A

Application for Approval as a Committee under the *Health Act 1993*

Send completed applications to:

Quality Assurance Committee Coordinator

Healthcare Improvement Division

GPO Box 825 Canberra ACT 2601

Or email: CHHSM-m@act.gov.au

1. What is the name of the organisation that will be responsible for managing the committee and/or activity?

Canberra Hospital Department of Urology

2. What is the name of the committee or activity?

Canberra Hospital Urology Quality Assurance Committee

3. Who is the first point of contact for this application?

Dr Andrew W Mitchell

4. Who will be the Chair of the committee?

Dr Andrew W Mitchell

5. Contact Details (including postal address, telephone and email address)

11 Moore St Canberra 2601, 0262076277

6. What does the Committee and/or activity involve? Tick all that apply

This question will determine whether your committee is eligible to be established as a Quality Assurance Committee under the Health Act 1993. If the activities below do not relate to the committee's functions, the committee does not meet the required definition of a quality assurance activity and therefore cannot be covered by the legislation.

Assessing and evaluating the quality of a health service (S36)	X☐
Clinical audits or records audits (S37)	X☐
Peer review (S37)	X☐
Quality review (S37)	X☐
Investigation into disease and death (S37)	X☐

The making of recommendations about the provision of health services as a result of an assessment, evaluation or study? X☐

Other – please provide details

Click here to enter text.

7. Public Interest

Before approving the establishment of a Quality Assurance Committee the Minister for Health must be satisfied that it is in the public interest to do so. Please explain how your committee's functions would be facilitated by the members or people assisting the committee being protected from liability.

Members of the committee wish to discuss surgical outcomes, without fear, prejudice, or legal ramifications. In the current situation this has been impossible due leaks of these discussions to outside parties, with negative consequences for individual committee members.

Please explain why the Secrecy provisions relating to protected and sensitive information should apply to information held by committee members.

To allow open discussions for improvement and understanding of clinical outcomes,a nd learning. In the current environment this cannot be held, as previous membership has used this as a means of degrading open discussion by using content of the committee to attack individuals.

8. Information sharing

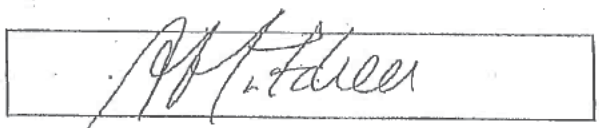
Do you agree to provide protected information to the:

- Coroner's Court (S43)
- Other Quality Assurance Committees (S44)
- Australian Health Practitioner Regular Agency and/or the Health Services Commissioner (S45)
- Minister for Health (S46)

Yes X☐ No ☐ (the application will not be accepted)

9. Declaration: I declare that the information provided in this form is accurate and truthful to the best of my knowledge.

Signature



Name

Dr Andrew W Mitchell

B

6

ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

Canberra Hospital Urology Quality Assurance Committee

TERMS OF REFERENCE

Date	August 2015
Role	To facilitate and conduct quality assurance activities for the purpose of assessing and evaluating health activities provided by the Canberra Hospital Urology Department
Reporting mechanism	• Annually to the Minister for Health to comply with the requirements an approved Quality Assurance Committee • Monthly to the relevant Canberra Hospital and Health Services governance forum
Functions	• Practice within the scope of legislation for an approved Quality Assurance Committee (QAC) under the *Health Act 1993* • Provide a regular quality review forum to evaluate and monitor the quality of the health services provided by the Department of Urology by: - clinical and record audits - peer review - investigation into disease and death - review of incidents occurring within the Department of Urology - review of cases referred to the Canberra Hospital Urology Quality Assurance Committee - identify areas for improvement in the provision of health services in the Department of Urology - identify and agree improvement actions and assign appropriate responsibility - implement, evaluate and monitor improvements to the provision of services within the Canberra Hospital.
Membership (Member list attached)	Membership of a Quality Assurance Committee, or changes to membership, must be approved by the Director-General. Territory Wide Surgical Services Director, Urology Department Consultants and Registrars from Canberra Hospital Other representatives will be invited as required. Invited representatives will be advised of the requirements under Section 35 of the *Health Act 1993* in relation to providing information to a Quality Assurance Committee. Members, delegates and invited guests must not disclose any identified information acquired by them through the approved QAC process and any conflict of interest must be declared to the committee.

ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

Quorum	A Quorum includes the Chair and/or Deputy Chair and 2 Consultants
Chair	Dr Andrew Mitchell, Director Territory Wide Surgical Services The Chair will support the function of the committee by: • Coordinating the meeting structure • Coordinating the record keeping of the committee's activity such as minute taking and case review information for presentation, recording outcomes and actions. • Coordinating the management of information, including the reporting requirements.
Deputy Chair	Dr Simon McCredie, Clinical Director Urology, Canberra Hospital
Secretariat	Dr Andrew W Mitchell or Delegate
Agenda requests	Items to be included on the agenda should be sent to the secretariat at least one week prior to the planned meeting date
Meeting Frequency	Minimum monthly
TOR Review Frequency	The Terms of Reference will be reviewed annually

ACT Government
Health

MEMBERSHIP OF QUALITY ASSURANCE COMMITTEE FOR APPROVAL

Canberra Hospital Urology Quality Assurance Committee

NAME	TITLE
Dr Andrew W Mitchell	Territory Wide, Surgical Services Director, MBBS FRACS
Dr Simon McCredie	VMO Consultant & Director Urology, MBBS FRACS
[redacted]	VMO Consultant Urology, MBBS FRACS
	VMO Consultant Urology, FRACS
	VMO Consultant Urology, MBBS FRACS
	VMO Consultant Urology, MB ChB
Registrars working in the Department of Urology, Canberra Hospital	

Approval

AGREED / NOT AGREED / PLEASE DISCUSS

.....

