Radical Prostatectomy with recon and lymphadenectomy	5.9	7.72	6.2	6	5.4	4.2
Radical Nephrectomy	9.1	6.9	10.4	7.2	7.8	13
Radical Prostatectomy	5.8	4.7	7.2	5.4	6.1	5.8
Total Excision of Bladder	17.7	14.4	19.9		19.6	17
TURP	2.9	2.8	2.8	3.4	2.8	3
Number of green - not all did all procedures		13	5	7	9	7
Number of red – not all did all procedures		2	1	0	0	3

Green better than average; yellow -in the vicinity of average; orange –quite far from average; red -much worse than average

Cells with no data indicates that the surgeon did not do the procedure.

SECTION 3– Ambulatory care

Review the management of the Outpatient department and surgical wait lists

- ***With reference to the national elective surgery targets***
- ***Conformance with the Department of health policy***

Outpatients

Pre 2014

There have been longstanding problems in relation to the Outpatient Clinic and these have been well documented and the frustrations well documented by the Manager certainly from 2011 to 2013. This would appear not to have caused any change or re-direction of the clinic, rather clinic staff had to endure complaints, angry patients and having to re-book patients because clinics, particularly for new patients, were not attended.

This has improved significantly since the appointment of [redacted] as Head of the Unit in 2013 and, as a result of a letter written to GPs (Appendix 4), criteria and requirements for GPs in sending patients to the Urology Clinic have been made clear.

It is of note that when you access TCH Outpatients web site, there is information and details for all surgical services in relation to timeframes and time for appointments, except for the Urology Unit. The web site shows inactivity and all appointments are greater than 60 days. This is therefore an unhelpful source of information for General Practitioners.

2014 system change

The May 2014 letter outlined the requirement for patients who have a likely category 1 problem but does not currently assist in managing the backload of non-category 1 patients. There would appear not to have been a cull of the outpatients list since well before 2012. This must be done as a matter of priority.

Waiting list audits are time-consuming and costly, but the only way that waiting lists can be actively managed is to be certain that those on the waiting list need to be on the waiting list, so that you're dealing with figures rather than appointments that may well have been sought from years ago and are no longer required.

Since late 2013 a nurse has been appointed in the outpatients to assist with urology patients. This is in addition to the existing prostate cancer nurse and the bladder cancer nurse, who also work full time to support the urology service. Discussion of how these nurses could better assist the efficiency of the unit as a whole will occur later in this report.

Leadership

As part of Head of Unit, requirements for the consultants to attend clinic and what they need to do and the number of patients to be seen has been a huge advantage. Not all of the consultants adhere to [redacted] apportionment of patient guidelines, but the clinic is very happy with the way this is working.

There appear to be no clear pathways for patients in relation to the outpatients setting. At the moment the patients are either 'new patients' or 'review patients', but there are clearly different sub-sets of those patients which ought to be straightforward enough to book into the system, so a new patient is genuinely a new patient to the clinic, to the service or with a brand new problem.

New models of care

A recent inpatient could be defined as a 'IP surg review' who needs to be reviewed within a timely fashion and a recent inpatient with a review and pathology 'IP Path review' needs to be reviewed in a more timely fashion and have their pathology discussed. This second group of review patients needs to have time with a consultant and not be part of a Registrar Review Clinic and ideally, have the prostrate nurse or the bladder cancer nurse with them to assist them in navigating the next steps of their treatment and care. Currently these patients are all booked as 'review'.

There are other review patients who may be on a surveillance programme or be part of an ongoing review for a problem unrelated to a malignancy and these need to be in a separate review category so that they can be reviewed by the Registrars. A sub-section of reviews will assist – these coos be known as 'FU (follow –up) review' or better 'Check review '.

Accountability

The matter of attendance at outpatients has improved but [redacted] continues to be regularly late and this needs to be addressed either by the Head of Unit or, more likely, by the Clinical Director as the Head of Unit appears reluctant to take on personalities and it is often very difficult to manage one's peers in relation to these performance issues without clear data as the basis of any discussion.

Pathways for patients

Pathways need to be put in place for the follow up and management of these key patient areas. An attempt was made at the MDT meeting to formulate some pathways for the management of these key patient groups – prostate cancer, bladder cancer, testicular cancer, urinary incontinence, post procedures. These are available on line in various other organisations (see Appendix 6) and need to be put in place so that patients and staff are very clear on what to do.

Booklets in relation to patients who have these diseases and these diagnoses would also assist them in navigating their care, which will go from surgical through to medical oncology, radiation oncology and through their GP, so this would assist all of them.

Database and follow-up

There is currently no database of urology patients to allow for follow up of date or important research. There is no reason why this could not exist, no reason why this should not be regularly harvested for interesting information and importantly to ensure the patients are not lost to follow up of their care, particularly with a positive histology result.

There has been some frustration from the GPs that the follow up processes within the Canberra Hospital are not as they should be for the Urology Unit and this needs to be addressed as a significant risk to the organisation and clearly a risk to the patient.

3.b.1 surgical waiting lists

Surgical waiting lists in Urology are allocated by surgeon which results in potentially longer waits for some patients. A system should be established and agreed by all staff, that 'routine' cases are managed from a generic patient waiting list while more complex, special interest cases are allocated to a nominated surgeon, after being discussed in the MDT.
This could also be reflected in the theatre list allocation, where a particular surgeon could have a 'general' urology list in one week and perform the more complex or difficult cases in another week. This would allow theatre to allocate appropriately skilled staff for each list and if the same principle was applied to all surgical disciplines, resources such as day case or overnight or ICU bed requirements could be optimised to minimise cancellations and smooth out overall hospital resource usage across the week.

SECTION 4 – CLINICAL GOVERNANCE FRAMEWORK

Review clinical governance activities pertaining to urological patients

- ***Including the adequacy of audit protocols, reporting and benchmarking against national standards***

Clinical governance at the Canberra Hospital is in its early phase of implementation. A recent appointment of a new Director of Clinical Governance however has brought about some changes but the need to present definitions of clinical governance to a senior forum would tend to indicate that the understanding of clinical governance and its role within the organisation is under developed.

Clinical governance within the Surgical & Oral Dental Health Unit appears somewhat haphazard and extremely high level with very little impact or influence in relation to practising clinicians. The framework appears to have very high level, very senior people looking at a limited amount of information.

We were finally given access to the ACHS Comparative data clinical indicator traffic light report prepared in January 2014; extraordinarily, there is no surgical data of any type at all in this report.

Quality Scorecard and hospital wide clinical indicators

There is a quality scorecard that exists for the organisation that is in its infancy and would appear only to be significantly populated by the human resource data. There is an attempt to list the data as part of the score card within national standards, which is good and certainly the need or the reality of formal accreditation in May 2015 may well be the prompt and the catalyst to energise clinicians and their involvement in relation to clinical governance.

Appendix 17 outlines an example of the scorecard. Currently there is data that is organisation-wide. The data is not division specific signed and also not for individual units.

If clinicians are to be engaged, they need to have data that is meaningful to them rather than high-level data that really doesn't tell you anything about their speciality. This is especially so when there is significant variation within units and within a tertiary hospital.

The hospital-wide clinical indicators are not routinely available by Division. This is a missed opportunity. These hospital wide clinical indicators are unplanned returns to hospital within 14 days, unplanned returns to hospital within 28 days, unplanned returns to the operating theatre and mental health re-admission within 28 days. Certainly unplanned return to the operating theatre should be very easy to extract

data based on not only individual division's specialties, but down to individual surgeons. This would be commonplace in many other organisations.

We requested this basic data and after some considerable time were given access to the Urology unit data over the last four years. The data is disturbing.

Clinical indicator	2011	2012	2013	2014
Unplanned return to the OT	5	7	6	3 to March
Unplanned readmission within 14 or 28 days	31	85	59	24 to June

These are very high rates and we suggest an experienced senior urologist review this data

The clinical governance forums that have just started to take place in the last few months attach minutes of patient safety conversations and it is well recognised that it was part of this patient safety conversation on Ward 9A that appeared to be a catalyst for the external review of the urology service. None of those issues that were listed in that discussion, although verbalised by the nursing staff in particular, really have any basis in reality then and certainly have no basis in reality now.

The participants in that 9A patient safety conversation were two nurses, a junior medical officer, the consultants were not involved or engaged in any of that information.

The clinical governance forum also looks at clinical reviews and M & M reviews and this again is certainly in its infancy. A template for M & Ms is being developed locally. Clinician's Handbook published in 2001 for New South Wales Health should be considered as an excellent tool for use throughout the organisation. It is very simple, very straightforward, easy for clinicians (doctors) to understand.

The actions listed that arose as a result of the patient safety conversation were fairly broad, such as the 'need to engage senior staff', the 'need to get this meeting to happen across divisions', the CNC to get information on 'possibly having pathways for patients' and gaining 'advice on teaching a RiskMan' really did not seem to be particularly substantive in terms of some of the concerns that appear to have arisen out of the conversation.

Cases reported for CRC for Surgery and Dental directorate –

Review of the meeting minutes for this Directorate.

One incident involved two patients with a fractured neck of femur, one was for a patient with a radical neck dissection, one was in relation to a urological patient in relation to a failure to follow up test results in the Pre-admission Clinic.

CRC is very active in reviewing cases. They note that they review all deaths within the hospital. It is unclear whether they also review episodes of severe morbidity that do not result in a patient death. This may possibly be of greater use to the organisation.

It is not clear that the quality loop is completed and in discussions with the Clinical Director, it is estimated that **about 70 % of the recommendations do not get followed up by anyone at any time** and many of them have been outstanding for over two years.

This is labour intensive model with a lot of very good people doing very good case review but, unless there is a robust system whereby those issues are identified and implemented and audited to check that those changes are taking place, then the review itself will not be particularly useful.

