Note: An addendum amending this statement was received by the Inquiry on 8 September 2023 and can be found at WIT-100367 to WIT-100408. Annotated by the Urology Services Inquiry.

UROLOGY SERVICES INQUIRY

USI Ref: Notice 3 of 2023

Date of Notice: 24th March 2023

Witness Statement of: Trudy Reid

I, Trudy Reid, will say as follows:-

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:**

(i) an explanation of your role, responsibilities and duties, and

1.1 In relation to this response my role was acute governance coordinator. The roles ofthe post are outlined in *1. Appendix File ACG Structures 2016*. Human resources records notes suggest I commenced this post on the 1st May 2016. However, in my diary I appear to have commenced my role on the 4th April 2016.

1.2 I am a registered general nurse and qualified in September 1989. I have completedthe Adult Intensive Care course and post graduate diploma section of a MSC in Infection Prevention and Control.

1.3 When I commenced my role as Acute Governance coordinator I did not receive an induction or handover from the previous post-holder. I attended and organized training courses, and completed eLearning in relation to my role, including RCN Education Conference 16/3/2016, Delivering Safer Care Together Creating accountable care organisations 02/03/2017, Falls learning event 30/03/2017, Risk Assessment Workshop 27/04/2017, Serious Adverse Incident (SAI) Training One Day Investigation Workshop 18/05/2017, Corporate Training Safe guarding children and adults 25/7/2017 HSC

numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

Signed: Trudy Reid

Dated: 16th May 2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 3 of 2023

Date of Notice: 24th March 2023

Addendum Witness Statement of: Trudy Reid

I, Trudy Reid, will say as follows:-

I wish to make the following amendments and additions to my existing response, dated 16th May 2023, to Section 21 Notice number 3 of 2023:

1. At paragraph 3.8 (WIT 95203-95204), I have stated *'With the passage of time and hearing about other processes ongoing at the time it is difficult to remember exactly when I became aware of the MHPS process but I do not recall being aware that there was another review process ongoing regarding Mr O'Brien until informed by Dr Boyce approximately on 04/08/2016.'* This should state '*With the passage of time and hearing about other processes ongoing at the time it is difficult to remember exactly when I became aware of the MHPS process but I do not recall being aware that there was another review process ongoing regarding Mr O'Brien until informed by Dr Boyce approximately on 04/06/2016.'* I also want to add *'However, upon further review of the evidence, I believe I first became aware of another review process regarding Mr O'Brien on 28th November 2017 when I received an email from Mr Carroll. Please see TRU-256445.'*

2. At paragraph 3.106 (WIT- 95228), I have stated '*I became aware of a 2nd process from Dr Boyce approximately on 04/08/2016.'* This should be amended to *'I became aware of a 2nd process from Dr Boyce approximately on 04/06/2016.'* I would also like to add *'However, upon further review of the evidence, I believe I first became aware of another review process regarding Mr O'Brien on 28th November 2017 when I received an email from Mr Carroll. Please see TRU-256445.'*

Urology Services Inquiry

21. In relation to Patient 137, from reviewing records there appears to have been a failure to progress MDM actions. A letter was drafted from Mr Haynes to Mr Young requesting assurances that he had processes in place to ensure MDM outcomes for patients under his care were actioned in a timely manner. This was given to Mr Young on 15/08/2018. I have no record of a response from Mr Young. A Datix was generated with respect to his patient. Please see documents attached to this statement as follows:

- Letter from Mark Haynes to Michael Young re Patient 137 dated 14 August 2018
- Patient 137, Staff Details Table
- SHSCT Governance Team (IR2) Form- New June 2018 Datix Personal Information redacted by the USI
- Incident Check List Name Patient 137 Personal Information redacted by the USI
- Time Line Patient 137

22. A Datix was generated in relation to patient Patient 138. The patient was subject to screening for SAI. There appears to have been human error in relation to tracking this patient. Documentation suggests that the issues in the incident were escalated to the Regional Cancer Performance Meeting. Guidance was developed to mitigate the risk of a similar incident happening again, Failsafe to ensure all patients are relisted for MDM discussion. (Tracked & Not Tracked Patients). Please see attached documents in relation to Patient 138:

- Datix Personal Information redacted by the USI
- Email 4 February 2019 From Barry Conway to Sharon Glenny and Ronan Carroll RE SE Screening Patient 138 H&C Personal Information redacted by the USI DATIX Personal Information redacted by the USI
- Screening Form Name Patient 138 Personal Information redacted by the USI
- 20190117Q12 Lynn Lappin internal notes HSCB Cancer Performance Meeting 2019-2021- can be located at WIT 23972- WIT-23973

Statement of Truth

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

Signed: Personal Information redacted by the USI

Date: 08/09/2023

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	**Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator**
BAND	8B
DIRECTORATE	ACUTE
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of, the Service Director and the Assistant Director with responsibility for Governance. They will provide an internal and external Directorate focus for the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust with respect to the CSCG agenda within the Directorate and as an integral part of the Trust CSCG Working Body and through close collaboration with the Trust's Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate CSCG plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director for CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.

The post holder will provide enhanced CSCG support and performance improvement expertise and intervention in this area to their Directorate and to corporate CSCG projects where required. He/She will provide their Directorate and the organisation with a suite of intelligent information analyses which demonstrate real time performance in relation to all areas of CSCG, including Incidents, Complaints, Risk, Litigation, Audit, Clinical Indicators and Patient Safety. The post holder will also be required in collaboration with the Trust Senior Management Team and the Trust CSCG Senior Manager, to develop the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic leadership and facilitation skills.

KEY DUTIES / RESPONSIBILITIES

Directorate Responsibilities

1. On behalf of the Director of Acute Services, to take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Service Director and the organisation.

2. Lead on ensuring that at each level of the Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk and that with in each service team this information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety.

3. In particular to coordinate via the Directorate governance team the timely and appropriate responses to both incidents and complaints on behalf of the Directorate and to ensure standards of response times and patient / client satisfaction is the complaints process is maintained.

4. To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation.

5. Lead on the investigation of serious adverse incidents in the Acute Directorate, ensuring that a consistently high standard of investigation and report writing is maintained at all times.

6. Lead on patient/family engagement in relation to serious adverse incidents within the Acute Directorate.

Date Commenced Post	Date Left Post	Contract Type	Position	Please see:
18/04/2005	31/07/2007	Permanent	Infection Control Nurse Hgrade and band 7	2a. JD Senior Infection Control Nurse
01/08/2007	30/09/2009	Permanent	Lead Nurse Infection Control (8A)	2b. JD Lead Infection Control Nurse
01/10/2009	23/04/2012	Permanent	HOS-General Surgery(8B)	2c. JD 8B Head of General Surgery
24/04/2012	01/01/2013	Temporary Move to Higher Band	AD - Surgery and Elective Care (8C)	

02/01/2013	30/04/2016	Permanent	HOS-Trauma and Orthopaedics (8B)	
01/05/2016	06/01/2019	Permanent	Governance CoordinatorAcute Directorate (8B)	1. Appendix File ACG structure 2016
07/01/2019	31/07/2022	Permanent (Temp HigherBd)	Asst Dir Clin & Soc CareGov (8C)	
23/03/2020	01/08/2022	Permanent (Temp HigherBd)	Interim Assistant DirectorIPC (8C)	2d. JD Interim Assistant Director Infection Prevention and Control
01/08/2022	31/12/2022	Permanent (Temp HigherBd)	Interim Director of Surgery & Elective Care,Cancer and Clinical Services and Integrated Maternity and Women's Health	2e. Appendix xx Interim Director of Surgery & Elective Care, Cancerand Clinical Services and Integrated Maternity and Women'sHealth
01/01/2022		Permanent	Dir Of Medicine & Unscheduled Care Services	2f. JD Director of Medicine and Unscheduled Care

Aimee Crilly

From: Corrigan, Martina [redacted]
Sent: 19 December 2011 10:25
To: Akhtar, Mehmood; O'Brien, Aidan; Young, Michael
Cc: Dignam, Paulette; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: FW: backlog

Dear all,

Please see below

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Scott, Jane M
Sent: 05 December 2011 11:33
To: Reid, Trudy; Corrigan, Martina
Subject: RE: backlog

Trudy/Martina – Can you speak to Consultants on 3 South and highlight backlog of results to be signed on 3 South .

There are 1000 unsigned results that need filed

Thanks
Jane

Jane Scott
Surgical Service Administrator
Southern Health & Social Services Trust
Surgery & Elective Care
Admin Floor
CAH
Ext: [redacted]
Mobile : [redacted]

Buckley, LauraC

From: Trouton, Heather
Sent: 09 November 2015 17:18
To: Corrigan, Martina; Nelson, Amie; Reid, Trudy
Cc: Carroll, Anita
Subject: FW: Triage

Dear All

Can you please see below. I think that is a reasonable suggestion . have you any concerns or do you support?

Heather

From: Carroll, Anita
Sent: 06 November 2015 14:56
To: Trouton, Heather; Conway, Barry; Gibson, Simon; Carroll, Ronan; McVey, Anne
Cc: Robinson, Katherine; Rankin, Christine
Subject: FW: Triage

Dear all

It has been brought to my attention that triage of referral letters can still be delayed in being returned to the RBC. Some areas in particular are very poor at doing this. To this end I would be grateful if you would all agree with your clinicians that where referral letters are not returned within a week or thereabouts (IEAP states 72 hours) that the RBC will add patients to the waiting list **with the priority type dictated by the GP**. Given that waiting lists are now much longer than they were previously this could cause problems so it is in everyone's interest to try and encourage quicker turnaround of triage.

Thanks Anita

Boyce, Tracey

From: Boyce, Tracey [redacted]
Sent: 04 April 2016 15:16
To: Walker, Helen; Carroll, Ronan; McVey, Anne; Gishkori, Esther; Carroll, Anita; Conway, Barry
Subject: Confidential: Acute Governance Structure alternative proposal April 16
Attachments: Acute Governance Structure proposal April 16.docx

Hi all
Based on the governance discussions we have had over the last couple of weeks and the lead nurse paper I have been thinking about an alternative option for our Governance structure – attached.

It incorporates the lead nurse role into the structure – which is something I know some of you were worried about.

I have left the band 7s role in as an option as I personally don't think the lead nurses would be able to cope with the amount of governance work that needs to be done, on top of their other roles –we have a SAI investigation backlog and we still haven't made a start on the 'implementing lessons learned' piece.

Can we discuss this at team talk tomorrow?

I have also asked David to create a high level SAI report – so that each Division can see where they stand in relation to the number of SAIs they have awaiting investigation – I may have it available tomorrow afternoon.

Please do not share or discuss this with anyone else outside the Acute AD structure – I do not want this option getting to Connie or Paul before I have had a chance to break it to them that their governance role may be affected.

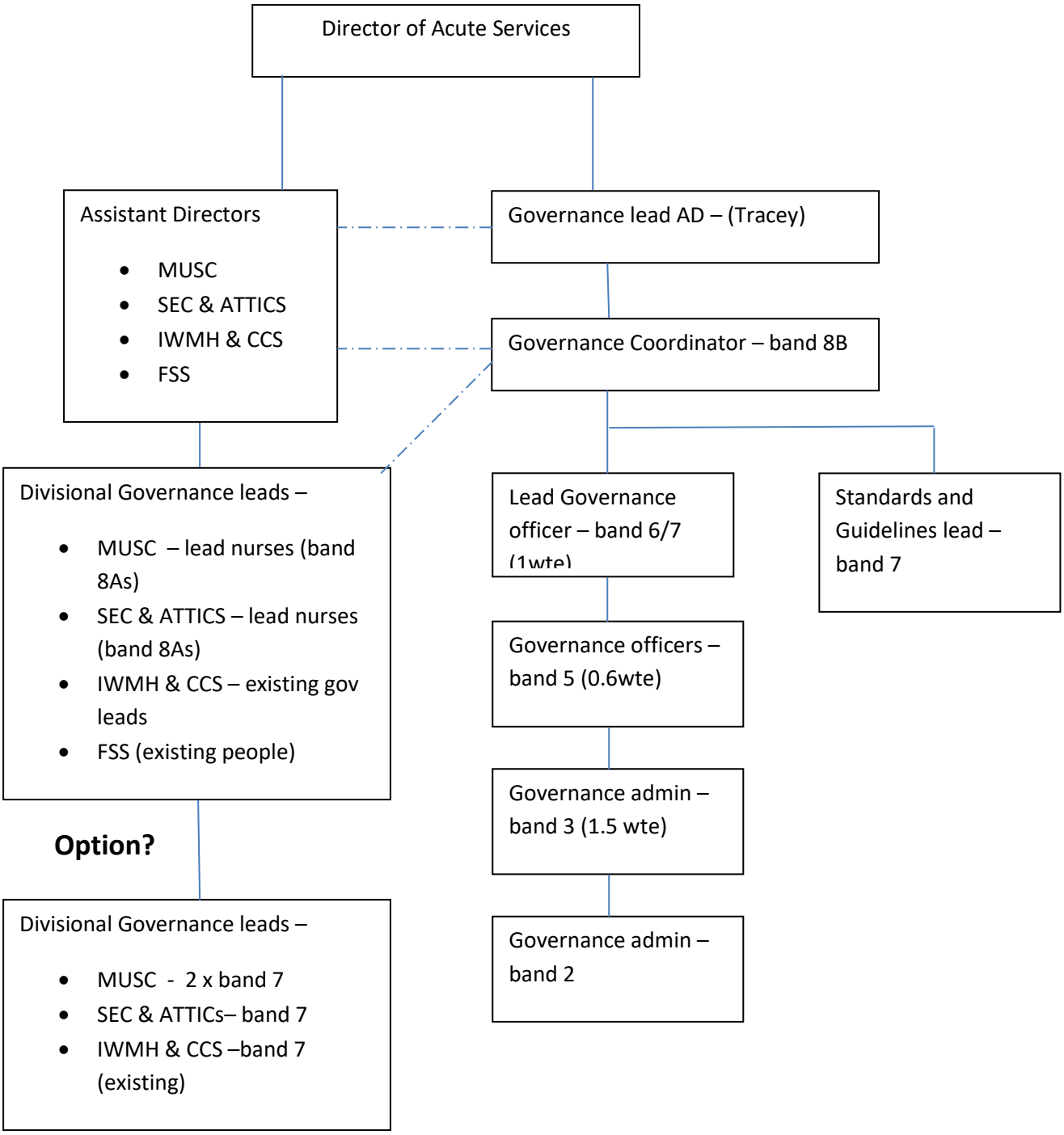
Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

[redacted]

Acute Governance Structure – alternative option for discussion



develop the service to provide robust governance structure. The structure suggested when I applied for the Acute Governance Coordinator the post was not progressed – *1. Appendix File ACG structure 2016.*

1.10 The structure at the time included a small complaints team with 2 full time staff members and 3 part-time administration staff. As part of a review of capacity one staff member was asked to concentrate significant amounts of their role on SAI administration. One of the part time team also supported the operational teams with risk register updates. During my tenure there were 5 weeks of unplanned leave.