Nicole Feely
Director-General

Date 28/6/15

Position in relation to committee

Chairman

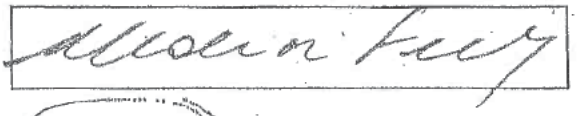
Date

~~28~~ August 2015

Approval

Endorsed ☑ Not Endorsed ☐

Signature



Director-General / Chief Executive Officer circle appropriate

Attachments

The following documents should be submitted with the signed application form:

- Terms of Reference
- Membership list (already approved by the CEO if a private company)

Notification Request - Notifiable instrument (pending)

Request by:	Megan Carey
Position title:	Manager Executive Coordination
Position number:	09954
Work phone number:	62050850
After hours phone number:	0419659545
On behalf of:	Health Directorate
Instrument type:	Notifiable instrument
	Principal legislation
Request submitted:	23 September 2015 12:43 PM

Please notify the making of the following instrument under the Legislation Act 2001, section 61:

Instrument to be notified:

Name:	Health (Canberra Hospital Urology Audit Committee) Quality Assurance Committee Approval 2015 (No 1)
Number:	NI2015-550
To be notified:	routine upload days (Monday or Thursday)

Does this instrument commence:

the day after notification

Authorising law(s):

Health Act 1993	*provision(s):* s25

Instrument maker(s):
Name (as signed):

Simon Corbell MLA	(*Title:* Minister for Health)
Date made:	15/09/2015
Request for notification made by/for:	delegate
Does this instrument repeal or amend another instrument?	No
Is this instrument an appointment?	No

Attachments

*notifiable instrument

I, Megan Carey certify that the attached file for the instrument to be notified contains an exact copy of the text of the instrument as made.

Certified

Please explain why the parliamentary counsel should enter this instrument in the register.

None

Does the instrument to be notified comply with the following requirements prescribed under the Legislation Regulations 2003, regulation 6?

- *a unique name that includes the year in which the instrument was made*
- *the date the instrument was made*
- *the name of the authorising law*
- *the authorising provision of that law*
- *the name (as signed) and title of each maker of the instrument*
- *the instrument's notification number*

Yes

Notes:

None

Back

D

Australian Capital Territory

Health (Canberra Hospital Urology Audit Committee) Quality Assurance Committee Approval 2015 (No 1)

Notifiable instrument NI2015– 550

made under the

***Health Act 1993*, s 25 (Approval of Health Facility QACs)**

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1 Name of instrument

This instrument is the *Health (Canberra Hospital Urology Quality Assurance Committee) Quality Assurance Committee Approval 2015 (No 1).*

2 Commencement

This instrument commences on the day after its notification day.

3 Approval

I approve the Canberra Hospital Urology Quality Assurance Committee as a quality assurance committee for Canberra Hospital and Health Services.

Simon Corbell MLA
Minister for Health

( ) September 2015

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601 | phone: 13 22 81
www.health.act.gov.au

UNCLASSIFIED

		TRIM No.: MIN15/717
To:	Minister for Health	Date Rec'd Minister's Office 15/5/15
From:	Dr Peggy Brown, Director-General ACT Health	
Subject:	Canberra Hospital Urology Accreditation Training	
Critical Date:	Not Applicable	
Critical Reason:	Not Applicable	

- DG Health 14/5/15 (PB)
- DDG CHHS .../.../...

Purpose

1. To provide you with information about the Royal Australasian College of Surgeons (RACS) and Urological Society of Australia and New Zealand (the college) accreditation of surgical education and training of urology trainees undertaken on 31 October 2014 at Canberra Hospital.

2. To notify you that a further onsite inspection by the college will occur on 4 June 2015.

Background

3. On 31 October 2014 an onsite inspection of the SET3-SET5 urology training posts at Canberra Hospital was undertaken by Mr Melvyn Kuan and A/Prof Prem Rashid. A draft report was provided to Canberra Hospital on 10 November 2014.

4. Following the inspection, Canberra Hospital received accreditation of these training posts for a further year, with re-inspection to occur in 6 months.

5. The college made a summary of remedial actions that required immediate attention. These actions were:

   a) Trainee reports need to be timely and reflect a consensus of the unit (not merely a majority vote). Proper process must be followed when assessment reports are collated. There must be regular monitoring and feedback to trainees as well as consultants of progress and remediation where required.
   b) Mentorship/Attendance in outpatients needs to be demonstrated and monitored.
   c) Consultant involvement in Radiology and Multidisciplinary Meetings needs to be satisfactory.
   d) There needs to be some regular formalised teaching program (outside of the usual operating lists & on the job training).
   e) Each member of the unit must demonstrate some contribution to teaching besides just attendance to service obligations.
   f) All members need to be supported in their respective roles within the unit.

6. In addition to the matters requiring immediate attention, the report did note that there have been a number of improvements made in the unit since 2012 however further progress, particularly in supervision and teaching, need to be demonstrated or these training positions may be disaccredited.