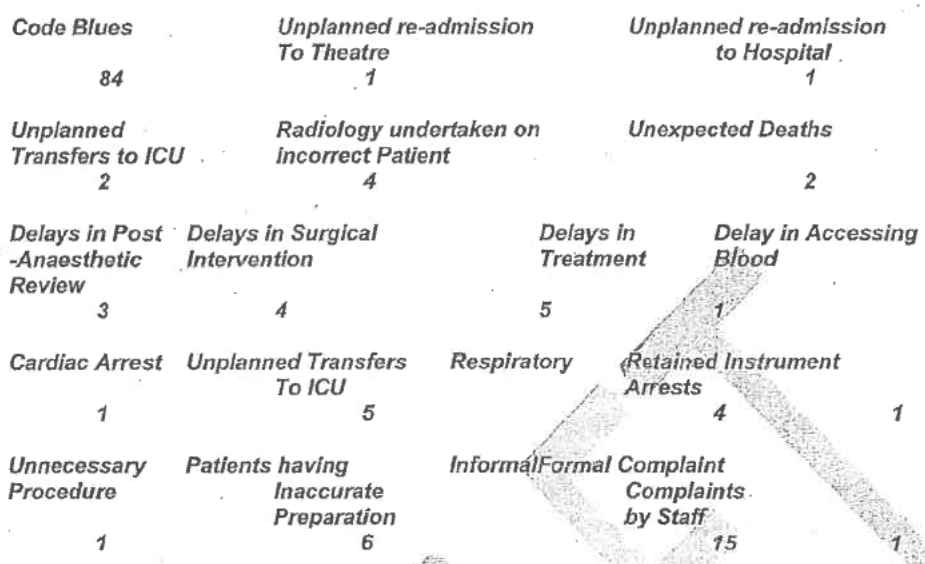
We identified issues for understanding and resolution from this single meeting and they included:

> Follow up of patients from Pre-Admission Clinic and having standardised investigation reports on where they go.
>
> Needing a documented clinical pathway for patients with a fractured neck of femur. Many of these are available and have been in use for many years. Particularly useful are the ones developed by Queensland Health.
>
> Issues in relation to a problem with surgical booking which presumably could be resolved for the benefit the entire organisation.
>
> Process for abnormal radiology reporting and sharing of that information. This is likely to be very significant and will relate far more than to one single patient and ought to be listed as an action with a timeframe, a person accountable and a report back, and a process by which someone follows up that those reports are actually undertaken. The potential for gaps in this system are potentially huge.
>
> This should have been the action sheet form the meeting; it was much less specific.

This was the only Clinical Governance Meeting that related to urology that has taken place. Prior to then there have been high level CRC Meetings but again, the actions and the follow up of those actions has been ad hoc and unsatisfactory. Incidents are looked at, are reported, and a report is provided typically to the Unit Manager on a monthly basis via the Quality Manager with responsibility for surgery.

Incident data

Graphs were provided in relation to incidents that had occurred over a three-year period: -



To date the text of these significant incidents have not been provided.

In forms of standard audit, there appears to be no information provided to the surgeons or to the ward in relation to their patients at all. Outstanding data to be provided included: -

- Incident summaries as discussed;
- Blood usage by specialty 2012 to 2013, 2013 to 2014;
- Blood usage by urologists and by procedure;
- Average length of stay by case for radical prostatectomy open, radical prostatectomy laparoscopic (Calgary), open nephrectomy, laparoscopic nephrectomy, open cystectomy, PCNL, urethoplasty and stress incontinence surgery;
- Average length of stay by case and average length of stay by case by surgeon;
- Average length of operation time by case type and by surgeon the case types;
- Unplanned returns to the operating theatre;
- Unplanned re-admissions to hospital;
- Unplanned transfers to ICU;
- Unexpected deaths;
- Any ACHS clinical indicator data for the hospital.

None of this is readily available.

MyHospital data

The MyHospital web site has information in relation to elective surgery waiting times.

For all urological surgery in 2012/13:

- Medium waiting time for urological surgery at the Canberra Hospital was 29 days compared to the National Peer Group of 25 days. **Not as good as average**
- Medium time for cystoscopy was 29 days compared to the National Peer Group of 23 days **Not as good as average**
- Medium time for prostatectomy was 39 days compared to the National Peer Group of 41 days **Not as good as average**
- Percentage of patients who waited longer than 365 days – 1.1% of patients at the Canberra Hospital waited for more than 365 days for urological surgery compared to the National Peer Group of 1 %. **Close**
- 0.5% of patients waited longer than 365 days for cystoscopy at the Canberra Hospital compared to the National Peer Group of 0.5 %. **On par**
- 3 % of patients waited longer than 365 days for prostatectomy compared to the National Peer Group of 1.9 %. **Not as good as average**

Similar information is available for vascular surgery and for orthopaedic surgery for the Canberra Hospital on the MyHospital web site.

This data suggests that THC is below the Peer Group for most of its surgical waiting times, but not grossly different in terms of activity.

Health Round Table Data:
As a member of the Health Round Table, access to shared member information enabled access 'Dionysus' data, which is data for the Canberra Hospital. It is to be noted that this is for TCH surgery in general, that in fact there are some newly 'red' [2]issues when compared to peers. They relate to: -

- ☹ Standardised rate of post-operative haemorrhage or hematoma;
- ☹ Standardised rate of post-operative respiratory failure;
- ☹ Reasons for operating theatre wait list cancellations by hospital;
- ☹ Relative procedure time index for laparoscopic cholecystectomy;
- ☹ Relative procedure time index for transurethral section of the prostate,
- ☹ Relative procedure time index for laparoscopic appendectomy.

The relative stay index for surgical services remains in the red, which is to say that it is significantly different to peers within the organisation.

This Health Round Table (HRT) data was not discussed nor spoken about by any of the clinicians, so it is unclear whether or not they share this information. Review of the HRT scorecard in relation to re-admissions, safety and quality cancellations, time to theatre and procedure time, then the Canberra Hospital certainly does not do well.

[2] Red - which is to say that it is significantly different to peers within the organisation.

It is of interest to note that for post-operative haemorrhage or hematoma, Dionysus was in the higher quartile rate of 2.15%. The highest was 6.2% and the lowest was at 2 %. It's interesting to note that, in comparing it with some of its more appropriate peers, Dionysus seems not to do nearly so well. It is of note that over the last three reporting sessions, the rate of postoperative haemorrhage has increased. Comparator organisations within this group include Fremantle Hospital and St Vincent's Hospital in Melbourne.

The relative procedure time index really is a marker of efficiency and is well explained within their discussions for the Canberra Hospital. This has increased in the time that it has been collected and certainly, the average time for transurethral resection of the prostate in minutes is 91.7 minutes compared to lower levels for St Vincent's Hospital in Melbourne at 86 %, the Mater Adult Hospital and the Austin Health, all of whom would have Registrars who potentially slow the timeliness of procedures down.

The point of this is not to criticise, but to demonstrate there is a great deal of information that is readily available but not shared with the specialists or the nurses providing that service to get a comprehensive sense of their clinical outcomes.

Complaints

There were no formal complaints that we could see on risk man report that we were given. However, there were 15 so-called informal complaints by staff and we asked for those to be shared with us and that has not occurred. Several complaints made against all manner of parts in the organisation by [redacted] take place on a regular basis. They take up a great deal of time and, as noted earlier, are bordering on the vexatious. Issues in relation to justifiable concerns need to be dealt with quickly, promptly and appropriately, rather than taking months and months as has occurred in the past.

Lack of data

One of the key elements of clinical governance is to do the 'right things more often and the wrong things less often'. Without data, it is very difficult to judge and assess the Urology Unit. It is unclear what ought to be taking place. That having been said, it is very difficult to see whether the service is safe and effective without any regular reliable data.

One of the great frustrations is that so much of this criticism and commentary has occurred in an informal at hoc hearsay and third hand manner, which doesn't allow for easy management. As a matter of urgency, a clear set of data as suggested by this review needs to be developed for the Urology Unit and this may be done as a pilot for the rest of the Division of Surgery.

One of the benefits of assessing and managing a surgical service is many of their outcomes are clear, can be measured and quantified and are not open to interpretation. This absolutely needs to be done as a priority, not just as the unit comparing itself to others, but for the individual performance of those commissions within that unit.

Only in this way can the Clinical Director ever hope to be able to manage, develop, enthuse and engage with consultants. Doctors remain scientists at heart and, when presented with data, have great interest in their data, particularly when its individual data compared to their peers. This ought to be done as a matter of urgency.

National standards

There was no mention of national standards or accreditation by the consultants. Apart from the organisation-wide scorecard that is shared with very few, there in no inherent understanding of the system nor an attempt to harness the very clear value of the standards to identify, audit and improve care.

Risk register

The clinical risk register was not shared with us, but risks have been identified throughout the review. Of significance would include: -

- Failure to follow up post-operative results; Biopsy results, either radiologically or operatively;
- Lack of effective communication to GPs re follow up plans for patients
- Delay with access to radiation oncology;
- Confusion in relation to access to radiation oncology;
- Delays in implementation of appropriate therapies once a diagnosis of malignancy takes place;
- Lack of clinical engagement
- An inability to know how well the service is performing.
- Difficult behaviours from senior medical staff that limit professional growth and development within the Unit.