1.11 The standards and guidelines team had one part-time lead and an administration assistant. During my tenure there were 9 weeks of unplanned leave.

1.12 Equipment management role was a staff member seconded from the estates team who provided part time cover.

1.13 A member of staff to support the governance around point-of-care testing was appointed in June 2018.

1.14 Temporary support was provided from the corporate governance team, they mostly provide M&M chair support.

1.15 In relation to SAIs and other governance functions there were two lead nurses and a redeployed ward sister when I commenced. One lead nurse was immediately returned to their substantive lead nurse role and completed the SAIs they had initially commenced over the coming months. The second lead nurse in May 2016 reported she had been approached by an AD and given two options: one to downgrade to band 7 in Acute Governance, or; move to 8A lead nurse in Surgery and Elective Care. Given the workload and personal circumstances redeployment back to lead nurse role in Surgery and Elective Care did not happen until October 2017 (*4.Appendix RE: Governance re-*

7. What, in your experience, was the culture within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?

7.1 The Acute Directorate is very busy with significant resources required for day-to-day operational management of the service. There had been a focus on performance and finance in recent years. However, good performance increases efficiency and flow of patients both electively and non-electively to reduce waiting times and risk. There was a verbal commitment to governance but operational challenges and available funding limited time to proactively manage and respond to governance issues. A Clinical and Social Care Governance Assurance Template completed in 2018 noted a number of weaknesses and opportunities within the Acute Clinical Governance systems.

7.2 It is my opinion that the resource required to operationally and clinically manage the daily operations of the acute directorate left limited time to proactively address clinical governance processes and risks. Systems of oversight and monitoring were not well developed, some actions were taken forward by operational teams but this was not always shared with the governance team, or if not able to be progressed this was not always shared. Some work streams were supported by both the operational and governance teams.

7.3 I believe this is also demonstrated by the move of the 8A nurse from governance to lead nurse post and the redeployment of the patient support nurses to support the SAI process rather than recruiting additional staff.

7.4 There was also a lack of commitment and/or funding to providing support clinical teams, and to the audit committee to facilitate robust audit programmes with Acute Audit Committee oversight.

From: Reid, Trudy
Sent: 10 October 2018 23:44
To: Khan, Ahmed; Marshall, Margaret
Cc: Boyce, Tracey; Gishkori, Esther
Subject: Clinical and Social Care Governance Assurance Template
Attachments: Clinical and Social Care Governance Assurance Template June 2018 (2).docx

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Dear Dr Khan and Margaret, please see a ached Clinical and Social Care Governance Assurance template, I had it in draft format, please accept my apology for my oversight in not forwarding you this response sooner.

Regards,

Trudy

Clinical and Social Care Governance Assurance Template – June 2018

Please consider the following when populating the assurance template

- *Effectiveness and robustness of present arrangements*
- *Clarity of roles & responsibilities*
- *Assurance mechanisms – operational/ corporate*
- *Cognisance of external reviews*

	Strengths •*What advantages does your does your current directorate processes and systems possess?* •*Given your existing assurance structures what do feel you do well?* •*What resources can your directorate draw upon that could be replicated in other service areas?*	**Weaknesses** • *What could be improved Trustwide?* •*What have staff in your directorate identified as weaknesses with current arrangements?* •*Could any identified weaknesses be*	**Opportunities** •*What opportunities can you identify to strengthen current systems and processes?*	**Threats** • *What factors are barriers to improvements?* •*When future challenges do you foresee?*
SAI investigations		Staff do not have sufficient training to make them confident with the SAI process- particularly for chairs of SAI panels Difficult releasing staff to attend SAI meetings (particularly clinical teams).	Training could be provided at a number of levels on SIA process • chair • panel member • Facilitator • general awareness including patient/family engagement, report writing, human factors, RCA/systems analysis	Barriers include resource, including clinician time. Engagement from clinicians following Coroner's inquest questioning of Chairs in relation to SAI

	Strengths • *What advantages does your does your current directorate processes and systems possess?* • *Given your existing assurance structures what do feel you do well?* • *What resources can your directorate draw upon that could be replicated in other service areas?*	Weaknesses • *What could be improved Trustwide?* • *What have staff in your directorate identified as weaknesses with current arrangements?* • *Could any identified weaknesses be*	Opportunities • *What opportunities can you identify to strengthen current systems and processes?*	Threats • *What factors are barriers to improvements?* • *When future challenges do you foresee?*
		There is a limited resource to facilitate SAI meetings Sourcing external chairs for SAIs is challenging and can significantly extend the duration of the SAI process	Allocated time to allow for the SAI process for clinicians, senior staff Resource to audit the implementation of recommendations	
Standard and Guideline Compliance	The Acute Directorate has robust processes in place in relation to S&G, including SMT fortnightly meetings to review Resource folder with SOP etc developed. NICE scholarship allowed for engagement with staff to allow systems and processes to be developed to support change leads. Many proactive service improvement work streams improve patient outcomes and ensure effective use of resources.	The S&G data base makes effective reporting difficult The number of guidelines and the level of detail required to provide an assurance to the Trust is very resource dependent, currently there are limited resources to progress this work. The lack of dedicated cross divisional meeting to discuss S&G can lead at times to fragmentation (limited time available in Governance Coordinators meetings does not allow for robust discussion on S&G)	A data base which is fit for purpose and can run detailed reports to support KPI's, HoS, Divisional and Directorate reports and other queries Additional resource to support the S&G process to ensure cross Directorate work to ensure an integrated approach to the patient journey and service improvements. Resource to audit the implementation of recommendations	Difficult releasing staff to be change leads (particularly clinical teams). There is currently significant difficulty getting change leads for the S&G below leading to significant risk- PHA letter Valproate HSC (SQSD) 19/17 - Resources to Support the Safety of Girls and Women Who Are Being Treated With Valproate. NICE TA 471 - Eluxadoline for treating irritable bowel syndrome with diarrhoea NICE TA 481 - Immunosuppressive therapy for kidney transplantation in adults

	Strengths • *What advantages does your does your current directorate processes and systems possess?* • *Given your existing assurance structures what do feel you do well?* • *What resources can your directorate draw upon that could be replicated in other service areas?*	Weaknesses • *What could be improved Trustwide?* • *What have staff in your directorate identified as weaknesses with current arrangements?* • *Could any identified weaknesses be*	Opportunities • *What opportunities can you identify to strengthen current systems and processes?*	Threats • *What factors are barriers to improvements?* • *When future challenges do you foresee?*
	Base line assessments and benchmarking inform business cases	Difficult releasing staff to be change leads (particularly clinical teams).		
Complaints Management	Good team working between Acute complaints team and the operational/clinical teams	The volume and complexity of formal and informal complaints and MLA enquires poses a challenge for staff investigating and responding to same. Number of reopened and ombudsmans complaints	Training on how to respond to complaints Additional resource to assist clinical teams to investigate and respond to complaints in a comprehensive and timely manner Resource to audit the implementation of recommendations	Capacity in operation and governance teams to ensure robust investigation in a timely manner to lead to robust action plans.
Clinical Audit	Examples of good audit practice including NCEPOD	Engagement with SMT and support from the Medical Director for audit work, to support e.g. Audit Conference which has recently not Lack of administration support for all forms of audit	Clinical teams are still supportive of audit, with additional administrative resource IT system to support audit	Capacity to support audit leads

	Strengths •*What advantages does your does your current directorate processes and systems possess?* •*Given your existing assurance structures what do feel you do well?* •*What resources can your directorate draw upon that could be replicated in other service areas?*	Weaknesses • *What could be improved Trustwide?* •*What have staff in your directorate identified as weaknesses with current arrangements?* •*Could any identified weaknesses be*	Opportunities •*What opportunities can you identify to strengthen current systems and processes?*	Threats • *What factors are barriers to improvements?* •*When future challenges do you foresee?*
		Lack of resource to review and ensure recommendations are implemented Lack of IT system to record audits, outcomes, recommendations and progress against same- to be available to clinical and operation teams to ensure awareness of risk and actions required across the organisation.	SMT support of Clinical Audit	

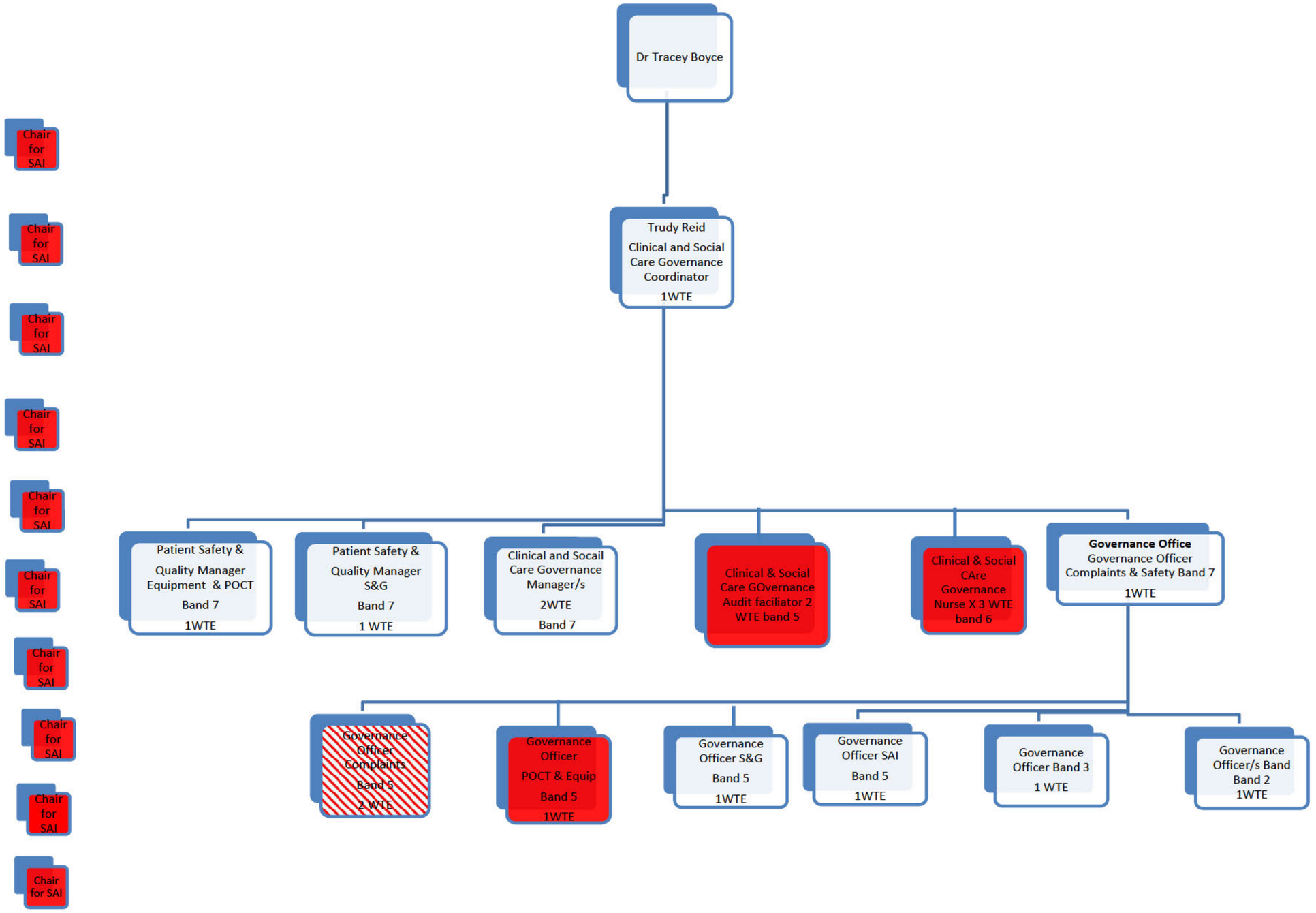
Incidents – Acute Falls Satisfactory compliance		Standards & Guidelines Limited compliance	Incidents – Medication Trust Satisfactory compliance Independent Sector Limited compliance

8.6 In relation to overall view of the effectiveness of governance systems within Acute my view was that, as per the governance assurance template and the responses regarding the requirements for a clinical governance system in question 7 and 8, there were weaknesses, challenges and gaps in the governance system. The workforce resource and information systems impacted on the effectiveness of the governance systems.

9. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

9.1 In my opinion it would have been good to have a review of the Acute Governance Structures with recommendations on improvement required to ensure governance structures were fit for purpose.

9.2 The Governance Assurance Template did highlight weaknesses. At the time and now, in my opinion, additional staffing resource in the Acute Governance team to allow the development of governance structures and systems including audit for improvement and assurance would greatly assist. Specialist training to equip governance staff for their roles would have improvedthe effectiveness of governance structures and systems. Dedicated highly trained SAI chairs to facilitate timely completion of SAIs for learning. Improved IT systems such as Datix, the S&G database, audit tools andinformation systems would allow for timely reporting and triangulation of data.



Received from Trudy Reid on 16/05/2023. Annotated by the Urology Services Inquiry.

Acute Governance Enhanced Structure – proposal for discussion

31ST May 2018

Additional funding may become available to enhance the Clinical Governance structure within the Acute Directorate in 2018/19. This paper proposes the additional posts/roles that would be added to the existing structure.

The existing structure of the Acute Governance Team is outlined in Appendix A. The existing posts are coloured blue and the proposed new posts are coloured red.

The introduction of additional posts would allow the Acute Governance team to introduce proactive governance activities such as governance dashboards, incident trend analysis, additional governance training and learning events related to trends/patterns identified from Trust incident reports.

Rationale for proposed new posts

3 wte band 6 Governance Nurses

- These posts would be embedded in the MUSC and SEC teams to work with them on their 'day to day' datix and complaint responses (potentially one for SEC, one for ED and one for the rest of MUSC – but need to agree this with the ADs if funded).

2 wte band 5 audit facilitators

- The Audit facilitator posts will be aligned to the Divisions within Acute, supporting the teams in their clinical audit work. At present there is no support for audit within Acute.

1 wte band 5 Equipment/POCT governance officer

- 1 Band 5 governance officer to work with the equipment management/POCT band 7, as from previous discussions with the Directors of Planning and HR, these post will need to take on the cross Directorate work which is not being addressed at the moment, rather than just focussing on the Acute Directorate.

1 band 5 Equipment/POCT governance officer

- 1 additional band 5 governance officer to improve our response to complaints, Ombudsmen enquires and risk register work/training for staff.

