect to get based on elective outpatient urology referrals from this area historically
- If feasible when we see the numbers we would then try and accept this defined population - BUT only on a temporary basis to end of March and only after referral has been made into NHSCT/WHSCT (with onward transfer to us)
- There should be no letter to GPs redirecting referrals - as this is a temporary measure only
- The impact on SHSCT performance will be understood by commissioner

Can you come back to us asap so we can ensure clinical team kept informed and we avoid rumours! Thanks

Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform
[redacted]
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Stinson, Emma M

From: Dean Sullivan [redacted]
Sent: 11 February 2015 15:56
To: Burns, Deborah; Dean SullivanPA
Cc: Clarke, Paula; McAlinden, Mairead; Lynne Charlton; Sara Long; [redacted]
Subject: Re: URGENT FOR RESPONSE - urology follow up
Attachments: image001.jpg; image002.jpg

"This email is covered by the disclaimer found at the end of the message."

Debbie - many thx. Yes, I can confirm your understanding. D

From: Burns, Deborah [redacted]
Sent: Wednesday, February 11, 2015 02:20 PM GMT Standard Time
To: Dean SullivanPA
Cc: Clarke, Paula [redacted] Lynne Charlton; Sara Long; Dean Sullivan; [redacted]
Subject: RE: URGENT FOR RESPONSE - urology follow up

Thanks Dean. Apologies for delay in responding. The team are happy to except the below with the clear caveat that this is not a re direction from GP's but from the NT PAS. Could you confirm Many thanks D

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

From: Dean SullivanPA [redacted]
Sent: 09 February 2015 15:54
To: Burns, Deborah
Cc: Clarke, Paula; McAlinden, Mairead; Lynne Charlton; Sara Long; Dean Sullivan; [redacted]
Subject: URGENT FOR RESPONSE - urology follow up
Importance: High

"This email is covered by the disclaimer found at the end of the message."

SENT OBO DEAN SULLIVAN

Debbie,

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In this context, grateful if you can confirm by return that you are content to take the 12 current patients and the additional 5 referrals per month in the interim (until end March).

Many thanks.

Dean

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Burns, Deborah Personal Information redacted by the USI
Sent: 28 January 2015 14:28
To: Lynne Charlton; Dean Sullivan; Clarke, Paula; Stinson, Emma M
Cc: Mairead McAlinden's email address Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up
Importance: High

Thanks
To be honest this info is difficult to understand. As you will see from our email and discussion with Dean we need to know the size of the population of BT 80 – so you believe this is around 26k – so also what would obviously be useful is a rough idea of historical referral data from that population – I appreciate that might be difficult but would be very useful and should be easily captured from current waiting list.

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Thanks
D

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Lynne Charlton Personal Information redacted by the USI
Sent: 28 January 2015 11:50

To: Dean Sullivan; Clarke, Paula
Cc: Burns, Deborah; McAlinden, Mairead; Sara Long; Lyn Donnelly
Subject: RE: URGENT FOR RESPONSE - urology follow up

"This email is covered by the disclaimer found at the end of the message."

Thanks everyone

Debbie I will call you secretary to determine the best time for you to take a call.

In the interim, for clarification, please see attached presentation which we tabled on Friday.

It shows that the entire Mid Ulster ICP is showing as having 15 practices (85,597). We have been working with BSO to obtain data regarding BT80. Initial information would suggest that the GP list size for patients residing in BT80 is in the region of 26,000, I am waiting further validation and confirmation.

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Our initial proposals are not to transfer from NHSCT waiting list but rather prospectively re direct any new referrals coming into NHSCT to SHSCT where the patient lives in BT80 code.

Thanks

Lynne
Cardiac Network Co ordinator/Programme Manager
Health & Social Care Board
12-21 Linenhall Street
Belfast
BT2 8BS

Mobile Personal Information redacted by the USI
Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Dean Sullivan
Sent: 28 January 2015 09:36
To: Paula Clarke's email address
Cc: Debbie Burns' email address Mairead McAlinden's email address Sara Long; Lynne Charlton; Lyn Donnelly

Subject: Re: URGENT FOR RESPONSE - urology follow up

Paula - yes, your understanding of the proposed way forward is correct. Sara and Lynne will be in touch with you-Debbie today-tomorro to finalise. Thanks again for your support with this. Dean

From: Clarke, Paula [redacted]
Sent: Tuesday, January 27, 2015 05:16 PM GMT Standard Time
To: Dean Sullivan
Cc: Burns, Deborah [redacted]
[redacted]
Subject: URGENT FOR RESPONSE - urology follow up

Dean just for sake of avoiding any confusion given the current pressures on us all here is what we understand the next steps are re urology:

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- There should be no letter to GPs redirecting referrals - as this is a temporary measure only
- The impact on SHSCT performance will be understood by commissioner

Can you come back to us asap so we can ensure clinical team kept informed and we avoid rumours!
Thanks

Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform
[redacted]
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Stinson, Emma M

From: Stinson, Emma M [redacted]
Sent: 19 January 2015 17:00
To: 'Dean SullivanPA'
Subject: FW: Urology Update
Attachments: image001.png; image002.png; image005.jpg

Hi Lucyna

Both Debbie and Mr Michael Young will attend Friday's meeting in person

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]

P Please consider the environment before printing this email

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From: Dean SullivanPA [redacted]
Sent: Friday, January 16, 2015 03:14 PM
To: [redacted] Burns, Deborah; [redacted]; 'Welsh, Jennifer [redacted] David McCormick [redacted] Allam, Christine [redacted] Janet Little [redacted] Bride Harkin [redacted] Paul Cavanagh [redacted]
Cc: Elaine Way Western Trust [redacted] McAlinden, Mairead; 'Tony Stevens ' [redacted] Sara Long [redacted] Lynne Charlton [redacted] Carolyn Harper [redacted] Michael Bloomfield [redacted]

Teresa Molloy's email address Clarke, Paula; 'Donaghy, Briege
Briege Donaghy's email address Briege Donaghy's email address
Shane Devlin's email address Shane Devlin's email address Sandra Moore
Sandra Moore's email address Paul Cavanagh PA Paul Cavanagh's email address
Subject: Urology Update

"This email is covered by the disclaimer found at the end of the message."

SENT OBO DEAN SULLIVAN

Dear Colleague

I refer to recent discussions in relation to the above, specifically the development and implementation of an action plan to address the immediate matters arising from current difficulties faced in the Northern area. I have arranged a further meeting at 4.00pm on Friday, 23rd January 2015 (CR2, Linenhall Street, Belfast) to update all on the current position and agree next steps.

If possible, it would be helpful for you to attend in person and as in previous meetings to have one clinical representative from each organisation, subject of course to their availability at this notice but videoconferencing will be available if required.

Please confirm attendees to Dean Sullivan's email address by 12noon on Tuesday, 20 January.

Many thanks.
Dean Sullivan

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Dean SullivanPA
Sent: 16 December 2014 15:57
To: Geraldine McKay's email address 'Burns, Deborah
Debbie Burns' email address Margaret O'Hagan's email address 'Welsh, Jennifer
Jennifer Welsh's email address
Cc: Elaine Way Western Trust; Mairead McAlinden's email address 'Tony Stevens ';
Michael McBride's email address ; Sara Long; Lynne Charlton; Carolyn Harper; Michael Bloomfield; Teresa Molloy's email address 'Clarke, Paula
Paula Clarke's email address 'Donaghy, Briege
Briege Donaghy's email address Shane Devlin's email address
Subject: Urology

SENT OBO DEAN SULLIVAN

I refer to the above.

Thank you to you and your clinical colleagues for attending today's meeting at short notice, and for engaging so constructively in consideration of the difficult issues we are currently facing in the Northern area.

We agreed that it would be helpful to meet again this Friday, 19 December 2014 at 3pm (venue: 5 floor meeting room, Linenhall Street). Videoconferencing facilities will be available if required.

Thank you for your continued support with this process.

Dean

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

From: Dean SullivanPA
Sent: 11 December 2014 15:48
To: Geraldine McKay's email address Burns, Deborah Debbie Burns' email address Margaret O'Hagan's email address Welsh, Jennifer Jennifer Welsh's email address t)
Cc: Elaine Way Western Trust; Mairead McAlinden's email address Tony Stevens ; Michael McBride's email address Sara Long; Lynne Charlton; Carolyn Harper; Michael Bloomfield; Teresa Molloy's email address Clarke, Paula Paula Clarke's email address Donaghy, Briege Briege Donaghy's email address Shane Devlin's email address
Subject: Urology Services
Importance: High

SENT OBO DEAN SULLIVAN

Dear Colleague

I refer to recent discussions in relation to the above, specifically the current difficulties faced in the Northern area. Given the scale of the issue and the urgent need for a resolved way forward maximising available resources across the region, I would like us all to meet at 8:30am on Tuesday, 16 December 2014 (venue CR4 in Linenhall Street, Belfast).

If possible, it would be helpful for you to attend in person. It would also be helpful to have one clinical representative from each organisation, subject of course to their availability at this notice.

Please confirm attendees to Dean Sullivan's email address by 12noon on Monday.

Many thanks.

Dean Sullivan

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

Stinson, Emma M

From: Haynes, Mark Personal Information redacted by the USI
Sent: 29 April 2015 06:10
To: Burns, Deborah; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Thanks Debbie

Could you express our considerable disappointment at this.

We took time out to meet with David / Lynne on Thursday as a pre-curser to this meeting in order to understand the aims and agenda to make this Thursday more productive. The draft agenda was only circulated to us after we requested it and at short notice allowing limited time for us as a team to review it to offer comments. Again at short notice rather than meet with us as was planned we were informed that they would not be coming but instead would be teleconferencing, and then at the meeting Lynne was only able to phone in on a mobile. The data that was presented to us to inform the discussions last Thursday was not discussed. The draft agenda was discussed and there was a single agreed outcome which was;

'The final agenda and all supporting information were to be distributed Monday 27th April in advance of the meeting on 30th April.'

This outcome has not been met and instead we are going into a meeting with an agenda which will clearly be supported by additional information which we will be expected to respond to 'on the hoof'.

Mark

From: Burns, Deborah
Sent: 28 April 2015 18:43
To: Young, Michael; O'Brien, Aidan; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: FW: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Still no data

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Lynne Charlton Personal Information redacted by the USI
Sent: 28 April 2015 18:02

To: Dean SullivanPA; Geraldine McKay's email address Margaret O'Hagan's email address Jennifer Welsh's email address Seamus.McGoran setrust; Burns, Deborah; Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; Colin Mulholland's email address Chris Hagan's email address Sam Gray's email address Young, Michael; Paul Kavanagh; Sara Long; Caroline Cullen; Mary Jo Thompson; Mary Haughey; Dean Sullivan
Cc: Michael McBride's email address Clarke, Paula; Clarke, Paula; McAlinden, Mairead; Elaine Way Western Trust; Tony Stevens' email address Hugh McCaughey SE Trust; Roisin Coulter's email address Shane Devlin's email address Briege Donaghy's email address Teresa Molloy's email address Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

"This email is covered by the disclaimer found at the end of the message."

Dear All

Re: Regional Urology Meeting.

Please find attached agenda for the regional urology meeting which will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

Thanks

Lynne

Head of Nursing, Quality, Safety and Patient Experience Public Health Agency
12-21 Linenhall Street
Belfast
BT2 8BS

Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Lynne Charlton
Sent: 28 April 2015 18:00
To: Dean SullivanPA; Geraldine McKay's email address Margaret O'Hagan's email address Jennifer Welsh's email address Seamus.McGoran setrust; Debbie Burns' email address Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; Colin Mulholland's email address Chris Hagan's email address Sam Gray's email address Michael Young's email address Paul Kavanagh; Sara Long; Caroline Cullen; Mary Jo Thompson; Mary Haughey; Dean Sullivan
Cc: Michael McBride's email address Paula Clarke's email address Paula Clarke's email address Mairead McAlinden's email address Elaine Way

Western Trust; [redacted] Hugh McCaughey SE Trust; [redacted] Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Dear All

Re: Regional Urology Meeting.

Please find attached agenda for the regional urology meeting which will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

Thanks

Lynne

Head of Nursing, Quality, Safety and Patient Experience Public Health Agency
12-21 Linenhall Street
Belfast
BT2 8BS

Office [redacted]
Email [redacted]

From: Dean SullivanPA
Sent: 13 March 2015 09:15
To: [redacted] Seamus.McGoran setrust; [redacted] Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; [redacted] Paul Kavanagh; Sara Long; Lynne Charlton
Cc: [redacted] Elaine Way Western Trust; [redacted] Hugh McCaughey SE Trust; [redacted] Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: Urology Services
Importance: High

SENT OBO DEAN SULLIVAN

Dear Colleague

I refer to the urology meeting held in late January, specifically the agreement to hold a regional urology meeting.

I can confirm this meeting will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

If possible, it would be helpful for you to attend in person, meeting objectives and agenda items will follow.

Please confirm attendees to [redacted] by Friday 10th April 2015.

Many thanks.

Dean Sullivan

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: [redacted]

A G E N D A
Regional Urology Meeting
12.00pm,Thursday 30th April, 2015
Linenhall Street

Aim of the meeting

To agree the principles to take forward the implementation of a regional approach to the delivery of urology services using an evidence base and built on good practice.

In order to achieve this we will need to

- Review current regional urology position.
- Consider alternative commissioning models.
- Discuss current modernisation/service improvement initiatives.
- Map regional expertise in urology conditions
- Consider current & future pathways for prostatectomy and reconstruction procedures.

1	**Welcome & Introductions**
2	**Context**

3	**Current regional urology position**
	• Workforce & Physical
	  ○ Referral patterns
	  ○ Demand & Capacity
	  • Unscheduled

4	**Alternative commissioning models** • SBAs • Waiting times • Long waiting procedures • Current modernisation/service improvement initiatives

5	**Regional expertise in urology conditions** • Stone • Cancer • Core
6	**Current & potential future pathways for procedures currently referred through ECR process** • Assessment for robotic prostatectomy • Reconstruction
7	**Agree process for implementation**
8	**Date of next meeting**

-

Stinson, Emma M

From: Burns, Deborah [redacted]
Sent: 29 April 2015 13:08
To: Young, Michael; Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Cc: [redacted]
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Unfortunately I am in trust board workshop and only have a pass to leave at 11am! But please go ahead without me

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

From: Young, Michael
Sent: 29 April 2015 12:15
To: Burns, Deborah; Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Cc: [redacted]
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

I think it would be a good idea if we all had a short meeting tomorrow morning ourselves again before attending main meeting Would 10 am in Martina office be good?

MY

From: Burns, Deborah
Sent: 29 April 2015 11:58
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Fab

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

From: Haynes, Mark
Sent: 29 April 2015 09:16

To: Burns, Deborah; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Thanks Debbie and hope all is well.

Yes I was going to be explicit that (a) we are meeting demand, (b) Backlog remains an issue and requires separate solution and (c) meeting demand now on current staffing, capacity analysis suggested that by 2 years we will need an additional member of the consultant team to meet demand and that this additional member was required to have any impact on backlog.

When it comes to 'how to count' I plan to describe to demand assessment process we went through and illustrate the deficiencies of the current methods. Will also be stating that one important principle is that as consultants we all see 'core' patients (as all patients are core up until a diagnosis is made) and so the new clinic is not sub-divided by speciality but that for review clinics we each see our core and sub-specialist interests.

Mark

From: Burns, Deborah
Sent: 29 April 2015 08:10
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Just a few thoughts (have time to think while being "mummy" on the other side and that is dangerous) Should we say up front that the team wanted to develop a model that would meet as far as possible demand coming through the door – and that this was treated as far as pos as core demand until differentiated Also wondered when we give figures on slide one - do we need to be explicit that this is meeting the demand (but that we have a backlog) so reduction in over nine looks less but impact of model is greater

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 29 April 2015 07:04
To: Burns, Deborah; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Morning All

I have made a start to a few slides for tomorrow and will continue to add to them this afternoon.

Attached are the first two slides regarding our changes and the impacts. All comments welcomed.

Mark

From: Burns, Deborah
Sent: 28 April 2015 18:43
To: Young, Michael; O'Brien, Aidan; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: FW: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Still no data

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Lynne Charlton Personal Information redacted by the USI
Sent: 28 April 2015 18:02
To: Dean SullivanPA; Geraldine McKay's email address
Margaret O'Hagan's email address Jennifer Welsh's email address
Seamus.McGoran setrust; Burns, Deborah; Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley;
Colin Mulholland's email address Chris Hagan's email address
Sam Gray's email address Young, Michael; Paul Kavanagh; Sara Long; Caroline Cullen; Mary Jo Thompson; Mary Haughey; Dean Sullivan
Cc: Michael McBride's email address Clarke, Paula; Clarke, Paula; McAlinden, Mairead; Elaine Way Western Trust; Tony Stevens' email address Hugh McCaughey SE Trust;
Roisin Coulter's email address Shane Devlin's email address
Briege Donaghy's email address Teresa Molloy's email address ; Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

"This email is covered by the disclaimer found at the end of the message."

Dear All

Re: Regional Urology Meeting.

Please find attached agenda for the regional urology meeting which will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

Thanks

Lynne

Head of Nursing, Quality, Safety and Patient Experience Public Health Agency
12-21 Linenhall Street
Belfast
BT2 8BS

Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Lynne Charlton
Sent: 28 April 2015 18:00
To: Dean SullivanPA; Geraldine McKay's email address Margaret O'Hagan's email address Jennifer Welsh's email address Seamus.McGoran setrust; Debbie Burns' email address Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; Colin Mulholland's email address Chris Hagan's email address Sam Gray's email address Michael Young's email address Paul Kavanagh; Sara Long; Caroline Cullen; Mary Jo Thompson; Mary Haughey; Dean Sullivan
Cc: Michael McBride's email address Paula Clarke's email address Paula Clarke's email address Mairead McAlinden's email address Elaine Way Western Trust; Tony Stevens' email address ; Hugh McCaughey SE Trust; Roisin Coulter's email address Shane Devlin's email address Briege Donaghy's email address Teresa Molloy's email address Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
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Belfast
BT2 8BS

Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Dean SullivanPA
Sent: 13 March 2015 09:15
To: Geraldine McKay's email address; Margaret O'Hagan's email address; Jennifer Welsh's email address; Seamus.McGoran setrust; Debbie Burns' email address; Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; Colin Mulholland's email address; Chris Hagan's email address; Sam Gray's email address; Michael Young's email address; Paul Kavanagh; Sara Long; Lynne Charlton
Cc: Michael McBride's email address; Paula Clarke's email address; Paula Clarke's email address; Mairead McAlinden's email address; Elaine Way Western Trust; Tony Stevens' email address; Hugh McCaughey SE Trust; Roisin Coulter's email address; Shane Devlin's email address; Briege Donaghy's email address; Teresa Molloy's email address; Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: Urology Services
Importance: High

SENT OBO DEAN SULLIVAN

Dear Colleague

I refer to the urology meeting held in late January, specifically the agreement to hold a regional urology meeting.

I can confirm this meeting will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

If possible, it would be helpful for you to attend in person, meeting objectives and agenda items will follow.

Please confirm attendees to Dean Sullivan's email address by Friday 10th April 2015.

Many thanks.

Dean Sullivan

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: Personal Information redacted by the USI

sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

Delivery 1 – Elective new referrals

- New patient clinic
  - All new patients.
  - Aim where possible all required tests performed prior to attending OPD (bloods, Imaging).
  - Some Direct listing
  - Deliver diagnostics at time of attendance.
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  - Reduction in dedicated elective TRUS biopsy sessions from 2 per week to 1 every fortnight at present.
  - Reduction in Consultant delivered diagnostic Flexible cystoscopy and haematuria sessions.
  - New outpatient waiting list (>9 week wait);
    - March to July 2014 increase from 522 to 1006 patients
    - Dec 2014 to Feb 2015 1169 to 1144 patients
    - New outpatient waiting list (total) 1812 Jan 2015 to 1775 April 2015

Delivery 2 – Inpatient Care

- Consultant of the week
- Impact;
  - Jan-March 2015 vs Jan-March 2014
    - Non elective LOS reduced (4.5 days vs 5.0 days)
    - Non-elective admissions reduced (203 vs 232)
    - Non elective operating (82 cases vs 80 cases)
    - Elective operating increased (322 vs 295)
    - Urology Bed-days reduced (2009 vs 1741)

Stinson, Emma M

From: Burns, Deborah [redacted]
Sent: 30 April 2015 09:42
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

This looks really good - only one suggestion on last slide I think we shouldn't say NI demand needs more staffing – leave that with them - I think - rest of last slide critical and needs emphasised and looks good

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

From: Haynes, Mark
Sent: 30 April 2015 05:20
To: Burns, Deborah; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
Subject: RE: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Morning

Attached are more slides for discussion this morning prior to this afternoons meeting.

Mark

From: Haynes, Mark
Sent: 29 April 2015 07:04
To: Burns, Deborah; Young, Michael; O'Brien, Aidan; Glackin, Anthony; Suresh, Ram; ODonoghue, JohnP; Corrigan, Martina; Trouton, Heather
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Subject: FW: Agenda Regional Urology Meeting - 12pm, Thursday 30th April, CR2 & 3 Linenhall Street

Still no data

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

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Sent: 28 April 2015 18:02
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Please find attached agenda for the regional urology meeting which will take place at 12pm – 4.30pm on Thursday 30th April 2015, CR2 & 3, Linenhall Street, Belfast (lunch will be provided).

Thanks

Lynne

Head of Nursing, Quality, Safety and Patient Experience Public Health Agency
12-21 Linenhall Street
Belfast
BT2 8BS

Office Personal Information redacted by the USI
Email Lynne Charlton's email address

From: Lynne Charlton
Sent: 28 April 2015 18:00
To: Dean SullivanPA; [redacted] Seamus.McGoran setrust; [redacted] Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; [redacted] Paul Kavanagh; Sara Long; Caroline Cullen; Mary Jo Thompson; Mary Haughey; Dean Sullivan
Cc: [redacted] Elaine Way Western Trust; [redacted] Hugh McCaughey SE Trust; [redacted] Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
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Head of Nursing, Quality, Safety and Patient Experience Public Health Agency
12-21 Linenhall Street
Belfast
BT2 8BS

Office [redacted]
Email [redacted]

From: Dean SullivanPA
Sent: 13 March 2015 09:15
To: [redacted] t'; [redacted] Seamus.McGoran setrust; [redacted] Janet Little; Miriam McCarthy; Michael Bloomfield; David McCormick; Bride Harkin; Paul Cavanagh; Lyn Donnelly; Iain Deboys; Paul Turley; [redacted] Paul Kavanagh; Sara Long; Lynne Charlton

Cc: [redacted]; [redacted] Elaine Way Western Trust; [redacted] Hugh McCaughey SE Trust; [redacted]; [redacted] Pat Cullen; Carolyn Harper; Beth Minnis; Michael Killen; Dean Sullivan
Subject: Urology Services
Importance: High

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If possible, it would be helpful for you to attend in person, meeting objectives and agenda items will follow.

Please confirm attendees to [redacted] by Friday 10th April 2015.

Many thanks.

Dean Sullivan

Lucyna Edgar
PA to Dean Sullivan, Director of Commissioning, HSCB
12-22 Linenhall Street, Belfast BT2 8BS Tel: [redacted]

Approach

- Demand / Capacity / Efficiency
- Efficiency of Consultant time
- Operative capacity primary challenge
  - Benchmarked against another trust.
  - By procedure type (not case number).

Delivery 1 – Elective new referrals

- New patient clinic
  - All new patients.
  - Aim where possible all required tests performed prior to attending OPD (bloods, Imaging).
  - Some Direct listing
  - Deliver diagnostics at time of attendance.
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    - March to July 2014 increase from 522 to 1006 patients
    - Dec 2014 to Feb 2015 1169 to 1144 patients
    - New outpatient waiting list (total) 1812 Jan 2015 to 1775 April 2015

Delivery 2 – Elective Operating

- Extended day operating (8am-8pm).
- No cross cover of leave.
- Impact
  - Increased available inpatient theatre time (28hrs per week average with cross cover to 31hrs per week with no cross cover).
  - Elective operating increased (322 vs 295 Jan- March 2015 vs 2014).
  - Inpatient waiting list >13 weeks static (499 March 2015 vs 494 March 2014).

Delivery 3 – Inpatient Care

- Consultant of the week
- Impact;
  - Jan-March 2015 vs Jan-March 2014
    - Non elective LOS reduced (4.5 days vs 5.0 days)
    - Non-elective admissions reduced (203 vs 232)
    - Non elective operating (82 cases vs 80 cases)
    - Urology Bed-days reduced (1741 vs 2009)

Summary

- Meeting Demand
  - At present but as demand increases will cease to.
- Historic Backlog major challenge
  - Requires additional solution outside of current capacity
- Capacity analysis suggested additional staffing required to deliver required capacity
  - Without additional staffing waiting lists will start to grow this year.

Moving Forwards

- Delivery of current NI demand not possible within current staffing.
- Demand / Capacity models.
  - Case mix
  - Bench marking
- Capacity must be responsive.
  - Commission to meet demand.
  - Performance data compared against agreed benchmark data.
  - Operating capacity.
- Demand management.
- Primary care capacity critical.
- Delivery of core services with networked delivery of sub-speciality services.

Stinson, Emma M

From:	Burns, Deborah [redacted]
Sent:	20 May 2015 14:22
To:	Young, Michael; Corrigan, Martina; O'Brien, Aidan; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP
Cc:	Stinson, Emma M
Subject:	FW: Urology - Planning and Implementation Group
Attachments:	Urology Planning and Implementation Letter - 190515 - DoA.doc; Planning and Implementation ToR 19 05 15.docx; Urology - Summary of Principles 19 05 15.docx; image001.png; image002.png; image003.jpg

This is important -what do you think?

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

From: Stinson, Emma M
Sent: 19 May 2015 13:42
To: Burns, Deborah
Subject: FW: Urology - Planning and Implementation Group

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]
P Please consider the environment before printing this email

Click on the link below to access the Acute Services Page

'You can follow us on Facebook and Twitter'

From: Rae Browne [redacted]
Sent: 19 May 2015 11:35
To: [redacted] Burns, Deborah;
[redacted] Seamus.McGoran setrust; 'OHagan, Margaret'

Cc: Sinead McCracken's email address Stinson, Emma M;
Trudy Flanagan's email address Mary Jo McQuilkin's email address Dean Sullivan;
Dean SullivanPA; Sara Long; Michael Bloomfield; Miriam McCarthy; Janet Little; David McCormick; Darren Campbell; Lynne Charlton
Subject: Urology - Planning and Implementation Group

"This email is covered by the disclaimer found at the end of the message."

OBO Dean Sullivan

Dear Directors of Acute Services,

Please find attached correspondence sent on behalf of Dean Sullivan.

Kind Regards
Rae

Rae Browne
Business Support Manager
Performance Management and Service Improvement Directorate Health and Social Care Board
12-22 Linenhall Street, Belfast, BT2 8BS
Tel: Personal Information redacted by the USI

Health and Social Care Board

Performance and Corporate Services

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Our Ref: DS
Date: 19 May 2015

TO:

Trust Directors of Acute Services

(By email)

Dear Colleague

UROLOGY – PLANNING AND IMPLEMENTATION GROUP

Further to the Regional Urology meeting held on 30 April 2015, it was agreed that a planning and implementation group would be established to develop a regional plan for urology. The regional plan will be underpinned by the principles agreed at the workshop. Terms of Reference and a copy of the principles have been attached for your information.

The HSCB now seek Trust nominations for representatives who have responsibility for managing and delivering urology services. The nominees should include a Clinical Lead, Nursing Lead and Managerial Lead.

The Trust should provide, **by Wednesday 29 May 2015**, the name and contact details of the nominations to Rae Browne, Business Support Manager Personal Information redacted by the USI.

A schedule of meeting dates will follow.

Yours sincerely

Dean Sullivan
Director of Commissioning

cc: Sara Long
Michael Bloomfield
Janet Little
Miriam McCarthy

Terms of Reference for the Urology Planning and Implementation Group

Context

In 2008/09 A Regional Review of (Adult) Urology Services was undertaken by a multi-disciplinary and multi-organisational Steering Group in response to service concerns regarding the ability to manage growing demand and maintain quality standards.

This review was supplemented in 2013/14 by a stocktake to assess progress to date with external independent advice provided to the HSCB by Mark Fordham, consultant urologist from the Royal Liverpool University Hospital Trust, who had provided support as a “critical friend” for the original 2009 review.

Since the completion of the stocktake, the HSCB has met with individual Trusts to explore how service redesign could help address the key challenges facing the service, including changing referral patterns and the current financial climate.

The urology community met at the end of April 2015 and agreed to develop a regional approach to the delivery of urology services. This approach will build on good practice to improve both quality of service provision and patient access across Northern Ireland.

Terms of Reference

To agree arrangements and identify resources for a system wide approach to the organisation and profile of urology services across Northern Ireland. The service reconfiguration will concentrate on the six principles that were agreed at the regional workshop:

- Development of a regional multi-professional workforce plan that maximises skills and expertise on a regional basis and is based on the agreed future service profile.

- Identify current and future needs for urology services at a regional level and development of robust service and budget agreements to reflect these needs.

- Eliminate regional variation through consideration of physical and staff infrastructure and best clinically agreed pathways.

- Review current access, consider and agree alternative pathways for patients currently waiting and agree future pathways which are evidence based and in line with best practice.

- Consider regional expertise in service configuration and explore cross Trust working.

- Consider clinical and cost effective NI solutions for those procedures where patients are currently travelling outside NI for treatment.

Summary of Principles

1	Development of a regional multi-professional workforce plan that maximises skills and expertise on a regional basis and is based on the agreed future service profile.
2	Identify current and future needs for urology services at a regional level and development of robust service and budget agreements to reflect these needs.
3	Eliminate regional variation through consideration of physical and staff infrastructure and best clinically agreed pathways.
4	Review current access, consider and agree alternative pathways for patients currently waiting and agree future pathways which are evidence based and in line with best practice.
5	Consider regional expertise in service configuration and explore cross Trust working.
6	Consider clinical and cost effective NI solutions for those procedures where patients are currently travelling outside NI for treatment.

Stinson, Emma M

From: Burns, Deborah [redacted]
Sent: 16 June 2015 16:34
To: Haynes, Mark; Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Suresh, Ram; Corrigan, Martina; Trouton, Heather
Subject: FW: Urology Planning and Implementation Group - Agenda and Schedule of Dates
Attachments: Urology PIG - Agenda 26 June 2015.docx

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

From: Rae Browne [redacted]
Sent: 16 June 2015 15:59
To: Burns, Deborah; Trouton, Heather; Corrigan, Martina
Cc: Stinson, Emma M
Subject: Urology Planning and Implementation Group - Agenda and Schedule of Dates

"This email is covered by the disclaimer found at the end of the message."

All

Please find attached the agenda for the urology planning and implementation group meeting scheduled for Friday 26 June 2015 3.00pm-5.00pm.

Can I ask for confirmation of your attendance please?

Please also see the table below for the schedule of dates for the next four urology meetings.

Date

Time

Venue

Tuesday 28 July 2015

2pm-4pm

CR3&4

Wednesday 26 August 2015

10am-12pm

CR2&3

Wednesday 30 September 2015

10am-12pm

CR1&2

Wednesday 28 October 2015

10am-12pm

CR1&2

Best regards
Rae

Rae Browne
Business Support Manager
Performance Management and Service Improvement Directorate Health and Social Care Board
12-22 Linenhall Street, Belfast, BT2 8BS
Tel: Personal Information redacted by the USI

UROLOGY PLANNING AND IMPLEMENTATION GROUP

FRIDAY 26 JUNE 2015

3.00pm – 5.00pm

CR 1, 2 & 3, HSCB, Linenhall Street

AGENDA

1. Welcome and Introductions
2. Excess Patient Waits
    - New Outpatients
    - Review Outpatients
    - IPDCs
3. Workforce Planning
4. Primary Care
    - Potential for Collaborative Working
    - CCG Banner Page Guidance
5. Referral Pathways
6. Procedure Based Service and Budget Agreements
7. Arrangements for redirection of urology referrals
8. Regional solutions for reconstruction and prostatectomies
9. AOB

Stinson, Emma M

From: O'Brien, Aidan [redacted]
Sent: 22 June 2015 21:17
To: Burns, Deborah
Subject: RE: Urology Planning and Implementation Group

Debbie,

Thank you,

Aidan.

From: Burns, Deborah
Sent: 22 June 2015 09:32
To: O'Brien, Aidan
Subject: RE: Urology Planning and Implementation Group

In agreement Aidan and will express

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

From: O'Brien, Aidan
Sent: 21 June 2015 20:32
To: Burns, Deborah
Subject: RE: Urology Planning and Implementation Group

Debbie,

I am concerned that this exercise is not only being dictated by HSCB, but is being done along Trust lines only.
Two particular concerns are the issues of reconstructive urological surgery and radical prostatectomy.

Regarding the former, the Northern Ireland Reconstructive Urology Network (NIRUN) was established one year ago, with consultant members from Altnagelvin, Craigavon, Belfast City and Ulster Hospitals.
We have had a monthly MDM, held in the Board Room of Lagan Valley Hospital and at which cases from all hospitals are presented, discussed and management plans agreed.
We have become increasingly convinced of the benefits to patients and confident regarding their management.
In fact, we more recently have nephrologists and renal transplant patients attending.
I believe that no decisions should be made regarding reconstructive urological surgery without the input of NIRUN.

Similarly, all matters pertaining to urological cancer services have their own network (NICaN) for over ten years.
As Lead Clinician, I will convene a meeting of all urologists involved in cancer services in September 2015, to discuss many matters regarding cancer services, including radical prostatectomy, and all the more so following Peer Review.

The point which I am trying to make is that this process should not just be a turf war between Trusts.
I believe that urologists should be given time and space outside of this process to discuss all of these matters, and certainly with the expectation that they will input into the process, and hopefully as a counterbalance to a process owned and driven by the Board.

I will be unable to attend on Friday 26 June 2015 as I am on call.
I would therefore be grateful if you would express these views on my behalf, if you are in agreement,

Aidan.

From: Burns, Deborah
Sent: 03 June 2015 15:51
To: Young, Michael; O'Brien, Aidan; Glackin, Anthony; Haynes, Mark; Suresh, Ram; ODonoghue, JohnP; Trouton, Heather; Corrigan, Martina
Subject: FW: Urology Planning and Implementation Group

Thoughts on a post card to Emma
(Sorry feeling cynical)
D

Debbie Burns
Acting Director of Acute Services
SHSCT
Debbie Burns' email address
Tel: Personal Information redacted by the USI

From: Rae Browne Personal Information redacted by the USI
Sent: 03 June 2015 15:48
To: Burns, Deborah
Cc: Corrigan, Martina; David McCormick
Subject: Urology Planning and Implementation Group

"This email is covered by the disclaimer found at the end of the message."

Deborah

I refer to the Urology Planning and Implementation Group and can confirm that the first meeting will be held on Friday 26 June 2015.

A formal letter, including agenda, will follow.

In the interim I would be grateful if you could forward to me any agenda items for consideration.

Best regards
Rae

Rae Browne
Business Support Manager
Performance Management and Service Improvement Directorate Health and Social Care Board
12-22 Linenhall Street, Belfast, BT2 8BS
Tel: Personal Information redacted by the USI

Stinson, Emma M

From: Kerr, Joanne [redacted]
Sent: 30 January 2014 11:23
To: Neill, Ruth; Somerville, Nicola; McNally, CatherineA
Cc: Burns, Deborah; Corrigan, Martina; McAlinden, Mairead
Subject: FW: Urology JD (H8992)

Hi Ruth

Please see below from Mrs McAlinden in relation to the Consultant Urologist post..

Can you please proceed with the offer letters to the appointed candidates?

Let me know if you have any queries.

Many thanks

Joanne

From: McAlinden, Mairead
Sent: 29 January 2014 19:17
To: Burns, Deborah; Kerr, Joanne; Corrigan, Martina
Subject: RE: Urology JD (H8992)

Yes can confirm approved as Commissioner (Michael Bloomfield) confirmed they would fund.

M

From: Burns, Deborah
Sent: 29 January 2014 13:10
To: Kerr, Joanne; Corrigan, Martina; McAlinden, Mairead
Subject: RE: Urology JD (H8992)

Approved by Cx – Mairead can you confirm D

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

From: Kerr, Joanne
Sent: 29 January 2014 12:23
To: Burns, Deborah; Corrigan, Martina
Subject: FW: Urology JD (H8992)

Debbie / Martina

Please see below email from recruitment in relation to the 6th Consultant Urologist post which was to be offered following the interviews last week.

Can you advise if this has been approved by Corporate Scrutiny? They cannot proceed with the offer letters unless they have Corporate Scrutiny approval.

Thanks

Joanne

From: Neill, Ruth
Sent: 29 January 2014 12:13
To: Kerr, Joanne; Somerville, Nicola; McNally, CatherineA
Subject: RE: Urology JD (H8992)

Joanne, this e-req (19095) is still sitting as pending corporate scrutiny approval,

Ruth

From: Kerr, Joanne
Sent: 28 January 2014 12:43
To: Somerville, Nicola; McNally, CatherineA
Cc: Corrigan, Martina; Young, Michael; MY; F Goldenberg's email address Neill, Ruth
Subject: FW: Urology JD (H8992)

Nicola / Catherine

Please see below email from Mr John McKnight (Specialty Advisor) approving the Consultant Urologist post.

Can you now proceed the offer letters to the appointed candidates? I have also attached the approved job description.

Give me a call to ext Personal Information redacted by if you have any queries.

Many thanks

Joanne

From: McKnight, John Personal Information redacted by the USI
Sent: 28 January 2014 12:38
To: Kerr, Joanne
Cc: Corrigan, Martina; F Goldenberg's email address
Subject: RE: Urology JD (H8992)

that's fine
John

From: Kerr, Joanne [redacted]
Sent: 28 January 2014 12:07
To: McKnight, John
Cc: Corrigan, Martina
Subject: RE: Urology JD (H8992)

Mr McKnight

Thank you for your comments in relation to the Consultant Urologist post in Craigavon Area Hospital.

Please find attached the updated job description / job plan as per your comments.

I would welcome your approval on this post at your earliest convenience.

Many thanks for your help.

Kind regards

Joanne

From: McKnight, John [redacted]
Sent: 22 January 2014 13:10
To: Goldenberg, Frances; Kerr, Joanne
Subject: RE: Urology JD (H8992)

Joanne/Frances,
I am broadly happy with JD.
In terms of job plan my understanding is that it should be advertised as a 10PA job plan total- ie to include on call.
I only see 5hr SPA. This would need to increase to 6.
With tweaks to change the above, the job would be ready for sign off.
John

From: Goldenberg, Frances [redacted]
Sent: 15 January 2014 14:26
To: [redacted]
Cc: McKnight, John
Subject: RE: Urology JD (H8992)

Dear All,

Apologies – the correct H reference number is H8992 for this second JD that was sent to Mr McKnight yesterday. Apologies for typing it wrong again.

Many thanks,

Frances

Frances Goldenberg | Professional Support Administrator | Professional and Clinical Standards
The Royal College of Surgeons of England | 35-43 Lincoln's Inn Fields | London WC2A 3PE

t: Personal Information redacted by the USI | f: Personal Information redacted by the USI | e: F Goldenberg's email address | w: http://www.rcseng.ac.uk

From: Goldenberg, Frances
Sent: 15 January 2014 14:23
To: Joanne Kerr's email address
Cc: John McKnight's email address
Subject: Urology JD (H8892)

Dear Joanne,

Thank you for your email, with the JD for a new Urology post for review.