- Inability to create a meaningful budget with very late and non submission of due fees from consultants

In addition,

- The quality of the pre-admission service and its reliability in relation to surgeons needs to be looked and listed as a risk.
- The management of patients on anti-coagulation at ward level is ad hoc and uncertain, particularly in the elderly male population, many of who would have co-existing heart disease. This can have significant implications not only for their surgery but for their ongoing cardiac maintenance, particularly when anti-coagulants are ceased for the sake of operative ease.
- The lack of clear surveillance of post-operative care and follow up is a risk and a risk that is not quantified would be complaints from patients in relation to post-operative impotence or urinary incontinence post their urological procedures.
- A clear flow chart needs to be developed for the management of test results, the apportioning of outpatient appointments, the role of documentation and information that occurs through the Multi-disciplinary Clinic. There needs to be standardised processes for booking, for confirmation of operating theatre, access time and diagnose

SECTION 5 – RESOURCE MANAGEMENT

Review sessional allocations, urological workloads and distribution of workloads between consultants

Outpatient Activity:

Consultants attend 9 outpatient sessions per month out of a possible 40 sessions available in that month.

Registrars undertake 3 sessions in their own clinics out of a possible 40 sessions for them per month.

Registrars also attend with a consultant at the consultant clinics.

As noted earlier, there have been many problems with the urology outpatient service over many years, but since the start of 2014 much has improved.

Elective Surgical Activity:

The 2013/2014 data demonstrates the following: -

Consultant	Available Sessions per year	No of operations	Ratio
[redacted]	6 times 11	80	1.2
	4 times 11	230*	5.2
	8 times 11	175	2.0
	8 times 11	258	2.9
	4 times 11	248	5.6

Elective surgical efficiency

Based on the number of patients removed from the elective surgical wait list and the number of contracted operating sessions, this can be a measure of the efficiency of urology consultants. These come out as –

[redacted] 1.2 (very low), 5.2, 2.0 (very low) [redacted] 2.9, 5.6

This is of particular interest as there is a significant discrepancy in the number of patients removed from surgical waiting lists based on the available

[3] HH The 2013/14 number of removed patients from the list was averaged based on his previous three full years

operating theatre time. One would expect that, if all consultants were doing roughly the same amount of work in roughly the same amount of time and roughly the same amount of complexity, the ratio would not vary much between 1 or 1.5. This significant discrepancy is of concern and needs to be addressed with the consultants in terms of their approach to surgical activity.

It is of interest that [redacted] has 8 operating sessions per month with a very low activity level. This may be because he typically allows his Registrars to do a great number of his cases so that they can "learn on the job".

[redacted] has 6 sessions per month. He is regarded as a very good teacher but regularly has 40 to 50 minutes in between his cases owing to operating theatre issues. It may be that the days he operates are particularly slow and particularly inefficient, but this is worth further investigation.

[redacted] and [redacted] are both young and enthusiastic and have very good activity ratios. [redacted] has a reasonable activity ratio.

In 2013/14, 1161 (averaged) elective surgical cases were undertaken within the unit. The graph below shows a clear pattern of activity per urologist.

[redacted] a steady increase with booking of cases on the wait list and a steady increase in activity.

[redacted] Reduction in activity since the peak of 2011/12. He started with similar numbers to [redacted], who started at the similar time to him, but this has steadily decreased. It is of interest to note that his general approach and attitude to the unit is very passive and one wonders if private discussions ought to take place in relation to his general sense and his general sense of his role within the unit.

[redacted] Data (2013/14 was estimated on a previous three year average) has increased and stayed at a high and steady rate since his appointment.

[redacted] Has a high level of waiting list and a high level of surgical activity.

[redacted] Has a much lower base than the others but has had a steady increase since 2012/13.

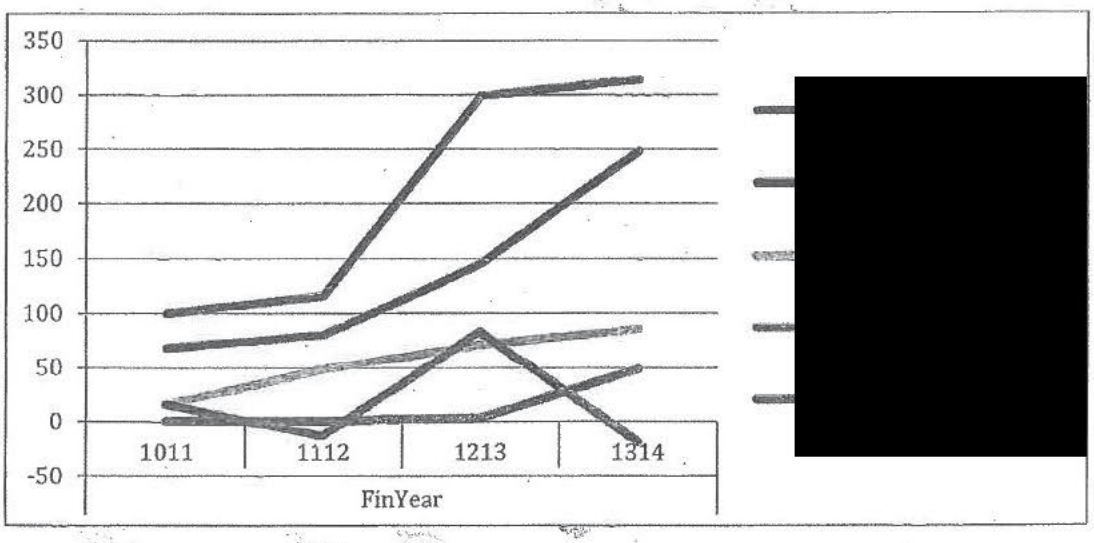
Review of surgical waiting list activity

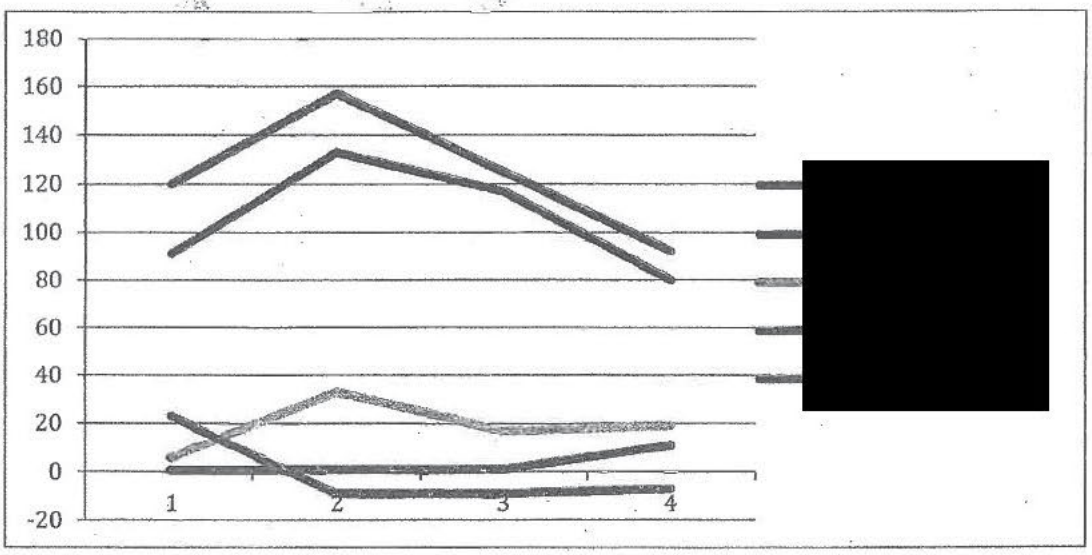
We have provided graphical representation of the raw data provided.

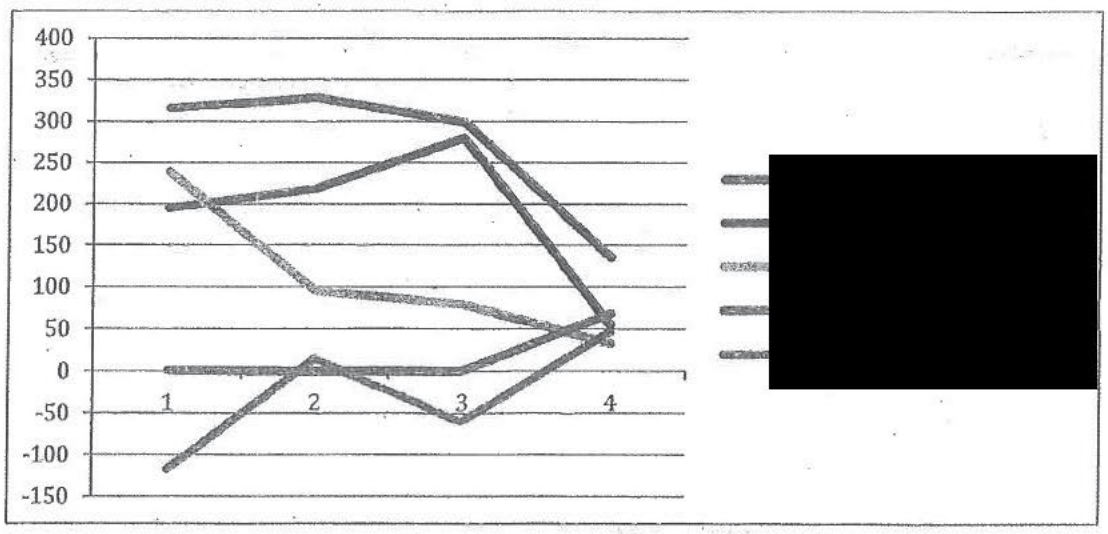
This is for activity over four consecutive years. It lists addition to the wait list; removals (by surgery) removal not by surgery. The difference (in purple) is marker of efficiency – i.e. removal for the wait list. It also shows the end of year census i.e. what is left.

This is the type of data that should be easily available for strategic within the directorate and performance related conversations within the Unit and the directorate.

Note the scales are not the same for each surgeon – some are much busier than others.