0.5 'Governance' PA for 10 consultants

- By creating 10 consultants with 0.5PA for governance we could address the current problems we have with the availability of Consultant medical staff for SAI chairs and other governance working groups. This also fits with the proposal Dr Kahn discussed with the Acute SMT in May. The model would merge aspects of IWMH Medical governance and also MHD's approach to leadership of SAIs. We would provide advanced SAI leadership training for this team of consultants.

Tracey Boyce
Director of Pharmacy/Acute Governance
31st May 2018

7.21 Audit was reported by the corporate governance team in the patient safetyreports at acute governance and acute clinical governance.

7.22 The audit committee meetings commenced but Mrs Gishkori did not always attend all the meetings and no additional administrative support was available for clinicians to facilitate audit and subsequently attendance at the acute meetings reduced meaning meeting were not quorate. The poor attendance and lack of additional resource for audit led to meetings not continuing. However, clinical audit did continue with the supportof the corporate clinical governance team and reports were presented to Acute Governance and Acute Clinical Governance Committees.

7.23 The lack of an audit committee meant there was no local acute oversight of audit activity meaning that triangulation of data was challenging. This impacted on the ability to identify risk and risk manage.

Education and training

7.24 When I commenced the Governance Coordinator post there appeared to havebeen limited governance training.

7.25 The limited number of staff within the Acute Governance Team and workload made it challenging to provide proactive training. However, the Corporate Governance team organised SAI training –training was provided by Consequence UK training in February and 1 day 3rd February 2016, 11th and 12th February 2016 and 7th and 8th March 2018 organised by.

7.26 In June 2016– I subsequently organised a further session using Consequence UK on the 18th May 2017.

7.27 I became aware of Clinical Leadership Solutions who provide training on SAIs. CLS provided on Investigating Incidents Building Competency 19th October 2018 and Investigating Incidents Master Class - 24th and 25th June 2019 and 16th 17 September 2019

7.28 With the Acute Governance team internal in-house training sessions were provided on clinical governance on nursing induction, Incident

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

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

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

58 Q. What were Mrs. Gishkori's reasons, to the best of your understanding, for deciding that she wouldn't take on this direct interfacing role?

A. From what I observed and understood, I think Mrs. Gishkori, Esther, was overwhelmed with the post. It was a massive post, the Acute Director post. Also maybe a level of inexperience in terms of the governance, leading governance in a very big, very vast wide-ranging directorate. I think the fact that I was there and had already been doing it sort of allowed her not to maybe take it back fully. It did make me nervous on her behalf because obviously then Esther was then going into the senior management team, the corporate governance meeting and so on, without that interface, so I was always nervous about how she could then represent, talk about her risks and so on. 10:41 10:41 10:42

I started with, put a short briefing meeting in her diary every Tuesday morning for half an hour first thing, like at half eight in the morning before the day started. I would have went with Trudy if I could, or one of us made sure we went to try and brief Esther on what had happened in the week past, because on Tuesdays at that point, the senior management team was on Tuesday morning, the corporate senior management team, so it meant then that Esther could have gone briefed to that and the senior management team had a rolling programme. So, once a month their agenda was fully governance. It was to make sure that Esther knew what 10:42 10:42

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 10 October 2018 21:49
To: McVey, Anne; Carroll, Ronan; Carroll, Anita; Conway, Barry; Boyce, Tracey; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Governance reports
Attachments: Weekly Re-Opened Report 09.10.18.xlsx; Current Complaints 9.10.18.xlsx; Ombudsman weekly 011018.xlsx; Major & Catastrophic Incidents week ending 091018.xlsx; Incident Review Position as at 01.10.18.xlsx; SAI Report to 9.10.18.xlsx; SAI Recommendations 9.10.18 no action plan or report.xlsx

Please see attached governance reports for information and action

Regards,

Trudy

Trudy Reid
Acute Clinical & Social Care Governance Coordinator
Craigavon Area Hospital
SHSCT
Mobile [redacted]

DIRECTORATE OF ACUTE SERVICES
Report on Re-Opened Complaints - 9 October 2018

Ref	Record name	Div	Loc (Exact)	Re-Opened	Current Stage	Ack or Holding Letter
AS325.15/16	Personal Information redacted by the	MUC	1 North & 1 South	05.10.17	Comments from Litigation finalised (6.9.18) - for approal by A McVey at next 1:1 meeting (10.9.18). Two areas under Dr Kadhim still to be finalized. Complaints File and copy of medical notes with A McV (10.9.18)	21.8.18
AS201.17/18	Personal Information	MUC & OPPC	AMU & Ramone WW	13.3.18	Draft Response almost finalized (1.10.18)	1.10.18
AS 174.17/18	Personal Information	MUC/SEC	ED/ENT/Neurology	11.5.18	Pre-Meeting held on 20 .8.18 with responses to concerns circulated for approval/amendment. Ronan Carroll to chair. Meeting in Sept cancelled by complainant with request to re-schedule November for clincal reasons. Meeting arranged for 12.11.18	N/A
AS 350.17/18	Personal Information	MUC	1 North	18.5.18	Draft Response approved by A McVey (9.10.18) but one query to be clarified by A McV (9.10.18)	24.8.18
AS402.17/18	Personal Information	MUC	DHH -ED & Female Med	21.5.18	C Connolly to respond to outstanding queries (19.9.18) Discussion and reminder to Connie (4.10.18)	24.8.18
AS 379.17/18	Personal Information redacted	MUC	ED	28.5.18	Draft Respose to A McVey for approval (10.9.18) - File and draft response with A McV as clarity required re swipe doors.	24.7.18
AS 67.18/19	Personal Information	MUC	1 North	19.7.18	To Esther for approval (9.10.18)	30.8.18
AS 44.18/19	Personal Information	MUC	ED CAH	23.8.18	A McVey to forward to Finance for advice (3.9.18) A McV sent request to fiance for advice 10.9.18. Reminder e-mail sent to A McVey (1.10.18)	23.8.18
AS 97. 18/19	Personal Information	MUC	ED	28.8.18	Sent to Dr Patton, Sr Holmes, M Burke, P Smith - ? Response/?Meeting (28.8.18) Response received from Dr Patton - awaiting mgt plan from P Smith/M Burke (11.9.18)	23.8.18
ENQ 9308	Personal Information	MUC	Booking Centre	3.9.19	Draft Response to Anita Carroll for Approval (4.10.18)	
AS410.17/18	Personal Information	MUC	1 North / ED	11.9.18	Awating response from Kay Carroll / Ruth Weir (PT)	
AS 82.18/19	Personal Information redacted	MUC	ED DHH	17.9.18	Meeting arranged for 10.10.18. Postponed by complainant - being re-scheduled for November 2018.	20.9.18
AS 145.18/19	Personal Information	MUC	ED CAH	25.9.18	To M Burke & Sister Holmes re possible meeting (1.10.18)	1.10.18
AS 151.18/19	Personal Information	MUC	ED CAH	2.10.18	New Complaint - For Advice	8.10.18
AS 137.18/19	Personal Information	MUC	ED CAH	2.10.18	Issued for advice on further response or meeting (8.10.18)	8.10.18
AS 33.18/19	Personal Information redacted	MUC	AMU	3.10.18	New Complaint - For Advice	8.10.18

b) Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
c) Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
d) Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
e) There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
f) Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

Please see attached 16. Appendix Terms of reference

3.5 Professional Governance for Doctors, Nurses, Midwives and Allied Health Professionals (AHP) and social workers is aligned to the Executive Directors of Medicine, Nursing and Social Work.

3.6 During my tenure it is my experience that professional issues being addressed through professional lines were not always known to the acute clinical governance team and visa versa. The Medical Director would have had governance processes such as appraisal and latterly I became aware of what I now know to be the Maintaining High Professional Standards (MHPS) process**.**

3.7 The Executive Director of Nursing, Midwifery and AHPs is responsible for nursing and AHP professional governance. The Executive Director of Nursing, Midwifery and AHPs post was combined with an operational Director remit until 2018.

3.8 With the passage of time and hearing about other processes ongoing at the time it is difficult to remember exactly when I became aware of the MHPS process

complaints and concerns. These redeployments reduced one layer of governance to address the need to support SAI reviews and report writing. There was a redeployed nursing sister in the team, One of the administration team from the complaints department supported this team. During my tenure there were 103 weeks of unplanned leave.

3.154 Nursing governance staff were asked to provide support with SAI reviews, regrettably for a number of reasons including sickness absence minimal support was provided.

3.155 The workload was significant for a small team, examples of the volumes of incidents, complaints and SAI's re illustrated below

3.156 The table below highlights the Incident reports by year during my tenure by service area:

	2016	2017	2018	2019	Total
Booking / Admin	12	19	12	0	43
Scheduling Team	19	25	72	0	116
Acute Directorate AHP's	3	14	13	0	30
Anaesthetics, Theatres and IC Services	444	606	613	9	1672
Cancer Services	20	50	63	3	136
Diagnostic Services	67	129	139	2	337
Laboratory Services	10	20	57	0	87
Pharmacy	29	76	87	0	192
Decontamination Services	37	74	51	0	162
Health Records	11	13	15	0	39
Linen Services	21	23	33	0	77
Locality Support Services (A&D)	4	4	5	0	13

Delays in appointment / diagnosis

Datix number	Patient details	HCN	Summary of issue	Outcome	Recommendations if any	
Personal	Personal	Personal	CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16.MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy.	13/07/16 - OPD letter - In essence, it is unlikely that there is any sinister problem but still I have requested an MRI spine and arranged for all relevant blood tests.		
Personal	Personal	Personal	It was reported from nursing home regarding below mentioned patient that she suffered TIA on 10th July at 9.00 am the care assistant was walking this nursing home resident to the toilet, whereby she loss power in her leg , care assistant lowered the patient called nursing staff who reported patient was unable to speak or stick out the tongue and had loss of right arm power and patient felt weak with it , observation were stable except BP was 78/50.it all resolved within 2-3 minutes This patient was seen on 06/06/16 at pacemaker check clinic ,patient had episode of Paraoxysmal Atrial Fibrillation, Cha2ds2vasc =4 , the cardiac physiologist brought it to my attention ,as this patient has mild Dementia and was being transferred to Belfast , the importance of being on anticoagulation was highlighted in view of age and eGFR and no murmur ,choice of DOAC was done , However the family preferred to get it referred to GP Personal , urgent letter was dictated on 06/06/16 with information of the GP outlined ,I also called the surgery to make sure that they had anticoagulant clinic locally and this patient warrants anticoagulation in view of AF on PPM check I was contacted on 11 July @11.30 am to report patient had experienced a TIA , On investigating further it seemed that the GP had not received any correspondence from us ,hence anticoagulation was not commenced.	Discharged Person 20/4/16		
Personal	Patient 136	Personal	Patient was waitlisted for removal of ureteric stent on 17/11/2014, This request was registered in the book in stone treatment centre. A green booking form was also filled in at the same time. But this was overlooked. Patient had to have the stent in unnecessarily too long He was reviewed in clinic today and realised that the stent was still ins itu. Arranged to remove the stent only today..			
Personal	Personal	Personal	SECRETARY TOOK A PHONE CALL FROM A PATIENT TO SEE IF SHE WAS ON THE WL FOR A REPEAT OGD AS SHE HAS BARRETT'S OESOPHAGUS, NOTES WERE IN CAH SO SECRETARY COULD NOT CHECK AT THIS TIME AS SHE IS BASED IN STH. SHE CHECKED WITH GP WHO CONFIRMED THEY HAVE A LETTER FROM 1.3.12 SAYING OGD TO BE REPEATED IN 2 YEARS. THE PATIENT WAS NOT ADDED TO THE WL. PATIENT WAS SCOPED BY A GPSE. PATIENT ADDED TO WL AND HAS BEEN GIVEN A DATE TCI ON 24/6/16	TCI 24/06/16 letter dictated 3/8/16 This lady had a surveillance upper GI endoscopy for Barrett's metaplasia. The OGD did indeed confirm Barrett's. Biopsies have not shown any evidence of dysplasia or malignancy. She will be booked for a repeat OGD in 2 years time.		
Personal	Breast clinic		Failure by A&C agency/bank staff to follow A & C protocol re printing appointment letters over 3 clinic sessions 140 patients affected. 140 PATIENTS DID NOT RECEIVE APPOINTMENT LETTERS. Immediate response by A and C team to rebook and phone patients.			
Personal	Personal	Personal	Chest x-ray performed 2014. Correctly reported tumour but not actioned. Represents now with abnormal CXR and CT has confirmed tumour. H&C Personal GP has made patient aware of 2014 x-ray Patient curently on lung cancer red flag pathway I have informed patient we will investigate above	OPD letter 9/6/16 poorly differentiated squamous cell carcinoma and his PET scan showed an FDG positive lesion in the right upper lobe with uptake in the hilar node and also a right paratracheal node.	Litigation request	
Personal	Personal	Personal	X-ray 4/7/15 not picked up 26/08/15 – not SAI was pending Personal report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon.	Died Personal Information under care of paliative team		
Personal	Personal Information	Personal	PATIENT RANG IN TO CHECK WHEN HE WOULD SEEN AST GRATRO - THIS ALERTED GASTRO SEC IN ACH AS PATIENT WAS NOT ON PAS. PATIENT WAS ATTENDING A NURSE LED CLINIC AND WAS SEEN AS A WALK IN AT DR Personal RF CLINIC. Personal DICTATED A REFERRAL TO GASTROENTEROLOGY. THIS WAS RECORDED ON THE NURSE CLINIC SHEET, THE CHART WAS SENT TO THE TYPIST, BUT AS THE PATIENT WAS NOT ON THE SHEET AS A WALK IN, THE LETTER WAS NOT PICKED UP TO BE TYPED AT THE TIME. THE REFERRAL WAS ACTIONED ON 24/3/16 WHEN A CLEAR UP WAS DONE ON DIGITAL DICTATION. REFERRAL TO GASTRO MADE AND GRADED AS URGENT. HEAD OF SERVICE FOR DERM AND ADMIN MADE AWARE. ACTIONS BY SERVICE ADMINISTRATOR •Admin Staff to ensure that if there are comments on the clinic sheet to follow up and pass to the relevant secretary. The secretaries to ensure that a fortnightly check of G2 is done for outstanding letters. Spot checks by SA extended to ensure that there is no outstanding dictation on G2 that is older than that recorded on the backlog report.	Clinic 8/6/16 letter states Certainly at this point I am not compelled to proceed with endoscopy. I will ask the GP if they can arrange a helicobacter breath test for this man and if positive eradicate. If he has steroids I would suggest PPI cover		
	Personal Information		screened some time as SEA – Barry wanted Helen to take forward as SEA but I think we need a clinician can we discuss - oesophageal CA see attached info Personal Information patient undergoing OGD as per Barrett's syndrome review on 10 March 2010. Hardcopy histology report stated: special status for P53 highlight the area of concern, strengthening the interpretation of dysplasia. Further biopsies are advised.' GP re- referred patient on 26 May 2015 upon noting the absence of any further review. Histology samples from examination on 17 June 2015 revealed esophageal mucous membrane adenocarcinoma.			
Personal information redacted by the USI	Personal	Personal	Personal Reg YEAR OLD ATTENDED AFTER rta KNEE PAIN XRAY INITIALLY READ BY ED DOCTOR NORMAL OFFICAL REPORT WAS THEN MADE BY REPORTING RADIOGRAPHER 2DAYS LATER REVEALING A FRACTURE. NO REPORT WAS FLAGGED TO SENIOR ED STAFF UNTIL HER ATTENDANCE TO ED PHYSIO ON THE 6TH JANUARY OF WHEN THE OFFICAL REPORT WAS NOTED AND ACTED UPON. NOTE ALSO IS THE LADY DID PHONE HER GP ON THE 29TH DEC WITH INCREASING PAIN AND THE GP WAS NOT ABLE TO PROVIDE PATIENT WITH INFO FROM HER ED ATTENDANCE OR READ THE OFFICAL REPORT FROM THE XRAY SYSTEM	Letter 2/9/15 This lady is now almost 9 months from her operation. She is undergoing physio in Person . With regards to mobilisation she now walks without aids and pain free. She finds that she cannot walk quite as far or as fast as before. The only movement that she has any problems with is walking down stairs when the knee feels a little weak.	Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, Ensure rapid creation and distribution for Name and Date stamp for each Emergency Department Clinician who are responsible for x-ray audit in the Emergency Department. Each patient record to be stamped by Clinician who undertakes the daily audit, Multi-disciplinary process needs to be formalised and documented in relation to the management and processing of abnormal x-ray findings. This process needs to reflect any amendments made in response to this SAI investigation. SHSCT Clinicians to consider making an entry in PACS detailing clinical findings and or management plan. This will support the Radiologists assessment to flag or not to flag any notable findings,	

