Patient Details – Affix Addressograph or write details	
Name:	Personal Information redacted by the USI
D.O.B.:	
H&C No:	

WIT-34474

Date of Clinic / Decision to list	15.06.26
Consultant	AO'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT URETERIC AND BLADDER INJURY
Procedure:	CYSTOSCOPY, REMOVAL OF STENT, RIGHT URETEROGRAPHY & CYSTOGRAM
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DHH

Urgency *Please tick appropriate box*	
Red Flag	
Urgent	✓
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DHH
Specific Unit Requirement	LEVEL 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☑ ENOXAPARIN 60 MGS DAILY

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐
- **Aspirin 300mg?** ☐
- **Clopidogrel** or **Prasugrel?** ☐
- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☑ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Personal Information redacted by the USI	**Print Name**	AO'BRIEN **Date** 07.06.26
Countersigned (Consultant)			**Date**

Terms of Reference for the Internal Urology Oversight Steering Group

Agreed 6th December 2021

The revised terms of reference set out below replace the "modus operandi" of the local urology coordination group by replacing the terms of reference as agreed on 19th November 2020 in order to reflect and adopt the Policy and Guidance for implementing a lookback review process

Note: The purpose of the policy and guidance is to provide a person-centred risk-based approach to the management of a Lookback Review and support to any service users and their families/carers who may have been exposed to harm, and to identify the necessary steps to ameliorate that harm. The scope of the policy and related guidance also includes providing information and support to those not directly exposed to the harm in question i.e. concerned members of the public.
Whilst the outcomes of a Lookback Review may inform other processes e.g. Serious Adverse Incident reviews or a Coroner's Inquest, this is not the primary purpose of a Lookback Review Process.

The Southern Trust Urology Oversight Steering Group will provide oversight in respect of patients identified as previously being under the care of Consultant A. The Group will also be responsible for providing the DOH with assurance regarding the rigour of approach pursued by the Southern Trust and the timeliness of patient review.

Specifically the Urology Coordination Group will be responsible for:

- Overseeing the service review/ risk assessment process to identify the scope of the issue and inform the decision to progress to the service review/audit and recall stages of the Lookback Review Process as required. Risk Assessment will be agenda item at each meeting. Review of lookback information completed and subsequent update of the risk assessment to reflect the situation at that time.

- Establishing the requirement for progression to Stage 3 "Service User Recall". This will be based on the completion of Stage 2. Terms of Reference specific to the purpose, scope, method and timeframe to be established when decision to progress to Stage 3 is agreed.

- Communicating the need for the service review/audit and recall stages of the Lookback Review Process through the organisation's governance structures/Assurance Framework to the Board of Directors and external stakeholders (including DoH);

- Using the Process Review Guideline as our framework for the Lookback Review Process. We will incorporate our actions and the allocation to

individuals, set timeframes and RAG rate actions according to priority. We will include actions completed prior to this group commencing to ensure a comprehensive record of the entire process is recorded.

- Overseeing operational management of all aspects of the Lookback Review Process and provide assurance of progression to the external Oversight Team

- The Action and Workplan will reflect the Process Review Guideline. Details of the methodologies to complete will be recorded as agreed at each meeting. A database of patients included in the review cohort will be maintained to allow outcomes for each patient to be recorded including type of review and outcome
- Developing a Lookback Review Action/ Work Plan which outlines the methodologies to be implemented in relation to the Audit and the Recall stages of the Lookback Review Process;

- At each meeting the group will provide details of number of patients that have had desktop/ clinical reviews completed, telephone and face to face appointments and will agree the next cohort of patients to be reviewed/ seen. This will also include patients who have been or need reviewed for SJR consideration and update of any newly identified issues/ themes.

- The group will discuss at each meeting the next cohort of patients that require review either virtually or face to face. The group will agree on those to be seen “in house” and allocation and planning actions to be recorded for creating this capacity, including additionality. If patients agreed for IS review, this will also be agreed and forwarded to IS contract manager for actionning. The Group must also note the discussions and potential impact on other service users when creating capacity to manage “in house”.

- Lookback Review Process, this should include service users not included in the ‘at risk’ cohort who also may be affected by the impact on services as a result of the Lookback Review Process;

- The group will ensure that all service users and staff involved are aware and have access to the dedicated Urology support services.

- Discussing and securing additional resources from Commissioners and ensuring service managers allocate the necessary resources to implement the Lookback Review Process and to meet associated demands;. This will be as the process progresses and when the need is identified that could potentially create a risk to enabling the Lookback Process to continue.

- The group will agree on the information provided to service users included in the Lookback Process. Communication will be patient specific and include details of support, and the outcome timescales.

The Group will be chaired by the Director Acute Services, SHSCT

Membership will include:

- Director of Acute Services (Chair of Regional group)
- Medical Director
- Assistant Director of Surgery and Elective Care
- Deputy Medical Director
- Assistant Director for the Public Inquiry and Trust Liaison
- Associate Medical
- Head of Service - Clinical Assurance
- Chair of any subgroups established by the group as and when regional only
- Clinical Nurse Specialist for Urology
- Representative for Patient and Client Council regional only - by request

Business support – HSCB regional only

Southern Health and Social Care Trust

Quality Care - for you, with you

Medical and Dental Oversight Group

Terms of Reference
2020

Summary & Purpose

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

Terms of Reference

The panel will review the case files of all medical and dental practitioners employed in the Trust, or engaged via Agency for whom there concerns have been raised about their professional practice. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed or was employed at the time concerns arose. Termination of employment, for whatever reason, does not necessarily end Trust responsibility in terms of MHPS or regulatory Fitness to Practice procedures.

Concerns about professional practice shall include;

- all Fitness to Practice procedures with regulatory agencies,
- all practitioners subject to procedures under MHPS (or equivalent procedures for doctors in training),
- restrictions, undertakings, suspensions or other sanctions imposed by a regulatory agency,
- all cases where NCAS have provided advice or assessment,
- all practitioners subject to a remediation process,
- practitioners whose performance has been called into question through appraisal and/or governance systems (as determined by the Responsible Officer),
- and all doctors for whom a recommendation to revalidate could not be provided at the time requested by GMC.

The Oversight Panel shall regularly review each case file with the Medical/Dental manager for the practitioner.

The Oversight Group shall ensure that any investigations taken under the management of performance comply with relevant guidance and occur in a timely manner.

The Oversight Group will at all times have due regard for ensuring patient safety.

The Oversight Group is required to provide additional assurance to the Trust that procedures under MHPS are undertaken in a fair and proportionate manner

All procedures under MHPS will be undertaken in accordance with this guidance and **SHALL NOT** be delayed until the next meeting of the Panel

MEMBERSHIP

The members of the Medical and Dental Oversight Group will comprise:

- Responsible Officer / Medical Director (Chair)
- Senior Manager MD Office
- Director of HR / Deputy Director of HR
- Head of Medical HR
- Associate Medical Director and/or Relevant representation from the Service (as set out below)*

*The Director or a nominated deputy.

The Oversight Panel may request additional members (including a legal representative) to provide expertise in particular areas. In the event of a member being unable to attend meetings an alternative professional representative may attend on his/her behalf.

ROLES AND RESPONSIBILITIES

To be discussed and completed here after further discussions with AMD's

The oversight panel shall consider each case and may give direction on further actions required. If the practitioner is a doctor in training then the Director of Medical Education and/or a representative of NIMDTA shall attend.

All meetings will be attended by a minute taker. Detailed minutes will be recorded of each meeting and retained.

All meetings will be chaired by the chairperson or in his/her absence, by a member nominated by the chairperson.

It is best practice that AMD's discussing cases at the Oversight Panel should ensure individual doctors are aware of the above process and that their case may be discussed as part of the Trust's process for handling concerns.

QUORUM

The Panel will not normally meet unless 2 members are present and meetings can only take place if the chairman (The Medical Director) is present or a nominated deputy.(Deputy Medical Director)

FREQUENCY OF MEETINGS

Meetings shall be held monthly

REPORTING ARRANGEMENTS

Minutes of the meetings of the Panel will be formally recorded and action notes distributed to Panel members and a full copy retained on the Medical Directors file.

REVIEW OF TERMS OF REFERENCE

The Terms of Reference will be reviewed at the first meeting of the Forum and thereafter annually. Any amendments to the Terms of Reference will be approved by the Medical Director; in the event of significant changes to the Terms of Reference these shall be presented to SMT for approval.

20200212
Q8.70 A2

From: Hynds, Siobhan [redacted]
Sent: 14 February 2020 16:50
To: OKane, Maria; McClements, Melanie; Toal, Vivienne; Gibson, Simon; Carroll, Ronan; Khan, Ahmed
Subject: Meeting of Oversight Group - MHPS case Mr A O'Brien

Importance: High

Dear All – please find note of the meeting on 12 February 2020. Please let me know if you have any amendments.

Regards,

Siobhan

Meeting of Oversight Group - MHPS case Mr A O'Brien

12 February 2020
17:20

In attendance:

Maria O'Kane
Melanie McClements
Vivienne Toal
Simon Gibson
Siobhan Hynds

Via Video Conference

Ronan Carroll

Via Phone

Ahmed Khan

Siobhan gave an overview of the process and investigation. Discussions were held in respect of the outstanding actions to be progressed and how these would be taken forward including recent correspondences from GMC and RQIA.

Melanie provided an update on the SAI processes and the sign off.

Actions:

- Maria - To have a meeting / conversation with Ted McNaboe, Clinical Director regarding him meeting with AOB regularly and seeking assurances through that supervisory process that AOB was working in accordance with the triage process, was not holding notes at home and was undertaking all digital dictation immediately following each individual clinical contact with a patient.

- Maria - to speak with Ted McNaboe and Mark Haynes to ensure an agreed job plan is in place for AOB as a matter of priority or to escalate to the next stage of the job planning process.
- Maria to seek assurance from Damien Scullion to ensure AOB is completing annual appraisals.
- Maria to draft a response to GMC and RQIA in respect of their recent correspondences to the Trust seeking additional information about the case.
- Siobhan to draft a terms of reference for the independent review of the SAI recommendations and the MHPS review recommendation. Terms of reference to go to the Group for agreement.
- Melanie to share SAI reports and recommendations with Siobhan for drafting of the TOR.
- Maria to speak to Dr Rose McCullough (GP) to undertake the independent review.
- Maria to update Shane
- Vivienne to progress AOB's Grievance process.

20191004
Q8.75

From: OKane, Maria [redacted]
Sent: 04 October 2019 22:45
To: Khan, Ahmed; Hynds, Siobhan; McClements, Melanie; Haynes, Mark; Corrigan, Martina
Cc: Gibson, Simon; Toal, Vivienne; Weir, Lauren; Reid, Trudy
Subject: URGENT :AOB concerns - escalation- oversight meeting request please
Attachments: FW: SHSCT - "Dr Urology Consultant" (84.3 KB); FW: URGENT - : General Medical Council In Response Please Quote SMC/1-22... (23.5 KB); Dr O'Brien – GMC No. 1394911- SHSCT response to request for info (192 KB)

Importance: High

Follow Up Flag: Follow up
Due By: 07 October 2019 09:30
Flag Status: Flagged

Lauren please arrange meeting for Tuesday as outlined below.

Dear all – unfortunately it wasn't possible for some of us to speak today at 4.15 – Mr Haynes has less flexibility than the rest of us but is available Tues 8th October when he and I have a 1-1 at a time between 1.30-3.30pm .
Can I ask that we try to get a best fit with this please? The GMC ELA has asked for an update on 7th October at 11am.

Unless advised otherwise by yourselves , I am led to believe there have not been any exception reports until this of the 16th September described below.

Agenda:
1. An outline of the escalation plan in relation to managing this and other potential exceptions within the services following on from the MHPS redacted report recommendations.
2. Update please on the recommended review of administrative processes described in the MHPS redacted report and referred to most recently by the GMC in the response attached 27.09.19 .
3. Update on progress of SAI reports which have arrived within the Trust recently and are being reviewed for accuracy
4. Outline of management of any potential risks to patient safety

Regards, Maria

From: Haynes, Mark
Sent: 03 October 2019 14:50
To: Khan, Ahmed; Weir, Lauren
Cc: Gibson, Simon; Hynds, Siobhan; OKane, Maria
Subject: RE: AOB concerns - escalation

Further update...

[redacted] (Male / [redacted] years)

IR1 going in from MDM today. Seen in OP on 16th August after MDM on 27th June (outcome was for Mr O'Brien to review and arrange a renal biopsy. No dictation has been done from the OP appointment, no biopsy has happened. Multiple emails have been sent to Mr O'Brien and his secretary but no update has been provided and no biopsy has occurred. Brought back to MDM today to endeavour to clarify what is happening (has also had enquiry from GP which I contacted Mr O'Brien after to enquire if all was in hand).

Mark

From: Khan, Ahmed
Sent: 03 October 2019 11:13
To: Weir, Lauren
Cc: Gibson, Simon; Hynds, Siobhan; Haynes, Mark; OKane, Maria
Subject: RE: AOB concerns - escalation

Lauran, I would be available between 2-4pm.
Thanks, Ahmed

From: OKane, Maria
Sent: 03 October 2019 00:04
To: Haynes, Mark; Khan, Ahmed; Hynds, Siobhan
Cc: Gibson, Simon; Weir, Lauren
Subject: RE: AOB concerns - escalation

Lauren can you arrange a teleconference for this Friday afternoon from a time from 1pm onwards please to agree next steps please? Many thanks Maria

From: Haynes, Mark
Sent: 01 October 2019 19:00
To: Khan, Ahmed; OKane, Maria; Hynds, Siobhan
Cc: Gibson, Simon; Weir, Lauren
Subject: RE: AOB concerns - escalation

The details are at the start of this mail (pasted below)

From: Corrigan, Martina
Sent: 16 September 2019 16:37
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: AOB concerns - escalation

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

CONCERN 2 – adhered to – no notes are stored off premises nor in his office (this is only feasible to confirm as there have been NO issues raised regarding missing charts that Mr O'Brien had)

CONCERN 3 – not adhered to – Mr O'Brien continues to use digital dictation on SWAH clinics but I have done a spot-check today and:

Clinics in SWAH
EUROAOB – 22 July and 12 August all patients have letters on NIECR
Clinics held in Thorndale Unit, Craigavon Area Hospital
CAOBTDUR - 20 August 2019 had 12 booked to clinic 11 attendances & 1 CND but no letters at all
CAOBUO – 23 August 2019 – 10 attendance and only 1 letter on NIECR

CAOBUO – 30 August 2019 – 12 booked to clinic, 1 CND, 1 DNA and 0 Letters on NIECR
CAOBUO – 3 September – 8 booked to clinic – 0 letters on NIECR
I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

From: Khan, Ahmed
Sent: 01 October 2019 16:13
To: OKane, Maria; Hynds, Siobhan
Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: RE: AOB concerns - escalation

Maria, I understand we are awaiting more details from Martina. Just spoke to Mark, he think number of non-adherence to agreed action plan.
Thanks, Ahmed

From: OKane, Maria
Sent: 30 September 2019 12:31
To: Khan, Ahmed; Hynds, Siobhan
Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: FW: AOB concerns - escalation

Dear Ahmed and Siobhan – any further updates on addressing the concerns raised by Martina please ? I am meeting with the GMC next Monday and I anticipate they will expect a description of what has occurred and how it has been addressed please? Many thanks Maria

Lauren bf for wed please

From: Weir, Lauren
Sent: 30 September 2019 09:00
To: OKane, Maria
Subject: AOB concerns - escalation

Dr O'Kane,
You asked me to bring this to your attention for today. I have it printed and on my desk for you

Lauren

Lauren Weir
PA to Dr Maria O'Kane – Medical Director's Office,
Southern Health & Social Care Trust

1st Floor, Trust Headquarters, CAH

Changed My Number

My Hours of work are: Monday – Friday 9.00am – 5.00pm

Please note my new contact number – External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by the USI

Personal Information redacted by the USI

From: OKane, Maria
Sent: 23 September 2019 13:27
To: Khan, Ahmed
Cc: Weir, Lauren; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Thank you.

Lauren bf 1 week please

From: Khan, Ahmed
Sent: 23 September 2019 13:04
To: OKane, Maria
Cc: Weir, Lauren; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Maria, I and Siobhan discussed this case last week. She has already requested more information /clarification from Martina therefore we will wait for this information. Siobhan also informed me trust grievance progress is on hold due to Mr AOB's lengthy FOI requested in progress. I will reply to Grainne Lynn once all this information at hand before contacting her.
Thanks, Ahmed

From: Khan, Ahmed
Sent: 18 September 2019 11:52
To: OKane, Maria
Cc: Weir, Lauren
Subject: FW: AOB concerns - escalation

Maria, see update report & concerns from Martina as Mr OBrien have failed to adhere to 2 elements of agreed action plan. I have requested an urgent meeting with Siobhan and Simon to discuss this issue and other updates as I am unaware of any further progress on his case.
Regards,
Ahmed

From: Khan, Ahmed
Sent: 17 September 2019 09:52
To: Corrigan, Martina; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Martina, thanks.

Siobhan & Simon, Can we meet to discuss this urgently please. I am can be available tomorrow am or pm.

Thanks,
Ahmed

From: Corrigan, Martina
Sent: 16 September 2019 16:37
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: AOB concerns - escalation

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

CONCERN 2 – adhered to – no notes are stored off premises nor in his office (this is only feasible to confirm as there have been NO issues raised regarding missing charts that Mr O'Brien had)

CONCERN 3 – not adhered to – Mr O'Brien continues to use digital dictation on SWAH clinics but I have done a spot-check today and:

Clinics in SWAH
EUROAOB – 22 July and 12 August all patients have letters on NIECR
Clinics held in Thorndale Unit, Craigavon Area Hospital
CAOBTDUR - 20 August 2019 had 12 booked to clinic 11 attendances & 1 CND but no letters at all
CAOBUO – 23 August 2019 – 10 attendance and only 1 letter on NIECR
CAOBUO – 30 August 2019 – 12 booked to clinic, 1 CND, 1 DNA and 0 Letters on NIECR
CAOBUO – 3 September – 8 booked to clinic – 0 letters on NIECR
I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Telephone:
Personal Information redacted by the USI (Internal)
Personal Information redacted by the USI (external)
Personal Information redacted by the USI (mobile)

Southern Health and Social Care Trust

Quality Care - for you, with you

Strictly Confidential

Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr A[redacted] K[redacted], Case Manager

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr A[redacted] O'B[redacted], Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'B[redacted] for comment on the factual accuracy of the report. I am in receipt of Mr O'B[redacted]'s comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'B[redacted] which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. (a) To determine if all patient notes for Mr O'B[redacted]'s patients are tracked and stored within the Trust.

   (b) To determine if any patient notes have been stored at home by Mr O'B[redacted] for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'B[redacted] are missing.

3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'B[redacted] in 2015 or 2016.

   (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'B[redacted] in dictating outpatient clinics.

   (c) To determine if there have been delays in clinical management plans for these patients as a result.

4. To determine if Mr O'B[redacted] has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

5. To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

1. (a) It was found that Mr O'B[redacted] did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'B[redacted]. Mr O'B[redacted] accepts this fact.

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'B[redacted] returned 307 sets of patient notes which had been stored at his home. Mr O'B[redacted] accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'B[redacted] returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'B[redacted].

3. (a) It was found that there were 66 undictated clinics by Mr O'B[redacted] during the period 2015 and 2016. Mr O'B[redacted] accepts this.

   (b) It was accepted by Mr O'B[redacted] that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC are that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'B[redacted] scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

7. Concerns about Mr O'B[redacted]'s practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'B[redacted] regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'B[redacted]'s practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'B[redacted] provided a detailed context to the history of the Urology service and the workload pressures he faced. Mr O'B[redacted] noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'B[redacted] noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'B[redacted] accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'B[redacted] did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'B[redacted]. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'B[redacted].

3. Mr Y[redacted] is the most appropriate comparator for Mr O'B[redacted] as both have historical long review lists which the newer Consultants do not have. Mr Y[redacted] managed triage alongside his other commitments. Mr Y[redacted] undertook Mr O'B[redacted]'s triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'B[redacted] from his home.

4. It was known that Mr O'B[redacted] stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'B[redacted]'s secretary did not flag that dictation was not coming back to her from clinics. Mr O'B[redacted]'s secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'B[redacted] indicated that he did not see the value of dictating after each care contact.

3. Mr O'B[redacted] was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'B[redacted]'s clinical ability with patients.

- There are clear issues of concern about Mr O'B[redacted]'s way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'B[redacted]'s reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'B[redacted] had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'B[redacted] did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'B[redacted]'s practice.

- Mr O'B[redacted] did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'B[redacted] has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'B[redacted] returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'B[redacted] worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'B[redacted]'s administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'B[redacted] for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'B[redacted]'s Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'B[redacted]'s practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'B[redacted] at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'B[redacted] has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'B[redacted] to adhere to known and agreed Trust practices and that there have also been failures by Mr O'B[redacted] in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'B[redacted]'s own individual professional responsibilities.

During the MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'B[redacted]'s conduct rather than his clinical ability. I have sought advice from

Practitioner Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'B[redacted] include:

- Failing to undertake non red flag triage, which was known to Mr O'B[redacted] to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'B[redacted], as a senior clinician had an obligation to ensure this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'B[redacted]'s failings must be put to a conduct panel hearing.