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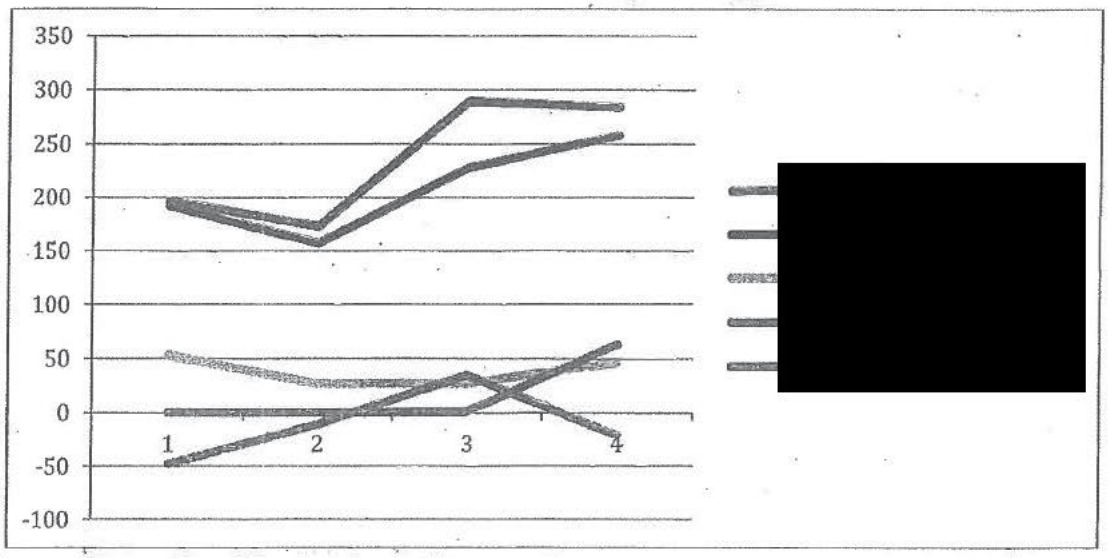
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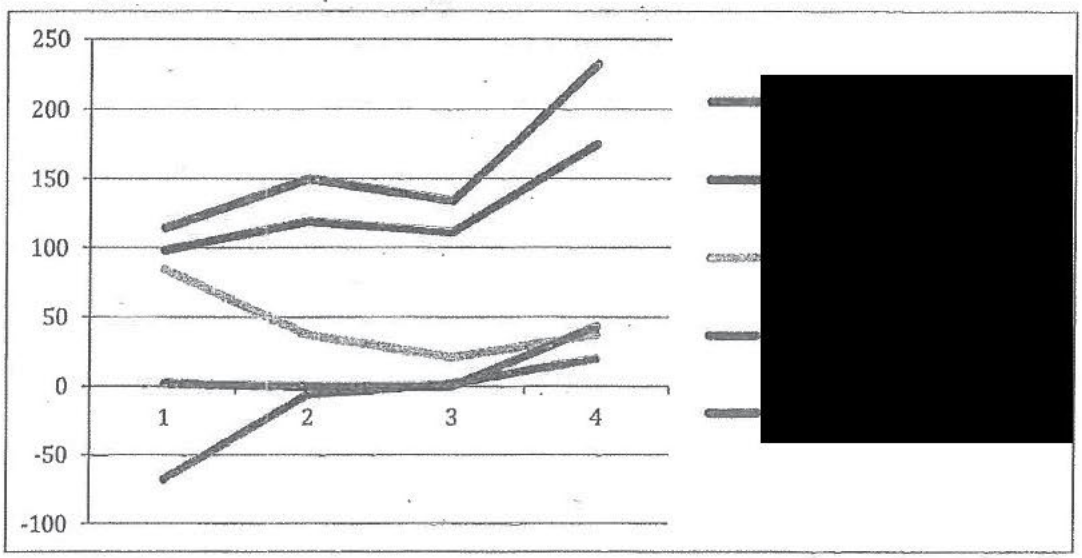
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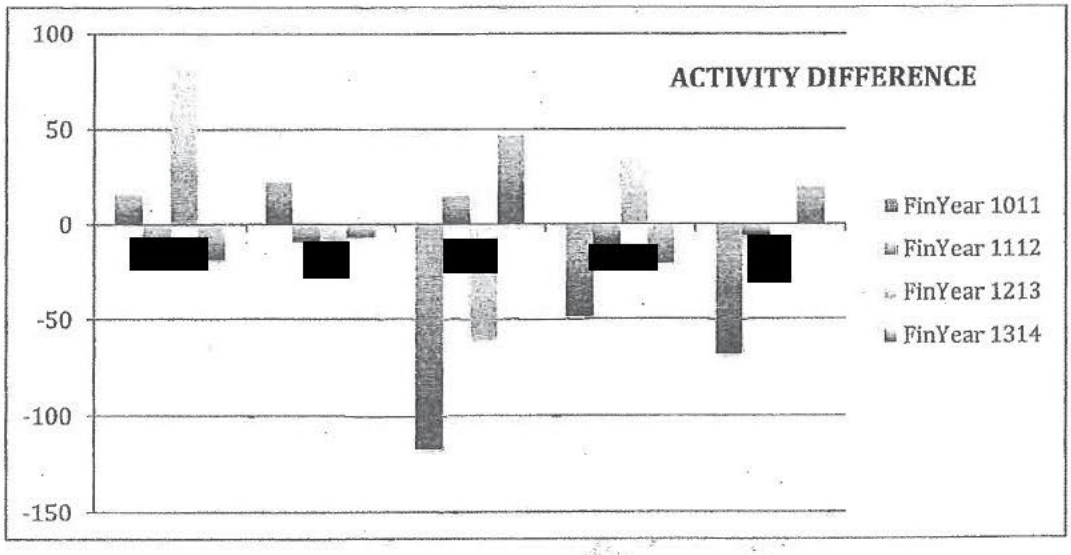
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EOY Census:

There has been a marked increase in the number of patients on the urological surgical wait list. This has been the case for all surgeons. It may reflect a new way of keeping records or, that since the start of 2014, there has been a marked improvement in outpatient attendance and a more functioning trainee Registrar and now two Registrars are available to update and better manage the waiting list and surgical list.

The recruitment of specific urology nurses in both outpatients and to manage the waiting list may also have more accurately captured data and process patients more efficiently and effectively. My hospital data reflects this as an improvement in wait time has occurred with more consultants in 2011. It notes a significant improvement in 2012/13 but it is unclear why this improvement occurred in 2013 and was not evident in the wait list improvement at that time.

Long Stay Waits:

At 30 June 2014 report, urology had no long wait category 1 patients. There were however 24 category 1 patients waiting – [redacted] 5, [redacted] 2, [redacted] 4, [redacted] 8, [redacted] 5.

The overall urology wait list percentage was 14.85 and this compares favourably to other units –

Urology	14.84 (5 surgeons)
Vascular	12.5 (3 surgeons)
Plastic	17.3 (2 surgeons)
ENT	24.18 (7 surgeons)
Orthopaedic	40.03 (11 surgeons)

It is of note that both orthopaedics and urology have a significant component of emergency surgery as part of their routine activity.

SECTION 6 – PROFESSIONAL DEVELOPMENT

Review educational requirements and access to professional development, teaching and training programme:

The individual consultants have a different approach to professional development. Three have personal logbooks and two do not. It is RACS college recommendation that Fellows (surgeons) maintain a personal logbook for them to audit and review and submit from time to time.

[redacted] is passionate about research and four of the consultants are passionate about teaching in formal and informal settings.

From the Registrars' point of view, [redacted] has dedicated teaching time, both via a Journal Club and individual Saturday sessions, and this is highly regarded by the Registrars. [redacted] is keen to organise research and does so for nurses, medical staff, junior staff as well as registrar staff. [redacted] undertakes additional training in robots and over time is keen to develop this service within the department.

Registrars:

The first accredited Urological Registrar post occurred in 2003 and a second post was created in 2011. The programme that the Canberra Hospital described is informal, very different to the structured programme that occurs in New South Wales and Victoria, which is not surprising as there are only two Registrars versus more significant numbers in metropolitan Melbourne in Victoria.

The Canberra rotation is seen as very beneficial as there is access to a great deal of surgery, both elective and emergency, with five different surgeons, five different perspectives. Importantly, the rotation provides access to outpatients, which does not occur in New South Wales hospitals.

It is considered a position where there is a great deal of surgical autonomy and time to get numbers into logbooks with a degree of professional freedom. As noted earlier, there is no formal scope of practice for the Urology Registrar in relation to their surgical activity.

The Registrars present at the Morbidity & Mortality Meetings and cases are discussed and reviewed at this time. This is not formally minuted and audits appear very few and far between. A cystectomy audit was discussed in August 2014 but there is no regular audit provided to the hospital. There is no regular audit provided within the group and there is certainly no research aside from [redacted] MRI research that is presented to any research within the broader Canberra Hospital community.

In terms of professional development, as noted earlier, there are no performance appraisals for the consultants and the appraisals for the Registrars are undertaken very quickly, are not particularly in depth and controversially there were some disagreements in relation to one of the trainees in the middle of 2014. This level of discussion is seen as healthy and allows for a very accurate plan to be put in place to assist the Registrar going forward. The professional development opportunities for the Registrars are there. They are not as structured as in other large hospitals, but certainly do occur.

SECTION 7 – RESEARCH

Review current research activities and performance and advise on strategies to improve research opportunities for the urological service at NACT Health.

The major research showcase is CHARM that has had minimal urological presence at this prestigious day over many years.

Research is certainly seen as a keen component of the Canberra Hospital but within urology, there appears no strong desire to do research. Research is largely and enthusiastically led by [redacted]. He is very active in submission of papers, largely to local meetings, and certainly keen to undertake work with Calvary Diagnostic Imaging Unit to assist them. [redacted] and [redacted] appear to have little interest in research and appear to do little to contribute to research within the department.