7. In response to this report the Urology Unit developed an action plan to address the remedial actions required by the college, and an inspection report for submission to the college has been prepared for the upcoming inspection in June 2015. Some of the actions undertaken to address the recommendations from the college are:

   A. Weekly training tutorials for trainees, with signed attendance records and a monthly review of attendance by the Head of Urology.
   B. Consultant attendance at Multi Disciplinary Team and Radiology meetings with signed attendance records.
   C. Increased Consultant attendance in the outpatients department, with signed attendance records.
   D. Consultant support for trainees to plan research projects.

8. [redacted]

9. The Urology Unit are looking at reorganising their respective roles and reconfirming each surgeon's responsibilities, aligning this with relevant RACS, USANZ and ACT Health policies.

10. Administrative support has been provided to the Urology Department to assist with rostering for consultants/registrars, secretarial support/record keeping and development of timetables for training.

11. Despite the significant work that the majority of the urology consultants have undertaken to ensure Canberra Hospital maintains accreditation of these positions, ACT Health is not certain that the Urology Unit will maintain accreditation for these training positions. [redacted]

12. [redacted]

Government Commitment – Other (and reason)

13. Nil

Issues

14. [redacted]

Financial Implications

15. Nil

Directorate Consultation

16. Nil

External Consultation

17. An external review of the Urology Department has been commissioned by ACT Health. A further briefing will be provided to you once this report is finalised.

Benefits/Sensitivities

18. Nil

Media Implications

19. No media interest is expected at this time.

Recommendations

That you note the information contained in this brief.

Noted / Please Discuss

Simon Corbell MLA..... 25/5/14

Minister's Comments

Signatory Name:	Barb Reid	Phone:	6244 3515
Title:	Executive Director, Surgery, Oral Health and Medical Imaging		
Date:	May 2015		
Action Officer:	Melanie Grimson	Phone:	6244 3207

ACT Government
Health

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601 | phone: 13 22 81
www.health.act.gov.au

UNCLASSIFIED

		TRIM No.: MIN14/1514.
To:	Minister for Health	Date Rec'd Minister's Office 16/2/15
From:	Dr Peggy Brown, Director-General ACT Health Ms Barb Reid, Acting Deputy Director-General Canberra Hospital and Health Services	
Subject:	Urology Department at Canberra Hospital	
Critical Date:	N/A	
Critical Reason:	N/A	

- DG Health 16/2/15
- DDG CHHS .../.../...

Purpose

1. To provide you with a briefing on the Urology Department at Canberra Hospital, focusing on:
    a. an overview of the Mullins Health Consulting draft report on the review of the Urology Department;
    b. an anonymous complaint made to the Urological Society of Australia and New Zealand late 2014; and
    c. correspondence received from a senior Urologist.

Background

Mullins Health Consulting Review

2. A review of urology services across both the Canberra and Calvary Hospitals was conducted between September and November of 2014, however the extent to which Calvary Hospital was reviewed was limited. The review focused on the efficiency and effectiveness of urological services including the Patient Journey, pre and post-operative care, theatre experiences and outpatients.

3. The review was commissioned following concerns that were raised about the delivery of urology services in the ACT across both Canberra and Calvary Hospitals. Concerns included a cluster of clinical incidents that were investigated by the Canberra Hospital Clinical Review Committee and which formed part of a Health Services Notification to the Director General.

4. The review was performed by Mullins Health Consulting which consists of [redacted] Fellow of the Royal Australian College of Medical Administrators and [redacted] Fellow of the Australian and New Zealand College of Anaesthetists. A draft report has been provided outlining a number of recommendations for improvement. The report is based on conversations with over 40 employees and contractors and an onsite review of documents conducted over four days in September 2014.

Complaint made to the Urological Society of Australia and New Zealand

5. [redacted] Chair, Board of Urology wrote to the Canberra Hospital advising of concerns raised by an un-named member of the consultant staff at Canberra Hospital. The concerns related to the provision of services and training for SET Urology trainees and were raised following a Training Accreditation visit undertaken by the Board.

Correspondence received from an individual Urologist

6. Over many years a senior Urologist, has written numerous vexatious complaints to the executive of Canberra Hospital, as well as to the Director General and previous Minister for Health. These generally focus on the quality of care provided by all of his colleagues as well as the general administration of the hospital.

Government Commitment

7. N/A

Issues

Mullins Health Consulting Review

8. The draft report is provided at Attachment A. Whilst the original scope was to include Calvary Hospital the review team did not visit Calvary due to time constraints.

9. The report commended improvements in the efficiency of the Outpatients function. This is attributable to the appointment of a Head of Unit position in 2013. As a result of this leadership role, in 2014 the function improved significantly and complaints and cancellations were almost zero.

10. Another positive identified in the report is that elective surgery wait times are below the national average. This may be further enhanced with improvements in the operating theatre processes that are currently being considered.

11. The report cites accountability as an opportunity for improvement. It notes that an improvement in the provision and analysis of clinical data would strengthen clinical accountability, by allowing for effective conversations between management and clinicians. Similarly there is an opportunity to improve communication between medical and nursing staff on the ward.

12. Accountability for individual behavior is another area identified for improvement. Interpersonal conflicts within the unit have created difficult working relationships. This has included one Urologist undermining his peers by querying the credentials of more than one peer. The billing practices of this individual are also raised. It was noted he consistently has longstanding financial claims undertaken in an ad-hoc manner. There is also a longstanding history of submitting invoices which in the view of the Directorate do not meet the terms of his contract. This causes a significant administrative burden to reconcile and negotiate with the Urologist.