4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.

There are no evident concerns about Mr O'B[redacted]'s health. I do not consider this to be an appropriate option.

5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'B[redacted]'s clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'B[redacted]'s administrative practices. The report highlights the impact of Mr O'B[redacted]'s failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'B[redacted]'s clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'B[redacted]. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'B[redacted] which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'B[redacted]. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'B[redacted].

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

Southern Health and Social Care Trust

Quality Care - for you, with you

26th September 2019

Via email: [redacted]

Ref: MOK/lm

Joanne Donnelly
Employer Liaison Service for Northern Ireland
General Medical Council

Dear Joanne,

RE: SHSCT - DR O'BRIEN – GMC NO. 1394911 – GMC REQUEST FOR FURTHER INFORMATION

In response to your correspondence dated 27th August 2019 please find below a table outlining Trust responses to your information requests.

GMC Information Request	Trust Response
Along with your referral of Dr O'Brien, you forwarded a copy of the MHPS Investigation Case Manager Determination (dated September 2018). Given the Report was completed last year, was there any specific reason the referral to the GMC was delayed?	The MHPS Case Manager Determination was notified to the Practitioner on 1 October 2018. The decision of the Case Manager at that time was not to refer to GMC but to conclude the internal process first, which was referral to a conduct panel. On further discussion of the MHPS case with the Trust's GMC liaison officer, a request to the Trust was made for referral to GMC and this was made by the Trust's Medical

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] / Email: [redacted]

	Director.
The MHPS Determination highlighted a number of "wider, systemic findings that must be addressed by the Trust" and "systemic failures by managers at all levels, both clinical and operational". What exactly were these specific systemic issues; have any inspections of these issues taken place. We also need information on what the Trust have done to address these issues so far?	The MHPS determination highlighted 'failures by managers at all levels, both clinical and operational' – this referred to failings to manage concerns in respect of the Practitioner when the issues were first known and on-going thereafter. The concerns about the Practitioner were known to managers at a number of levels within the organisation over a number of years and the report noted that management of the concerns was not as it should have been. The Trust have committed to an independent review of the relevant administrative processes and roles and responsibilities. This review has not yet commenced.
It is noted that the Trust were also asked to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels, and to look at the full system wide problems. Has this review has been completed; what were the findings (or an update on the current progress)?	Please see above response.
The referral also raised questions about Dr O'Brien's lack of insight into the concerns raised about his practice. Can you confirm specific details of what these issues were, including any examples suggesting the doctor lacked insight?	The MHPS Case Investigator referred to a lack of insight on the part of the practitioner in the formal investigation report following conclusion of the investigation. This was primarily in respect of the Practitioner's responses during the investigation into the issues of concern and impact of his administrative practices on the HSC patients on his caseload. The one clear example of his lack of insight was in respect of his response on the impact on the 5 patients with a confirmed cancer diagnosis.

We note there was a return to work plan meeting held on 09/02/2017 where Dr O'Brien was informed of what he needed to do in terms of his admin processes. Was his return to work monitored in any way by the Trust at that time and if so, what was the outcome?	The return to work action plan was put in place at the time of Mr O'Brien's return to work and this continues to be monitored by the operational Head of Service. The Head of Service reports any deviation from the action plan, by exception, to the MHPS Case Manager.
In addition, is Dr O'Brien's admin processes / work still being monitored at the present time? If so, can the Trust provide an update on how the doctor is currently performing and whether he is managing his administrative duties effectively?	As of Monday 16 September 2019, the operational Head of Service has notified the MHPS Case Manager of a deviation from the action plan by Mr O'Brien. The scale of this deviation is currently being scoped and a meeting will be held with Mr O'Brien once the full extent of this deviation is known. Prior to this, Mr O'Brien has been working in line with the return to work action plan.
Have there been any recent or new concerns raised about his practice (or his admin processes) that haven't already been considered under the MHPS or the Trust SAI Investigations?	Please see above I respect of a very recent deviation from the Trust's return to work action plan in respect of Mr O'Brien's administrative practices. I have no information in respect of further SAIs.
Has Dr O'Brien made any recent statements or provided any evidence, in response to the concerns being raised about him?	I am not aware of any recent statements.
When we spoke on 14 March 19 (see attached) you advised that SHSCT staff have come under external pressure not to challenge Dr O'Brien (pressure from his high-profile/influential private patients). Can the Trust provide any further information to support this/in relation to this?	A member of SHSCT staff referred to Dr O'Brien's standing with some patients under his care who felt his practice was of an exemplary standard. This had no bearing or influence on the Trust decision to make a GMC referral.
We don't appear to have a copy of the formal local/SAI Investigation Report (we only have the MHPS Case Manager Determination). We understand that you indicated the Report(s) would be posted to us – however we don't	The local SAI reports are currently being reviewed by the Trust operational governance teams; these will be shared with the GMC when available.

appear to have received it. Could an electronic copy to be forwarded too?	

If you have any queries please do not hesitate to contact me directly.

Yours sincerely,

Personal Information redacted by the USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

20191004
Q8.75 A3

From: Gibson, Simon [Personal Information redacted by the USI]
Sent: 24 April 2019 16:56
To: Practisefi@gmc-uk.org
Cc: Parks, Zoe; Hynds, Siobhan; OKane, Maria
Subject: FW: URGENT - : General Medical Council In Response Please Quote SMC/1-2251053156

Dear Mr Durrant

We have considered your request, and do not have **any** letters/emails/correspondence **from** or with Dr O'Brien in regards to these concerns he raised.

Kind regards

Simon

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

From: GMC Fitness to Practise FI [mailto:Practisefi@gmc-uk.org]
Sent: 17 April 2019 13:02
To: OKane, Maria
Subject: FW: General Medical Council In Response Please Quote SMC/1-2251053156

Dear Dr O'Kane

I wrote to you on **09/04/2019** to ask for some information. A copy of this email is enclosed within the thread below.

I write to you now, as we have not yet received a response.

If possible, please respond to this request by **25/04/2019**. You can send this to our Manchester address below, or direct to my email address.

Again, if you have any questions please let me know.

Kind Regards

John Durrant
Enquiries Team
General Medical Council
3 Hardman Street, Manchester, M3 3AW
Website: www.gmc-uk.org
Telephone: [Personal Information redacted by the USI]

From: GMC Fitness to Practise FI
Sent: 09 April 2019 12:13

To: 'OKane, Maria'
Subject: General Medical Council In Response Please Quote SMC/1-2251053156

Dear Dr O'Kane

Thank you for sending us your email dated 02/04/2019.

To help us decide how best to deal with the information you provided, we need some extra information from you, which I have set out below.

Information we need from you
Please send the following information by **16/04/2019** to the Manchester address below or by emailing it to me at practisefi@gmc-uk.org

- In your referral to the GMC, you have advised that Dr O'Brien has raised patient safety concerns previously – you have stated that 'he has raised concerns throughout about waiting lists which are well recognised'. Could you provide us with some further details in relation to these patient safety concerns. This may include:
    - Elaboration in terms of what these concerns were in regards to the waiting lists (including when he raised them)
    - Details of any actions that have been undertaken as a result of these concerns being raised.
    - Any letters/emails/correspondence you have from or with Dr O'Brien in regards to these concerns he raised.
    - Any other documentation/details you feel relevant to these patient safety concerns

Why is this information needed?
We need this further information to decide whether the information you provided needs a full investigation. Our role is to ensure that doctors who are registered to practise medicine in the UK are safe to do so. We only take action where we believe we may need to restrict or remove a doctor's registration to protect patients.

Once we have received the further information, a senior member of GMC staff will review your complaint and we will write to you again to update you on the progress of your complaint.

In the meantime, if you have any questions just let me know and I will be happy to help.

Kind Regards

Sarah McDermott
Enquiries Team
General Medical Council
3 Hardman Street, Manchester, M3 3AW
Practisefi@gmc-uk.org
Personal Information redacted by the USI

General Medical Council

3 Hardman Street, Manchester M3 3AW

Regents Place, 350 Euston Road, London NW1 3JN

The Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh EH8 8AE

4th Floor, Caspian Point 2, Caspian Way, Cardiff Bay CF10 4DQ

9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

20190827
Q8.77

From: OKane, Maria [redacted]
Sent: 27 August 2019 14:37
To: Gibson, Simon; Hynds, Siobhan; Haynes, Mark; Corrigan, Martina
Cc: McClements, Melanie; Montgomery, Ruth; Toal, Vivienne
Subject: FW: SHSCT - Dr O'Brien – GMC No. 1394911 – GMC request for further information (27.8.19)
Attachments: FW: SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'... (115 KB)

Follow Up Flag: Follow up
Due By: 03 September 2019 16:00
Flag Status: Flagged

Dear all – can these queries be addressed please and returned to Simon and Siobhan for collation by the 4th September ? I will inform the GMC of the need for time to respond. Regards, Maria

From: Joanne Donnelly [redacted]
Sent: 27 August 2019 09:19
To: OKane, Maria; Gibson, Simon
Cc: Support TeamELS
Subject: SHSCT - Dr O'Brien – GMC No. 1394911 – GMC request for further information (27.8.19)

Dear Maria,

GMC Triage Team require the following additional information urgently:

1. Along with your referral of Dr O'Brien, you forwarded a copy of the MHPS Investigation Case Manager Determination (dated September 2018). Given the Report was completed last year, was there any specific reason the referral to the GMC was delayed?

2. The MHPS Determination highlighted a number of "wider, systemic findings that must be addressed by the Trust" and "systemic failures by managers at all levels, both clinical and operational". What exactly were these specific systemic issues; have any inspections of these issues taken place. We also need information on what the Trust have done to address these issues so far?

3. It is noted that the Trust were also asked to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels, and to look at the full system wide problems. Has this review has been completed; what were the findings (or an update on the current progress)?

4. The referral also raised questions about Dr O'Brien's lack of insight into the concerns raised about his practice. Can you confirm specific details of what these issues were, including any examples suggesting the doctor lacked insight?

5. We note there was a return to work plan meeting held on 09/02/2017 where Dr O'Brien was informed of what he needed to do in terms of his admin processes. Was his return to work monitored in any way by the Trust at that time and if so, what was the outcome?

6. In addition, is Dr O'Brien's admin processes/work still being monitored at the present time? If so, can the Trust provide an update on how the doctor is currently performing and whether he is managing his administrative duties effectively?

7. Have there been any recent or new concerns raised about his practice (or his admin processes) that haven't already been considered under the MHPS or the Trust SAI Investigations?

8. Has Dr O'Brien made any recent statements or provided any evidence, in response to the concerns being raised about him?

9. When we spoke on 14 March 19 (see attached) you advised that SHSCT staff have come under external pressure not to challenge Dr O'Brien (pressure from his high-profile/influential private patients). Can the Trust provide any further information to support this/in relation to this?

10. We don't appear to have a copy of the formal local/SAI Investigation Report (we only have the MHPS Case Manager Determination). We understand that you indicated the Report(s) would be posted to us – however we don't appear to have received it. Could an electronic copy to be forwarded to?

I would be grateful if you would reply to me just as soon as you can. I note we have a routine ELA/RO meeting on 6 Sept 19, so it would be good to have your e-mail response before then so that we can discuss at our meeting if necessary.

Best wishes
Joanne

Joanne Donnelly [redacted]
GMC ELA for NI

STeamELS@gmc-uk.org – FTP –other – SHSCT - Dr O'Brien – GMC No. 1394911 – request for further information (27.8.19)

20190827
Q8.77 A1

From: Joanne Donnelly [redacted]
Sent: 20 March 2019 15:07
To: OKane, Maria [redacted]
Cc: Gibson, Simon; Parks, Zoe; Support TeamELS
Subject: FW: SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'Brien - GMC No. 1394911
Attachments: FW: IMPORTANT - Redacted MHPS investigation into AOB (67.0 KB)

Importance: High

Dear Maria,

Just to let you know further to our telephone conversation on Fri 15 March 19- during which you advised that you would be referring Dr O'Brien – GMC No. 1394911 - to the GMC after you had an opportunity on Tuesday 19 March 19 to inform him – that we have not yet received a referral. Please do not hesitate to let me know if I can assist in any way.

We also discussed that as Dr O'Brien's revalidation submission date is 27 April 19 – his revalidation date will be put on hold if a GMC investigation is opened. If Dr O'Brien's revalidation date is put on hold, you will not need to make a recommendation in respect of him – however you should ensure that he is still engaging in local revalidation processes – as his duty to engage in revalidation itself has not been put on hold (just his revalidation date).

Please do not hesitate to contact me should you wish to discuss further.

Kind regards
Joanne

Joanne Donnelly [redacted]
GMC ELA for NI

STeamELS@gmc-uk.org – FTP- refer doctor – SHSCT - Dr Aidan O'Brien - GMC No. 1394911 - urology Consultant- concerns re timeliness of management of patient triaging/referrals (20.3.19)

From: Joanne Donnelly [redacted]
Sent: 15 March 2019 13:05
To: OKane, Maria [redacted]
Cc: Gibson, Simon; STeamELS@gmc-uk.org
Subject: FW: SHSCT - "Dr Urology Consultant"- advice to refer - Mr Aidan O'Brien
Importance: High

Dear Maria,

Just to confirm our telephone call yesterday evening.

You advised that "Dr urology consultant" is Mr Aidan O'Brien (you did not have his GMC number to hand).

You advised that:

- Mr O'Brien does not do any work outside the SHSCT other than private work from his own home – and that he has been required to agree an undertaking that he would not do any work from his own home. I note from my e-mail below that I had previously been advised that the doctor's practice is currently restricted in the interests of patient safety and that the doctor is complying with a local action plan.
- So far as you are aware Mr O'Brien is not registered with the Medical Council of Ireland.

- You have concerns that Dr O'Brien has a lack of insight.
- There is an SAI investigation relating to an incident in Feb 18 – [redacted] year old man with renal problems – died. Lack of preoperative preparation. This death was reported to the coroner. SAI report is almost complete.
- A new incident came to light last week – a suspicious shadow on x-ray was not followed up as outpatient letter was not completed. You did not provide any more detail on this during our call.
- Mr O'Brien has not completed his 2017 or 2018 appraisals. He has had no 360 feedback. His revalidation submission date is in April 19- will need to be deferred because of involvement in local processes.
- NI cannot send data to the National Data Reporting System – so NI does not benefit for the red flag alerts that this system generates.
- Dr O'Brien has issued a grievance against a number of SHSCT staff in relation to handling of the local management of the concerns.
- SHSCT staff have come under external pressure not to challenge Mr O'Brien – external pressure from his high-profile/influential private patients.

I hope this is an accurate summary of our conversation - if you consider that there are any inaccuracies I would be grateful if you would let me know.

Further to our telephone conversation and to my email below – I reaffirm my advice that this doctor should be referred to the GMC, immediately. The referral should be made using the Referral Form that is found in your GMC Connect account – if you have any difficulties accessing GMC Connect you should send your referral to gmcftp@gmc-uk.org (copied to me). Please include as much information as possible in the Referral Form as this will allow matters to be dealt with more quickly.

You may find the following links useful: (1) information on the Doctor Support Service - https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors/doctor-support-service-.; (2) information on the GMC investigation process: https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/how-we-investigate-concerns

I would be grateful if you would advise whether any other local action is to be taken in respect of this matter. I would also be grateful if you would confirm if there are any other doctors in the SHSCT who have not completed their 2018 (or earlier) appraisals.

During our call we discussed that there may be systems learning opportunities in respect of the approach in this case to the escalation and management of concerns about this doctor and the approach to management of non-participation in appraisal. I am available to support you in your consideration of such learning – we have a routine ELA/RO meeting scheduled for 29 March 19, however if you feel it would be helpful to meet to discuss before then I can make myself available. And please feel free to contact me on my mobile at any time.

Kind regards
Joanne

Joanne Donnelly [Personal Information redacted by the USI]
GMC ELA for NI

STeamELS@gmc-uk.org – FTP- refer – SHSCT - Dr Aidan O'Brien urology Consultant- concerns re timeliness of management of patient triaging/referrals (15.3.19)

From: Joanne Donnelly [Personal Information redacted by the USI]
Sent: 14 January 2019 13:20
To: maria.okane [Personal Information redacted by the USI]
Cc: 'Gibson, Simon'; STeamELS@gmc-uk.org
Subject: FW: SHSCT - "Dr Urology Consultant"- advice to refer
Importance: High

Dear Maria,

See below for your attention – as SHSCT RO.

Best wishes
Joanne

Joanne Donnelly [Personal Information redacted by the USI]
GMC ELA for NI

STeamELS@gmc-uk.org – Ftp – refer – SHSCT – Dr Urology - advice to refer- probity/record keeping/confidentiality/ - all impacting on clinical competence/patient safety (14.1.19)

From: Joanne Donnelly [Personal Information redacted by the USI]
Sent: 09 January 2019 16:56
To: 'Gibson, Simon'
Cc: OKane, Maria; White, Laura; Hynds, Siobhan; Moiza Butt [Personal Information redacted by the USI]; STeamELS@gmc-uk.org
Subject: RE: SHSCT - "Dr Urology Consultant"- advice to refer
Importance: High

Dear Simon,

Thank you for your e-mail. Apologies for the delay in replying to your e-mail- due to annual leave.

I note that the attached report refers to a number of concerns including: (1) issues that may be classed as probity concerns (advantage to patients who had seen him first in a private capacity- which may have resulted in advantage to doctor); (2) actual harm to at least 5 patients and potential harm to a large number of patients (relating to delayed cancer diagnosis and significant delays in commencing appropriate treatment); (3) failure to make contemporaneous notes in patient records; (4) potential breach of patient confidentiality – keeping patient notes at doctor's home.

On the basis of the information you have provided – these concerns appear to me to meet the threshold for referral to the GMC as they are allegations of serious and persistent failures to practise in accordance with the principles set out in Good Medical Practice (I acknowledge that the doctor's practice is currently restricted in the interests of patient safety and that the doctor is complying with a local action plan).

Please do not hesitate to contact me should you wish to discuss further. See GMC guidance **GMC Thresholds**: https://www.gmc-uk.org/-/media/documents/dc4528-guidance-gmc-thresholds_pdf-48163325.pdf

I note the comments in the report about management responsibility and note also the date(s) of the original incident(s)- if you would find it helpful to discuss this also I am of course happy to do so.

Best wishes
Joanne

Joanne Donnelly [Personal Information redacted by the USI]
GMC ELA for NI

STeamELS@gmc-uk.org – Ftp – refer – SHSCT – Dr Urology - advice to refer- probity/record keeping/confidentiality/ - all impacting on clinical competence/patient safety (9.1.19)

From: Gibson, Simon [Personal Information redacted by the USI]
Sent: 18 December 2018 10:53
To: Joanne Donnelly [Personal Information redacted by the USI]
Cc: OKane, Maria; White, Laura; Hynds, Siobhan
Subject: FW: SHSCT - "Dr Urology Consultant"

Dear Joanne

Following our meeting, please find attached redacted MHPS investigation as discussed.

Kind regards

Simon

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

From: Joanne Donnelly Personal Information redacted by the USI
Sent: 12 December 2018 11:47
To: OKane, Maria
Cc: Support TeamELS; Gibson, Simon; Parks, Zoe
Subject: SHSCT - "Dr Urology Consultant"

Dear Maria,

At the local concerns part of our meeting on 4 Dec 18 we discussed "Dr Urology Consultant"; I understand that Simon advised that he would forward to me the relevant SAI and MHPS reports.

I look forward to hearing from you/Simon in this regard.

Best wishes
Joanne

STeamELS@gmc-uk.org - FTP- monitor – SHSCT - Dr Urology Consultant- concerns re timeliness of management of patient triaging/referrals (12.12.18)

The Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh EH8 8AE

4th Floor, Caspian Point 2, Caspian Way, Cardiff Bay CF10 4DQ

9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

Southern Health & Social Care Trust IT Department [redacted]

Corrigan, Martina

From: McClements, Melanie
Sent: 08 July 2022 18:18
To: Corrigan, Martina
Subject: FW: SHSCT - Dr O'Brien – GMC No. 1394911 – GMC request for further information (27.8.19)
Attachments: FW: SHSCT - "Dr Urology Consultant"- advice to refer doctor - Mr Aidan O'... (115 KB)

From: OKane, Maria [redacted]
Sent: 27 August 2019 14:37
To: Gibson, Simon [redacted]; Hynds, Siobhan [redacted]; Haynes, Mark [redacted]; Corrigan, Martina [redacted]
Cc: McClements, Melanie [redacted]; Montgomery, Ruth [redacted]; Toal, Vivienne [redacted]
Subject: FW: SHSCT - Dr O'Brien – GMC No. 1394911 – GMC request for further information (27.8.19)

Dear all – can these queries be addressed please and returned to Simon and Siobhan for collation by the 4th September ? I will inform the GMC of the need for time to respond. Regards, Maria

From: Joanne Donnelly [redacted]
Sent: 27 August 2019 09:19
To: OKane, Maria; Gibson, Simon
Cc: Support TeamELS
Subject: SHSCT - Dr O'Brien – GMC No. 1394911 – GMC request for further information (27.8.19)

Dear Maria,

GMC Triage Team require the following additional information urgently:

1. Along with your referral of Dr O'Brien, you forwarded a copy of the MHPS Investigation Case Manager Determination (dated September 2018). Given the Report was completed last year, was there any specific reason the referral to the GMC was delayed?