There is no formal mechanism to support research; there is no seemingly accessible patient or procedure database; there is no admin support; there would appear to be no training in relation to undertaking research and there's certainly no easy data available from which to do research. This is despite an extremely good electronic medical record, an extremely good electronic pathology results system and there really is no reason why good clinical research could not take place within the unit.

It is noted however that all five consultants are VMOs and typically research is one of the requirements of staff specialists, who have allocated time to undertake that process. The work that [redacted] is doing is certainly enthusiastic and certainly inspiring and is engaging Registrars and is to be applauded.

Appendices:

1. Organisation Chart Division of Surgery & Oral Health
2. Letter outlining the Review
3. List of those Interviewed
4. Risk Man Incident List
5. Outpatient Activity Data
6. Wait time and Elective Surgery Access Policy
7. ACT Gov. Wait time and Access policy
8. Duty Statement Urology Nurse
9. Urology Elective Surgery Wait List Activity 2010 to 2011, 2013 to 2014
10. Blood Incidents
11. Urology Clinic Referral Letter May 2014
12. Copy of 2013 contract
13. Copy of Claim Form from [redacted]
14. Copy of Claim Form from [redacted]
15. MBS Schedule Extracts
16. MDT Minutes 11 September 2014
17. June 2014 Clinical Governance Meeting Agenda
18. Patient safety conversation minutes
19. Blank Clinical Governance Hospital-wide Score Card
20. MyHospital Data for The Canberra Hospital 2010 to 2013
21. Health Round Table Data for Dionysus
22. RAC Surgical Competencies & Performance
23. RACS Code of Conduct
24. CHARM Notice for 2014

Appendix 3

List of those interviewed:

Dr Bryan Ashman	Clinical Director of Surgery	
Dr Tanya Robertson	GP Liaison Unit	
Lorraine Erikson	CNC 9A	
Jodie Skriveris	Director, Outpatient Services	
Janelle Corey	Director, MOSU	
Cathy Burns	ADON, Surgical Bookings	
Amanda Keogh	Quality and Safety Officer	
Kerri Reeves	ADON, Theatres	
Irene Upton	CNC Outpatients	
[redacted]		
Barbara Reid	Exec Director, Division of Surgery	Oral Health and Imaging
Dr Frank Bowden	Chief Medical Officer	
Clare Crawford	VMO Payments Officer	
Dr Lisa Salter	Urology Registrar	
Dr Simon McCredie	Unit Director – Urology	
Dr Heath Liddle	Urology Registrar	
Deborah Brown	Executive Director, Audit and Clinical Governance	
Shayne Brown	Risk Management Coordinator	
Stephen Linton	Industrial Relations Officer	

APPENDICES TO THE REPORT

	Recommendations	Action	Action Officer (s)	Executive Sponsor
1	**Accountability**			
1.1	Clarification of the precise role and activities of the prostate cancer CNS and the bladder cancer CNS should be clear to the Urology unit. Their role in relation to patient follow up for bookings of appointments, liaison with medical and radiation oncology needs to be clear to the Registrars, the Consultants and the nursing staff alike. They should attend the monthly Urology Unit meeting and provide their valuable insights into patient processes and this should be welcomed and encouraged Actively involved in surgical wait list management.	Improve communication with Bladder and Prostate Cancer Nursing Specialists. Clarify the role of each individual within the multidisciplinary team and invite both roles to participate in the month unit meeting.	Gaynor Stephens / Unit Director / Karen Faichney	ED CACHS
1.2a	CHHS should clarify the timeframes for submission and payment of VMO fee for service claims. This will allow for more accurate budgeting, more accurate financial management of the hospital and ensure that these activities are undertaken in an efficient manner without undue stress to the pay and finance departments.	Develop process in consultation with PSSB, which we will also put forward in the next VMO contract negotiations. We will have a discussion with the Urologists to develop an efficient process for their submission of bills and our payment.	ED SOHAMI PSSB (S Linton)	ED SOHAMI
1.2b	*Ideally, claims are made within one month of the activity, but no claims should be paid after the end of the financial year in which the activity took place. A letter outlining those requirements should be sent to the VMO's and a certificate needs to be signed by the VMO at the end of each financial year indicating that they will not claim for any additional services in the previous financial year.*	*This is outside of what is permitted under the current contractual requirements. Implementing this would put CHHS in breach of contract.*		
1.3	A clear system of data collections, review, sharing and discussions opportunities should be provided to the urology unit in order to : - discuss defined morbidity and outcomes to include deaths, unplanned returns to OR, unplanned readmissions within 14 days, unplanned readmission within 28 days, infection rates for key procedures, long term complications in patients such as impotency or urinary incontinence, survival rates of prostate, bladder and renal related tumours. - clarify appropriateness of activity - discuss impacts on length of stay	Work with the Urologists to determine the level of data that they require to inform their unit. Request information from the BIU. Provide information received to the Urologists for analysis.	Unit Director ED SOHAMI BIU	ED SOHAMI
1.4	Agreed management of surgical registrars, especially accredited surgical registrars, should be consistent across the unit while allowing for individual specialist personal variation. Registrars should have a clearly defined scope of practice that relates to the type of procedure with which they are involved and the level of supervision that is required. This scope of practice should be assessed on appointment and re-assessed at month 6 and month 9 of their 12 month appointment. This information should be shared with operating theatre, bookings, and anaesthetic staff and regularly reviewed as described above. This is consistent with NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations. Defined Projects each year	Trainer acknowledgement document designed and agreed to by all Urologists. Ready for implementation with the 2015 junior medical officers.	[redacted]nd Unit Director	ED SOHAMI
1.5	VMO Payment criteria for the need for consultant review of inpatients should be noted at the end of each procedure and after initial post-operative registrar review. In this way, claims of under-servicing or over-servicing in relation to inpatient review can be debunked. A note in the record by the registrar, nurse unit manager requiring consultant review should take place. This can be routinely audited against VMO claims.	Strengthened controls and improved escalation process to CD and ED for resolution .	VMO Accounts Officer	ED SOHAMI
1.6	External data such as My Hospital, Health Round Table and ACHS clinical indicator data are all very relevant and important sources of external benchmarking. The British Association of Urological Surgeons has an excellent website and clinical audit programme that CHHS Urologists should consider implementing with dedicated Quality Unit staff supporting.	Noted by ED SOHAMI, Clinical Director and Unit Director	Regularly discussed at Unit Meetings by unit director	
2	**Accountability / Clinical Governance**			
2.1	The requirement of all urologists (and all clinical units within CHHS) is to meet and discuss data, provide a formal report and explanation of the outcomes to the clinical director on a twice yearly basis.	Refer 1.3 and 1.6	ED SOHAMI Unit Director	
2.2	relation to activity based funding the need to work within the constrained budget rather than as if required by the medical staff. Targets of surgical activity were not known by the members of the Urology Unit. This needs to be made clear at the start of each year and resource feedback as to their progress ought to be given as part of standard reporting.	Business plans are developed at a Divisional level across CH&HS. Targets and activity are discussed at the regular meeting with the urologists.	ED SOHAMI CD SOHAMI Unit Director	ED SOHAMI CD SOHAMI
2.3	Nurse unit managers and associate unit managers should attend the Unit Meeting, which will require a proper agenda to include such as: - Activity against agreed KPI's - Outcomes against agreed KPI's - Workforce requirements - Risk Management - incidents, complaints, problems, risks - Quality improvement - activities reporting back - Problem solving - Progress towards accreditation survey in 2015 - Equipment needs - Around table discussions and problems	Discussion with the urologists and the CNC of the Urology ward to develop an agenda and meeting schedule to discuss ward related issues and performance.	CNC ADON DON Unit Director	ED SOHAMI
3	**Ambulatory Care**			
3.1	An active cull of the existing surgical and outpatient waiting list needs to take place. While appreciating that this is time consuming, only in this way can an accurate denominator of demand and activity be made available so that ACT Health benchmarks	Letters have been sent to GPs outlining the criteria for preparation of patients to attend the clinics. Regular triage and review of outpatient lists is being undertaken by the registrars and the Urology CNC.	Unit Director Registrar's	ED CACHS ED SOHAMI

