SCRUTINY COMMITTEE

21 OCTOBER 2015

UROLOGY SERVICES in SUNDERLAND

REPORT OF CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

1. Introduction

1.1 Urology services provide a comprehensive hub and spoke arrangement to a wide geographical area. It operates from a number of sites including Sunderland, South Tyneside, Durham (including Shotley Bridge and Bishop Auckland). It provides a full range of secondary care services and provides tertiary care for penile cancer and cryosurgery.

2. Background

2.1 From November 2013 there has been increased internal focus with support for the department of Urology as a consequence of a range of performance issues. The team has delivered significant improvements in performance which are currently sustained.

2.2 In July 2014 there was a Coronial inquest following the death (from natural causes) of a patient who experienced delays in treatment. CHS was provided with a series of actions following a regulation 28. It resulted in a visit by the Coroner to CHS on 8 January 2015 in order to provide reassurance of completion. The issues and actions are discussed below.

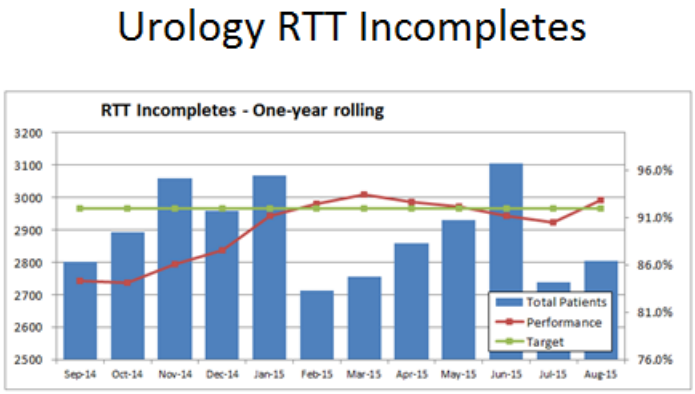
2.3 In the interim period there has been a formal CQC review and the Trust outcome was “Good”. The CQC had noted delays in waiting times and improvements are examples in the performance section of this paper. The CCG continue to provide scrutiny but have acknowledged the significant improvements.

2.4 In August 2015 there was a Coronial inquest following the death of a patient from natural causes following urinary catheterisation and a single action following a regulation 28.

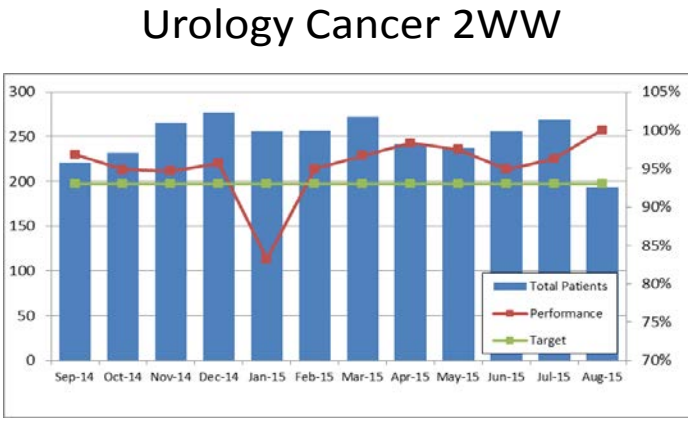
3. Improving Performance

3.1 Although this not the primary focus of the paper it is useful to put into context the performance of the Urology department against national targets over time. There is demonstrable improvement against a set of difficult targets which are proving a challenge nationally.

3.2 The graphic below demonstrates linear improvement which has typically been sustained.



3.3 The graphic below outlines sustained delivery of the 2 week cancer referrals.



3.4 The graphic below demonstrates linear and sustained improvements in communication with primary care and patients.

4. Issues and Actions

4.1 The principal issues in scheduling are discussed below. The vulnerabilities in the system were exposed in Urology as a consequence of volume, complexity and multi-site working. However many of the issues existed in other specialties and therefore the actions have been applied across the organisation.