There was an AAC that took place at your Trust on Monday (13th January) for a Urology post that had previously been approved by Patrick Keane. We have now heard from the Assessor from the AAC that you have confirmed financial support for, and are appointing a second consultant in Urology from the AAC that took place. The JD you sent through to us for review by Mr McKnight, we believe is for this second post that you appointed at the AAC. Is this correct?

With regard to this second appointment, the Trust may wish to consider whether it would be open to challenge from candidates who might have applied had they been aware there were two posts available. The College cannot give legal advice on this, so this would be for you to decide.

We have sent the JD for the second post to Mr McKnight to review the Job Description.

Many thanks,

Frances

Frances Goldenberg | Professional Support Administrator | Professional and Clinical Standards
The Royal College of Surgeons of England | 35-43 Lincoln's Inn Fields | London WC2A 3PE
t: Personal Information redacted by the USI | f: Personal Information redacted by the USI | e: F Goldenberg's email address | w: http://www.rcseng.ac.uk

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Southern Health & Social Care Trust IT Department [redacted]

Stinson, Emma M

From: Corrigan, Martina [redacted]
Sent: 28 March 2014 12:09
To: Burns, Deborah
Cc: Trouton, Heather; Lappin, Lynn; Stinson, Emma M
Subject: RE: Urology Review Stocktake - Further Information
Attachments: Job Plans for 6 consultants.docx

Importance: High

Debbie

Please see attached.

I have no job plans included for Middle Tier Doctors as it is unlikely that we will recruit any time soon.

The job plans that are attached are what all the consultants are currently doing and what we plan that the two new consultants will do for the interim but as you know the plan is to move to a team job plan which will be a rolling plan and will not look like the attached although there will be no loss in actual sessions.

The Nurses job plans will also change to take into account NICE and NICAN guideline but again there will be no loss of sessions.

Happy to discuss

Thanks

Martina

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

From: Burns, Deborah
Sent: 20 March 2014 10:03
To: Corrigan, Martina
Subject: FW: Urology Review Stocktake - Further Information

Martina

Not sure if you have received this email?

E

From: Beth Malloy [redacted]

Sent: 19 March 2014 21:51
To: Burns, Deborah
Cc: Lappin, Lynn; Trouton, Heather; David McCormick
Subject: Urology Review Stocktake - Further Information

"This email is covered by the disclaimer found at the end of the message."

Dear Debbie

I appreciate we have not yet had the meeting with the Trust in relation to the Urology Review Stocktake. We are meeting next week, as discussed last week and prior to the meeting it would be helpful if the Trust provided the information below in relation to both the 5 posts and the additional 6th post. This should include vacant posts.

Please could you arrange for the following information to be sent to the Board?

Details of the Job Plan PAs for each of the following individuals within Urology of the SouthernTrust. Showing the details by day and total PAs for each of the Consultants and Other Support Staff in the Directorate Consultants (confirming their specialist area) Middle Tier Doctors (including grade) and Clinical Nurse Specialists (showing their grade)

It would be helpful if this information was submitted by COP on Tuesday of next week. So that we may consider with Mark prior to the meeting on the 3 April.

Regards

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board
Headquarters
12-22 Linenhall Street

Belfast
BT2 8BS
Northern Ireland

Mobile Personal Information redacted by the USI
Landline Personal Information redacted by the USI Ext Personal Information redacted by
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Current Job Plans for Urology Consultants in Southern Health and Social Trust

CONSULTANT Mr M Young - (with Specialist interest in Stones and Lead Clinician) currently on 12.25 PA's

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	Day Surgery – South Tyrone Hospital (Week 1) Admin – CAH (Weeks 2) OPD – Banbridge Outpatients Clinic (Week 3) OPD - South West Acute Hospital (week 4)	Stone Treatment Centre – (Week 1,2,3 &5) OPD - South West Acute Hospital (week 4)
Tuesday	Theatre – CAH (weeks 1,2 & 4) (9am) **note all day theatre starts at 9am and runs through to 7pm)*	Theatres – CAH (weeks 1,2 & 4) (7pm)
Wednesday	Stone Treatment Centre Treatments and OPD	OFF
Thursday	Radiology Meeting Ward Round Departmental Meeting	2pm – 5pm – MDT Weekly
Friday	Specialist Clinic and Urodynamics	OPD – Craigavon Area Hospital

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

CONSULTANT Mr A O'Brien - (with Specialist interest in Oncology and Urodynamics) currently on 12 PA's

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	OPD – Banbridge Outpatients Clinic (Week 1 & 5) OPD - South West Acute Hospital (week 2) OPD – Armagh Community Hospital (week 3 & 4)	OPD - South West Acute Hospital (week 2) SPA – (weeks 1,3,4,5)
Tuesday	Day Surgery – Craigavon Area Hospital (weeks 1 & 3) Admin – (weeks 2,4 & 5)	OPD – Craigavon Area Hospital (weekly)
Wednesday	Theatre – CAH (weeks 1,2 & 4) (9am) **note all day theatre starts at 9am and runs through to 7pm)*	Theatres – CAH (weeks 1,2 & 4) (7pm)
Thursday	8:30am - Radiology Meeting Ward Round Departmental Meeting	MDT Weekly - Chair
Friday	OFF	Specialist Clinic and Urodynamics

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

CONSULTANT Mr A Glackin - (with Specialist interest in Oncology) currently on 10.5 PA's

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	OPD Oncology - CAH	OPD – General - CAH
Tuesday	Day Surgery – South Tyrone Hospital – one GA and One LA (weeks 2 & 4) Admin – (weeks 1,3 and 5)	OPD – South Tyrone Hospital (weeks 2 & 4)
Wednesday	One Stop Prostate Clinic (week 2 and 4)	TRUS Biopsy Clinic (week 2 & 4)
Thursday	8:30am - Radiology Meeting Ward Round Departmental Meeting	MDT Weekly
Friday	Theatres **note all day theatre starts at 9am and finishes at 5pm*	Theatres

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

CONSULTANT Mr K Suresh - (with Specialist interest in Stones but currently doing oncology due to the demand) currently on 10.5 PA's - ***Note when Mr Hann starts Mr Suresh will be doing a stone treatments instead of Oncology***

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	OPD General - CAH	OPD – oncology – CAH
Tuesday	Day Surgery – Craigavon Area Hospital – (weeks 2 & 4) Theatres	Flexible Cystoscopies for one-stop haematuria clinic (weeks 1, 2 and 4)
Wednesday	One Stop TRUS Biopsy Clinic (week 1 and 3)	One Stop Biopsy Clinic (week 1 & 3)
Thursday	8:30am - Radiology Meeting Ward Round Departmental Meeting	MDT Weekly *Note when Mr Hann starts Mr Suresh will be doing a stone clinic instead of MDT
Friday	Admin	Theatres (weekly)

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

CONSULTANT Mr M Hann (not starting until Mid-May - (with Specialist interest in Oncology) will be on 10.5 PA's **PROPOSED**

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	Main Theatres	Main Theatres
Tuesday	Day Surgery – South Tyrone Hospital – one GA and One LA (weeks 1 & 3) Admin – (weeks 1,3 and 5)	OPD – South Tyrone Hospital (weeks 1 & 3)
Wednesday	One Stop Prostate Clinic Weeks 1, 3 & 5	TRUS Biopsies Weeks 1,3, & 5
Thursday	8:30am - Radiology Meeting Ward Round Departmental Meeting	MDT Weekly
Friday	OPD – Oncology	Admin

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

CONSULTANT Mr J O'Donaghue (not starting until beginning of August - (with Specialist interest in Female Urology) will be on 10.5 PA's **PROPOSED**

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	Main Theatres - CAH	OPD – General - CAH
Tuesday	Specialist Clinic including LUTs and Urodynamics	SPA
Wednesday	Main Theatres - CAH	LA Theatre List - CAH
Thursday	8:30am - Radiology Meeting Ward Round Departmental Meeting	Admin
Friday	Day Surgery – Daisy Hill Hospital	Outpatients – Daisy Hill Hospital

1 PA for oncall, 1 PA for Ward Rounds and 1.5 SPA

Specialist Nurse Band 7 – Kate O'Neill Band 7 – full-time 37.5hrs (10 PAs)

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	Uro-oncology clinics	Results Clinics
Tuesday	Prostate Biopsy Clinic	Haematuria Clinic
Wednesday	One Stop Prostate Clinic	One Stop Prostate Clinic
Thursday	Admin/Sisters/departmental meetings	MDT
Friday	Uro-Oncology Clinics	Results (telephone) and Admin

Specialist Nurse Band 7 – Jenny McMahon Band 7 – Part-time 30hrs (8 PAs)

DAY	AM (Sessions are 9am-1pm)	PM (Sessions are 2pm – 5pm)
Monday	LUTs Clinics (Review)	Admin
Tuesday	Off	OFF
Wednesday	One stop prostate clinic	One stop prostate clinic
Thursday	Haematuria clinics	MDM/Admin
Friday	Urodynamics	Urodynamics

Stinson, Emma M

From: Burns, Deborah [redacted]
Sent: 27 May 2014 10:29
To: Stinson, Emma M
Subject: RE: Draft for Discussion Narrative Report on the Stocktake of Urology Review
Attachments: image001.png; image002.png; image003.jpg

ok

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

From: Stinson, Emma M
Sent: 27 May 2014 10:06
To: Burns, Deborah
Subject: RE: Draft for Discussion Narrative Report on the Stocktake of Urology Review

Debbie

Heather called in there to say that Mr Young is in theatre all day today but that she and Martina are going to talk to him between cases and then they can meet/brief you this afternoon if that's ok as meeting is tomorrow at 9am

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]
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From: Burns, Deborah
Sent: 23 May 2014 18:57
To: Trouton, Heather; Young, Michael; Corrigan, Martina
Cc: Stinson, Emma M

Subject: FW: Draft for Discussion Narrative Report on the Stocktake of Urology Review

Do we have a pre meeting scheduled – if not we need one

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Beth Malloy Personal Information redacted by the USI
Sent: 23 May 2014 17:33
To: Seamus.McGoran setrust; 'Welsh, Jennifer'; 'OHagan, Margaret' Margaret O'Hagan's email address Mckay, Geraldine; Burns, Deborah
Cc: Dean Sullivan; Lucyna Edgar; Michael Bloomfield; Beth Minnis; David McCormick; Mark Fordham Personal Information redacted by the USI Janet Little; Siobhan McIntyre
Subject: Draft for Discussion Narrative Report on the Stocktake of Urology Review

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Dear all

Please find attached the draft for discussion narrative report on the urology review stocktake. This is a draft document is for further discussion and dialogue. We will be discussing this with each of you at the meetings planned to be held over the next week or so. Please advise me of any issues with factual accuracy.

Thanks

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board
Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS
Northern Ireland

Mobile Personal Information redacted by the USI
Landline Personal Information redacted by the USI

Narrative report on the Stock-take for the Health and Social Care Board of Urology Services in Northern Ireland; February to May 2014

Introduction

Following the implementation of the "Review of Adult Urology Services in Northern Ireland – A modernisation and investment plan" of March 2009 the HSCB requested a stock-take of adult urology services in Northern Ireland to assess progress after the 5 years since the review. To provide external independent advice to the HSCB, Mark Fordham the consultant urologist from the Royal Liverpool University Hospital Trust who had provided support as a "critical friend" for the original 2009 review was invited to provide a similar service for this project.

Terms of reference

The terms of reference for this 2014 stock-take of urological services in Northern Ireland were prepared by the HSCB (A – H).

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full range of urology procedures

G) Review the service delivery to those acute hospitals sites that do not have an on-site urology team

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `Nice guidance CG175' [Prostate cancer management].

Plan for conducting the stock-take

A team consisting of Beth Malloy and David McCormick from the HSCB and Mark Fordham as the external advisor was established. Arrangements were made for:

1) Visits to be made to each of the hospital trusts which provide in-patient urological services to meet the urological clinical and management teams (Ulster Hospital, BCH, Craigavon, Causeway, Altnagelvin and Antrim Hospital)
2) To meet with clinicians who have a specific responsibility for providing regionally based administrative services for the organisation and planning of provision of urological care. This was to including meeting the regional BAUS representative (John McKnight), the training programme lead (Siobhan Woolsey), the urological cancer lead (Aidan O'Brien), the lead for audit in urology (Siobhan Woolsey), the RCS representative for Professional affairs in surgery (Terry Irwin) and the regional lead nurse consultant in the Public Health Agency(Siobhan McIntyre).
3) To have access to and review urological data reflecting the way the workforce is organised and the current level of the workload including the waiting list backlogs, together with an assessment of the current commissioning arrangements.
4) To review data germane to this work that is in the public domain relating to urological activity, care pathways, guidelines, contributions made by the urological staff, published audits and research.

1) Reports on the review meetings at Hospital Trusts

Present at all these meetings were Mark Fordham and Beth Malloy, with David McCormick at all except Antrim Hospital.

The aim of the meetings was to allow each Trust team to describe how they saw their current position and any challenges that existed, and what progress they had made since the 2009 Review. The HSCB did not offer any comments on the data presented.

Belfast Trust
Date: Tuesday 11th March
Present: Representative Urology consultants and management
Points raised by the Trust:
Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Increasing workload especially from increasing numbers of cancer referrals to its Cancer Centre
3. Consultant changes and increasing emergency work [especially acute stone cases] resulting in significant reduction in workforce capacity and in the skills base in particular surgical reconstruction services.
4. Recruitment of clinical staff remains difficult

5. Growing waiting lists especially for core urology and outpatient services
6. Primary care catchment areas overlapping with other providers making allocation of referrals challenging.
7. Limited space for day diagnostic services and limited theatre sessions, but helped by using the theatres at White Abbey Hospital to provide some diagnostics and day cases
8. The Trust raised the issue of the provision of Robotic Surgery
9. On ongoing problem with a small group of patients awaiting complex reconstructive surgery was described.

Achievements

1. Established Cancer Centre along Improving Outcome Guidance recommendations; weekly MDT with video links to cancer units;
2. Well-established training services for junior urologists

South Eastern Trust

Date: Wednesday 12th March

Present: Urology consultants and management representatives

Points raised by the Trust:

Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Current 3 consultant team is overstretched: 4 peripheral sites covered as well as the main hospital; BCH provides clinical work at Lagan Valley
3. Rising demand for both cancer and core urology services

Achievements

1. Strong support from the 2 specialist nurses including delivering flexible cystoscopy and outpatient work
2. Activity delivered to contract but a growing waiting list
3. Target length of stay and day-case rates satisfactory
4. Potential for excellent training of junior urologists

Northern and Western Trusts (at Causeway Hospital)

Date: Thursday 13th March

Present: Representative urology consultants from Western Trust as well as consultant urologists from Northern Trust together with management teams from both Trusts.

Points raised by the Trusts :

1. The 2009 Review had recommended that the Northern Trust and the Western Trust urology services were amalgamated into a single team. A helpful document summarising the teams work towards this amalgamation was presented. The 2 teams have worked on and proposed a method for achieving this and have conducted an assessment of their proposals with the input of a senior and very well respected consultant urologist. To create a combined Northwest team the plan proposes continued cross team co-operation and development of working relationships, establishment of 2 new operating theatres on the Altnagelvin site to support increased urological activity, build a dedicated diagnostic and treatment facility on the Causeway site, increase within

Team NW numbers of consultant [to 6], staff grade [to 4], urology trainees/fellows [to 2] and specialist nurses. An analysis of capacity based on the recommended workload per clinician and current and likely increase in demand was presented to support the manpower and facility development proposals. It is recognised by the Trusts that investment will be needed to achieve these objectives.

Challenges

1. Waiting times for outpatients and surgical procedures remain high with significant numbers of patients on the operative waiting lists particularly for core urology procedures.
2. The arrangements for cross cover on-call arrangements between the two sites are not yet fully operational.
3. The 2 new operating theatres on the Altnagelvin site are not yet completed and do not have an agreed timescale for construction.
4. The loss of the defined cancer operations to the Cancer Centre has not been backed up with clear annual outcome data to assess whether improvements have resulted. The work to deliver these data is not within the scope of team NW.
5. The costing for some of the Team NW proposals are not yet fully worked out and no clear decision regarding possible funding has been taken.
6. Recruitment of clinical staff has remained difficult (both consultants and specialty doctors).

Achievements

1. A determined collaborative undertaking with external assessment to develop a plan to achieve the 2009 review recommendations.

Additional comments:

1. The clinical director for surgery pointed out that losing urological inpatient services from the Causeway Hospital Trust could have a negative effect on the functioning of the Trust, and he hoped that the service would remain as it is.

Northern Trust at Antrim Hospital

Date: Friday 14th March

Present: Consultants in general surgery and in gynaecology

Points raised by the Trust :

1. Patients with urological conditions are admitted via A&E under the care of the general surgeons. Although there is acute support from the urologists in the Northern Trust in Causeway Hospital and there are arrangements for urological input from the Belfast City Hospital team, in reality patients may not experience optimal care and may remain in hospital for longer than would be the case in hospitals with a urology directorate particularly for the patients who are undiagnosed or have medical type urology pathologies.
2. The 6 gynaecologists in Antrim Hospital would welcome the presence of a urological service to collaborate with providing functional urinary services as well as some operative procedures.
3. Operating theatre space is limited but facilities at Whiteabbey Hospital have traditionally been used by outreach urology services from Belfast Trust.

Southern Trust
Date: Thursday 3rd April
Present: Urology consultants and management staff
Points raised by the Trust:
A helpful document summarising the directorates progress on implementing the 2009 review recommendations was presented.
Challenges

1. The waiting lists particularly for outpatient services have very long waiting times.
2. Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases.
3. The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand.
4. Recruitment of clinical staff [consultants, juniors and specialist nurses] has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant.
5. Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site.
6. Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&E.
7. Administration time for consultants is significant and is not reflected in their job plans. There is a particular worry in delays in consultant to consultant referrals, MDT referrals and triage.

Achievements

1. An improved diagnostic and treatment outpatient facility has been completed which will enable one-stop services to be improved and developed.
2. Recent new consultant appointments are hoped will allow a significant improvement in waiting times and reduction in waiting lists.
3. An elective admission ward has helped improve day surgery numbers and improve theatre utilisation

Additional comments

1. General surgeons provide urological care at Daisy Hill Hospital and SWAH; vasectomy services at Craigavon Hospital are provided by the general surgeons.

2) Reports on the review meetings with regional leads

Regional BAUS representative; John McKnight
Date: Wednesday 5th March
Present: John McKnight and Mark Fordham
Points discussed

1. Regional meetings and updates
2. Regional audit
3. Sharing best practice
4. Supporting trainees
5. Ways to improve consultant recruitment
6. Managing competing needs of local hospital urology services while delivering regional urology services
7. Availability of Mark Fordham to meet and speak with the consultant urologists at any time about the stock-take.

Regional Programme director for urological trainees; Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Beth Malloy, David McCormick
Points discussed:

1. Training arrangements for juniors
2. Expansion of training posts and training accredited hospital locations
3. Opportunities for juniors to present research and audit studies

Regional Urology Audit lead: Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Beth Malloy, David McCormick
Points discussed:

1. Local and regional audit meetings
2. Opportunities for local and regional presentations of audited best practice
3. Development of care pathways and referral and treatment guidelines

Regional Urology Cancer Lead; Aiden O'Brien
Date: Thursday 3rd April
Present: Aiden O'Brien, Mark Fordham, Lisa McWilliams [NICaN Manager], Beth Malloy, David McCormick
Points discussed:

1. Annual meeting to review audited numbers and results, complications and outcomes from the regional urological cancer services teams to include reports from the regional radiotherapy, medical oncology and surgical urology cancer centre teams. This annual meeting has not yet happened.
2. Plans and preparations for the Urological Cancer Peer Review planned for July 2015
3. Recent changes in the urologist cancer lead.

4. Opportunities for sharing best practice
5. Developments in the roles of specialist urology nurse practitioners for diagnosis, treatment and follow up of urology cancer patients.
6. Preparation for the June NICaN meeting

Regional RCS representative for Professional affairs; Terry Irwin
Date: Friday 14th March
Present: Terry Irwin, Mark Fordham, Beth Malloy
Points discussed:

1. Emergency surgery services including urology
2. Consultant responsibilities between hospital and regional based services
3. Appraisal and Revalidation

PHA Regional lead nurse consultant: Siobhan McIntyre
Date: 2 April 2014
Present: Siobhan McIntyre [by video link], Mark Fordham, Beth Malloy
Points discussed:

1. Opportunities for training of specialist urology nurses
2. Specialist nursing skills recognition between hospital trusts
3. Numbers currently of specialist urology nurses
4. Numbers of Macmillan trained urology specialist nurses
5. Recognition of urology nursing associations [British and Irish]
6. Links with University training courses
7. Value of developing links with past president of BAUN [Jerome Marley] who works at University of Ulster and Craigavon Hospital Trust.
8. Appropriate use of specialist nurse workforce including robust job plans and recording of activities
9. The data below was kindly collected by questionnaire circulated by Siobhan McIntyre to the Trusts. The 0 to 4+ grading is approximate to give an indication of activity.

Clinical Nurse Urology Specialist data	Number of CNS in urology	Access to training and development [0 to 4+]	Community continence nurses	Community catheter care and change [0 to 4+]	Attendance at national and local meetings [0 to 4+]
Belfast Trust	2	++++	10	++++	++
Northern Trust	2	+++	4	++	++
SET	2	++++	4	+	+
Southern Trust	2	+	-	-	++
Western Trust	5	++++	7	++++	++++

3) Requests were made for data reflecting workload, waiting lists and waiting times, workforce numbers and workforce job planning, current methods and assumptions underpinning commissioning service level agreement contracts

3.1 The HSCB provided data on waiting lists and waiting times
3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.
3.3 Discussions took place with HSCB to understand the methods underpinning the way Service and Budget Agreements (SBA) are devised and commissioned.

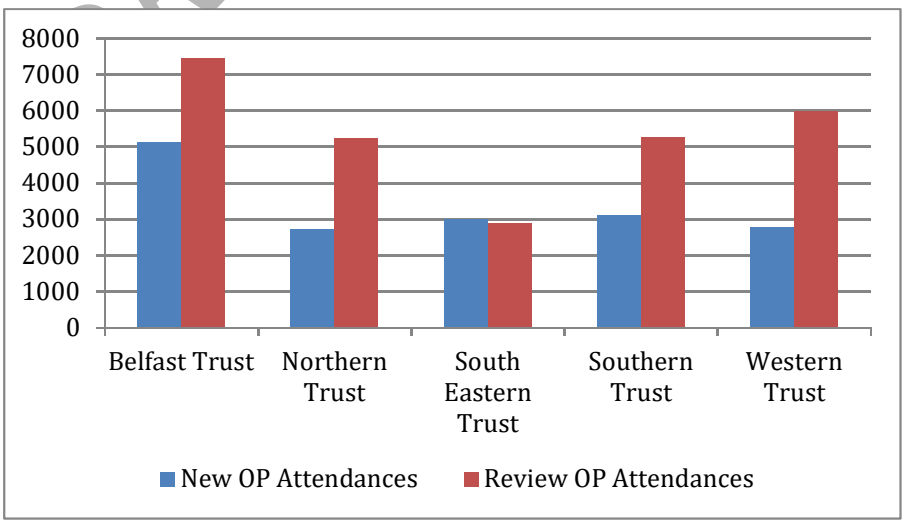
3.1 The HSCB provided data on waiting lists and waiting times

Reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The 2012/13 New : Review outpatient ratio is 1.6 (16,711:26,806) with DNA rates for first and review visits at 7.5% and 8.8% comparing favourably with the Dr Foster urology data for England. However this does not take into account for some units the very large numbers of patients waiting for out-patient appointments in particular review appointments.

The overall outpatient work for 2012/13 for the 5 Urology Directorates is shown in the table and histogram

2012/13	New OP Attendances	Review OP Attendances
Belfast Trust	5131	7447
Northern Trust	2717	5233
SET	2998	2870
Southern Trust	3095	5271
Western Trust	2770	5985

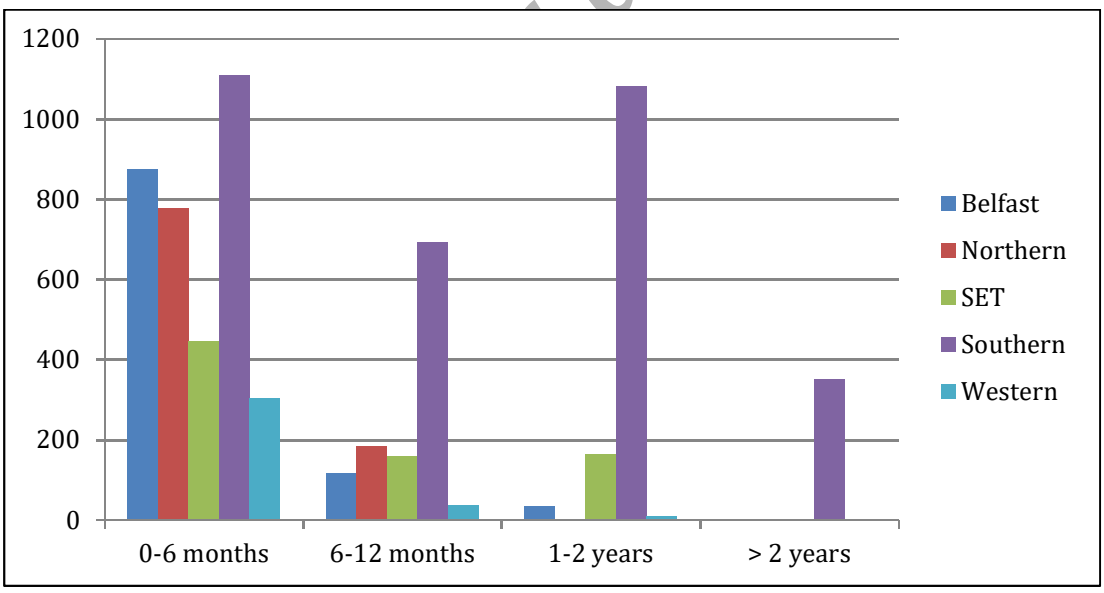


The waiting list and waiting times for patients booked for a review out-patient appointment are shown in the table and histogram below;-

Numbers of patients awaiting review out-patient appointments [time elapsed since the appointment was due is shown in the table below i.e. 'a backlog']. However it is also worth noting that in addition to these there are a number of patients currently still within their clinically indicated review appointment waiting time but yet to be seen are: BHSCT 3170; NHSCT 800; SET 1025; SHSCT 1300; WHSCT 1270. This represents a significant workload which may result in additions to the patients who breech their review clinic waiting time.

	0-6 months	6-12 months	1 – 2 years	> 2 years	Total
B HSCT	874	118	35	0	1027
NHSCT (Causeway)	778	185	0	0	981
SEHSCT	446	159	164	0	769
SHSCT	1109	692	1083	351	3235
WHSCT	304	39	11	0	354
Total	3529	1193	1293	351	6366

The same data is presented in a histogram



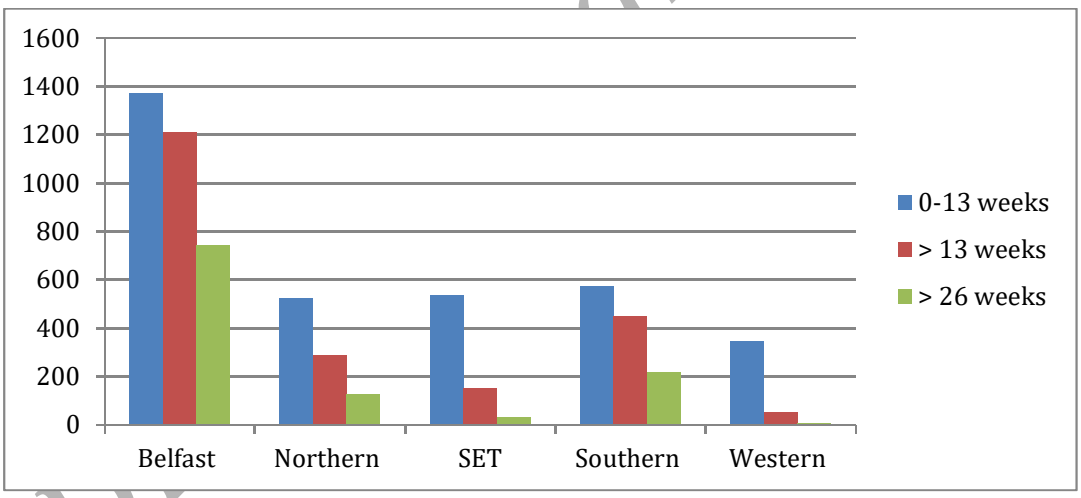
Despite the rising referral rate the in-patient operative activity shows overall stability with day case activity increasing gradually year on year and in-patient operative work largely stable.

In-patient bed usage appears satisfactory with average regional lengths of stay (LoS) at 2.71 days for elective and 5.24 days for non-elective cases, with little variation between the trusts.

Using data from the Theatre Management System [TMS] theatre utilisation shows almost no overruns throughout the region but each Trust has some theatre usage below 80%. This may in part result from the regional average operative cancellation rate of about 12% with a range from 7% to 25%. It should also be noted this utilisation is measured against available Trust reported capacity and not necessarily the capacity funded by the commissioner. This point was raised by several consultants who highlighted that theatre operating time was a key limiting factor.

The in-patient and day case waiting lists numbers (at 3/2/2014) are presented in this table and histogram below, these may increase when all the out-patient appointments have been completed:-

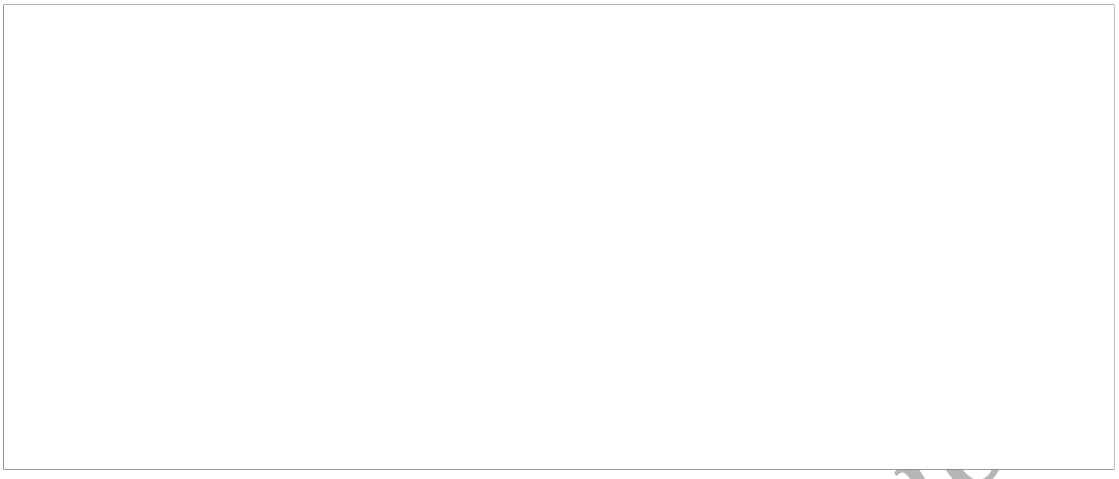
	0-13 weeks	**>13 weeks**	**> 26 weeks**
Belfast Trust	1368	1206	741
Northern Trust	521	267	126
SET	534	148	30
Southern Trust	573	449	217
Western Trust	345	52	4



The waiting list for operative procedures is shown in the table with the total number given together with 6 specific procedures with higher numbers of patients awaiting treatment.

	BCH	Northern	SET	Southern	Western
Total	2576	808	682	1022	398
Cystoscopy	1047	364	105	342	204
Ureteroscopy	0	0	0	58	0
TURP	155	150	24	83	27
ESWL	123	0	0	129	0
Circumcision	165	34	40	64	0
Vasectomy	381	22	7	56	27

The same data as above is presented in a histogram



3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.

The table below reflects the workforce (both staff in post and vacancies) in each Hospital Trust as accurately as can be assessed from the information provided.

Hospital	Consultants	Staff grades	Specialist urology nurses
BCH	9	2	2
Northern	3	2	2
SET	3	0	2
Southern	5	4 (inc 1 GPSI)	2
Western	3	1	5

Only a few complete job plans were submitted together with some tables representing the global clinical commitment of the urology teams within a hospital. From the information received it was possible to see that more imaginative ways of using the contracted time might be worth considering.

3.3 Discussions took place with HSCB to understand the methods underpinning the way SBA are devised and commissioned.

As part of the task of understanding the balance between the capacity of the urology service and the demand from both primary care referrals and emergency patient work Mark Fordham, Beth Malloy and David McCormick spent time establishing and examining the assumptions underpinning the calculation of the specific numbers of consultations, diagnostic procedures and therapeutic operations that are the basis of the commissioned service level agreements between the HSCB and the individual Trusts.

Three observations were made:-

1) The use of the BAUS workload numbers, particularly for outpatient work, do not fully reflect modern ways of providing patient centred services [one stop services including diagnostic tests] . Local estimates are needed based on patient referral types and modernised patient centred services and commissioned in a way which incentivises innovation.

2) This traditional method of commissioning clinical work has an inherent unintended consequence. By defining the work expected of the workforce [based on the BAUS recommendations], no cognisance is taken by the Trusts of the demand placed upon the system. Consequently any mismatch between capacity and demand will result in an excess workload that has not been costed or commissioned leading to a backlog of patients requiring treatment that will require additional extra-contractual arrangements and expenditure to always be funded by the Board.

3) Because the responsibility for dealing with demand over the service level agreement lies with the commissioners ie the HSCB, the clinical directorate and the Hospital management team are absolved from the responsibility of looking for imaginative and innovative ways of delivering the clinical service. It would seem this stifles any new or modern ways of delivering a better and more cost efficient service.

4) To review data germane to this work that is in the public domain relating to urological activity: care pathways; guidelines; contributions made by the urological staff; published audits and research; publications by public bodies and political committees

The impressive work that is undertaken by the urological consultants of Northern Ireland is easily available on the Internet on various sites where their work features. There are numerous publications, both academic and popular together with minutes of meetings and documents dealing with ways of improving services. In addition there are many documents published by the various health related public bodies and political committees that provide information regarding the best ways of delivering health care for patients, and in particular urological patients.

Research, audit, guidelines and care-pathways:-
A small sample of the contributions of the urological consultants include:-
Brian Duggan chaired the Northern Ireland urology clinical guidelines panel which produced draft guidelines for a range of urological conditions [lower urinary tract symptoms; haematuria; scrotal masses; raised PSA; renal colic; acute kidney obstruction; acute urinary retention] which have been accepted by the regions urologists. He has published papers on urethroplasty.
Paul Downey was part of the BAUS team that produced the nationally accepted guidelines for the management of patients with suspected kidney stones. He oversaw the safe introduction of laparoscopic renal surgery in UK urological practice through a national audit. He has published papers on flexible cystoscopy and reduced length of stay for TURP patients.
Aidan O'Brien is part of a national research project investigating a new drug for the treatment of angiomyolipoma disease.
Patrick Keane has been instrumental in developing the role of the specialist urology nurse, chairing the various regional urology cancer committees and co-authored the NHS guidelines on PSA testing; he has had a major role in aspects of training, education and examining trainees.
Siobhan Woolsey has published on stone disease, urodynamics, reconstructive and functional urology
Colin Mulholland has been responsible for developing a PSA tracker and its economic benefits.
Chris Hagan was part of the team that conducted a comparative audit on the care of prostate cancer patients in Northern Ireland in 1996, 2001 and 2006 and an audit on the prostate red flag referrals.

Cancer agenda:
The minutes of NICaN show what progress has been achieved under the various chairmen and members of the committee, in particular the work to make the 2009 Review become effective. More recently plans have been developed to make the MDTs effective, introduce patient representation and develop the regional annual plan.

Transforming Your Care:
This is a major review of Health and Social care in Northern Ireland produced at the Assembly's request incorporating comments from a large number of participating groups from the general public as well as professionals within the Health Service.
It covers topics that are relevant to urology such as:-
The ageing population [between 2009 and 2020 there will be a 40% increase in people> 75 years old] – no specific point are made about catheter care, but this will certainly impinge on urology services.
Long term conditions; this will include chronic conditions such as prostate and bladder cancer; incontinence; stone disease.
Patients with physical disabilities; the area of caring for adults who have required surgery as children eg spina bifida patients who may need treatment for stone disease, continence problems and renal impairment.
Acute care: the report makes the point that these are the sickest patients and they need the best informed clinical care.
Technology: the document endorses the best use of modern technology to offer both the best treatment for patients and in many cases the most cost efficient.

The Assembly's Committee for Health, Social Services and Public safety
This committee, chaired by Maeve McLaughlin [Sinn Fein]and vice chairman Jim Wells [DUP], has recently been hearing evidence from experts about the ways of improving patient care by managing waiting lists and waiting times. The video recordings and the Hansard records of the presentation and the discussion are all available on the Committee website:-
http://www.niassembly.gov.uk/Assembly-Business/Committees/Health-Social-Services-and-Public-Safety/Minutes-of-Evidence/

The evidence presented is of the highest quality and is worth looking at. There is much debate about recording Referral to Treatment Time [RTT].

Comments on the stock-takes findings related to the Terms of Reference

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

In summary the Review of Urology Services published in March 2009 looked at 2 main areas of concern:-

1. Specialisation within urology
2. Delivering timely urological care

1) Specialisation within urology;
In particular moving urological procedures from general surgery into urological practice and moving urological cancer services into line with the 2000 NHS cancer plan such that defined cancer operations as described by the Improving Outcomes Guidance [IoG] were performed in sufficient numbers in a cancer centre and for all defined cancer cases to be discussed at a regional MDT.

2) Delivering timely patient-centred urological care:
This was to cover new and review outpatient services, operative procedures and on call arrangements for the care of urological emergencies.

The review described 3 main proposals aimed to achieve these objectives:-

1) Referral patient pathways and care protocols to be agreed amongst the urological consultants so patients with urological symptoms would be seen by the right specialist first time and would have an agreed best care plan wherever they were seen in Northern Ireland.

2) To fund an increase in the urological consultant numbers [to 23 wte] and specialist urology nursing workforce [at least 5 cancer nurses] to allow the best redesign of diagnostic [one stop] and review clinics and day-case and in-patient operative capacity in line with the BAUS capacity recommendations to minimise delays in patient care supported by any necessary changes to the job plans of the clinical workforce

3) A regional urological clinical service model of 3 teams [NW; E and S] created by the amalgamation of the current urology directorates within the existing 5 acute hospital trusts, each team with responsibility for acute on call services and clinical support services for the hospitals within their defined area and where necessary support from management to negotiate new contractual and job plan arrangements.

Progress seen from the stock-take:-

1) Specialisation within urology:-

1. BCH has become the defined urology Cancer Centre and this has led to a net importing of complex work without any concomitant reduction in the core urology service.
2. The other urology cancer units no longer undertake the IOG defined cancer operations.
3. A weekly regional MDT takes place with video linkage from the cancer units to the cancer centre. The exact composition of this MDT is not yet clear and those attending should be reviewed.
4. An annual meeting to review audited data including numbers, complications and outcomes to be presented by the Cancer Centre team including the Radiotherapists, Medical Oncologists and Urological Surgeons to all users of the urology cancer service has not yet taken place.
5. A peer review is due in July 2015. This will need careful preparation.
6. As a consequence of specialisation for cancer surgery other urology units have begun to specialise in stone services
7. Female urology and andrology are poorly developed at present.