3.2	Review and follow up of patients is not robust. Consideration should be given to a database and a checking process by which all patients giving had investigation of biopsies of malignancies are followed up accurately and they are not left to be lost in the system.	The CNC for the urology outpatients is currently devising a system to record patients who require follow up. We will investigate options for a database.	CNC Urology OPD	ED CACHS ED SOHAMI
3.3	Activities within outpatients are to be made clear. Consultants will see all new patients (in accordance with ACT Health Guidelines). This may be done after initial Registrar review as part of their learning, but it should be made clear that sitting back and only seeing patients when asked is unacceptable. The GP requires a letter from the Consultant in relation to the new patients being seen.	The Urology Unit will need to plan and agree to any changes as a Unit.	Unit Director and Unit members	ED SOHAMI
3.4	Changes to the urology outpatients are to be commended. However, consideration should be made for five additional consultant clinics to occur one per month to assist in the significant backlog of patients.	Investigation of the need for further clinics to be undertaken.	ED SOHAMI Unit Director Unit Members Client Manager CACHS management	ED SOHAMI
3.5	Time of attendance at outpatients is to be routinely kept for all Consultants attending and all outpatients staff and be part of their performance appraisal on an annual basis. Regular latecomers should be escalated to the Head of the Unit and to the Clinical Director for management.	The urology team have implemented this recommendation utilising a sign in book.	CNC Urology OPD- Already Underway	ED SOHAMI
4	**Clinical Governance**			
4.1	The philosophy of thorough audit and review of all deaths should be reconsidered to include those patients who do not die but have a serious morbidity. For example, patients who have more than one admission to the intensive care unit, patients with a length of stay greater than 20 days, patients with a blood transfusion of more than 4 units or patients with more than 3 MET calls would all be worthy of serious case review. This may be a richer source of data and better understanding of systems and consistent with a more contemporary approach, which is to not wait for sentinel events or deaths in order to review a case, but to look at those system processes of those who suffered significant morbidity.	Work with the Urologists to determine the level of data that they require to inform their unit. Request information from the BIU. Provide information received to the Urologists for analysis.	Unit Director Unit Members	ED SOHAMI
4.2	Ward processes could be improved with improved communication of Registrars and Unit managers on a daily basis to clarify plans for patients.	Refer 2.2	CNC Urology Ward Unit Director	ED SOHAMI
4.3	Active reporting of clinical audit must occur and be communicated to the Division of Surgery on an annual or twice-yearly basis. This is in keeping with the *RACS Code of Conduct* and the need for continuous review and improvement as part of national standards. Establish a weekly M&M report that lists the cases, issues, activities and outcomes that have occurred. These meeting minutes must be noted, tabulated and submitted for review by the Clinical Director on a six monthly basis.	Template available through CHHS to be sent to Unit Director To be submitted quarterly. Report to be developed in consultation with BIU	Unit Director BIU	ED SOHAMI
4.4	Consideration should be given for the CRC to consider doing in-depth case reviews of not just people who have died but those who have significant morbidity as a way of better understanding limitations of the system and more importantly, to see where the system recognised the problem and managed it.	Underway through CRC	Completed	
4.5	Process for a surgeon undertaking a new procedure must be clear. Individual surgeons need a specific scope of practice for sub-specialty urological procedures. The review of the 2011-14 data showed a number of consultants doing less than three of a given procedure over that time. Currency of skills in a given sub-speciality procedure needs to be demonstrated for that scope of practice to be approved and continued. A formal review of the process for privileging / scope of practice is also recommended.	MDAAC progressing with consideration being given towards JMO's	Completed	
4.6	There is a significant variation in average length of stay for the 17 typical urology cases. Some surgeons have done less than three of these procedures in three years. A specific scope of practice for sub specialisation in urology should be considered.	Refer 2.2	BIU to provide data	ED SOHAMI
5	**Financial**			
5.1	Inefficiency in use of surgeon operating times as outlined in the report should be internally reviewed.	Review underway. Performance information portal provides regular information. Also to be discussed at regular meetings refer 2.2	Unit Director ED SOHAMI Clinical Director	
6	**Professional Development**			
6.1	A clear process for annual performance appraisal needs to be put in place for all surgeons within the Urology Unit in consultation with the Clinical Director of Surgery.	Template developed, will be provided by end Feb.	Clinical Director Unit Director	ED SOHAMI
6.2	Annual review of CPD requirements should be considered as part of annual appraisal of Consultant staff.	Responsibility of the urologists	AHPRA	ED SOHAMI
	An annual meeting with the Head of Unit and the Clinical Director and another unrelated Executive should occur as the basis of all annual review. Consideration of the Townsville Hospital SMPR (Senior Medical Performance Improvement Process) should be considered for implementation across the Surgical directorate as a means of partnering for performance.	develop as part of performance plan to be undertaken with unit director and unit members	Clinical Director Unit Director	ED SOHAMI CD SOHAMI
6.3	Opportunities for staff to share their work within the division would be useful, such as a Registrar research week once a year to allow them to showcase their good work and encourage engagement and learning within the surgical directorate.	Enable staff to participate in the annual college scientific presentations	[redacted] Unit Director ED SOHAMI Clinical Director	ED SOHAMI
7	**Research**			
7.1	A formal database of urology patients should be established so the clinical research can more easily be undertaken. Assigned quality unit staff to assist in this important resource for all surgical units who have need of similar frameworks for patient outcome review. This will also reduce the chance of patients being "lost in the system", particularly in relation to important malignant conditions follow up.	Investigate the options.	Unit Director Dr HH - Urology Issue	ED SOHAMI

Finalisation and implementation of the Review of Urology Department at Canberra Hospital 4 February 2015.

Action	When	Responsible Officer
Draft Report		
Finalise response to recommendations and provide feedback to Mullins Consulting	Mid Feb	ED SOHMI
Mullins Consulting to provide Executive Summary suitable for broader consumption	Mid Feb	CMA
Communication		
Meet with Urology Department and present review findings and recommendations	By End Feb	DDG CH&HS?, ED SOHMI, CMA, Clinical Director - Surgery
Implementation		
Finalise assignment of responsibilities for the implementation of each recommendation	Complete	ED SOHMI
Commence implementation of recommendations	March	All
Regular reporting and monitoring of progress	Monthly	DDG CH&HS?, ED SOHMI, CMA, Clinical Director - Surgery

ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

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[redacted]
Urological Society of Australia and New Zealand,
Suite 512 Eastpoint, 180 Ocean Street, Edgecliff, NSW 2027

Dea[redacted]

I am responding on behalf of the Canberra Hospital to your letter to Professor Frank Bowden, Chief Medical Administrator, regarding the concerns raised with the Board of Urology by an un-named member of the consultant staff at Canberra Hospital with respect to the provision of Urology services and training for SET Urology trainees at Canberra Hospital. I understand from your letter that these concerns were raised after the recent Training Post accreditation visit undertaken by the Board of Urology.

I will address each concern as itemised in your letter:

Concern: The selection and allocation of one of the SET Urology trainees to the Hospital in 2015

Response: the Hospital understands that this particular trainee has been the subject of a prejudicial complaint by the consultant and that the Board is concerned this may jeopardise the trainee's need to have an unbiased assessment during his term at Canberra Hospital. The Hospital will undertake to assist the Unit Director and Supervisor of Training in minimising direct contact between this trainee and the un-named consultant and that any input into his performance by this consultant will be quarantined from his overall assessment

Concern: a number of consultants in the Urology Unit are not suitable to supervise trainees

Response: without knowing the specific reasons why the complainant considers some urologists to be unsuitable as trainers, it is impossible for the Hospital to make any comment about this issue beyond saying that we have no reasons ourselves to hold any doubts about the ability of any member of the Urology unit to supervise trainees. If there is specific information that the complainant can provide to the Hospital, we would be happy to respond.

Concern: a lack of confidence in the current supervisor of training who does not fulfil the requirements of the position of supervisor

Response: the Executive Director of Surgical Services, Barbara Reid, and me were both invited to attend a meeting of the members of the Urology Unit on 5 December 2014 to observe the process of electing the supervisor of training. There were two nominations and [redacted] was elected by majority vote. This would indicate that [redacted] is supported by the majority of his colleagues to continue as the supervisor of training. As far as fulfilling the requirements of the position of supervisor is concerned, I refer to the published College policy on the role and responsibility of surgical supervisors. Section 3.2 states that to be eligible for appointment as a surgical supervisor a surgeon must be a Fellow of the RACS (or if a non-Fellow may only be approved by Council in exceptional circumstances), be a staff member of the Hospital holding the training post, be familiar with the training program and have demonstrated experience with clinical, administrative and teaching skills, and should have undertaken appropriate College training in supervision. To the best of our knowledge, [redacted] fulfils these requirements. We would like to point out that a previous supervisor of training did not fulfil the requirement to have an RACS Fellowship but no concerns about this were raised with the Hospital during his tenure.

Concern: there is no appropriately determined education program and a lack of formal tutoring for trainees. It is 'ad hoc' in nature and without structure

Response: this concern was raised by the Inspection Report of [redacted] and [redacted] and the Hospital understands work is underway to address this concern by the supervisor of training for the 2015 rotation beginning in February

Concern: previously there was always a dedicated uro-pathology fortnightly meeting but this was abandoned by the histopathologists allegedly because of poor attendance by the trainees

Response: following discussion with Dr McCredie, the Hospital understands that a pathologist now attends the regular urological oncology multidisciplinary meetings

Concern: there are varying qualities of practice in urology at Canberra Hospital. Allegations have been made against a number of urology consultants at the Hospital that include poor quality care, on table and post operative deaths.

Response: there have been many complaints by a single urologist about the quality of care of all his colleagues over many years. Usually these complaints are non-specific generalisations that are not backed up by evidence or specific details. However, on the few occasions this individual has provided the Hospital with enough information to allow further investigation, invariably none of the complaints have been substantiated and these findings were communicated back to the complainant. One some occasions, though, the investigation revealed that the complainant himself was at fault.

With respect to surgical deaths, the clinical governance structure at Canberra Hospital reviews all deaths through the Clinical Review Committee. Examination of this committee's records for the last five years (2010-2014) reveals that there were three unexpected surgical deaths in the urology unit. Our reviews revealed no systemic issues for the Hospital and no individual performance issues for the surgeons involved. All of these deaths have been reviewed by the ACT Coroner as well and to the best of our knowledge no action that relates to surgical care has been recommended.

With respect to poor quality of care, the clinical governance framework for reporting adverse events during patient care is based on a hospital wide anonymous system called Riskman. Examination of this system since its introduction in July 2011 reveals that there were 428 reported incidents to 30 June 2014 involving the urology unit (as discussed below, the denominator of total episodes of care for urology admissions during this time was just under 4000, so the rate of reported adverse events is about 10%, bearing in mind that the national rate of adverse events for all hospital admissions is about 14%). Of the 428 events only 51 were rated moderate or above and most of these were related to medical emergency team calls. There have been no reported events of a moderate or more severe rating that related to quality of surgical care (complications, returns to theatre, unplanned readmissions)

With respect to varying qualities of urological practice, the Canberra Hospital subscribes to The Health Roundtable group of 147 major and regional hospitals in Australia and New Zealand. The annual report for Urology at Canberra Hospital for 2013/14 shows that the unit had a total of 1300 episodes of care for the 12 months. We have a peer group of ten other like-sized hospitals with between 1000 to 1500 Urology admissions per year. Our average length of stay was the longest at 2.9 days (peer range 1.5 to 2.9) and between the five urologists in the unit the range was 1.7 to 5.0 days. The complication rate for the unit was 13% (peer range 3% to 17%) and between the individual clinicians the range was 8% to 19%. This included all possible complications such as constipation, electrolyte imbalance, skin problems etc as well as postoperative problems and sepsis. So it is true to say that indicators of practice vary from surgeon to surgeon but none appear extraordinary.