2. The MHPS Determination highlighted a number of "wider, systemic findings that must be addressed by the Trust" and "systemic failures by managers at all levels, both clinical and operational". What exactly were these specific systemic issues; have any inspections of these issues taken place. We also need information on what the Trust have done to address these issues so far?

3. It is noted that the Trust were also asked to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels, and to look at the full system wide problems. Has this review has been completed; what were the findings (or an update on the current progress)?

4. The referral also raised questions about Dr O'Brien's lack of insight into the concerns raised about his practice. Can you confirm specific details of what these issues were, including any examples suggesting the doctor lacked insight?

5. We note there was a return to work plan meeting held on 09/02/2017 where Dr O'Brien was informed of what he needed to do in terms of his admin processes. Was his return to work monitored in any way by the Trust at that time and if so, what was the outcome?

6. In addition, is Dr O'Brien's admin processes/work still being monitored at the present time? If so, can the Trust provide an update on how the doctor is currently performing and whether he is managing his administrative duties effectively?

7. Have there been any recent or new concerns raised about his practice (or his admin processes) that haven't already been considered under the MHPS or the Trust SAI Investigations?

8. Has Dr O'Brien made any recent statements or provided any evidence, in response to the concerns being raised about him?

9. When we spoke on 14 March 19 (see attached) you advised that SHSCT staff have come under external pressure not to challenge Dr O'Brien (pressure from his high-profile/influential private patients). Can the Trust provide any further information to support this/in relation to this?

10. We don't appear to have a copy of the formal local/SAI Investigation Report (we only have the MHPS Case Manager Determination). We understand that you indicated the Report(s) would be posted to us – however we don't appear to have received it. Could an electronic copy to be forwarded to?

I would be grateful if you would reply to me just as soon as you can. I note we have a routine ELA/RO meeting on 6 Sept 19, so it would be good to have your e-mail response before then so that we can discuss at our meeting if necessary.

Best wishes
Joanne

Joanne Donnelly Personal Information redacted by the USI
GMC ELA for NI

STeamELS@gmc-uk.org – FTP –other – SHSCT - Dr O'Brien – GMC No. 1394911 – request for further information (27.8.19)

4th Floor, Caspian Point 2, Caspian Way, Cardiff Bay CF10 4DQ

9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

Terms of Reference- Agreed by Group 11 October 2021

Trust's Task and Finish Group into Urology SAI Recommendations

Terms of Reference of Task and Finish Group

The Task and Finish group is charged with implementing all the recommendations and providing assurance/evidence to the Urology Oversight Group

Membership of Task and Finish Group

Consultant	Nurse	Manager/Admin
Philip Murphy, Deputy Med Director Shahid Tariq, Deputy Med Director Mark Haynes – Deputy Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, Gen Surgery Kevin McElvanna General Surgery Art OHagan Dermatology Geoff McCracken, Gynae Helen Mathers Breast Rory Convery Lung Christina Bradford;, Hematology Anthony Glackin,; Urology Marian Korda, ENT	Clair, Quin, Cancer Lead Tracey McGuigan, Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Service Improvement Lead Sharon Glenny, performance manager Jane Scott performance manager Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Sarah Ward, Head of Service Clinical Assurance

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-disciplinary teams to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Life span of Task and Finish Group

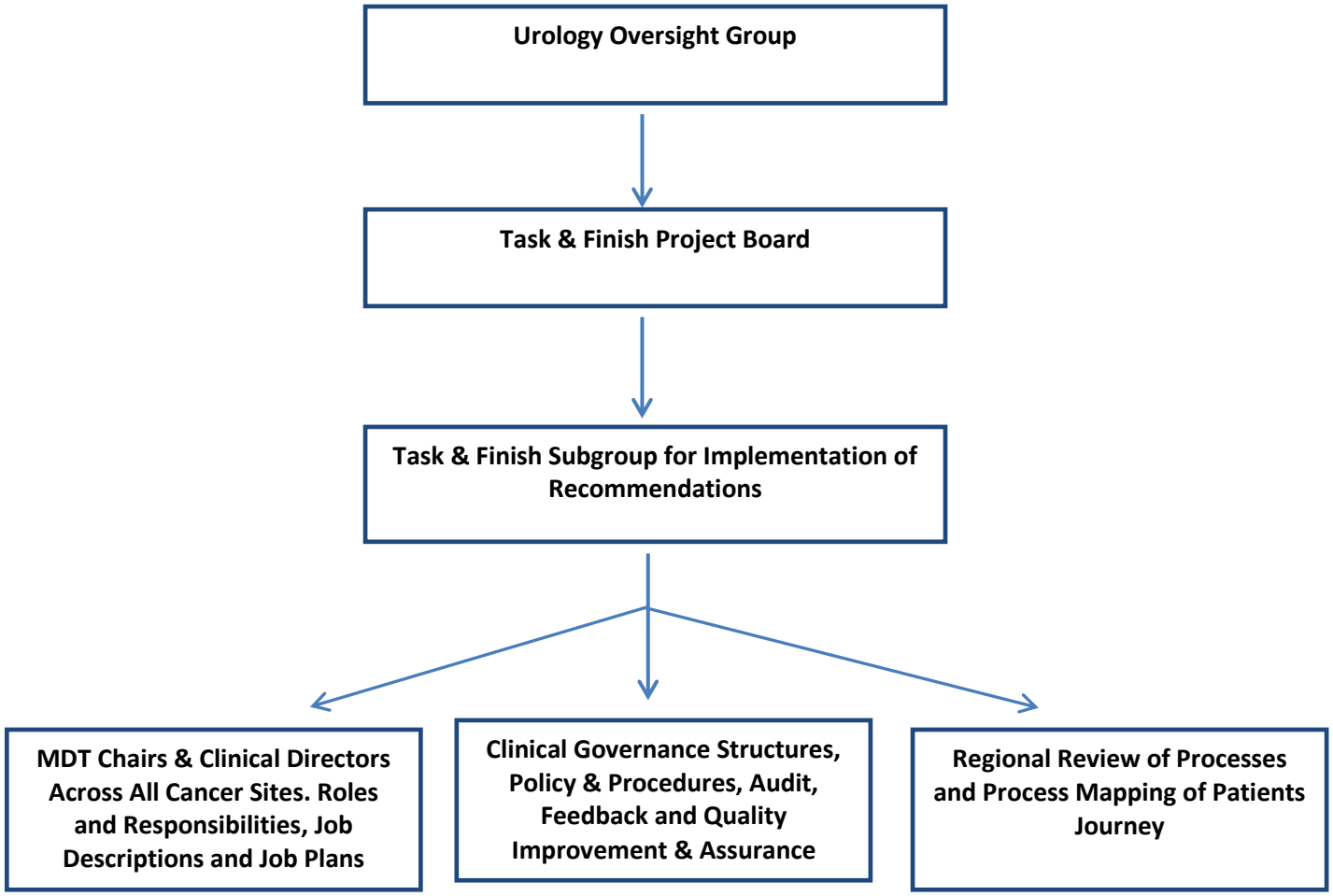
The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.

2. Task and Finish Group will report to the Urology Oversight Group Meeting and regular updates will be provided to the HSCB, DoH and families involved in the SAI's.

Governance and Accountability



Frequency of Meetings

Monthly

20190402
Q8.82

From: Trouton, Heather [redacted]
Sent: 02 August 2019 10:30
To: Carroll, Ronan
Cc: McClements, Melanie; OKane, Maria
Subject: 3 South

Dear Ronan

[redacted]

Following our most recent conversation regarding 3 South with Melanie on 28th June and the plan to talk to Barry re any work with Gynae/ Sr Webb, and other moves within 3 South itself , have you any update re that suggestion?

I also believe that Grace is meeting with yourself on Thursday to update the risk assessment . Following that I think it is time that we met again as a senior team , Melanie , Maria , yourself and I to agree a way forward.

We are very happy to support the ward staff with development , leadership training, team effectiveness and ward identity work etc and I think that would be very useful as well as the structural changes that may be needed.

Trust this approach is helpful.

Kind regards
Heather

Mrs Heather Trouton
Interim Executive Director of Nursing, Midwives and AHP's
Southern Health and Social Care Trust
TEL: [redacted]
Mobile: [redacted]
Email: [redacted]

Changed My Number
Internal with new AVAYA phone: [redacted]
Internal with old Legacy Phone: [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

TERMS OF REFERENCE

COMMITTEE	**Nurses in Difficulty**
PURPOSE	Being fit to practice requires Nurses and Midwives to have the skills, knowledge, health and character to do their job safety and effectively. Nurses in Difficulty 'Clinics' has been established to ensure that Nurses and Midwifes are supported along with their manager throughout any fitness to practice process using a collective leadership approach.
MEMBERSHIP	• Assistant Director of Nursing, Patient Safety Quality and Experience • Secretary to Assistant Director of Nursing • Head of Nursing, Patient Safety and Quality of Care • Senior Human Resource Advisor • Acute Directorate Professional Nurse Lead • MHD Directorate Professional Nurse Lead • OPPC Directorate Professional Nurse Lead • CYP Assistant Director for Specialist Child Health & Disability • Nurse Bank Manager In exceptional circumstances if members are unable to attend they must send a professional HoS representative and ensure a robust handover is provided in advance of the meeting.
DUTIES	• To ensure there is a consistent and transparent person centred approach in making decisions about Nurses and Midwifes fitness to practice. • To discuss all Nurses and Midwifes who are undergoing a formal fitness to practice process • To discuss and problem solve escalated issues relating to fitness to practice • To provide support to the Nurse or Midwife and their manager • To promote a culture of learning from mistakes • To provide assurance to the Executive Director of Nursing and Allied Health Professionals of all Nurses and Midwives
CONFIDENTIALITY	Everything that is discussed during a NiD clinic must remain confidential unless it has been agreed that the case should be discussed outside of the clinic. NiD database is password protected and only the core membership are given access to their directorate tile on SharePoint.
AUTHORITY	The committee operates under the delegated authority of the Executive Director of Nursing and Allied Health Professionals

CHAIR	Assistant Director of Nursing, Patient Safety Quality and Experience
MEETINGS	**Quorum** - A quorum is the minimum number of members of a clinic necessary to conduct business and especially to make binding decisions. A quorum includes the Chair, secretary and one representative from each Directorate. **Frequency of Meetings -** The Clinics will take place every 2 weeks allowing each care directorate to attend one monthly meeting 'clinic'. **Papers** – Agenda and relevant papers for meetings will be produced in time for members to prepare. All documentation will comply with the Trust's Information policy.
REPORTING	A nominated member of the Nurses in Difficulty Committee will report on the work of the Committee to Trust Board on a bi annual basis.
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for members, co-opted members to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
REVIEW	The Terms of Reference will be reviewed in 6months following the pilot, or earlier as required.
DATE	April 2022

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday, 7th June 2019

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

1.0	**Apologies**: Esther Gishkori, Patricia Kingsnorth	
2.0	**Notes from last meeting** **Matters Arising/Actions**	
3.0	**Electronic Sign off** SIGNOFF_201904_SHSCT.PDF This was discussed during some of the SAI report reviews. Meeting organised for 26/7/19 with MD.	
3.0	**Standards and Guidelines** Papers sent on separate email	
4.0	**Audit** **Patient Safety Report**	ADs and AMDs
5.0	• **SAIs**: Gareth Hampton + Anne McVey Philip Murphy Personal Information Final 05 09 2018.docx SEA Personal Final draft 31.5.19.docx Personal Information redacted by the – Dr Murphy presented the report. Dr Hampton updated the meeting on the actions that have been taken following this incident and the new kit boxes and guidance set up in EDs for tube replacement. the enteral feeding team have been very helpful. Report approved. Personal Information – Dr Murphy presented the report. The IBD MDT is up and running. Delays	AMDs/ CD

	in the review scopes were discussed and the breakdown in communication that happened in this case. A more robust method is needed to ensure results such as this do not get lost. Mark Haynes + Ronan Carroll  SAI level 1 Personal Final 11.4.19.docx  - SEA Personal Information ACG June 2019 final draft.  RCA Report for ACG June 2019.docx  SEA Personal .docx Personal Information – the report was discussed. The issue of result sign off and a system to follow up unsigned reports was discussed. Teams need to sort plans for this and be consultant led. The working group is meeting 26th July to discuss result sign off with the MD. Admin help is required and some sort of failsafe system. Could we pilot using chest x-rays to get all signed off. Rec 2 needs to be changed to 'need to have a robust system'. Report approved. Personal Information – the report was discussed. Capacity to do the stent work on time is an issue. The recommendations need to say that we 'will' do these things rather than 'should'. Report approved subject to this change. Personal Information – the report was discussed. Report approved. Personal Information – the report was discussed. Discussion re the SEAs coming out of the backlog issues and the lack of learning that is within our control. Report approved.  SEA final draft 22.5.19 Personal .docx Barry / Imran Personal Information redacted by – Barry presented the report. Report approved subject some changes that Barry Conway has requested and will lead on.	
6.0	**Complaints Position** – See large presentation	Tracey
7.0	**Incident Management Position**  Incident Review Position as at 21.05.1 • Majors and above for April 2019 – 0 • Medicines incidents  April 2019 Acute.xlsx	Tracey
8.0	**Risk Registers** – additions, amendments and closures to the governance team.	ADs & AMDs

	 Directorate RR May19.xlsx  List of Risks on Datix as Corporate Risks Nc  FSS Div.HOS.Team RR May19.xlsx  IMWH Div.HOS.Team RR May 19.xlsx  SEC.ATICS Div.HOS.Team RR Ma  CCS Div.HOS.Team RR may19.xlsx  MUC Dir.Div.HOS.Team RR	
9.0 SI	**Mandatory training**  CMT - Acute Compliance Report fo	
13.0	**Any Other Business**	
14.0	**Date of Next Meeting:** **TBC at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 13 Sept 2019

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

1.0	**Apologies**: Patricia kingsnorth	
2.0	**Notes from last meeting** **Matters Arising/Actions**	
3.0	**Electronic Sign off** SIGNOFF_201907_SHSCT.pdf	
4.0	**Standards and Guidelines** • Infrastructure associated with S&G – challenges	
5.0	**Audit** 8) Clinical audit summary for Acute Cl **Patient Safety Report** Acute Governance Report Sept19.doc	ADs and AMDs

6.0	• **SAIs**: **Shahid** 1. Level 1SEA Personal.docx Dr Tariq summarised the report for the meeting. Dr Hampton raised the importance of staff being persistent if they are not happy with care and that everyone is aware of the CUS tool. The issues identified would not have made any difference to the patients outcome as it was a catastrophic brain haemorrhage. Report accepted with the change of would from 'should' to 'will'. (not for family sharing- this was done for internal learning). **Ronan/ Mark** RCA Report for ACG June 2019- amended 3 RCA level 2 Personal Information 28.8.19.docx ACG - Ronan summarised the report for the meeting. (red text needs to be sorted in report?) There were questions from the meeting about what questions raised at handover. Recommendation 2 is to be reworded as the meeting felt a definite timescale is difficult and it should be daily review based. Personal Information redacted by the – Ronan summarised the report for the meeting. It is written in quite a complex way and may be difficult for the family to understand. Mr Haynes to be asked to work on the report to simplify and then offer to meet the family to take them through the report. Before the family is met Ronan to check that the recommendations are in place and working. Damian SAI Personal Information redacted by the ACG.docx Change to rec –resus lead to have manadatory trachy Barry/ Aoife RCA Report Personal - 9TH JULY 2019.docx Aoife – some issues with answers to family questions as they were too defensive and did not answer the question in places – Aiofe to discuss with review team and amend – then to be sent on to family. Anne/ Gareth/ Philip	AMDs/ CD Ronan/Mark

	 [redacted] final draft report.docx  [redacted] final revised draft 260719  -SAI Level 2 draft 20.8.19 ACG.[redacted]  final HSC RCA SAI level 2 Final Draft ACG.do [redacted] – Gareth summarised the report. Report approved with change to recom re cardiology opinion must be sought. [redacted] – Philip summarised the report. Report approved. Others ([redacted] & [redacted] – to be brought to October meeting	
7.0	**Monthly Acute Governance report**  July 2019 Acute SMT Governance Report.d **Complaints Position** – See large report 7.0	
8.0	**Incident Management Position** See large report 7.0	
9.0	**Risk Registers** – additions, amendments and closures to the governance team.  Corporate Risk Register May 2019.dc  Directorate RR Sept19.xlsx  CCS Div.HOS.Team RR Sep19.xlsx  FSS Div.HOS.Team RR Sep19.xlsx  IMWH Div.HOS.Team RR Sep19.xlsx  MUC Div.HOS.Team RR Sep19.xlsx  Pharmacy Div.HOS.Team RR Se	ADs & AMDs
10.0 **SI**	**Mandatory training**  CMT - Acute Compliance Report fo	
11.0	**Any Other Business**	
12.0	**Date of Next Meeting:**	

	Friday 11 October at 8.00 am in the Board Room, CAH	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 11th October 2019, 8am

1.0	**Apologies**: Patricia Kingsnorth, Dr Hogan, Barry Conway, Anne McVey, Mark Haynes, Damian	
2.0	**Notes from last meeting -** taken **Chairs Business** • Acute Sepsis work plan – ED and ward based • There is concern that this has lost focus – Tracey will catch up with Dr O'Kane. Emily Hanna has been put forward from Medicines.	
3.0	**Electronic Sign off** Update if available – Melanie updated on discussions with the medical director – they plan to meet and work through realistic options for progress. At the GP interface forum it was also discussed. Update next month. The policy document has also been discussed between labs and Trudy Reid.	
4.0	**Standards and Guidelines** • Joanne Bell has now taken over from Caroline Beattie	
5.0	• **SAIs**: Ronan/Mark • Personal Information • Personal draft SAI report.docx Dr Murphy presented the case. The report doesn't record if the consultant was asked why the stent was not removed? The long waiting list is contributing to the issues with temporary stents. Report approved. • Personal Information • Personal final draft (4) (2).docx Ronan presented the report. Discussion as to how realistic recommendation 7 is given our waiting list issue. At the moment there is no solution to this however it is the right thing to do. In Rec 6 the datix would be done retrospectively. Neville updated on the new email address now in place for POA so inpatients are seen in time. The fact that he has admitted medically meant that the issue was not picked up sooner and Dr	AMDs/ CD

	Haynes has agreed that this is an issue that needs addressed. Junior medics need to be empowered to escalate this up to the consultant on-call. Dr Murphy to discuss Dr Hampton. Report approved. • Personal Information  Personal SEA final draft report.docx • Ronan presented the report. This child should have been accepted by Belfast rather than treated in CAH – the communication issues with Belfast and their approach to our staff continues. There is a section about the Belfast view of the plaster application that contradicts itself – Tracey to follow up. This patient would fall into the call and send policy now. Report accepted. • Personal Information  Personal final draft report.docx • Ronan presented the report. The line re the discharge needs to be amended on page 5. Report accepted. Anne/ Gareth/ Philip • Personal Information  Personal SAI Final Draft.docx • Dr Murphy presented the report. We need to chase up where we are with the actions, particularly the joint training between ED and PSNI. Report approved. • Personal Information redacted by  Personal final revised draft 260719.docx • Philip presented the report. Report accepted. • Personal Information  Personal final SEA draft final.docx • Philip presented the report. Report accepted	
6.0	**Audit** **Patient Safety Report**  Patient Safety Acute Governance Report O	ADs and AMDs
7.0	**Monthly Acute Governance report**  August 2019 Acute SMT Governance Rep	

	Complaints Position –  Current Complaints 23.09.19.xlsx	
8.0	**Incident Management Position**  Incident review position as at 25.09.1  Acute Medication incidents August 201	
9.0	**Risk Registers** – additions, amendments and closures to the governance team.	ADs & AMDs
10.0 **SI**	**Mandatory training** No report this month	
11.0	**Any Other Business** • Potential to rotate the day of the meeting to allow greater SEC consultant input – decided to try 8am on Wednesdays from now on to facilitate the surgeons attendance.	
12.0	**Date of Next Meeting:** **Wednesday 6th November at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 17th January 2020

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

1.0	**Apologies**: Chris Clarke, Shahid Tariq, Damian Scullion, Clare McGalie, Neville Rutherford-Jones, Anne McVey	
2.0	**Notes from last meeting** No action notes available	
3.0	**Chairs Business**  FINAL REPORT for ISSUE - HSCB-PHA SA  Ltr HSC Trust Chief Executives - Novemb • The learning from SAI was discussed; the report does show that SHSCT is reporting less incidents t the board than other trusts. Patricia suggested we review the current process of internal investigations, and we will bring the process to the next meeting for discussion.	
4.0	**Electronic Sign off**  SIGNOFF_201912_SHSCT.XLSX The reports shows that southern trust is ahead of other trusts in relation to Electronic sign off. **There is a small focus group being set up by Dr OKane.**	
5.0	**Standards and Guidelines** Papers sent separately	
6.0	**SAIs**: **Barry**  1. Level 1 Report final for ACG.docx **remove to next month (talk to Barry)** **Anne / Gareth**	AMDs/ CD