8. Some urological procedures [e.g. vasectomy] are still performed by general surgeons. If this ceases it will impact on the urology waiting lists and waiting times.

2 Delivering timely patient-centred urological care;

1. Investigation and treatment pathways have been developed but no regional audit has assessed how well they are used and whether they offer best practice
2. The total number of consultants has increased but recruitment has been difficult
3. There are significant waiting lists in the region with some very long waiting times for both out-patient and in-patient services.
4. Emergency care for urological patients is variable with some areas with a service that is not optimal.
5. The use of specialist urology nurses is variable, but where they are established they contribute a significant addition to the clinical workforce making an important contribution to timely and patient-centred care.
6. There are some areas of urological practice that cannot be provided within the current skill or technology base
7. The number and distribution of urological teams favours some areas over others to the detriment of patient care.

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

The amalgamation of the Belfast and Ulster Hospital urology teams for on-call services has been thoroughly assessed. It is clear that the area to be covered, the lack of continuity of care of acutely ill patients and each teams unfamiliarity with the other departments facilities may lead to the clinical care not being optimal. It would seem appropriate to accept that this model has not been ideal and for each Trust in Team East to consider managing their own on-call arrangements.

The amalgamation of the Northern and Western Trust urology teams has been looked at in detail, with external high quality urological assessment of the Team's proposal.

At present the two teams have not combined their on-call rotas and the proposed plans to make the amalgamation possible require significant investment. The two Trusts have reported their continued commitment to the concept of North West Team Urology, although there was little quantifiable evidence to support how the team functioned for acute on-call and sharing waiting lists on an on-going basis.

The Southern Trust urology team in Craigavon Hospital has several peripheral hospitals to serve but the plan did not involve them in amalgamating with another urology team.

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

It is helpful to recognise that the urology consultants have a dual role within their professional responsibilities. Clearly they are responsible for delivering their clinical commitments according to their job plan for their Trust, but in addition they have a responsibility to deliver a regionally coordinated service whereby they are able to share best practice through clinical audits, to review cancer services collectively and support patient-centred care-pathways, and to support the training of the specialist registrars.

Leadership is needed both locally in individual urology directorates to establish suitable job plans to make best use of the trust facilities as well as to encourage innovation and adopt best practice but also regionally to support those with regional responsibilities involving teaching, training, audit, research and cancer services.

The annual appraisal and the subsequent GMC revalidation require evidence that the consultant has contributed to these aspects of the service and have combined reflective practice as well as participation with the audits and meetings.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

Without all the consultants complete job plans it is not possible to give an accurate assessment on any limitations to operating theatre access. However at each of the hospital visits the consultants said that they were limited in their access to theatre and needed more sessions to deliver the surgical work that was required.

Most urology teams seemed to feel that they had a satisfactory supply of theatre kit.

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

The evidence nationally and from speaking to the urologists in Northern Ireland is that suitable candidates for staff grade jobs are now virtually no longer available. This is the result of fewer subcontinent trainees coming to the UK as a result of EU rules and the changes in training for UK registrars.
For this reason, it would make sense to vire any current funding for unfilled staff grade posts and convert them into consultant posts. This would be in line with the NHS ambition for a consultant orientated service.

There has been a long standing difficulty in finding suitable candidates to appoint to vacant urology consultant posts in Northern Ireland. The training opportunities for urology HSTs are considerable and a short term increase in HST places in NI would act to increase the number of locally trained urologists who may be more likely to consider a consultant post in the Province. This is an area the regional BAUS representative and the Urology Programme Director may consider approaching the Urology Specialist Advisory Committee directly.

The current method of commissioning a service level agreement requires specific numbers of outpatient visits, diagnostic procedures and therapeutic operations. With changes in clinical practice aimed to deliver patient-centred care, the one-stop clinic visits, and the increasingly complex operations being performed. It will be necessary to consider a more sophisticated method of specifying and monitoring what work should be delivered for what budgetary agreement.

Alternatively, the commissioning contract [using historical levels of resources and funding as a guide] could aim to provide funding for a Trust management team so they are responsible for delivering the clinical service within the totality of budget. The measure of success and productivity being determined by achievement of waiting list targets as opposed to delivering of units of activity. In this way each team would be encouraged to develop innovative ways of delivering high quality cost effective clinical care. This has been demonstrated in England where outcome/target based budget contracts allowed hospital chief executives to vire funds towards the areas that are most needed. It was this environment that produced some of the most worthwhile patient-centred service developments during the Action on Urology project.

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full ranges of urology procedures

One area of urology that benefits from state of the art theatre technology is stone surgery. As each acute centre will have to deal with its own share of acute stone patients having the appropriate kit would ensure high quality clinical care for patients wherever they presented in Northern Ireland. Such kit would include both rigid and flexible uretero-renoscopes and suitable laser technology to break up impacted stones. The specialist technique of percutaneous nephrolithotomy is generally best performed where there is interventional radiology support.

Two other areas that are worth considering:-

Flexible cystoscopies – using video style flexible cystoscopes has the advantage that teaching trainees is much easier, it is possible to make recordings of the examination if needed and there is less strain on the surgeon's neck. This technology would be an appropriate addition to the outpatient diagnostic services.

Robotic surgery – Robot assisted laparoscopic radical prostatectomy [RALP] is becoming the standard of care for surgically curable prostate cancer patients. Conventional laparoscopic surgery is recognised as a challenging procedure to perform and has a long learning curve.

It was little used in USA but with the introduction of RALP this is now standard practice. In the UK we have been slower to develop the use of robotic surgery, but it is clear that each region in the UK will be expected to deliver on this type of surgery.

Most regions have seen an increase in cases of surgically curable prostate cancer due both to PSA testing and following the regular review of all cases at the regional MDT.

In addition to prostatectomy, most robotic centres are using the robot for laparoscopic nephron sparing surgery, and are developing on the Scandinavian and USA experience of robot assisted cystectomy.

Northern Ireland should assess the need for access for its population to robot assisted laparoscopic radical prostatectomy. Recent studies and guidance provides greater clarity on the position in regard to the benefits and cost effectiveness of robotic assisted prostatectomy. The potential for this to be provided locally should be considered. The benefits of such a local service would demonstrate how forward looking the region is and could well result in increasing the quality and number of applicants for consultant posts.

Some urological conditions and procedures are rare or seldom performed. In a region of 1.8 million it is likely that some procedures will not be suitable for the regions skill set. This may include some reconstructive procedures, and some prosthetic devices. Arrangements for such patients to be treated elsewhere would seem appropriate.

G) Review the service delivery to those acute hospitals sites which do not have an on-site urology team

The initial review recommended that arrangements should be in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology units. The only major acute hospital trusts which have no urological team based on site is Antrim Hospital Trust and SWAH.

The discussion with the general surgeons and the gynaecologists at Antrim clearly showed their need to have urological services based there. Currently the patient care may not be optimal despite acute support from the Causeway urology team and visits from the Belfast urology team.

It would make sense to consider the enhancement of the urology services based at Antrim Hospital. The work would inevitably be mainly acute urology and core urology and initially the operative facilities may be based only at Whiteabbey

Hospital, although in time it is likely sessions would become available at the Antrim site, when the mobile Theatres are provided on the site or earlier if possible [much as was the case when the general surgeon Arthur McMurry was there].

The advantage of such a development is that some of the core urology cases that currently go to BCH would be redirected to Antrim taking some of the pressure off the regions urology Cancer Centre.

In the current stocktake South West Acute Hospital was not visited.

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `NICE guidance CG175' [Prostate cancer management].

As stated earlier, reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The audit headed up by Chris Hagan has shown that red flag referrals do not represent all the suspected cancer cases as demonstrated by reviewing the eventual outcome of the investigations. A more helpful statistic is that about 50% of men who undergo prostate biopsy are found to have a prostate cancer.

The evidence from England [and the USA and Europe] is that the numbers of patients having a localised prostate cancer identified are increasing significantly. This is reflected in the numbers of patients undergoing radical surgery.

The NICE guidance CG175 is a wide ranging series of recommendations for all aspects of referral, investigation and treatment of all stages and complications of prostate cancer. This document offers an excellent blueprint against which the regional cancer audit can compare itself and be able to present at their Peer review in 2015.

Some specific areas that the Cancer group may wish to look at would include information and decision support for men with prostate cancer, their partners and their carers; the management of post radical prostatectomy sexual dysfunction and the investigation and management of hormone therapy induced osteoporosis.

Comments and Conclusions

Many of these points have been made earlier in this narrative.

This section aims to summarise some of these points and add some comments that might be helpful in devising better ways of delivering excellent cost-efficient patient-centred services and to provide opportunities for regional planning.

In discussions at the hospitals with the consultant urologists and the management it was clear that all groups are keen to deliver an excellent clinical service. Most groups describe common types of difficulties including

- insufficient theatre capacity,
- the challenges of shared responsibility for clinical care especially those patients admitted as an emergency;
- increasing referrals from primary care,
- significant difficulties in recruiting suitable candidates to consultant posts

In discussions with those clinicians with regional responsibilities it is clear there is an untapped real opportunity to use the annual regional audit meetings, the annual regional cancer review meeting, and the regional representative report meetings to create regional cohesion amongst the urology teams. Each of these meetings would offer an opportunity to share best practice amongst the teams, provide an occasion for the trainees to present their research or audit projects [possibly with a prize for the best one], and to review the data from the BAUS complex operations audit. It is common practice in many other regions to combine the regional representative meetings with an evening meal giving the chance for consultants and trainees to meet socially.

To generate ideas for suitable patient-centred audit the technique of process mapping a service can be helpful and the work done during the Action on Urology project in England might offer some guidance.[see this pdf with a summary of some of the projects:-]
http://www.qualitasconsortium.com/index.cfm/publications/service-transformation/action-on-guides/action-on-urology-good-practice-guide/

There seem to be significant challenges in delivering the three team arrangement that the 2009 Review recommended. From a clinical governance perspective the Eastern Team has encountered problems and the NW Team development seems to be dependant on a significant financial input that has not yet been agreed. It seems that this three team recommendation should be reconsidered. This would impact on any new on-call arrangements, but would return them to the pre-review on-call arrangements.

It is not possible to form a complete picture of the current arrangements of the consultants job plans as so many were deemed confidential and were not released to the team undertaking the stocktake . Access to job plan information should be a prerequisite if future funding is to be approved. However there are ways of improving service delivery by suitable adjustment of job plans that can

also deliver an improved working practice for the consultant. It is for the Hospital Trusts and the HSCB to review this possibility.

There is a strong recommendation in Transforming Your Care for the best use of technology to improve patient care. Ensuring each urology unit can offer best practice acute renal stone services seems essential.
Video flexible cystoscopes have advantages over the eye-to-lens variety. These instruments would help train specialist nurses who wish to develop these skills as well as junior urologists.

It would seem ideal that the regions specialist urology nurses are encouraged to meet to discuss clinical topics perhaps supported by the consultant urologists. Their membership of either BAUN or IAUN and attendance at the national meetings would seem desirable [contacting a past president of BAUN, Jerome Marley who works at Craigavon and the University of Ulster, might help develop this]. Ensuring that community based nurses can provide both continence catheter care including catheter changes can reduce the numbers of A&E attendances.

There is a detailed commentary within the narrative regarding robotic assisted prostatectomy. It is likely that the colo-rectal surgeons and the gynaecologists would also need to be trained on this equipment if the purchase of the robot was to be a viable option.

A regular observation from both the urological surgeons and the hospital managers was that they did not have sufficient theatre capacity for the use of the surgeons. This is clearly part of a much bigger audit as so many different surgical specialities are dependent on access to theatres with appropriate anaesthetic and theatre staff support.

Although recruitment of suitable candidates for the consultant urology posts has been challenging, a worthwhile addition to the skill set for the regions urologists would be the appointment of an academic urologist. Such an appointee would have the opportunity to initiate audit and research with the trainees and to contribute to the regional leadership. Initially this may have to be a senior lecturer but in due time a chair of urology would add enormously to the development of the urology services in Northern Ireland.

As a long term strategy, aiming to increase the numbers of Higher Surgical Trainees within the Northern Ireland training circuit could bring benefits for locally trained urologists keen to apply for consultant post in Northern Ireland.

A SWOT analysis of the stock-take and ideas for a strategic way forward for urology services in Northern Ireland.

1. **A SWOT analysis**

One strength of a stock-take such as this is that it allows a small team to visit the whole of the regions urology providers and ask about their perceived challenges and what their aims are for delivering an improved and modern urology service. Individual trusts can present their plans allowing the team to draw conclusions about how well the service is integrated regionally and where the different Trusts could share best practice.

Another strength is that the team can critically assess the current commissioning methods that generate the SBA in an attempt to see what role this plays in dealing with waiting times and waiting lists. This includes reviewing the various numerical data and to review the workforce and how it is distributed.

One weakness of this stock-take is that it looks at the urology services over only a short period of time. However we have tried to ensure the narrative is reviewed by all the Trusts to correct any factual errors before it is finally circulated, and the hope is a longer term audit for the Region to assess different Trusts performance will be seen as helpful.

Very few organisations as complex as a Health Care System are perfect requiring no improvements. This stock-take has tried to identify opportunities to improve urology services aimed at a patient-centred guideline unified service. Various ideas have been presented in the text and are summarised in the second half of this section dealing with ideas for a strategic way forward.

Any stock-take or visit to assess a teams work patterns and productivity will represent a potential threat and challenge to the autonomy of the group. However, this stock-take has looked both at the clinical services and at the commissioning methods as well as how Trust management and clinical leadership are working to deliver a patient centred urology service. This has been done to give an overall regional picture and under pins the ideas in the next section.

2. **Ideas for a strategic way forward for urology services in Northern Ireland**

Below are three points of view based on how the challenges of delivering a clinical service are perceived:-

From a patients' perspective the long waiting times for new and review outpatient visits, the waiting times for diagnostic and operative procedures and the current imbalance in regional acute urology services would seem to be a major concern. A longer term patient anxiety would be to have easy access to the local clinical outcomes of treatments and procedures and know they are

satisfactory and that the inevitable occasional complications or adverse outcomes are at least within an acceptable range.

To achieve this level of service needs a constant reassessment of how audited processes are performing, to regularly introduce better diagnostic processes and better clinical methods that can be studied for their efficacy, and to maintain a regularly updated clinical outcome and complications data base that can be presented collectively to a regional meeting.

From a public health perspective, commissioning clinical services needs to be based on a clear understanding of the needs of the patient population, the assessment of the different types of work that are being funded while giving the providers freedom to develop value for money methods of delivering the clinical service without diminishing the service below an acceptable level.

From a providers' point of view the clinicians should have the kit and the access to operating and outpatient time that is needed to efficiently deliver the work during their contracted time. The trust management have the challenge of balancing the hospital's resources by wise deployment and appropriate use of their workforce.

What has this stock-take identified and what ideas might be worth examining to improve the clinical service for patients?

1) The current commissioning method for creating the SBA has within it two consequences that may have influenced the build up of waiting lists and long waiting times. Firstly by defining specific numbers of out patient clinic consultations and specific numbers of operative procedures but without recognising the wide variability of both types of clinical work the current method is guilty of a one-size-fits-all method and gives no allowance for innovative ways of managing patient care.

    a. For example the one stop service where a patient with haematuria will have an initial consultation, an ultrasound scan, a flexible cystoscopy and then a 'follow up' consultation where all the results are discussed and a management plan decided all at the same visit represents much more than a single outpatient attendance.

    b. Similarly a cystoscopy and biopsy under general anaesthetic to exclude a bladder lesion does not compare to a 30 gram bladder tumour resection or a 100 gram prostate resection.

The second inherent consequence is shown by the perceived imbalance between the clinical work commissioned and the actual numbers of patients referred to be investigated and treated. The responsibility to deal with the excess clinical work devolves straight back to the commissioners whose solution is to attempt to commission more clinical work from a urology service which already states itself to be a fully employed workforce and maximally utilising hospital facilities. This seems to also have the potential unintended consequence of removing the

responsibility for the Trust team to look for imaginative cost effective new ways to deliver the service such as those that were developed in the Action on Urology project [see website given earlier]. Many of the smarter ways of working involved better use of specialist urology nurses including stable hormone controlled prostate cancer patient clinics, telephone follow up clinics and pre-investigation consenting clinics for example.

How might this apparent anomaly be address? One method is to provide a historically calculated budget but with the expectation that the Trust will use it imaginatively to achieve the best value for money for the total referral cohort– a sort of 'consume your own smoke' model. This is different from the current commissioning arrangement whereby delivery of SBA units of activity are used as the key measure of productivity.

2) To best engage the whole clinical team in looking proactively for better ways of delivering a clinical service the process mapping technique ['patient journey'] proved very effective during the Action on Urology project. This would only be possible regionally if a project manger was funded to support the different teams in their work. For example:-
    - Different ways of addressing the challenges of processing new referral patients, dealing with review of patients' results, appropriate review clinic protocols and better ways of maximising theatre usage would all be worthwhile areas to investigate.

3) As part of each consultant developing their appraisal portfolio in readiness for their annual appraisal and eventually their reaccreditation, involvement in regional audit meetings, regional cancer outcome meetings and involvement with education and training of BST and HST doctors as well as urology specialist nurses would all pay dividends. There is a responsibility for those clinicians with a regional role to organise worthwhile meetings and for the management to support the urologists attendance.

4) A necessary part of the annual appraisal is reassessing each consultants job plan. This works both for the management who ensure the contractual hours are used efficiently and for the consultant to ensure that the resources necessary for him or her to carry out the work are available. There are several ways of using this job planning review for the benefit of both parties.

5) The idea of negotiating an increase in HST places in NI has been mentioned as a way of training some home grown potential consultants to ensure efficient succession planning.

6) An acute hospital such as Antrim without any urological team based within the hospital is not consistent with the delivery of high quality acute urological care. Ideally Antrim should have its own self contained urology consultants. As there are 6 gynaecologists working there with an

interest in functional urology such an interest would be ideal for urologists appointed there.

7) Northern Ireland urology could look much more attractive to prospective consultant applicants if it shows itself to be innovative and using the most modern technology. This would be one reason to consider supporting the local provision of RALP. Clearly the robot could be used for radical prostatectomy but also the general surgeons and the gynaecologists are increasingly developing its use. However recent studies may suggest that robotic prostatectomy might be a cost-effective alternative to open prostatectomy, if more than 150 cases were treated each year.

8) It is likely that NI urology will not be able to provide all aspects of urological procedures. To what extent reconstructive and prosthesis surgical procedures will need to be exported will depend on how closely the different teams are able to collaborate.

9) Any new consultant appointment could usefully reflect the regions urology skill needs as well as the Trusts needs. A reconstructive surgeon, an academic appointment or a robotically trained urologist would all add significantly to the regions skill base.

10) The recruitment of a regional urology improvement management, on a fixed term basis, could support Trusts develop innovative ways of delivering patient care. This would involve process mapping and identifying new ways of working to improve patient care and productivity within existing resources.

11) Finally, it seems paradoxical that a stock-take with a particular remit to look at operative procedures and waiting lists should find that hospital Trusts claim to have insufficient staffed operating theatre capacity to satisfy the needs of their surgical staff. Theatre usage will have peaks and troughs and some attempt is needed to average out demand to calculate what capacity is needed, however once the capital expenditure for an operating theatre has been paid the main expense is in staffing it. This could suggest that having over-capacity of theatre facilities would be at minimal cost when not in use, but allow immediate use of the facility when required.

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday, 14th August 2015 8am

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

	(h) SAI Summary spread sheet – paper for information and Tracey happy to answer any questions. **(i)** Automatic distribution of SAI screening notices and finished reports to clinical teams. – screening form to AMD who will send it to the consultant. The final report draft goes to clinical team for factual accuracy before it comes to AMD governance meeting.	
4.0	**Complaints Position** (paper enclosed)	All
5.0	**Incident Management Position** • Incident review position - paper enclosed for information	
6.0	**Regional NEWS Trigger Reset Guidance** – information to be sent out for discussion and response.	Anita ADs and AMDs
7.0	**Risk Registers** – additions, amendments and closures to Vivienne Kerr	ADs & AMDs
8.0	**Acute Medical Audit Committee** • AMDs to identify the top 10 priority audit areas for their Division update	AMDs
9.0	**Standards & Guidelines –** • Standards and Guidelines Accountability report update – ADs and AMDs to respond to Anne Quinn's email by the cop today. Tracey will resend email from Anne	ADs and AMDs
10.0	**Any Other Business**	
11.0	**Date of Next Meeting:** **Friday 11th September 2015 at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

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

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier: [redacted]

Responsible Lead Officer: Paul McGarry

Designation: **Consultant Emergency Department Craigavon**

Report Author: Review Team: Mr Sam Thompson, Consultant Paediatrician, Mr John Campbell, Consultant Anaesthetist, Mr Alan McKinney, Consultant Emergency Medicine (External), Mr Robert Gilliland, Consultant Surgeon (External), Mrs Sharon Holmes Emergency Department Sister Craigavon, Mrs Mary Burke, Head of Service Medicine and Unscheduled Care, Miss Paula Fearon Governance Co-ordinator,

Facilitator – Mr Paul Smyth, Lead Nurse Governance

Date report signed off:

Date submitted to HSCB:

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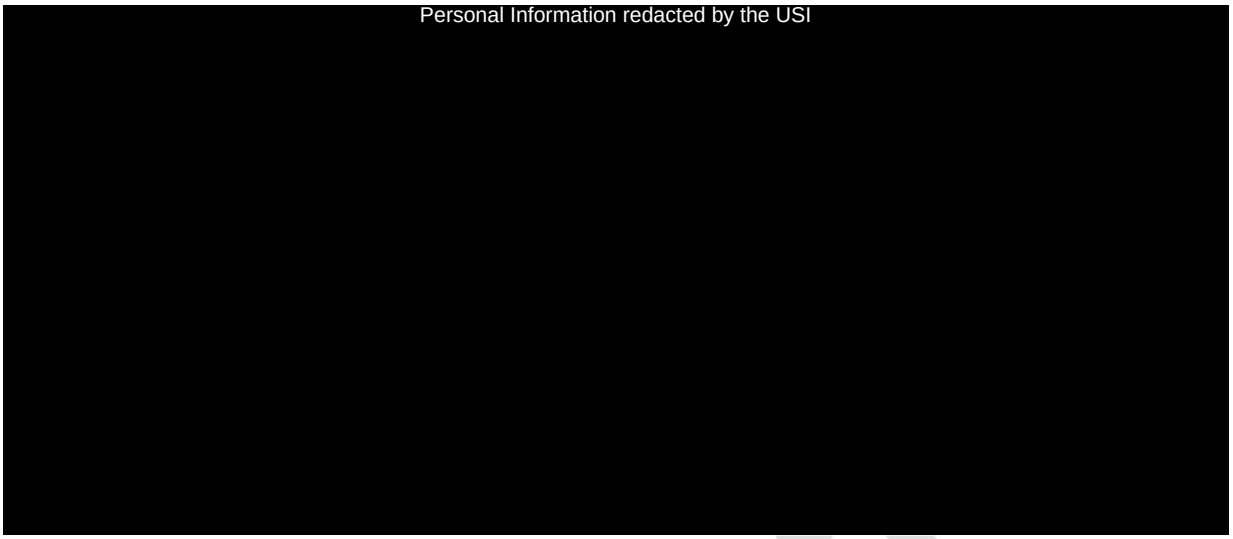
1.0 EXECUTIVE SUMMARY



This tragic case was recorded as a patient safety incident. An emergency screening meeting was commissioned by the interim Director of Acute Services, Southern Health and Social Care Trust (SHSCT). The tragic death was a catastrophic incident and as such a Level 2 – Root Cause Analysis (RCA) investigation was commissioned.

In the immediate aftermath of this incident the Trust carried out a risk assessment to estimate the realistic likelihood and consequence of recurrence. An interim protocol for assessing attendees that present to Personal Information redacted by the USI Emergency Department with abdominal pain was developed and put in place.

Communication is on-going with Personal Information redacted by the 's family who have provided the Trust with information from their perspective and questions they would like answered.

The review panel identified care and service delivery issues as well as contributory factors. Recommendations have been made and a copy of the final Level 2 – Root Cause Analysis (RCA) report will be shared with Personal Information redacted by the s parents, those involved in Personal Information redacted by the s treatment and care as well as the Coroner.

Action plans will be addressed through the operational Governance arrangements and assurance of the implementation of actions will be provided by the operational Assistant Directors and Associate Medical Directors to the Interim Director of Acute Services.

2.0 THE INVESTIGATION TEAM

Names	Titles
Paul McGarry (Chair)	Consultant Emergency Medicine
Sam Thompson	Consultant Paediatrics
John Campbell	Consultant Anaesthetics

2.0 THE INVESTIGATION TEAM	
Alan McKinney	External Consultant Emergency Medicine
Robert Gilliland	External Consultant Surgeon
Mary Burke	Head of Service Medicine & Unscheduled Care
Sharon Holmes	Sister Craigavon Emergency Department
Paula Fearon	Governance
Facilitator - Paul Smyth	Lead Nurse Governance

3.0 TERMS OF REFERENCE OF INVESTIGATION/REVIEW TEAM

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

- To carry out a review into the clinical care provided to Personal Information redacted by the from Personal Information redacted by the USI until his tragic death on the Personal Information redacted by the USI using the National Patient Safety Agency Root Cause Analysis methodology.
- To analyse the interactions with medical and nursing staff, ambulance staff and staff on the paediatric ward. Consider and conclude if each of these interactions were of the standard we expect for our patients
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on document evidence and staff accounts of events as well as input from Personal Information redacted by the 's family.
- To identify the key contributory factors which may have had an influence or contributed to Personal Information redacted by the treatment and care. Ascertain could and should anything have been done differently and consider whether this may have resulted in a different outcome for Personal Information redacted by the
- To ensure that recommendations are made in line with evidence based practice
- To set out the findings, recommendations, actions and lessons learnt in an anonymised report.
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT to the staff associated with this incident.
- To share the report with the family of Personal Information redacted by the

This investigation will adhere to the principles contained within the National Patient Safety Agency (NPSA) Policy documents on "Being Open – Communicating Patient Safety Incidents with Patients and their Carers". (Appendix 2)

http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

Roles and responsibilities

The Chair will lead the Review Team and will provide the final written report to the Director of Acute Services.

The review team will provide information to the Chair to ensure the review is complete and the review team will contribute to the development and review of the report for factual accuracy and thorough analysis.

4.0 INVESTIGATION METHODOLOGY

The Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Emergency department notes
- Inpatient notes Personal Information redacted by the USI
- Family correspondences
- Staff rotas, nursing and medical
- Information from attendances on computer Electronic Emergency Medicine System(eEMS)
- Information obtained from relevant medical, nursing and management staff
- Discussions with and responses from specific medical and nursing staff in relation to aspects of Personal Information redacted by the s care and assessment and treatment.
- Review of Relevant Reports, Procedures, Guidelines

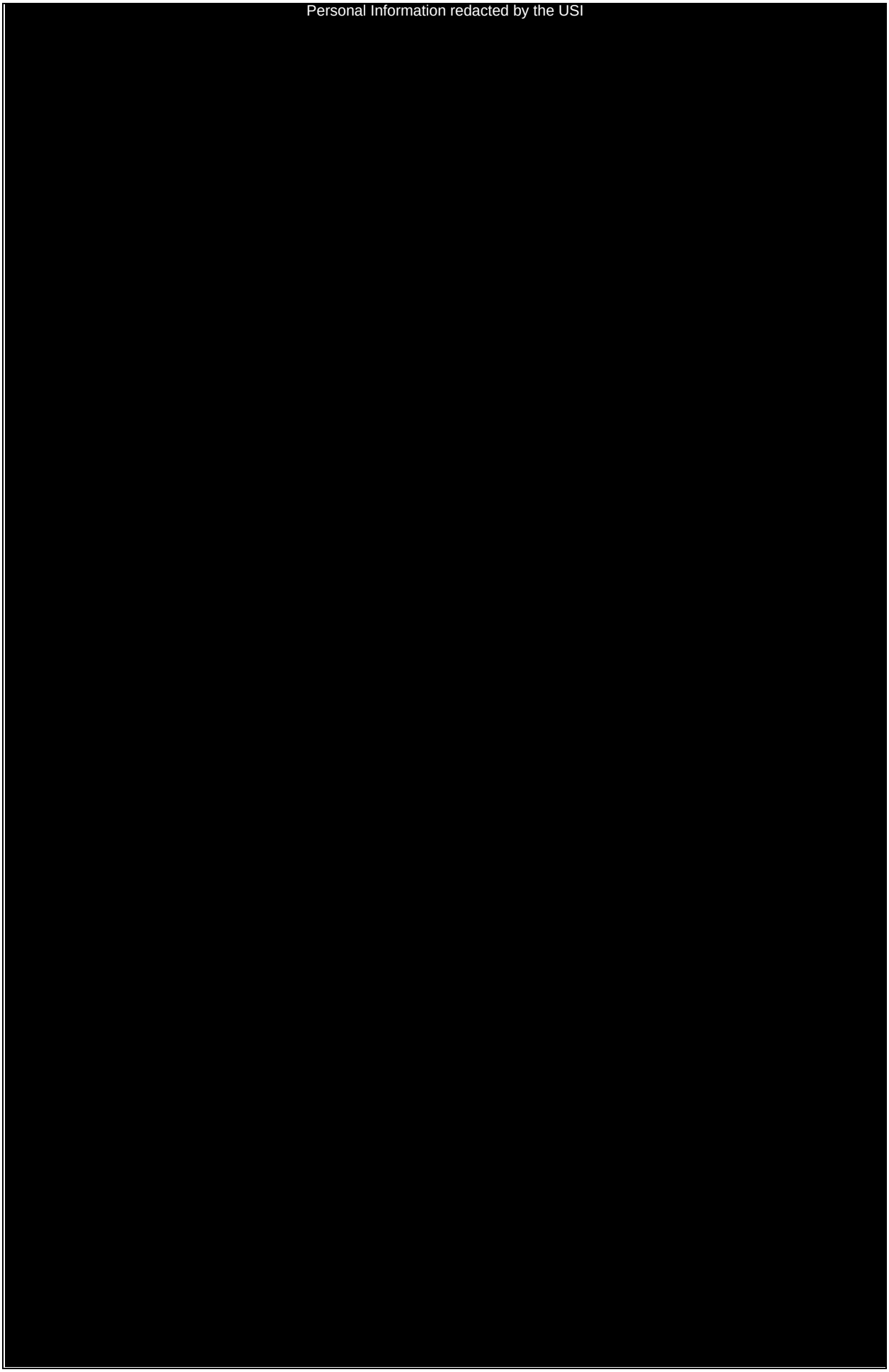
Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

Background

Personal Information redacted by the USI



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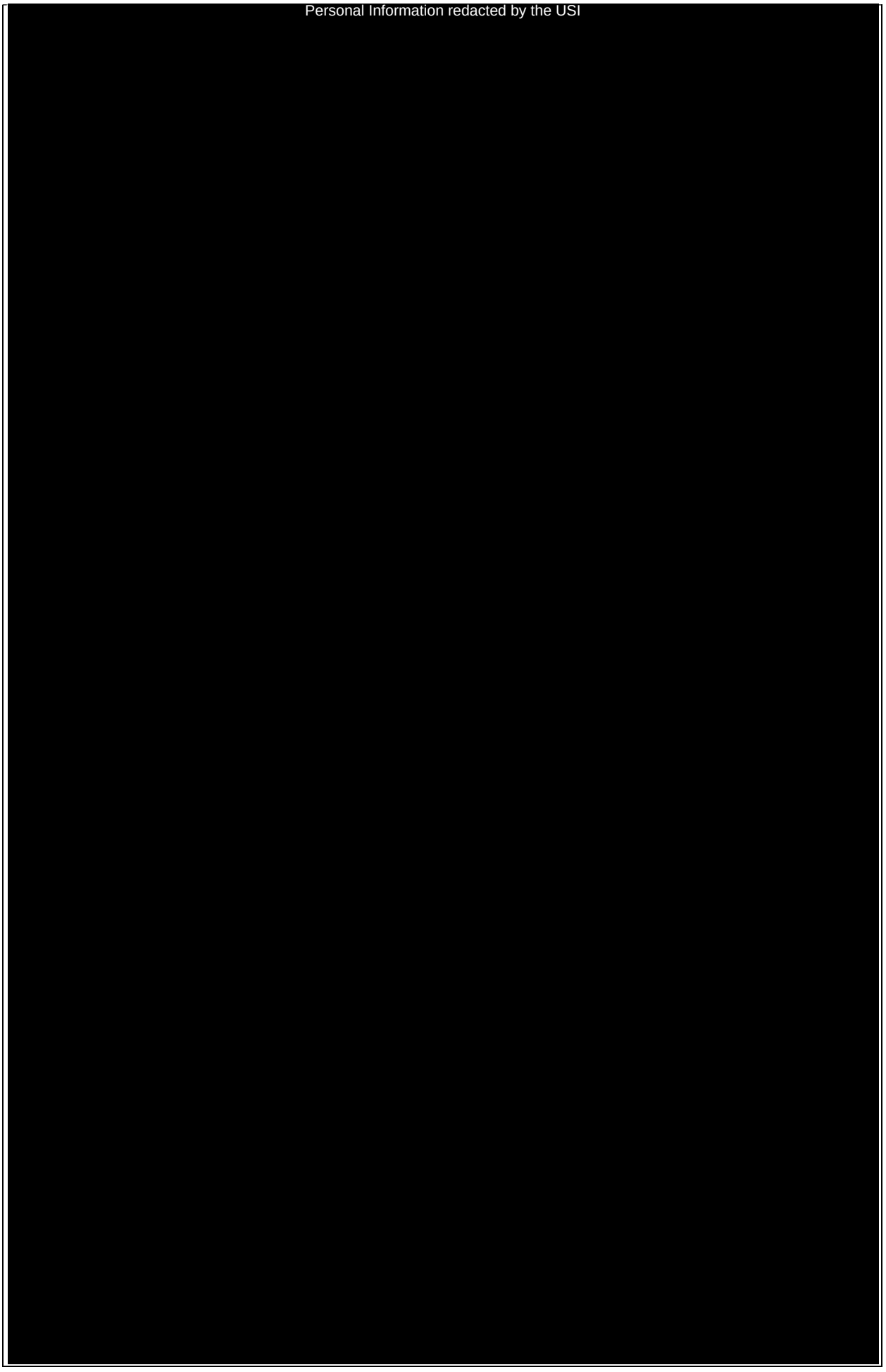


Personal Information redacted by the USI

6.0 ANALYSIS/FINDINGS

The review panel used a narrative chronology of Personal Information redacted by the care along with change analysis to detect if there was normal accepted procedure throughout Personal Information redacted by the attendances, and if there was a change from this that would indicate care delivery or service delivery issues. They also used a contributory factors checklist to identify any contributing factors.

Discharge plan post-surgery Personal Information redacted by the USI

A Review of inpatient notes Southern Trust and the NIECR did not show a planned follow up after surgery Personal Information redacted by the USI by either the Southern Trust or the RBHSC. The review panel were unable to access the RBHSC inpatient notes and relied on information on the NIECR. From his parents correspondence it appears Personal Information redacted by the was fairly active and did not suffer any obvious post- operative debility. The review panel agreed that a planned review some months post-operative Personal Information redacted by the USI would not have altered events subsequently.

Attendance to Personal Information redacted by the USI **ED** Personal Information redacted by the USI

The review panel feel Personal Information redacted by the details were logged promptly on this attendance by reception staff. Nursing triage assessment was performed 18 minutes after arrival. This was 3 minutes outside the recommended 15 minute standard for assessment from arrival. The panel did not consider this a significant delay.
The panel felt the triage priority of P 3 (urgent) assigned was appropriate using the Manchester Triage Methodology.
Nurse 1 did appropriately complete a pain score assessment and recorded a pain score of 7. When asked why she did not consider giving analgesia then, nurse 1 explained to the chair at interview she thought Personal Information redacted by the may have been given medication earlier that evening. The panel observed this was not recorded in her notes.
The clinical observations recorded in triage and later when called into the cubicle were within acceptable limits as per the PEWS chart and did not show deterioration. Personal Information redacted by the was not weighed during his first attendance, this would not be done routinely,

but it would be best practice to weigh children to help with drug dosage calculations if they are being prescribed. In spite of not having a recorded weight, the review panel felt that appropriate drug doses were prescribed and administered during his first attendance.

Placement in waiting area.

Personal Information redacted by the USI has a total of 16 cubicles, 3 are in the resuscitation room and 4 are in minors. There is 1 paediatric cubicle and an isolation cubicle as well as 7 major's cubicles. The Emergency Medical System (EMS) for the night of Personal Information redacted by the USI and the morning of Personal Information redacted by the USI was reviewed, this is the computer system that logs and tracks patients in the department. On Personal Information redacted by the s arrival at Personal Information redacted by the hours there were 18 patients already in the department being assessed and waiting on assessment. Most of these were high acuity patients. Nurse 1 did state she wanted to place him in a cubicle after triage but none were available. The review team acknowledged this but belevied Personal Information redacted by the USI should have been placed in a cubicle much sooner. They felt it was not appropriate for a child with abdominal pain to remain in the waiting area for such a significant period of time. This the panel agreed was a systems failure.

Time of medical assessment

Once assessed by the triage nurse, patients are assigned a priority. Personal Information redacted by the was given priority 3 which is urgent. The aim is to have priority 3 patients seen within 60 minutes. This is not always possible in emergency departments due to the volume and acuity of patients attending at unscheduled times. From a review of the attendances on the EMS it appears there was a backlog of patients that needed assessed from earlier that night. The medical staff on night shift were working to clear this backlog. Two patients that arrived after Personal Information redacted by the were assessed before him. They had been assigned a priority 2 (very urgent) classification and as such the doctors attended to them before seeing Personal Information redacted by the. The panel confirmed this would be normal practice in emergency departments.
Doctor 1 advised at interview she was about to see Personal Information redacted by the at approximately Personal Information redacted by, but was called away to an emergency patient in the resuscitation room. The nursing staff interviewed did indicate this was a busy Saturday night with major cases and children, but not extra ordinary. Doctor 1 recognised there were long delays, but felt it was manageable.
The review team conclude that Personal Information redacted by the should not have waited so long to have been seen by a doctor.

Medication prescribed Personal Information redacted by the USI

The medications prescribed were pain killers and anti-emetics. The review panel felt that the medication was appropriate and prescribed in line with The Trust Medicine Code.

Doctor 1 assessment Personal Information redacted by the USI

History taking and clinical examination are crucial in assessing abdominal pain in children. Doctor 1 explained at interview she accessed the Northern Ireland Electronic Care Record (NIECR) to view Personal Information redacted by the previous medical history and was aware of his previous surgery and post-operative complications. She advised the review team she took a history from Personal Information redacted by the and his mother. She has recorded this previous history in her notes. The review panel were satisfied that the doctor took a full medical history

and this was reflected in her notes.
The notes were reviewed by the panel and they were satisfied there was an appropriate clinical examination of the abdomen and this was appropriately documented in the notes.

Tests/investigations

Nurse 1 informed the team that blood samples were not taken in triage. She stated nursing staff would not routinely take bloods on children. This would usually be done by the medical staff. Doctor 1 confirmed she did not feel blood tests were indicated. The doctor stated her training in assessing children with abdominal pain teaches to focus on history taking and the clinical examination and not to rely on laboratory investigations. She felt Personal Information redacted by the s vomiting had resolved. The panel agreed that this approach to assessing abdominal pain in children is correct, however they felt blood tests may have been considered in light of the fact that Personal Information redacted by the had been vomiting.