Concern: following the training post accreditation visit in 2012 no information was communicated to the individual members of the unit and there was no opportunity to address concerns that were identified at that time

Response: following discussion with Dr McCredie who was the supervisor of training at that time, it seems that this complaint is not correct

Concern: allegedly all trainees over the last 15 years have identified significant problems with a number of consultants and did not wish to be associated with those consultants, their surgery or patients other than post-operative ward care

Response: if this allegation is based on exit interviews of each and every trainee for the last 15 years conducted independently by the complainant, then none of this information has been shared with the Hospital, previous Unit Directors or Supervisors of Training. It is our understanding that the Board of Urology conducts post-rotation interviews or feedback opportunities with the trainees after each posting and again there has been no information passed back to the Hospital to substantiate this concern. If the Board makes this information available to the Hospital we would be happy to respond.

Concern: the recent training post accreditation visit demonstrates a degree of dysfunction within the Urology Unit at Canberra Hospital

Response: this problem was also identified by the external review of the Urology Unit which was recently concluded. Although the other findings and recommendations of this review are still under consideration by Hospital management, it is clear to us that this dysfunction relates directly to the disruptive behaviour of one individual surgeon. Once the review findings have been assessed and a remediation plan developed, the Hospital will deal with any individual who can be shown to have acted deceitfully, maliciously or vexatiously in the pursuit of unproven and unsubstantiated claims against his peers or the Hospital.

Finally, I wish to assure the Board, on behalf of Canberra Hospital management, that we fully support the current Unit Director and Supervisor of Training. We will do whatever we can to ensure that the recommendations of the Inspection Report are implemented before the 6 month review.

Yours faithfully,

Bryan Ashman

22 December 2014

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601
Website: www.health.act.gov.au
ABN: 82 049 056 234

To: Katy Gallagher MLA, Minister for Health

Subject: Urology Review

Through: Dr Peggy Brown, Director-General 20/9/14

Ian Thompson, Deputy Director-General, Canberra Hospital and Health Services

Received in Minister's office:

22 SEP 2014

Critical Date N/A

RETURN FOR FURTHER ACTION
DUE BY 30/10/14

Purpose

2. To provide you with information in relation to a Urology Review conducted by Mullins Health Consulting.

Background

3. The Urology review was conducted following a serious of wide ranging concerns that were raised about the delivery of urology services in the ACT across both Canberra and Calvary hospitals.

4. Concerns included a cluster of clinical incidents relating to the Urology Unit that were investigated by the Canberra Hospital Clinical Review Committee and which formed part of a Health Services Notification to the Director-General.

5. The breadth of the complaints and concerns extended across the clinical, quality and safety, teaching and training, and professional behavior domains of the urology team (including senior and junior doctors) and included issues relating to:

   - Individual clinical performance
   - VMO contract extensions
   - Billing and on-call arrangements
   - Excessive waiting times for outpatients
   - Difficult interpersonal relationships between senior staff
   - The level of supervision provided to junior medical staff
   - Allegations of bullying of junior medical officers.

6. [redacted] of Mullins Health Consulting and [redacted] Monash Health, conducted the Urology Review during 8-11 September 2014.

7. Feedback from the review has not yet been received but an oral report from [redacted] is anticipated within the next week and receipt of the formal written report is expected within 3-4 weeks.

8. Once received, the Deputy Director-General, Canberra Hospital and Health Services, Chief Medical Administrator and Executive Director of Surgery and Oral Health will review the report before the findings are disseminated.

Communication Implications (including media)

9. Depending on the outcome of the review, the issue has the potential to generate media attention. Additional advice will be provided once the review report has been received and considered.

Issues

10. N/A.

Financial Implications

11. N/A

Internal Consultation

12. N/A

External Consultation

13. N/A

Benefits/Sensitivities

14. N/A

Recommendation

That you note the above information.

NOTED/PLEASE DISCUSS

Katy Gallagher 28/9/14
Katy Gallagher MLA

I would like to be briefed on this pl as per para (8)

Action Officer: **Josephine Smith**
Phone: **x42169**

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601
Website: www.health.act.gov.au
ABN: 82 049 056 234

To: Katy Gallagher MLA, Minister for Health

Subject: Response to letter from [redacted] regarding provision and funding of Urology Services in ACT's public hospitals

Through: Dr Peggy Brown, Director-General

Stephen Goggs, Deputy Director-General, Strategy and Corporate

Received in Minister's office:

10 NOV 2014

Critical Date N/A

Purpose

2. To brief you on the concerns raised in a letter from [redacted] concerning the provision of urological services in ACT's public hospitals, and to seek your signature to a response.

Background

3. [redacted] wrote to you on 25 September 2014 regarding the provision of Urology services at both Canberra Hospital and Calvary Health Care – Bruce. A copy of [redacted] letter is at Attachment A. A response to [redacted] is at Attachment B.

4. [redacted] has raised a series of concerns which are summarised below:
   - Delays in accessing outpatient and surgery for a particular patient.
   - Claims that the surgery delays related to the use of Canberra Hospital theatre staff at Calvary John James Hospital, as a part of the program to manage public elective orthopaedic services.
   - Problems with theatre management practices that result in difficulties with accessing surgery.
   - Management of Calvary Public Hospital theatre sessions that reduce the efficiency of access to surgery, which are related to a failure of government to adequately fund Calvary Public Hospital.
   - Particular concerns with the provision of services by a colleague, which includes breaking of instruments, poor clinical outcomes and bullying of junior doctors.
   - Inability to receive feedback from hospitals in relation to correspondence and phone calls relating to his concerns.

5. [redacted] also sought to meet with you to discuss these matters.

Communication

6. This matter is not expected to result in media comment.

Issues

7. Both Canberra and Calvary Hospitals have provided advice in relation to [redacted] concerns. These responses, together with general advice from ACT Health are noted below.

Delays in accessing outpatient and surgery for a patient

8. [redacted]

9. [redacted]

10. [redacted] as one other patient had been postponed due to ill health. The operating rooms management team had already prioritised the allocations of staff to other theatres, prior to the request being made. This meant that staff were not available to complete an extra case on [redacted] list. The surgery was also unable to be accommodated as operating rooms were experiencing an increased demand for emergency surgery, and other cases were given priority due to the clinical urgency of their conditions.

11. Simultaneously the operating rooms were also experiencing a higher than average number of staff on personal leave with six scrub nurses and five anaesthetic nurses accessing short notice personal leave. In order to maintain services, the operating rooms management team had sourced a number of staff to work additional recall and overtime shifts.

12. [redacted]

13. [redacted]

Claims that the surgery delays related to the use of Canberra Hospital theatre staff at Calvary John James Hospital as a part of the program to manage public elective orthopaedic services

14. The timing and rescheduling of the surgery is not related to the recent relocation of elective orthopaedic surgery to Calvary John James Hospital or to other work in private hospitals, as alleged by [redacted]

Problems with theatre management practices that result in difficulties with accessing surgery

15. Notwithstanding the above, ACT Health recognises that improvements need to be made in terms of operating theatre efficiencies.

16. In consultation with clinicians, new performance measures and reports have been developed to highlight issues with operating theatre utilisation. This information is informing projects to increase the use of current theatres to maximise efficiency, reduce out-of-hours use and improve patient access.

17. In addition, the new Central Waiting List Service will provide a more coordinated allocation of elective surgery across ACT public hospitals to further improve access and efficiency.

18. Canberra Hospital will pilot the establishment of a duty anaesthetist position to control access to operating theatres, as a means of improving the efficient allocation of theatre time.

Management of Calvary Public Hospital theatre sessions that reduce the efficiency of access to surgery, which are related to a failure of government to adequately fund Calvary Public Hospital

19. ACT Health funds Calvary Hospital to deliver a range of services including elective and emergency surgery cases. ACT Health also provides funding for Calvary to meet the costs of replacement and enhancement for medical equipment.

20. You have recently been briefed on the funding issues related to Calvary Hospital.

21. Calvary has noted (in recent Finance and Performance Committee meetings) that it has a range of capital expenditure requirements for medical equipment that are essential for the safe and efficient management of services, including surgical services.

22. ACT Health accepts that there are capital issues associated with equipment at Calvary and that replacements are required to ensure safe operating practices.

23. However, ACT Health has repeatedly asked for the details of Calvary's requirements in order to make an assessment on the capacity of the Territory to fund essential equipment replacements. This information was provided in late October 2014. ACT Health is seeking further clarification on the items in order to determine a possible funding level for 2015-16 using funding already available to ACT Health.

24. ACT Health will also determine the capacity of the 2014-15 budget to provide essential upgrades to equipment which are related to clinical incidents.

25. In relation to [redacted] concerns about the provision of surgery on [redacted], Calvary has advised:

- Urology surgery requires both a large volume of staff and equipment in particular flexible and rigid endoscopes to allow rapid turnover of patients for the flexible cystoscope lists. The day referenced by [redacted] was a dual list day. The local anaesthetic list was heavily booked with 18 cases booked and 17 performed. This list could not be completed in the allocated time frame for that session and had to be completed at the end of the General Anaesthetic (GA) list which was occurring adjacent to the allocated theatre (OR 7).