	2nd draft report [redacted] ACG.docx [redacted] draft report ACG Jan.docx [redacted] SEA final report for ACG.docx [redacted] to be brought back to Feb meeting [redacted] approved by acute and cyp – ensure [redacted] added to report. SEA report [redacted] 105816 - fv for apprc (Approved on [redacted] report passed, no abdominal x ray was done. Consideration should be given to families for psychological support. [redacted] – Recommendations not strong, need to be more specific, using SMART pneumonic. Abdominal hernia is difficult to detect and require CT and lactate. Radiology should have been contacted before recommendations. [redacted]- recommendation 1 not achievable go back to chairperson, recommendation 2 approved . Ronan (Ronan to offer assurance that measures in place will prevent recurrence) [redacted] – Ronan presented – the systems and processes were in place and the processes advised staff there was a problem. The process recommends the process was not followed. This has been the 3rd incidence of this nature, This is a cultural issue- approved Ronan – approve on the basis of strengthening recommendation 1. [redacted] – to be deferred to Feb 2020 – Ronan presented - **Reports need to go M+M for learning** [redacted] draft report 28.11.2019 Jan ACG. RCA 69133_Urology Report [redacted] _FINAL an [redacted]- suggestions to go back to medical director to advise that the report was discussed today, they acknowledge the external report and that the process has been debated. The overall summation is that the recommendations are too broad and difficult to deliver. The recommendations do not follow the SMART process. This report needs to be agreed and shared with the ombudsman's office. PK will take to MDO to take back to the chair.	
7.0	**Audit** 1) Clinical audit summary for Acute Cl **Patient Safety Report** Acute Governance Report Jan20.doc Reports for information	ADs and AMDs
8.0	**Monthly Acute Governance report**	

	November 2019 Acute SMT Governanc Discussion about the need for action plans for learning from complaints. **Complaints Position** – Re-opened complaints report 10.; Current MLA Enquiries; Informals 0; Action plan report.xlsx; Ombudsman 04.01.20.xlsx; Current Complaints 13.01.20.xlsx	
9.0	**Medicine Incidents/ Incident Management Position** medication incidents year to date.xlsx; Incident review position as at 02.01.2 Reports shared for information	
10.0	**Risk Registers** – additions, amendments and closures to the governance team. CCS Div.HOS.TEAM RR by Owner Dec19.; FSS Div.HOS.Team RR by Owner Dec19.; IMWH Div.HOS.Team RR by Owner Dec19.; Dir.Div.HOS.Team RR; MUC Div.HOS.Team RR; Pharmacy De SEC.ATICS Div.HOS.Team RR by	ADs & AMDs
11.0 **SI**	**Mandatory training** Will be available in Feb 2020	
12.0	**Any Other Business** Patricia discussed the need for medical staff to assist with SAI investigations. There are training places available but some medics are not taking up the training slots as they don't want to be involved in the process.	
13.0	**Date of Next Meeting:** **Friday 14th February at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 14th February 2020

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

1.0	**Apologies**: Dr McCaffery, Dr Bradley, Dr Clarke Dr Currie, Dr McGalie Attendees: Melanie McClements, Tracey Boyce, Anne McVey, Ronan Carroll, Barry Conway, Philip Murphy, Seamus Murphy, Ted McNaboe, Damian Scullion, Imran Yousuf, Shahid Tariq Gareth Hampton Patricia Kingsnorth	
2.0	10012020 Acute Clinical Governance a **Notes from last meeting**	
3.0	**Chairs Business** •	
4.0	**Electronic Sign off** SIGNOFF_2020_01_SHSCT.xlsx **There is a small focus group being set up by Dr OKane.**	
5.0	**Standards and Guidelines** Papers sent separately	
6.0	**Update on previous reports** Personal Informat – Recommendations not approved at meeting- there was a meeting between review team and AD to discuss the workability of the recommendations. Agreement was sought and following discussions with the Director/ AMD and AD a decision was made to agree the report and share with the family. Report PM recommendation 1 not robust and recommendations 2 Final draft report Personal ACG.docx New recommendations now reads: 1. Morbidly obese patients attending the SHSCT radiology departments **must** be accompanied and monitored by a doctor familiar with the patient. The patient should be transferred with appropriate monitoring equipment to maintain patient safety and facilitate rapid turnaround within the department.' 2. The report will be presented at ED, Surgical and Medical	AMDs/ CD

mortality and morbidity (M&M) meeting for learning.

3. The report will be shared with nursing ED staff to highlight the importance of commencing a NEWS chart and recording of observations prior to discharge.

[redacted] – recommendations – back to chair to review.

SAIs:

Barry


1. Level 1 Report final for ACG[redacted].docx


SEA report [redacted] 106323 fv for Acute S

- Shahid

Barry presented [redacted] report had been previously shared and radiology was unhappy to sign off. Amendments were made and represented this month. Comments made in the body of the report to be shared with chair of review team.

Barry presented the case today - recommendations need amended, there is a problem in the body of the report to suggest radiology is responsible for following up on reports despite sharing

GP have a good system in terms of system to display all blood results daily and alert to GPs. PK to go back to Stephen Hylands


[redacted] SEA final report for ACG.docx


SEA [redacted] final report for Feb ACG.d

Phil presented [redacted] - comments sent back to the chair – there was no identified learning in this case- go back to chair.

Ronan presented [redacted] Approved pending some word changes in the recommendations relating to the Senior consultant and the appropriate place in recommendation 2.


1. Level 1 Report 20.01.2019[redacted].docx


1. Level 1 Report 20.01.2019[redacted].docx

Ted presented 5 urology cases


1. Level 1 Report 20.01.2019[redacted].docx


1. Level 1 Report 20.01.2019[redacted].docx)


1. Level 1 Report 20.01.2019[redacted].docx


RCA [redacted]_Urology Report_5 cases_afte

There were a number of concerns with this report, staff members names in the body of the report and some of the action plans have already been joint report.
Individual reports need to be worked through properly. Asked Maria O'Kane Medical Director, if recommendations concerning consultant's recommendations can be omitted for family copies as not relevant also 10 and 11 need to be sorted. Dr O'kane will go back to the chair regarding the HSCB recommendations as Trusts do not usually make

	recommendations for the HSCB or other trusts. To take off the table and work through with Melanie and PK. 4 cases with no impact should be a summary report for families as he did not suffer any adverse event as a result of the delay. Only one case was affected.	
7.0	**Audit**  1) Clinical audit summary for Acute Cl Melanie advised that all attached reports below are available for information. **Patient Safety Report**  Acute Governance Report Jan20.doc	ADs and AMDs
8.0	**Monthly Acute Governance report** Reports for information  December 2019 Acute SMT Governan **Complaints Position** –  Current Complaints 10.2.20.xlsx	
9.0	Reports for information. **Medicine Incidents/ Incident Management Position**  December 2019 Acute.xlsx	
10.0	Reports for information **Risk Registers** – additions, amendments and closures to the governance team.  CCS Div.HOS.TEAM RR by Owner Dec19.:  FSS Div.HOS.Team RR by Owner Dec19.:  IMWH Div.HOS.Team RR by Owner Dec19.:  MUC Dir.Div.HOS.Team RR  Pharmacy Div.HOS.Team RR De  SEC.ATICS Div.HOS.Team RR by	ADs & AMDs
11.0 **SI**	**Mandatory training**	

	Will be available in Feb 2020	
12.0	**Any Other Business**	
13.0	**Date of Next Meeting:** **Friday 14th March at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 14th March 2020
8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

1.0	**Apologies**: Melanie McClements, Anne McVey, Gareth Hampton, Attendees Tracey Boyce, Barry Conway, Philip Murphy, Patricia Kingsnorth, Una Bradley, Damian Scullion, Aoife Currie, Pat McCaffery	
2.0	**Notes from last meeting** 14.2.2020 Acute Clinical Governance A	
3.0	**Chairs Business** **Geoff Kennedy – Cyber security Labs** Geoff provided a presentation in the event of a cyber-attack on the back of a cyber-attack in the UK which had a major effect on the health service in England. Task and Finish group had required Geoff to provide a contingency to the Senior Management of what would happen to our services in the event of a cyber-attack. Impact of an attack would be fairly minor to extreme. Results could be telephoned – however, must phones are IP and will go down. Only red phone will be available. Machines will go down as they work on OS platforms. Other labs will also be affected. There is a business continuity plan. Labs will focus on the major diagnostic areas – ICU and ED but would drop from 20,000 tests to 100 tests per hour. Analysers would be disengaged from the networks. Clinicians need to realise they need to have a contingency plan without labs and how they can manage without critical results. POC tests can still go ahead but they are low volumes. Geoff will share his presentation with the SMT Results will need to be printed and put into the pods for porters to deliver. Life threatening results will be communicated through the red phone.	

4.0	**Electronic Sign off**  SIGNOFF_2020_02_SHSCT.XLSX **There is a small focus group being set up by Dr OKane.** There are still some challenges in particular with outpatient services. Antenatal clinics signed off electronically with mixed results. Midwives sign all normal results but abnormal require a doctor to sign off.	
5.0	**Standards and Guidelines** Papers sent separately	
6.0	**SAIs**: update  Perso nal draft report ACG Jan.docx Personal Informatio – chair happy to remove recommendation 1. Person al – suggestions were made from radiology and comments returned to chair. Chair would like to meet with AMD radiology to discuss. **Barry** **Anne / Gareth** Ronan / Mark  SAI Level 1 report Person al agreed final versi Report approved.	AMDs/ CD
7.0	**Audit**  3) Clinical audit summary for Acute Cl reports available to read **Patient Safety Report**	ADs and AMDs

	Acute Governance Report Mar20.doc	
8.0	**Monthly Acute Governance report** January 2020 Acute SMT Governance Rep reports available to read **Complaints Position** – Current Complaints 9.3.20.xlsx; Current MLA EnquiriesInformals 02; Ombudsman 17.02.20.xlsx; Reopened Complaints Report 14	
9.0	**Medicine Incidents/ Incident Management Position** Medication incidentes January 2020 Acute.; incident review position as at 11.03.2 reports available to read	
10.0	**Risk Registers** – additions, amendments and closures to the governance team. FSS Div.HOS.Team RR Jan2020.xlsx; MUC Div.HOS.Team RR Jan2020.xlsx; Pharmacy Div.HOS.Team RR Jan; SEC.ATICS Div.HOS.Team RR Jan; SEC.ATICS Div.HOS.Team RR by; CCS Div.HOS.TEAM RR Jan2020.xlsx; IMWH Div.HOS.Team RR Jan2020.xlsx; Directorate RR Mar2020.xlsx; 10b. Corporate Risk Register January 202 Reports available to read There was some discussion around screening for corona virus and ensuring the correct population are screened which would ensure the correct use of resources.	ADs & AMDs
11.0 **SI**	**Mandatory training**	
12.0	**Any Other Business**	
13.0	**Date of Next Meeting:** **Friday 14th March at 8.00 am in the Board Room, CAH**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 9th October 2020

8am, Melanie's my space. Personal Information redacted by the USI

1.0	**Apologies**: Anne McVey	
2.0	**Notes from last meeting**  September 2020 Acute Clinical Governa	
3.0	**Chairs business** **7 new reports and 4 representing reports.**	
4.0	**Electronic Sign off**  SIGNOFF_2020_08_ SHSCT.pdf	
5.0	**Standards and Guidelines** See fortnightly meeting papers.	
6.0	**SAIs** **Philip/ Gareth**  SAI Level 1 Personal Final draft for ACG.docx  Personal Level 1 Report.docx  Personal draft report.docx  Draft Report Personal Information - revised post septemb (represented with changes)  Personal report resubmission to ACG. (represented in view of previous recommendations not smart and issues regarding wording of delay in ED). Same addressed **Ronan/ Mark**  1. Level Personal final draft for ACG.docx  SAI Personal draft Wed 23rd Sept.docx  1. Level 1 Report final for ACG Personal amer Personal Inform report was previously submitted and not agreed in view of recommendations. The chair of this review would like to escalate this review from an internal review to a level 1 SAI.	AMDs/ CD

	Barry/ Aoife/Meeta  SAI report template Personal Information redacted by the USI - for SMT a re- presented by CYP – issues last time regarding E coli Personal Information redacted by the USI – there were a few queries the team had. 1. The risk factors for e coli were not addressed in the report – did the mother have any positive urine cultures which may have highlighted e coli infection? Who was the independent expert noted on the review panel? There was one question around the advice given to parents to seek medical help if unwell. – is there any clearer guidance of where to go – as mother went to ward and not ED??  HSC RCA draft Thermablate HS V3 fir (case represented in view of insufficient content).	
7.0	**Effectiveness and Evaluation**  10) Clinical audit summary for Acute Cl **Patient Safety Report**  Acute Governance Report Oct20a.doc	ADs and AMDs
8.0	**Monthly Acute Governance report**  August 2020 Acute SMT Governance Rep **Complaints Position** – (communication and staff attitudes main complaints)  Current Complaints 28092020.xlsx Complaints – frames 49 complaints -21 outstanding (red) 28 within time  Reopened Complaints Report 10 Re-opened complaints – 21 reopened – 8 are new and 3 meeting are being arranged.  Ombudsman 29.09.2020.xlsx Ombudsman – 1 new and 9 active  Current Enquiries & Informals 28092020.x MLA - 16 ongoing 8 of which are new	

9.0	**Medicine Incidents/ Incident Management Position** August 2020 Acute.xlsx	
10.0	**Risk Registers** – additions, amendments and closures to the governance team. Directorate RR Aug20.xlsx CCS Div.HOS.TEAM RR Aug2020.xlsx FSS Div.HOS.Team RR Aug2020.xlsx IMWH Div.HOS.Team RR Aug2020 2nd draf Emergency Medicine Div.HOS.Team RR Au MUC Div.HOS.Team RR Aug2020.xlsx Pharmacy Div.HOS.Team RR Au SEC.ATICS Div.HOS.Team RR Au Corporate Risk Register May 2019.dc	ADs & AMDs
11.0 **SI**	**Mandatory training** Trustwide CMT Compliance Summary	
12.0	**Any Other Business** Continuous observations in Mater **recommendation from** Personal Informatio n redacted **SAI** **Recommendation 9 urology SAI** **Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.**	
13.0	**Date of Next Meeting:** **8.00 am Friday 13 November 2020 via** Personal Information redacted by the USI	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 13th November 2020

8am, Melanie's meeting space. Personal Information redacted by the USI

1.0	**Apologies**: Barry Conway, Attendances: Melanie McClements, Patricia Kingsnorth, Clare McGalie , David Gilpin Gareth Hampton, Philip Murphy, Aoife Currie, Wendy Clarke, Pat McCaffery, Tracey Boyce, Mary Burke, Ronan Carroll, Seamus Murphy Una Bradley Anne McVey	
2.0	**Notes from last meeting** October 2020 Action notes Acute Clinical G	
3.0	**Chairs business** IHRD Workstream 5 - Serious Adverse Incic Patricia advised of the draft document of the IRHD regarding family engagement. Need to be aware that families will be seeking questions and the review team are obliged to answer where possible even if they sit outside the review. Connie Connolly to talk for a few minutes at the end of the meeting. In relation to the outbreak SAI review, Connie has advised around the Family engagement and the position of the liaison officer who has been engaged to work with families. Connie will update Patricia to liaise with the operational teams. Included in the outbreaks – haematology / MMW and 4 S. Melanie advised there have been 25 deaths in total but not all are being included in the SAI, however any learning identified will be shared for all the cases. There are 29 patients – 15 deaths involved in the SAI review. Formal letters of apologies from Shane. Cover letters provided to explain to the terms of reference and the SAI leaflets / liaison officer role leaflets and a leaflet describing the role of PCC who are happy to provide support to some families who don't want to avail of the Trusts support. Connie has advised that all families are engaging well with the exception of one and have been very well	

	received. Some questions from families will be forwarded to the review panel who plan to complete the review by May. The ACG team asked about maybe inviting the liaison officer Beverley Lappin to one of our meetings. Connie is engaging with staff side- and working with the ICO for sharing the positive results only with the review team ensuring not identifying staff members with the results. The results are only for identifying the genotyping. Melanie advised there is a lot of work from the PHA regarding the Covid responses. The Chief executive of PHA has visited the Trust and have provided 9 recommendations they wish us to implement to get us to a higher level in managing the current situation. Anne advised there are a surge of haematology patients scattered around the hospital which needs addressed. Melanie will share the recommendations with the operational teams. **4 new reports and 4 representing reports.**	
4.0	**Electronic Sign off** SIGNOFF_2020_10_SHSCT.pdf advised re: updated electronic sign off	
5.0	**SAIs** **Philip/ Gareth** draft report 04.11.20.docx Philip presented this case, nil orally and was provided with a breakfast – recommendation, improved liaison between nursing and domestic services – Sept 2121. General discussion with family,. Meal times are supposed to be overseen by a registered nurse. PK to ensure actions get shared with nursing colleagues. **Approved**. **Ronan/ Mark** Personal Information presented Mr Gilpin discussed the case. – diagnosis of abdominal pain was not a medical case- patient should have been reviewed on the take by the surgical team. should have recognised it was appendix. Should highlight the risks of admitting a patient to a medical ward when they should have been admitted to the appropriate ward. Comments from Aoife regarding patient almost moribund by time help arrives. Recommendations 1 Surgical reviews should have a surgical assessment not consideration. Change to strongly recommend a surgical review. Pat advised this case is 6 years old what changes are put into place. Additional recommendation – ask Gareth. The trust needs to develop a stronger development a written process about sharing medical and	AMDs/ CD

surgical.
Can put on take in sheet – not our patient but must see.
Una – highlighted there have been a number of times when junior SHO sent for surgical review – this should not happen. Mr Gilpin advise it must be a more senior doctor.
It would have been prudent to have a consultant physician on the panel.
Patricia to link with Mr Gilpin for recommendations.

Personal Information- Mr Gilpin presented- discussion – **approved** pending changes recommendation 1 unfair for nurses. – reword the recommendations should have a failsafe only, not the nurses responsibility to agree the – importance of formal handover main issue in this case. This should be amended to reflect.

Personal Information – presented by Mr Gilpin – discussion –the report does not go far enough to say that a consultant psychiatry out of hours is not adequate. Page 8 – paragraph 7- f1 and psychiatry services – member less that More senior doctor than an F1. Feels it leaves the F1 vulnerable. Needs to be a recommendation about what to do in the interim eg. If a consultant wants a referral to psych team then this should be a consultant to consultant. Gareth cautioned that following a previous inquest that the trust did say that a consultant psychiatrist is available for consultation if required. He asked if that had been sought in recent cases and Aoife confirmed that she did have consultant to consultant conversations about patients. Not to wait over the weekend. Ronan concerned about the nursing training, Patricia advised that this is the purpose of the recommendation to provide a proper resourced service that would work seamlessly with acute and mental health services. Aoife states are really vulnerable.
If someone needs to section someone under the mental health order this can be challenging for medical and nursing staff in the acute setting as their experience would not be sufficient to manage mental health patients using the law. They would need guidance and support from their colleagues. **Approve** with amendments need an interim measure in the recommendations with regards to how staff access mental health services out of hours urgently. PK to discuss with Pat McMahon.