Urinalysis is a useful investigation for children presenting with abdominal pain. A urinalysis was performed and it did show the presence of ketones. However the presence of ketones in even minor illness is common and non-specific. The panel acknowledged that Doctor 1 considered that vomiting had settled and felt Personal Information redacted by the would be able to tolerate oral fluids. Nurse 1 and doctor 1 advised the panel they did not recall mentioning a second urinalysis. The panel felt a repeat urinalysis would not be routinely undertaken as it would not usually alter or add to the previous results and their interpretation.

The review panel recognised that abdominal x- rays are not routinely performed in children that present with abdominal pain. Doctor 1 advised that her training in assessing children with abdominal pain taught to focus on clinical examination on determining a clinical diagnosis. The review panel would agree with this. However in this case, given Personal Information redacted by the s previous abdominal surgery and complications along with his vomiting, the panel conclude that an abdominal x ray should have been considered. They also conclude that there would be no certainty that an abdominal x ray would have been abnormal.

Diagnosis

The review panel stated assessment of paediatric abdominal pain can prove a diagnostic challenge. The preliminary diagnosis of ischaemic entercolitis from post mortem is a very rare presentation in children. The panel recognise that children presenting with ischaemic bowel often will have very subtle or absent clinical findings. Doctor 1 diagnosed Personal Information redacted by the with constipation. She based this on absence of significant findings on her clinical examination and the absence of abdominal tenderness, as well as his bowels not opening in 2-3 days and his urge to open his bowels. This together with stable clinical observations after a 6 hour period in the department reassured doctor 1 of no other significant pathology.
The panel felt that given the level of experience of doctor 1, this would appear a logical conclusion. However the panel felt taking account of Personal Information redacted by the previous surgical history, his history of vomiting and abdominal pain, that a more senior experienced doctor may have recognised the fact that Personal Information redacted by the was unwell and may have considered additional investigations and admission.

Discharge

The discharge plan and medications would have been appropriate for a diagnosis of constipation. The clinical observations recorded Personal Information redacted by the USI were again within acceptable limits and the review panel felt this further set of clinical observations may have served to reassure staff that Personal Information redacted by the was stable and fit for discharge.

Staff on duty Personal Information redacted by the USI

The panel analysed the staff rota for that shift. They concluded there were appropriate nursing staff with 4 registered nurses and 1 health care assistant on shift. They felt their level of experience was appropriate. Nurse 1 who dealt with Personal Information redacted by the on his first attendance has over 20 year's emergency nursing experience.
There were 2 doctors working until 21:00 hours and a consultant working until 22:00 hours. The medical rota had 2 doctors on night shift; one was a foundation doctor and the other a locum SHO temporary doctor. The panel considered guidance from the Royal College of Emergency Medicine (RCEM) on grades of staff and staffing for emergency departments.

The panel recognised doctor 1 did have a satisfactory level of experience. However this would not be considered a level of experience equivalent with a middle grade in emergency medicine. They acknowledged that getting sufficient middle grade medical staff to work night duty in emergency departments is not just a issue for Irrelevant information redacted by the ED but for most emergency departments in Northern Ireland and the UK. The second doctor working night shift in ED is currently covered by locum SHO temporary staff.

Phone call to ED Personal Information redacted by the USI **.**

Doctor 1 advised the panel at interview she received the phone call and spoke to Personal Information redacted by the s mother. This was the same doctor that assessed Personal Information redacted by the earlier in the emergency department. The panel recognised that because doctor 1 had assessed Personal Information redacted by the 2 hours previously she was happy to reassure his mother over the phone. The panel considered that as Personal Information redacted by the had vomited again this was an opportunity to reconsider the diagnosis and advise the family to return with Personal Information redacted by the for reassessment. The panel also noted the absence of any documentation regarding the phone call and that the fact that doctor 1 could not recall if she had given any advice to return to the department.

Phone call to Children's ward

The ward manager and the staff nurse on the Children's ward were interviewed. Nurse 2 that received the call Personal Information redacted by the USI recollects she advised Personal Information redacted by the s father to re-attend the emergency department. The review panel felt that was the only appropriate advice that could have been given in the circumstances. They concluded the line cut off most likely due to a technical fault as neither terminated the call. The panel concluded this would have been quite distressing for Personal Information redacted by the s family. The ward manager advises that this technical issue has since been fixed.

Ambulance service

The Northern Ireland Ambulance Service provided the review panel with information sought in relation to their communication with Personal Information redacted by the family. They stated in their experience that meeting a vehicle on route to hospital is always difficult to arrange given the variety of routes available and the inability to pinpoint the exact location of

the vehicle the ambulance is to meet. The panel noted the willingness of the NIAS to meet the family at a future date if that would be beneficial.

Re-attendance Personal Information redacted by the USI .

The review team interviewed the Nurse 3 that witnessed Personal Information redacted by the USI return into the waiting area on Personal Information redacted by the USI . Her role which is a specialist one is to assess and diagnose specific patients that attend with minor injuries. While calling in one of these patients she noticed Personal Information redacted by the arrive. She stated she advised his mother to bring him straight through but that he wanted to go to the toilet first. Her intention was to bring him into a cubicle for urgent assessment and not to wait at reception in a queue. The review panel felt she did recognise Personal Information redacted by the USI as being acutely unwell and had planned to bring him straight through. She did inform the triage nurse of his presence to alert her as he was unwell.
Nurse 4 explained at interview that after completing her patient assessment she did search the waiting area and both she and Nurse 3 found Personal Information redacted by the USI in the toilets with his mother and carried him to the resuscitation cubicle. The panel conclude there were no preventable delays when Personal Information redacted by the presented on Personal Information redacted by the USI

Resuscitation

The review panel studied the notes of the 4 consultants involved in resuscitation. The panel felt that the cardiac arrest bleeps were activated promptly at Personal Information redacted by the hours and that appropriate staff had attended. Resuscitation was appropriately led by the ED consultant with a paediatric consultant, an anaesthetic consultant and a surgical consultant in attendance. The presenting heart rhythm was a pulseless electrical activity arrest (PEA). The notes and the fluid charts were reviewed and the panel felt that appropriate drugs were prescribed and administered along with appropriate fluids. The review panel felt that resuscitation was appropriate and the notes indicated a team effort working to advanced paediatric life support guidelines.

Resuscitation led to a return to Personal Information redacted by the 's heart beating again, he remained intubated and ventilated and was still critically ill. In this post resuscitation stage, tests and investigations were carried out and contact was made with the RBHSC transfer team who agreed to come to Personal Information redacted by the USI ED and transfer Personal Information redacted by the to RBHSC.

The review panel reviewed the blood tests and the chest x ray reports. They felt the post resuscitation care was appropriate, They felt that stabilisation until the paediatric transfer team arrived was the best course of treatment. They felt consideration at this stage for surgery in Personal Information redacted by the USI would not have been an option. They commented that the blood gas analysis showed a severe metabolic acidosis which did not improve at any stage during his second attendance before suffering a second cardiac arrest. The panel felt this second resuscitation adhered to advanced paediatric life support guidelines. Unfortunately this was not successful. The outcome of cardiac arrest in children is invariably poor.

Summary of findings

After analysis of the information, the review panel felt they had identified the main service and care delivery problems. They have also identified contributory factors as well as the root causes.

Care and Service delivery issues

1. There was an undue delay in placing Personal Information redacted by the USI in a cubicle on the Personal Information redacted by the USI
2. There was an undue delay in medical assessment on his first presentation
3. An incorrect diagnosis was made during Personal Information redacted by the first presentation
4. There was a missed opportunity to return for reassessment before deterioration

Contributory Factors in the incident

The review team reviewed the National Patient Safety Agency contributory factors classification framework and considered were there such factors evident.

1 Previous surgery and post-operative complications**.**

The panel felt Personal Information redacted by the s pre-existing abdominal surgery with adhesions may likely have contributed to his presentation to ED in Personal Information redacted by the USI but this would rely on confirmation from the full post mortem. The preliminary report from the coroner was made available to the panel. The panel contacted the coroner's office but were unable to get any additional detail regarding the post mortem results at this time.

2 Lack of capacity

The team considered if the delay in the waiting area contributed to Personal Information redacted by the 's outcome. They felt it was inappropriate he waited so long in the waiting area, they also believe that the significant period spent in the department had in some way reassured the staff that the diagnosis of constipation was appropriate as he had not deteriorated in his time there and that all his recordings of vital signs were within acceptable limits.

3 Lack of clear Guidelines for children with abdominal pain for staff

The review panel recognised there are no national guidelines for the assessment of children with abdominal pain.

4 Lack of senior staff/use temporary staff

The panel considered if a more experienced trained doctor would have made a different diagnosis. They felt a more experienced emergency department doctor may have considered a different diagnosis. They acknowledged the RCEM guidelines that concern staffing and seniority of medical staff that should be on duty. They also stated that the problem of recruiting appropriately trained middle grade staff for night duty is an issue not just in Personal Information redacted by the USI ED but also in other departments in Northern Ireland and nationally.

Root causes

A. Failure to identify a rare diagnosis in a child

B. Lack of available middle grade medical cover in the out of hour's period to staff emergency departments.

7.0 CONCLUSIONS

From the analysis and findings above the following conclusions have been drawn:

- **Ischaemic entercolitis in children is a very rare occurrence.**
  The review panel recognise this report is based on the assumption ischaemic entercolotis occurred as a complication of Personal Information redacted by the previous surgical problems. This would need confirmed by the findings of the coroners post mortem.

- **There was an undue delay in placing Personal Information redacted by the in a cubicle and him being assessed by the doctor**
  The panel accepted there was a backlog of patients and cubicles were full. Staff intimated they felt this was manageable. There was no escalation. The panel conclude this was too long for a child with abdominal pain to wait on assessment.

- **There was a failure to identify the correct diagnosis.**
  Placing together the previous medical history of bowel surgery with adhesions and obstruction along with his new presentation of vomiting and abdominal pain could have led to the doctor considering a different diagnosis other than constipation. Had another diagnosis been considered and Personal Information redacted by the been admitted his death may have been avoided.

- **The family could have been advised to return to the emergency department when they phoned at Personal Information redacted by the USI.**
  An opportunity was missed for another assessment and alternative diagnosis prior to Personal Information redacted by the s deterioration.

- **A more experienced middle grade doctor in emergency medicine may have determined an alternative diagnosis to constipation**

7.0 CONCLUSIONS

- **There are no clear National Guidelines for medical staff to follow in assessing and diagnosing children in adnominal pain.**

- **There is a deficit in middle grade cover in the out of hour's period in** Personal Information redacted by the USI **Emergency Department.**

8.0 LESSONS LEARNED

The review panel have been advised that the coroner's post mortem report is not yet available and as such this should be acknowledged as a vital piece of information for informing of lessons learned.

- Children that present that are unwell should be placed promptly in a cubicle after triage and there should be a contingency when all cubicles are full.
- There should be clear guidelines for staff to escalate if there are long delays in priority 3 children being assessed.
- There are no clear guidelines for assessing and treating children with abdominal pain.
- There should be a system to record telephone advice in emergency departments.
- There is a requirement for increased middle grade cover in the out of hours period in the Emergency Department Personal Information redacted by the USI.

9.0 RECOMMENDATIONS AND ACTION PLANNING

The review panel advise that the full post mortem findings when available should be reviewed along with the RCA report. This should not delay the reports progression. The review panel wish to make the following recommendations for operational teams to action.

Recommendation 1

The interim protocol put in place post Personal Information redacted by the 's death for patients that attend with abdominal pain should be reviewed with senior medical paediatric input.

Recommendation 2

The induction booklet for Emergency Department medical staff should be reviewed to ensure there is up to date reference to the interim protocol for attendees with abdominal pain.

Recommendation 3

The induction booklets for Emergency Department medical staff should be made available for all staff including locum staff

Recommendation 4

The middle grade rota in Personal Information redacted by the USI Emergency Department should be reviewed as part of a workforce review and a plan to address gaps in middle grade medical cover should be formulated and enacted urgently

Recommendation 5

A clear protocol for the placement of ill children in cubicles and their prompt assessment should be developed urgently and put in place with a staff communication plan

Recommendation 6

A system for ensuring that advice given over the telephone to patients and their relatives is recorded should be adopted in both Emergency Departments in the Southern Trust.

Recommendation 7

There should be provision for on-going support for Personal Information redacted by the 's family and staff affected by this tragic incident

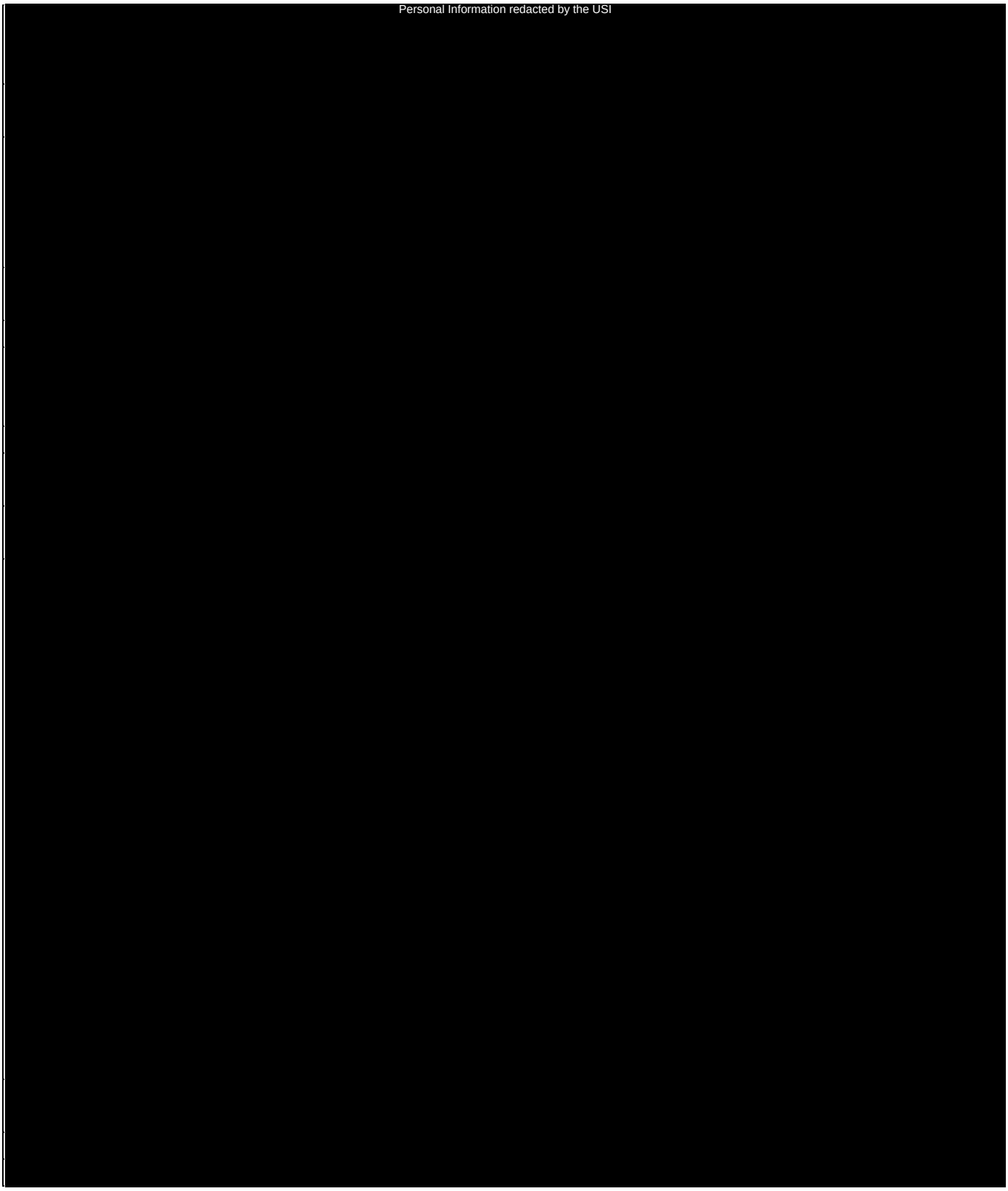
10.0 DISTRIBUTION LIST

Chronology of Events

Date	Source of information	Events – includes contacts, assessment
Personal Information redacted by the USI		

Date	time	Event	Staff involved	Source of information
Personal Information redacted by the USI				

Personal Information redacted by the USI



Southern Health and Social Care Trust

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

Organisation's Unique Case Identifier: ID [redacted]

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier:

Responsible Lead Officer: Mrs Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Panel

Date report signed off:

Date submitted to HSCB:

Southern Health and Social Care Trust

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2. EXECUTIVE SUMMARY

This SAI Review was undertaken at Level 2

On [redacted] at 18:52 hours (hrs) Ms [redacted], a [redacted] old lady presented to Daisy Hill Hospital Emergency Department (DHH ED) with abdominal pain, accompanied by her sister. The abdominal pain had a sudden onset in the left lower quadrant on the morning of [redacted]. Ms [redacted] was triaged by Staff Nurse 1 at 18:37 hrs. Oral analgesia was prescribed for abdominal pain and was administered at 18:50 hrs.

Ms [redacted] was seen and examined by Dr 1 at 21:03 hrs. Impression: fullness in left iliac fossa (LIF). Query constipation, for home with analgesia. Further analgesia was prescribed and administered at 21:25 hrs. Ms [redacted] was discharged home at 22:45 hrs with her sister and advised to return if any concerns or attend General Practitioner (GP) if the pain didn't settle.

On [redacted] at 12:20 hours, Ms [redacted] arrived at Daisy Hill Hospital Emergency Department at 12:20 hrs unresponsive after having a cardiac arrest at home. Cardio-pulmonary Resuscitation (CPR) was in progress throughout transfer from home to hospital but Ms [redacted] remained in asystole. Resuscitation was in keeping with Advance Life Support Guidelines by Doctors 2,3,4 and 5. CPR was stopped after 9 minutes and 15 seconds with the full agreement of all medical staff in attendance. Ms [redacted] did not respond to the resuscitation attempts and sadly passed away at [redacted] hrs.

3.0 THE INVESTIGATION TEAM

Dr Hilda Nicholl (Chair)	Consultant in Emergency Medicine
Mr Damian McKay	Consultant Surgeon
Mr Barry Conway	Assistant Director of Emergency Medicine
Mrs Mary Burke	Head of Service for Medicine and Unscheduled Care
Mrs Connie Connolly	Lead Nurse Acute Governance.

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4.0 INVESTIGATION TERMS OF REFERENCE

The terms of reference for this review will be finally approved by the Chair and review team members at the initial SAI review meeting.

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

- To carry out a review into the care provided to Ms [redacted] in Daisy Hill Hospital, on the [redacted]

- To carry out this review into the care provided to Ms [redacted] using the National Patient Safety Agency Root Cause Analysis methodology

- To use a multidisciplinary team approach to the review

- To provide an agreed chronology based on documented evidence and staff accounts of events

- To identify the key contributory factors which may have had an influence or contributed to [redacted]'s treatment and care

- To ensure that recommendations are made in line with evidence based practice

- To set out the findings, recommendations, actions and lessons learnt in an anonymous report

- To adhere to the principles of confidentiality throughout the review

- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of Ms [redacted] and the staff associated with Ms [redacted]'s care

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5.0 INVESTIGATION METHODOLOGY

The Review Team considered the following when undertaking the SAI:

- Medical and Nursing records pertaining to the care of Ms [redacted]
- Report of Autopsy
- Discussion with and responses from relevant Nursing and Medical staff in relation to all aspects of care for Ms [redacted] on the [redacted]
- Review of duty rotas for both Nursing and Medical staff on [redacted]
- Guidance in relation to the management of abdominal pain issued in Daisy Hill Hospital- in effect from 23 April 2015
- Best Practice Guidelines issued by the College of Emergency Medicine Dec 2014- Management of Pain in Adults
- Triage Position Statement issued in April 2011 by the College of Emergency Medicine, Emergency Nurse Consultant Association, Faculty of Emergency Nursing and the Royal College of Nursing
- British National Formulary March 2015 to September 2015

6.0 DESCRIPTION OF INCIDENT/CASE

Emergency Department Summary (Integrated Medical and Nursing)

[redacted]

Ms [redacted] attended the Emergency Department in Daisy Hill Hospital on [redacted] at 18:32 hours complaining of sudden onset of left lower quadrant abdominal pain in the morning. No diarrhoea or vomiting. Bowels opened in the morning. Denied any urinary symptoms. No analgesia taken. Pain score [redacted] as noted as 7, and Ms [redacted] was triaged as a Priority Code 3. Triage was done at 18:37 hrs and National Early Warning Score (NEWS) was completed and documented.
Temperature (temp) 36.3 Heart Rate (HR) 71 Respirations (Resps) 22
Blood Pressure (b/p) 125/62. Oxygen Saturation (SaO2) 98%. Urinalysis revealed + protein and Leucocytes 25.

Past Medical History of [redacted]. Current medications included:

[redacted]

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5.0 INVESTIGATION METHODOLOGY

Emergency Department Summary (Integrated Medical and Nursing)

Personal Information redacted by the USI

Co-Codamol (30/500) 2 tablets orally (PO) were prescribed at 18:45 hrs , and were administered at 18:50 hrs.

Ms Personal Information redacted by was examined by Dr 1 at 21:05hrs. History of LIF pain, loud grumbling on waking, sharp but not too troublesome. Went for a walk and pain became intense to pain score of 5-6/10. Still sharp, pain did not migrate. Associated nausea. Bowels opened this morning, did not affect pain. Past Medical History: nil medical. Family History: nil. On examination, comfortable lying in the bed, turning in the bed with no pain. Impression: fullness in LIF, mild tenderness, no guarding, bowel sounds present. Urinalysis noted. Blood Investigations for Full Blood Picture (FBP), Urea and Electrolytes (U&E), Liver Function test (LFT), C-Reactive Protein (CRP) and Amylase taken at 19:35 hrs.

Results:	Normal Range
Haemoglobin (Hb) 128 g/l	(115-160 g/l)
White Cell Count (WCC) 14.2* e9/l	(4-11 e9/l)
Platelets (Plt) 342	(150-450 e9/l)
CRP 0.8	(0-5 mg/l)
LFT- normal	
Sodium (Na) 138	(133-146 mmols/l)
Potassium (K) 4.0	(3.5-5.3 mmol/l)
Urea 5.8	(2.5-7.8 mmol/l)
Creatinine (Creat) 60	(45-84 umol/l)
Amylase 43	(28-100 U/L)

Nurse 1 recorded that Ms Personal Information redacted by was complaining of nausea. HR 99 b/p 125/67 SpO2 recorded at 98%.

Ondansteron 4mg sublingually prescribed at 20:10 hrs and administration time was not recorded. Given by Nurse 6.

Nurse 2 records that Ms Personal Information redacted by was taken to cubicle 5 as feeling sick and weak. Observations continued and waiting to be seen by Doctor. At 20:15 hrs, NEWS recorded as 1 by Nurse 7. Temp 36.4, HR 98, Resps 16 b/p 128/62 SaO2 98%.On Ms Personal Information redacted by 's NEWS chart, observations were recorded at 21:20 hrs. Temp 36.3, HR 71, b/p 152/83, Resps 16 SaO2 96%

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5.0 INVESTIGATION METHODOLOGY

Emergency Department Summary (Integrated Medical and Nursing)

Personal Information redacted by the USI

Nurse 3 records that Ms Personal Information redacted by was attached to the observation monitor at 21:25 hrs in cubicle 3. Seen by Dr 1 at this time, analgesia prescribed. Buscopan 20 mg orally was prescribed at 21:25 hrs and given at 21:25 hrs. Clinical note states '?constipation, home with analgesia, return if any concerns and attend GP if not settling'. The final diagnoses was: Constipation. The investigations were bloods and urinalysis. The ED Discharge plan was: home. GP if not settling ?Ultra Sound Scan (USS). Examination finish time documented as 22:15 hrs. Medications on discharge were Buscopan 20mg orally four times daily (QID) as required. 14 tablets were dispensed and Co-codamol 30/500 2 tablets orally QID as required, 32 tablets dispensed by Nurse 5.

At 22:42 hrs Nurse 5 has documented the medications were given as prescribed to Ms Personal Information redacted by and discharged home. Discharge observations at 22:45 hrs Temp 35.5, HR 81 Resps 18 SaO2 98%.

Personal Information redacted by the USI

On Personal Information redacted by the USI at 12:30 hrs, Ms Personal Information redacted by presented to the ED in DHH via ambulance following a 'Stand-by Call' to all ED Staff by the Northern Ireland Ambulance Service (NIAS). Ms Personal Information redacted by was unresponsive following an out of hospital cardiac arrest and was priority code 1. Cardio-pulmonary resuscitation (CPR) was in progress by paramedics on arrival to the ED. Ms Personal Information redacted by was seen by Drs 2,3, 4 and 5 as well as Nurses 4 and 7.

Note by Dr 5: Advanced Life Support (ALS) protocol in progress. Evidence of haematemesis. Asystole in transport.18 gauge venflon inserted into Right (Rt) groin for bloods only.

Result	Normal Range
Hb 184* g/l	(115-160 g/l)
WCC 18.6* e9/l	(4-11 e9/l)
Na 142	(133-146 mmol/l)
K+ 6.4*mmol/l	(3.5-5.3 mmol/l)
Creat 135* umol	(45-84 umol/l)
Urea 14.0* mmol/l	(2.5-7.8 mmol/l)
CRP 78.2* mg/L	(0-5 mg/L)
Amylase 41 U/L	(28-100 U/L)
Gases pH 6.63*	(7.350-7.450)

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5.0 INVESTIGATION METHODOLOGY

Emergency Department Summary (Integrated Medical and Nursing)

Personal Information redacted by the USI

Intravenous (i/v) fluids commenced. See notes from Drs 3 and 4. Seen here last night with sudden onset abdominal pain. Diagnoses: constipation and was discharged home. Resuscitation discontinued at Personal information hrs with agreement of entire team. To discuss with relatives sister Personal Information redacted by the and brother Personal Information redacted by the. Advised will need Post-Mortem examination. Coroner contacted at 13:15 hrs. Same arranged. Clinical summary to be done. Retrospective note at 12:30 hrs by (Anaesthetic) Doctor 2. Out of hospital arrest and 'Stand By' call. Witnessed collapse. Weak pulse on arrival of paramedics, went to Pulseless Electrical Activity (PEA) and CPR was commenced. Seen in ED last night with abdominal pain. No other history available.

On examination: asystole, CPR on-going, i-jel in place and vomit++ seen via i-jel.

Note by Doctor 2 continued

I-jel replaced by Endotracheal Tube (ETT), larynx soiled +++, bilateral air entry. Naso-gastric tube in place, little on suctioning. Following Venous Blood Gas (VBG) and 9 minutes of CPR, decision to stop on-going CPR as futile- all team in agreement.

Retrospective note by Doctors 3 and 4. Cardiac arrest call at 12:10 hrs. History as per Dr 2. Role of Dr 4: grey i/v cannula inserted into right anti-cubital fossa (5 mls of blood taken off) Adrenaline given through this line. CPR stopped at Personal information redacted by USI after 9 minutes and 15 seconds of hospital CPR. PEA with paramedics; asystole on arrival-remained in asystole throughout.

Note by Nurse 4: cardiac team and anaesthetist await arrival of patient. CPR in progress, see medical notes. i/v fluids in progress via blue cannula in left arm-same extravisated and stopped. Adrenaline administered through grey venflon in right arm. CPR stopped at Personal information after 9 mins and 15 seconds of hospital CPR.

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7.0 FINDINGS

Emergency Department Analysis- Medical

DATE: [redacted] **TIME: 18:32 hrs until 22:45 hrs**

and

DATE: [redacted] **TIME: 12:30 hrs until 13:15 hrs**

On [redacted] the medical staffing in the Emergency Department in Daisy Hill Hospital consisted of Doctor 6 (ED Consultant) until 22:00 hrs, Doctors 1 and 7 (CT2) came on duty at 21:00, Doctor 9 (FY2) was on duty until 19:00 hrs and Doctor 8 (FY2) was on duty until 21:00hrs.

At 18:30 hrs, there were 34 patients in the ED, with 8 awaiting admission: at 22:15hrs there were 28 patients in the ED and at 22:45 hrs, there were 25 patients in the ED.

Upon Ms [redacted] presenting to ED at 18:32 hrs, priority code 3 was allocated, and Ms [redacted] was triaged by Staff Nurse 1 at 18:37hrs. Documentation reveals that Ms [redacted] was prescribed Co-codamol 30/500 at 18:45 hrs. This was administered at 18:50 hrs. Doctor 1 came on duty at 21:00 hrs and Ms [redacted] was seen and examined at 21:05 hrs.

The Review Panel did note that it appeared Ms [redacted] was prescribed oral analgesic containing codeine and paracetamol at 18:50 hrs but without a clinician assessing the patient. This assumption is based on the absence of any documentation in relation to patient assessment by medical staff around or at 18:20hrs. During discussion with Nurse 1, it was clarified that it was custom and practice that Co-codamol 30/500 was the strongest analgesia which could be given without a clinician having to assess the patient prior to prescription. The decision to prescribe is based on the information provided by the Staff Nursing making the request.

The Review Team are of the opinion that Doctor 1's examination was appropriate and was well documented. The investigations which were ordered were appropriate and done in a timely manner. The Emergency Medicine System (eMS) was examined and the data would support that that Department was busy and this could/would account for the delay in examination from Triage at 18:32 hrs until 21:05hrs. The NEWS score for Ms [redacted] was recorded on 4 occasions while a patient in the ED. All recordings were within relatively normal limits.

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Emergency Department Analysis- Medical continued

The Review Panel reviewed Ms Personal Information redacted by's regular medication.

Personal Information redacted by the USI

The drug profiles were compiled and there is unanimous agreement that Ms Personal Information redacted by's drug profile did not indicate any undue or obvious risk in relation to constipation or constipation being listed as a major side effect.

The Review panel believe that a rectal examination should have been done. The presence of constipated stool, may have provided a significant clinical finding. The absence of stool in the rectum could have been the clinical bases to instigate an abdominal xray, given the ongoing abdominal pain . With the rectal exam not being done, the presence of potential clinical clues and the effect of an alternate course of management cannot be assessed.

The Review panel noted the findings of the series of blood results all being within normal limits with the exception of a slightly raised WCC at 14.2 e9/l. The Review Panel are completely satisfied that the blood results did not warrant any further investigations and did not give significant clinical cause for concern or alarm when taken in the context of the clinical assessment.

After considering the NEWS scores, the physical examination and blood results, the Review Panel discussed if there was a need to escalate the findings to a more senior clinician. There is no reference within any of the clinical notes to the consideration for a more senior review or referral to the Surgical Team.

On reflection, the Review Panel agreed that the total documented clinical picture did not clearly indicate the need for any senior review at that time. Dr 1 was interviewed by 2 members of the Review Panel on 22 May 2015. The Panel representatives found Dr 1 to be a co-operative and articulate witness. Dr 1 was asked directly if any concern was raised by nursing staff in relation pain levels or in relation to the discharge of Ms Personal Information redacted by. Dr 1 was also asked if he considered arranging a more senior review by an ED Consultant or the Surgical Team.

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Emergency Department Analysis- Medical continued

Dr 1 explained that he recalls returning to check on Ms [redacted] following the administration of Buscopan 20 mg at 21:25 hrs and noted that Ms [redacted] was able to turn/roll on the trolley. It was his belief that the ability to independently make this movement meant there was no typical peritonitic presentation. He recalls asking Ms [redacted] how she was feeling after the second analgesia, and her response was she was 'feeling better' and Ms [redacted] then got up and stood. Dr 1 remembers that Ms [redacted]'s sister was worried about Ms [redacted] and asked Dr 1 if Ms [redacted] was going to be ok. Dr 1 believes he said 'it looks like constipation', and to 'come back if it doesn't settle'. Dr 1 does not recall the time of this conversation. At this point Dr 1 states that he was called away to see another patient and Ms [redacted] was not brought to his attention again. Dr 1states he did not see Ms [redacted] leave the department. Dr 1 is clear that none of the clinical team on duty that evening, escalated any concern in relation to Ms [redacted] level of pain or Ms [redacted] being discharged.

Dr 1 clearly articulated that he was not anxious about the findings in relation to the physical assessment in conjunction with the blood results and the clinical observations. Dr 1 believed a rectal examination was not needed as Ms [redacted] said there her bowels had moved normally in the morning. Dr 1 referred back to the second conversation with Ms [redacted] after receiving Buscopan 20 mg and explained that at that exact time, his opinion was that Ms [redacted] did not need to be re-assessed and was fit for discharge. On concluding the interview with Dr 1, he expressed his shock and sorrow at being informed of the sudden passing of Ms [redacted].

Ms [redacted]'s primary reason for presentation was abdominal pain. The Review Panel believe that referencing pain status within the discharge planning/note would have been valuable reassurance and evidence that pain had been reassessed and /or resolved. The Review Panel believe that it is plausible that the administration of codeine, paracetamol, ondansteron and buscopan within a 2 hour and 35 minute window potentially provided some symptom relief for Ms [redacted]. This may explain why when Dr 1 returned to check on Ms [redacted], there were no typical outward signs of clinical concern or for Dr 1 to consider admission to hospital. The available documentation does not stipulate the time frame from Dr 1 checking on Ms [redacted] and the time of discharge.

The Review Panel then considered if a more senior ED clinician or a member of the Surgical Team would have significantly changed the diagnoses, subsequent management of constipation and tragic outcome for Ms [redacted]. Dr 6 was available for consultation by Dr 1 from 21:00 hrs to 22:00 hrs. As already stated, Dr 1 did not believe there was a need for escalation and reassessment by a more senior clinician

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Emergency Department Analysis- Medical continued

The Review Panel discussed the impact of access to telephone Senior surgical review. The Review Panel are not convinced that a phone consultation with a Senior Surgical team with the blood results and NEWS scores available, would have changed clinical management. The Review Team agree that the clinical criteria for an Out of Hours CT scan via a Senior Clinician would not have been approved based on clinical evidence between 21:05 hrs and 22:45hrs on [redacted]. The Review Panel agree that a Senior Surgical Team member assessment may have considered of admission to the Surgical ward overnight .The Review Panel agree that there is no absolute assurance that the clinical outcome for Ms [redacted] would have definitely been positive if Ms [redacted] was admitted to hospital on [redacted] It is the opinion of the Review Panel that admission to hospital may have provided the potential to compile a more holistic clinical and pain assessment overnight. Senior surgical review would have taken place after 08:30 hrs on [redacted]. It is the opinion of the Review Team that if Ms [redacted] had been a hospital in-patient on [redacted] there would have been the possibility of earlier detection of clinical deterioration. The Review Panel concur that there may have been an opportunity for detection of clinical deterioration but it cannot be assumed that this would have definitely reversed clinical deterioration or the tragic outcome on [redacted].

The Review Panel examined the documented information in relation to Ms [redacted] attendance to the Daisy Hill ED at 12:20 hrs on [redacted]. Upon completion of a chronological timeline from 12:30 hrs to 13:15 hrs and the compilation of clinical detail, the Review Panel agree that all policies and procedures were followed in relation to an out of hospital Pulseless Electrical Activity (PEA) cardiac arrest. All relevant staff were in attendance immediately upon arrival of Ms [redacted]. CPR was sustained from time of the PEA cardiac arrest as per Advanced Life Support Guidelines (ALS). A blood sample was obtained on arrival.

Result	Normal Range
Hb 184* g/l	(115-160 g/l)
WCC 18.6* e9/l	(4-11 e9/l)
Na 142	(133-146 mmol/l)
K+ 6.4*mmol/l	(3.5-5.3 mmol/l)
Creat 135* umol	(45-84 umol/l)
Urea 14.0* mmol/l	(2.5-7.8 mmol/l)
CRP 78.2* mg/L	(0-5 mg/L)
Amylase 41 U/L	(28-100 U/L)
Gases pH 6.63*	(7.350-7.450)

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Emergency Department Analysis- Medical continued

There was evidence of hematemesis and I-jel airway inserted by the Paramedics was replaced with an ET tube by Dr 2 on arrival. The clinical consensus was to cease CPR 9 minutes 15 seconds following arrival to the ED. There was no cardiac output detected during resuscitation. The Review Team have no concerns or comment in relation to these events.

Ms [redacted] sadly passed away at [redacted].

Dr 5 and Staff Nurse 7 then spoke to the brother and sister of Ms [redacted]. Clinical actions were explained and Ms [redacted]'s family were informed that Ms [redacted] had passed away at [redacted] hrs after unsuccessful resuscitation. The need for Post Mortem was discussed with the family and consent was given.

Dr 5 and Staff Nurse 7 were interviewed by 2 members of the Review Panel. Dr 5 stated that the family were concerned about the way Ms [redacted] was treated. Dr 5 cannot recall the exact form of words used by Ms [redacted]'s sister, but Dr 5 recalls that the sister of Ms [redacted] made specific and clear reference to Ms [redacted] having been discharged from the ED in a wheelchair due to abdominal pain on [redacted]. Dr 5 is certain that she responded to this particular comment as it was unusual. Dr 5 apologised for this happening as this was not normal practice. Dr 5 remembers that the sister of Ms [redacted] also referenced that the nurse at discharge made a flippant remark in relation to her query about Ms [redacted] having an xray on the evening of [redacted]. Ms [redacted] sister clearly recalled that the discharge nurse told her and Ms [redacted] on discharge that her Ms [redacted]'s xray had been normal, and it showed constipation. Again, Dr 5 remembers apologised as no xray had been done, for the inappropriate comment and any distress it may have caused.

Staff Nurse 7 recalled that her primary role in relation to this incident was to support Dr 5 and the family of Ms [redacted]. Ms [redacted]'s brother and sister were escorted to the relative's room on arrival, as Ms [redacted] was taken to the Resuscitation Area within the department. S/N 7 advised the family in attendance that Ms [redacted] was very ill and they may want to notify family members. Resuscitation stopped at [redacted] hrs. S/N 7 and Dr 5 then went to the relative's room to inform family members that Ms [redacted] had passed away. S/N 7 remembers that Dr 5 answered a number of questions in relation to the discharge of Ms [redacted] the previous evening. Ms [redacted]'s sister stated that she was told on discharge the previous night that Ms [redacted]'s xray showed constipation. The brother and sister made reference to telling the discharge nurse that Ms [redacted] was 'not 100%'.

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Emergency Department Analysis- Medical continued

Given the sudden and unexpected nature of death of Ms [redacted], Dr 5 contacted the Northern Ireland Coroner's office. Post Mortem was advised and was completed on [redacted].

The final report has been issued and the cause of death has been listed as:

1a) necrosis of large bowel and bowel obstruction due to

b) faecal impaction.

The post mortem report supports the diagnoses of an extreme level of constipation. These findings support the clinical investigation planning on [redacted]. The Review Team agree that at the time of testing, the NEWS score and the blood results at 21:05 hrs on [redacted] did not typically indicate large bowel ischaemia in this [redacted] old patient.

Emergency Department Analysis- Nursing

DATE: [redacted] **TIME: 18:32 hrs until 22:45 hrs**

and

DATE: [redacted] **TIME: 12:30 hrs until 13:15 hrs**

Ms [redacted] attended the Emergency Department in Daisy Hill Hospital on [redacted] at 18:32 hours complaining of sudden onset of left lower quadrant abdominal pain in the morning. No diarrhoea or vomiting. Bowels opened in the morning. Denied any urinary symptoms. No analgesia taken. Pain score was noted as 7, and Ms [redacted] was triaged as a Priority Code 3. Nursing Triage was done at 18:37 hrs by Staff Nurse 1. National Early Warning Score (NEWS) was completed and documented. Temperature (temp) 36.3 Heart Rate (HR) 71 Respirations (Resps) 22 Blood Pressure (b/p) 125/62. Oxygen Saturation (SaO2) 98%. Urinalysis revealed + protein and Leucocytes 25.