Personal	Patient 128	01/08/2014 Personal	In August 2012 Personal Pati underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Pati was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Pati did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Pati might have recurrent disease, Pati 's GP referred Pati back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.	RIP Personal	The Review Team recommends a robust system for managing overdue Uro-oncology review is established. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. 3) All radiology reports must be actioned if required and signed off by an appropriate person. 4) A timely discharge letter should be dictated for every Urology patient. 5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker	
Personal	Personal	30th October 2013. Personal	(CAH) with a six month history of painless rectal bleeding. Perso was seen in November 2007 at which time a rigid sigmoidoscopy was carried out and barium enema arranged. This was done on 4th January 2008. The subsequent correspondence to the GP (21/02/08) indicated the barium enema revealed a constant filling defect consistent with pedunculated polyp therefore a flexible sigmoidoscopy would be arranged. Perso underwent colonoscopy on 30th October 2013. An un-resectable 2cm polyp, which was suspicious of malignancy, was noted in the distal sigmoid colon. A 4x3cm soft tissue lesion was seen on CT scan (07/11/13) - malignancy could not be ruled out. On 12th November 2013 Perso underwent a "High anterior resection and right hemi-colectomy". The histology findings confirmed a "Dukes A tumour (adenocarcinoma), and 6mm nodule containing metastatic neuroendocrine carcinoma" within the "high anterior resection" specimen and a "neuroendocrine carcinoma" contained within the "right hemicolectomy". Perso was referred to an Oncologist for further management and was seen on 24th May 2014, treatment was not required at this time.	Letter April 16 Mater Hospital Personal female admitted electively for left hepatectomy. Previous right hemicolectomy and anterior resection in 2013. Asymptomatic on admission. Had been feeling well up until lesions were noted. MRI liver in January showed two masses in segment 1Vb of liver. No intra or post op complications. Post op, pain controlled with paracetamol. Personal is feeling well, eating and drinking, sitting out of bed and mobilising on ward.	Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy Recommendation 2 The current requesting system should be reviewed to incorporate a stringent method for checking that endoscopy requests have been actioned by the secretarial support team. Recommendation 3 Currently General Practitioners receive a regular bulletin from the Trust on current waiting times for each specialities' procedures/investigations. The circulation list should be expanded to include all clinicians so that they are aware of these times, so that when they are explaining the plan for a patient's on-going treatment/investigation, they can give the patient an indication of when to expect an appointment.	
Personal	Personal	Personal	This patient was undergoing bowel investigations. Previous history of Rt hemicolectomy and ileostomy for malignancy. Colonoscopy done on 6/3/14 and 5/4/14 with poypectomys done on both occasions. Patient reviewed by consultant 26/8/14 and patient informed that there evidence of malignant disease in polyps. Patient should have been reviewed in April 2014 with results. Cons informed pt and wife of omission	Letter 28/7/16 I am pleased to say that Personal recent CEA was normal at 2.5. I look forward to seeing him again at his next review appointment.	Creation of Trust-Wide Standard Operating Procedures for the clerical teams in relation to allocation of review appointment following investigative procedures. This will have to include input and support from Clinicians in all specialties to ensure that each procedure reflects each specialty's processes. Creation of Trust-Wide written guidance in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered.	
Personal	Person	Personal HCN	Missed cancer.Anaemia CT Colon- May 14 ? cancer ascending colon.Direct visualisation advised- not booked. Patient presented April 15 Obstructing caecal cancer with Liver mets- likely incurable disease.	Deceased Personal	The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times The Trust- Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis The Trust-Wide Outpatient Consultation Rooms are furnished with Radiology waiting times for routine procedures The SHSCT Induction includes instruction that all Doctors are expected to provide clear and precise instruction in relation to patient review. The SHSCT need to consider formally discouraging the term 'in due course' within every specialty.	
Personal	Perso	Perso	Patient anaesthetised for a procedure. After anaesthetic induced the surgeon decided that surgical intervention was inappropriate and the patient was woken and sent to recovery	Letter 13/12/15 Personal died prior to my post-take ward round after being admitted drowsy and clinically septic. We were away of his metastatic colorectal carcinoma and appropriate comfort measures had been commenced from point of admission and he had been declared not for cardio pulmonary resuscitation. I apologise for the delay in this notification.	Trust-Wide written guidance needs to be created in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered. There needs to be agreement and documented process that if there is a mis-match between proposed/current management, Radiology will electronically flag the abnormal result to the Clinician making the imaging request. There is a fundamental need to ensure that clinicians provide adequate clinical history in a format suitable to PACS and the Radiologist on submission of Radiology requests. The SHSCT need to consider implementation of a Pre Op Investigation Pathway or check list which records current and timely information in relation to prepratory investigations (where relevant). This needs to be available on the day of admission to the medical and nursing staff admitting the patient in an easily accessible format. The action plan needs to include investigations done for NHS patients which are done in the private sector. The SHSCT Radiology team require the current process in relation to the hardcopy circulation of hardcopy x-ray reports to be revised to ensure more timely delivery. Target delivery times for reports, the format of reports need to be agreed and maintained. The action plan needs to include investigations done for NHS patients which are done in the private sector. Acute Services within the SHSCT need to consider training, process map and the utilisation of the 'PACS worklists' option in an effort to support the timely management of radiological requests for clinicians. The Review Panel recommends that there is regular communication or meetings in relation to clinical and radiological mis-matching on both Acute sites in the first instance. These meetings should be open to all specialties to provide a forum to discuss and address any issues around classifications of referral or clinical mis-matches. The action plan needs to include investigations done for NHS patients which are done in the private sector.	
Personal Information	Patient 10	Patient 10	Patient Patient 10 . Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Pati was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the |GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Pati sent OP appointment for 6/1/2016. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Pati was seen in clinic on 6/1/16. the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan.	Letter OPD 16/08/16 Diagnosis: Currently undergoing treatment for breast cancer Complex renal lesion felt likely to be cystic renal cancer Outcome: Outpatient review 8 weeks I reviewed this lady today. She continues on her breast cancer treatment. She tells me her chemotherapy had to be discontinued. I also note she was admitted with an atypical chest infection towards the end of June. Her next treatment is radiotherapy and this is due to start in the next week or two for duration of 5 weeks of treatment. I plan to review her in 8 weeks. She has had a follow up CT scan which was performed during her admission and on this CT scan the renal lesion is unchanged in size. Providing all is well when I see her in 8 weeks I will look to arrange her renal surgery.	Under review	
Personal	Personal	Personal	patient attended with history of fall, facial bruising denied neck tenderness. discharged following asesment and facial bones x rays. attended ED DHH 2 days laer with vomiting. CT brain NAD, no c spine t5enderness, admitted as minor head injury to femaile surgical ward. Ct C spine 23/10/15 showed c spine fracture.	Solicitor letter received regarding compensation	Feedback should be given to relevant staff as a way of informing practice The Emergency Nurse Practitioner Head Injury protocol needs reviewed to define clearly "Minor Head Injury" and advise on the exclusion of additional neck injury in high risk patients	
Personal	Perso	13.05.16	Pe year old attended ED with head injury and neck pain after fall in nursing home. was discharged back to NH after x rays. returned ED 3 days later unwell. admitted UTI, off feet. subsequently established C Spine fracture was not indetified on her initial attendence 12/05/15. patient arrested and died on ward Personal	Died Personal	The report should be shared with operational teams for learning There should be a senior review on vulnerable patients with head/neck injuries .prior to discharge from ED When a patient is required to wait for an extended period of time in the ED for return to a Nursing Home they should have a nursing assessment and care documented. Patients re-attending following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance A full assessment and examination should be carried out on all patients admitted to MAU in a timely manner. The Trust should have appropriate procedures in place for when discharge back to nursing homes is either not appropriate or possible in the out of hour's period. The Trust should create a system for the timely reporting of ED X rays	
Personal	Personal	29/07/2016 Personal	Patient attended gynae OP with intermenstrual and postcoital bleeding on several occasions diagnosis of cervical cancer made on 29/07/2016 investigation and referred onwards to BCH		The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained 3 inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Tim will investigate Might need to involve the GPs surgery Perso	

Southern Health and Social Care Trust

CLINICAL GUIDELINES ID TAG	
Title:	Diagnostic Tests – Including the Requesting Process and Review and Acknowledgement
Author:	
Specialty / Division:	
Directorate:	Acute Services
Approval By:	
Version:	001
Date Uploaded to Trust intranet:	
Review Date	
Clinical Guideline ID	

1.0 Introduction

This Guidance has been developed in response to the introduction within the Trust, during XXXX, of Northern Ireland Electronic Care Record. It sets out clearly the responsibility of clinicians with regard to requesting and acting on the results of diagnostic tests, in line with GMC good medical practice guidance
All the statements in this Policy assume that individuals are acting within the guiding principles of the Data Protection Act, the Trust Access to Medical Records Policy and the Trust Data Protection, Confidentiality and Disclosure Policy.

2.0 Purpose

Diagnostic tests can be used to determine what conditions, diseases or syndromes a patient may currently have or is likely to develop. These tests can be used in a variety of ways including screening, monitoring chronic conditions, suggesting diagnoses, ruling out or confirming suspected diagnoses, monitoring patients following treatment for side effects or recurrence, and predicting future events. Because of the variety of tests employed and the range of professional review and subsequent actions that may occur as a result of testing, there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated.

The intention of this document is to enable all clinical Acute Directorate Trust staff in ensuring that all diagnostic tests undertaken within the organisation are appropriate and managed to minimise the risk to patients and to improve patient outcome and quality of care.

3.0 Definitions

Diagnostic Testing Procedures

This Guidance includes the management of test procedures and results relating to all diagnostic tests including:

- Radiological Imaging: Plain Film X-rays, Other X-Ray procedures,
- CT Scanning, MR Imaging, US Imaging and Isotope Imaging
- Endoscopy
- Pathology tests for all disciplines including Microbiology, Haematology, Biochemistry, Histopathology, Cytology, Immunology, Molecular biology, and Genetics.
- ECGs and other Physiology Measurement Tests such as Lung Function,
- Oeophageal function, Ambulatory Blood Pressure, Ambulatory Rhythm monitors and others

Standing Operating Procedures (SOPs)

A clear, step-by-step instruction of how to carry out agreed actions that promote uniformity to help clarify and augment processes. SOPs document the way activities are to be performed to facilitate consistent conformance to requirements and to support data quality. SOPs provide individuals with the information needed to perform a job properly and consistently.

Independent Contractors

The Trust uses a number of external laboratories and other contractors to provide specific tests or overall services. These external agencies are all subject to appropriate quality control measures and the Trust receives confirmation of their accreditation to undertake such tests. The results received from such independent contractors are entered into Trust systems so that they are available to clinicians through 'Review'.

Accredited Laboratories
See above

4.0 Duties within the Acute Directorate

Director of Acute Services

The Director of Acute Services takes final responsibility for adherence to, and the implementation of all this Guidance Document issued and approved by Acute Clinical Governance Committee

Acute Clinical Governance Committee

The Acute Clinical Governance Committee receives regular reports concerning clinical governance issues within the Acute Directorate, and this should include a report every year concerning the matters related to this guidance, particularly relating to the acknowledgment of receipt of tests, clinical incidents arising from the failure to act on a report and the overall safety of the diagnostic process to include the incorrect attribution of specimens or reports to individual patients.

Any serious incident concerning patient safety, patient confidentiality or data protection should initiate a review well before the issue is raised at the CGC.

The implementation of this policy is supported by the following:

Clinical Directorates and Lead Clinicians

Ensures the development, and adherence to, of local SOPs relating to diagnostic testing procedures and the management of associated risks (see 6.1). Monitors adherence to good Medical Practice with regard to Diagnostic tests

Healthcare and Administrative Staff

All healthcare and administrative staff involved in requesting, receiving, acknowledging and acting on diagnostic tests should be aware of their responsibilities in this role. They will be expected to undertake training as required and agreed. Formal training will be provided with regard to using the electronic processes for Diagnostic tests. Individual clinical departments may need to develop protocols or standing operating procedures (SOPs) to ensure safe and confidential practice.

5.0 Education and Training

All staff engaged by the Acute Directorate who are expected to access the diagnostic test systems will be expected to undergo a period of training to familiarise themselves with the electronic systems. All staff involved in diagnostic testing procedures, particularly junior and senior doctors, nursing and allied health professionals and clinical secretaries should be aware of the competencies needed and the training requirements expected by the organisation. Development of training in this area should be subject to a training needs analysis.
Many areas of diagnostic testing, such as Radiology, Neurophysiology and Endoscopy, are subject to external accreditation processes. The accreditation process is often subject to peer review on a rolling basis. Those leading the peer review process internally require support and training. Peer review itself often highlights further areas for remedial education and training.