Personal Information redacted by – this case was deferred until December. PK advised that this case was previously presented. There were issues regarding agreeing a recommendation regarding the review of the current triage process. The chair did not agree to make the changes and there was a significant delay to reach an agreement. When the report was finally signed off, this patient's condition deteriorated and he has since passed away. The family are very angry that the report describes human error as a minor issue when this minor issue resulted in the delay in diagnosis of a cancer which cost their father's life.
The team advised they would need more time to discuss this case in deeper detail and to **bring it back in December ACG**.

	tor 1. Level 1 Report [Personal] for ACG November 2([Personal] draft report.docx SAI [Personal] Family Copy.docx SAI level 1 [Personal] final draft for representati represented 1. Level 1 Report final for ACG [Personal] amer [Personal] report was previously submitted and not agreed in view of recommendations. The chair of this review would like to escalate this review from an internal review to a level 1 SAI. **Approve to forward as a level 1.** Aoife/Wendy [Personal] Aoife presented this case. This report was undertaken by an external team. The report is well written and describes the issues very well. A term baby who passed away after 1 hour 28 mins. Baby had an obstructed airway – intrapartum monitoring. 30% fewer midwives. Concerns about the CTG- very junior midwives. Good report and recommendations have been agreed with Wendy and Barry before submission. **Approve** [Personal] – Aoife presented the case – report represented. – Under call the fact that this was a 39 year old there was a gap in the timeline. Concerns that lysis not administer to her. Discussion with coroner- summary Amended report does address the issues – more robust. There was a lot of discussion about the prophylaxis. **Approve** HSC RCA Report final October 2020 1 [Personal] 1. Level 1 SAI report [Personal] 27.10.2020.docx	
6.0	**Effectiveness and Evaluation** 10) Clinical audit summary for Acute Cl advised to review the reports **Patient Safety Report** Acute Governance Report Oct20a.doc	ADs and AMDs
7.0	**Monthly Acute Governance report** September 2020 Acute SMT Governan advised to review reports	

7.1	**Complaints Position** – (communication and staff attitudes m… complaints)  Current Complaints 28092020.xlsx Complaints – time frames  Reopened Complaints Report 10 Re-opened complaints – meeting are being arranged.  Ombudsman 29.09.2020.xlsx Ombudsman –  Current Enquiries & Informals 28092020.… MLA - 16 ongoing 8 of which are new Reports shared for information.	
8.0	**Medicine Incidents/ Incident Management Position**  August 2020 Acute.xlsx shared for information	
9.0	**Risk Registers** – additions, amendments and closures to the governance team.  Directorate RR Aug20.xlsx  CCS Div.HOS.TEAM RR Aug2020.xlsx  FSS Div.HOS.Team RR Aug2020.xlsx  IMWH Div.HOS.Team RR Aug2020 2nd draf  Emergency Medicine Div.HOS.Team RR Au  MUC Div.HOS.Team RR Aug2020.xlsx  Pharmacy Div.HOS.Team RR Au  SEC.ATICS Div.HOS.Team RR Au  Corporate Risk Register May 2019.dc	ADs & AMDs
10.0	**Mandatory training** shared for information  Trustwide CMT Compliance Summary	
11.0	**Any Other Business**  EMERGENCY DEPARTMENT ADMIS for discussion – Gareth presented this document in relation to ensuring there is a written document to try to capture the	

	The ED admissions rights. . There have been four SAI in relation to patients being admitted to the wrong ward which has resulted in serious consequences. ED admission rights Melanie asked if the team can go away and consider the document and PK will set up a meeting with the relevant teams. To discuss and agree a process.	
12.0	**Date of Next Meeting:** **8.00 am Friday 11th December 2020 via** [redacted] Personal Information redacted by the USI	

Health and Social Care Board

Review of Adult Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

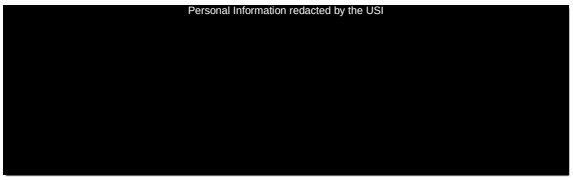
Ministerial Foreword

The health service in Northern Ireland has been able to make remarkable progress in improving access to services and sustaining the quality of those services. That work, as part of the current programme of modernisation and reform of health and social care services is ensuring that many more patients are gaining timely access to the services they need than was the case only a few short years ago. I am determined that this progress should continue.

However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned.

The review considers workforce planning, training and development needs and future resourcing and proposes a model of service delivery which I am confident will produce a reformed service fit for purpose, with high quality services provided in the right place at the right time by appropriately trained and skilled staff.

Ensuring that the patients who need our health and social care services remain at the centre of everything we do is of course a fundamental step of developing and improving service provision. I hope that many of you, especially those with experience of the service, will respond with comments and suggestions which will inform the future development of this important
Speciality.



Michael McGimpsey
Minister for Health, Social Services and Public Safety

Index

Appendices

Tables

Figures

1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

For the purposes of this review all Urology services and Urological related procedures should be taken in the context of Adult Urology only.

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within

the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more

specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

2. INTRODUCTION AND CONTEXT

Introduction

2.1 A regional review of Adult Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

2.2 A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009. Membership of the group is included in Appendix 1.

2.3 An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

2.4 Terms of Reference were agreed (Appendix 2), with the overall purpose of the review being to;

Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.

2.5 A literature search of guidance and policy documents was undertaken. This included consideration of reports on previous reviews in Northern Ireland. A list of the key documents considered during this review is included as Appendix 3. Sections in italics within this report are direct quotes from these documents.

2.6 During the course of the review, a significant number of discussion papers, detailed information and datasets were collated, copies of which are not included in this report but are available on request.

Context

2.7 The speciality of Urology predominately covers the assessment, diagnosis and treatment of Urogenital Conditions involving diseases of the Kidney, Bladder, Prostate, Penis, Testis and Scrotum. Bladder dysfunction, Male and Female Continence Surgery and Paediatric Peno-Scrotal Conditions make up the rest.

2.8 Thirty years ago the field of Urology was one of the many that was the province of the General Surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

2.9 Prior to 1992, fully trained dedicated Urologists were based only at the Belfast City (BCH) and Royal Victoria (RVH) Hospitals providing a unified service to these two sites and a referral service for the rest of Northern Ireland. In 1992, Urologists were

appointed at Craigavon, Mater and Altnagelvin Hospitals. By 1999 there were ten full time Urologists in post, providing services on the above sites along with Lagan Valley and Coleraine Hospitals. In addition to these ten Urologists, there were two Consultant General Surgeons (one based in Mater, one based in Ulster) who were accredited as Urologists and whose workload was increasingly in the field of Urology. Since 2002, further appointments were made in the Belfast Hospitals, Altnagelvin and Craigavon Hospitals, along with the development of a Urology Service based in Causeway Hospital. At the time of this review 2008/2009, there is a funded establishment of 17 wte Consultant Urologists, which is in line with the recommendations of the 2000 Northern Ireland Review. However, the 2000 Review envisaged the Northern Board area Urology Services being based in Antrim Area Hospital rather than at Causeway Hospital.

2.10 Urology work can be divided into two categories;

- Medical and surgical treatment of the urinary tract, (kidneys, bladder, ureters, urethra, prostate), with these surgical procedures known as 'M'code (OPCS 4.4)
- Medical and surgical treatment of the genital and reproductive system (peno-scrotal), with these surgical procedures known as 'N'code (OPCS 4.4)

2.11 Both categories comprise elective and non-elective and cancer and non-cancer elements, albeit there are much fewer non elective and cancer cases in the 'N' code category.

2.12 In recent years, with the retirement of General Surgeons who historically undertook a substantial amount of Urology work, the number of General Surgeons who undertake urinary tract operative procedures (M Code) has significantly reduced. A small number continue to undertake diagnostic cystoscopies, which to varying degrees represents a substantial proportion of their workload. Should any subsequent treatment be required, the patient is referred into the Urology Team. A General Surgeon in the Northern Trust continues to undertake Inpatient and Day Case "M" code work in the Mid-Ulster Hospital.

Recommendation

1.	Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2.13 Peno-scrotal operative procedures ('N' Code) continue to be undertaken by many General Surgeons predominately based outside of Belfast. This position is not surprising given the current number of urologists in the Southern, Western and Northern Trust areas.

2.14 Table 1 below identifies the type, volume and surgical speciality for N Code work.

Table 1 - Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)

Trust	Total Activity	General Surgeons	Urologists	% of 'N' Code undertaken by Urologists	Number / % undertaken as day case		V	C	H
NHSCT	807	767	40	5%	701	87%	517	129	35
SHSCT	612	521	91	15%	493	81%	314	135	36
WHSCT	614	544	70	11%	528	86%	318	143	38
SEHSCT	1244	650	594	48%	1148	92%	860	147	45
BHSCT	674	103	571	85%	407	60%	209	164	49
Total	**3951**	**2585**	**1366**	**35%**	**3277**	**83%**	2218	718	203

V Vasectomy
C Circumcision
H Hydrocele

2.15 Consultant General Surgeons have gained substantial experience and expertise in these procedures over the years and it is not envisaged that Trust's should make any immediate plans to pass this work onto Urologists. However, it is likely that future appointees to Consultant General Surgeon Posts, will have had little experience in undertaking such procedures and therefore Trust's will need to plan and consider the implications of impending retirements in General Surgery.

Recommendation

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

2.16 Gynaecology is another specialty which undertakes urinary tract diagnostic and operative 'M' code procedures and medical treatments for female bladder dysfunction (non cancer) and incontinence. The surgical specialty of Uro-Gynaecology has developed in the last decade, with most Trusts now having trained surgeons in post, for whom, such surgical procedures, represent a significant proportion of their surgical workload.

2.17 More complex surgical procedures are referred to Urologists and this aspect of Urology is termed as female/functional Urology. The demand for these specialist surgical services is increasing and there is a need, in some cases, to have joint working e.g. complex cancer Gynaecological Surgery and complex Urological Surgery.

2.18 Female continence (stress and urge incontinence) services (non surgical) are provided in Primary Care, Community Services and in Gynaecology Secondary Care. However, *there is evidence of large undeclared demand for continence services which is held in check by the embarrassment factor* (Action On Urology). Current services in NI are fragmented, disparate and are not managed in accordance with NICE Guidelines –Urinary Incontinence: The Management of Urinary Incontinence in Women (2006).

2.19 The referral review exercise undertaken as part of the review demonstrated that GP's are not generally referring these patients into urology and as 80-90% of such patients will not require surgical intervention, it was agreed that this service would not be considered as part of this review. However, it is clear from developments

elsewhere in the UK, that continence services can be significantly enhanced and redesigned within a multidisciplinary team model (GP's, Urologists, Gynaecologists, Physiotherapists and Nurse Practitioners) and is very suitable for development in a non secondary care environment.

Recommendation

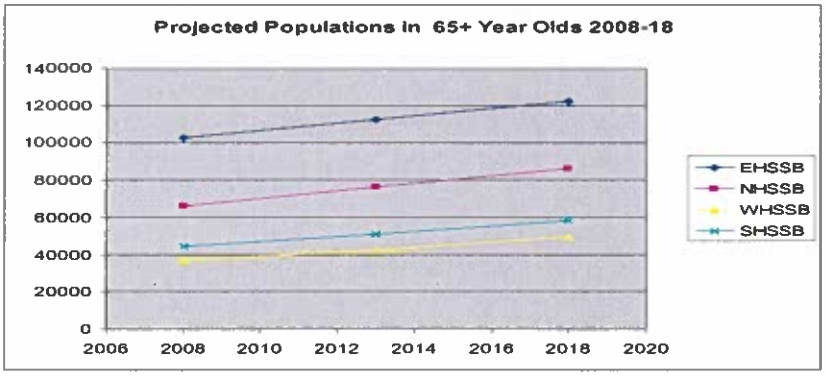
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Demography

2.20 The current population in Northern Ireland is 1.76 million with a projected rise to 1.89 million by 2018. The greatest increase will be seen in the 65+ year age group from 249,663 in 2008 to 316,548 (+27%) in 2018. This is particularly relevant for Urology as it is the ageing population that makes the heaviest demands upon Urology care (cancer and non cancer).

Figure 1

Demography 65+ years (Health and Social Services Boards)



Source NISRA

Total	249,663	282,877	316,548

3. CURRENT SERVICE PROFILE

Location of Urology Services

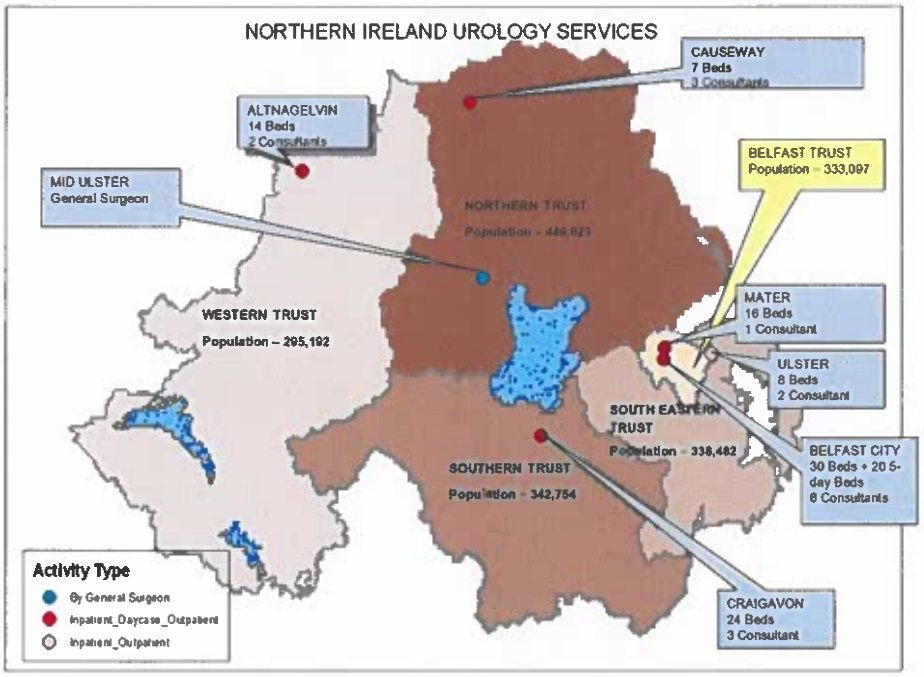
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

Table 2 – Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

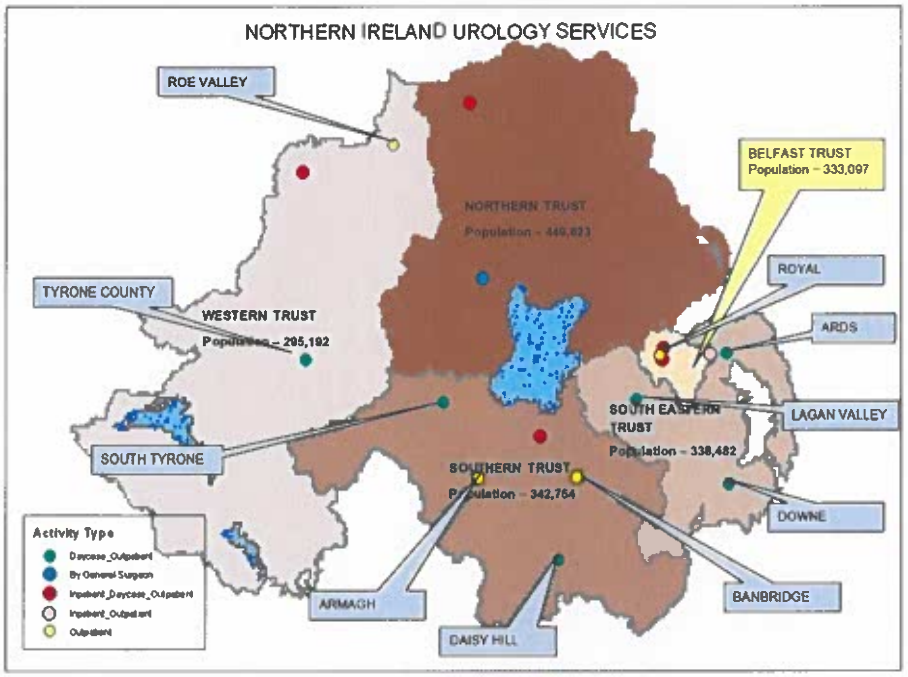
3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

Figure 2 – Urology Services – Inpatient Services



3.3 Figure 3 layers on the additional sites within each Trust which provide a range of Outpatient, and Day Surgical Services.

Figure 3 – Urology Services – Outpatients, Day Surgery



3.4 Figures 2 and 3 identified the resident populations for each of the 5 Trusts, however, the actual catchment populations significantly differ when adult only services and patient flows are considered. Table 3 indentifies the inpatient and day case population served by each Trust/Consultant.

Table 3 – Catchment populations served by each Trust

	Consultant urological surgeons number	Inpatient catchment population	Inpatient catchment population per consultant	Daycase catchment population	Daycase catchment population per consultant
BHSCT	7	873,000	124,700	646,000	92,300
NHSCT	3	218,000	72,700	245,000	82,000
SEHSCT	2	130,000	65,000	321,000	160,000
SHSCT	3	305,000	102,000	287,000	96,000
WHSCT	2	236,000	118,000	262,000	131,000
Total	**17**	**1,762,000**	**103,000**	**1,762,000**	**103,000**

3.5 This analysis demonstrates a significant flow of inpatient/day case work (and therefore outpatient/assessment and diagnostic workup) from the Northern Trust area to Belfast. It also demonstrates that although South Eastern Trust services a significant catchment population for day case work (and outpatient, assessment and diagnostics) it serves a smaller proportion of its population with inpatient care. This is due to the fact that a significant volume of outpatients, diagnostics and day surgery is undertaken in the Lagan Valley Hospital by a Consultant Urologist outreached from Belfast. Any subsequent inpatient treatment is then carried out in BCH.

Outpatient (new) Services

3.6 A referral review exercise was held in December 2008, at which a number of primary and secondary care clinicians (5 General Practitioners and 5 Consultant Urologists) and Trust Managers undertook a quantitative and qualitative analysis of all new outpatient referrals received (368) in Urology for a full week in November 2008.

Table 4 - Analysis of Urology Referral Letters

Gender	Belfast	Northern	Western	Southern	SE	Regional
Male	111	39	34	42	55	**281**
Female	33	13	10	11	18	**85**
Blank	0	1	1	0	0	**2**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Age Range	Belfast	Northern	Western	Southern	SE	Regional
0-14	2	0	0	1	0	**3**
15-30	17	4	5	3	7	**36**
31-40	19	4	5	8	4	**40**
41-50	29	9	4	7	5	**54**
51-60	18	13	9	6	4	**50**
60+	59	22	22	28	9	**140**
Blank	0	1	0	0	44*	**45**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Urgency	Belfast	Northern	Western	Southern	SE	Regional
Red Flag	6	2	3	3	4	**18**
Urgent	30	11	10	10	12	**73**
Routine	108	40	32	40	57	**277**
Blank	0	0	0	0	0	**0**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Named Cons	Belfast	Northern	Western	Southern	SE	Regional
Y	35	13	6	12	15	**81**
N	109	40	39	41	58	**287**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Ref Source	Belfast	Northern	Western	Southern	SE	Regional
Non-GP ref's	15	12	1	5	14	**47**
GP Ref's	129	41	43	48	59	**320**
Blank	0	0	1	0	0	**1**
Total	**144**	**53**	**45**	**53**	**73**	**368**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

** Data on percentages is **Appendix 4**

3.7 Regionally 76% of the referrals were male, which was to be expected. 87% of the referrals were from GPs with the remaining 13% spread across Consultant to Consultant (internal and external), A&E referrals and other sources. 78% of the referrals were referred into Urology as a specialty, with only 22% having a named Consultant. Regionally (excluding SET) 63% of the referrals related to the over 50's age range. Referrals marked by GPs as red flag or urgent represents 25%.

3.8 A breakdown of the referrals by presenting symptoms/conditions is in Table 5 below. Data on percentages is included in Appendix 5. Clinicians have indicated that this outcome is fairly representative of the nature and type of referrals they receive.

Table 5 - Analysis of presenting symptoms/conditions

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		19		10		10		5		12		56	
	frank		*11*		*3*		*4*		*2*		*6*		*26*
	microscopic		*6*		*5*		*6*		*2*		*6*		*25*
	blank		*2*		*2*		*0*		*1*		*0*		*5*
Prostate/raised PSA		14		7		8		9		12		50	
Other		21		4		5		8		8		46	
Ncode procedure (All)		21		2		1		3		14		41	
	vasectomy		*11*		*0*		*1*		*1*		*4*		*17*
	foreskin		*1*		*0*		*0*		*2*		*7*		*10*
	epididymal cyst		*3*		*2*		*0*		*0*		*3*		*8*
	hydrocele		*4*		*0*		*0*		*0*		*0*		*4*
	varicocele		*1*		*0*		*0*		*0*		*0*		*1*
	blank		*1*		*0*		*0*		*0*		*0*		*1*
Recurrent UTI's		17		9		4		6		4		40	
LUTS		11		7		2		5		7		32	
Prostate/BPH/prostatitis		11		5		4		6		2		28	
Renal stones/colic/loin pain		11		5		1		2		4		23	
Testicular/ Scrotal lumps or swelling		8		0		5		0		8		21	
Andrology (ALL)		7		2		3		6		2		20	
	erectile dysfunction		*2*		*2*		*0*		*3*		*1*		*8*
	Peyronie's disease		*2*		*0*		*2*		*0*		*0*		*4*
	blood in ejaculate		*3*		*0*		*0*		*0*		*0*		*3*
	ulcer/lesion on gland		*0*		*0*		*1*		*1*		*0*		*2*
	balanitis/discharge		*0*		*0*		*0*		*2*		*0*		*2*
	Blank		*0*		*0*		*0*		*0*		*1*		*1*
Unknown		3		1		1		2		0		7	
Ca Bladder/Kidney		1		1		0		1		0		3	
Blank		0		0		1		0		0		1	
Total		144		53		45		53		73		368	

3.9 The categorisation of patients by presenting symptoms/condition is a useful process and the outcomes of this exercise should assist Urology teams in determining the nature and frequency of assessment and diagnostic clinics. There was an overlap in symptoms for some patients e.g. many patients with enlarged prostate, known benign prostatic hyperplasia (BPH) or prostatitis have a range of lower urinary tract symptoms (LUTS). However, for the purposes of this exercise, if prostatic disease was identified on the referral letter, these patients were recorded as such, whereas patients presenting with just LUTS were categorised as such. Where LUTS

services are in place, both of these groups of patients are seen and treated within the same pathway.

3.10 General comments;

- A small number of the referrals (<10) were not for a new outpatient appointment but were asking for a review appointment, which was overdue, to be expedited. In addition, a small number of referrals (<10) were for patients who had been discharged from outpatients due to not responding to a booking letter or had DNA'd and who had subsequently visited their GP and asked for another referral to be processed.

- In overall terms, the quality and appropriateness of the referrals was deemed to be good. Internal referrals (A&E, inpatient etc) were often handwritten and were not as structured as GP referral letters.