4.2 Scheduling of Out-Patient (OP) appointments:

4.2.1 The historical system required the waiting list team to organise an OP appointment based on the electronic booking out document which was completed by the clinician. Patients who needed investigations prior to he next appointment or who were subject to cancellation were not automatically addressed in a timely fashion and delays could occur.

4.2.2 The scheduling process now involves a number of additional safety steps:

1) All patients who need an appointment within 6 weeks have an appointment made (this time period markedly reduces cancellations).
2) All patients who need an appointment beyond a 6 week period are placed on a “pending list” and this includes a date by which they need to be seen.
3) The pending list is reviewed and managed on a weekly basis. Once they are within the 6 week window they are appointed. If there are capacity issues these are resolved.

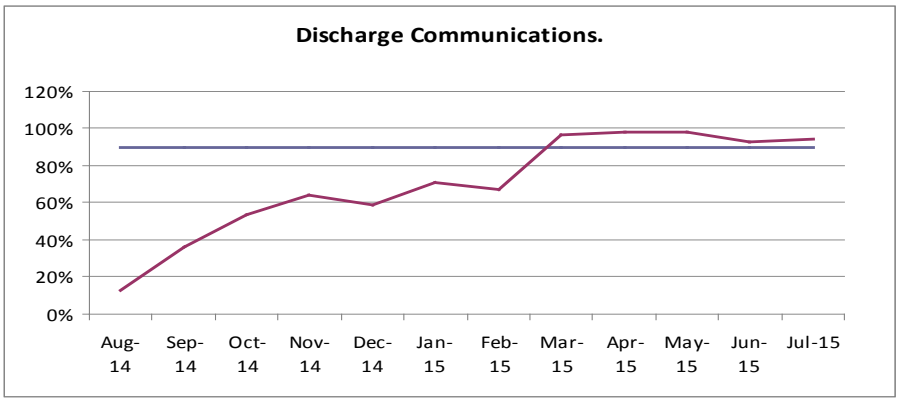
4.3 Scheduling Treatments

4.3.1 The historical system involved a paper based request that was sent via fax from the clinician to the waiting list team. It failed to differentiate cancer and urgent patients.

4.3.2 The scheduling process now involves a number of additional safety steps:

1) All off-site requests are via a secure email address and are acknowledged with a read receipt.
2) On-site requests are hand delivered to the waiting list team.
3) Dates for investigations, anaesthetic pre-assessment and for surgery can be provided in many cases on the day.
4) Cancer and urgent cases are clearly differentiated
5) Improved communication with patients via “clinic-on-the-day”. A process where the patient can leave clinic with a typed letter in addition to dates outlined in point 3

4.4 The graph below demonstrates an improvement in communication. The example is discharge communication. The blue line indicates a performance target of 90%.



5. Inquest 2

5.1 Inquest 2 involved a case of a patient admitted under Care of the Elderly whose care was complicated by urinary retention. His bladder catheterisation was complicated and required the input of the Urology team. His subsequent urethral injury was implicated in his death, demonstrated at a post mortem.

5.2 It was discussed that there are in excess of 30,000 catheter days in CHS and the literature estimates the incidence of urethral injury at 10-30%. It was further discussed and accepted that procedure was followed, that reasonable steps were taken, that the injury was recognised and managed appropriately.

5.3 Death was determined to be as a consequence of natural causes.

5.4 A rule 28 was issued because it was recognised nationally to be an issue that nursing and medical notes are separate and may result in missed opportunities to recognise the need to involve the urological team. This is being addressed locally with a unified document and a refresh of policy.

6. Summary

6.1 The Urology team have engaged with and improved their performance. They have worked with other teams to address vulnerabilities in the scheduling process which has also benefitted other services.

6.2 The details of the second and more recent inquest have been included for completeness although it involves the urology team peripherally.

6.3 The paper is presented to provide assurance.

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