Past Medical History of [redacted]. Current medications included:

[redacted]

Southern Health and Social Care Trust

Personal Information redacted by the USI

The Review Panel noted that it was the testimony of Staff Nurse 1 that Ms Personal Information redacted by stated that the review medications were Personal Information redacted by the USI. The Review Panel noted within the Post Mortem Report, Ms Personal Information redacted by had a past medical history of Personal Information redacted by the USI

Emergency Department Analysis- Nursing

DATE: Personal Information redacted by the USI **TIME: 18:32 hrs until 22:45 hrs**

DATE: Personal Information redacted by the USI **TIME: 12:30 hrs until 13:15 hrs**

During an interview with Staff Nurse 1, S/N1 explained that Ms Personal Information redacted by appeared to be in a lot of pain on arrival. S/N 1 remembers that Ms Personal Information redacted by was very pale. S/N1 stated that Ms Personal Information redacted by said she had not taken any analgesia prior to arrival, and had eaten very little all day. S/N 1 sought a prescription for analgesia from one of the Doctor. It is custom and practice within DHH ED that patients with a moderate pain score (7) can be given 2 Co-codamol 30/500 without being seen by a doctor prior to prescription. The diagnoses of constipation had not been made at this time.

S/N 1 remembers the sister of Ms Personal Information redacted by knocking the door where she was working, stating that Ms Personal Information redacted by felt faint and nauseated in the main waiting area. Records reveal the Staff Nurse 6 administered Ondansteron 4mg at 20:10 hrs for nausea. Staff Nurse 1 recalls thinking this as was reasonable for Ms Personal Information redacted by due to the pain, having codeine/paracetamol and little diet throughout the day. Staff Nurse 1 was off duty at 21:00 hrs and did not see the patient leave the ED.

Staff Nurse 2 was also interviewed by panel members. Staff Nurse 2 recalls the department being very busy and the nursing staff were having to rotate some patients from the cubicles to waiting areas as there was a high demand for cubicle space. S/N 2 recalls she was asked to take Ms Personal Information redacted by to cubicle space 5 due to feeling faint and nausea. S/N 2 did not document the time of this observation but Staff Nurse 3 noted in the documentation that it was 21:25 hrs and Ms Personal Information redacted by was attached to the observation monitor and was seen by the Doctor. Buscopan was prescribed by Doctor for pain. (did Ms Personal Information redacted by stay in cubicle til d/c)

The last nursing entry was by Staff Nurse 5 at 22:42 hrs which notes discharged medications were given to patient as prescribed and Ms Personal Information redacted by was discharged home. Discharge medications included Buscopan 4mg orally 4 times daily as required and Co-codamol (8mg codeine/500 mg paracetamol) orally 4 times daily as required. Interview with Staff Nurse 5 recalls that he did not see Ms Personal Information redacted by until he was asked to

complete discharge observations. S/N 5 recalls that when he went to hand-over the discharge medications and complete the discharge observations, the patient was not in the cubicle. Staff Nurse 5 saw Ms [redacted] return from the toilet. Staff Nurse 5 states that he handed over the medication and completed observations. Temp 35.5 pulse 81 Resps 16 SaO2 98%. Blood pressure and pain score were not recorded. S/N 5 can't remember the exact wording of the conversation with the sister of Ms [redacted] but stated that Ms [redacted]'s sister asked about an xray for Ms [redacted]. S/N 5 responded to Ms [redacted]'s sister with, or words similar to 'I don't have anything to do with x-rays'. S/N 5 does not recall any detail about the condition of the patient on discharge or specific detail around the patient leaving department for home. S/N 5 states he is 95% sure that Ms [redacted] was not discharged from the department in a wheelchair on [redacted]. In the absence of any other evidence from the staff on duty or access to family testimony, no further comment on the manner of [redacted] discharge can be included in this report at this time.

Emergency Department Analysis- Nursing

DATE: [redacted] TIME: 18:32 hrs until 22:45 hrs

and

DATE: [redacted] TIME: 12:30 hrs until 13:15 hrs

The Review Panel has already made reference to the prescription and administration of combined codeine and paracetamol on discharge for constipation, is not supported by best practice. Codeine is contra-indicated in the management of constipation as this is one of it's significant side effects. (British National Formulary 2015). It is the opinion of the Review Panel that both the medical and nursing team failed to connect the link between the diagnoses of constipation and the know side effect of codeine being constipation when prescribing and dispensing the discharge medication. There appears to be a further failure to connect the diagnoses with the discharge medication when there was no laxative prescribed for Ms [redacted].

The Review Panel has observed that the nursing documentation has notable key omissions. Ms [redacted]'s presented with abdominal pain. The presumptive diagnosis on [redacted] was constipation.

The pain score is recorded during triage but it is not referenced again.

The clinical monitoring and subsequent documentation up until the time of discharge on [redacted] does not adequately capture the effect of the prescribed drugs.

It is the opinion of the Review Panel that the Nursing documentation does not demonstrate that the Nursing assessments were being linked to either the presenting complaint or the diagnoses. The condition of Ms [redacted] is not clear from the documentation following the administration of medication, following the completion of

clinical observations or more crucially, at discharge. It is the opinion of the Review Panel that on discharge, the S/N 5 did not adequately evaluate the appropriateness of the discharge medication. S/N 5 has already admitted that a blood pressure recording was not done on discharge. The pain score on discharge did not appear to be assessed or recorded prior to discharge.

8.0 CONCLUSIONS

This Level 2 Review has raised a number of omissions which the Review Panel agree could have directly impacted on the decision to discharge Ms [redacted] on [redacted].

The medical assessment should have included a rectal examination given the diagnoses was constipation.

The Review Panel agree that in the absence of local policy stating otherwise, Dr 1 discharged Ms [redacted] based on his findings and condition of Ms [redacted] and without escalation to a more senior clinician. This was after checking with Ms [redacted] had got some relief with the Buscopan prescribed. In the absence of any other documented evidence or any escalation by nursing staff on [redacted], Dr 1's decision to discharge home was reasonable. In relation to the prescription of the discharge medication, analgesia containing codeine should not have been prescribed for the management of constipation. A laxative should also have been included.

The ED nursing staff were in contact with Ms [redacted] 6 times including Triage. Clinical observations were done on 4 occasions. The nursing documentation is brief with notable omissions. Different nurses gave the 2 doses of analgesia and the anti-emetic for nausea. There is no reference to the effect of any of the drugs prescribed during attendance. The clinical observations did not include reference to pain scoring, with the exception of triage. Crucially, there is no information in relation to the condition of Ms [redacted] on discharge. The discharge nurse did not appear question the prescription of codeine containing analgesia and the absence of a laxative.

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9.0 LESSONS LEARNED

Clinicians should be aware of patients presenting with abdominal pain, out of keeping with clinical findings,- especially in patients with [redacted]. In these patients ischaemia should be considered and a lower threshold for admission should exist.

There is no local written policy in relation the prescription of analgesia for triage patients without being seen by a clinician

The Daisy Hill Emergency Department does not issue any written advice to patients diagnosed with abdominal pain, and how to contact services if needed. There is a lack of written information given to patients in relation to the medications prescribed and supplied

There was poor documented evidence of the monitoring of Ms [redacted]'s pain even though this was the primary cause for concern. There are no documented comments in relation to the Ms [redacted]'s response to analgesia and/or anti-emetic

There is minimal information available about the discharge of the Ms [redacted]. Secondary to this omission, there is no clear clinical picture to confirm whether or not clinical management was successful/ unsuccessful.

10.0 RECOMMENDATIONS AND ACTION PLANNING

The Review Team acknowledge that since the death of Ms [redacted], the following action has been taken:

Guidance for 'The Process for Management of Patients Presenting with Abdominal Pain with a provisional diagnoses of constipation or query obstruction to Daisy Hill Hospital Emergency Department' Implemented 23 April 2015. This guidance was created to support the medical staff on the Daisy Hill. Daisy Hill Hospital frequently utilises locum staff and often does not always have access to 24 hour Registrar cover in the Daisy Hill Emergency Department. The guidance states:

- All patients presenting with Abdominal Pain must have Full Blood Picture, Urea and Electrolytes, C-Reactive Protein, Liver Function Test, Amylase, Venous Blood Gas including Lactate.

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10.0 RECOMMENDATIONS AND ACTION PLANNING

- In the case of constipation, a rectal examination is mandatory in all adults. If a rectal examination is negative, an abdominal should be done

- Discharge is permitted in hours provided that the patient's clinical status and investigations are all normal AND the Emergency Department Consultant has reviewed the patient and this is clearly documented in the Emergency Department notes

- During times when there is no Emergency Department Consultant on duty (ie: after 22:00 hrs each evening and after 17:00 hrs at weekends), a senior surgical opinion (middle grade or above) MUST be sought from the in-house surgical team on site or by phone. Where a decision cannot be reached following this opinion the Emergency Department Consultant on-call should be contacted and admission considered.

The Review Team acknowledge the guidance which supports the Medical Team in the Daisy Hill Emergency Department and suggest the following inclusions:

- Consideration of the creation and validation of written local Clinical Guidance in relation to the prescription of strong analgesia for patients assessed in Triage without being seen by a clinician.

- Creation and validation of written discharge information patient information leaflets explaining- what investigations have been completed, discharge medications and advice and service contact details for patients experiencing persisting symptoms.

The Review Team recommend urgent update training for both medical and nursing staff in relation each and all of the recommendations.

Update training is required in relation to 'Process for Management of Patients Presenting with Abdominal Pain' emphasising the escalation responsibilities of both medical and nursing staff. The Review Panel acknowledges that this training is included as part of staff induction, but update training will need to be provided for permanent medical and nursing staff as well. Consideration will need to be given on how to ensure each Locum, Bank and Agency staff member is made aware of this site-specific guidance and there is documented evidence of receipt.

Update Training must include responsibilities regarding the monitoring and documentation of pain status for all patients presenting with pain. This needs to incorporate the recording of pain assessment by both medical and nursing staff on admission and discharge, pain score recording while completing National Early

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10.0 RECOMMENDATIONS AND ACTION PLANNING

Warning Score assessment and the recording of the effect of any drugs administered. The selection of appropriate analgesia by medical staff and nursing staff in relation to patients being diagnosed with constipation in particular needs to be integrated.

The Review Panel recommends that this update training also includes revisiting the Escalation of the Deteriorating Patient Policy for all levels of nursing staff and attendance recorded. All training related to these recommendations must be urgently integrated into the Emergency Department Induction programmes for both Nursing and Medical staff if not already included and attendance records compiled for same.

11.0 DISTRIBUTION LIST

This report will be forwarded to the HSBC and Coroner's Office when approved by the SHSCT Senior Management Team

MS Personal Information redacted by 's family will be offered a copy of the report and invited to meet with the Chair of the Review Team and the Director of Acute Services

The learning from the Review will be shared as appropriate through the SHSCT governance and professional communication structures/mechanism.

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Clinical Timeline

Date/Time	Source	Time Line	Comments
Personal Information redacted by the USI 18:32 hrs	ED Flimsy	Personal Information redacted by the old lady presented to Daisy Hill Hospital Emergency Department (ED) presenting with abdominal pain. Sudden onset of left lower quadrant pain in the morning. No diarrhoea and vomiting. Bowel opened in the am. Denies any urinary symptoms. No analgesia taken.	Staff Nurse 1: Triage at 18:37 hrs- clinical observations (obs): Temperature (Temp) 36.3, pulse 71, Respirations (resps) 22, Blood Pressure (b/p) 105/62. Oxygen Saturation (SpO2) 98%. Urinalysis- +protein, leucocytes 25.
21:05		Seen by Dr 1. Mild grumbling pain on waking. Sharp but not too troublesome. Went for walk and pain became more severe. 5-6/6. Pain did not migrate. Associated nausea. Bowels opened this morning, but did to affect pain. On examination (o/e) comfortable lying in bed. Turning in bed with no pain. Impression of fullness in Left iliac fossa. Mild tender, to same. ?guarding. Bowel sounds present. ? Constipation. Home with analgesia. Return if any concerns. GP if pain not settling. (examination finish time 22:15. Departure time 22:15)	Bloods ordered. FBP/U&E/LFT's/CRP/Amylase at 19:35 hrs. Nursing comment by Staff Nurse 6: Complaining of (c/o) nausea, and pain. Observation recorded. b/p 125/67, pulse 99, SpO2 98%. Staff Nurse 2 writes: Patient taken to cubicle 5- feels very sick and weak. Observations continued, awaiting to be seen by Dr. Urinalysis noted, Haemoglobin (Hb) 12.8, White Cell Count (WCC) 14.2, C-Reactive Protein (CRP) 0.8
22:25	ED Flimsy	Staff Nurse 3 recorded: attached to monitor. Clinical observations as per appendix One. Seen by (s/b) Dr.1 Analgesia given as prescribed	Co-codamol 30/500 given at 18:00 Ondansteron 4mg prescribed at 20:10- no admin time National Early Warning Score (NEWS) at 20:15- 1. Temp 36.6, pulse 98, resps 18, SpO2 98%, b/p 128/62 NEWs at 21:20- not totalled. Temp 36.3, pulse 71, resps 16, SPo2 96% b/p 152/83. Buscopan 20mg orally given at 21:25

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Clinical Timeline

Date/Time	Source	Time Line	Comments
Personal Information redacted by the USI 22:45		Left ED department with prescription for Buscopan 40 mg QID PRN and Co-codamol 30/500 QID PRN. Diagnoses: constipation. Discharge plan: home, GP if not settling. ?USS 22:42 Medications given as prescribed by Staff Nurse 5.	Investigations: bloods and urinalysis. Discharge Observations: Temp 35.5, pulse 81, Resps 16 b/p not recorded by Staff Nurse 5. SpO2 98%
Personal Information redacted by the USI Personal information	ED Flimsy	Personal Information redacted by the old lady arrived to Daisy Hill Hospital Emergency Department at Personal information hrs unresponsive after out of hospital arrest. Unresponsive. CPR in progress. Standby cardiac arrest. Arrest team present. ED staff present	Consultant 5 on arrival ED staff: need clarification
		Advanced Life Support (ALS) guidelines. Evidence of hematemesis. CPR in progress, asystole in transport in ambulance. Intravenous (i/v) fluids commenced. Seen here last night with abdominal pain with sudden onset. Unwell this am. Resuscitation discontinued at Personal information hrs with agreement of team. Discussed with (d/w) relatives sister and brother. Advised need for Post Mortem.	18g in Rt groin for bloods only.
Personal information		Anaesthetic note- Dr 2. OOH arrest/stand by call. Witnessed collapse. Weak pulse on arrival of paramedics—PEA/CPR started. Seen in ED last night—abdominal pain. No other hx available. o/a- asystole/CPR on-going/I-jel in situ (vomit++via i-jel and mouth). Asystole confirmed—CPR. Following Venous Blood Gas (VBG)/ 9 min CPR, decision to stop ongoing CPR- all team in agreement.	

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Clinical Timeline

Date/Time	Source	Time Line	Comments
12:42		Retrospective note by Dr 3. Medics on call- Drs 3 and 4. Cardiac arrest call 12:10. History as before, as per anaesthetist. Role of Dr 3- CPR. Role of Dr 4. Grey i/v cannula inserted into Right anti-cubital fossa (5ml blood taken off). CPR stopped at Personal information after 9 minutes and 15 seconds of hospital CPR. PEA with paramedics: asystole on arrival- remained in asystole throughout.	
Personal Information redacted by the USI Time Not recorded		Nursing summary: Resuscitation (Resus)- cardiac team, anaesthetist awaiting arrival of patient. CPR in progress, see medical notes. i/v fluids via blue cannula. Left arm inserted by paramedics. Same extravisated and stopped. Adrenaline administered via cannula Right arm. CPR stopped at Personal information following 9 minutes, 15 seconds of hospital CPR.	

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Quality Care - for you, with you

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

Organisation's Unique Case Identifier: **SAI** Personal Information redacted by the USI

Date of Incident/Event: 2012-2014

HSCB Unique Case Identifier:

Responsible Lead Officer: Mr Anthony Glackin

Designation: Consultant Urologist

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

Table of Contents

1.0 EXECUTIVE SUMMARY

In August 2012 aged [redacted] underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. [redacted] was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013.
[redacted] did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that [redacted] might have recurrent disease, [redacted]'s GP referred [redacted] back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.

2.0 THE INVESTIGATION TEAM

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

3.0 INVESTIGATION TERMS OF REFERENCE

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

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

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

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

4.0 INVESTIGATION METHODOLOGY

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

Review of Records

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

- Medical Notes
- Nursing Notes
- Radiology Reports

Discussions with relevant staff

The Investigation of Patient Administration System

Review of Relevant Reports, Procedures, Guidelines

- Serious Adverse Incident Report

The review team also considered the following:

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

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

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

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

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

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

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

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

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

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

5.0 DESCRIPTION OF INCIDENT/CASE

On 13th June 2012 Patient 128 presented to ED with central abdominal pain and frank haematuria and was referred to the Haematuria Clinic Daisy Hill Hospital. Patient 128 was prioritised as an urgent referral and underwent a diagnostic endoscopy of bladder and ultrasound of urinary tract on the 4th July 2012. The ultrasound report stated "No focal defects noted in the liver and spleen. The left kidney and bladder appeared normal. There is a large right renal mass measuring 13.6 x 9.1 cms". The right renal tumour was evident on CT scan of urinary tract (13/07/12) and Renal CT (24/07/12). Renal function assessed by NM Renal DMSA (01/08/12) highlighted a reduction in renal function in the right kidney. There was no evidence of metastatic disease on bone scan (10/08/12).

Dr 1 (Consultant Surgeon) referred Patient 128 to Dr 2 (Consultant Urologist) for surgical management (14/08/14). Following pre-operative assessment and work up Patient 128 was admitted to Craigavon Area Hospital for surgery. Dr 2 performed a right radical nephrectomy (29/08/12), the tumour was adherent to the liver and extended posteriorly to the duodenum. Surgery was complicated by a tear in the vena cava, there was extensive intra-operative bleeding. Patient 128 was transferred to Intensive Care Unit (ICU) following surgery and recovered well, returning to the Ward on 31/08/12 and was discharged on 6th September 2012.
Patient 128's case was discussed at the Multi-disciplinary Team Meeting (MDM) on 6th September 2012. Histology reported features of a conventional clear cell adenocarcinoma, this extended through the renal capsule to involve perinephric fat. The tumour was staged as pT3a Furhman Grade III tumour. The MDM management plan recorded Patient 128 was to be reviewed by Dr 2, have further CT scanning in November 2012 and subsequent MDM discussion.

Patient 128 was reviewed by Dr 2 on 15th September 2012, and a CT request was completed electronically for imaging to be carried out in November 2012.
The CT scan was carried out on 17th January 2013.The radiology report was as follows:

CT Chest and abdomen and pelvis with contrast at 13:38
Clinical history: *Right radical nephrectomy in August 2012 for PT3b renal cell carcinoma.*

Technique: *CT chest, abdomen and pelvis performed following oral and intravenous contrast. Comparison made with previous CT scan examination of 24/07/2012.*

Findings

Lungs are clear. No mediastinal lymphadenopathy seen. Liver show four no. focal lesion. Stones are seen in the gallbladder. Spleen and pancreas appear normal. Right kidney is surgically absent. Prominant subcentimeter lymph nodes are seen in the renal hilar region and potrahepatis region. Left kidney show no focal lesion. Normal urinary bladder. No uterine lesions seen. The pyloric antrum is apparently thick walled. This is nonspecific and could be due to collapse lumen. Clinical co-relation suggested.

Multilevel degenerative changes are seen in the spine.

Conclusion: *Subcentimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen.*

Patient 128 was reviewed by Dr 3 (Consultant Urologist) on 8th February 2013 and a further CT scan was requested electronically for May 2013, with review planned for June 2013.
Patient 128 had a CT scan of chest abdomen and pelvis on 16th May 2013. The radiology report was as follows:

CT Chest and abdomen and pelvis with contrast at 15:16CT chest, abdomen and pelvis performed following oral and intravenous contrast.

Comparison made with previous CT scan examination of 17/01/2013.

Findings: *Lungs are clear. No hilar or mediastinal lymphadenopathy seen.*

Liver show no focal lesion. Stones seen in the gallbladder. Spleen and pancreas appear normal. Right kidney is surgically absent. Prominent sub centimeter lymph node in the right renal hilar/porta hepatic region but is not significantly enlarged according to size criteria. Left kidney show no focal lesion. Normal urinary bladder. No uterine lesion seen. Diverticular seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine.

Conclusion: *No metastasis or significantly enlarged lymph nodes are seen.*

Radiological reports need to be interpreted within the clinical context and may require discussion and explanation with the patient to avoid misunderstanding.

Patient 128 was next seen on 26th August 2014 in response to a letter received from Patient 128's GP requesting a review as Patient 128 had been "lost to follow up" and now presented with symptoms suggestive of metastatic disease. The patient was noted to have weight loss and fatigue and severe iron deficiency anaemia.
A CT scan on 1st September 2014 revealed multiple abnormalities consistent with local recurrence and metastatic renal cell carcinoma. The report was as follows:

CT Chest and abdomen and pelvis with contrast 11:39

CT chest, abdomen and pelvis performed following oral and intravenous contrast.
Comparison made with previous CT scan examination of 16/05/2013.

Findings

No lung mass lesion seen. There is no hilar or mediastinal lymphadenopathy.

Right kidney is surgically absent. Large perideudenal/mesenteric enhancing mass seen.

6x3.4 cm enhancing, retrocaval mass seen on the medial aspect of liver. Multiple irregular hypodense lesion seen in the segment VI of the liver, the largest measure 6cm in size. Stones seen in the gallbladder. Spleen and pancreas appear normal. Left kidney show no focal

lesion. Urinary bladder is empty. No uterine lesion seen. Diverticular disease seen in the sigmoid colon. Multilevel degenerative changes are seen in the spine.

Conclusion

Recurrent disease.

1. Large perideudenal/mesenteric mass which appear to involve/projecting into the lumen of deudenum. Endoscopy/barium meal examination suggested for further evaluation.

2. Large retrocaval mass on the medial aspect of the liver.

3. Large metastasis in the segment VI of the liver.

Patient 128's care was discussed at the Urology MDM on 4th September 2014. At that meeting a review by Dr 2 was arranged and a direct referral to a Consultant Oncologist (Dr 6) was made for consideration of further management.

Patient 128 was reviewed by Dr 2 on 5th September 2014 and was advised of CT scan results at this time.
Patient 128 was admitted for investigation under Dr 5 (Consultant Urologist on call) on 6th September 2014. During this admission Patient 128 had blood transfusion and a diagnostic OGD and biopsy (09/09/14) which confirmed renal cell carcinoma. Patient 128 was discharged home on 10th September 2014 for oncology review at Belfast City Hospital and for review with Dr 2 at CAH.
Patient 128 was reviewed on 16th September 2014 by Consultant Oncologist (Dr 6) at BCH Oncology clinic.

6.0 FINDINGS

Management 13th June 2012- 6th September 2012
The Review Team is satisfied that Patient 128's initial diagnostic investigations and subsequent surgical intervention were appropriate, timely and met Cancer Guidelines.

When it became apparent that Patient 128 required a nephrectomy Dr 1 (Consultant Surgeon) transferred Patient 128's care to Dr 2 (Consultant Urologist) who specialises in this surgery. Transfer and pre-operative support were carried out correctly. The Review Team noted surgery (29/08/12) was difficult as there was hilar lymph node disease.
Patient 128 was first discussed at a Urology Multi-disciplinary Team Meeting (MDM) after surgery (06/09/12). The Review Team is aware this is neither unusual nor unreasonable.
Patient 128's history, surgery, imaging and histology findings were discussed during MDM so that an appropriate management plan of care could be determined. It was agreed that Patient 128, who was discharged from hospital that day, should be reviewed by Dr 2 who would arrange further CT scanning in November 2012 after which Patient 128's case would again be reviewed at MDM.
Although Patient 128's discharge letter was not dictated until the following April (03/04/13), a letter containing the MDM discussion (6/09/12) and management plan was sent to

Patient 128's general practitioner (GP) which invited the GP to make contact if further information was required. The Review Team are satisfied that in this instance relevant information was issued to Patient 128's general practitioner through the MDM Report. The Review Team are of the opinion however that it is good practice for a discharge letter to be sent to the GP within a few weeks of patient discharge.

Post-operative Review

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

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

Request for CT scan November 2012

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

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

Review 8th February 2013

Patient 128 was reviewed by Dr 3 (Consultant Urologist) on a shared clinic code. Clinical codes are generated by each Trust and indicate the specific location, consultant and activity of the clinic. If clinic codes are shared between consultants it is not possible to identify which consultant is ultimately responsible for each patient. The clinic letter to the patient's GP stated the patient was well on review. Although recurrence of renal cancer was not detected, Dr 3 advised that in view of the high risk of recurrence, serial scans were required. Dr 3 confirmed booking a further scan for May 2013 with next review in June 2013.

The Review Team accept that the intention to scan at intervals was appropriate given Patient 128's histology findings and agree it was appropriate to book a further scan for May of that year. Dr 3 indicated Patient 128 would be reviewed in June 2013. The Review Team agreed the timing of this was acceptable as it would allow for the CT findings to be received.

The CT scan was carried out on 16th May 2013. At this time the Trust protocol was that the report which was generated on 17th May 2013 should be sent by hardcopy to Dr 3's secretary for action by Dr 3. The review team could find no record of the CT report of the 16th May 2013 being signed off or actioned in the clinical record.

Dr 3, the consultant who had requested the scan, had left the Trust before the result was generated. An arrangement had not been made to forward such results to another consultant. There had been no formal transfer of cases nor was there a system in place to generate "results worklists" through which outstanding results can be readily visualised and actioned.

Review arrangements for June 2013

Patient 128 was placed on the out-patient review waiting list in use on 8th February 2013. This

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

Discussion

The Review Team has considered if robust handover arrangements and results worklist as discussed above (Review 8th February 2013) may have afforded opportunities for Patient 128 to be prioritised for an earlier review.

There is an ongoing regional capacity deficit for Uro-oncology review. At present some consultants actively prioritise "high risk patients" that is patients who are at risk of recurrence and manually prioritise their review date from the computerised waiting list. It is acknowledged that the traditional model of cancer patient review is inefficient and unsustainable (Department of Health 2011). A new model of care for cancer survivors which incorporates a "risk stratification" process to tailor follow-up to the level of care required for the individual; and which takes account of the disease process, treatments and the patients' ability to self-manage has been developed (http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/risk-stratification/).

The "Recovery Package" is incorporated into the Regional Transforming Cancer Follow Up" (TCFU) initiative which is being advanced strategically by the Health and Social Care Board in partnership with Macmillan (http://be.macmillan.org.uk/be/s-689-recovery-package.aspx.). It is recognised that the roll out and sustainability of this strategy is dependent on adequate numbers of Clinical Nurse Specialist (CNS) in adult cancer being trained and in post. There is a lack of such CNSs regionally; this is hampering the implementation of TCFU in some specialities (Northern Ireland Cancer Network 2010). A recent census has revealed that with the exception of .6 whole time equivalent CNS for prostate cancer, there are no CNSs specifically for Uro-oncology within Northern Ireland (Macmillan 2014). The Review Team is of the opinion that addressing this deficit in conjunction with implementing a risk stratified model of follow up has the potential to address the current recognised capacity issues which exist in Uro-oncology review.

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

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

Discussion

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

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

Presentation/Referral August 2014

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

7.0 CONCLUSIONS

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

8.0 LESSONS LEARNED

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

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

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

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

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

Summary of Recommendations

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

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

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

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

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

Table of analysis, recommendations and Action Planning

9.0 RECOMMENDATIONS AND ACTION PLANNING				
Summary of Analysis/Findings	Recommendation	Action Planning	Lead	Timeframe
The Urology Service has a number of Oncology patients who are not being reviewed at the required intervals	A robust system must be developed to ensure Urology Oncology patients are reviewed in a timely manner	Designated Urology Review Clinics with specific Oncology Consultant Codes Capacity-Nurse led follow-up for suitable Urology Oncology patients- advance in conjunction with NICaN Guidance	 Martina Corrigan Head of Service ENT Urology and Outpatient Department	Complete In line with regional progress
The patient caseload of a Consultant leaving the Trust employ is not automatically transferred to another appropriate Consultant within the Trust Clinic codes had been allocated to more than one Consultant which made it difficult to identify caseloads	Robust handover arrangements must be put in place to ensure patients are transferred from a Consultant who is leaving to a suitable Consultant still within the Trust employ Each Consultant should have an exclusive clinic code	The Southern Trust should develop a Policy for Caseload Transfer A task and finish group should be convened to advance this All Urology Consultants have individual tracking codes.	Assistant Directors	3 months Complete
The CT scan of 16th May 2013 was not signed off or actioned by a Consultant.	A mechanism must be put in place to ensure all radiology reports are seen, actioned and	NIECR sign off is available. A task and finish group to be set up to undertake work	Janette Robinson Head of Service for Diagnostics	3 months

9.0 RECOMMENDATIONS AND ACTION PLANNING				
	signed off by an appropriate person. Use of facilities on Northern Ireland Care Record (NIECR) is recommended	list sign off for all results		
There was a delay of 8 months in dictating Patient 128's discharge letter. Information regarding Patient 128's surgery and follow up was however contained within the MDM letter sent to GP.	Discharge letters must be timely. A timeframe for issue of discharge letters should be agreed by the Urology service.	Timeframe for discharge letters to be determined. Barriers, if any to achieving this should be identified and addressed.	Martina Corrigan Head of Service ENT Urology and Outpatient Department	3 Months
it is good practice for a letter to be sent to the GP within a few weeks of every outpatient appointment	Outpatient letters must be timely. A timeframe for issue of discharge letters should be agreed by the Urology service and monitoring process put in place	Timeframe for outpatient letters to be determined. Barriers, if any to achieving this should be identified and addressed.	Martina Corrigan Head of Service ENT Urology and Outpatient Department	
It was unclear from the patient's records the detail of information shared regarding cancer diagnosis prognosis and follow-up.	It is important that a record of consultation is maintained following a patient being given a cancer diagnosis. This should be contained within the care record and the patient offered a copy	Advanced Communication Training for those imparting information- Urology Consultants A task and finish group to be set up to design and implement a communication record.	 Mr Tony Glackin Consultant Urologist	Complete 3 Months
The concept of Key Worker is	It is recommended	The Trust must continue to work	Fiona Reddick	

9.0 RECOMMENDATIONS AND ACTION PLANNING				
accepted as an integral aspect of cancer follow-up. Key Workers have been established for some cancer specialities but not others. A Key Worker was not identified for Patient 128.	that named Key Workers are identified for Uro-oncology patients It is imperative that a Key Worker is identified for every cancer patient to ensure continuity of care.	with Northern Ireland Cancer Network (NICaN) to ensure equitable services for all cancer groups.	Head of Service Cancer Services and Martina Corrigan Head of Service ENT Urology and Outpatient Department	

10.0 DISTRIBUTION LIST

Following SMT approval the report will be:

- forwarded to the HSCB
- shared with Patient 128
- shared with relevant staff to take forward learning.

Timeline SAI Personal information redacted by USI

Date	Time	Event
13/06/12		Referral to Surgical Assessment Unit, Haematuria clinic by Emergency Department XR abdomen and chest
15/06/12		Haematuria clinic Dr 1 (Consultant Surgeon) Added to waiting list GP suspect cancer, **priority**: urgent
04/07/12		Admitted as a day case under Dr 1. Exam: diagnostic endoscope Neoplasm of uncertain or unknown behaviour: Kidney CT scan booked on MDM Urology.
04/07/12	10.08	**US Urinary Tract** No focal defects noted in the liver and spleen. The left kidney and bladder appeared normal. There is a large right renal mass measuring 13.6 x 9.1 cms. Urgent CT referral advised.
13/07/12	13.45	**CT Urinary Tract**
24/07/12	15.27	**CT Renal Tumor Protocol Study.** CT Renal with contrast. Both Kidneys **Indication:** Large right renal tumour. Query metastasis. **Findings:** Right renal tumour is again demonstrated. This arises from the upper pole of the right kidney, and has a maximum diameter of 11 cm and contains a central low density area, possibly necrotic. There is a solitary right renal artery. There is no convincing evidence of any tumour thrombus within the right renal vein or inferior vena cava. **Conclusion:** There is no evidence of any metastatic deposits.
01/08/12	13.50	**NM Renal DMSA** **Conclusion:** Only small functioning part of the right kidney is still seen in its lower pole and markedly reduced split renal function of the right kidney
10/08/12		NM Bone whole body 14:47 **Conclusion:** No evidence of bony mets.
14/08/12		Ref from Dr 1 to Dr 2 (Consultant Urologist) - Urology Clinic, priority – urgent
17/08/12		Patient attended Dr 2 pre op assessment clinic (nurse led)– patient fit eGlomerular Filtration Rate >60. Liver function test (LFT) normal. No cardiovascular co-morbidity. **Plan:** Full blood picture (FBP). U&E, LFT, serum iron, group and hold. Admit Tuesday 28th August for cross match 4 units packed cells. Right radical nephrectomy for 29/08/14
28/08/12		Patient admitted 3 South for - right radical nephrectomy
29/08/12		**Right radical nephrectomy** Locally advanced disease. Right flank incision large tumour mass adherent to liver and extending posterior to second part of duodenum. Tumour surrounding right renal artery and vein. Tear in antero-lateral aspect of inferior cava, excessive intra-operative bleeding prior to and during repair. Transferred to Intensive Care Unit post-Surgery
31/08/12		Transfer to Surgical Ward
06/09/12		Ward referral to Dr 2 clinic, routine Discharged home
06/09/12		Multi-disciplinary Team Meeting (MDM)

Date	Time	Event
		Large renal cell carcinoma histological features of conventional clear cell adenocarcinoma which extends through renal capsule to involve perinephric fat (pT3a). Furhman Grade 111 tumour. For Review by Dr 2 and arrange further CT scanning November 2012 and subsequent MDM discussion.
15/09/12		**Dr 2 Urology Clinic** Seen by Dr 2 CT request to be carried out November 2012
17/01/13	13.38	**CT Chest and abdomen and pelvis with contrast** **Conclusion:** Sub-centimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen.
08/02/13		**Dr 2 Urology Clinic** Seen by Dr 3 (Consultant Urologist) **Follow Up:** CT, REV JUNE 2013 Reviewed today. Had a right radical nephrectomy in August 2012 for a renal cell carcinoma. Histology showed a 98mm clear cell carcinoma. This invaded into perinephric fat, therefore was pT3a, although renal vein was clear. Histology showed a Fuhrman grade III tumour with positive lymphovascular invasion and necrosis. Margins were clear. However, as there was a little intra-abdominal fat, they were close to the resection margin. Patient doing very well and is now back to work. No pain. Recent staging CT scan shows some small nodes at right hilum, which were not significant by size criteria, although will need to be followed up. There was no evidence of metastatic disease. I have reassured the patient today that there is no definite evidence of cancer recurrence. Will obviously need to have serial CTs, given the high risk nature of primary tumour. I have therefore rebooked a CT for May 2013 and have checked routine bloods today. We will review in June 2013.
08/04/13		Discharge letter for 29/08/12 admission <u>dictated 03/04/13</u> and typed <u>08/04/13</u> Dr 2: Surgery and histology and current review plan given Patient underwent Right Radical Nephrectomy on 29/08/12 for locally advanced, renal cell carcinoma of right kidney. Presented with central abdominal pain and episode of frank haematuria. Mass was palpable in right hypochondrium, large right renal tumour measuring 11cm in diameter, was confirmed on CT scanning in July 2012. On CT scan it was noted to have a mild splenomegaly and multiple gall stones. A right flank incision, resecting the cartilaginous tip of the right tenth rib, a large right renal tumour mass was found to be adherent to the liver and extending posterior to the second part of the duodenum. Right renal vein and right renal artery were surrounded by the tumour mass. Unfortunately, right radical nephrectomy was complicated by a long tear in the antero-lateral aspect of the inferior vena cava resulting in excessive intra-operative haemorrhage, prior to and during its repair. Nevertheless, Patient had remarkably uncomplicated post-operative recovery

Date	Time	Event
		Histological examination of the resection specimen found to have a poorly differentiated, Fuhrman Grade 3, clear cell adenocarcinoma which extended through the renal capsule to involve peri-nephric fat. This tumour is associated with an increased risk of local recurrence and of metachronous metastatic disease. However, as reported by Dr 3 at review in February 2013, there was no evidence of any local recurrence or of metastatic disease on CT scanning in January 2013. Patient due to have further CT scanning performed in May 2013 and I hope to review with the report in June 2013.
16/05/13	15.16	**CT Chest and abdomen and pelvis** with contrast **Conclusion:** No metastasis or significantly enlarged lymph nodes are seen.
14/03/14	10/02	XR Lumbar spine– (requested by GP) There is a background of mild / moderate degenerative change. There is also impression of mild osteopenia; however, no significant insufficiency fracture is convincingly demonstrated. Sacroiliac joints are unremarkable. Note is made of right upper quadrant metallic clips, presumably related to previous surgery.
21/08/14		Letter received by Urology Service from patient's GP dated 20/08/14 – "Thank you for seeing patient lost to follow up from urology following removal of a high grade renal tumor >1year ago. Had normal CT scan March 2013 but no review since despite being told would have frequent checkups. Had two severe episodes of low back pain. First Jan 2014 and most recent August 14. Normal x-ray March 14. Feels weak, nausea and unwell. I am concerned Patient 128 may have metastatic disease or recurrence of tumor. Recall / review of urology cancer patients is a cause for concern as lengthy delays ++++ current Hb 9.1 (was 13.9 1 yr ago). Recent onset acute back pain, no real ppt. In pain no radiation was in bed for 2 days couldn't move. Worse coughing. Thought she was 'dying'. Anxious +++ previous renal cancer (high grade and risk of recurrence). Haematuria. Walks without limp. SLR 80 deg legs hips and knees ok reflexes and power. Lumbar flexion and rotation excellent. Ketoprofen Gel 2.5% 100 gram, Cyclizine tablets 50mgs 30 tablet. FBP and bloods check urine expect urology review as suspected metastatic renal cancer".
21/08/14		**Referral to Dr 2 clinic from General Practitioner**- "Red Flag" referral as GP suspect cancer following triage, urgent. Referred to clinic. Referred to oncology as per MDM. Discharged from clinic on 14/10/14
21/08/14		Ref to Clinic Dr 4 (Consultant Surgeon) anaemia triage, urgent
26/08/14		Patient 128 **reviewed by Dr 2**. Iron Deficiency Amameia CT scan requested and MDM review with reports.
01/09/14		Attended Dr 4 clinic (Consultant Surgeon) Re anaemia– Boarded for OGD and colonoscopy, aware of referral to Urology Service and follow up there re CT scan.
01/09/14	11.39	**CT Chest and abdomen and pelvis** with contrast **Conclusion** Recurrent disease.