- The exercise included looking at the time between the date recorded on the referral letter and the hospital date stamp indicating receipt. A significant variance between these two dates was noted in internal referrals (Consultant to Consultant). There did not appear to be any significant delays with regard to GP referrals.

Recommendation

4.	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

- Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. This is particularly relevant when considering the service capacity requirements to assess and investigate potential cancers within cancer standard timescales. This has been confirmed in a recent Cancer Registry, full year analysis of the cancer waiting times database, with a total of 700 red flag GP referrals and 875 referrals which Consultants upgraded to red flag at triage recorded.

- It has been noted that the development of agreed referral guidelines/criteria for suspected Urological cancers is a priority piece of work for the recently formed NICaN Group and this should work should be advanced as soon as possible.

Recommendation

5.	NICaN Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

Areas of Urology

3.11 As a specialty, Urology can be sub-divided into a number of special interest areas, most of which also comprise elements of general or 'core' Urology work.

3.12 **Core Urology** includes the assessment, diagnosis, medical treatment and (non complex and/or endoscopic) surgical treatment of diseases/conditions of the kidney,

bladder, prostate, penis and scrotum. LUTS, BPH, haematuria, simple stones, erectile dysfunction (ED) and 'N' code work are considered to be core Urology. Urologists in NI, regardless of special interest area, all provide core Urology services. Over 80% of all 'M' and 'N' code inpatient and daycase procedures are peno-scrotal, cystoscopy, TURBT (trans urethral resection of bladder tumour), TURP (trans urethral resection of prostate) and urethral catheterisation.

3.13 **Uro-Oncology.** Around 40% of Urology work is cancer related and most of the assessment, diagnostics and medical/ simple surgical treatments are appropriately undertaken at local level. Less than 10% of Urological cancers require radical/complex surgery. (see section 7).Specialist cancer services are based in BCH, where there are three designated 'cancer' Urologists. One Urologist in Altnagelvin and one/two in Craigavon would also be considered to have a special interest in cancer.

3.14 **Stones/Endourology** includes the management and treatment of renal and ureteric calculi. This involves open surgery, endoscopic intervention or stone fragmentation using multimodal techniques such as laser, lithoclast with or without US (ultrasound) and ESWL (Extracorporeal shock wave lithotripsy). Craigavon has the only fixed-site lithotripter, with BCH and Causeway serviced by a mobile facility on a sessional basis. With regard to special interest Urologists, there are currently two in Belfast Trust and one in each of the other four Trusts.

3.15 **Andrology** includes the treatment of erectile dysfunction, particularly post prostate surgery, penile curvatures and deformities (Peyronie's disease) and other conditions of the male reproductive organs. Currently all Consultants provide andrology services within their commitment to core Urology. The service would benefit from having a specialist Urologist to manage and treat the more complex cases, including penile prostheses work.

3.16 **Reconstruction,** which is often combined with the functional side of Urology, includes reconstruction of urinary continence in men, bladder reconstruction after oncological surgery and in a neuropathic bladder, e.g. spina bifida, spinal cord injury, bladder reconstruction in congenital and developmental LUT pathology (adolescent), urethral reconstruction for strictures and reconstruction prior to transplantation. There are currently two Consultants (one on long term sick leave) in Belfast who specialise in this area, working closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

3.17 **Female/functional** relates to the management and treatment of incontinence and bladder dysfunction in women, which on some occasions overlaps with reconstruction surgery. Some of this work is undertaken by Urologists however, the majority is undertaken by Uro-Gynaecologists as outlined in section 2. There is a shared view among Urologists that each Urology team should have at least one Urologist with a special interest in female/ functional Urology, and who for this aspect of their work, should work within a multidisciplinary team of Gynaecologists, physiotherapists and nurse practitioners in providing care for urinary incontinence, prolapse and fistula repair.

Recommendation

6.	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model

Non-Elective Services

3.18 There are approximately 2,500 non-elective FCE's (coded as Urology on admission or discharge) per annum (approximately 7 a day) with little variation in these numbers from year to year.

3.19 In broad terms, non-elective admissions fall into the following categories;

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection—recurrent UTI's/ pyelonephritis
- Urinary retention /haematuria

3.20 The majority of admissions fall into urinary retention and renal colic which do not usually require an immediate surgical operation, neither does treatment of infections. Testicular torsion and acute kidney obstruction require emergency (often surgical) intervention.

3.21 There are currently 15 hospitals in NI with A&E Departments (varying opening times) and acute medical and surgical facilities. With the implementation of DBS (Developing Better Services) this position will change in future years. However, for the purposes of this review the profile of services and location of non-elective Urology patients is assumed to be as is at present.

3.22 The majority of non-elective admissions are admitted to the 'presenting' acute hospital and unless it is BCH or CAH are admitted (out of hours) under General Surgery, until transfer to the care/specialty of Urology, if appropriate, on the next working day.

3.23 Even in a redesigned Urology service it is not envisaged that these arrangements will change for the foreseeable future, as it would not be viable to provide 24/7 onsite Urology cover in all 15 hospitals. However, the requirement to have clearly defined protocols and pathways in place for the management of these admissions has been identified.

Recommendations

7.	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8.	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9.	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week.

ICATS (Integrated Clinical Assessment and Treatment Services)

3.24 ICATS was launched in NI in 2005/06, as one element of the Department's Outpatient Reform Programme and in response to very lengthy waiting times for first outpatient appointments.

3.25 ICATS were designed to provide services, in a variety of primary and secondary care settings by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. One of the fundamental elements was that many patients didn't need to be seen or assessed by a hospital Consultant at an outpatient clinic and that quick triage of referral letters and assessment and diagnostics by the most appropriate health care professional within ICATS teams, with onward referral to secondary care, only if required, would divert large numbers of outpatient referrals from hospital consultants. Another fundamental design principle was that non urgent referrals would, in the first instance, go to ICATS to be triaged and that all subsequent flows to secondary care consultants would be from the ICATS team.

3.26 It was agreed that, to begin with, ICATS would be implemented in a small number of core specialities (4) and these were identified based on those specialities with the highest volumes and longest waiting times in 2005/06. Urology was one of the 4 initial specialties identified. Across all ICATS specialties £2m was allocated in 2006/07, increasing to £9m recurrently from 2007/08.

3.27 The design of ICATS included 5 possible next steps/pathways for patients referred into the service-

- to diagnostics,
- for direct treatment on an inpatient/day case list,
- for return to primary care with advice on further management,
- to tier 2 outpatient services (non Consultant assessment and treatment) or
- to hospital (Consultant) outpatients.

3.28 For a variety of reasons, the development of Urology ICATS has been difficult, slower than planned and somewhat fragmented with regard to service model design, which differs significantly in each of the Board areas.

3.29 Table 6 below outlines the progress to date in Urology ICATS.

Table 6 - Urology ICATS - Current Position

Board Area	Current Position	Ring fenced funding/ Investment Made	Comments
NHSSB	Hospital based (Causeway) Nurse specialists undertaking mostly cystoscopies. Consultant led referral triage.	£642K	Original intention to expand nurse service to LUTS/haematuria/prostate clinics and review/follow-up clinics.
SHSSB	GPSI and specialist nurse Tier 2 clinics for haematuria, prostate, LUTS, stones, andrology. ICATS in separate building on Craigavon Area Hospital site. Consultant led referral triage.	£240K	Oncology review and urodynamics clinics being established.
WHSSB	Nurse led clinics (LUTS, prostate) and single visit haematuria clinics with nurse specialists/staff grade in place for some years. Predominately hospital based (Altnagelvin). Consultant led referral triage.	£211K	ICATS plan now approved – expanding diagnostic, LUTS services and involving GPSI'S in referral triage process in order to improve links with primary care and improve referral information and patterns.
EHSSB	SET – plan approved by EHSSB late 2008. Nurse specialist undertaking cystoscopies for some time outwith any ICATS model. BELFAST – no progress but nurse led services in place for some time and single visit haematuria clinic established late 2008. Consultant led referral triage in both SET +Belfast	£350K	GPSI'S appointed some time ago but posts not yet activated.

3.30 It is clear that Urology services have been developing non Consultant delivered outpatient, assessment and diagnostic services, such as haematuria, LUTS, ED, prostate, stones etc for some years prior to the launch of ICATS. These services were/are largely provided by nurse specialists, staff grades and radiology staff in a hospital environment.

3.31 Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.

3.32 They indicate that they are fully committed to developing further non Consultant assessment, diagnostic and some treatment services and supportive of *providing appropriate, safe and sustainable, cost effective care closer to home, so that urology services are delivered in the right setting, with the right equipment, performed by the appropriate skilled person* (NHS, Providing Care for Patients with Urology Conditions- Guidance).

3.33 This approach was evident during the referral review exercise in December 2008, with Consultants readily indicating that patients should be booked straight into diagnostics or nurse led clinics such as LUTS, prostate, haematuria.

3.34 Consultant Urologists are very clear that the need to ensure that whoever the specialist practitioner is and wherever they work, they should be part of, or affiliated to, the local Urology team, led by a Consultant Urologist.

3.35 In light of the already changing shape of Urology services and the further developments that will arise out of this review, it is appropriate and timely to take stock of ICATS, its design principles and future development and investment. A review of all ICATS Services is planned for the first quarter of 2009/10 year and the outcomes of this review should guide the future direction of travel for ICATS services within Urology .

Recommendation

10.	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Links with Renal Transplantation

3.36 Renal transplantation is the definitive preferred treatment for end-stage renal failure. Kidneys for transplantation become available from either deceased or live donors. In 2006 the DOH commissioned a Taskforce to investigate and make recommendations to increase the level of organ donation. In 2008/09 the DHSSPS set a target for access to live renal transplantation and investment has been made to increase the live donor programme at Belfast City Hospital.

3.37 There are currently two wte transplant surgeons in post, a long-term locum transplant surgeon and in addition there is 0.2 wte input from an Urologist. The Urologist only undertakes live donor kidney retrieval using laparoscopic techniques, which is an essential quality component for the live donor programme.

3.38 Taskforce recommendations would suggest that cadaveric retrievals and transplantations should be increased to 50 per year (currently approximately 30) and within Priorities for Action there is a target for an additional 20 live donor retrievals and transplantations per year by March 2011. With the increase in laparoscopic live donor retrieval, additional input from Urologists may be needed and the current review of the renal transplantation service will need to take account of this requirement, along with the Urology input required if any reconstruction of the urinary drainage system is needed before transplantation.

4. CAPACITY, DEMAND AND ACTIVITY

4.1 Urology is a specialty that is categorised by high numbers of referrals for relatively simple initial diagnostics (often to exclude pathology) or surgical procedures. In addition, around 40% of Urology is cancer related and as more elderly patients are referred and treated, there is a need for follow-up services and patient surveillance.

4.2 The increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK.

4.3 The Action On Urology Team (March 2005) reported that:

Demand for Urology services is rising rapidly and the pattern of disease is changing.

- *There is an overall rise in demand from an ageing population especially the over 50's who make the heaviest demands upon Urology care.*
- *Prostate disease incidence is rising rapidly and PSA requests are generating further demand.*
- *Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks and flexible cystoscopes.*
- *Work is shifting away from surgery towards diagnostics and medical treatment.*

4.4 In addition, there has been an increased "medicalisation" of Urology as the pharmacology of the urinary tract has become better understood and the increasing availability and ever improving range of drugs.

Activity/Demand/Capacity Analysis

4.5 During the review detailed analysis was undertaken by SDU and the Boards, and the following represents the most accurate information available at this time.

Outpatients

4.6 New outpatient referrals and attendances (activity) have been increasing year on year. Not all referrals result in attendance as many are removed for "reasons other than treatment" (ROTT) and are appropriately discharged from the system without having been seen.

4.7 The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008 (2008 ROTT rates applied). This does not however represent a 'true' picture as during this period two Trusts changed their recording/management of activity from General Surgery to Urology. It has been difficult to quantify, with a degree of accuracy, the impact of these changes on the information, as increases, (albeit smaller), in General Surgery are also being estimated. Notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be between 10 and 15%. It has also been concluded that this increase is likely to be as a result of those factors outlined at the beginning of this section i.e. ageing population, patient expectation and demand with the increased emphasis on men's health, changing pattern of disease, availability of assessment and diagnostic modalities to exclude pathology, along with decreasing waiting times and previously unmet need.

4.8 A regional referrals management review, led by SDU Primary Care advisors is due to commence in April 2009.

Table 7 - Urology – Service and Budget Agreement Levels and Activity

	SBA [1]	07/08 Outturn [2+4]	Projected 08/09 Outturn [3+4]
Elective Inpatients	4,155	4,937 + 295(IS)	5,823+606(IS)
Non-elective Inpatients	2,109	2,369	2,496
Daycases	8,715	12,416 + 462 (IS)	13,252+1028(IS)
New Outpatients	5,824	7,593 + 571 (IS)	9,984 +519(IS)
Review Outpatients	12,566	15,967	19,224

(1) Information from 4 Boards SBAs
(2) 2007/08 outturn from PAS (includes in-house additional activity)
(3) Projected 2008/09 outturn (including in-house additional activity) based on November 2008 position
(4) IS information provided by EHSSB

4.9 In 2008, the Boards completed a detailed capacity and demand model across a number of specialities, inclusive of Urology. A number of assumptions/estimates were applied and both the recurrent gap against SBA and non-recurrent (backlog) was identified. The recurrent gap does not take account of growth in demand. The backlog (non-recurrent) gap relates to the in-year activity required due to the need to reduce waiting times for inpatient/day cases and outpatients to 13 and 9 weeks respectively by March 2009.

4.10 It has been agreed that the maximum elective access waiting times for 2009/10 will remain at 13 and 9 weeks and with a year of steady state, Trusts and Commissioners will therefore be better placed to assess both the 'real' demand and capacity to treat.

4.11 As part of this review EHSSB undertook further analysis of demand and capacity within urology and identified a significant recurrent gap, against SBA volumes.

Conclusion

4.12 Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand. Significant non-recurrent funding has been allocated in recent years to ensure Trusts were able to undertake this activity and to meet the elective access waiting times and cancer access standards. Within Trusts large numbers of additional clinics and theatre sessions have been funded non-recurrently and there has also been significant use of the independent sector.

4.13 Both increased and additional capacity to assess and treat patients is urgently required in Urology. However, additional recurrent investment in capacity (resources-human and physical) which is required in this speciality and is detailed later in this report is not the only solution. Trusts will also be required to ensure optimum use and efficiency of their existing capacity and will need to be creative in developing new ways of working and re-designing and modernising services to increase the capacity already in the system and to manage the increasing demand into secondary care.

4.14 The IEAP (Integrated Elective Access Protocol) provides detailed guidance on tried and tested systems and processes which ensure effective and efficient delivery of elective services, along with improvements to the patient experience. The Scheduled Care Reform Programme (2008-10) includes significant developments such as, pre-op assessment, admission on day of surgery, increasing day surgery rates, reducing cancelled operations, optimising the use and productivity of theatres, booking systems and a management of referral demand exercise. All of these will build/create additional capacity within the system.

Recommendation

11.	Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

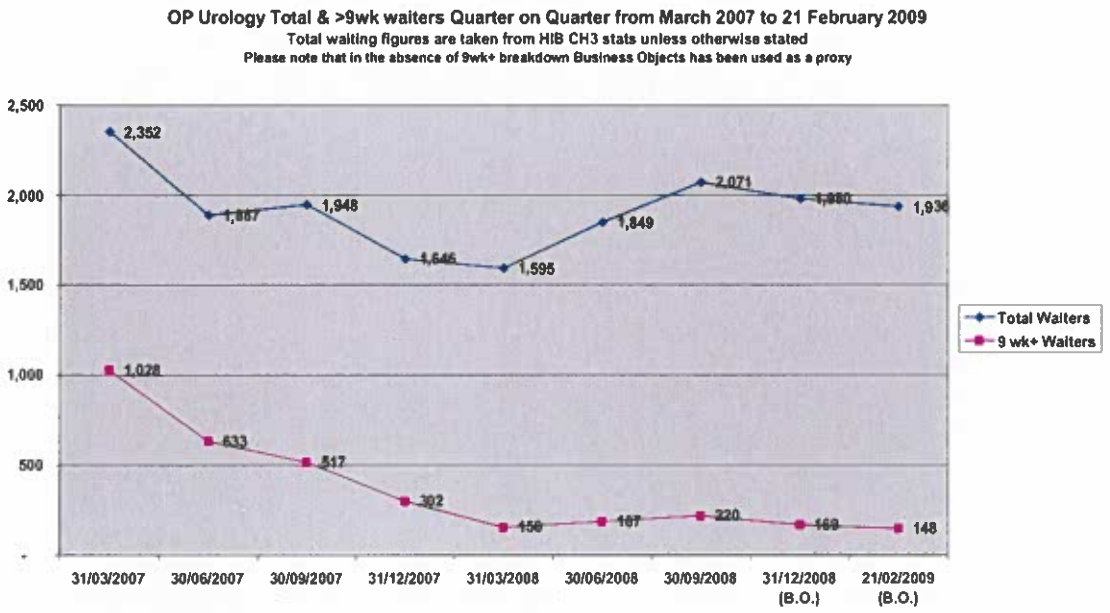
5. PERFORMANCE MEASURES

Elective access waiting times

5.1 There have been significant reductions in waiting times since 2005, in line with PFA (Priorities for action) targets and as a result of the elective reform and modernisation programme.

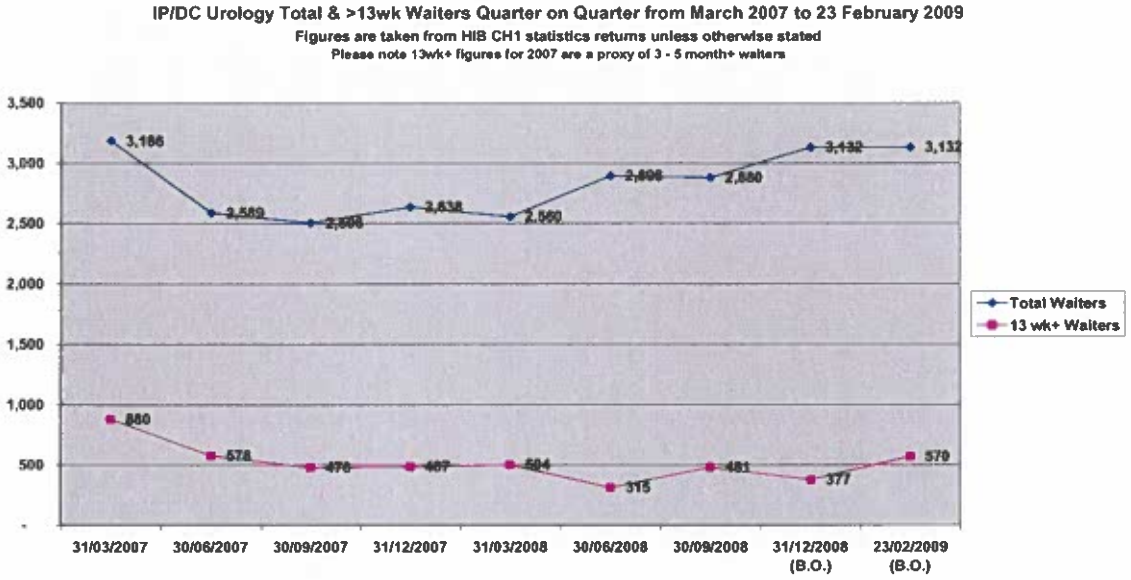
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

Figure 4



(B.O. – refers to Business Objects)

Figure 5



5.2 As at February 2009, all Trusts, with the exception of Belfast, are indicating that they will meet the target waiting times for outpatients, diagnostics, Inpatients and daycases. Belfast Trust is reporting in excess of 100 anticipated breaches in Inpatient/daycase work.

Urology Cancer Performance

5.3 The Cancer Access Standards were introduced from April 2007. These introduced waiting times standards for suspected cancer patients both urgently referred by the General Practitioner or those referrals triaged by the Consultant as suspected cancer. It also set standards for those patients diagnosed with cancer and how long they should wait for treatment.

5.4 The 2008/09 Cancer Access Standards were defined as below:

- 98% of patients diagnosed with cancer from decision to treat, should begin their treatment within a maximum of 31 days
- 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days.

* decision to treat is the date on which the patient and clinician agree the treatment plan.

5.5 It is recognised that a considerable amount of the actions required to achieve the cancer access standards are associated with service improvement. These include the identification and agreement of the suspected cancer patient pathway, the introduction of robust administrative systems or processes and the proactive management of patients.

5.6 The recent cancer access standard performance in relation to the 62 day standard shows that up to 24 February 2009, across all Trusts, the number of Urological cancer patients achieving the 62 day standard is at 62%. This shows that of the 34 confirmed cancers treated up to this date, 13 of these had not been treated within 62 days.