13. In discussions regarding the report, [redacted] dentified that this individual senior Urologist provided extremely negative feedback covering all aspects of the urology department. This individual has been identified as the author of a number of potentially vexatious complaints, submitted to a variety of health monitoring organisations. [redacted] considered that this level

of negativity and poor behavior is a considerable risk to the successful implementation of the recommendations within the report. These issues are discussed further later in the brief.

14. The supervision of Registrars is also addressed in the report. There is an opportunity to implement a more formalized training program and consistent approach to the level of supervision and support provided to Registrars. It should be noted in saying this, the report noted no risks to occupational health and safety or human resource issues of concern.

15. It has also been suggested to formalize the professional development of both registrars and consultants at the point of re-appointment and re-credentialing. This includes formalizing the scope of practice for the provision of urology services.

16. The draft report has identified a number of recommendations to improve the urology services and address the issues mentioned above. The suggested recommendations have been reviewed and Attachment B outlines the suggested response to these recommendations.

17. An implementation plan has been drafted outlining the key steps towards the communication and implementation of the recommendations. This can be found at Attachment C. One of the key objectives for the Division of Surgery Oral Health and Medical Imaging is to support the unit director in addressing the difficult inter personal relationships within the unit.

18. The Division is currently working with the unit director to develop reporting tools that will both address the issues raised by the review panel and well as support the unit in making informed business decisions, establishing audit processes and reviewing activity and theatre utilisation.

Complaint made to the Urological Society of Australia and New Zealand

19. In response to the complaint received by the Society, the Clinical Director of Surgical Services, Dr Bryan Ashman has investigated the concerns raised. A detailed response has been provided and can be found at Attachment D. Feedback from the Board has indicated that if their investigation finds the complaints to be unfounded, they may consider action against the complainant.

20. The complaint, whilst identified as being from a consultant at the Canberra Hospital, is anonymous. It does however reflect similarities to previous complaints received directly by the hospital.

Correspondence received from an individual Urologist

21. A senior Urologist has been the author of numerous complaints including Ministerial correspondence. ACT Health believes that these complaints are unfounded, due to the lack of substantive evidence or details provided. The complaints clearly aim to undermine other Urologists within the unit and are often general in nature. On the few occasions where enough information has been provided to allow an investigation, none of the complaints have been substantiated. On one occasion the investigation revealed that the complainant himself was at fault.

22. The Mullins review has independently identified this Urologist as a significant risk to the implementation of the recommendations of the review and improving the operations of the Urology unit.

23. The Canberra Hospital executive is currently looking at these issues and options for appropriate remediation. You will be briefed separately on this.

Financial Implications

24. N/A

Directorate Consultation

25. Due to the draft status and confidential nature of the report, it has not been made broadly available.

26. The Executive Director Surgery Oral Health and Medical Imaging, the Clinical Director Division of Surgery will undertake the appropriate consultation with the Deputy Director General, Canberra Hospital and Health Services prior to consultation occurring with the Clinical Director of the Urology Department and the individual specialists.

External Consultation

27. Consultation will then need to take place with each of the individual Urological Specialists in relation to the draft report recommendations and subsequent action plans.

Benefits/Sensitivities

28. The report has been identified as being confidential in nature.

Media Implications

29. There is no media interest expected at this time.

Recommendation

That you note the information contained in this brief.

Noted / Please Discuss

Simon Corbell MLA..... 17/2/14

Minister's Comments

Signatory Name:	Barb Reid	Phone: x43515
Title:	A/Deputy Director General CHHS	
Date:	19 January 2015	
Action Officer:	Joanna Redmond	Phone: x42169

COPY

CONFIDENTIAL

ON SITE REVIEW OF UROLOGY SERVICES AT ACT HEALTH - CANBERRA HOSPITAL & CALVARY HOSPITAL

NOVEMBER 2014

CONFIDENTIAL

This Report is based on conversations over forty ACT Health employees and contractors and an on-site review of documents and over four days in September 2014. It is confidential. Any use of this document for any purpose other than the purpose for which it was developed is prohibited.

Mullins Health Consulting, November 2014

EXECUTIVE SUMMARY

ACCOUNTABILITY

Accountability needs to be significantly improved in relation to the Urology Unit and the Canberra Hospital. Effective clinical accountability is impeded by lack of objective data. Accurate contemporary data provides the currency for effective conversations to take place between peers and between management and clinicians.

There are a number of staff members within the organisation who collect this data, but the sharing of this data in a meaningful, transparent and useful way to clinicians appears to be minimal. This needs to improve.

Contractual accountability needs to improve and contracts need to be managed by the letter of the contract. Issues in relation to performance, clinical and supervisory expectations and activities are contained in part within the contracts and, if not within these, they are contained within obligations within the Royal Australasian College of Surgeons and the Medical Board of Australia. These need to be highlighted, enforced and behaviours improved.

Financial accountability needs also to be improved. A situational habit of longstanding financial claims being submitted by one of the Urologists in an ad-hoc manner on non-official forms must cease. A standard process for submission of claims for fee for service must be enforced throughout the organisation. This includes a requirement for claims for remuneration to be submitted within the current financial year and on an acceptable format to the Finance Department.

Supervisory styles and accountability varies between Consultants. There is no desire to quash individual styles, but clear expectations for the level of supervision must be made clear. Currently, the most senior urology registrar within the Canberra Hospital is at SET3 and for most procedures needs close supervision. An independent consultant approach to supervision must change and must be standardised.