Date	Time	Event
		1. Large peri-duodenal/mesenteric mass which appear to involve/projecting into the lumen of duodenum. Endoscopy/barium meal examination suggested for further evaluation. 2. Large retro-caval mass on the medial aspect of the liver. 3. Large metastasis in the segment VI of the liver.
04/09/14		**Discussed at MDM**
05/09/14		**Dr 2 Review** Reviewed Patient 128 and advised of CT findings and MDM**.**
06/09/14		**Admitted for blood transfusion and OGD.** 3 Units packed red cells. OGD 09/09/14 –biopsy of probable duodenal carcinoma – previous CT scan – large periduodenal/mesenteric mass which appears to involve/project in to lumen of duodenum. Arrangements for follow up: Oncology review BCH – referred by MDT 04/09/14. Seen 16/09/14 Await pathology results - Histology confirmed renal cell carcinoma Review by Dr 2 CAH OPC- 19/09/14
10/09/14		**Discharged**
16/09/14		**Reviewed Oncology Service**
19/09/14		**Reviewed by Dr 2**
25/09/14		Referral to Oncologist (Dr 6) and discharge from Urology formalised at MDM
		MDM report 25/09/14 Diagnosis: Renal clear cell carcinoma. Laterality: Right Referred due to complaining of central abdominal pain and frank haematuria. On examination, mass in right hypochondrium. Blood and urine – no malignant seen. Ultrasound reported a large right renal mass. Flexible cystoscopy was clear. Diagnosis of probable right renal tumour. CT urinary tract 24/07/12. There was no evidence of any metastatic deposits. DMSA 01/08/12 – only small functioning part of the right kidney was still seen in its lower pole and markedly reduced spilt renal function of the right kidney. Bone scan 10/08/12 – no evidence of bony metastasis. Right radical nephrectomy performed 29/08/12 and histology reported features of a conventional clear cell adenocarcinoma which extended through the renal capsule to involve perinephric fat (pT3a) CT C/A/P 17/01/13 – subcentimeter lymph nodes in the right renal hilar/portahepatis region. No metastasis seen. History There was no evidence of metastatic disease or of significant lymphadenopathy on CT scanning performed in May 2013. Patient was referred again in August 2014 with a one month history of weight loss and fatigue. Was found to have severe iron deficiency anaemia. Patient attended for review 26/08/14. CT chest abdomen and pelvis requested. For review at MDM with reports and for review by Dr 2 on 06/09/14 CT C/A/P, 01/09/14 – 1. large periduodenal / mesenteric mass which appear to involve / projecting into the lumen of duodenum. Endoscopy / barium meal examination

Date	Time	Event
		suggested for further evaluation. 2. Large retrocaval mass on the medial aspect of liver. 3. Large metastasis in the segment VI of the liver Patient advised of findings of CT scanning at review on 05/09/14. Admission on 06/09/14 arranged for transfusion and for upper GI endoscopy as an inpatient Patient reported that continued to feel better since transfusion, when reviewed on 19/09/14. Her only persistent symptom was of mild nausea. Probable tumour had been found to infiltrate second part of duodenum at OGD on 09/09/14. There was no report of active bleeding. Biopsies have since confirmed renal cell carcinoma. Patient reviewed 16/09/14, when Hb had decreased to 95. For further discussion at MDM on 25/09/14 and discharged from urological review.

Personnel Code

Dr Code	Dr Grade
Dr 1	Consultant Surgeon
Dr 2	Consultant Urologist
Dr 3	Consultant Urologist
Dr 4	Locum Consultant Surgeon
Dr 5	Consultant Urologist
Dr 6	Consultant Oncologist

Southern Health and Social Care Trust

Quality Care - for you, with you

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

Organisation's Unique Case Identifier: **SAI** [redacted]

Date of Incident/Event: 2007-2014

HSCB Unique Case Identifier: S

Responsible Lead Officer: Damian McKay

Designation: Consultant Surgeon

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

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1.0 EXECUTIVE SUMMARY

In August 2007 Personal Information redacted by the was referred to the Rectal Clinic at Craigavon Area Hospital (CAH) with a six month history of painless rectal bleeding. Personal Information redacted by the was seen in November 2007 at which time a rigid sigmoidoscopy was carried out and barium enema arranged. This was done on 4th January 2008. The subsequent correspondence to the GP (21/02/08) indicated the barium enema revealed a constant filling defect consistent with pedunculated polyp therefore a flexible sigmoidoscopy would be arranged.

Personal Information redacted by the underwent colonoscopy on 30th October 2013. An un-resectable 2cm polyp, which was suspicious of malignancy, was noted in the distal sigmoid colon. A 4x3cm soft tissue lesion was seen on CT scan (07/11/13) - malignancy could not be ruled out.

On 12th November 2013 Personal Information redacted by the underwent a *"High anterior resection and right hemi-colectomy".* The histology findings confirmed a "Dukes A tumour (adenocarcinoma), and 6mm nodule containing metastatic neuroendocrine carcinoma" within the "*high anterior resection"* specimen and a "neuroendocrine carcinoma" contained within the *"right hemicolectomy".*

Personal Information redacted by the was referred to an Oncologist for further management and was seen on 24th May 2014, treatment was not required at this time.

2.0 THE INVESTIGATION TEAM

Names	TITLES
Damian McKay	Consultant Surgeon (Chair)
Anne McVey	Assistant Director of Integrated Maternal and Women's Health
Katherine Robinson	Contact and Booking Centre Manager
Paula Fearon	Governance Support

3.0 INVESTIGATION TERMS OF REFERENCE

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

- To carry out a review into the care provided to Personal Information redacted by the, from August 2007 until April 2014
- To carry out a review into the care provided to Personal Information redacted by the using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on document evidence and staff accounts of events.

- To identify the key contributory factors which may have had an influence or contributed to Personal Information redacted by the treatment and care
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT to staff associated with this care
- To share the report with Personal Information redacted by the

This investigation will adhere to the principles contained within the National Patient Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".(Appendix 2)
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

4.0 INVESTIGATION METHODOLOGY

Review of Records
The Review Team analysed the following records associated with the case:

- Datix Incident Report
- Medical Notes
- Nursing Notes
- Patient Administration System (PAS) records

Review of Relevant Reports, Procedures, Guidelines
The Review Team also considered the following:

- http://www.cancerresearchuk.org/about-cancer/type/bowel-cancer/treatment/dukes-stages-of-bowel-cancer

5.0 DESCRIPTION OF INCIDENT/CASE

On 18th August 2007 a GP referred the then Personal Information redacted by the USI old Personal Information redacted by the to the Rectal Clinic of Dr 1 (Consultant Surgeon) at CAH. The referral letter indicated the patient had a six month history of painless rectal bleeding. Rectal examination was normal. The patient had not lost weight, had a good appetite and did not have diarrhoea. The GP requested the patient be seen for consideration of sigmoidoscopy.

Personal Information redacted by the was seen as requested on 5th November 2007 by Dr 2 (Staff Grade Surgeon)

who documented Personal Information redacted by the had a year long history of bright red rectal bleeding, two episodes of which occurred after July. There was no abdominal pain, weight loss, nor change in bowel habit or passing of mucous. Personal Information redacted by the did not have a family history of bowel problems. On examination Personal Information redacted by the's abdomen was soft, there was no tenderness. A small haemorrhoid was noted on rigid sigmoidoscopy -to 7 centimetres cms- but the view was obscured by faeces. Dr 2 planned a barium enema for the patient and a review with the results and advised the GP of this plan in a letter dictated 05/11/07.

Personal Information redacted by the had the barium enema as an outpatient on 4th January 2008. Dr 3 (Specialist Registrar to Dr 1) dictated a "Surgical Department Results Letter" to the patient's GP on 21st February 2008. The letter informed that the barium enema (04/01/2008) revealed a constant filing defect in the distal sigmoid colon. This measured over a centimetre and was consistent with a stalked (pedunculated) polyp. Direct visualisation of this was advised by Radiology. There were some small diverticula also noted but otherwise the rest of the colon appeared normal. The letter stated Dr 3 had already arranged for Personal Information redacted by the to have the flexible sigmoidoscopy as an outpatient after which the GP would be written to with the results. The sigmoidoscopy did not take place.

Personal Information redacted by the was invited to take part in the Northern Ireland Bowel Cancer Screening Programme in 2013. The test was positive for blood (21/10/13). Dr 1's secretary contacted Personal Information redacted by the the following day to arrange colonoscopy.

On 30/10/13 Dr 1 carried out a visual examination of Personal Information redacted by the's colon using a colonoscope. A < 2cm polyp was seen in the distal sigmoid colon. The polyp had adenomatous change around the base which was very broad. It was not possible to resect the polyp endoscopically. As the appearance was concerning for malignancy a CT scan of chest abdomen and pelvis (CAP) was ordered. Provided this did not reveal disease below (distal to) this section of bowel, it was planned to offer Personal Information redacted by the a sigmoid colectomy. The CT scan was carried out on 7th November 2013 and revealed a known sigmoid polyp and a soft tissue lesion 4x3 cms in size and close to the ileocaecal junction. The terminal ileum was thick walled. It was not possible to verify if the soft tissue lesion was malignant on CT imaging.

Personal Information redacted by the was admitted for laparotomy and sigmoid colectomy on 12th November 2013. A "*laparotomy high anterior resection and right hemicolectomy*" was carried out that day. Personal Information redacted by the recovered well following transfer to a surgical ward on 13th November and was discharged home on 25th November with District Nurse and Stoma Care Nurse support.

Personal Information redacted by the's case was discussed at the Lower Gastroenterology Multidisciplinary Team Meeting (Lower GI MDM) on 21st and 25th November 2013. The Histology Report of Personal Information redacted by the's surgery was discussed. The surgery specimen was subdivided into 3 areas of the bowel:

1. **The High Anterior Resection**

An adenocarcinoma was present in this section. The pathological staging of this adenocarcinoma was classified as:

Dukes A (*tumour in innermost lining of colon or rectum or slightly going into the muscle layer*)
TNM T2 (*tumour into muscle layer of bowel wall*)
N0 (*no lymph nodes involved 0/12 positive for disease in this tissue*)
M0 (*no evidence of metastatic disease*).

A 6mm fibrous nodule showed metastatic neuroendocrine carcinoma.

2. Rectal Rings
No evidence of malignancy

3. Lesion Ileocaecal Valve Right Hemicolectomy
This section contained a Grade 1 (*well differentiated*) neuroendocrine carcinoma.
TNM T4 (*the tumour has grown through the outside membrane of the bowel wall*)
N1 (*there is cancer cell spread to the lymph nodes 5/11 lymph nodes involved in this tissue*)
M1 (*there is spread away from the cancer. Neuroendocrine tumour was present in appendix, peritoneal nodule and in rectal specimen*).
There was extensive lymphovascular invasion.

An Octreotide scan and gut hormone profile were ordered and Personal Information redacted by the was referred to Dr 7 (Professor Oncology) for further management.
The Octreotide scan was carried out on 29th January 2014, no evidence of active neuroendocrine tumour was identified. Dr 7 saw Personal Information redacted by the on 14th May 2014 and discussed the two separate pathologies (adenocarcinoma and neuroendocrine) with Personal Information redacted by the. Dr 7 advised that pending results of GI hormones and 24 hour urine for 5HIAA (tests to detect endocrine tumour activity) treatment would not be necessary. Personal Information redacted by the is currently under review but has not had further treatment.

6.0 FINDINGS

The Review Team has reviewed Personal Information redacted by the's treatment and care throughout the time frame August 2007-May 2014.

Referral and Investigations August 2007-January 2008
The Review Team is of the opinion that the initial referral from General Practitioner to CAH Rectal Clinic was appropriate. The timeframe from receipt of referral to Personal Information redacted by the being seen at the Rectal Clinic was acceptable. The examination of Personal Information redacted by the and requested investigations were correct for the presentation.

Return to System October 2013
Personal Information redacted by the was referred from the Northern Ireland Bowel Cancer Screening Programme in 2013. All investigations, treatments and referrals were undertaken in a timely manner.

The Relevance of the Omission of Flexible Sigmoidoscopy 2008 to the Bowel Pathology Findings 2013
The Review Team is of the opinion that, in the absence of any other polyps within the surgical specimen, the polyp visualised in 2007 is almost certainly the same polyp which was identified on histology of the surgical specimen in 2013. The adenocarcinoma of colon was not visible on barium enema in 2008. Had the planned

flexible sigmoidoscopy been undertaken in 2008, the then benign polyp would have been removed. It is likely that had the polyp been removed in 2008 Personal Information redacted by the would not have gone on to develop this colon cancer. The colon cancer (adenocarcinoma) which was surgically removed in 2013 is a potentially curable cancer that has been treated appropriately.
The neuroendocrine cancer is an *incidental* finding- that is a chance discovery during the investigation of something else- in this case the investigation of an identified rectosigmoid polyp. This separate entity would still have developed even if the polyp had been removed in 2008 and Personal Information redacted by the would still have required surgery to treat this neuroendocrine cancer.

Request for Flexible Sigmoidoscopy (2008)
The Review Team explored the process which was in place in 2008 to arrange flexible sigmoidoscopy for those requiring the procedure as an Outpatient. It has been ascertained that at that time there was no form used to request this procedure. There was an expectation that the audio typist charged with typing the letter to the patient's General Practitioner would add the patient's name to the day case waiting list. Unfortunately this did not happen on this occasion. The General Practitioner did not follow up on this omission however the Review Team is of the opinion that given the volume of on-going investigations in General Practice it would be unrealistic to have expected a GP to raise this. Furthermore waiting times vary for endoscopy procedures. Clinicians are not routinely updated regarding this. The Review Team noted there is no documentation to indicate the patient had been advised of the upcoming procedure, the rationale for it, the expected timeframe or how or whom to contact if an appointment was not received within a given timeframe. The Review Team is of the opinion that the booking process in existence in 2008 was not robust.

The current process was then mapped. The audio typist still adds patients to a waiting list. A specific yellow coloured paper endoscopy form is also filled in manually by the clinician and attached with the patient's chart which is sent to the Consultant's secretary. This acts as a prompt for the secretary to check the patient's name has been added to the list, if not there is an expectation that the secretary will make the addition. The current process, although arguably marginally safer, contains several steps at which error can occur: the request may not be completed; the paper request may potentially go missing; it may be assumed "someone else" did or will enter the request. The Review Team therefore is of the opinion that the appointment booking pathway should be reviewed with a view to streamlining the process. Ultimately the Review Team recommends that an electronic booking system should be used by the requesting clinician at the time of the decision to scope.

The Review Team appreciate this development will take time to introduce. In the interim period therefore it is suggested that consideration is given to extend the spot checks currently undertaken by Service Administrators -to assure follow up by secretaries and audio-typists- to endoscopy requests.

7.0 CONCLUSIONS

This investigation has reviewed the treatment and care given to Personal Information redacted by the in regard to bowel management from 2007-2013. The Review Team has concluded that with the exception of the flexible sigmoidoscopy all investigations, treatments and

7.0 CONCLUSIONS

management were undertaken in a timely manner by the correct grade of staff.

Having reviewed the histology of Personal Information redacted by the's surgical specimen (2013) it has been concluded that the neuroendocrine cancer was an incidental finding at this time. It is the opinion of the Review Team that the omission of flexible sigmoidoscopy in 2008 did adversely impact on Personal Information redacted by the's management as the identified polyp was not removed at that time. This omission was not acceptable. The Review Team wish to apologise to Personal Information redacted by the on behalf of the Southern Trust.

The investigation has concluded that the process in place in 2008 for ordering sigmoidoscopy was not robust. Although the process has since changed the "paper requests" currently used also afford the possibility of a similar event happening in the future therefore the Review Team recommends that a more stringent process is devised and introduced.

8.0 LESSONS LEARNED

A paper request can go missing. It can also be difficult and time consuming to verify if requests have actually been inputted, at what time and by whom. An electronic system of requesting endoscopy would facilitate a safer requesting and review system and allow a quick check to confirm requests have been made.

It is important that processes for ordering requests are simple and streamlined so that there is no ambiguity as to who should input investigations and at what point. It is unsafe to assume "someone else" will do so.

This review has again highlighted the importance of good communication. Endoscopy waiting times fluctuate; clinicians should be kept updated. Giving patients' information of why an investigation is planned and whom to contact regarding perceived delays or a worsening of symptoms is good practice and may reduce unfilled requests being missed in some instances.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

Consideration should be given to developing and introducing an electronic system of request for endoscopy.

Action Plan

A task and finish group with the appropriate skill set should be convened to advance this.

Lead

Anita Carroll Assistant Director of Functional and Support Services

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 2

The current requesting system should be reviewed to incorporate a stringent method for checking that endoscopy requests have been actioned by the secretarial support team.

Action Plan

The feasibility of expanding the current Service Administrator audits to incorporate endoscopy requests should be explored. This assessment should include potential resource implications and requirements.

Lead

Anita Carroll Assistant Director of Functional and Support Services

Recommendation 3

Currently General Practitioners receive a regular bulletin from the Trust on current waiting times for each specialities' procedures/investigations. The circulation list should be expanded to include all clinicians so that they are aware of these times, so that when they are explaining the plan for a patient's on-going treatment/investigation, they can give the patient an indication of when to expect an appointment.

Action Plan

A task and finish group should convene to consider the detail of information required and how best to communicate this and to whom.

Lead

Damian McKay Consultant Surgeon and Anita Carroll Assistant Director of Functional and Support Services

10.0 DISTRIBUTION LIST

Date	Time	Event
18/07/07		**GP referral letter** (dated 16/07/07) to Rectal Clinic (Dr 1. Consultant Surgeon, Craigavon Area Hospital (CAH)) Letter content: Many thanks for seeing. The patient has a history of rectal bleeding for about 6 months. Appetite is good no diarrhoea or weight loss. The bleeding is painless and normal rectal exam ?sigmoidoscopy
05/11/07		**Appointment Surgical Outpatient Department** (CAH Dr 1 Clinic) Seen by Dr 2 (Staff Grade Surgeon) 1 year history of PR bleeding- streaked bright red rectal bleeding (BRRB). No mucus, no change in bowel habit. 2 episodes since July. No weight loss. Smoker 10 a day. No abdominal pain. No family history bowel problems. **O/E:** Abdomen soft non-tender (SNT). Rigid sigmoidoscopy to 7cm showed a small haemorrhoid, but view obscured by faeces. **Plan** Barium Enema and we will review with the results.
07/11/07		**Surgical Department Outpatient Letter to GP** to inform of above
04/01/08		**Barium enema** (OPD)
21/02/08		**Surgical Department Results Letter to GP from Dr 3** (Specialist Registrar to Dr 1) Patient had outpatient barium enema performed on 04/01/08 which revealed a constant filling defect in the distal sigmoid colon measuring more than 1cm consistent with pedunculated polyp. In direct visualisation of this area has been advised. The rest of the colon revealed small diverticula, right colon and appendix and terminal ileum were normal. In view of this I have arranged for an outpatient flexible sigmoidoscopy. We will write to you with the results.
		**********
21/10/13		**Bowel Screening Form-Visible blood**
22/10/13		Hand written note on Participant Assessment Sheet "22/10/13 Dr 1 secretary rang to say patient has to be done on Dr 1 list. Patient contacted and informed of same. Patient to ring Dr 1 sec to confirm date."
30/10/13		**Colonoscopy** **Colonoscopy Report** from op carried out on 30/10/13: (patient consent for op) I**ndications**: Bright red rectal bleeding and colonic polyp in sigmoid 2008. **Report**: Bowel prep 2L Moviprep good. Digital rectal examination performed. Colonoscope inserted via the anus to the caecum which was identified positively by the ileocecal valve, the appendicular orifice and the tri-radiate caecal fold. The scope was retroflexed in the rectum. Lesions: 1 sessile polyp (20mm) within (a- marked on diagram within distal

Date	Time	Event
		sigmoid) **Diagnosis**: Colonic polyp **Advice/Comments**: Colonoscopy to caecum. <2cm distal sigmoid polyp - adenomatous change around base with very broad base. Irresectable endoscopically, concerning for malignancy. For CT CAP (chest abdomen and pelvis) and then sigmoid colectomy if no evidence of distal disease
07/11/13	11:28	**CT Chest, abdomen and pelvis with contrast** (South Tyrone Hospital) **Clinical Details** Colonoscopy showed a distal sigmoid polyp – probably malignant. Not resectable endoscopically. For sigmoid colectomy. **Report:** Thyroid enlarged, heterogenous appearance retrosternal extension. No lung mass seen. Mild atelectasis seen in medial segment of middle lobe. Subcentimeter epicardial lymph nodes seen in right cardiophrenic angle region. Liver no focal lesion. Gallbladder spleen pancreas and both kidneys appear normal. Normal urinary bladder. No uterine lesion seen. 4x3cm soft tissue lesion seen on superomedial aspect of ileocaecal junction. The terminal ileum is thick walled. **Conclusion**: 1. Known case of sigmoid polyp. 2. Soft tissue lesion superomedial to ileocaecal region. Neoplastic or inflammatory nature of this lesion cannot be ascertained on CT. Further evaluation/MDT discussion suggested.
08/11/13		Pre-op assessment booklet completed. Clinic / Decision to list for op green sheet completed.

Date	Time	Event
12/11/13		**Sigmoid Colectomy**
	A.M.	Admitted, fasting **laparotomy and sigmoid colectomy**. Seen by Stoma/colopractology nurse: spoken to again re proposed surgery. 'sigmoid colectomy' and further questions answered. Potential stoma site marked right and left side of abdomen with patients site and co-operation
	17:35	Returned to Recovery ward following **high anterior resection and right hemi colectomy**.
	21:30	Seen by Dr 4 (Consultant Anaesthetist) Sigmoid Colectomy today. ECG changes noted. No chest pain / SOB **Plan:** Repeat tropins at 23:00. Repeat ECG – if both normal return to ward.
13/11/13		**Ward Round** (Dr 1) (Recovery Ward) Day 1 – Right Hemi Anterior Resection- explained to patient. No bleeding since theatre. Continue Laxido. Eat and drink as able.
	10.00	**Post Op Review ICU** (Dr 5 F2 ICU) Hypertension, raised cholesterol, non-insulin dependent diabetes mellitus (NIDDM) Intra-operative ST depression. Kept in Recovery for observation. Sitting out comfortably pain well controlled. Monitor urinary output Physio Ongoing Surgical Management
	11.20	**Review** Consultant ICU (Dr 6) Hartman's 250mls Ward Monitor urine output.
	18:45	Transferred from Recovery Ward to Ward
21/11/13		**Multidisciplinary Meeting** (MDM) (Consultant Dr 1) MDM update: **Colonoscopy** 30/10/13-revealed a distal sigmoid polyp – probably malignant. Not resectable endoscopically . **CT Chest/Abdomen/Pelvis** 07/11/13 **High Anterior Resection and Right Hemicolectomy** 12/11/13 **Pathology High Anterior Resection**

Date	Time	Event
		Dukes A pT2 N0 R0 tumour with 0/12 nodes positive. A 6mm polyp resected confirmed as metastatic neuroendocrine carcinoma **Pathology Right Hemicolectomy** pT4 N1 M1 Neuroendocrine carcinoma with 5/11 nodes positive For Octreotide scan and referral to Dr 7(Professor Oncology) **RADIOLOGY** **CT Findings** **Chest Abdomen and Pelvis** (as 07/11/13)
21/11/13		**Letter to GP**: (Dr 9 Registrar to Dr 1) Patient was discussed at Lower GI MDM meeting today. Pathology showing pT2 N0 adencarcinoma of sigmoid colon and a pT4 N1 M1 neuroendocrine carcinoma of ileocaecal valve. The M1 is for reasons of peritoneal spread. Requires octreotide scan, gut hormone profile and referral to Dr 7 in Belfast
25/11/13		Discharged home with District Nurse and Stoma Nurse support.
25/11/13		**Report from Cellular Pathology** (reported 21/11/13): **Summary**: **Specimen:** Rectal Resection/Anastamosis Rings/Colonic resection. **Clinical details:** 1, polyp of rectosigmoid junction. High anterior resection. 2 rectal rings. 3 Lesion ileocaecal valve right hemicolectomy. **Diagnosis:** **Rectum**, high anterior resection. Adenocarcinoma. Metastatic neuroendocrine carcinoma. Lymph nodes with high anterior resection, no evidence of malignancy. **Rectal ring**, no evidence of malignancy. **Right hemicolectomy**, ileum, well differentiated (grade 1) Neuroendocrine carcinoma. Lymph nodes, metastatic neuroendocrine carcinoma. Appendix metastatic neuroendorcrine carcinoma.
25/11/13		NM Octreotide scan whole body requested (Dr 1)
06/01/14		Letter from (Registrar to Dr 1) to GP Informing GP re histology and referral to Dr 7
29/01/14		**NM Octreotide scan with SPECT** (stamped received report 11/02/14) Normal distribution of isotope and no abnormal uptake can be identified. **Conclusion:** no evidence of active neuroendocrine tumour can be identified.
07/03/14		Letter from Dr 9 to Dr 7 Request patient be seen for ongoing management post right hemicolectomy and

Date	Time	Event
		high anterior resection for sigmoid tumour and right colon tumour. Pathology pT2 N0 adenocarcinoma of sigmoid and grade 1 pT4 N2 neuroendocrine carcinoma of right colon with extensive intra and extramural lymphovascular invasion. Peritoneal involvement with neuroendocrine tumour with separate nodule identified in peritonealised fat in the bowel resection specimen. Octreotide scan shows no abnormal uptake of iodine.
26/03/14		**Letter from Belfast Health and Social Care Trust** (to Patient) Dr 1 has asked me to see you as follow up from your recent surgery. I will be sending you an appointment shortly for this.
31/03/14		**Letter to GP** (typed from dictation Dr 10 SHO to Dr 1) Admitted following suspicious colonoscopy underwent laparotomy high anterior resection and right hemi colectomy 12/11/13. Intraoperatively ST depression on ECG resolved. Discussed at MDT recommended octrecotide scan and referral to Dr 7. Reviewed as planned on 06/01/14 at Dr 1 OPD.
14/05/14		**Letter Belfast Health and Social Care Trust** Dr 7 to Consultant 1 (received CAH 14/05/14) **Clinic Attendance 25/04/14** –Diagnosis: Small Bowel Neuroendocrine Tumour (Grade 1, pT4 N1 M1) with nodal and peritoneal involvement, rectosigmoid adencocarcinoma pT2, N0 M x Duke's A, resection November 2013. We did discuss the diagnosis and tried to distinguish between the two different tumours. The patient is feeling well. Made a good recovery and describes no flushing or diarrhoea. Patient was asking about liver and from a CT scan and octreotide scan this was clear. CT Scan had shown some heterogeneous appearance of the thyroid. However, octreotide scan was clear and I do not feel that we need to pursue this. What we have arranged is firstly checking blood GI hormones and 24hr urine 5HIAA. We will discuss case at the neuroendocrine tumour multidisciplinary meeting but I envisage no treatment being necessary at this stage subject to seeing hormone levels and review will be in 4 months' time at the neuroendocrine clinic.

Code	Grade / Title

Dr 1	Consultant Surgeon
Dr 2	Staff Grade
Dr 3	Specialist Registrar
Dr 4	Consultant Anaesthetist
Dr 5	F2, ICU
Dr 6	Consultant Anaesthetist
Dr 7	Consultant Oncologist NICC BCH
Dr 8	Consultant Surgeon
Dr 9	Specialist Registrar to Dr 1
Dr 10	SHO to Dr 1

Southern Health and Social Care Trust

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Investigation Report on a SEA Level 1

Organisation's Unique Case Identifier:
HSCB Unique Case Identifier:

Date of Incident/Event: 25th – 26th /01/2015
Responsible Assistant Director: Mr Ronan Carroll
Designation: Assistant Director for Acute Services
Responsible Lead Officer: Mrs Brigeen Kelly
Designation: Lead Nurse ATICS

Report Author: Mrs Brigeen Kelly

Report Contributors and Reviewers:

Dr D Orr Consultant Anaesthetist
Sr Helena Murray Theatre Sister
Ms Jilly Redpath Pharmacist
Dr Beverley Adams Consultant Obs & Gynae
Mrs Alison Little Governance IMWH
Dr Shah Consultant Paediatrician

Date report signed off:

Contents

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE:	Personal Information redacted by
DATE OF SIGNIFICANT EVENT:	Personal Information redacted by the USI
DATE OF SIGNIFICANT EVENT MEETING:	15th April 2015
SEA FACILITATOR/ LEAD OFFICER:	Mrs Brigeen Kelly
TEAM MEMBERS PRESENT:	Dr D Orr Chair Helena Murray Jilly Redpath Dr Beverley Adams Mrs Alison Little

WHAT HAPPENED?

During an emergency caesarean section, following spinal anaesthesia the patient became unwell (Crash Team called for assistance) – initially unsure of the aetiology of the incident. The next day([redacted]) on reflection of the incident it became apparent that the patient received an undiluted dose of medication.(Phenylephrine)

Baby checked by Paediatrics at birth – required some ventilation breaths in initial minutes; no sustained bradycardia beyond first 30 seconds. Follow up NEWS – 0.

WHY DID IT HAPPEN?

- Miscommunication within the team.
- Drug checking procedure failure.
- Drug requested must be diluted prior to use, is only available as a concentrate.

WHAT HAS BEEN LEARNED?

- Clearer communication on what has been verbally requested and the correct checking procedure carried out when handing over the requested item.

WHAT HAS BEEN CHANGED?

- Concentrated ampoules of drug to be quarantined – to ensure the infusion is prepared using the ampoules and they are transferred immediately back to the 'Dilute to use' box.

RECOMMENDATIONS FOLLOWING THE LEVEL TWO SEA:

Recommendation 1

Action: To quarantine drug in 'Dilute to use' box – boxes purchased.
Lead : Brigeen Kelly
Timeframe : 2 weeks - COMPLETE

Recommendation 2

Action: Clearer communication between teams regarding the request made is requested and repeated on receipt of drug.
Lead : Anesthetists & Nursing staff
Timeframe: To be discussed & minuted at Nursing Staff meeting & Anaesthetic Directorate Meeting within 1 month. May 2015 – ONGOING

Recommendation 3

Action: Phenylephrine must be checked & diluted immediately.
Lead: Anesthetists & Nursing staff
Timeframe: With immediate effect

Recommendation 4

Action : To seek ready diluted drug
Lead : Ms. Jilly Redpath
Timeframe : 12 months – April 2016 - ONGOING

Recommendation 5
Action : Issue regarding this incident to be disseminated regionally
Lead : SHSCT
Timeframe : 3months –August 2015 - TBD

Where a Level two or three investigation is recommended please complete the sections below

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

Date	Time	Source	Event - including contacts, assessment, referral dates
	22:48	SN A Statement	Bleeped to attend Emergency Section in Delivery Suite Fluids ran through Hotline & Phenylephrine infusion prepared as per protocol – checked with Dr 1. Spinal trolley prepared & opened.
Personal Information red	22.55	Midwifery Careplan	Time admitted to Theatre.
	22:56-23:00	SN A statement	Pre-operative checklist carried out, patient feeling unwell and discussed with SN A that she was known to the Cardiology Department. Monitors, Fluids & infusion attached to patient. SN A assisted with the spinal anaesthetic.
	Approx. 23:00	Dr 1 statement	Dr 4 requested to attend Maternity Theatre for emergency C- section – as Dr 4 was already busy with patients in Resus – Dr 1 offered to attend Maternity theatre. On assessment of the patient it was noted that the patient had been vomiting since admission – had previously been prescribed & Ranitidine administered @21:50 (as per Kardex), continued to vomit- Sodium Citrate requested – given but vomited again.
	23.00		Anaesthetic commenced by Dr 1 Fluids erected 1000mls Compound Sodium Lactate (No1) - 16 g cannula already in situ Phenylephrine Infusion commenced - 100mcg/ml running @ 30-40 mls/ hour via syringe pump.

		Anaesthetic chart/statement Dr1	Patient vomited prior to insertion of spinal block
	23.06		Spinal administered : Heavy Bupivacaine 2.5ml Diamorphine 250mcgs
			Became hypotensive – Systolic 79
	23.13		Requested SN A to pass the syringe Glycopyrrolate (on top of anaesthetic machine) previously drawn up by Dr 1 & to draw up some phenylephrine from the bag in a 2 ml syringe and give the syringe to Dr 1. SN A handed Dr 1 the Glycopyrrolate syringe & went to prepare the requested Phenylephrine. Glycopyrrolate 200mcgs administered, whilst waiting on the Phenylephrine Dr 1 was manually checking the radial pulse. Dr 1 did not see the syringe being prepared. SN A informed Dr1 the syringe was ready and had left it on the trolley beside Dr 1. Dr 1 injected 0.25mls of Phenylephrine .Immediately after the 0.25mls bolus the patient became unwell – complained about a headache and a general feeling of being unwell. ECG changes - (sinus tachycardia, thin complexes then broad becoming polymorphic.) Heart increased to 170bpm BP – diastolic of 125 mm Hg and a systolic less than 200 mm Hg
	23.15		Patient was pale and Dr 1 requested immediate surgical intervention. Surgery Commenced BP remained elevated

	23.15		Baby delivered Phenylephrine infusion reduced to 20 mls /hr. Propofol 50mgs administered Crash team, crash trolley & anaesthetic help requested.
	23.20		Magnesium 5gs in 500mls 0.9% NaCL (No3) Oxytocin 3IU administered – Oxytocin infusion commenced- 40IU in 500mls0.9% NaCL (No 2)
	23.25		Propofol 50mg administered Alfentanil 250mcgs administered Paracetamol 1g Ondansetron 4mgs
	23.50		Alfentanil 250mcgs administered Moved to Recovery Area – close monitoring overnight – hypotensive throughout night 02 overnight @ 4L/min Reviewed IV fluids and analgesia administered.
	23.55		Post spinal – patient felt dry IV fluid given (No 1) Had been vomiting since admission BP 79 systolic Increased Phenylephrine infusion Heart rate 82 Glycopyrrolate & small bolus of Phenylephrine given Heart rate increased initially – broad complexes/irregular & fast

			Patient began to feel unwell Headache + GCS 14/15 Rousable but somnolent (sleepy/drowsy) Highest BP 172/112 Propofol administered Called crash team (no documentation), crash trolley & anaesthetic help. BP low – heart rate high & erratic Dr 2 – called to deliver baby (emergency) Spinal block adequate Arterial Line inserted Analgesia Administered Antiemetics given Discussed patient with Cardiology – to have an ECHO carried out on 26/01/15 12 ECG now ECG monitoring overnight Discussion with patient – patient recalls previous ectopics & palpitations on 24hr tape – no further issues. Explanation given to patient & husband.
[redacted]	22:48 – 01:00	SN A statement	After spinal anaesthetic was administered & the patient was positioned, the patient's condition deteriorated. Dr 1 requested help, we were aware Dr 4 was in Resus with another patient. SN A requested by anaesthetist to complete multiple tasks. Dr 1 requested SN A to draw up some phenylephrine. I drew up one ampoule of phenylephrine 10mgs/ml and SN A handed the syringe to Dr 1, SN A checked the contents of the ampoule with Dr 1 by displaying the phenylephrine ampoule & read the contents out loud.

			SN a continued with other tasks as requested. Dr 1 requested help again & Sr 1 called the Crash Team although the patient did not arrest. SN A's recollection is that Dr 4 arrived approximately at the same time as the Crash Team. SN A telephoned Theatres to request assistance with running through an arterial line. Baby delivered & patient brought to Recovery Area in Delivery suite.
Personal Information redacted by	23:35	Paediatric notes	Called to emergency Section 38wks 2 x previous sections Maternal collapse on insertion of spinal Very little blood in cord @ delivery Transferred to Resuscitaire Pale; Heart rate < 100, no respiratory effort. HR 60 Inflation breaths x 5 Hear rate improved but decreased to < 100 again Secretions suctioned under direct vision Further 5 inflation breaths & continuous ventilation breaths until 4 /min Respiratory effort improved Strong Sats 95% @ 8 mins and maintained Baby wrapped & given to parents.
Personal Information red	01.00	Anaesthetic chart-note added Dr 1	Seen by Dr 2– to be discharged to Post Natal Ward
	09.00	Patient Maternity notes	Discharged to Ward 2 West

Personal Information red			
	09.45	Patient Maternity Notes	Bloods ECG 24 hr. tape ongoing ECHO carried out Midwifery Care ongoing
	09.45 – 00.00	Patient Maternity notes	Bolus of Phenylephrine given when low BP Asked SN A assisting me to prepare a 2ml syringe with Phenylephrine from the bag Handed syringe & I (Dr 1) administered 0.25 of 1 ml = 0.25mls (Dr1) retrospectively asked the SN A if the drug came from the box (undiluted) or bag(diluted) SN A confirmed the syringe contained undiluted drug which I had not realised when I had administered the drug. The patient received 2.5mgs Phenylephrine at that time. This error has been explained to the patient today (27th), all questions answered, very understanding – reassured that herself & baby are well. Patient wished to meet Dr 1 with husband- meeting arranged 11am (No further note of meeting)

Personal Information redacted	09.00	Anaesthetic Chart – 2nd additional note	Cardiology Review by Dr 3 Asked to review due to TTE result ECHO post-partum – mild LVSD (EJ 50%) Severe basal hypokinesis – otherwise structurally NAD ECG – nil acute 24hr tape – Normal sinus rhythm – No arrhythmias No cardiac history Currently asymptomatic This pattern on TTE can occasionally be seen in cardiomyopathy associated with endogenous catecholamines i.e. Regional Takotsubo syndrome; therefore obviously maybe associated with iatrogenic Phenylephrine infusion. Advise: Repeat ECHO 1month (Dr 3 to arrange) If LVF not resolved for OPC appointment - ? further investigations
	14.00	Patient Maternity Notes	To be discharged home following review.
Personal Information redacted	16.00 – 17.30	Patient Maternity Notes	Post natal check completed. Cardiology & obstetric review complete - to be reviewed at both Outpatient clinics. Discharge information given & questions answered. Discharged to community team
Personal Information redacted		Patient notes – Obs.Gyn Outpatients with Dr 2.	7/52 post caesarean section ECHO not booked – to be followed up by Dr 2 ECHO now complete – normal result Bottle feeding Wound site checked – satisfactory

			Awaiting outcome of investigation into theatre incident.
Personal Information red		Baby notes - Dr 7	Obs note review - Discussed baby's progress with mother, reassured that the baby did not suffer any period of oxygen deficit. Effective resuscitation carried out – No CPR required. Baby sent to PNW - NEWS 0. Mother worried that the baby may have suffered significant hypoxia. Dr & 7 reassured the mother that baby recovered very quickly and the events were not long. Baby was managed very well by the trainee Doctors (Dr 5 & Dr 6) on site. Baby will not have any problems in the future due to the events at birth. As such baby is now 4 months old and doing well. Mother was very reassured.
Personal Information red		Chairperson of SEA	Contacted mother by telephone to discuss this incident findings & recommendations – discussed at length. Mother emailed Chair to express her gratitude in having the explanation & recommendations discussed.

FLUIDS ADMINISTERED		
No 1	**1000 mls**	**Compound sodium Lactate**
No 2	**500 mls**	**0.9% Sodium Chloride**
No 3	**500 mls**	**0.9% Sodium Chloride**

Southern Health and Social Care Trust

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE	Personal Information
DATE OF SIGNIFICANT EVENT	Personal Information redacted by the USI
DATE OF SIGNIFICANT EVENT MEETING	**15/05/15**
SEA FACILITOR/ LEAD OFFICER	Alison Little Acting Risk Midwife
TEAM MEMBERSHIP	Dr Beverley Adams Consultant Obstetrician Jan Meyer Medical Manager Out of Hours Cathy Daly Consultant Emergency Department Claire McNally Out of Hours Governance Sharon Holmes Sister Emergency Department

WHAT HAPPENED?