All staff will be expected to be aware of their responsibilities in relation to this policy.

This Guidance will be disseminated to all staff through the Directorate Managers and Clinical Directors. All Clinical Leads will be expected to be aware of, and understand their responsibilities in terms of implementing this policy.

6.0 Duties of Clinicians, including Documentation

6.1 Duties of Clinicians (see Reference 2 under '8')

a. In line with Good Medical Practice (GMC), when diagnostic tests are requested details should be noted in the patients' record (electronic or otherwise), and clinicians should ensure that diagnostic tests comply with appropriate protocols for patient assessment
b. When using 'Review' to view results the clinician should document acknowledgment of results by 'Signing Off' electronically. By 'Signing Off' the result a Clinician is indicating that they have noted the result, and have taken appropriate action on the patients' behalf

For critical findings the formal report should be verified and available on PACS/NIECR within 1 hour following communication of the verbal report to the clinician. All reports showing urgent findings should be available by the end of the working day. The majority of reports showing significant and significant unexpected findings should be reported within 24 hours. This recognises that further imaging or a second opinion may be necessary in some cases before a formal report can be issued.

E. Reject inadequately completed requests for studies

The booking clerks should ensure that all received requests are adequately completed. Details of the patient and referrer and renal function/eGFR will be mandatory fields in electronic requesting and request cannot be completed until these are included. Clinical details are added as free text and if insufficient the request will be returned to the referrer for further information. There will be an electronic process for this to occur.

F. Assurance that all results are reported

The radiology department will monitor exams waiting to be reported on a weekly basis. Any unreported exam will be expedited by escalating to the Duty Radiologist or the radiologist to whom it has been assigned.

G. Audit template

Compliance with these recommendations should be audited regularly. An audit template is included in Appendix C. Data could be collected by choosing a site-specific cancer (e.g. lung) and listing all MDT referrals for that cancer site in the last 3-6 months. The radiology reports could then be reviewed to assess if the urgent referral policy has been applied.

H. Accident and Emergency

It is suggested to further define the policy for A and E such that ALL reports where a fracture has been identified will have the phrase 'code red' added to the end of the examination report. These reports will appear in red in results review. Urgent, critical and unexpected findings in patients referred from A and E will also be highlighted as discussed in the above policy.

I. All Radiology Reports should be reviewed by Clinicians according to specific time frames outlined in the 'Management of Diagnostic tests Policy' as approved through CMB and JBD, see Appendix D and 6.1 e).

6.4 Taking Action on Diagnostic Test Results

It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action (such as a Medical Secretary), it is important that they bring this to the attention of someone who can.

Actions taken should be recorded and the method of communication indicated (face to face contact, phone call, letter, e-mail and so on)
Radiology tests requested by hospital clinicians are copied to the GP for information only. It remains the responsibility of the requester to ensure that the result is reviewed and acted upon.

6.5 Documenting Diagnostic Test Results

Retaining test results electronically means there is no need for paper copies to be filed in the notes. However, some Clinical Teams may feel that they wish to retain certain results as a paper copy. They should develop local policies for this.
Otherwise the documentation may be in the form of a flow chart, or a written communication (electronic or paper based) to the patient, another carer, another team or the patient's General Practitioner

6.6 Process for Communication of Diagnostic Test Results

a. It should be made clear to patients as to how and when they should expect to receive the results of a Diagnostic test.
b. The nature of the communication of the result will depend on the test itself and the implications of the result. Clinical teams may develop local policies or guidance around communication of results.

6.7 Audit

An audit of unacknowledged (not 'signed off') results will be undertaken on a regular basis. This will identify those teams or individuals who fail to acknowledge 'XXXX' results within 48 hours or who do not appear to view or sign off their results.

6.8 Equality Impact Assessment

This policy has been equality impact assessed. Please refer to Appendix A

7.0 Monitoring Compliance with the Document

7.1 Process for Monitoring Compliance

Compliance with this policy within local clinical teams or specialty areas will be the responsibility of the Lead Clinician, accountable to their Clinical Director.
The 'Review' system can provide an audit trail of all individuals who have accessed results

How will this be Monitored?

The System Administrator for the 'Review' and 'tQuest' products will be responsible for establishing processes to monitor compliance with acknowledgment. This will be managed through a system of exception reporting, initial reports going to Lead Clinicians and the

Southern Health and Social Care Trust

ACUTE DIRECTORATE

Process for the Reporting of Serious Adverse Incidents (SAI) & Reporting Early Alerts – June 2016 update

When a Serious Adverse Incident (SAI) occurs:

1. **The Staff member, on becoming aware of the incident, must telephone their Line Manager who will notify their Head of Service, Assistant Director and Acute Governance Coordinator.**
   The Staff member must also immediately complete a Trust Adverse Incident Reporting Form (IR1) online via Datix Web. [redacted]

*NB some incidents (e.g. high media profile incidents / homicide / inpatient suspected suicide etc. will require immediate meeting/conference call between AD/ Director/AMD/HoS/Governance Coordinator and subsequent contact with the Chief Executive's Office and Public Relations Department.

An adverse incident is defined as: "*Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'*, arising during the course of the business of a HSC organisation / Special Agency or commissioned service: The following regional criteria will determine whether or not an incident constitutes an SAI. This list is not exhaustive: (if in doubt report!)

4.2.1. Serious injury to, or the unexpected/unexplained death of:
- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2. Unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3. Unexpected or significant threat to provide service and/or maintain business continuity;

4.2.4. Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5. Serious self-harm or serious assault (including homicide and sexual assaults)
- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and / or known to/referred** to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident;;

4.2.6. Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) **and /or known to/referred** to mental health and related services (Including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

4.2.7. Serious incidents of public interest or concern relating to:
- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner

CONTACT DETAILS:

Acute Governance Coordinator: Trudy Reid
Tel: [redacted] or [redacted]
E-mail: [redacted]

Connie Connolly: [redacted]

Medicine & Unscheduled Care:-
Anne McVey (Asst Dir): [redacted]

Heads of Service
(HoS) Mary Burke: [redacted]
(HoS) Kay Carroll: [redacted]
(HoS) Katriona McGoldrick: [redacted]
(HoS) Louise Devlin: [redacted]

Surgery & Elective Care and Anaesthetics Theatres Intensive Care Services
Ronan Carroll (Asst Dir): [redacted]

Heads of Service
(HoS) Martina Corrigan: [redacted]
(HoS) Amie Nelson: [redacted]
(HoS) Brigeen Kelly: [redacted]
HoS) Mary McGeough: [redacted]

Integrated Maternity & Womens Health and Cancer & Clinical Services:
Heather Trouton (Asst Dir): [redacted]

Heads of Service.
(HoS) Patricia McStay: [redacted]
(HoS) Brian Magee: [redacted]
(HoS) Fiona Reddick: [redacted]
(HoS) Jeanette Robinson: [redacted]

Function Services:
Anita Carroll (Asst Dir): [redacted]

Pharmacy:
Tracey Boyce (director of pharmacy: [redacted]

2. EARLY ALERT PROCESS:

The decision about activating the DHSSPSNI/HSC BOARD "Early Alert"(EA) process will be **taken solely by the Director / Assistant Director** (*following discussion with the Governance Coordinator and Head of Service) in order to ensure that DHSSPSNI and/or the HSC Board are notified as appropriate. (The purpose of the Early Alert System is to ensure that the Trust notifies DHSSPSNI and HSC Board in a **timely way** of any issues that may require the attention of the Minister or the Chief Officers.

Current Regional Early Alert criteria are:

1. **RISK & WIDER HSC:** Urgent regional action is required by the DHSSPS e.g. where risk identified that could impact on the wider HSC service or systems.

2. **TRUST NEED TO CONTACT PATIENTS/CLIENTS re HARM/POTENTIAL HARM:** The Trust is going to contact a number of patients or clients about harm or possible harm that has occurred as result of care they received.

3. **TRUST TO ISSUE PRESS RELEASE RE HARM/POTENTIAL HARM:** The Trust is going to issue a press release about harm or potential harm to patients or clients (may relate to one patient or client)

4. **MEDIA ENQUIRY ABOUT EVENT:** The media have enquired about the event

5. **PSNI INVOLVED IN INVESTIGATION OR DEATH/SERIOUS HARM:** The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service (where there are concerns that a HSC service or practice issue whether by omission or commission may have contributed to or caused the death of a patient or client)

(this **does not include any deaths routinely referred to the Coroner** unless there has been an event which has given rise to a Coroner's investigation; or evidence comes to light during Coroner's investigation or inquest which suggests possible harm was caused to patient as result of treatment or care they received or the coroner's inquest is likely to attract media interest.)

6. **IMMEDIATE SUPENSION OF STAFF** There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

7. **DEATH/SIGNIFICANT HARM – CHILDRENS SERVICES**
   a. Always notify the following
      - Death of or significant harm to a child, and abuse or neglect are known or suspected toe a factor;
      - Death of or significant harm to a Looked after Child or a child on the Child Protection Register;
      - Allegation that a child accommodated in a children's home has committed a serious offence;
      - Any serious complaint about a children's home or person working there.

3. ROLES & RESPONSIBILITIES

All Staff
Report the incident immediately & verbally to line management & also via Datix, after taking all immediate, appropriate, reasonable and proportionate actions to minimise the likelihood of the incident recurring. The situation must be made safe.

Assistant Director / Heads of Service via their Team Leaders / Ward & Facility Managers will ensure that:

- Ensure isolation & centralization of healthcare notes / all relevant documentation (if applicable). Original notes are to be sent to the Acute Governance Department, CAH.
- Where appropriate and where it would be beneficial to assist in the investigation of the incident, photographs should be taken and retained as evidence – this is particularly useful in Health and Safety type incidents or where damage had occurred to property
- CCTV footage should be sourced and a copy made for all cases which would be subject to PSNI investigation or where CCTV can assist with immediate review of events e.g. AWOLs etc.
- Security staff and/or the PSNI should be informed immediately, where appropriate. PSNI advice should be followed until directed otherwise by them e.g. where they advise to cordon off a specific area/room etc. Staff should document the content of conversations/interaction with PSNI.
- Consideration should be given to the need to activate site based emergency / contingency plans if necessary (in line with current emergency procedures).
- An immediate debrief is conducted and any staff support requirements are identified, offered and /or provided in a timely manner.(see Appendix 1)
- In liaison with the Governance Coordinator ensure that the SAI review is completed and a report is provided to the Director / Assistant Director for submitting to all relevant agencies where applicable e.g. RQIA/HSC Board/Coroner.
- Ensure that any SAI review action plan/recommendations are implemented & monitored and that any learning is disseminated appropriately. The HOS will provide regular updates to the relevant governance fora on the implementation of recommendations.

The Acute CSC Governance Office in liaison with the reporting staff member(s) / Head(s) of Service / Assistant Director / Director / AMD will:-

1. Notify Chief Executive's office and Communications Department *where appropriate.

2. Assist the Assistant Director / Director in reporting an Early Alert, if required.

3. Report the SAI to all relevant bodies within the required timescales via the Corporate Governance Office.

4. Coordinate **all stages** of the SAI review process including service user/family engagement and report compilation/submission process.

5. Maintain central coordination function between Acute and other departments/agencies e.g. Litigation Dept. (who process requests from coroner for statements/casenotes); Health & Safety Dept.; nominated PSNI liaison person etc.; HSCB/RQIA/DHSS. All communications with external agencies should be issued via the Governance Office.

6. Liaise with the Trust's Lead Social Worker for Adult Safeguarding, Professional Governance and external agencies where appropriate.

APPENDIX 1
ACUTE DIRECTORATE

Brief Guidance on supporting Acute staff during the respectful management and review of an adverse incident / serious adverse incident –

The Trust promotes an open, just, honest and participatory culture in which adverse incidents can be reported, discussed and reviewed without fear of reprisal. This enables lessons to be identified; allows for active learning to take place and the necessary changes made to improve our services and practices. A key part of that culture involves the need to respectfully support staff during the adverse incident management and investigation/review process.

Staff Support
Depending upon the nature and circumstances of an adverse incident the levels of support required by staff will vary. Such support can be provided by line managers in a number of ways, for example:

- Providing immediate assistance/aid if required.
- Contacting the relevant staff member(s) as soon as possible following the incident to discuss same.
- Facilitating an immediate informal and/or formal debrief of the staff / team involved in the incident allowing sufficient time to do so. This should include providing staff with the opportunity to discuss their involvement and/or the circumstances leading up to the incident and how they feel about it.
- Reaffirming confidence in staff and not apportioning blame or accountability either directly or inferred.
- Informing staff of the Directorate's processes in relation to incident investigation / review; keeping staff informed of likely next steps in that process; the rationale for same, and, informing staff of who they can contact for advice including the Acute Governance Office on Tel 028 3861 2932 who coordinate all serious adverse incident reviews. In some circumstances staff may be required to prepare a statement as part of the incident investigation/review data gathering process. Where this is the case support for development of such statements may be provided by the Acute Governance Office, the Trust Litigation Department, Trust Legal Advisors or via the appropriate professional bodies.
- Being visible to all staff members. Physical presence by line managers post-incidents helps decrease anxiety related to an investigation/review and provides an accessible resource for clarification of any issues staff may have.
- Providing information on the Trust and external support systems currently available for staff who may be distressed by incidents. This includes counselling services offered by professional bodies; stress management courses; Occupational Health Services, Carecall or Hospital Chaplains.
- For incidents involving Violence and Aggression, refer to the MOVA Guide to Post Incident Management Support, Reporting and Analysis (click here).
- Providing feedback to staff at the different stages of an investigation/review and in particular in relation to the outcome(s) of incident investigations / reviews and any lessons learned.