A clear scope of practice for the level of supervision for the Urology Registrars ought to occur at the time of their appointment, at six months and at nine months into their rotation.

There appeared to be no occupational health & safety and human resource issues of concern.

UTILISATION & PRODUCTIVITY

The Outpatients' service is currently performing at a significantly improved level than it has done so for many years. There is demonstrable need for additional Consultant Clinics and additional Registrar Clinics to not only follow inpatients and patients requiring long-term follow up, but also to meet the urological demand of the general population. An attempt to improve information to general practitioners in relation to a test to be done prior to Outpatients is welcomed and should be expanded.

The operating theatre is currently under review and there are acknowledged inefficiencies within that system. We would support any improvements in relation to that area.

The urology component of ward appears to function adequately, but does not function as well as the vascular surgery component of the ward. Conversations ought to occur with nurse management and the Urology Unit to see how this can improve and behave similarly to the vascular unit in terms of a cohesive group that manages patients, trains junior staff and medical staff and liaises appropriately and effectively with the nursing staff.

The urology unit ward round, although a good idea, does not occur in practice and this ought to be implemented at a time where all Consultants can attend and nursing staff engagement be better involved.

Significant attempts need to be made to improve communication between the medical and the nursing staff on Ward 9A. Regular meetings of Registrars and the nurses in charge ought to occur and clinical handover needs also to improve.

AMBULATORY CARE & WAITING LIST MANAGEMENT

The waiting list for Outpatients has improved as a result of internal changes since the middle of 2014. The current improved system nonetheless only manages (severe) Cat 1 patients and those with less significant conditions are required to attend private clinics and pay out of pocket or wait for years for an appointment.

There is a significant surgical waiting list and comments have been made in relation to individual clinician efficiencies or inefficiencies within that area within the report. Again, data in relation to this is readily available but needs to be turned into an accessible format for managers to have conversations with individual clinicians in relation to their efficiency and performance.

A formal partnering performance (aka performance appraisal system) must be implemented to improve engagement between the Canberra Hospital and its senior Urologists. Often Heads of Unit find this challenging because they are unused to managing peers and colleagues and the Director of Surgery ought to have an active role in relation to this. Timely and relevant personalised data is the key to having effective and meaningful conversations with clinicians.

CLINICAL GOVERNANCE

There appear to be so many sources of data and yet so little information shared with clinicians at the Canberra Hospital. Basic internal comparisons of activity of complications of outcomes ought to occur.

Our analysis of three years of length of stay (LOS) data for 20 common conditions reveals significant differences between the Consultants. This needs to be reviewed and discussed. This data also revealed some Consultant undertaking small numbers of certain procedures in the three-year period. Hence a specific scope of practice for key procedures ought be considered to maintain surgical skills and outcomes.

External benchmarks such as the MyHospital website, and the Health Round Table similarly ought be reviewed as there are some concerning trends in relation to the urology service and the surgical service in general.

It should be a requirement for mandatory audit to occur within the Urology Unit; that the annual plan be made clear at the start of the year and those audits reviewed and looked at, at directorate and clinical governance level.

RESOURCE MANAGEMENT

The report indicates clear inefficiencies within the Urology Unit. These need to be explored and discussed within the Unit and with the relevant individual Consultants.

Professional development needs to be a part of a re-appointment and re-credentialing process within the Canberra Hospital. Specific urological competencies appear not to take place and a formalised scope of practice for the provision of urology services needs to be implemented at Consultant and Registrar level.

A more formalised Registrar teaching programme needs to be put in place so that it compares favourably with those that occur within the other large metropolitan urology training programmes.

RESEARCH

The Urology Department, aside from [redacted] appears to have little interest in research. This is disappointing and clarification of the requirements for participation in research needs to be made clear and be part of ongoing contractual requirements for the specific Urology Consultants.

CONCLUSION

All staff members who participated in conversations with the reviewers did so in a spirit of professionalism.

Access to timely data was problematic but owing to persistence from the surgical executive, it was eventually forthcoming. The issue of provision and sharing of timely process and outcome data is critical and must be resolved so that data can be the currency for effective communication, engagement and management of clinicians.

LIMITATION OF THE REPORT

Owing to time constraints we did not visit Calvary hospital nor meet with any of their staff. The system there seems to run smoothly and no concerns were raised. Indeed, it was held-up as a much more efficient way to undertake surgical procedures than at TCH.

We did not use a specialist Urologist on the review team as most of the issues were system–based .The cases of unplanned returns to the operating theatre and unplanned admissions within 14 or 28 days are extremely concerning and should be reviewed by a senior urologist, and we would be happy to arrange for that to occur.

[redacted] **FRACMA and** [redacted] **FANZCA**
Mullins Health Consulting
November 2014

CONTEXT OF THE REVIEW

Background and context

ACT Health has identified a need to undertake a review of the efficiency and effectiveness of urological services including the Patient Journey, pre & postoperative care, theatre experiences and outpatients across both Canberra Hospital and Calvary Hospital.

Reviewers

Clinical reviewers are to be appointed by ACT Health.