Personal Information was Personal Information redacted by the USI old primigravida with a BMI of 39 who smoked 5 cigarettes a day and consumed 20 units of alcohol a week. On the Personal Information redacted by the USI at 23:16 hrs. Personal Information contacted the Out of Hours GP Service by telephone with abdominal cramps from previous day and a heavy discharge. A telephone history was taken of Personal Information having lower abdominal discomfort radiating to her lower back, with some ease with micturition, urinary frequency but no dysuria or malodour. A new yellowish vaginal discharge was noted. Personal Information had vomited 3 times yesterday but was eating and drinking with no fever. A past medical history taken identified Personal Information had irregular periods, her last period being 10 months ago, that she was sexually active and did not use contraception. The possibility of pelvic inflammatory disease was discussed. Personal Information was advised to try a warm bath/paracetamol that night and to attend her GP for review in the morning so swabs could be taken prior to commencing antibiotics. Personal Information was advised to attend the Emergency Department if her condition deteriorated. From the recorded telephone conversation of the consultation with the Out of Hours GP the possibility of pregnancy was discussed and not fully excluded with the patient highlighting she had irregular periods due to Polycystic Ovarian Syndrome.

Personal Information contacted her GP by telephone on Personal Information redacted by the USI advising the GP that she had a history of frequency and pain passing urine. She also complained of feeling nauseated. Her GP was concerned re: a possible Pelvic Inflammatory Disease. Once she established there was no discharge, an antibiotic was prescribed for 3 days.

Personal Information also contacted the Out of Hours Service by telephone on Personal Information redacted by the USI at 18:18 hrs. At that time Personal Information was taking trimethoprim and using paracetamol for analgesia but was requesting stronger pain relief. The Out of Hours service telephoned the patient back at 21:08 at which time Personal Information had attended the Emergency Department.

Personal Information self-presented to the Emergency Department at 19:47 hrs. complaining of abdominal pain. She stated that she had been prescribed trimethoprim earlier that day for a UTI. She was assessed by a GP/ST1 at 22:06 hrs. at this time Personal Information gave a history of having a period 20 weeks ago. On examination a lower abdominal mass was identified and an intrauterine pregnancy was suspected. A urine sample was requested at the time of triage and produced at 23:44 hrs. on Personal Information redacted by the USI. A pregnancy test was carried out that was hCG positive. The notes document the referral to Gynaecology at 00:04 hrs. on Personal Information redacted by the USI.

Personal Information was seen in the Maternity Admission and Assessment Unit on Personal Information redacted by the USI at 01:30 hrs. and was confirmed to have an undiagnosed pregnancy. An USS was performed by an ST5 Trainee that confirmed a pregnancy of approximately 39+5 weeks gestation with reduced amniotic fluid index. No fetal heart activity was identified and intra uterine fetal death was confirmed. History revealed no movements had been felt at any stage and there was suspicion of ruptured membranes 2 days before. On vaginal examination Personal Information cervix was 6 cm dilated and foul smelling liquor was noted. A diagnosis was made of suspected sepsis and Personal Information redacted was admitted to delivery suite. A full septic screen was carried out, urgent booking bloods sent, intravenous antibiotics were commenced and the findings were discussed with the consultant on call. Personal Information labour was augmented with a syntocinon infusion and she had a vaginal birth of a stillborn Personal Information redacted by the USI.

The Coroner was contacted following delivery and the baby was transferred for post mortem as per the coroner's recommendation. Personal Information was discharged on Personal Information redacted by the USI on oral antibiotics.

WHY DID IT HAPPEN?

Cause of stillbirth as per post mortem:
'Intra-amniotic infection, acute chorioamnionitis.'

WHAT HAS BEEN LEARNED?

Possible delay in identifying pregnancy and assessment of viability.

If there is insufficient clarity regarding a patient's LMP an onsite pregnancy test should be offered.

Increase awareness of undiagnosed pregnancy.

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

Recommendation 1

All GPs who work in GP OOHs will consider pregnancy as a possible factor in all women of a fertile age during consultations.
Action: Clinical lead to advise GPs in GP OOHs of this learning.
Lead: Clinical Lead

Time frame June 2015 - completed

Where a level two or three investigation is recommended please complete the section below

THE INVESTIGATION TEAM:
INVESTIGATION TERMS OF REFERENCE:

Southern Health and Social Care Trust

Southern Health & Social Care Trust

Findings of Root Cause Analysis Investigation
Reference Number: Datix Personal Information redacted by
(Personal Information **Ref:** Personal Information redacted by the USI

CONTENTS

INTRODUCTION

The Office of the Chief Executive Southern Health and Social Care Board received a letter (Personal Information redacted by the USI) from the daughter of the recently deceased Personal Information expressing her concern regarding the communication of diagnostic information to her mother prior to her death in Daisy Hill Hospital (DHH) on Personal Information redacted by the USI (Appendix One). The Interim Director of Acute Services of the Southern Health and Social Care Trust (SHSCT) requested a root cause analysis (RCA) review be undertaken to investigate the content of the complaint letter. This paper presents the findings of this review.

TEAM MEMBERSHIP

The investigation team for this Root Cause Analysis was as follows:
Bronagh McGleenon Consultant Geriatrician
Fiona Reddick Head of Cancer Services
Kathleen McGoldrick Acting Head of Service Elderly Medicine and Stroke Unit
Paula Fearon Nursing Governance Co-ordinator

TERMS OF REFERENCE

The terms of reference for the review of the care and treatment provided to Personal Information were:

- To carry out review into the communication of information and care provided to Personal Information in Daisy Hill Hospital (DHH) from the time of transfer from the Royal Victoria Hospital on Personal Information redacted by the USI to the time of her death on Personal Information redacted Personal Information redacted by Personal Information redacted by using the National Patient Safety Agency RCA methodology.
- To use a multidisciplinary team approach to the review.
- To identify those factors which may have had an influence on, or may have contributed to the issues identified in the complaint raised by Personal Information's daughter.
- To agree the outcome of the review and subsequent recommendations, actions and lessons to be learnt.
- To report the findings and action the recommendations of the review through the Director of Acute Services SHSCT and disseminate to the staff associated with care.
- To share the report with Personal Information's daughter who raised the complaint.

SUMMARY OF CASE

On [redacted] [redacted] sustained a peri-prosthetic fracture of right femur and was admitted to RVH for repair (undertaken [redacted]). [redacted] was treated for Hypercalcaemia on admission. Investigations undertaken revealed [redacted] had multiple lung and liver metastases (secondary cancer spread). [redacted] had a palpable breast lump and it was noted had been referred to the Symptomatic Breast Clinic [redacted] but had not followed through to appointment.

[redacted] was transferred to DHH for rehabilitation on [redacted]. The transfer documentation indicated [redacted] "currently does not wish to be informed about results of recent scans or a diagnosis".

[redacted] developed respiratory symptoms on [redacted] and was treated for pneumonia. From [redacted] [redacted] had episodes of black vomitus. Oesophago-gastro duodenoscopy (OGD) was arranged. During the consent discussion [redacted] requested information about the results of the investigations undertaken in RVH. [redacted] was informed of her cancer diagnosis and metastatic spread.

Unfortunately [redacted]'s condition continued to deteriorate. Chest x-ray showed an increase in the size of metastatic deposits and fluid. [redacted] did not respond to treatments and died on [redacted].

Outcome, Consequences and Action Taken

Following the death of her mother, [redacted]'s daughter ([redacted]) wrote to the Chief Executive of the Southern Health and Social Care Trust to request an independent report to investigate what happened to her mother and why she deteriorated quickly and died.

A root cause analysis into the case was subsequently commissioned by the Interim Director of Acute Services, SHSCT, in response to this correspondence from [redacted]'s daughter.

This Report contains the findings of that investigation.

REVIEW METHODOLOGY

Review of Records

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

- Medical and Nursing Records
- Transfer information from RVH to DHH

Review of Relevant Reports

The review team also considered the reports referenced below and the correspondence letter received from [redacted]'s daughter

REFERENCES
Department of Health Social Services and Public Safety DHSSPS (2003) Reference Guide for Consent for Examination Treatment or Care www.dhsspsni.gov.uk Ref 202/02.
Breaking Bad News and Communicating Difficult Information-Key Principles. Guide for Southern Trust Staff Version 1 (010611)
Department of Health Social Services and Public Safety DHSSPS (2003) Breaking Bad News …Regional Guidelines
General Medical Council (2008) Consent: patients and doctors making decisions together www.gmc-uk.org/guidance
National Institute for Health and Clinical Excellence (2014) Pneumonia Diagnosis and management of community -and hospital-acquired pneumonia in adults NICE clinical guideline 191 www.guidance.nice.org.uk/cg191
Nathaniel a and Andrews T (2010) The Modifiability of Grounded Theory Grounded Theory Review (Issue 1 Volume 9 March 2010)

Analysis

The analysis contained in this review focuses on:
1) Communication of information to Personal Information and family
2) Personal Information's care in the final week of her life

Stakeholders Involved
The stakeholders involved in this review are as follows:

Personnel Code

Dr1	Consultant Physician/Geriatrician
Dr 2	CT1
Dr 3	Associate Specialist
Dr 4	FY1
Dr 5	FY1 Foundation Yr 1 Trainee
Dr 6	FY1 Foundation Yr 1 Trainee
Dr 7	FY1
Dr 8	Consultant -On call
Dr 9	Core Trainee
Dr 10	Core Trainee
Dr 11	FY1
Dr 12	Locum Consultant Surgeon
Dr 13	CT2 Surgery
Dr 14	Consultant

DESCRIPTION OF INCIDENT

Past Medical History

Personal Information redacted by the USI year old Personal Information lived alone with a care package and family support. Medical history included previous history of Personal Information redacted by the USI Personal Information had been referred to the Symptomatic Breast Clinic in Personal Information redacted by but did not finalise her partial booking appointments.

Background to admission

At home on Personal Information redacted by Personal Information's right leg gave way as she was using her rollator to walk to the bathroom. She was seen in the Emergency Department of DHH and transferred from there to the RVH. Personal Information was admitted to the fracture service of the RVH on Personal Information redacted by with a peri-prosthetic fracture of her right femur. The fracture was fixed on Personal Information redacted by with cable plating to the prosthesis. Personal Information was transferred from the RVH to DHH on Personal Information redacted by the USI.

On admission to RVH Personal Information reported having felt generally unwell for 2-3 weeks; her serum calcium was markedly raised (3.57) on admission. This hypercalcaemia was treated with ibandronic acid; serum calcium was 2.44 on Personal Information redacted by. The cause of hypercalcaemia was investigated. Bone scan (Personal Information redacted by) showed spinal uptake at T11 which may have been due to osteoporotic collapse, nil else to indicate bone metastases. CT Scan (Personal Information redacted by) showed multiple lung and liver metastases. This information was clearly communicated to the team in DHH on a transfer letter from RVH, as was the patient's and family's wish for no further investigation nor discussion of cancer diagnosis with Personal Information at this time.

ANALYSIS and FINDINGS

The review team wish to offer their condolences to the family circle of Personal Information, and understand her death seemed very sudden and was a great shock to them. In her letter to the Trust, Personal Information's daughter speaks of a range of issues she was unhappy about during Personal Information's time in DHH, and has requested more information on her care. The review team has taken each issue separately, and have detailed the response below.

Information provided to Personal Information's daughter in RVH prior to transfer to DHH.

It would seem likely that Personal Information had Personal Information redacted by the USI. In this time the cancer had spread to Personal Information's liver and lungs, but was only discovered when she presented to RVH with a fractured hip. Personal Information's daughter was told of her mother's metastatic cancer (Personal Information redacted) when it was confirmed on imaging scans. Personal Information

died [redacted] later which was a very short timeframe for her family to adjust not only to an unexpected diagnosis of cancer but also the reality that the disease was already incurable. Furthermore it would appear that both [redacted] and her family perceived her recovery from the fractured hip to be the priority.
Although [redacted]'s records indicate the results of her scans were discussed with her daughter in the RVH, there is no detail of the content of the discussion. It is not possible to ascertain from the record if the implications of extensive metastatic cancer and the unpredictable nature of the final stage of this illness was explained to [redacted]'s daughter.
[redacted] had been reviewed by the consultant (Dr 1) in charge in DHH, but unfortunately her family did not have an opportunity to meet with him prior to her death. This had no impact on her subsequent decline, but the review team felt an earlier meeting with senior staff may have helped the family understand the poor outlook.

Communication with [redacted] of diagnosis, care and treatment

The Review team have scrutinised the records from [redacted]'s admission to DHH on the [redacted] until her death on the [redacted] and have also reviewed the transfer information from the RVH which was clear and comprehensive.
On several occasions the Medical and Nursing records indicate that [redacted] did not want to know the results of her scans or be told a diagnosis. These statements are qualified on each occasion by the terms "at present" or "currently". The Medical transfer document also states that a discussion was held with [redacted] and her daughter in which [redacted] was advised that a breast biopsy would be required before a referral could be made to an Oncologist-that is a doctor who specialises in cancer treatment- to discuss further management. [redacted] had agreed to have investigations of the breast lump "in the future".
The transfer letter confirmed [redacted]'s doctors in RVH were of the opinion that [redacted] had the "capacity" –that is the ability to understand and use information in order to make a decision- to decide that she did not want any further investigations of the breast lump or information of scan results at the point of transfer. [redacted]'s capacity was never felt to be in doubt throughout her illness.
[redacted]'s wish not to be given information was respected until the [redacted]. At this point, there is clear documentation that the patient requested more information about her diagnosis, and specifically asked about results of scans performed in the RVH. It is important to appreciate that patients have the right to change their mind at any stage about their own care and treatment. (DHSSPS 2003 4.9). At the point at which there was a change in [redacted]'s condition the review team are of the opinion that it was appropriate for medical staff within SHSCT to verify with [redacted] whether she wished further information or investigations. This conversation was documented in detail in the medical notes and is contained within the accompanying Timeline.

Communication of cancer diagnosis to [redacted] after transfer to DHH
[redacted]'s daughter raised a concern that Dr 2 (CT1) informed [redacted] of a cancer diagnosis on the [redacted] even though it was documented in the medical and nursing notes and transfer documents from RVH to DHH that she did not want to know her cancer diagnosis.
Until relatively recently many patients were not told they had cancer, this was especially true if the patients were elderly. Often relatives were given information

without the patient's permission and which patients themselves may not have been offered. It was recognised this practice should stop and information should be given to the extent and at a pace which is correct for the individual. Although patients may decide not to have information at a particular time, they retain the right to request/seek more information at any point (DHSSPS 2003 4.9).

On Personal Information redacted by the USI Personal Information condition deteriorated, with gastrointestinal (GI) bleeding (discussed in detail below). This was a new event for the patient, and despite conservative measures Personal Information continued to have distressing symptoms over the next day accompanied by a fall in blood haemoglobin. To potentially alleviate the symptoms, a decision was made to offer Personal Information an OGD. Consent was gained for this procedure, and as part of that discussion, the patient started to ask questions regarding her overall care, treatment and diagnosis. This was not initiated by the doctor, who clearly understood the established wish for no information.

The General Medical Council guidance stipulates "*In deciding how much information to share with your patients you should take account of their wishes. The information you share should be in proportion to the nature of the condition, the complexity of the proposed investigation or treatment and the seriousness of any potential side effects, complications or other risks*" (GMC 2008 p 5). There was a possibility that Personal Information's GI bleeding was related to her cancer and the potential risks of the procedure could only be fully explained in the context of her cancer diagnosis.

The review team have read the transcript of Dr 2's 'bad news' discussion and are of the opinion it reflects a sensitive, empathetic and skilled approach to this difficult conversation. Personal Information actively sought answers to her questions about her investigations in the RVH. She referred to knowledge of the breast lump, with the implications she already knew about the probability of a cancer. The patient has a right to a change of heart at any stage in their illness, and Dr 2 acted on this request at that time. At the end of the discussion, the patient was recorded as being thankful to the doctor for this conversation. Given her unstable condition, it was felt necessary to have this conversation at this time, rather than delaying until family were with her. In her letter Personal Information's daughter described her mother as "still the boss" and spoke of how active she was. It was right therefore that although Dr 2 offered to speak to Personal Information's family regarding their conversation Personal Information's refusal was respected.

The review team felt that ideally, a second member of the team (e.g. nursing staff) should have been with Personal Information for this discussion, in line with the Southern Trust Guideline for breaking bad news (2011). However, since the discussion occurred unexpectedly, at the request of the patient, this did not happen.

Follow up from breaking bad news discussion held with Dr 2 on Personal Information redacted by Personal Inform

The Review team is satisfied it was appropriate for Dr 2 to disclose Personal Information's results, their significance and expected prognosis. It was also correct to seek permission to share this information with family members and respect Personal Information's decision at that time.

It is recognised that it may be necessary to go over the information with the patient on more than one occasion (DHSSPS 2003). It is the opinion of the review team that had nursing staff been part of this discussion, there would have been greater opportunities to support Personal Information and allow nursing staff to discuss the situation more freely with both patient and family over the weekend. The review team acknowledge that the discussion with Dr 2 took place on a Friday, with on call medical cover over the weekend. This team were not asked to meet with family, and this could have been considered given the patient's deterioration. This was felt to be a missed

opportunity to minimise the family's distress. These more detailed discussions happened on Monday [redacted], with both the senior doctor on the ward Dr 3 (Associate Specialist), and the palliative care nurse.

Rationale for undertaking OGD on [redacted]

On [redacted] had recurrent episodes of vomiting a black liquid – altered blood. [redacted] was commenced on Pantoprozole 40mgs and fluids intravenously. [redacted]'s haemoglobin was noted to have dropped by 2 grams. Given the potential that [redacted] might experience a significant gastrointestinal bleed the Gastrointestinal Team (G.I.T) was contacted regarding the feasibility of undertaking an OGD to identify the source of bleeding and potentially provide an intervention to counter the bleeding. The decision was taken to offer [redacted] an OGD on [redacted].

[redacted]'s daughter has questioned the decision to undertake OGD in light of her mother's metastatic disease.

The review team appreciate it can be distressing for family to think of a loved one undergoing a procedure which will not extend the patient's life and might therefore seem to be unnecessary. [redacted] had suffered bleeding in her GI tract, which sometimes settles with conservative (non-surgical) measures including medications such as Pantoprozole. This approach was tried however [redacted] had reported further episodes of vomiting over 24 hours. She was receiving necessary fluids through a drip, and was unable to eat that day from symptoms of nausea. The review team felt the necessary fasting for a few hours before the procedure were not likely to have caused any additional suffering. The decision to offer [redacted] an OGD was based on finding the source of bleeding, and providing a treatment to stop it, all in the one procedure. This had the potential to improve her nausea symptoms and stabilise the bleeding. This decision was a judgement call on the day taken by the Medical team in conjunction with the specialist G.I.T. Having determined the procedure was a feasible and reasonable intervention, the medical team in charge correctly discussed the proposed OGD with [redacted].

The General Medical Council (GMC 2008) stipulates the doctor has an overriding duty to work in partnership with the patient in regard to decision making. This principle requires the doctor to discuss treatment options in a way the patient can understand. Getting consent is considered part of a discussion and decision-making process rather than an isolated event.

[redacted] was consented for OGD on [redacted] the intended benefit was documented as "Diagnosis". Serious or frequently occurring risks discussed and listed on the consent form included "bleeding, infection, perforation, sedation risks". The procedure was carried out that day. The review team are of the opinion that it was appropriate to offer [redacted] the OGD as an urgent procedure; the consent process was followed correctly; and the documented discussion relevant. There is nothing to suggest [redacted] did not have the capacity to consent to the procedure. The theatre notes indicate [redacted] had no complications during her procedure, with normal oesophagus and duodenum visualised, but the stomach view was poor due to blood. As the stomach could not be clearly viewed staff were unable to offer any intervention or injection therapy.

[redacted]'s daughter has questioned why she was not informed about the OGD in advance of the procedure. The conversation with [redacted] regarding an OGD was incorporated into a wider discussion in relation to [redacted]'s diagnosis, prognosis and advanced care

planning. At this point, Dr 2's offer to speak with Personal Information's next of kin (daughter) was declined, and Personal Information stated she wished to talk to her daughter herself. The Review Team is of the opinion it is probable that Personal Information would have agreed to her daughter being informed specifically of the planned OGD, in isolation of the cancer information discussed, but accept Dr 2 felt she was following the patient's wishes. The procedure was carried out a few hours after the discussion and some family members were present and aware that Personal Information had consented to OGD. The action of the medical & nursing staff was reasonable in the circumstances. The Review Team understands the decision to offer and proceed with OGD caused upset for Personal Information's daughter, and wish to apologise for the distress caused. With the benefit of hindsight this distress could have been lessened had there been more open & timely communication between patient, staff and daughter.

The Diagnosis and Treatment of Pneumonia

The term "Lower Respiratory Tract Infection" refers to acute illness which usually has a cough as the main symptom with other symptoms such as fever, sputum, breathlessness, wheeze, chest discomfort or pain. Pneumonia, acute bronchitis and flare up of chronic obstructive airways disease are all types of lower respiratory tract infection (NICE 2014).

"Pneumonia" is caused by bacteria, virus or fungal agents. The air sacs within the lungs fill with micro-organisms with build-up of fluid and inflammatory cells. The lungs cannot subsequently work effectively and a chest x-ray may show evidence of infection in a particular part of the lungs. (The National Institute for Health and Social Care Excellence (NICE) 2014).

Pneumonia and lower respiratory tract infection (or chest infection) are often used interchangeably in medical settings, both conditions receiving similar treatments. Personal Information's daughter spoke of her perception that the term chest infection implied the infection in Personal Information's lungs was less serious than pneumonia, which is a simple misunderstanding. It is important when sharing information that all health care professionals clarify the information offered within the context of the individuals lived experience and explain the significance of that information as it relates to the individual patient.

In this instance, the pneumonia was likely acquired during Personal Information's hospital stay. Hospital acquired pneumonia (HAP) is defined as "Pneumonia that develops 48 hours or more after hospital admission and that was not incubating at hospital admission" (NICE 2014 p 9) Personal Information's infection required specific and prompt antibiotic treatment. The team felt the choice of antibiotic and therapy was appropriate. In this case, the presence of lung metastases had a major negative impact on Personal Information's response to this treatment.

In her complaints letter Personal Information's daughter recounted a conversation with Dr 2 in which Dr 2 informed her that her mother had pneumonia when she was transferred to DHH. The Transfer Note from RVH to DHH (Personal Information redacted) documented Personal Information was clinically and medically fit for discharge. This was confirmed by her normal examination & clinical observations on arrival in DHH. Blood test confirmed that C Reactive Protein (CRP), a marker for infection, was reducing (51.7 reduced from 71). The review team agreed that at the point of transfer, Personal Information would have been incubating rather than symptomatic of the infection so would have appeared clinically well and medically fit for transfer as indicated in the Transfer letter.

Personal Information was reviewed by Dr 4 at 20.18 the following evening (Personal Information redacted by the USI) after a change was noted in her observations. Her respiratory rate was increasing (26 breaths per minute) and crepitations were noted in the base of her lung. A chest x-ray was ordered, which confirmed left lung pneumonia. The correct decision was taken to initiate intravenous Tazocin antibiotic in keeping with SHSCT Guidelines. She was reviewed the next day (Personal Information redacted by the USI) by the Associate Specialist (Dr 3) on the ward, who summarised her care to date, and agreed with continued treatment with antibiotics. The consultant (Dr 1) reviewed her on Personal Information redacted by the USI, and noted stable observations, initial response to treatment, and plan to complete a 5 day course of antibiotic.

From the Personal Information redacted by the USI, Personal Information's condition gradually deteriorated. She developed increasing nausea and had several episodes of vomiting blood. Her chest examination showed no deterioration on Personal Information redacted by the USI, and she underwent an uncomplicated OGD later that day.
The following day (Personal Information redacted by the USI) there was further overall deterioration. Personal Information had inceasing respiratory symptoms, and the on call team noted new crepitations in the right lung field. The team considered aspiration of stomach content to the lung as a cause, and chest x-ray was repeated. The chest x-ray noted increase in size of the pulmonary nodules (metastates) from the previous week, and a degree of fluid on the lung. Personal Information was kept on the antibiotic, with subsequent change in antibiotic on Personal Information redacted by the USI after discussion with microbiology department. The Review Team felt at this stage, the growing metastatic deposits in Personal Information's lungs and secondary development of fluid were the major factors in her decline.
Personal Information continued to deteriorate despite all treatments, and the grave situation was discussed with family by Drs 3 and 2 on the morning of Personal Information redacted by the USI. Personal Information's daughter was advised that her mother was "likely entering the terminal phase of her illness" and comfort would be ensured. The risk of developing HAP immediately or long after admission was explained as was the concern that Personal Information may develop a recurrence of C-Difficile colitis. Dr 3 gave opportunity to ask questions and offered to talk with the family again if they would like. A palliative care review was requested during which Personal Information's symptom management plan was reviewed and appropriately altered. Personal Information passed away peacefully on the evening of Personal Information redacted by the USI.
Whilst pneumonia was recorded as the cause of death on the death certificate, this was in the context of rapidly changing pulmonary metastases, and gastrointestinal haemorrhage. Personal Information had also developed pulmonary oedema (fluid) which did not respond to diuretic therapy, and was likely a complication of her pulmonary metastases and infection. The review group felt it was the combination of these factors that resulted in her rapid decline, rather than failure to respond to a simple bacterial pneumonia.
Personal Information's daughter wrote of her shock at how quickly her mother died from pneumonia and expressed an opinion that her death was speeded by the trauma of being told she had cancer. We cannot dispute or measure the impact that receiving bad news can have on the physical health of a patient; however Personal Information's subsequent deterioration was clearly explained by her physical findings.

Placement of Personal Information in a Side Room

Personal Information's daughter has indicated that she was upset that her mother was placed in a side-room on transfer from RVH to DHH. The Review Team have verified with the Trust's Lead Infection Control Nurse Specialist that it is the accepted rule and

standard practice within the SHSCT that all patients admitted from other hospitals are screened for MRSA and isolated for a minimum of 72hours. Single rooms provide a greater level of privacy to individual patients over placement on communal wards. For this reason, where it is medically safe to do so, staff try to allocate side rooms to patients who are most unwell. The concern raised by Personal Information's daughter vividly expresses the sense of isolation and vulnerability patients and relatives can feel if in a side room. It is important therefore to explain to patients why isolation is standard practice on transfer and also to verify with patients that they are content with this placement should it continue after the required 72 hours.

Palliative Care Input

Personal Information was referred to the palliative care team (PCT) on the Personal Information redacted and seen by a palliative care nurse (PCN) on Personal Information redacted. The entry in the medical notes documents that Personal Information declined further input from the PCT at this stage but did agree to a referral being made for community palliative care services at the time of discharge. There is no detail of the content of this discussion. Discussion of the patient's perception of her illness, desire for information or family involvement is not documented. There is no record of communication between the PCN and the ward staff in relation to how best to support Personal Information psychologically.

Personal Information was reviewed by a PCN at 12.30 on Personal Information redacted by the USI and complained of being uncomfortable with generalised pain and shortness of breath. Together they discussed a management plan and Personal Information agreed to take oral medications for possible shortness of breath, distress and pain; with subcutaneous medication also prescribed to be administered if required. There is no indication that the PCN explored with Personal Information her perception of how ill she was, or how she felt about the information Dr 2 had given her. From the records it appears the focus of the review was on managing physical symptoms.

Request for information from ward staff regarding deterioration in Personal Information's condition

Personal Information's daughter has indicated that she was concerned regarding her mother's deteriorating condition from Personal Information redacted by the USI. When she spoke to nursing staff about her concerns she continued to feel un-informed and was also told to contact the Consultant's secretary the following Monday to make an appointment to discuss her mother's condition. The nursing documentation of Personal Information redacted by the USI verifies this. Personal Information's daughter did make contact with the secretary on the Personal Information redacted by the USI morning and an appointment was made for the Personal Information redacted by the USI Dr 2 contacted Personal Information's daughter early on Personal Information redacted by the USI and the senior doctor on the ward met with Personal Information's family to discuss their mother's condition.

Discussion

Personal Information continued to deteriorate over the weekend of Personal Information redacted by the USI, and no further communication between medical staff and family occurred until Personal Information redacted by the USI.

The events of Personal Information redacted by the USI, have been discussed above and no direct information was given to the family, (at the request of the patient), who said she wished to speak to her family personally. It seems this never occurred, and her condition deteriorated over the week-end.

It wasn't until [redacted] that family had the opportunity to have an open conversation regarding her poor prognosis.
This block on communication created uncertainty for the nursing staff, who were not clear about what information could be shared. Where a patient's condition deteriorates there is a need to re-evaluate the information given to families. There is no record that nursing staff made further enquiries to [redacted] about sharing information on her condition with her family, despite indications she was alert & able to communicate at times. In such instances, it is common for nurses to refer to the responsible consultant ([redacted]), but this was not possible until [redacted] morning. The review team feel that involvement of the on call medical team to clarify and communicate with family (as deemed appropriate) would have been helpful. There are no records in nursing notes that this was requested and the review team accept that was not satisfactory.

The inclusion of ward staff in the initial bad news consultation on [redacted] or a plan agreed between medical and nursing staff for information sharing, would likely have helped.
By the time [redacted] had arrived in DHH, blocks had been placed on the communication pathways necessary for open awareness. This very sad case has reinforced the importance of breaking bad news in a way that respects the wishes of the patient but also offers the patient and family the necessary support to manage the final stage of the patient's illness.

Conclusion

The Review Team wishes to express their sympathy to the family of [redacted] on the death of their mother and is sorry that [redacted]'s daughter's experience was so difficult.

The review team accept that [redacted]'s medical treatment and care was appropriate and timely. The review has evidenced that [redacted] was informed to the level she requested regarding her diagnosis, prognosis and treatment decisions. The medical team were responsive to [redacted]'s request for disclosure. In keeping with her request she was included in the decision making process and treatment planning at this point. It was appropriate for Dr 2 to offer to speak to [redacted]'s family and to respect her wish to refuse.

By the time [redacted] arrived in DHH there were already restrictions placed on the open sharing of information between the patient, her family and professionals. It is the opinion of the review team that these caveats adversely impacted on the quality of communications to [redacted] and her family and the level of support they received during this difficult time. Even so despite these restrictions, engagement with the family in the final week of Mrs [redacted]'s life could have been better. There were opportunities to foster more open communication and to clarify and rectify misconceptions around medical terminology used, the significance of results and address the preparation of [redacted]'s daughter regarding how sick her mother was.

Learning and Recommendations

This case has highlighted that good quality communication is crucial for patients and carers. It is imperative that all information offered is communicated in a way that ensures an understanding of its significance. The Review Team will ensure that the concerns expressed in Personal Information's correspondence and the learning from this review will be anonymised and shared with clinical staff through the Trusts governance structures in order to improve communication and enhance the patient and carers experience.

1) **Breaking Bad News**: Staff should be reminded of the need for appropriate support to the patient in the event of a 'bad news' discussion, even where this is unplanned. This support should be in the form of a family member (at the patient's consent), and/or a second professional engaged in the patients care. Where "bad news" discussion is impromptu the doctor should pause the conversation in order to seek the presence of a nurse. Updates on the Trusts guideline are available to staff members.

2) **Family requests for information regarding deterioration in patient condition**: It is recommended that, where possible, information is given at the time it is requested.
In the context of a relative raising a concern regarding perceived deterioration, it is not acceptable to inform relatives to make an appointment -via a secretary- to speak with the consultant the next week. The request must be addressed at the time either: by the professional; *or* escalated to an appropriate senior person if the individual does not feel able to answer the query.
The skills set of those with advanced communication skills -for example the palliative care team- should be called upon as required, to support ward staff in addressing the particular challenge of successfully meeting the communication needs of the patient and family, yet, at the same time, respecting confidentiality and the patient's wishes *if* restrictions have been placed on the usual communication process.

3) **Weekend review**: Personal Information's continued deterioration over a weekend left the family frustrated by a lack of information. The medical staff reviewed the patient and were aware of the deterioration, but family were not present at that time. Nursing and medical staff could have met with family over the weekend to outline the situation to the next of kin. It is recommended that, where possible, the team caring for the patient pro-actively seek to inform the next of kin when there is an adverse change in a patient's condition.

Appendix One

31st July 2014

Chief Executive
Southern Health & Social Care Trust

Dear Madam,

Re: the late [redacted]

I would be very grateful if you could arrange to have an independent report done on the above named case, please. My mother died on [redacted].

My mother was seen at Accident & Emergency in Daisy Hill Hospital on Friday [redacted], after a fall, and x-ray showed that she had sustained a compound fracture of her right femur. The Consultant transferred her to the Royal Victoria Hospital in Belfast, that same day. On [redacted], surgery was performed by the Consultant, who inserted a plate and he also strengthened her hip joint as she had a prosthesis on that side for twenty-eight years. The Consultant told her afterwards that the operation was very successful, and she did very well post-operatively.

Prior to her operation, tests showed that she had high calcium levels in her blood and the doctor mentioned that they were going to do further tests the following week to determine the cause of this. The doctor also said that they had found a lump in her breast, and they were going to investigate it. I was not unduly worried about these issues as my main focus at that particular time was the worry that my mother would get through the surgery and, thankfully, she did.

She had the planned tests done the following week, including x-rays and scans. I visited my mother every afternoon when she was in the Royal, and the following Friday when I was visiting, Dr X saw me there with my mother and she came over, pulled the curtain round the bed, told my mother that she had some results, did she want to hear them, but my mother did not want to hear anything, she was quite adamant that she had enough with a fractured femur, and all she wanted was to get mobile again. The doctor mentioned the lump in her breast, but she said No, she did not want anything done about that.

Next thing I was being ushered into the doctor's office, and a nurse came too. I sensed that there must be bad news, and was very, very shocked when I was told that my mother had advanced secondary cancer in her lungs and her liver. They did not know where the primary site was and, therefore, they wanted to do further tests. They also wanted to test for bone cancer. Both a nurse and a doctor were very compassionate to me as they could see that I was absolutely devastated with all this bad news.

I do not know how I drove the car home from the Royal that day as I cried the whole way, and then I cried the whole weekend, day and night, it was one of the worst weekends of my life. As my mother did not want to know about the cancer, it was decided that just my two brothers, my sister, my aunt and a few other trusted close relatives would be told the news. We did not want it all round the place, as news like this travels like 'wild fire'.

I was not able to go and see my mother again until Monday, and this time a Consultant came and asked my mother could he speak with me. He then said that they wanted to do a needle biopsy of the breast lump and a mammogram. When I went back to my mother, she told me that she did not want anything done with it, she did not want anyone poking or prodding her.

I had to go to the doctor at the desk and tell him that mother did not want any tests done on her breast, she did not want to be asked about it again. No further demands were put on her. At least the test for bone cancer was negative.

As she was progressing, the Royal were making arrangements for her to be moved to Daisy Hill Hospital later that week. I was there every day, and when I went in on Friday, the nurse came and told me that she was being transferred to Newry that evening. She said that my mother was doing well, her kidneys were working better than when she came in, and she also emphasized that they would not move her if there was anything untoward. She arrived in Daisy Hill Hospital that night. I went over to the hospital, and asked specifically, although the Royal had put it on her RVH noted that no-one was to go in and tell my mother that she had cancer, as she did not want to know about it.

I continued to visit my mother in Daisy Hill every day, and then I noticed that she was getting an antibiotic intravenously, and it then materialized that she had a chest infection, but I did not notice an improvement from day to day. I was not able to visit on [redacted] Personal Information [redacted], but my aunt was there and she rang me to say that my mother was going to theatre to have a camera put down. I would hasten to add that no-one had rang to tell me that she was going to have a gastroscopy. My aunt has cancer, and she went on to tell me that a doctor had gone in and told my mother that day that she had cancer in her lungs and her liver! My aunt could not believe that a doctor had done this, but even though she was shocked that she had been told, she tried to pass it off by saying that everyone has a little cancer. The doctor was also trying to get her to have the breast lump investigated. There was no close relative with my mother when she was given that bad news about the cancer.

My husband and I went over to Daisy Hill that night and my mother was not well at all, she had nothing to drink all day on account of this awful procedure, and this was the first cup of tea that she had got. I wondered what was the procedure for, was the doctor trying to find the primary site of the cancer. It was strange that the patient's next-of-kin was not even informed as to why they were doing this. No communication whatsoever. I made a point of enquiring as to who the doctor was who had gone in and told my mother that she had cancer, and it was Dr 2

Next day ([redacted] Personal Information redacted by my younger sister came from Personal Information redacted by the to visit, and when she arrived, mother was not very well. She was in a little Ward on her own at the bottom of the corridor. My sister ran for a nurse, it seems her blood pressure dropped, and her heart was going very slow. She was put on oxygen. I had a 'phone call from my aunt later that afternoon that my mother was not very well, so I dropped everything and went to the hospital rightaway. When I enquired about my mother, I was told that if I had any questions, I would have to make an appointment on Monday to see the Consultant Dr 1.

On [redacted] Personal Information redacted [redacted], my mother was worse. I noticed that her arms, legs and feet were swollen, and I asked the Nurse if she was retaining fluid, were her kidneys not working properly, but no explanation was given.

On [redacted] Personal Information [redacted], I rang and asked for an appointment with Dr 1, he was not there that day and I was given one for Tuesday afternoon. About an hour later, I had a telephone call from Dr 2 she said that I needed to come into the hospital, my mother was not very well, and then she said, "You know she has pneumonia"!! I was shocked, I did not know this, I thought she just had a chest infection; then she said, pneumonia is a chest infection! I asked her when did she get pneumonia, the reply was that she had it when she came from the Royal. I told her that could not be right because I was there when the Nurse in the Royal told me that

she was fine to go, they would not transfer her if there was anything. I asked Dr 2 had she told my mother that she had cancer, and she said yes, and I said to her that the shock of that alone must have caused her to go downhill and I called the rest of my family, so we were all there when she died that night.

Dr 1 rang me the next morning, I never actually got to meet him, and he told me that the cause of death was being put down as pneumonia. However, I suggested that the shock and emotional trauma of being told she had cancer in her lungs and in her liver, killed her. I was in good health when I was told that my mother had cancer, and I was devastated for three days, what must it have been like for my poor mother, who was in poor health when she was told, the shock killed her [redacted] days.

I want to know why Dr 2 took it upon herself to tell my mother that she had cancer that [redacted], and then put her through a gastroscopy also. Why all this when the poor woman was suffering from a chest infection, or should I say pneumonia? I wonder did anything happen to her in the theatre that [redacted], did she get an Infection?

As next-of-kin, Dr 2 was able to find my 'phone number when she had to ring me to tell me to come, my mother was dying, why could she not ring me and discuss with me that she was having a gastroscopy done, why could she not discuss with me the issue about her not wanting to know the cancer diagnosis, even though it was all in the notes from the Royal which were sent with my mother, and the nurses had endorsed that instruction on the Daisy Hill notes as well. At least the nurses adhered to it, but this doctor did not.

Dr 2 can say what she likes about my mother wanting to know, I was there every day, and she never once asked about test results; in fact, I am convinced that she thought that if the breast lump was investigated, it might show up cancer, so by not getting this done, she was putting it out of the way. She was only interested in getting mobile, that was her main aim.

I contacted the Royal Victoria Hospital at the beginning of July, and spoke to both a doctor and a nurse, and they remembered my mother very well. They could not believe that she had died, and they both said that she would not have been moved if she had a chest infection, it is against their policy to move an ill patient.

Fifteen years ago, my father died from pneumonia in Daisy Hill Hospital. He did not go in with pneumonia, but he got it in there, and he had it for quite a few weeks before he died. On the same note, I do not think my mother would have died as quickly as she did from pneumonia, the trauma of being told she had cancer speeded her death. I spoke to the Nurses and they were shocked at how quickly she went downhill.