USEFUL CONTACT NUMBERS
In addition to contacts within your operational team:

Name - Role	Contact Details
Trudy Reid (Acute Clinical & Social Care Governance Coordinator)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Karen Wasson / Marian Fitzsimons (Litigation Department)	Personal Information redacted by the USI or Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Carmel Harney (Assistant Director AHP Governance, Workforce Development & Training)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Fiona Wright (Assistant Director for Nursing Governance)	Personal Information redacted by the USI or Tel Personal Information redacted by the USI
Lynn Fee (Assistant Director of Nursing Workforce Development & Training)	Personal Information redacted by the USI or Tel: Personal Information redacted by the USI
Ray King Head of Health & Safety SHSCT	Personal Information redacted by the USI
Victim Support Northern Ireland	028 9024 4039 or 0845 3030 900
Citizens Advice Bureau	028 9023 1120
Community Safety Unit	028 9082 8555
Care call	0808 800 0002
Samaritans	0845 790 9090
The Compensation Agency	028 9024 9944
Law Society of Northern Ireland	028 9023 1614
Trade Union Side Office, Newry	028 3083 5166
Catriona Campbell - Occupational Health –	Personal Information redacted by the USI
Management of Violence & Aggression (MOVA) Specialist Advisors for MHD - Eamonn Hughes / Margaret Tierney	Personal Information redacted by the USI
Anne Coyle – Bereavement Co-ordinator	Personal Information redacted by the USI or Personal Information redacted by the USI
Edel Corr – Quality & Patient Support manager	Personal Information redacted by the USI (Craigavon Hospital Office Tuesday – Friday) Personal Information redacted by the USI (Daisy Hill Hospital Office Mondays only)

Urology	**Consultant**	
SAI 52720	Mr O'Brien	SAI review
SAI 69120	Mr O'Brien	SAI review
SAI 69120	Mr O'Brien	SAI review
SAI 69120	Mr O'Brien	SAI review
SAI 69120	Mr O'Brien	SAI review
SAI 69120	Mr O'Brien	SAI review
SAI 69133 & complaint 7118	Mr O'Brien	SAI review Complaint response
Complaint7872	Mr Glackin	Complaint response
SAI 82964	Mr O'Brien	SAI review
SAI 42161	Mr R Suresh	SAI review
SAI 83235	Mr Glackin	SAI review
Review of care		Review of Care
Screening – MDM process	Mr Young	Letter sent to Mr Young following screening regarding the MDT process.

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	17:17

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	17/11/2014
Time (hh:mm)	14:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient was waitlisted for removal of ureteric stent on 17/11/2014, This request was registered in the book in stone treatment centre. A green booking form was also filled in at the same time. But this was overlooked. Patient had to have the stent in unnecessarily too long.
Action taken Enter action taken at the time of the incident	He was reviewed in clinic today and realised that the stent was still ins itu. Arranged to remove the stent only today.
Learning Initial	
Reported (dd/MM/yyyy)	30/03/2015
Reporter's full name	Kothandaraman Suresh
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	14/04/2015
Last updated	Martina Corrigan 09/07/2015 12:32:31
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 136

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Clinical Area
Loc (Exact)	X-ray Dept (Radiology)
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job title	Originated from
Trouton, Heather	Personal Information redacted by the USI	30/03/2015 17:18:15	Personal Information redacted by the USI		Assistant Director of Acute Services	Level 1 Form
Connolly, Connie	Personal Information redacted by the USI	30/03/2015 17:18:15			Acting Acute Governance Co-Ordinator	Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	Eamon.Mackle Personal Information redacted by the USI	30/03/2015 17:18:15				Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	caroline.moorcroft Personal Information redacted by the USI	30/03/2015 17:18:14				Level 1 Form
Smyth, Paul	Personal Information redacted by the USI	30/03/2015 17:18:14			Head of Unscheduled Care	Level 1 Form
Corrigan, Martina	Personal Information redacted by the USI	30/03/2015 17:18:13			Head of ENT and Urology	Level 1 Form
Glenny, Sharon	Personal Information redacted by the USI	30/03/2015 17:18:13			Operational Support Lead	Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	cathy.rocks Personal Information redacted by the USI	30/03/2015 17:18:13				Level 1 Form
Newell, DeniseE	Personal Information redacted by the USI	30/03/2015 17:18:12			Head of Diagnostic Services	Level 1 Form
Graham, Andrene	Personal Information redacted by the USI	30/03/2015 17:18:12			Modality Lead	Level 1 Form

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	

Date of final approval (closed date) (dd/MM/yyyy)	07/09/2015
Date Notification Sent to External Agency	
Date Terms of Reference Due	
Date SAI Report Due	
SAI Level (1,2 or 3)	
External Agency SAI Ref No.	
Date SAI Report Sent to External Agency	
Date SAI Report Shared with Family/NOK	
Date HSCB/RQIA/Coroner Queries Received	

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	Treatment, procedure
Sub Category	Urinary
Detail	Delay

Datix CCS2

Type	
Category	
Sub-Category	
Detail	
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?
Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI? Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.	No
Is this incident RIDDOR reportable?	No

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition): 1. Employee or self-employed person working on Trust premises is killed or suffers a major injury 2. A member of the public on Trust premises is killed or taken to hospital 3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work) 4. Dangerous Occurence attributable to the work of the Trust 5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease	
Is this a NIAIC Incident NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable; - design or manufacturing problems - inadequate servicing and maintenance - inappropriate local modifications - unsuitable storage and use conditions - selection of the incorrect device for the purpose - inappropriate management procedures - poor user instructions or training (which may result in incorrect user practice	No

Investigation

Investigator	Martina Corrigan

Date started (dd/MM/yyyy)	07/09/2015
Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Minor

Risk grading
Click here

When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	◉	○	○	○
Unlikely (Expected to occur annually)	○	○	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○
	Grade: Medium Risk				

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	040915KR- PAS interogatition confirmed that the green form had been actioned on PAS. Therefore this is not an admin issue. The wait is related to capacity. Communication email sent to HOS to comment and close
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	No

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	discussed at Urology departmental and governance meetings and a new process agreed that all patients that have a stent fitted need to be added to a waiting list with a planned date to come in
Date investigation completed (dd/MM/yyyy)	07/09/2015
Was any person involved in the incident?	No
Was any equipment involved in the incident?	No

Notepad

Notes
Use this section to record any efforts you have made as part of your investigation e.g. phonecalls

MAJOR / CATASTROPHIC INCIDENT CHECKLIST [redacted]

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	
Incident (IR1) ID:	**Complaint requires datix to be completed**
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	Mr R Carroll Mr C Weir Coordinator Mrs T Reid
If Incident involved the death of a service user, was the coroner informed:	**No**
Brief Summary of Incident:	[redacted] had a history of metastatic colorectal cancer, small volume lung metastases and a left pelvic mass associated with ureteric obstruction. [redacted] was considered for palliative pelvic radiotherapy in July 2016, urology stents management was required prior to radiotherapy; there was a delay in the management of stents. In December 2016 radiotherapy was no longer considered an option for [redacted]. [redacted] died [redacted]
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	The review team considered there was sufficient failings in systems and processes including communication within the urology department to require a SAI review.

Decision on Level Review Type AND rationale for this:	Level 1 SAI
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☒ ☐ NO
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal Review :	

Southern Health and Social Care Trust

APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: 10/07/2016

HSCB Unique Case Identifier: [redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: (M) Age: ([redacted] yrs)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 27 January 2020

[redacted]

9.0 RECOMMENDATIONS AND ACTION PLANNING

correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4

The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB

Recommendation 5

In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6

The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Melanie McClements, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

Patient 16 [redacted]" family

Patient 16

David Cardwell

SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.

Incident Details
ID & Status

Incident Reference ID	Personal Information
Submitted time (hh:mm)	20:25

Incident IR1 details

Notification email ID number	Personal Information
Incident date (dd/MM/yyyy)	20/11/2014
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102's Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr H for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondance created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.
Connie Connolly 18/11/2015 14:31:09	PATIENT DISCUSSED AT UROLOGY M
Action taken Enter action taken at the time of the incident	Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.
Learning Initial	
Reported (dd/MM/yyyy)	21/10/2015
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	18/11/2015
Were restrictive practices used?	
Does this incident involve a safeguarding concern which is alleged/confirmed?	
Has safeguarding been considered?	
Has an APP1 been completed?	
Last updated	Andrew Noble 01/31/2023 13:50:39
Andrew Noble 31/01/2023 13:50:39	David Cardwell 06/17/2016 09:17:40
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 102

Location of Incident

			s there was no correspondence for the appointment – so it wa sn't that the secretary didn't type it – I think it was that it was n't dictated so that would need to go to Head of Service for ur ology to discuss with consultant. Regards David Cardwell Pleas e go to http://vsrdatixweb/Datix/Development/index.php?actio n=incident&recordid=[redacted] to view the incident	
18/11/2015 14:29:44	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Martina- i have take n this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if neede d. Connie Please go to http://vsrdatixweb/Datix/Development/ index.php?action=incident&recordid=[redacted] to view the incide nt	
18/11/2015 14:29:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Martina- i have take n this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if neede d. Connie Please go to http://vsrdatixweb/Datix/Development/ index.php?action=incident&recordid=[redacted] to view the incide nt	
18/11/2015 14:29:43	Connolly, Connie	Corrigan, Ma rtina	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Martina- i have take n this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if neede d. Connie Please go to http://vsrdatixweb/Datix/Development/ index.php?action=incident&recordid=[redacted] to view the incide nt	
18/11/2015 14:29:43	Connolly, Connie	Robinson, Ka therine	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Martina- i have take n this back to SEC as it appears no dictatation was done. Will need review by yourself and governance will support if neede d. Connie Please go to http://vsrdatixweb/Datix/Development/ index.php?action=incident&recordid=[redacted] to view the incide nt	
18/11/2015 11:41:44	Connolly, Connie	Mark.Haynes [redacted]	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gav e access to all. Moved to review Connie Please go to http://vsr datixweb/Datix/Development/index.php?action=incident&reco rdid=[redacted] to view the incident	
18/11/2015 11:41:43	Connolly, Connie	Robinson, Ka therine	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gav e access to all. Moved to review Connie Please go to http://vsr datixweb/Datix/Development/index.php?action=incident&reco rdid=[redacted] to view the incident	
18/11/2015 11:41:43	Connolly, Connie	Forde, Helen	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gav e access to all. Moved to review Connie Please go to http://vsr datixweb/Datix/Development/index.php?action=incident&reco rdid=[redacted] to view the incident	
18/11/2015 11:41:42	Connolly, Connie	Carroll, Anita	This is a feedback message from Connie Connolly. Incident for m reference is [redacted]. The feedback is: Hi all- i have moved this to FSS for investigation and close. There may be 2 teams which cross over in relation to this issue. I wasnt sure so i gav e access to all. Moved to review Connie Please go to http://vsr datixweb/Datix/Development/index.php?action=incident&reco rdid=[redacted] to view the incident	

Medication details

Stage

incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	17/06/2016
David Cardwell 17/06/2016 09:17:40	<no value>
Incident Grade	
Date Notification Sent to External Agency	
Date Terms of Reference Due	
Date SAI Report Due	
SAI Level (1,2 or 3)	
External Agency SAI Ref No.	
Date SAI Report Sent to External Agency	
Date SAI Report Shared with Family/NOK	
Date HSCB/RQIA/Coroner Queries Received	

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	Access, Appointment, Admission, Transfer, Discharge
Andrew Noble 31/01/2023 13:50:39	<no value>
Sub Category	Transfer
Andrew Noble 31/01/2023 13:50:39	<no value>
Detail	Transfer - delay/failure
Andrew Noble 31/01/2023 13:50:39	<no value>

Datix CCS2

Type	Patient Incidents
Andrew Noble 31/01/2023 13:50:39	<no value>
Category	Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)
Andrew Noble 31/01/2023 13:50:39	<no value>
Sub-Category	Monitoring/On-going Assessment of Patient Status
Andrew Noble 31/01/2023 13:50:39	<no value>

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the
Submitted time (hh:mm)	13:43

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	17/05/2017
Time (hh:mm)	16:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at MDM 12th January 2017. Outcome = to be referred to endocrine MDM. Unfortunately this did not happen. Further GP referral 12/5/17 brought this to my attention and a referral has now been done.
Action taken Enter action taken at the time of the incident	Referral made to endocrine MDM on 17/5/17 (4 month delay). See ECR for relevant letters etc.
Learning Initial	
Reported (dd/MM/yyyy)	18/05/2017
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	23/11/2017
Were restrictive practices used?	
Does this incident involve a safeguarding concern which is alleged/confirmed?	
Has safeguarding been considered?	
Has an APP1 been completed?	
Last updated	Martina Corrigan 12/05/2017 16:14:55
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 137

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

INCIDENT CHECKLIST **Name: -** Patient 137

Directorate:	**Acute Services**
Reporting Division:	**Acute**
Date of Incident:	**12/01/2017**
Incident (IR1) ID:	Personal Information redacted by the USI
Grade of Incident:	**Major**
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	**Mr R Carroll** **Mr C Weir** **Mrs P McAloran** **Mrs T Reid (facilitator)** **Mr Haynes AMD**
If Incident involved the death of a service user, was the coroner informed:	**NA**
Brief Summary of Incident:	Patient 137 had a CT on 20/12/2016 IN SWAH with a coincidental finding of 'A large fatty tumour in the left perirenal space which may be in keeping with an angiomyolipoma with extrarenal growth. Differential diagnosis should include liposarcoma, adrenal teratoma or adrenal myelolipoma. Specialist referral is advised' Patient 137 was referred to CAH urology. Patient 137 was 'discussed' at the urology MDM and referral was to be made to endocrine team. This referral was not made; on the 12/5/2017 GP letter was received highlighting [redacted] Patient 137 had not received an appointment.

Southern Health and Social Care Trust
Quality Care - for you, with you

14 August 2018 Ref: Datix: [redacted] ID: [redacted]

Private and Confidential

Mr Michael Young
Consultant Urologist

Re: [redacted]

Dear Michael

This Datix Report has been reviewed by the Surgical Adverse Incident Screening Panel, of Mr M Haynes, Mr R Carroll and Mrs T Reid on Tuesday 9th January 2018 in relation to the delay in referring [redacted] to the Endocrine Service in the Belfast Health and Social Care Trust.

On 12th January 2017 [redacted] was discussed at the Urology MDM. Please see attached Appendix 1- Urology MDM outcome.

This MDM outcome was not actioned, and on the 12th May 2017 [redacted]'s GP sent a referral letter to Urology highlighting that [redacted] had not received an appointment. On receipt of this letter a referral was then made to Endocrinology by another consultant Urologist on 18th May 2017.

The review team concluded that following MDM, any actions must be progressed by the Consultant nominated as responsible for the action required as per the MDM outcome report. Referrals for specialist care need to be sent from Consultant to Consultant.

Can you provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner?