Terms of Reference

1. *Review the structure of the Urological Department, including the role of the Head of Department, senior and junior staffing levels and staffing models. Review lines of accountability and make recommendations to ensure that urological services are provided in an efficient and effective manner; and that the hospitals meet their OHS and HR obligations including fair and equitable treatment of all staff.*
2. *Review the staffing and management of the urological services including the utilisation and productivity of the theatre, wards and outpatient clinics, make up of teams and how they function and communication – verbal and written documentation.*
3. *Review the management of Outpatient Department and Surgical waitlists with reference to achieving the National Elective Surgery Targets (NEST) and conformance with Department of Health policy.*
4. *Review clinical governance activities pertaining to urological patients including the adequacy of audit protocols, outcome reporting and benchmarking against national standards.*
5. *Review sessional allocations, urological workloads and the distribution of workloads between consultants.*
6. *Review educational requirements and access to professional development, teaching and training program.*
7. *Review current research activities and performance, and advise on strategies to improve research opportunities for urological services in ACT Health.*

Governance and Support

Review support will be provided by the Executive Director Surgery, Oral Health and Medical Imaging and the Clinical Director of Surgery.

Implementation of the review recommendations will be overseen by the soon to be established Urological Review Committee chaired by the Clinical Director of Surgery.

WHAT IS A QUALITY SERVICE?

A key component of clinical governance is the definition of quality. In 2004, the then Australian Standard for Safety & Quality in Health Care provided information relating to the dimensions of quality. These dimensions were **effectiveness, appropriateness, accessibility, responsiveness, safety and equity**. In an attempt to summarise a view of the Urology Unit, application of these definitions provide a framework to summarise the finding of this review.

Is the Urology Unit effective?

Effectiveness is combination of efficiency and reliability. In terms of efficiency outpatients is functioning much better but with such an extraordinary waiting list, even if half or 70 % is culled, there still needs to be additional outpatient sessions to meet demand. The Unit needs to be rewarded for its provision of information to GPs in relation to what investigations need to be done for some key category 1 situations, but the same ought to be applied for other category 2 and 3 conditions should they be able to see them.

If the hospital is unable to provide key services such as a vasectomy, then it needs to be made clear what it can and can't provide to the GPs and they can make some plans accordingly. The entire suite of services listed under outpatient category 2 and 3 needs to be revised and some truthful decisions need to be made and conveyed to GPs in relation to the provision (or not) these services.

One additional Outpatient Clinic undertaken by the five Consultants would be an enormous benefit to the community surrounding the Canberra Hospital and more efficient use and demarcation of sub-category of appointments within these clinics will assist in better flow through.

The Outpatient Registrar Clinic is useful but it is important that straightforward post-operative reviews without the need for histological discussion should be sent to those clinics and this could be overseen by the prostate and the bladder cancer nurses.

The operating theatre is not efficient and that is well recognised. A current review is looking at ways of improving that efficiency. Many of those people undertaking the reviews have been in the unit for some years and it may well be that fresh eyes may assist them in this endeavour. The waiting list has improved over time but additional Consultant resources will ensure that.
The ward appears efficient but lacking in optimal nurse doctor communication. There is great variety in individual Consultant average length of stay for many procedures.

Is the Urology Unit efficient in terms of service delivery?

Data available suggests that here is wide variation in their level of efficiency. Some are always late for outpatients; others always on time. Some see all new patients; some see none.
From an elective surgical perspective, some manage their allocated sessional time well; and others have a very low ratio of cases per session. Average length of stay varies greatly in many conditions.

Is the Urology Unit efficient in terms of supervision?

The Registrars note that some consultants are there all the time and others are there as required, but certainly the Registrars enjoy the post at the hospital. Are they effective as colleagues to each other? No they are not! There is not a strong sense of cohesion within the Unit, in contrast to the vascular unit who are co-located in Ward 9A.

The team model of Consultant demarcation [redacted] and [redacted] works well in terms of Registrars' experience, but one does not get a sense of them working together as a team or particularly proud to be together as a team. They are not good colleagues and they are not good team players. MM's activities in undermining peers and generally creating trouble, needs to be managed as an absolute priority.

In terms of effectiveness is the Urology Unit reliable?

Yes, they provide a regular service for the hospital. The weekend cover and after hours cover is led by Registrars where they get varying levels of activity and involvement, everything from ward rounds over the weekend to ward rounds only if required, and a middle ground needs to be found where surgeons who are on call will see patients and also setting clear boundaries by which Registrars can open theatre need to be established, given they are relatively junior as SET3 trainees.

Is the Urology Unit appropriate?

It's difficult to know because there is very little outcome data that says is the care that they're giving appropriate. There are no measures in between the five consultants. There are no measures across other Urological Units. The Mater Hospital data would suggest that there is some inefficiencies largely of wait list management.

The Health Round Table data suggests similarly that the use of blood is certainly more substantial than in other hospitals and the fact that there are five newly red indicators on the Health Round Table[tm] data that relate to surgery warrants general concern from the organisation. It is difficult to know whether their management of individual cases is appropriate, as M & M Meetings do not have any data or recorded information in relation to any of those discussions. In terms of behaviour, the behaviour of some of the members of the team is quite clearly inappropriate.

Is the Urology Unit accessible?

The MyHospital data would suggest that there are some wait list problems that are not particularly different to other peer hospitals. The letters to the GPs in relation to accessibility to outpatients has clearly revolutionised the outpatient experience, not only for patients but for the staff, and this is to be commended and additional work based on that very good response should take place in terms of category 2 and 3 patients, and especially the need to have clear pathways for patients with known and documented malignancies to manage throughout the unit.

It is noted that since [redacted] returned, there has been a substantial increase in his waiting list and that needs to be discussed in terms of appropriateness for those patients and the time in which that has taken to build that up so quickly.

Is the Urology Unit responsive?