I cannot understand why patient's relatives are not told that they have pneumonia, instead they are just told that they have a chest infection. Unlike medical terminology, with which I am very familiar, pneumonia is a layman's term and most people associate pneumonia as worse than a chest infection. Why are patient's relatives not told, why do hospitals cover it up by letting people think it is less that it really is? I was aware of the worry that elderly people, who get a fracture in their hip or femur, can get pneumonia, and yet I only heard that my mother had pneumonia when she was on her death-bed! This issue needs to be addressed.

I have spoken to a few medical people and they are in agreement that Dr 2 overstepped the mark. Unfortunately, she did not think of the consequences of her actions. My mother may have had advanced cancer, but due to her advanced years, the cancer would not have been as aggressive as it would have been in a younger person. My brother died with advanced

carcinoma of the oesophatus at the age of forty-three, he got four months from when he was diagnosed, so I think we could have had my mother for a bit longer.

There is a huge difference between the way that my mother was handled by the Royal and the way that she was handled in Daisy Hill. She had a bed just opposite the Nursing Station in the Royal and they kept an eye on her all the time. However, she was put in a little side Ward in Daisy Hill and nearly forgotten about. I was kept well informed by what was happening to my mother all the time that she was in the Royal, but there was no communication in Daisy Hill. If there were any questions, an appointment had to be made with the Consultant, but the Consultant was only there from Personal Information redacted by the USI, and by the time that I got a date and time, sadly my mother had already passed away.

My mother was precious and I miss her very much, but I have gone over and over all the things that happened since she arrived in Daisy Hill until she died, and there are lots of questions which remain unanswered. I only wish she had never been moved to Daisy Hill.

I would hasten to add that my mother may have been Personal Information redacted by the USI, but she was not a little old lady who sat in the corner, she was a very well-known businesswoman, and had been in business for over sixty years. She was still the boss and was writing cheques for the business up until a week before she took ill. Nothing will bring my mother back, but I want to know what exactly happened to her.

I hope your investigation will throw some light on what actually happened to my mother, that she just went downhill very quickly and died.

Thanking you,

Yours sincerely,

Patient's Daug

Appendix Two
Chronology of Events

<table>
<tr><th>DATE</th><th>EVENT</th><th></th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Personal Information redacted by the USI
20.30 hours</td><td>Admitted from RVH to Level 6 Rehabilitation/Stroke ward DHH under care of Dr 1 Consultant Physician for rehabilitation after repair to a periprosthetic fracture of the right femur</td><td></td></tr>
<tr><td>Personal Information redacted by the USI</td><td>Transfer Note from RVH to DHH
Including:
Acute on chronic renal failure:
<table>
<tr><td></td><td>eGFR</td><td>Creatinine</td></tr>
<tr><td>Personal Information redac</td><td>21</td><td>196</td></tr>
<tr><td>Personal Information redac</td><td>54</td><td>54</td></tr>
<tr><td>? date</td><td>31</td><td>143</td></tr>
<tr><td>1 Personal Information r</td><td>43</td><td>109</td></tr>
</table>
Physiological Observations on transfer:
Respiratory Rate 19; Oxygen saturation 96% on Room Air; Apyrexic; Blood Pressure 146/57; Heart Rate 54.
Patient clinically and medically fit for transfer.
To remain on Enoxaparin for 6 weeks post-operatively-dose reduction as reduced renal function
Methotrexate for arthritis held.
DHH please review Enoxaparin dose and recommencement of Methotrexate
Non weight-bearing for 6 weeks post operation.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Personal Information redacted by the USI</td><td>RVH Fracture Unit Transfer Information Form (Nursing)
History and treatment summary also: Antibiotics x 24hours post operatively Review Fracture Clinic at 6 weeks for x-ray. Non weight bearing for 6 weeks. Hoist for all transfers. Lives alone carers twice per day. Patient clear coherent and compos mentis.
Infection sites” none known”.
CT CAP lung and liver metastasises. Patient not wishing to know diagnosis. Family aware. Patient requires mammogram and biopsy-patient refusing at present time while she is “not on feet”.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Personal Information redacted by the USI
00.45</td><td>Southern Trust Medical Admission Proforma
Dr 5 FY1
Transfer-history re: fall, hypercalcaemia; breast lump; CT + Bone Scan results;
“These results discussed with patient + daughter and prospect of further investigations. Patient decided she does not want further investigations into breast lump at present. Agrees will</td><td></td></tr>
</table>

	get investigations in the future." **Problem List/Management Plan** includes: **Problem:** "Breast lump, liver, lung metastases" **Management Plan:** "Further discussion with patient and family re ? further investigation and treatment"	
Personal Information redacted by the USI	**Nursing Admission** History of fall and care in RVH. Urinalysis positive for blood protein nitrates and leucocytes- sample sent to laboratory. Oxygen Saturation 95%. Breast lump detected in RVH patient not keen for further investigation at present (*wording as appeared in referral letter from RVH*)	
Personal Information redacted by the USI **12.10**	**Post Take Ward Round** Consultant 14 Bloods mane Rehab input. History from RVH to be non-weight bearing. Assess breast lump	
Personal Information redacted by the USI	**Multidisciplinary Reporting** Seen and examined by Dr 5 on examination chest clear wound site clean. Plan Analgesia, Physio. Further discussion with patient and family re further investigation and treatment. Multidisciplinary Team (MDT) workup ? restart Methotrexate. Chase MSSU, CRP improving. If temperature spike reconsider.	
Personal Information redacted by the USI **20.18**	**Medical Notes** Dr 4 FY1-Asked to see patient (ATSP) regarding National Early Warning Score (NEWS) 4 Comfortable Respiratory rate 26 oxygen saturation 96% on Room Air Right (lung) base course creps ECG sinus bradycardia 53 beats per minute Impression-? post-operative chest infection await chest x-ray and bloods Plan Repeat bloods, ECG, CXR booked Hold Bisoprolol in am.	
Personal Information redacted by the USI	**Medical Notes** X-ray review Dr 6 FYI ↑opacification left base. Inflammatory markers raised. Commenced intravenous antibiotic therapy In light of inflammatory markers and chest x-ray changes start Tazocin as per guidelines for hospital acquired pneumonia (HAP) Review in am.	
Personal Information redacted by the USI **10.15**	**Medical Notes** Dr 4 –ATSP regarding irregular pulse (+ bradycardia 47-51bpm Nursing notes) ECH sinus rhythm Impression sinus rhythm -bradycardia hold Bisoprolol	

Personal Information redacted by the USI **11am**	**Nursing notes** (Correlates with Medical Notes) Reviewed by Dr 3 Associate Specialist Calcium noted likely metastatic breast cancer patient doesn't want to know Family aware" Tazocin for 5 days ?HAP Analgesia. Practice stand/transfers on left Keen for home rather than step down/nursing home	
Personal Information redacted by the USI	Reviewed by Dr 1 History noted + ↑calcium (Adj 2.82 Personal Informa; 2.75 Personal Informa) "Patient states doesn't want anything done about breast lump" "Refer to Palliative Care Team (PCT) re raised calcium management in community" Reduced air entry Plan includes: Palliative Care Team (PCT) re ↑calcium management in community-bloods weekly Complete 5/7 Tazocin If stable recommence Methotrexate next week	
Personal Information redacted by the USI	Nausea and retching overnight	
Personal Information redacted by the USI **13.30**	Sickness settled Seen by Palliative Care Nurse (PCN 1) Personal Information does not want any further regular input from palliative team. Will input on request. Did agree to community referral on discharge. **Plan** Input on request. Inform on discharge. Repeat corrected calcium next week. Refer to dietician. All MDT re discharge planning.	
Personal Information redacted by the USI	**Review Dr 2** History as before including: " Right breast lump noted. Multiple lung and liver mets. Patient declined further investigation of breast lump at present." PCN review findings noted Complete 5 days Tazocin tomorrow for presumed HAP. Continue with Rehab, aim toward home discharge. Monitor oral intake + food chart.	
Personal Information redacted by the USI	**Nursing Evaluation** Visited by daughter this afternoon who agrees with her Mum's decision re no further investigations. Symptoms will be treated if arise as per PCN	
Personal Information redacted by the USI **02.30** **07.00**	**Nursing Evaluation** Vomited approximately 50mls undigested food ? altered blood. Off omeprazole whilst on Tazocin Vomited further mouthful coffee grounds. Clinical observations stable.	
Personal Information redacted by the USI	**Medical Notes**	

10.40	Seen by Dr 2 Episode of brown vomiting noted nausea settled at moment, abdomen non tender **Plan** Antiemetic if nauseated Monitor urea + electrolyte Monitor oral intake Cease Tazocin after final dose tonight Contact me if concerned	
Personal Information redacted by the USI **07.30**	**Medical Notes** Dr 11 FY1 ATSP Vomited large coffee grounds about 200mls + 3 small episodes. Dipstick –ve for blood Plan Bloods + Group and Hold Nil by Mouth (NBM), IV Fluids IV proton pump inhibitor (PPI) Stat Pantoprozole 40mgs I.V. Antiemetic Hold Clopidogrel ? GI/Surgical review ? need for Oesophagogastrostomy (OGD) Currently Haemodynamically stable	
Personal Information redacted by the USI **09.03**	Dr 2 Review Including events overnight+ this am noted Haemoglobin 91 (reduced from 108/105/99) Examination undertaken consent gained for rectal examination. X present as chaperone. “patient declined further investigation of breast lump and declined to be informed of results of recent scans” “long discussion with patient -Explained concern that vomiting black liquid may be a sign of bleeding in the stomach (altered blood). -Discussed current ongoing issues-patient states she is aware of the breast lump-has been there for a while however she felt that due to her age there was no point in further investigating it. Aware that she had scans in RVH however states no one ever came back to inform her of the results. States she would like to know these results. Explained unfortunately the results have revealed bad news-there is evidence of cancer which has spread to the liver and the lungs. The most likely primary is the breast lump. Discussed likely fairly advanced given the spread to the liver/lungs. Patient states she had been feeling very nauseated with reduced appetite prior to admission. Discussed that we could refer her to the breast clinic here for further investigation of the lump-she stated however she would not want this at present. Feels too weak after the hip surgery and would not want any intensive treatment of the probable breast cancer. Discussed our main concern at present is the possibility of bleeding in the stomach and that the only way to confirm this	

	would be with an OGD. Patient would be agreeable to this as she would like to try to treat it and stop vomiting/nausea. Did discuss that there is always a possibility that the vomiting may be related to the cancer. Spoke with patient regarding future management-given underlying cancer with evidence of spread would not be appropriate for Intensive Care Unit-patient states would not want to be intubated/ventilated. Also discussed that in the event of a cardiorespiratory arrest attempts of successful resuscitation are unlikely given frailty and comorbidities. Discussed patients feelings regarding resuscitation –she states she would not want active resuscitation and that if she were to deteriorate comfort would be her main priority and that she would wish to pass away peacefully. Expressed regret to have brought her the bad news re results-patient thankful and happy with discussion. Explained I am happy to discuss with her family however she states this is not necessary as she can speak with them". Plan as 07.30 entry + in event of cardiorespiratory arrest not for resuscitation nor escalation to Intensive Care Unit Contact me if concerned. Spoke with GI Reg + Surgical SHO re review.	
Personal Information redacted by the USI	**Do Not Attempt Cardiopulmonary Resuscitation** 1) "Does patient has capacity to make and communicate decisions about CPR"-YES 2) "Summary of main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interest" –"Frail lady, significant co-morbidities likely primary breast cancer with lung and liver metastases. Successful CPR unlikely" 3) "Summary of communication with patient (or Legal Representative). If this decision has not been discussed with the patient or Legal Representative state the reason why" "patient's wish is not for active resuscitation in event of Cardiorespiratory arrest" 4) "summary of communication with patient 's relatives or next of kin" "Nil present" "Health care professional completing this DNACPR order" Signed Dr 2 "Review and Endorsement by most senior health professional;" Blank	
Personal Information redacted by the USI **13.20**	**Surgical Review** Dr 12 Consultant Surgeon Seen and examined Plan Diagnostic OGD risks explained PPI infusion for 48hours. Consented for OGD Dr 13 CT2 Surgery	
Personal Information redacted by the USI **16.30**	OGD -confirmed black liquid in stomach, no bleeding source identified Continue PPI's. Surgical Team will review if	

17.30	haematemesis reoccurs or haemoglobin (Hb) down Returned to ward. No sedation throat spray, to fast x 2 hours (19.30)	
Personal Information redacted by the USI **12.30**	**Medical Notes** Respirations 23, feeling short of breath Reviewed by Dr 8 Consultant on Call Further deterioration, respiratory rate increased (26) chest x-ray changes worse-? Aspirate ? HAP.Oramorph 4 hourly if short of breath/distressed/pain. Antibiotics recommenced. Remained unwell comfort measures introduced.	
Personal Information redacted by the USI **15.50**	**Nursing Notes** Vomited 100-200mls dark coloured fluid.Blood pressure reduced NEWS 8 Dr 7 FY1 bleeped + Dr 9 CXR ordered. Urea 15.4; Creatinine 116; C-Reactive Protein 62.2; White cell count 12. Tazocin given Stat + IV fluids. Blood pressure 106/58 Respirations 26 Oxygen saturation 98% on 2 litres oxygen Patient's daughter contacted ward concerned Mother was ill and she was not contacted. Nurse advised sister was present and aware Mother was not well. Nurse stated would not have contacted her as daughter/sister present. Daughter raised concerns that doctor had informed Personal Information of diagnosis yesterday. Nurse apologised (not on duty yesterday). Visited in evening by daughter Personal Information . Personal Information stated Personal Information does not want to know her diagnosis, annoyed she was informed yesterday. Personal Information wants Nursing staff to contact her if Personal Information unwell even if sister is on ward.	
Personal Information redacted by the USI	Personal Information complained of pain left side of back 1 gram Paracetamol with good effect	
Personal Information redacted by the USI **13.00** **20.35**	**Nursing Record** Daughter advised to speak to Consultant. Needs reviewed by doctor re IV fluids Venous access poor difficulties cannulating , arms oedematous++ also generalised body oedema. Colour extremely pale. Vomited Coffee grounds approx. 150 mls Settled and slept	
Personal Information redacted by the USI **01.30** **06.50** **07.30**	**Nursing Record** Complaining of severe pain in back between shoulder blades Oramorph given with good effect. Settled quickly and rested peacefully. Complaining of severe pain in between shoulder blades Oramorph with effect. Daughter Personal Information rang re Personal Information's condition advised to contact Consultant's secretary and make appointment to discuss Mother in am.	

Personal Information redacted by the USI **09.20**	NEWS 9. Reviewed by Dr 2. Weak +lethargic. Pale Pitting oedema. Dry. Little oral intake. Short of breath. Temperature 34.9C Microbiologist contacted- change Tazocin to Meropenem Catheter in situ-monitor intake/output Slow IV fluids Hold furosemide Continue with PPi Happy to speak with family at any stage Daughter Personal Information contacted by Dr 2 re Personal Information's condition. Advised to come to ward. PCN contacted to review patient Seen by PCN (12.30)- Continue with Oramorph and Cyclizine. Prescribed Midazolam and Diamorphine.	
Personal Information redacted by the USI **12.00**	**Medical Notes** Dr 3 "Lengthy discussion with daughter Personal Information, Dr 2 present. Personal Information is angry mother told results of scans last week-informed she specifically asked and Dr 2 obliged to tell her. Annoyed "well" when left RVH, now pneumonia and vomiting –discussed risk of Hospital Acquired Pneumonia after prolonged admission/immediately. Discussed condition likely entering terminal phase-will ensure comfort. Given opportunity to discuss issues and happy to discuss again"	
Personal Information redacted by the USI **18.50**	Further discussion with, Dr 10 (Core Trainee) and opportunity for family to ask questions.	
Personal Information redacted by the USI **21.00** **21.30** Personal information	Nursing Entry Summary -Patient distressed at times Midazolam and Diamorphine prescribed as necessary. Respirations 32 Oxygen saturation 88-89% temperature 35.5 C Warming blanket. Daughter and sister present aware Personal Information weak. Antibiotics changed to Meropenem Family present, feel Personal Information distressed Midazolam given little effect Diamorphine 5 mgs given observations unrecordable. Family advised Personal Information passing away.	
Personal Information redacted by the USI 23.15	Personal Information died Personal information Dr 6 contacted certified Personal Information death	

SAI Level 1 Report
04-Aug-15

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Current Status
CC	[redacted]	SEC	19.11.14	[redacted]	[redacted]	Personal Information redacted by the USI	Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smyth Miss Paula Fearon Mrs Anne Quinn	19.11.14	N/A	Mr Robin Brown Mrs Connie Connolly Sr Sheila Mulligan Mrs Amie Nelson Ms Cathy Magee Sr To Be confirmed	17.12.14	No	[redacted]	13.4.15		24.4.15 Letter of acknowledgement sent to Mr [redacted] in [redacted] & English.					12.5.15 - Completing report. .
CC		SEC	19.11.14	[redacted]	[redacted]		Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smyth Miss Paula Fearon Mrs Anne Quinn	19.11.14	N/A	Chair Connie Connolly	17.12.14	No	[redacted]	14.4.15 - Acknowledgement issued. 25.3.15 Paul Smith spoke to Mrs [redacted] advising her of SAI and she would receive acknowledgement and a report shortly afterwards.			20.3.15	21.4.15	22.4.15 by email and letter.		23.4.15 - Sent to HSCB. hard copy of report sent to [redacted].
PS		MUC	24.10.14	[redacted]	[redacted]		Mr Seamus O'Reilly Mrs Anne McVey Mr Paul Smyth Mrs Anne Quinn	16.6.15	N/A	Chair Mr Seamus O'Reilly Mr Paul Smyth Sr Debbie Murnan Rn Louise McConnell Dr Richard Wilson NIAS TBC	14.7.15	[redacted]	[redacted]	3.12.14 letter issued to family informing them of SAI.Next of Kin to be confirmed. Letter advising NOK of review will be issued 2 weeks after death							15.5.15 - Notification to be completed
CC		SEC	19.11.14	[redacted]	[redacted]		26.11.14 Mr Mackle Mr S Gibson Mrs Connie Connolly Mr Paul Smyth Mrs Anne Quinn	11.3.15		Mr Hewitt Chair Mr Murugan Ms Amie Nelson Mr Paul Smyth	8.4.15		[redacted]	1.12.14 Letter issued to Mr [redacted] informing him of SAI.							13.4.15 Connie contacted Amie Nelson re: Availability of chair. - Connie spoke to Amie, Amie to speak with chair re dates for meeting.
CC		SEC	20.12.13	[redacted]	[redacted]		Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Mr Paul Smith Mrs Anne Quinn	1.5.15		Dr Damian Gormley Mrs Martina Corrigan Mr Tony Glackin Sr S Kennedy Mrs Connie Connolly	29.5.15	No	Wife RIP shortly after husband, NOK to be identified.			31.3.15				12.5.15 - Completing report 22.4.15 - Report to be completed. 6.3.15 - Meeting arranged for 11.3.15.
CC		MUC	28.10.14	[redacted]	[redacted]		6.11.14	3.11.14	N/A	Mr S Gibson Dr A Khan Mr S O'Reilly Ms W Clarke Ms A McMullen Mrs C Connolly	1.12.14	[redacted]	[redacted]				Report approved by Acute on 20.3.15 and CYP on 21.4.15.	23.4.15	Given to family at meeting.		
PS		MUC		[redacted]	[redacted]		Belfast Trust Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith Mrs Margaret Marshall		N/a	Mr Seamus O'Reilly Mr Barry Conway Mrs Margaret Marshall Mr Paul Smith						11.2.15				15.5.15 - Notification to be completed
PS		SEC	28.12.14	[redacted]	[redacted]		Seamus O'Reilly Mr Barry Conway Mr Pauls Smith OPPC rep	28.1.15		Mr Seamus O'Reilly Dr D McMurray Mr Paul Sheridan Sr C Douglas Mr Paul Smith	25.2.15	[redacted]	[redacted]	Telephone 4.3.15 Letter 1.6.15		4.3.15					13.4.15 - Paul trying to get address for sister of patient. 24.3.15 - Paul to complete Acknowledgement letter.
PS		MUC	19.2.15	[redacted]	[redacted]		Seamus O'Reilly Mr Barry Conway Mr Paul Smith	23.1.15		Mr Conor O'Toole Dr R Doyle Dr A Ferguson Sr S Holmes Brian Magee Dr Mark Feenan Mr Paul Smith	20.2.15	No	[redacted]	27.3.15 by letter		11.3.15					27.3.15 - Acknowledgement letter issued.

	Personal Inform					Personal Information redacted by the USI															
CC		SEC	15.1.15	Person	Person		21.1.15 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	28.1.15		Dr Michael McCormick Mr Ronan Carroll Sr Tracey McGuigan Mrs Connie Connolly	25.2.15	Personal	Personal Information redacted by the USI .	Call from Dr McCormick on 8.4.15. Letter issued on 15.4.15. 8.6.15 Letter of consent issued to family.							8.6.15 letter for consent issued to family. 12.5.15 - Completing report 22.4.15 - Family notified on 8.4.15. 6.3.15 - Report in process of completion.
CC		MUC	2.3.15	Person	Person		4.2.15 Mr Seamus O'Reilly Mr Barry Conway Mrs Connie Connolly	11.3.15		Dr Dave Patton Sr Sharon Kennedy Dr Jilly Redpath Mrs Connie Connolly	8.4.15	No	Personal Information redacted by the USI	24.6.15 Dr David Patton spoke with Son. 24.6.15 letter issued after discussion with son.							13.4.15 - Review team advised of their nomination. Connie Connolly to speak with chairperson before completing acknowledgement. 25.3.15 Acknowledgement being drafted. 11.3.15 - Submitted to Board report due 8.4.15. 5.3.15 - Notification to be approved By DB at Tuesday meeting.
CC		SEC	25.1.15	Person	Pe		11.3.15 25.2.14 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	20.3.15		Mrs Trudy Reid, Sr Sharon Kennedy, Ms Jilly Redpath, S/N Lorna Cargill S/N Aileen Lavery S/N Liz McCarragher S/N Rosemary Robinson S/N Lynn Harrison S/N Anne McKenna S/N Jane Liggett S/N Jackie Major Mrs Connie Connolly	17.4.15	N/A	N/A			7.5.15					12.5.15 - Review postponed due to staff not available. 22.4.15 - Meeting arranged for 7.5.15. 17.4.15 -Staff have met, Screening done. Review not started.
PS		MUC	14.2.15	Person	Pe		2.2.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smith Mrs Connie Connolly	12.3.15					N/A								
CC		MUC	14.9.15	Person	Per		Mr Philip Murphy Mr Simon Gibson Mrs Mary Burke Dr Una Bradley Mrs Connie Connolly	24.3.15		Dr Shane Moan Sr Nicola McKnight Mrs Connie Connolly	28.4.15	No	Personal Information redacted by the USI	Dr S Moan contacted family on 18.5.15. Follow up letter issued on 18.5.15.		18.5.15					18.5.15 - Dr Shane Moan spoke to family on 18.5.15. Followup letter issued. 12.5.15 - Meeting arranged for Monday 18 May at 2pm in DHH.
PS		MUC	25.3.15	Person	Per		1.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith	13.4.15	N/A	Dr Gareth Hampton Chair Mr Hurriez Sr Sharon Holmes Mrs Mary Burke	11.5.15	N/A	Personal Information redacted by the USI	17.6.15							23.4.15 - Acknowledgement being completed. 14.4.15 - Waiting confirmation of review team members.
PS		MUC	Person	Person	Pers		24.3.14 Mr Simon Gibson Mr Philip Murphy Dr Una Bradley Mrs Mary Burke Mr Paul Smith	22.4.15	N/A	S Walker Sr L Cullen Mrs Kay Carroll	20.5.15	YES	Personal Information redacted by the USI	23.4.15							12.5.15 - Coroner quering when death was reported. Paul to complete correspondance and return.

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

PS	[redacted]	MUC	24.4.15	Person	Per	[redacted]	29.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith	6.5.15	N/A	Mr Erskine Holmes Sr Sharon Holmes Mrs Mary Burke Mr Paul Smith	3.6.15	No	Personal Information redacted by the USI	Barry Conway spoke with ex wife. She waw to discuss with husband. 24.6.15 - letter issued							
PS		MUC	5.5.15	Person	Pers		4.5.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	29.5.15	N/A	Mrs Mary Burke Sr Sharon Holmes Mr Paul Smyth	26.6.15	No	Personal Information redacted by the USI	28.5.15 Dr Tom Young contacted patient, Letter of acknowledgement issued 8.6.15.							
PS		MUC	3.6.15	Person	Per		3.6.15 Mr Simon Gibson Dr Philip Murphy Mr Paul Smyth	3.6.15	N/A	Mrs Helen Forde Mrs Kay carroll Mr Paul Smyth	1.7.15	No		6.6.15 Letter to Patient advising of suspension of complaint and SAI began.							
CC		SEC	27.4.15	Person	Per		22.5.15 Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	4.6.15	N/A	Mr Robin Brown Dr Richard McConville Mrs Katherine Robinson Amie Nelson Mrs Connie Connolly	2.7.15	N/A	Personal Information redacted by the USI	30.6.15							
CC		SEC	9.3.15	Person	Pe		Original 22.5.15 Not SAI Further review on 3.6.15 SAI Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	8.6.15	N/a	Chair TBC Dr Martin Brown Dr Jilly Redpath Mrs Gillian Henry Mrs Martina Corrigan Mrs Connie Connolly	6.7.15	N/A	Personal Information redacted by the USI								
PS		MUC	29.5.15	Person	Person		8.6.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smyth	10.6.15	N/A	Dr Andrew Murdock Mrs Louise Devlin Mr James Gilpin Trauma Consultant TBC Mr Paul Smyth	8.7.15	N/A	Patients own mobile Personal Mr Personal Information redacted by the USI								
PS		MUC	11.5.15	Person	Per		8.6.15 Mrs Heather Trouton Mr Eamon Mackle Mr Paul Smyth	10.6.15	N/a	Mr Epanomeritakis Sr Sheila Mulligan Mrs Amie Nelson Mr Paul Smyth	8.7.15	Yes Personal	Personal Information redacted by the USI								
PS		MUC	Personal	Person	Pers		Dr Philip Murphy Mr Simon Gibson Mrs Connie Connolly Miss Paula Fearon Mrs Anne Quinn	17.10.14	N/A	Chair Mr Paul Smyth	9.1.15	Personal	Personal Information redacted by the USI	Letter issued on 24.10.14 offering meeting		13.11.14		20.7.15	17.7.15 - Letter issued to family advising of completed report.		
PS		SEC	12.5.15	Person	Pers		Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly	29.7.15	N/A	Chair TBC Mr Jonny Bunn Mrs Anne McVey Mrs Trudy Reid Physician TBC		Personal	Personal Information redacted by the USI								

SAI Level 2
04-Aug-15

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	SAI screening meeting DateScreening Team	SAI Form to Board/Date	SAI Review Team Chair & Members & Coordinator	Date Report due	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Date case Closed	shared with family - outcome of family meeting	Current Status
PF	Personal Inform	EC	31.7.14	Person	Pers	Personal Information redacted by the USI.	Mrs Heather Trouton Mr Eamon Mackle Mrs Connie Connolly Mr Paul Smith Miss Paula Fearon Mrs Anne Quinn	11.12.14	Mr Gerarde McArdle Mrs Anitha Carroll Dr Nora Scully Mr Enda Coulan Miss Paula Fearon	5.3.15	No	Personal Information redacted by the USI Personal Information redacted b	17.1.15						21.4.15 - Acknowledgement letter with Director for approval and signing. ?? Mr Lewis spoke with Daughter	14.7.15 - Waiting on Chair to add his part to report. 30.6.15 - still awaiting Chair's section. Had hoped he could meet last week or yesterday. 20.5.15 - Email address to be used. Personal Information
PF		EC	7.9.14	Person	Pe		24.10.14 Mr Simon Gibson Dr Una Bradley Mrs Connie Connolly Mr Paul Smith Mrs Margaret Marshall	27.11.14	Dr Michael McCormick Mrs Catriona McGoldrick Mrs Kay Carroll Ward Manager tbc	29.12.14	Personal	Personal Information redacted by the USI	1.12.14						Asknowledgement issued. Paula spoke with daughter week comencing 9.4.15.	14.7.15 - Completed report in the process of completing timeline and to be shared with review team for approval before sending to Tracey & Debbie. 30.6.15 - post last email Chair emailed to say if KC not back with requested section to send as is. KC contacted + sent bullet points 2 days later- I will write up + include if can merge same. I am checking report with Ward Sister re factual accuracy today, post this will remind the team that Action Plan needs completed from recommendations
PF		EC	15.10.14	Person	Pers		Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Miss Paula Fearon Mr Paul Smith	19.11.14	Dr Tony Glackin Mr Simon Gibson Mrs Helen Forde Mrs Margaret Marshall Miss Paula Fearon	11.2.15	No	N/A	2.3.15		17.12.14				Mr O'Brien spoke with patient. Acknowledgement issued.	14.7.15 - Tracey to followup with Debbie and to discuss with Simon Gibson. 30.6.15 - still with Tracey + Debbie re recommendations + content 23.6.15 - Draft with Tracey and Debbie 18.5.15 - still awaiting comments back from Tracey + Debbie re report
PF		EC	8.11.13	Person	Person		Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly Miss Paula Fearon Mr Paul Smith	19.11.14	Dr Damian McKay Mrs Anne McVey Mrs Katherine Robinson Miss Paula Fearon	11.2.15	No	N/a	23.2.15		11.3.15				Mr Mackle spoke with family Acknowledgement issued on 9.2.15.	14.7.15 - Report completed sent to Emaon Mackle for approval. 30.6.15 - to meet Chair to finalise on 6th July 23.6.15 - Chair has sent me draft, am working on same this am + will need to contact him re 1 query when I have completed.
PF		EC	Personal	Person	Per		Mr Eamon Mackle Mr Simon Gibson Mrs Connie Connolly Mrs Anne Quinn Mr Paul Smith	10.12.14	Mr Adrian Neill Dr Simon Porter Sr Tracey McGuigan Mrs Trudy Reid Miss Paula Fearon	4.3.15	Personal Information redacted	Personal Information redacted by the USI	9.2.15		20.4.15				Paula spoke with son, acknowledgement issued on 9.2.15	14.7.15 - Waiting on Trudy Reid and Tracey with fedback. 30.6.15 - still awaiting TR+ TMcG section, have meyt with Chair but this content is subject to change post return of TR+TMcG section 23.6.15 - met with Chair last week have sent draft work to Chair with one area of concern highlighted, still awaiting response from Trudy + Tracey, will try again today .
CC		EC	24.3.15	Person	Person		Initial Screening 25.2.15 with Mr Eamon Mackle Mr Ronan Carroll Mrs Amie Nelson Mrs Connie Connolly Further screening on 23.3.15 with Mr Eamon Mackle Mrs Heather Trouton Mrs Amie Nelson Mrs Connie Connolly	13.4.15	Mr Gerry McArdle Dr Rutherford Jones Dr Anthony McBrearty Mr Ronan Carroll	6.7.15 TOR & Membership due	Y Personal Telephone call made to Coroner at 09.50 hrs followed by Clinical summary sent to coroner.	Personal Information redacted by the	16.3.15 Mr Mackle contacted son. 9.7.15 Acknowledgement letter issued.					Mr Yousaf spoke to family. Acknowledgement issued on 16.4.15.	Initally screened not SAI. Second screening SAI Level 2.
PF		MUC	Personal	Persona	Person		Mr Barry Conway Mr Seamus O'Reilly Mrs Mary Burke Mrs Anne McVey Mr Paul Smith Mr Paul Sheridan Mr Conor o'Toole Mr Erskine Holmes Dr Tracey Boyce	30.3.15 31.7.15 TOR & Membership submitted to Board.	Mr P McGarry Chair S Thompson Paeds Mr John Campbell A McKinney WHSCT Robert Gilliland External Sr S Holmes Mrs Mary Burke Miss Paula Fearon Mr Paul Smyth	22.6.15	Personal	Personal Information redacted by the USI	13.5.15 15.7.15 Holding letter issued.						18.5.15 - Paul +I were to meet, first meeting of review team tentative date was to be Thursday 28th May. Unsure if this still stands as Paul to check with Debbie re involvement therefore meeting between Paul + me postponed awaiting further word from Paul. Possibly upgrade to L3.
PF		MUC	Person	Person	Perso		1.4.15 Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smith	13.5.15 TOR & Membership to Board on 24.6.15	Dr Hilda Nicholl Chair Dr Damian McKay Mr Barry Conway Mrs Mary Burke	6.7.15	YES Personal	Personal Information redacted by the USI	15.7.15 holding letter issued. 18.5.15 - Letter issued. 13.5.15 - Consultant spoke to relation by phone.		15.5.15 23.6.15 7.7.15				Acknowledgement to be issued.	10.6.15 - Meeting arranged for 23.6.15. 18.5.15 - 13.5.15 - Dr Hilda Nicholl contacted family. 18.5.15 follow up letter issued. TOR & Membership due 11.5.15
PS			Personal	Person	Per		20.5.15 Mr Barry Conway Mr Seamus O'Reilly Mrs Mary Burke Mr Conor O'Toole Mr Paul Smyth	21.5.15	Dr Gareth Hampton Anaesthetic Cons Surgical Con Medical Con Sr Sharon Holmes Mrs Mary Burke Mr Paul Smyth	26.6.15 TOR due 21.8.15 Report due	Y Person	Personal Information redacted by the USI								

PS	[redacted]	MUC	27.5.15	Person	Per	[redacted]	21.5.15 Barry Conway Seamus O'Reilly Paul Smyth	29.5.15	Mr Barry Conway Mr Seamus O'Reilly Mr Paul Smyth	TOR due 26.6.15 Report due 21.8.15	Yes 1.6.15	[redacted]	7.7.15							
PS	[redacted]	MUC	20.5.15	Person	Per	[redacted]	8.6.15 Mr Barry Conway Dr Philip Murphy Dr Una Bradley Mr Paul Smyth	10.6.15	General Physician TBC Dr N Morgan Renal Cons Mr Trudy Reid Mrs Catriona McGoldrick Trauma Cons TBC Microbiologist Con TBC Anaesthetic Con TBC	TOR due 8.7.15 Report due 2.9.15	Yes [redacted]	[redacted]	15.7.15 Acknowledgement letter to brother.							
CC	[redacted]	SEC	27.3.15	Person	Pers	[redacted]	10.6.15 Mr Eamon Mackle Mrs Heather Trouton Mrs Connie Connolly	17.6.15	Mr Gerarde McArdle Mrs Anita Carroll Ms Anne Tate Mrs Nicola McClenaghan Mrs Katherine Robinson Dr Neville Rutherford Jones Mrs Connie Connolly	9.9.15 TOR & membership 15.7.15	No	[redacted]								
PS	[redacted]	MUC	4.2.15	Person	Per	[redacted]	Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith	4.3.15	Mr Gareth Hampton Chair Sr Sharon Holmes Dr David McEneaney	27.5.15	No	[redacted]	27.2.15 by phone. 15.6.15 by letter.					In holding bay		
CC	[redacted]	MUC	22.12.14	Person	Per	[redacted]	**LEVEL 1 INFORMATION 19.1.15** **Mr Philip Murphy** **Mr Simon Gibson** **Mrs Connie Connolly**	**28.1.15**	**LEVEL 1 INFORAMTION** **Dr Ryan Boyle Chair** **Dr Una Bradley** **Mrs Trudy Reid** **Mrs Connie Connolly**	**26.2.15**		PF spoke with Mrs [redacted])." I have explained the process and she is aware it will be some months before we have a report through. I have invited her to contact me at any point in the future if she is wondering how things are progressing."	24.2.15						Waiting on TOR for this case from CC	
PS	[redacted]	MUC	23.4.14	Person	Pers	[redacted]	Mr Seamus O'Reilly Mr Barry Conway Mr Paul Smith	29.1.15	Mr Paul Kerr Mr Manos Epanimerotakis **External ED consultant tbc by Tracey Boyce** **Band 6 ED nurse tbc by Sharon Holmes**	23.4.15	No	[redacted]	?							
CC	[redacted]	SEC	25.7.14	Person	Per	[redacted]	23.7.14	1.8.14	?	24.10.14	No		Presently the patient remains ill. A decision has been taken that at present it would not be in his best interest to inform him of this referral. This decision is under review							
CC	[redacted]	CCS	[redacted]	Person	Per	[redacted]	16.7.15 Dr Philip Murphy Mr Simon Gibson Mr Tim McCormick Mrs Patircia McStay Mr Ronan Carroll Dr Chris Clarke Mrs Connie Connolly	22.7.15	Chair TBC by Dr McAllister Dr Mark Roberts Mr Tim McCormick Mrs Heather Trouton Mrs Kay Carroll Mrs Connie Connolly	TOR due 19.8.15 Report due 14.10.15	Yes [redacted]	[redacted]								This family will be notified by Dr Gail Browne week commencing 10 August 2015 as she had a lot of family contact. Dr Browne is aware.
CC	[redacted]	MUC	[redacted]	[redacted]	EG	[redacted]	15.7.15 Mr Seamus O'Reilly Dr Philip Murphy Mr Barry Conway Dr Chris Clarke Mrs Connie Connolly	23.7.15	Chair Dr Ryan Boyle Dr Peter Sharpe Dr Raymond McKee Ms Jilly Redpath Mr Barry Conway Mrs Connie Conolly	TOR due 20.8.15 Report due 15.10.15	Yes [redacted]	[redacted]								

SAI Level 3 Report
04-Aug-15

Lead Nurse	Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	Date SAI screening meeting Screening Team	SAI Form to Board/Date	Others informed (RQIA etc)	SAI Review Team Chair & Members & Coordinator	Date Report due	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Report shared with family - outcome of family meeting	Date case Closed	Current Status
	Persona	SEC	14.12.14	Perso	Pe	Personal Information redacted by the USI	7.12.14 Mr Eamon Mackle Mr Philip Murphy Mrs Heather Trouton Mr Simon Gibson Mrs Connie Connolly	30.12.14 TOR due 13.8.15 Report due 9.10.15		24.3.15 Dr Michael Gibbons Mr Manos Epanimerotakis Mrs Anne MCVey Miss Paula Fearon	Persona		Personal Info redacted by the USI	18.5.15						.	30.6.15 - I am doing background timeline for info only, decisions re RT, + Level to be reviewed + case to be allocated 23.6.15 -? raise Level or add to RT. Have some work done on background Timeline (In folder) but unlikely to get to add to it this week)

SAI Level 2 Under investigation
04-Aug-15

Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Description of incident	SAI screening meeting DateScreening Team	SAI Form to Board/Date	SAI Review Team Chair & Members & Coordinator	Date Report due	Coroner informed Y/N Date	Family Details	Date family informed of SAI	Date DRO Queries received and responded.	Dates of SAI meetings	Date to Governance meeting	Date report submitted to Board	Date case Closed	Current Status	Upgraded from Level 1 to Level 2

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Level 1 upgrade to Level 2
04-Aug-15

Incident date	Reporting Division	Date Reported on Datix	Datix ID	Patient Initials	Reason why upgraded from Level 1 to Level 2	Screening Team	Level 1 report to board advising of upgrade	SAI Level 2 Review Team Chair & Members & Coordinator	Date TOR due to Board	Date Report due	Coroner informed Y/N Date	Family Details	Date family informed of Level 2 SAI & by whom	Current Status