Yours sincerely

[redacted]

Mark Haynes

Associate Medical Director

TRU-178398

Mr Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	[redacted]
Submitted time (hh:mm)	15:50

Incident IR1 details

Notification email ID number	[redacted]
Incident date (dd/MM/yyyy)	25/10/2018
Time (hh:mm)	12:18
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient details - [redacted] GP phoned Mr Glackin's Secretary on 25.10.18 to enquire about patients follow up. Secretary looked into patients history and it was discovered that this patient had their bladder surgery but that patients pathology had not been discussed at the Urology MDM, which takes place on a weeks basis. The secretary then phoned the urology cancer tracker to advise of same and asked why and how this had happened. The tracker looked into the patients details on CaPP's (System used to track suspect and confirmed cancers) and could see that patient was listed for MDM discussion on 28.12.17 (virtual MDM) but outcome was to defer to the next week with pathology, which was not available at that time, Unfortunately due to human error the tracker did not schedule patient for discussion the following week and patient was overlooked. The patients episode was closed off on CaPP's as they had underwent their first definitive treatment so this oversight was not picked up via tracking. As this patient was not discussed at MDM there was no post surgical review appointment arranged and no follow up procedures arranged, if deemed necessary as per Consultant.
Action taken Enter action taken at the time of the incident	I initially spoke with tracker to establish what had happened. Escalated what had happened to OSL and how this had happened. Fully investigated patients pathway. Advised Tracker to list for MDM discussion for 01.11.18. Secretary advised Consultant of what had happened - advised that OP appointment was to be arranged. This was booked for 29.10.18. Failsafe for all trackers is currently being worked on to prevent this happening in the future.
Learning Initial	?
Reported (dd/MM/yyyy)	30/10/2018
Reporter's full name	Vicki Graham
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	30/10/2018
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	[redacted]

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Support Area
Loc (Exact)	Admin Floor
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Glenny, Sharon	[redacted]	30/10/2018 15:50:38	[redacted]		Operational Support Lead
Reddick, Fiona	[redacted]	30/10/2018 15:50:38			HOS : Cancer Services
Litte, Alison	[redacted]	30/10/2018 15:50:38			Risk Midwife
McAloran, Paula	[redacted]	30/10/2018 15:50:38			Senior Governance Officer
Reid, Trudy	[redacted]	30/10/2018 15:50:38			Interim Assistant Director of Corporate Governance

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	Brigeen Kelly Sharon Glenny
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send	

We can discuss at our next meeting which I think is 21 Feb.

Barry.

From: Glenny, Sharon
Sent: 31 January 2019 11:33
To: Carroll, Ronan; Conway, Barry
Cc: McAloran, Paula; Kingsnorth, Patricia; Clayton, Wendy
Subject: RE: SEC screening Patient 138 H&C Personal Information redacted by the USI Datix Personal Information redacted by the USI

Hi Ronan

Our Trust Cancer Performance Meeting was cancelled last week in view of the fact we had the Regional Cancer Performance Meeting.

We will keep this on the agenda though for the next meeting in February.

Vicki – can you add this as an agenda item please.

Thanks

Sharon

From: Carroll, Ronan
Sent: 31 January 2019 11:18
To: Glenny, Sharon; Conway, Barry
Cc: McAloran, Paula; Kingsnorth, Patricia; Clayton, Wendy
Subject: FW: SEC screening Patient 138 H&C Personal Information redacted by the USI Datix Personal Information redacted by the USI
Importance: High

Sharon/Barry
I don't recall we discussed this at last performance meeting.
What systems/reports are employed in the other 4 trusts to prevent this happening?
Ronan

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

From: McAloran, Paula
Sent: 29 January 2019 15:21
To: Carroll, Ronan
Cc: Kingsnorth, Patricia
Subject: FW: SEC screening Patient 138 H&C Personal Information redacted by the USI Datix Personal Information redacted by the USI

Re: Patient 138 H&C Personal Information redacted by the USI

Ronan

As per email below, This is the performance meeting I was asking about earlier.

Kind Regards
Paula

Paula McAloran
Senior Governance Officer
Admin Floor Craigavon Area Hospital, Craigavon BT63 5QQ.
Extension [redacted]
External Number [redacted]

From: Carroll, Ronan
Sent: 15 January 2019 15:11
To: Glenny, Sharon; McAloran, Paula; Reid, Trudy
Cc: Kingsnorth, Patricia; Haynes, Mark; Scullion, Damian; Conway, Barry
Subject: RE: SEC screening [redacted] H&C [redacted] Datix [redacted]

Sharon
Happy if we all discuss at next Thursday performance
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]
Ext [redacted]

From: Glenny, Sharon
Sent: 15 January 2019 15:03
To: McAloran, Paula; Reid, Trudy
Cc: Kingsnorth, Patricia; Carroll, Ronan; Haynes, Mark; Scullion, Damian; Conway, Barry
Subject: RE: SEC screening [redacted] H&C [redacted] Datix [redacted]

Hi Paula

The cancer tracker team was met with following this incident and I can confirm that this was entirely human error and the tracker was extremely distressed about it.

Once a patient is closed on the cancer pathway, the tracker will not be prompted to follow up on any actions.

Ronan - to improve systems and processes should we explore the possibility of a having a report set up on Business Objects which will pull out all the patients which have been closed on CaPPs during a certain time period and reasons for closing which can be screened by MDM/consultants?

Thanks

Sharon

From: McAloran, Paula
Sent: 15 January 2019 12:06
To: Glenny, Sharon; Reid, Trudy
Cc: Kingsnorth, Patricia; Carroll, Ronan; Haynes, Mark; Scullion, Damian; Conway, Barry
Subject: FW: SEC screening Patient 138 H&C Personal Information redacted by the USI Datix Personal Information redacted by the USI

Dear all
Can you please provide an update.

Kind Regards
Paula

Paula McAloran
Senior Governance Officer
Admin Floor Craigavon Area Hospital, Craigavon BT63 5QQ.
Extension Personal Information redacted by the USI
External Number Personal Information redacted by the USI

From: Reid, Trudy
Sent: 09 December 2018 21:16
To: McAloran, Paula
Subject: FW: SEC screening Patient 138

Did we ever get an update
Trudy

From: Conway, Barry
Sent: 28 November 2018 12:26
To: Carroll, Ronan; McAloran, Paula; Haynes, Mark; Scullion, Damian
Cc: Reid, Trudy
Subject: RE: SEC screening Patient 138

Dear all – Sharon is following up and we will update on this soon.

Barry.

From: Carroll, Ronan
Sent: 27 November 2018 15:38
To: McAloran, Paula; Haynes, Mark; Scullion, Damian
Cc: Reid, Trudy; Conway, Barry
Subject: RE: SEC screening Patient 138
Importance: High

Paula
Reading the attachment this is a human error at tracking/mdm level.
From this lesson what have we put in place to reduce the risk of reoccurrence
Ronan

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

Screening Form Name Patient 138 Personal Information redacted by the USI

Directorate:	**Acute Services**
Reporting Division:	**sec**
Date of Incident:	
Date of Screening	
Incident (IR1) ID:	
Grade of Incident:	
Names / Designations of those considering Incident: *(Should include Director, Assistant Director, AMD & CSCG Coordinator)*	
If Incident involved the death of a service user, was the coroner informed:	
Brief Summary of Incident:	Patient had TURBT 22/12/17 was listed for MDM 28.12.17 (virtual MDM) patient was closed on cancer tracker system and not followed up until GP phoned to enquire 25/10/18. Histology report 28/12/17 showed Transitional cell carcinoma.
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	For screening. Red Flag team investigating for timeline 19.11.18 For Screening 18/12/2018 Trudy discussed with Mark Haynes. 15/01/2019 Email to Sharon Glenny & Trudy for update. 30/01/2019 see emails from Trudy Reid and Sharon Glenny.

	30/01/2019- Datix feedback. This issue was raised at the Regional Cancer Performance meeting and it was agreed that the AD for cancer services would place the responsibilities of trackers on the regional Cancer meeting and an agreement shared with all Trusts. 19.2.19 Discussed at screening-Close. 25.2.19. Discussed with Mr Haynes. Patient did not come to any harm. CLOSE.
Decision on Level Review Type AND rationale for this:	
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	
Is it appropriate to inform the Medical Executive/Executive Directorate of Nursing?	☐ Yes ☐ NO
Contact for service user and / or designated relatives / carers: *(Either Lead Professional or Chair of Review)*	
Date and by whom service user and / or designated relatives / carers informed of review taking place:*(If there is an exceptional case where this is inappropriate rationale must be documented):*	
If case referred to the Coroner - Date and by whom coroner informed of SAI / Internal	

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Personal Information redacted by USI

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

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

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Personal Information redacted by USI
Importance: High

Can we discuss please?

Thanks

Martina

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

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Personal Information redacted by USI
Importance: High

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

Sent from my BlackBerry 10 smartphone.

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

From: Reid, Trudy
Sent: 06 September 2023 16:25
To: Reid, Trudy
Subject: FW: URGENT : Final reminder - DRO query - TOR and Team Membership - Trust Ref: SHSCT SAI Personal Information redacted by the HSCB Ref: Personal Information redacted by

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From: Reid, Trudy <T[Personal Information redacted by the USI]>
Sent: 03 June 2016 10:18
To: Farrell, Roisin <[Personal Information redacted by the USI]>
Subject: RE: URGENT : Final reminder - DRO query - TOR and Team Membership - Trust Ref: SHSCT SAI Personal Information redacted by the HSCB Ref: Personal Information redacted by

Roisin I spoke with the DRO and we discussed the case at length, he appeared content with the team we membership we suggested, he did state we may during the review want to take the opportunity to ask for an independent opinion if the team felt it useful, particularly in relation to X-ray, however he did appear content that we start the SAI without an external representative

Regards,

Trudy

Trudy Reid
Acute Clinical & Social Care Governance Coordinator
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

From: Farrell, Roisin
Sent: 03 June 2016 09:42
To: Reid, Trudy
Subject: FW: URGENT : Final reminder - DRO query - TOR and Team Membership - Trust Ref: SHSCT SAI Personal Information redacted by HSCB Ref: Personal Information redacted by

Hi Trudy
From the email below the DRO has suggested the Trust consider adding someone from outside the Trust to sit on the review panel.
Connie has said that you have spoken to the DRO at length and he is happy for the Trust not to include an external member to the review team.

Can you please give me a line to send to the DRO regarding your telephone call and what was agreed.

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 13 November 2017 18:01
To: Gishkori, Esther
Subject: RE: CONFIDENTIAL SAI

Dear Esther it is the chair of the M&M. I will discuss with litigation and request some advice.
Happy to discuss

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Administration Floor
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

From: Gishkori, Esther
Sent: 13 November 2017 15:12
To: Reid, Trudy
Subject: RE: CONFIDENTIAL SAI

Trudy,
I know we talked about this but just to clarify, this is the chair of the investigation and not the chair of the organisation?
Also, I wonder if we should check with the legal team about this. If our documents are public then he can see them but I'm not sure if all correspondence would fall into this category.
Many thanks
Esther.

From: Reid, Trudy
Sent: 10 November 2017 16:00
To: Trouton, Heather; Carroll, Ronan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: CONFIDENTIAL SAI

Good afternoon as you are aware we are doing an SAI on a number of patients where triage and waiting list management may have been a contributing factor.
The Chair has asked for any previous correspondence/investigation/action in relation to AOB triage and waiting list management.
I wonder if you could assist in identifying any of the above documentation

From: Reid, Trudy [redacted]
Sent: 28 November 2017 15:14
To: Carroll, Ronan; Corrigan, Martina
Cc: Gishkori, Esther; Boyce, Tracey; Haynes, Mark
Subject: RE: URGENT -AOB

Dear Ronan happy to discuss, however previous management of triage etc. may have had an influence on these patients triage and possible outcomes, from the meetings this appears to be Dr Johnston's view and therefore he feels relevant to this SAI.

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Administration Floor
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone [redacted]
Mobile [redacted]

From: Carroll, Ronan
Sent: 28 November 2017 15:03
To: Reid, Trudy; Corrigan, Martina
Cc: Gishkori, Esther; Boyce, Tracey; Haynes, Mark
Subject: RE: URGENT -AOB
Importance: High

Trudy
Can I ask that this SAI is 'tight' on its remit.
We have a another Trust process which will pick up on several of the questions being asked
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Reid, Trudy
Sent: 28 November 2017 12:26
To: Corrigan, Martina
Cc: Carroll, Ronan; Gishkori, Esther; Boyce, Tracey
Subject: URGENT -AOB

Martina for the SAI process Dr Johnston has asked for some further information

Could we please get AOB sick leave for the period our SAI ? November 2016 – April 2017

Is there a formal report on the look back exercise?

Do you know how many were upgraded to RF in total?

What was the longest referrals re-triaged?

Do you remember who had discussions regarding AOB

Do you have an action plan for the Patient 10 SAI?

Regards,

Trudy

Trudy Reid
Acute Clinical & Social Care Governance Coordinator
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

Toal, Vivienne

From: OKane, Maria [redacted]
Sent: 12 May 2019 14:08
To: Reid, Trudy; Gibson, Simon; Haynes, Mark; Toal, Vivienne; Corrigan, Martina; Carroll, Ronan; Montgomery, Ruth
Subject: RE: [SECURE REPLY] Encryption : Urology draft report -encryption

Ruth - could you set up a meeting as soon as possible with the above or reps of please to discuss this please- I have some concerns about the quality of the report- I will forward and can be password protected with UROLOGY -SAI thanks maria

Dr Maria O'Kane
Medical Director
Tel: [redacted]

-----Original Message-----
From: Reid, Trudy
Sent: 09 May 2019 22:17
To: OKane, Maria
Subject: FW: [SECURE REPLY] Encryption : Urology draft report -encryption

Please see attached

Trudy

-----Original Message-----
From: julian.johnston@[redacted]
Sent: 06 May 2019 23:57
To: Reid, Trudy
Cc: julian.johnston[redacted]
Subject: Re: [SECURE REPLY] Encryption : Urology draft report -encryption

Final Report
Having some diffciulty getting these to go.
Will try again
Julian

To: Reid, Trudy
Subject: RE: SAI

Could you send me this in the report so that I can read in context. WE could pick up those that were not triaged so a bit confused. Although I thought this was done and dusted months ago!

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Reid, Trudy
Sent: 25 March 2019 22:36
To: Robinson, Katherine
Subject: SAI

Katherine Mark has reviewed the report and before I forward to Dr Johnston would you be happy with this form of words relating to the informal process

This process allowed the booking office to allocate patients who had not been triaged in time to be allocated to a 'waiting list' using the GP triage category. Therefore, while this IDT process of putting patients on the waiting list without triage meant that they did not get missed, there was a comment MTNL added to a comment field, however there was a potential this could be over written with a new comment. This meant that there was no simple way of picking up who had not been triaged nor was there a safety net for incorrect GP referrals.