The overall sense is that it is more of a reactive rather than a proactive service. Most of the consultants are happy to come in. They are certainly responsive to the Registrars. They do not appear to be particularly responsive to the nursing staff. Aside from the unit meeting, there is no general ward meeting where they meet with associate Unit Managers or educators or the Quality Manager in terms of their understanding their unit.

Is the Urology Unit responsive to the organisation?

No they are not. Attempts to have regular meetings appear have failed. The Head of Unit position would appear to be somewhat of a poison chalice rather than something that is sought after and, certainly within the Board of Surgical Directorate, there is wide-ranging, inappropriate and poor responsiveness in terms of collegiality.

Is the Urology Unit safe?

It is very difficult to know. The Registrar certainly works to a significant extent in an unsupervised way and may relate to the individual confidence of the Registrar rather than their particular prowess. In outpatients, new patients are seen and not necessarily actively managed by all of the consultants and this may lead to delay or inefficiency in decision making, which may compound some of the outpatient waiting list problems. Based on the Health Round Table Initiatives data, there is a higher than average rate for Canberra Hospital of blood usage and hematomas post-operatively. This may be contributed significantly to by the Urology Unit and that would be worth further investigation.

Is the Urology Unit safe in terms of outcomes?

Well, it's difficult to know because, aside from deaths that are looked at, no other outcomes are looked at in any structured way. There are an extraordinary number of patient safety clinical governance audit and related officers throughout the Canberra Hospital and it is unclear where all their work comes to be able to be shared with individual units to help and improve their services. This absolutely needs to be done as a priority and could well be done in the context of needing to have demonstration of outcomes as part of National Standards Accreditation.

Morbidity is discussed regularly but no notes are kept, so there is no knowledge of immediate post-operative problems or complications or differing techniques and this is very disappointing, so it is actually difficult to say whether this unit is safe or not. All that can be said is that in the three-month period it had one reportable death to the CRC as opposed to several others, one of whom is noted having died as a result of having a minor dental procedure.

There is a great variety in LOS data by consultant by procedure. This should be internally discussed and reviewed. There is no LOS data for surgical registrars when they are the primary surgeon.

Is the Urology Unit equitable?

Certainly within the hospital there's no discussion of private insurance status. Patients are booked in on the basis of their name, not their insurance, and they are apportioned on the waiting list in that way. In terms of equity, the Registrars are able to manipulate the operating list, but this is done within a fairly clear guideline of patients who need to be seen, so there's no sense that patients are being cherry-picked over other patients.

There is a concern with the May 2014 letter from Outpatients suggesting that the patients, if they have a delay, can (and are encouraged to) be seen in the Consultants' rooms. This does raise a significant issue in relation to equity, as almost invariably those patients would have a fee attached to that private visit, but then have them added to the hospital wait list.

It can be seen that when [redacted] returned, 68 additional patients were added to his wait list that have come from his private rooms. This does raise an ongoing murky issue for the Canberra Hospital that VMOs, by their definition, will work in public and private and may well have equity issues in relation to their patients. This has been a perennial problem but it is good to see that, at the hospital level, Wait List Managers and Outpatient Managers don't differentiate on the basis of private insurance.

In conclusion, unless there is clear and reliable data; the value of the Unit, its safety and quality profile will remain unclear.

RECOMMENDATIONS

1. A clear system of data collection, review, sharing and discussion opportunities should be provided to the Urology Unit in order to:
   - Clarify appropriateness of activity
   - Discuss impacts on length of stay
   - Discuss defined morbidity and outcomes to include deaths, unplanned returns to theatre, unplanned re-admissions within 14 days, unplanned re-admissions within 28 days, infection rates for key procedures, long term complications in patients such as impotence or urinary incontinence, survival rate of prostate bladder renal and related tumours.

2. A requirement of all urologists (and this should occur for all clinical units within TCH) should be to meet and discuss this data, provide a formal report and explanation of the outcomes to the Clinical Director on a twice-yearly basis.

3. Create a weekly Morbidity and Mortality (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.

4. Regular data on the following must be provided to the urology unit for them to discuss and provide commentary back to the Clinical Director. These actions are in keeping with the Medical Board of Australia Code of Conduct Section 4 *Working with Other Health Professionals* and Section 6 *Managing Risk* and Section 7 *Maintaining Professional Performance* and the RACS Code of Conduct Section 2 *Standard of Clinical Practice,* Section 4 *Working with other Health Care Professionals*, Section 6 *Minimising Risk*, Section 7 *Maintaining Professional Performance* and Section 8 *Professional Behaviours.*

5. 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.

6. Criteria for the need for consultant review of in-patients 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 or associate nurse unit manager requiring consultant review should take place. This can then be routinely audited against VMO claims.

7. 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 TCH urologists should consider implementing with dedicated Quality Unit staff supporting.

8. 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 is an 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.

9. 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 a 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 the who have suffered significant morbidity.

10. The Canberra Hospital should manage the VMO contracts according to the letter of the contract.

11. Fee for service submissions should be on an official TCH form and have a place for the doctor to certify that the claims are correct. Instances of over-claiming should be actively investigated and, if they continue and are found to be erroneous, they should be referred to the internal auditors or to the Auditor General for an explanation.

12. TCH should clarify the timeframe for submission and payment of VMO fee for service claims. Ideally, claims are made within one month of the activity, but

no claim 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 VMOs 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 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.