- The GA list (OR7) only had four cases, however this took until 3:20pm to complete. An emergency case was then performed by the urology team in OR 4 and the remaining case (TRUS biopsy) from the local list was completed in OR 7 going to recovery at 5:41pm (41 minutes after the session was scheduled to finish). There were other patients allocated to the GA list but they were cancelled for various reasons - one of which was a patient requiring a Trans Urethral Resection of Bladder Tumour (TURBT) who cancelled on the day of surgery due to a chest infection. Two other patients self cancelled and another patient (requiring laser), was awaiting test results and the surgery was then deemed to be no longer required.

- Further to this, all surgeons are involved in operating list planning and are required to agree to the final list 2 weeks prior to the scheduled operating date.

- The elective surgery team including administrative staff at Calvary Health Care have always been committed to working closely with all surgeons, including [redacted] to ensure timely access to surgery for patients, and that both appropriate levels of theatre time and equipment is made available relative to the demand and contractual requirements. This has included involvement in theatre list planning and scheduling including double lists, making available ad-hoc theatre time to accommodate Category 1 patients during periods of high demand and the consultation in theatre equipment purchases.

Particular concerns with the provision of services by a urology colleague [redacted] which include breaking of instruments, poor outcomes and bullying

26. Issues related to the performance of a clinician within a craft group should be directed initially to the head of that group. Where this is not managed in a manner that is considered acceptable by the clinician who noted concerns, there are other bodies within both hospitals to which these concerns should be directed.

Inability to receive feedback from hospitals in relation to correspondence and phone calls relating to his concerns

27. Both hospitals have advised that they do respond to concerns raised by [redacted]

Financial Implications

28. Any additional funding of urology services will be considered as part of the 2015-16 budget process.

Internal Consultation

29. Input has been sought from the Canberra Hospital and Health Services.

External Consultation

30. Calvary Health Care has been consulted in the preparation of this briefing.

Benefits/Sensitivities

31. N/A

Recommendations

That you:

- Note the above information.

NOTED/PLEASE DISCUSS

- Agree to sign the letter to [redacted] at Attachment B.

AGREED/NOT AGREED/PLEASE DISCUSS

Katy Gallagher 10/11/14

Katy Gallagher MLA

Phil Ghirardello
Director
Performance Information

Action Officer: **Ruth Boddy**
Phone: **x51227**

Katy Gallagher MLA

CHIEF MINISTER

MINISTER FOR HEALTH
MINISTER FOR REGIONAL DEVELOPMENT
MINISTER FOR HIGHER EDUCATION

MEMBER FOR MOLONGLO

Original Sent by Minister's Office
11/11/14 M066

[redacted]

Dear [redacted]

Thank you for your letter of 25 September 2014 in which you raise concerns about the delivery of urological services at Canberra Hospital and Calvary Health Care Bruce, both generally and in relation to patients under your care.

I have sought advice from both Canberra and Calvary hospitals about the issues you have raised.

In relation to the specific patient you refer to in your letter, I am advised that surgery was provided at Canberra Hospital in a timeframe which did not have a detrimental impact on the patient's condition. Earlier access to surgery would have been preferred, but there was a higher level of staff on personal leave than would normally be the case on the Monday on which the patient presented at Canberra Hospital. Surgery was not able to be performed on the following day due to the need to prioritise more urgent patients. I am further advised that the patient underwent an uncomplicated recovery on the ward.

I can assure you that the delays which your patient experienced in accessing surgery purely related to higher levels of staff on personal leave and patients with higher priority conditions. No part of the delay was related to the performance of public orthopaedic surgery at Calvary John James Hospital (CJJH). CJJH is required to provide their own staff to provide nursing care. Orthopaedic surgeons who provide services at CJJH do so as a replacement of sessions that would have occurred at Canberra Hospital. Anaesthetic support is provided through the provision of additional funding to ensure that Canberra Hospital is not affected by the transfer of cases to CJJH.

In relation to your comments about your theatre session at Calvary Hospital on [redacted] Calvary has advised that 17 of the 18 cases booked were completed on the day. In addition, Calvary notes that the capacity to provide for a full dual-list was not possible due to demands on the day, including an emergency case which consumed a large amount of time.

ACT LEGISLATIVE ASSEMBLY

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CANBERRA

Notwithstanding the above, both Canberra and Calvary hospitals continue to work to improve access to and utilisation of operating theatres to ensure patients are admitted for surgery as soon as possible. Access to new systems will soon provide better access to information about the relative performance of operating theatres, and this information will be used as a means of driving improved efficiency in the delivery of surgery services into the future, including the ability to better utilise theatres and reduce the need to cancel surgery.

While there are categories of emergency surgery which provide for longer waiting times for access to an operating theatre, there are often additional consequences, such as fasting and increasing anxiety which are the basis for the current activities being undertaken to improve operating theatre utilisation.

In relation to funding provided to Calvary Hospital, ACT Health and Calvary agree on an annual performance plan which includes an agreement to a set level of activity and funding. This agreement is developed collaboratively, with funding provided by the ACT Government in accordance with the agreed level of activity and in recognition of the need to address expenditure on capital assets and equipment as well as recurrent items. The agreement for activity and funding levels for 2014-15 are nearing completion and this will again ensure appropriate compensation by the Territory for the public hospital services provided from the Calvary site.

In relation to your comments about the performance of one of your colleagues, I would suggest that you raise these matters with the head of urology surgery in the first instance. In addition, you could refer your concerns to the Clinical Practice Committee should you consider the matters impact on patient outcomes.

In response to your request for a meeting, I am not in a position to meet with you at this time. I encourage you to continue to work within the Urology Surgery Group and with ACT Health to improve access to public urology services in the ACT.

Thank you for writing to me about your concerns.

Yours sincerely

Katy Gallagher MLA
Minister for Health

10 NOV 2014

A

[redacted]

Thursday, 25 September 2014

Ms Katy Gallagher
Chief Minister & Minister for Health
GPO Box 1020
Canberra ACT 2601

Dear Minister

Unfortunately, you are the only one I feel I can appeal to in relation to significant problems with the delivery of urological services in the Public Hospital system in Canberra at both The Canberra Hospital and Calvary Public Hospital.

I have attempted to communicate with the Administration at both these hospitals. Most of my correspondence is completely ignored by the people that I have sent copies of this letter to.

Currently there is a problem with dealing with category 1 and urgent patients in both hospitals.

I had an all day operating list on [redacted] at The Canberra Hospital. [redacted]

[redacted]

[redacted]

This has led to a significant waste of theatre services at The Canberra Hospital yesterday.

The Floor Manager informed me that there were only 11 theatres out of 14 theatres in operation on that day. He said that some of his theatre staff have been sent to John James Private Hospital to deal with the orthopaedic joint replacement service which has been hived off from the public system to the private system.

We attempted to do the case later in the evening, but I deemed it unsafe to operate on him after 8.00pm at night in terms of having knowledgeable nurses familiar with urology instrumentation to carry out the operation safely.

[redacted]

The facilities are there but the staff refuse to allow us to use the facilities. This is a recurring problem. This example is something that happens on a regular basis and there has been no attempt to have this fixed in the public hospital system.

The same problem is occurring at Calvary Hospital. I had an all day operating list there last Friday with a dual list in the morning doing flexible cystoscopies and other smaller procedures, under a local anaesthetic, in the adjacent theatre.

The instrumentation for that flexible list was far below what is necessary to run a busy list and there were extreme delays as a result of this.

The parallel all day general anaesthetic urology list was significantly underbooked.

[redacted] is writing to me about problems with category 1 patients and they are not allowing the list to run in a smooth fashion.

Calvary Hospital has been starved of funds to allow it to carry on on a day-to-day basis to meet its targets.

The nursing staff have told me that there has been no increase in the money allocation for instrumentation at the hospital for 10 years. I find this an impossible situation to understand, considering the new technology that we use and the increased number and throughput of cases despite no increase in funding.

I think that ACT Health has significantly underfunded Calvary and there is a resentment between the two public hospitals, so that we cannot go forward and provide a territory wide service to the public here as a result of this. This mainly comes from ACT Health who are unwilling to properly fund Calvary Public Hospital.

There are problems with instrumentation. One of the 5 Urologists in Canberra we feel is responsible for breaking a significant number of instruments. Both hospitals are aware of this and have not addressed the problem with my colleague.

I have written to Professor Bowden and a number of people at The Canberra Hospital, as well as [redacted] at Calvary Hospital, about this particular individual because of his poor clinical outcomes and harassment and bullying of junior medical doctors, as well as allied health and nursing staff within both hospitals.

I have had no response or acknowledgment that the letters have been received by these people. It would appear that they are just merely trying to sweep the matter under the carpet.

Recently, a review has been undertaken of the Urology Unit and perhaps this is going to look at part of this, but your administrators are failing to deal with the severe problems that are present with ACT Health. This failure has supported continuing this poor performance and continuing serious risks for patients and staff.

I would urge that you make time available for me to meet with you.

These problems need to be fixed at the Ministerial level, not at the level of the Department of Health, or at the level of each individual hospital.

There appears to be a system of management where good news is given to managers all along the line right up to you, without the real problems that exist being dealt with. Clinicians, VMO's and Staff Specialists are denied input into management at both hospitals.

There are many political fights going on amongst the management at both hospitals and it is not helping to deliver safe, efficient and improved service to the public of this region. I feel that the matter needs to be reviewed independently by a judicial panel to allow you to support appropriate changes.

I look forward to a response from you and a time for an urgent meeting to have these matters discussed.

Yours sincerely

[redacted]

Cc Prof Frank Bowden, Director of Medical Services, The Canberra Hospital
[redacted] Services, The Canberra Hospital
[redacted] Calvary Hospital