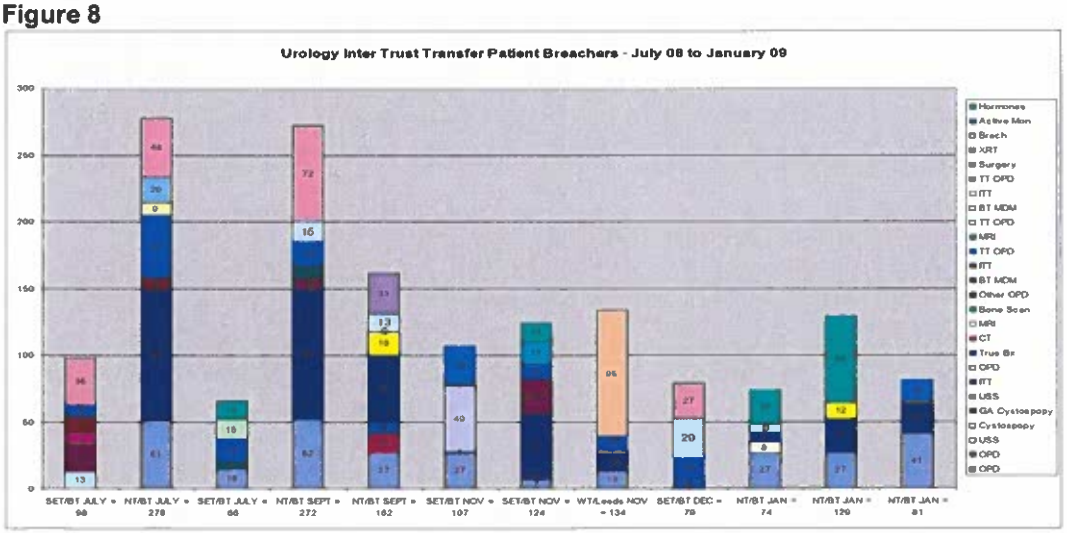
Figure 6

5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they waited on average 50 days from their decision to treat to their first treatment.

Figure 7

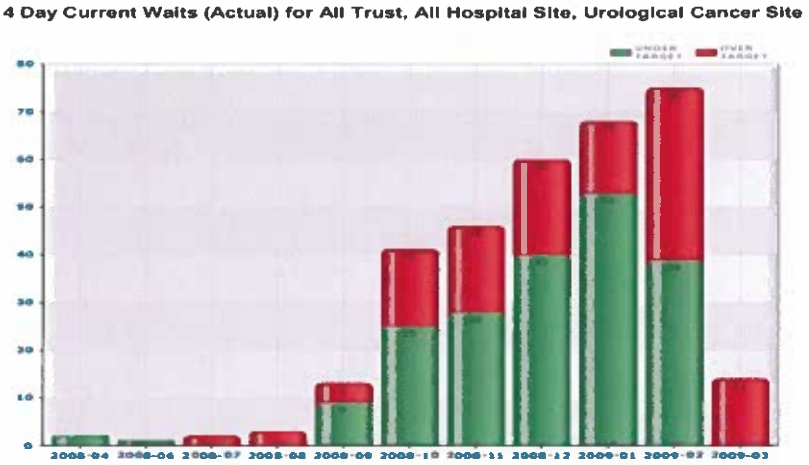
5.8 It is accepted that those patients who transfer from one Trust to another for treatment are more likely to breach the target, than those who remain within the one Trust for their complete pathway. These patients are referred to as Inter Trust Transfer (ITT) patients. These ITT patients that breach the target are analysed in more detail. The detail for the period July 2008 to January 2009 is shown on Figure 8 below. This shows that of the suspected 'red flag' cancer patients referred who breached the 62 day target, 12 of these were ITT patients and they waited from 66 to 278 days from referral to their first treatment. It is accepted as a regional standard, for all tumour sites that if the patient is to be transferred for treatment, all diagnostic investigations should be completed and the patient should be ready for transfer by day 28 of the 62 day pathway. From this evidence it shows that this is not happening in the majority of cases.

Figure 8



5.9 Whilst this analysis only refers to ITT patients, it is probably representative of the pathway for those patients that breach the target and remain only within the one Trust. For example, for the 'front end' of the patient pathway, the number of days the patient can wait for their initial outpatient appointment and subsequent investigation can be over 150 days. This has improved in recent months, but to achieve the 28 day standard this should be completed within approximately 21 days. This is further evidenced by the analysis of the 14 day waiting times for suspected Urological cancers referrals; this showed that of the referrals seen in February only 52% were seen within 14 days. As highlighted any delay at the front end of the pathway will have an impact on the Trusts ability to achieve the treatment times and the 62 day standard.

Figure 9



5.10 Whilst it is clear that some element of redesign of the pathway is required, the evidence appears to indicate that for the number of suspected 'red flag' cancer referrals received or triaged by the Consultants, additional capacity at the front end to complete timely investigations is required. For example, the introduction of one-stop clinics for investigations such as haematuria can have an impact and reduce the number of days the patient waits for investigations as well as reducing the number of times that the patient has to attend the hospital. This needs to be matched with sufficient Consultant capacity for treatments, including theatre capacity, Oncologists for oncology and radiotherapy.

5.11 All Trusts have reported that Urology is the key tumour site which they are at most risk with and their achievement of the cancer access standards by March 2009. In addition, at a recent ITT Executive Directors Services Steering Group the Belfast Trust reported they estimate 15 to 20 urological patients will breach the cancer access standards. Some of this is due to the late transfer of patients, but also due to a lack of available Consultants and theatre capacity. If the number of patients forecasted breach the target, this will mean that as a region NI will not achieve the cancer access standard.

Recommendation

12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

NHS Better Care, Better Value Indicators

5.12 A number of better care, better value Indicators are useful performance measures to apply to Urology in assessing levels of efficiency, productivity and patient experience.

5.13 Length of stay (LOS) is one of the greatest variables between Trusts, hospitals and individual Consultants. By reviewing and improving admission and discharge processes, Trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

5.14 Some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater co-morbidity and patients with higher levels of social deprivation.

Table 8
Urology Episodic Average Length of Stay (06/07, 07/08, 08/09 - Apr 08 to Nov 08)

	Elective			Non Elective		
	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Regional average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Trust	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	3.9	3.4	3.3	5.5	4.9	5.0
Northern Health and Social Care Trust	2.3	2.9	2.5	4.3	5.4	5.6
South Eastern Health and Social Care Trust	3.8	3.9	3.3	3.9	4.4	3.4
Southern Health and Social Care Trust	3.7	4.0	3.5	4.5	4.8	4.9
Western Health and Social Care Trust	3.6	2.8	3.1	3.9	3.8	3.7
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

	Elective			Non Elective		
Site	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	3.6	2.8	3.1	3.9	3.8	3.7
Belfast City Hospital	4.1	3.5	3.4	5.5	4.7	5.0
Causeway	2.3	2.9	2.5	4.3	5.4	5.6
Craigavon Area Hospital	3.7	4.0	3.5	4.5	4.8	4.9
Down and Lisburn	1.0	0.0	1.2	0.0	0.0	0.0
Mater Infirmorum Hospital	3.2	2.7	2.5	5.9	6.4	5.0
The Royal Group of Hospitals	0.0	0.0	0.0	0.0	0.0	0.0
Ulster Community and Hospitals	3.8	4.0	3.5	3.9	4.4	3.4
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.15 All Trusts have longer average LOS for non elective patients than elective. The Southern Trust has the longest average LOS for elective patients and for elective and non-elective combined. Northern Trust has the shortest elective LOS which reflects their lower levels of major surgery.

5.16 Hospital Episode Statistics (HES) data, which combines elective and non-elective LOS, indicates a reduction in England over a three year period from an average of 3.8 days in 2005/2006 to 3.3 days in 2007/2008. Only South Eastern and Western Trusts have an average (combined) LOS of less than 4 days.

Recommendations

13.	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

Day Surgery

5.17 *For any surgical operation there is a large variation in performance throughout the UK with regard to time spent in hospital. Some units favour certain procedures to be performed on a day case basis while others, for the same procedure may regard an overnight stay as the norm. (BADS Directory of Procedures 2007)*

5.18 Hospitals are increasingly focussing on the short stay elective pathway. Carrying out elective procedures as day cases, where clinical circumstances and specialist equipment and training allows, saves money on bed occupancy and nursing care, as well as improving patient experience and outcomes.

5.19 The Audit Commission has identified 25 operations across a number of surgical specialties which could be carried out as day cases and has set a target of an average day case rate of 75% across the 25 procedures. This target has now been adopted within Priorities for Action, to be achieved by March 2011. Three of the procedures specifically relate to Urology (orchidopexy, circumcision, transurethral resection of bladder tumour). BADS (British Association of Day Surgery) identifies another 28 Urology operations (M and N code) which could be done as day surgery. The BADS Directory also suggests a % rate that can be achieved, which is 90% for the majority of the operations.

5.20 Table 9 below identifies the day case rates (% of all elective work undertaken as day case) in Urology by Trust and by hospital. It excludes Independent Sector activity and cystoscopies (M45) and prostrate TRUS, +/- biopsy (M70), both of which are not considered to be 'true' surgical operations and could equally be treated and coded as an outpatient with procedure case.

Table 9 Urology Day Case Rates excluding M45 and M70.3 & Y53.2 (06/07, 07/08, 08/09- Apr 08 to Nov 08)
Independent Sector Activity has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional Total	50.0	48.4	48.7

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	47.1	42.9	46.4
Northern Health and Social Care Trust	31.1	32.6	27.9
South Eastern Health and Social Care Trust	78.0	74.0	69.9
Southern Health and Social Care Trust	43.7	45.4	49.1
Western Health and Social Care Trust	47.1	51.3	42.2

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	47.1	51.3	42.2
Belfast City Hospital	49.9	45.5	48.9
Causeway	31.1	32.6	27.9
Craigavon Area Hospital	43.7	45.4	49.1
Down and Lisburn	98.8	100.0	89.3
Mater Infirmorum Hospital	4.9	4.2	6.9
The Royal Group of Hospitals	100.0	100.0	100.0
Ulster Community and Hospitals	76.6	71.2	66.3

5.21 There is a significant variation in day case rates across the Trusts/hospitals, ranging from 30% in Northern to 70% in South Eastern. Some of this can be explained due to the variation in 'N' code work undertaken by Urologists as opposed to General Surgeons (see Chapter 2). Trusts have also reported that on some sites access to dedicated day surgery facilities is limited and that this hampers the development of short stay elective pathways.

5.22 The CSR (Comprehensive Spending Review) is driving Trusts to reduce inpatient costs and to redesign/remodel their bed stock. This along with day surgery targets in Priorities for Action and the HSC Board's Elective Reform Programme will require Urology services to be creative in the development of day and short stay surgery, ensuring the provision of a safe model of care that provides a quality service to patients.

5.23 Trusts will need to consider procedures currently undertaken using theatre/day surgery facilities and the appropriateness of transferring this work to procedure/treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery. Some operations will require specialised equipment and training for clinicians and some require longer recovery or observation times and so are only possible as a true day case if performed on morning sessions. Therefore, the development and expansion of day surgery may require reconfiguration of day surgery/main theatre lists, redesign of clinical pathways and investment in appropriate equipment/technology.

Recommendation

15.	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

Outpatients

Table 10

Urology Outpatient Attendances - Consultant Led (06/07, 07/08, 08/09 - Apr 08 to Nov 08) - New : Review ratios

Independent Sector has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional new to review ratio	1.93	2.04	1.93

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	1.68	2.14	1.97
Northern Health and Social Care Trust	1.97	1.74	1.46
South Eastern Health and Social Care Trust	1.15	1.10	1.09
Southern Health and Social Care Trust	4.04	3.27	3.85
Western Health and Social Care Trust	2.34	2.21	2.78
Average new to review ratio	1.93	2.04	1.93

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	2.34	2.21	2.78
Belfast City Hospital	1.84	2.90	2.44
Causeway	1.97	1.74	1.46
Craigavon Area Hospital	4.04	3.27	3.84
Down and Lisburn	1.06	1.18	1.24
Mater Infirmorum Hospital	1.63	1.11	1.47
The Royal Group of Hospitals	0.83	0.91	0.88
Ulster Community and Hospitals	1.19	1.07	1.01
Average new to review ratio	1.93	2.04	1.93

*Information for 08/09 is cumulative from 01/04/08 to 30/11/08

5.24 Regionally, there is an average new: review ratio of 1:2, with little variation from year to year. English HES data for 2006/07 reports a 1:2.4 new: review ratio. Variations are to be expected between hospitals and individual Consultants when case mix and complexity are taken into account e.g. BCH, due to a more complex case mix and Lagan Valley/RGH due to the fact that only day surgery is undertaken on these sites.

5.25 Craigavon Hospital is an outlier with regard to review ratios, with Altnagelvin Hospital having the second highest ratio.

5.26 It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the (intended) date of their review has past (some by many months). This is referred to as a review backlog and if most of these patients had been seen within the same 2008/09 timeframe for the data above, then the new: review ratios would have been higher, particularly in Belfast and Southern Trusts. (Backlog; Belfast 5,599, Southern 2,309, Northern 668, South Eastern 431, Western 379). All Trusts have submitted action plans to address the review backlog that has arisen across a number of specialties.

Recommendations

16. Trusts should review their outpatient review practice, redesign other methods/staff where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17.	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

6. CHALLENGES AND OPPORTUNITIES

6.1 At an early stage in the Review, an extensive round of meetings/discussion sessions were held with the various stakeholder organisations and staff to scope the challenges and opportunities of service delivery.

Challenges

6.2 A number of key themes were articulated and are summarised below:

- Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection and shorter waiting times arising from the elective access targets and cancer access standards, which is generating a previously unmet need in assessment and diagnostics.

- Capacity pressures (staffing), with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards. This has resulted in significant reliance on independent sector and large numbers of additional clinics and theatre sessions being held internally. Both of these have been funded non-recurrently, year on year and are not sustainable in the future.

- Capacity pressures (infrastructure), on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector. Access to elective Urology beds, in times of emergency admissions pressures, was also an issue for some sites.

- The challenges presented by the operation of 2 to 3 person Consultant teams outside of Belfast and the impact this has on on-call/cross cover arrangements, attraction and retention of clinical staff and the opportunity to develop sub specially interests and expertise. The size of the team is directly linked to its catchment population and the viability and sustainability of Urology services is dependent on a critical mass of work, of sufficient variety of conditions and treatments, to attract both training and substantive posts. The arrangements for the management and admission of acute Urological patients, particularly out of hours, in some Trusts, and the impact that the lack of such a service has on other sites was also raised as an issue.

- Impact of junior doctors hours, EWTD (European Working Time Directive) and in particular, changes to the training programme have resulted in a reduction in "the medical workforce", a shift from Consultant led services to Consultant delivered services and additional requirements on Consultants to directly provide and supervise training opportunities.

- Challenges around the cancer agenda and in particular, compliance with IOG (Improving Outcomes Guidance) and preparing for the Peer Review Exercise in 2010.

- Concerns were expressed about how service development tends to take place within and is restricted by Trust/Organisational boundaries. Also about inconsistent access/pathways for patients.

Opportunities

6.3 Within the various service and staff groups there was a strong desire and commitment to making significant improvements to Urology services in Northern Ireland.

6.4 There was general acceptance that additional investment was not the only solution: Making better use of the existing resources was also necessary and that the review of Urology services created significant opportunities to develop and re-design services, provide high quality, timely and cost effective services to patients and the community and to support and develop the individual and teams within this important specialty.

6.5 There was also a strong sense of wanting to do things differently and of the need to change and adapt to a changing landscape in terms of public expectations, targets and standards, changing pattern of disease and treatment, new technologies and techniques and employment and training legislation and entitlement.

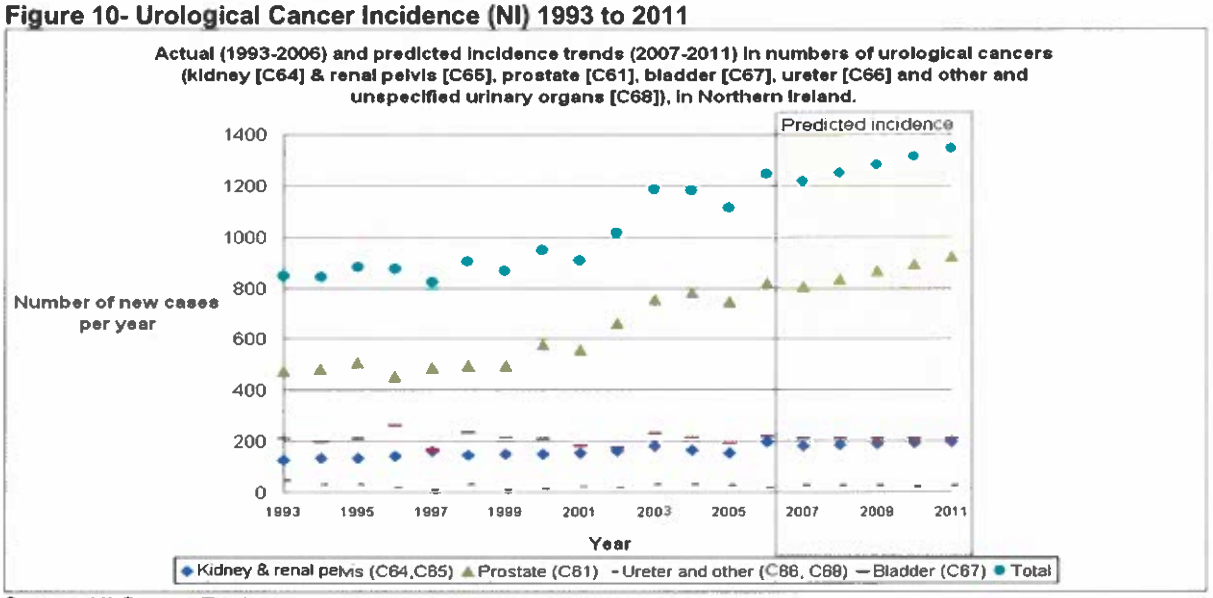
7. UROLOGICAL CANCERS

7.1 Around 40% of Urology work is cancer related and in addition to intensive assessment, diagnostics and treatment requirements, there is also a requirement for considerable patient follow-up, support and surveillance services. Cancer becomes more common with increasing age with almost 2 out of every 3 cancers diagnosed in people aged 65 and over.

7.2 Cancer of the prostate, testis, penis, kidney and bladder as a group has the highest volume of cancer incidence than any other specialty, with 1,246 incidence recorded on the cancer registry for 2007. The next highest is breast, followed by colorectal and lung.

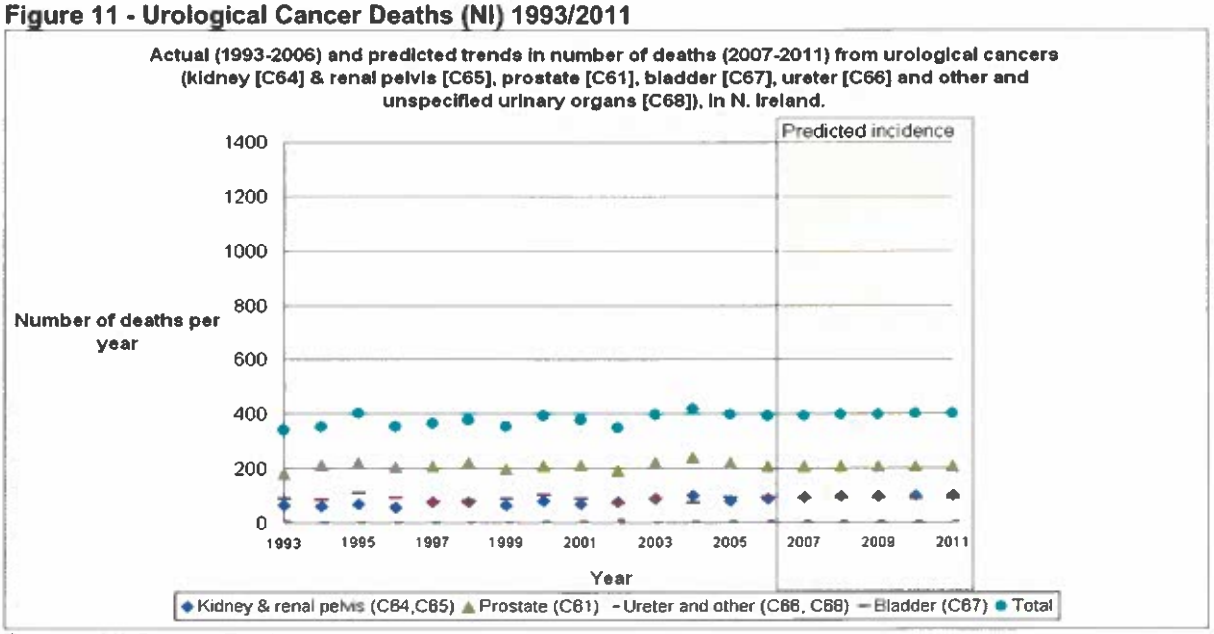
Cancer Incidence and Mortality

Figure 10- Urological Cancer Incidence (NI) 1993 to 2011



Source: NI Cancer Registry

Figure 11 - Urological Cancer Deaths (NI) 1993/2011



Source: NI Cancer Registry

7.3 Bladder and ureter incidence has been and is likely to remain stable (approximately 230).

7.4 Kidney cancer incidence has increased by almost 50% between 1993 and 2006 (196 in 2006), with a corresponding rise in deaths. By 2011, there could be further slight increases.