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

Robinson, Katherine

From: Robinson, Katherine [redacted]
Sent: 26 March 2019 10:04
To: Reid, Trudy
Subject: RE: SAI

Trudy I would prefer my original comments to stay. We did escalate and we were advised to go by GP priority. Also it is incorrect to say that the comment MTNL could not be viewed, it could on a PTL. The odd comment would have been overwritten when the patient was selected for booking. Anyone viewing PTLs were fully aware that there were loads not triaged.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Reid, Trudy
Sent: 26 March 2019 09:41
To: Robinson, Katherine
Subject: FW: SAI

Katherine as requested

Trudy

From: Robinson, Katherine
Sent: 26 March 2019 09:35

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

From: Reid, Trudy
Sent: 29 December 2016 12:18
To: Kerr, Vivienne
Cc: Boyce, Tracey
Subject: Strictly Confidential
Attachments: Copy of Urology Complaints Jan11.Dec16.xlsx

Vivienne would you please check I have the correct patients, I have put in hospital numbers for those without can you get me the hospital numbers

Happy to discuss

Regards,

Trudy

Ref	Date Received (Complaints - All dates)	Name	Consultant	Type Of Complaint	Division	Site	Speciality	Loc (Exact)	Subjects (Subjects)	Description	Outcome	Grade	Consequence	Action taken (Investigation)	Replied done (Complaints - All dates)	Response time
Personal Information redacted by the USI	23/04/2012	Personal Information redacted by the USI	18/07/12 -AKHTAR - ZIY RIP Person	FORMAL	SEC	Craigavon Area Hospital	Urology Surgery	3 South	Treatment and care quality	Patient who is fed via peg tube unable to be given food provided by family as there was no pump available. Family also concerned that patient was put into wheelchair at 11am, however he did not arrive home to 7.30pm and by this stage was incontinent.	Complainant assured that whilst a pump was not available for the type of peg tube used, patient had appropriate IV fluids. Apology given for the delay in the provision of an ambulance for transport and for the fact that patient arrived home incontinent.	LOWRIS	MINOR	Staff reminded of importance that personal hygiene needs of patients must be fully met	11/05/2012	13
	09/05/2012			FORMAL	SEC	Craigavon Area Hospital	General Surgery	3 South	Treatment and care quality	Complainant unhappy with general standard of treatment and care offered to patients.	Apology given to family that communication was not to a standard which was expected and should have been delivered	LOWRIS	MINOR	No action plan	25/07/2012	52
	08/05/2012		Mr Sureshreferred - 6/10/15 suspected cancer -diagnosis of prostate cancer	INFORM	SEC	Craigavon Area Hospital	General Surgery	3 South	Appointments, delay/cancellation (outpatients)	Complainant would like to know when he will receive a date for his operation. he has had 2 pre op assessments.	Patient has been put on waiting list for laparoscopy and appendectomy. Waiting time is 36 weeks, patient will receive surgery before 30.11.12.				20/06/2012	10
	24/09/2012			FORMAL	MUC	Craigavon Area Hospital	General Medicine	General Medicine Clinic	Appointments, delay/cancellation (outpatients)	Complainant unhappy with length of time he is having to wait for review appointments	The 3 issues raised by complainant of treatment for carpel Tunnel Syndrome, treatment at pain clinic and urology. Complainant has been advised further correspondence will be read and filed. Complainant advised of the complaints guidelines April 2009. 24.4.14 Complainant advised complaint still with Ombudsmen. FILE IN REOPENED DRAWER.	LOWRIS	MINOR	No action plan	05/10/2012	9
	01/11/2012			ENQUIR	SEC	Craigavon Area Hospital	General Surgery		Appointments, delay/cancellation (outpatients)	MLA enquiry re consultants appointment being cancelled and query re new appointment date.	Consultants secretary contacted explanation for cancellation given, new appointment date relayed and assured letter already posted. MLA's office contacted,reason for cancellation explained and new appointment date relayed.	LOWRIS	MINOR	Consultants Secretary called informed of reason for cancellation, new date for surgery and assured letter in post. Contacted MLA's office and relayed information - reason for cancellation and new date		0
	08/04/2013		Personal AOB - NO urology pl centre letters but haematology letter This gentleman who was referred to me initially as an in-patient in Derry Hill was reviewed at today's Haematology Clinic. Person was found to have pancytopenia while undergoing investigations for heamaturia. Subsequently as you know he has been found to have a transitional cell carcinoma of his bladder and has a cystectomy and is to have follow-up Radiotherapy **3 MDM letters and 4 urology discharge letters**	FORMAL	SEC	Craigavon Area Hospital	General Surgery	3 South	Theatre/operation/procedure, delay/cancellation	Complainant unhappy that he was given breakfast on morning of his operation by staff which then meant he incurred a further 10 day delay on hospital	Patient advised on the sequence of events and the reason as to why his surgery was delayed. HOS contacted complainant and resolved outstanding issues	LOWRIS	MINOR	No action plan	28/05/2013	34
	19/07/2013		Mr O'Donaghue - routine referral -This gentleman's cyst in his right kidney hasn't shown any evidence of recurrence. I don't think the kidney is the cause of his right sided abdominal flank pain. I am not arranging to see him again.	ENQUIR	SEC	Craigavon Area Hospital	Urology and ENT			Caller very unhappy that has waited almost 52 weeks for his surgery, was advised at time of being added that he would wait not longer than 30 weeks' but this has now been the case. Caller alleges that even though he was transferred from Mr Connolly's (has now left/SHSCT) list to Mr Glackin's list that if done chronologically he should still have now been seen by now. Caller feels let down and very unhappy with his treatment or lack thereof and tells me he is constantly in pain.	Bmc spoke with Elizabeth, Mr Glackin's sec who advises that she herself spoke with Person this morning and advised him of wait in list and the meeting that it to occur with senior mgmt to alleviate those waiting the longest - says Person does not seem to accept this. Bmc emailed Martina Corrigan Hos for Urology to ask her to personally ring Person or pass on a form of words for me to ask - Bmc 19072013 M Corrigan spoke to patient morning of 22/7/13 and patient happy.					0
	16/10/2013			FORMAL	SEC	Craigavon Area Hospital	General Surgery	3 South	Discharge/transfer arrangements	Complainant advised during morning ward round that he would remain in hospital but by 4pm was being discharged to care of DHH and would like to know why change of plan	Complainant advised the patient was transferred back to DHH as he would be closer to his family and the Consultant Surgeons believed patients care could be managed by General Surgeons in DHH. Apology given for distress caused. 24.3.14 - Complainant advised patient was transferred back to DHH in the interests of the patient. Apology given for not explaining properly. There is no official transfer policy between two hospital as these are within the one trust.	LOWRIS	MINOR	No action plan	30/10/2013	11
	19/11/2013			FORMAL	SEC	Craigavon Area Hospital	General Surgery	3 South	Admission into hospital (delay, cancellation) (Inpatients)	Complainant not happy that his mothers procedure was cancelled and she was discharged. When she was readmitted also cancelled a second time.	Apology given for distress patient felt. Complainant advised due to more urgent cases the patients ERCP had to be postponed but has since took place.	VLORIS	MINOR	Ward staff addressed on the importance of good communication with patients and family.	14/01/2014	37
	10/12/2013			FORMAL	SEC	Craigavon Area Hospital	Urology Surgery	3 South	Treatment and care quality	Complainant unhappy with the lack of medical care given to her following her operation.	Complainant advised when 3 South is full they use beds in 1 West to accommodate Urology patients. On this occasion it would appear that the patient was note recorded on 3 South's white board, leading to the patient being missed on consultants round. This has now been addressed, when patient is admitted to 1 West staff there informs 3 South of the patient.	LOWRIS	MINOR	No action plan	31/01/2014	35
	11/12/2013		APA NR A PAHUJA &K. Suresh MS.	FORMAL	SEC	Craigavon Area Hospital	Urology Surgery	3 South	Staff attitude/behaviour	Complainant unhappy with the dismissive nature of her consultant so much so she wishes to be removed from his care	Consultant apologised if the patient felt he was rude and dismissive. Consultant has since left Trust, patients care has been transferred to another consultant.	LOWRIS	MINOR	No action plan	20/01/2014	25

Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Reid, Trudy
Sent: 20 September 2018 10:46
To: julian.johnston Personal Information redacted by the USI
Subject: Urology draft reports - encryption

Dear Dr Johnston please see attached drafts of the urology SAI for your consideration before sharing with the wider review team .
I am happy to discuss/amend as required.

I am happy to organise a review team meeting to consider the reports. If you let me know your availability I will organise a meting.

Dr Khan has requested to see the draft as the process he is involved with is concluding and he would like to cross reference the issues identified in his process and our SAI. I wonder if you would be happy to share the draft report?
Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Administration Floor
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

From: Reid, Trudy
Sent: 17 September 2018 08:51
To: julian.johnston Personal Information redacted by the USI
Cc: McAloran, Paula; Farrell, Roisin
Subject: Urology draft report - RCA Checklist new template 17 09 2018 encryption

Dear Dr Johnston please see 1st draft of the urology triage SAI.
I am happy to amend as required, add more detail etc.

The other patient report did not sit well with this, I am almost finished a draft for consideration.

If you approve I will forward to other members of the review team for accuracy checking etc.

Dr Khan has requested to see the draft as the process he is involved with is concluding and he would like to cross reference the issues identified in his process and our SAI. I wonder if you would be happy to share the draft report?

Regards,

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien'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'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. 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'Brien 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'Brien. 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'Brien.

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.

Hynds, Siobhan

From: McClements, Melanie [redacted]
Sent: 10 February 2020 21:19
To: Reid, Trudy
Cc: OKane, Maria; Hynds, Siobhan; Kingsnorth, Patricia; Wallace, Stephen; Gibson, Simon; Toal, Vivienne
Subject: RE: URGENT FOR YOUR RESPONSE: Oversight Meeting

Follow Up Flag: Follow up
Flag Status: Flagged

Dear all
I would prefer to discuss this in person where clear roles and remits need identified. There is a lot of background information that I am not fully aware of.
Thanks Melanie

On 10 Feb 2020 19:33, "Reid, Trudy" [redacted] wrote:

Melanie and Maria from review of the action plan I have some comments/suggestions that could provide clarity, the recommendation was that

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.

I note that there is reference to urology, the case review recommendation was an Acute wide review — are the actions in the plan wider than urology? Does the plan reflect an internal review and is there an independent review planned?

The plan received does appear to reflect previous processes, although they may have changed but this is not evident, it could be updated to reflect

1. Date actions were implemented
2. Frequency of continuous monitoring reports, content of reports and who runs them
3. Who receives the reports for review and action at specialty level
4. Escalation processes
5. Provide clarity of roles and responsibilities
6. Articulate senior management Directorate oversight of the plan e.g. review at a governance or performance committee including reviewing/monitoring the reports/actions noted in the plan- this including frequency of reports

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile [redacted]

From: OKane, Maria
Sent: 10 February 2020 14:53
To: Gibson, Simon
Cc: Hynds, Siobhan; Kingsnorth, Patricia; Reid, Trudy; Wallace, Stephen; McClements, Melanie
Subject: FW: URGENT FOR YOUR RESPONSE: Oversight Meeting

Simon – from all this - I think you are saying is that
- the MHPS report raised concerns about patient safety because of an individual's interaction with the triage system in Autumn 2018,
- there was a recommendation in the report that the system for capturing this was reviewed as it was not thought to be robust and had not captured the concerns earlier
- this review hasn't started yet and as such acute is having to rely on what was in place originally?
- In keeping then with the Vincent model of Quality Assurance, then the system that is being relied on and is used to give the GMC assurance is not reliable?

Regards, Maria

From: Gibson, Simon
Sent: 10 February 2020 13:37
To: Hynds, Siobhan; Kingsnorth, Patricia; Reid, Trudy; OKane, Maria
Cc: Wallace, Stephen
Subject: FW: URGENT FOR YOUR RESPONSE: Oversight Meeting

Dear Maria/Stephen

Having read the draft response, I do feel that this is best considered in discussion.

In essence, the response uses the "Backlog Report" as evidence of assurance, even though this Backlog Report has significant weaknesses within it, as indicated in the minutes from the recent meeting with operational and clinical staff (attached for ease of reference)

I am unaware of the progress against the conclusions agreed at this meeting, which could be pivotal in the response to RQIA and GMC. Again, these could be considered in discussion with relevant staff as Siobhan suggests.

Kind regards

Simon

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

From: Wallace, Stephen
Sent: 10 February 2020 11:26
To: Gibson, Simon; Hynds, Siobhan; Kingsnorth, Patricia
Cc: Reid, Trudy; OKane, Maria
Subject: RE: URGENT FOR YOUR RESPONSE: Oversight Meeting

Simon / Siobhan, Trudy has received a summary re administrative processes from Patricia.

Patricia - The attached refers to independent review however was there a local review and if so was the outcome that the existing processes were robust as is?

Thanks
Stephen

From: Gibson, Simon
Sent: 10 February 2020 10:42
To: Hynds, Siobhan
Cc: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: URGENT FOR YOUR RESPONSE: Oversight Meeting

Dear Siobhan

Trudy and Stephen are co-ordinating a response to RQIA in relation to a number of issues, including AOB. As Stephen summarises in his e-mail, one of the questions being asked;

- Information on any plans to undertake a review of the administrative processes within the Trust or rationale underpinning a decision not to proceed with review if this was the case

Would it be best to discuss this response – ensuring consistency in communication to all organisations – at the meeting provisionally set for Friday?

Maria – would you prefer a more direct response from Acute Services?

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
[redacted] (DHH)

From: Hynds, Siobhan
Sent: 07 February 2020 16:09
To: McClements, Melanie; OKane, Maria; Toal, Vivienne; Gibson, Simon; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Cc: Buckley, LauraC
Subject: URGENT FOR YOUR RESPONSE: Oversight Meeting
Importance: High

Dear All

There are a range of matters which need to be discussed and progressed in respect of A O'Brien's case. Can I please ask you to provide Laura Buckley with your availability for a meeting to discuss. We have correspondence from GMC which has a deadline for response which we also need to discuss and therefore I would ask for an urgent date for the group to meet. I am looking a date next week if at all possible.

Many thanks

Siobhan

Laura – can you please co-ordinate as a matter of priority.

Mrs Siobhan Hynds

Incidents – Acute Falls Satisfactory compliance		Standards & Guidelines Limited compliance	Incidents – Medication Trust Satisfactory compliance Independent Sector Limited compliance

8.6 In relation to overall view of the effectiveness of governance systems within Acute my view was that, as per the governance assurance template and the responses regarding the requirements for a clinical governance system in question 7 and 8, there were weaknesses, challenges and gaps in the governance system. The workforce resource and information systems impacted on the effectiveness of the governance systems.

9. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

9.1 In my opinion it would have been good to have a review of the Acute Governance Structures with recommendations on improvement required to ensure governance structures were fit for purpose.

9.2 The Governance Assurance Template did highlight weaknesses. At the time and now, in my opinion, additional staffing resource in the Acute Governance team to allow the development of governance structures and systems including audit for improvement and assurance would greatly assist. Specialist training to equip governance staff for their roles would have improvedthe effectiveness of governance structures and systems. Dedicated highly trained SAI chairs to facilitate timely completion of SAIs for learning. Improved IT systems such as Datix, the S&G database, audit tools andinformation systems would allow for timely reporting and triangulation of data.