7.5 Prostate cancer incidence increased by 70% between 1993 and 2006 (817 in 2006). By 2011, it is predicted to increase by a further 20% compared with current incidence, but the number of deaths remains stable.

7.6 Prostate cancer is the second most frequently diagnosed cancer among men of all ages; testicular cancer, although relatively infrequent, is nevertheless the most common cancer in men under 45 years of age. Cancer of the penis, by contrast, is rare. Cancers of the kidney and bladder are roughly twice as common among men.

7.7 The main presenting symptoms of primary urological tumours fall into 3 groups:

- Lower urinary tract symptoms
- Haematuria and
- Suspicious lumps.

7.8 Haematuria is the most common symptom of both bladder and kidney cancer, although kidney cancer is often asymptomatic until it reaches a later stage.

7.9 Early, asymptomatic prostate cancer is being diagnosed more in recent years due to increase use of PSA testing and men's health awareness programmes.

Guidance and Standards

7.10 The NI Report "Cancer Services: Investing in the Future" (The Campbell Report) published in 1996 recommended that delivery of cancer services should be at three levels: Primary Care, Cancer Units and the Cancer Centre. The 2000 Review of Urological Services in Northern Ireland endorsed the principles of the Campbell Report and took account of them in their recommendations.

7.11 In 2002, NICE published guidance on cancer services-"Improving Outcomes in Urological Cancers-The Manual" (IOG).

7.12 The key recommendations from IOG are in Appendix 6. The recommendations relate to the requirement to have dedicated, specialist, multidisciplinary Urological cancer teams, making major improvements in information and support for patients and carers, with nurse specialist having a key role in these services, and having specific arrangements in place to undertake radical surgery for prostate and bladder cancer.

7.13 In 2008, under the auspices of NICaN (Northern Ireland Cancer Network) a new Urological tumour group was set up and has to date met on three occasions. Mr H Mullen chairs this group with Mr P Keane, Consultant Urologist, Belfast Trust, serving as the lead clinician. Mr Keane is also a member of the Review Steering

Group (as a NICAN lead) along with Dr D Hughes, NICaN Medical Director and Mrs B Tourish, NICaN, Clinical Network Co-ordinator.

7.14 The NICaN Group has agreed priority areas of work, based on IOG, including the development and implementation of formal dedicated MDTs / MDMs, implementing referral guidelines and agreed pathways for diagnostics and treatment of each of the cancers, developing patient information and guidance and ensuring suitable arrangements are in place prior to the Peer Review planned for 2010.

Recommendation

18.	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

7.15 A key element of IOG is the requirement to undertake radical pelvic surgery on a single site, serving a population of 1 million or more, in which a specialist team carries out a cumulative total of at least 50 such operations (prostatectomy (M61)and cystectomy (M34) per annum.

7.16 Tables 11 and 12 outline the number of radical pelvic operations carried out in 2006/07 and 2007/08 by Trust and Consultant.

Table 11 – Radical Pelvic Surgery 2006/07

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	3	11	*14*
	Cons B	8	14	*22*
	Cons C	9	11	*20*
	Cons D	5	0	*5*
Total		**25**	**36**	***61***
SHSCT	Cons A	3	1	*4*
	Cons B	8	5	*13*
	Cons C	2	5	*7*
Total		**13**	**11**	***24***
WHSCT	Cons A	3	17	*20*
Total		**3**	**17**	***17***
Grand Total		**41**	**64**	***105***

Table 12 – Radical Pelvic Surgery 2007/08

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	6	12	*18*
	Cons B	7	18	*25*
	Cons C	20	12	*32*
	Cons D	3	0	*3*
	Cons E	1	0	*1*
Total		**37**	**42**	***79***
SHSCT	Cons A	0	1	*1*
	Cons B	3	1	*4*
	Cons C	5	3	*8*
	Cons D	0	3	*3*
Total		**8**	**8**	***16***
WHSCT	Cons A	0	7	*7*
Total		**0**	**7**	***7***
Grand Total		**45**	**57**	***102***

7.17 The Northern and South Eastern Trust do not undertake such operations and patients requiring/choosing radical surgery are referred to BCH.

7.18 In 2007/08 77% of radical pelvic operations were undertaken in Belfast Trust (BCH). Neither the Southern or Western Trust (separately or together) undertake the required number (50) of such operations. Four of the existing Consultants undertake small (<5) numbers of each of the procedures. With a total of just over 100 procedures a year, a population less than 2 million and, with the potential for this activity to reduce with the implementation of a brachytherapy service in the next year, a single site for radical pelvic surgery is considered to be the appropriate way forward if IOG compliance is to be achieved.

Recommendations

19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

8. CLINICAL WORKFORCE REQUIREMENTS

Consultant staffing

8.1 In 1996, BAUS (British Association of Urological Surgeons) recommended a Consultant: Population ratio of 1:80,000 by 2007. In 1999 the ratio in Northern Ireland was 1:167,000 population reducing to 1:103,000 population at the time of the review in 2009, with a funded establishment of 17 wte Consultants.

8.2 In the 2000 "Report of a working group on Urological Services in Northern Ireland" a ratio of 1:100,000 population was recommended due to Northern Ireland's younger age profile. BAUS had indicated that the demand for Urological Services is related to the age structure of the population and specifically with the proportion of 65 years.

8.3 In 1996, the percentage of those aged 65 years and over in Northern Ireland was 12.85% and at this time was considerably lower than in England (15.8%) and Wales (15.2%). By 2007 Northern Ireland's percentage of over 65 had risen to 14.1% and is predicted to rise further to 16.7% by 2018.

8.4 A total population of 1.76 million in 2008 and a Consultant to population ratio of 1:80,000, would equate to a funded establishment of 22 wte Consultant Urologists.

8.5 The NI Urology SAC (Specialist Advisory Committee), in estimating the number of higher specialist trainees required by 2018, have used a Consultant Urologist workforce of 38 wte by 2018. In projecting future staffing, SAC took account of "Developing a Modern Surgical Workforce" published by the Royal College of Surgeons in England (2005) and subsequent interim review of October 2006. The Royal College suggests that for a population of 1 million the requirement will be 8-9 specialist surgeons and 8-10 generalists.

8.6 Based on an average age of retirement of 60 years of age, the anticipated retirements in Urology between 2009 - 2018 is four. Taking this into account along with the Royal Colleges projected future staffing requirements, SAC have recommended an increase in the number of higher specialist trainees from the current 8 at ST3+ (year 3 and above) to up to 15 by 2018.

8.7 SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000.

Consultant Programme

8.8 Guidelines for a Consultant job plan (agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland) are based on a commitment of 10 notional half days.

8.9 The traditional Consultant contract has 6 + 1 (special interest) fixed sessions with 3 flexible sessions. BAUS Council recommend a 5 + 1 fixed session contract with 4 flexible sessions for Consultant Urologists.

"A Quality Urologist Service for Patients in the New Millennium - Guidelines on Workload, Manpower and Standards of Care" (BAUS 2000) recommends a typical job plan as outlined below:

Operating Theatre	3 NHD
Outpatient Clinics	2 NHD
Specialist Interest	1 NHD
Ward Round plus on-call	1 NHD
Post Graduate Education:	1NHD

To Include:

- Audit, teaching
- Pathology and X-ray meetings
- Clinical Governance
- Quality Assurance
- Mortality and Morbidity meetings

Flexible commitment	2 NHD

On-call rota 1:5

- *Special interest sessions may be used to provide additional operating, specific outpatient clinics, uro dynamics, lithotripsy or to supervise the research activities of the Department.*
- *Involvement in clinical management, audit and clinical governance will occupy significant clinical time and provision must be made for these activities within the job plan, as should participation in MDM's for all Urologists.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinic administration, travel, inter-departmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patients relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

Workloads

8.10 Both BAUS and The Royal College of Surgeons outline similar workloads/activity that can be expected from a Consultant's working week, based on a 42 week working year.

8.11 **Outpatients (new and review) -** A Consultant working alone should see between 1176 and 1680 patients per annum. *Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic.*

8.12 To allow sufficient time for proper assessment and counselling, it is accepted practice to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow-up consultation. Therefore in a standard clinic an Urologist, working on his own should see 7 new patients and 7 follow-up patients. This can be

adjusted locally depending on case complexity up to a maximum of 20 patients (new and review) per clinic.

8.13 **In patient/day case activity -** *The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.*

8.14 The activity analysis outlined in section 4 of the report outlines projected activity of 21,571 episodes in 2008/09. This figures includes in-house additional activity provided by Trusts but excludes activity sent out to the Independent Sector. With no further reduction in elective waiting times in 2009/10, it will be possible to make a more robust assessment of recurrent demand during the year.

8.15 The activity delivered by Trusts in 2008/09 equates to 21.5 wte consultant staff, taking account of the average workload figures above. However, due to complexity/casemix issues not all Consultants will perform the average number of FCEs. For example, with the creation of single site for radical pelvic surgery there will be a requirement for an additional Uro-oncology Consultant at the BCH.

Recommendation

21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

8.16 This level of investment in staffing infrastructure will allow Urology services to be recurrently provided at 2008/09 outturn levels. In terms of future proofing, Trusts will be required to look at further efficiencies within existing capacity with a view to increasing the average workload per Consultant to the higher level in the context of changing demographics with an older population which will place additional demands on Urology services over the coming years. This is particularly relevant to the Northern and Southern Trusts where Consultant workloads are significantly below their peer colleagues and BAUS guidelines.

Recommendation

22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

Nurse Staffing

8.17 The additional nursing and support staff requirements to support the additional clinics and theatre sessions that will be implemented with the appointment of new Consultants are included in the estimated costing in Appendix 7.

8.18 To ensure high quality nursing services and effective and efficient use of highly specialised equipment and instruments it is essential that nurses working in Urology wards, theatres and other departments are fully trained and competent in the field of Urology.

8.19 Specialist nurses and practitioners have a key and expanding role to play in a modern Urology Service. There are many examples of nurses, within and outwith ICATS teams, undertaking assessment, diagnostic, treatment and follow-up of areas of Urology such as erectile dysfunction, LUTS (Lower Urinary Tract Symptoms), haematuria clinics, stones etc.

8.20 Specialist (Uro-Oncology) nurses must be dedicated, fully participating members of any cancer MDT, actively represent the patient's interests at MDM's and have a key role to play in carrying out detailed assessment of patients needs in order to provide, or coordinate good care. They have a particular role to play at "results" clinics and in assisting patients and carers in making informed decisions and choices regarding treatment options, the management of and living with the symptoms and consequences of their cancer and the treatments/interventions.

8.21 Under the auspices of NICaN, in collaboration with the senior nurses for cancer services across the Northern Ireland and English networks, a number of cancer site specific, clinical nurse specialist benchmarking censuses have been completed. There are a total of 12 specialist nurses in Urology in Northern Ireland at this time. However, few of these staff are solely dedicated to cancer care and therefore an estimate of the wte (whole time equivalent) has been made. In November 2008 there were estimated to be 4 wte oncology nurse specialists -1.5 in BCH, 2 in Altnagelvin and .5 in the Ulster.

8.22 Table 13 below outlines the results of a benchmarking exercise completed in November 2008, in which each of the cancer networks identified the incidence of cancer and calculated an average caseload per Clinical Nurse Specialist (CNS).

Table 13 - CNS caseload benchmarking data

	Lung	Breast	Urology	Colo-rectal	Gynae	Upper GI	Haem	Skin	Head & Neck	Brain
Cancer incidence	845	1,031	1,246	995	450	562	411	208	127	109
Total no CNS in post 2008	7.5	14	4	3	2	1	3	3	2	1
NI mean caseload	112	73	311	331	225	562	137		63	109
England mean caseload	122	81	131	89	77	98	70		66	81
Additional nos needed	3	2	5	4	4	3.5	5	1	2.5	1
Future NI mean caseload	80	64	138	142	75	125	52		51	54.5

8.23 There are higher numbers of Urological cancer incidences than in any other speciality and these CNSs have the third highest (upper GI is the highest at 562) mean caseload at 311, which is more than double the English mean caseload.

8.24 This shortfall will need to be addressed if significant improvements are to be made in the cancer pathways, waiting times, support and follow-up for Urology patients in Northern Ireland.

Recommendation

23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNSs should be undertaken in mid 2010.

Radiology Staffing

8.25 The assessment and diagnostics of Urological diseases/conditions involves intensive and high volumes of radiology services across a broad range of modalities-ultrasound (KUB, TRUS), IVP, CT and MRI scans, along with the provision of an interventional radiology service. As Urology services are redesigned and streamlined, radiology services will be required to respond and adapt to the new service models and pathways and in particular accommodate more single visit haematuria, LUTS, prostate and stones clinic.

8.26 In addition to any further investment, radiology services will be required to ensure optimum and enhanced use of current available capacity by modernising and reforming the systems and processes currently in place.

8.27 In recognition of the significant capacity gap in Urology to meet the growing demand, a number of additional Consultants will be appointed and a significant number of additional patients will need to be assessed and treated internally. Additional radiology staffing to support these appointments (included in the estimated costs in Appendix 7) has been calculated using the Adenbrookes formula of .3 wte Consultant Radiologist per wte Consultant Urologist and a ratio of 6 wte band 5 Radiographers per wte Radiologist.

Pathology and Radiotherapy Services

8.28 It is recognised with the volumes of Urological cancers, the Urology service is a high user of both pathology and radiotherapy services. However, given the work being undertaken by NICaN, within the Cancer Services Framework and the supporting cancer investment plan, and the Pathology Services Review, published in December 2007, it was agreed that the current Urology review would not include a detailed assessment of these services. Investment in an additional band 7, BMS is however included in the estimated costs in appendix 7, in recognition of the increased diagnostic workload associated with growing PSA work and the centralisation of radical pelvic surgery on the BCH site.

9. SERVICE CONFIGURATION MODEL

9.1 In section 6 the key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability, with a stable workforce that can continue to attract the necessary expertise across all of the professions.

9.2 It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability. This will require a reconfiguration of teams/services into more sustainable units thus enabling the service to make the best use of any investment made.

9.3 A number of models (6) for future service delivery were developed. These ranged from 5 teams in NI, with each Trust having its own discrete urology service and its staffing and workload based on its current catchment population, to 2 teams in NI.

9.4 A sub group of clinicians, Trust and Board Managers developed criteria and a weighted scoring system against which each of the models could be assessed. The 5 criteria (Appendix 8) were:

- Service stability/sustainability (population, team size, dedicated skilled radiology and nursing staff, rotas and EWTD.
- Feasibility (ease and speed of implementation).
- Compliance with DHSSPS policy/strategy, commissioner intent/support, compatibility with Trusts strategic development plans and impact on other services.
- Inpatient accessibility.
- Organisational complexity.

9.5 At the Steering Group meeting on 20 January 2009, each of the 6 models was evaluated against the agreed criteria. Model 3 (Appendix 9) was agreed as the preferred model and was deemed to be the most appropriate way forward for urology services.

Recommendation

24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

9.6 Model 3 comprises 3 teams, which for ease of description are called Team North, Team South and Team East. Table 14 below outlines the main elements of each of these teams.

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

9.7 In response to concerns expressed at the Steering Group Meeting in January 2009, Speciality Advisor (local and 'Island of Ireland') advice was sought around the issue of a single handed Consultant doing on-call from home covering elective and non elective patients on different sites. The advice has confirmed that such arrangements are possible and that a similar situation exists in other specialties e.g. Trauma and Orthopaedics.

9.8 Urologists have advised that there are very few occasions when a Consultant's presence is required, out of hours, to deal with an elective post operative complication/event. Equally, as described in the previous section of this report, the vast majority of non elective admissions, out of hours, do not require a Consultant's intervention. However, surgeons undertaking elective inpatient surgery on a site other than the main acute unit should use morning lists so as to further ameliorate the impact of out of hour's events. They can minimise the impact further through careful choice of the nature and type of surgery undertaken.

Recommendations

25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

10. IMPLEMENTATION ISSUES

10.1 To implement the review recommendations a recurrent (full year) investment of £2.875m has been estimated (Appendix 7). Commissioners will need to consider the method of allocating funding to support the full implementation of the recommendations, particularly with regard to aligning the allocation to the additional Consultant distribution profile.

10.2 Trusts and Commissioners will need to take forward discussions with General Practitioners around referral pathways and patient flows in the context of the proposed three team model.

10.3 Trusts will be required to submit detailed business cases prior to funding being released.

10.4 Trusts and Commissioners will need to agree timescales and the measurable outcomes in terms of additional activity, improved performance, a phased reduction in Independent Sector usage and service reform and modernisation plans.

10.5 The implementation of the recommendations of the review may/ will require capital investment to put in place additional physical infrastructure such and to fund equipment associated with technologically driven sub-specialty areas. e.g. endo-urology, reconstruction, laser surgery. Where capital requirements are identified, Trusts should process these bids through their normal capital and business planning cycle.

10.6 The new Teams (Trust partnerships) will be required to submit project plans for implementation of the new arrangements which is envisaged to be on a phased and managed basis. The new Health and Social Care Board will establish an Implementation Board to oversee the process.

GLOSSARY OF TERMS/ABBREVIATIONS

BADS- British Association of Day Surgery

BPH – Benign Prostatic Hyperplasia
A non –cancerous condition in which an overgrowth of *prostate* tissue pushes against the *urethra* and the bladder, restricting or blocking the normal flow of urine. Also known as benign prostatic hypertrophy. This condition is increasingly common in older men.

Biopsy
Removal of a sample of tissue or cells from the body to assist in diagnosis of a disease.

Bladder reconstruction
A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.

Brachytherapy
Radiotherapy delivered within an organ such as the prostate.

CNS
Clinical Nurse Specialist

Cystectomy
Surgery to remove all or part of the bladder.

Cystoscope
A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.

Cystoscopy
Examination of the bladder and *urethra* using a *cystoscope*.

ED
Erectile dysfunction

EWTD
European Working Time Directive

Genital
Referring to the external sex or reproductive organs.

Haematuria
The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.

HES/Hospital Episode Statistics
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.

Incontinence
Inability to control the flow of urine from the bladder (urinary) or the escape of stool from the rectum (faecal)

IVP – Intravenous Pyelogram
An x-ray examination of the kidneys, ureters and urinary bladder that uses iodinated contrast material injected into veins.

KUB
Kidney, Ureter, Bladder (Ultrasound)

Laparascopic surgery
Surgery performed using a laparascope; a special type of endoscope inserted through a small incision in the abdominal wall.

LUTS
Lower Urinary Tract Symptoms

MRI - Magnetic resonance imaging
A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).

MDMs
Mutli-disciplinary meetings

MDTs
Mutli-disciplinary teams

NICaN
Northern Ireland Cancer Network

Oncology
The study of the biology and physical and chemical features of cancers. Also the study of the causes and treatment of cancers.

Prostatectomy
Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.

Prostate gland
A small gland found only in men which surrounds part of the urethra. The prostate produces semen and a protein called *prostate specific antigen (PSA)* which turns the semen into liquid. The gland is surrounded by a sheet of muscle and a fibrous capsule. The growth of prostate cells and the way the prostate gland works is dependent on the male hormone *testosterone*.

PSA – Prostate Specific Antigen
A protein produced by the *prostate gland* which turns semen into liquid. Men with prostate cancer tend to have higher levels of PSA in their blood (although up to 30% of men with prostate cancer have normal PSA levels). However, PSA levels may also be increased by conditions other than cancer and levels tend to increase naturally with age.

Radical treatment
Treatment given with curative, rather than *palliative* intent.

Radiologist
A doctor who specialises in creating and interpreting pictures of areas inside the body. The pictures are produced with x-rays, sound waves, or other types of energy.

Radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill tumour cells. Conventional external beam radiotherapy also affects some normal tissue outside the target area. Conformal radiotherapy aims to reduce the amount of normal tissue that is irradiated by shaping the x-ray beam more precisely. The beam can be altered by placing metal blocks in its path or by using a device called a multi-leaf collimator. This consists of a number of layers of metal sheets which are attached to the radiotherapy machine; each layer can be adjusted to alter the shape and intensity of the beam.

Renal
Of or pertaining to the Kidneys.

Resection
The surgical removal of all or part of an organ.

Scrotum
The external sac that contains the testicles.

Testicle or testis (plural testes)
Egg shaped glands found inside the scrotum which produce sperm and male hormones.

TRUS Tran-rectal ultrasound (TRUS)
An *ultrasound* examination of the prostate using a probe inserted into the rectum.

Trans-uretharal resection (TUR)
Surgery performed with a special instrument inserted through the urethra.

Trans-urethral resection of the prostate (TURP)
Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.

Ultrasound
High-frequency sound waves used to create images of structures and organs within the body.

Ureters
Tubes which carry urine from the kidneys to the bladder.

Urethra
The tube leading from the bladder through which urine leaves the body.

Urogenital system
The organs concerned in the production and excretion of urine, together with the organs of reproduction.

Urologist
A doctor who specialises in diseases of the urinary organs in females and urinary and sex organs in males.

Urology
A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary organs in females and the urogenital system in males.

Uro-oncologist
A doctor who specialises in the treatment of cancers of the urinary organs in females and urinary and sex organs in males.

Vasectomy
Surgery to cut or tie off the two tubes that carry sperm out of the *testicles*.

WTE
Whole Time Equivalent