13. Medical records staff should check entries in the medical records before a fee for service is paid.

14. Surgeons and Anaesthetists should write the item number for their services on the operation sheet at the time of the operation to further improve the efficiency of the system

15. Registrars should have a clear framework and timetable for supervision by the Unit to ensure consistency over their time at Canberra. This should include inter alia – weekly meetings, review, case presentation, discussions, journal club, research opportunities, etc.

16. Specific times for formal feedback to the registrar should occur at 3, 6, 9 and 12 months from all consultants, the unit manager of the ward and the prostate and bladder clinical nurse specialists. This would also be an opportunity to review their scope of practice.

17. Junior staff should also be provided with formal feedback at least once in their rotation from one of the accredited registrars and at least two of the Consultant seniors to assist them in their professional development.
18. Support should be given to the operating theatre review and consideration of the use of external consultants to assist in this process would seem an efficient approach to this longstanding problem.

19. 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.

20. 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 can be more accurately interpreted.

21. Review and follow up of patients is not robust. Consideration should be given to a database and a checking process by which all patients having had investigation of biopsies of malignancies are followed up accurately and they are not left to be lost in the system.

22. Elective surgery wait times are below the national average, although have improved over previous years, but this may improve with an improvement in the operating theatre processes to allow for more cases to be undertaken within a given operating theatre list.

23. Ward processes could be improved with improved communication of Registrars and Unit managers on a daily basis to clarify plans for patients.

24. Nurse unit managers and associate unit managers should attend the M & M Meetings.

25. Nurse unit managers and associate unit managers should attend the Unit Meeting, which will require a proper agenda to include items such as:-
    - Activity against agreed KPIs
    - Outcomes against agreed KPs
    - Workforce requirements
    - Risk Management – incidents, complaints, problem, risks.
    - Quality improvement – activities reporting back'
    - Problem solving
    - Equipment needs
    - Around table discussions and problems
    - Progress toward accreditation survey in 2015

26. A timetable of agreed activities for registrars and HMOs should be published on a monthly basis. Expectation of audits to be undertaken by registrars and HMOs should be clarified at the start of each rotation and have a Consultant assigned to support their activities and be regularly reviewed. This is in line with RACS Code of Conduct 6.1.

27. 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 Unit Meeting and provide their valuable insights into patient processes and this should be welcomed and encouraged.

28. The Urology Unit membership should include all five consultants, registrars and house medical staff, CNS nurses, 9A nurse unit manager and at least one associate nurse unit manager, urology outpatient nurse, urology operating theatre nurse, operating theatre wait list management nurse and the prostate and bladder cancer nurses and they need to meet as a unit on a monthly basis. In this way issues can be identified and resolved in an efficient and effective manner, with minutes being taken for follow up and review.

29. Clinics should be re-named and have specific bookings to allow for new patients; review of current patients with malignancies; review of current patients with non-malignant problems; immediate post op patients; old patients with new problems.

30. 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 patient being seen.

31. Time of attendance at outpatients is to be routinely kept for all Consultants attending and all outpatient staff and be part of their performance appraisal on an annual basis. Regular latecomers should be escalated to the Head of Unit and to the Clinical Director for management.

32. Regular, timely and available process and outcome data must be provided to the Urology Unit in an orderly and planned way in order to review and learn. The unit should see a list of clinical process and outcome data on a regular basis as contained within the body of the report and be required to provide an explanation for the data.

33. A dedicated time for the quality unit should be provided to ensure this data is readily available and shared at the unit meeting on a monthly basis. Automatic extracts from the hospital IT system should be feasible and would facilitate this process.

34. 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.

35. Flagged cases should be formally identified and reported on at regular Morbidity & Morality Meetings. These should be determined immediately and may include:

    - Unplanned return to the operating theatre;
    - Blood transfusion more than two units;
    - Length of stay greater than the average length of stay for the given procedure;
    - Number of surgical procedures to remain competent;
    - Planned admission to the Intensive Care Unit;
    - MET call greater than 2;
    - Complaints – incidents of an ISR 1 or 2 in match up.

36. A clear six monthly report is to be forwarded to the Clinical Director in relation to the Urology unit clinical governance activities.

37. 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.

38. Review of Registrar length of stay activity and other outcomes should be included in Consultant length of stay activity for key procedures as listed out in the report.

39. Key clinical indicators such as unplanned returns to OT and unplanned readmissions within 14 -28 days are extremely high and need to be reviewed as a priority.

40. 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 skill 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.

41. The Urologists should all be provided with the RACS Code of Conduct and be required to sign off as to the content. In particular they need to be aware of the College obligations outlined in Section 4 in relation to working with other health care providers.

42. 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 specializing in urology should be considered.

43. Annual review of CPD requirements should be considered as part of annual appraisal for Consultant staff.

44. An annual meeting with the Head of Unit and the Clinical Director and another unrelated executive should occur as the basis of annual review. Consideration of the Townsville Hospital SMPR (Senior Medical Staff Performance Improvement Process) should be considered for implementation across the Surgical Directorate as a means of partnering for performance.

45. No business plan was available for the reviewers for the Urology Unit. These should occur to satisfy targets of unit activity, particularly in relation to activity based funding and the need to work within a constrained budget rather than as if required by the medical staff. Targets of surgical activity were not known by members of the Urology Unit. This need 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.

46. Inefficiency is use of surgeon operating time as outlined in the report should be internally reviewed.

47. Consideration should be given to require all surgeons with appointments to the Canberra Hospital to keep a personal log book consistent with RACS suggestions as an element of good practice.

48. 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.

49. A list of projects at the start of the year needs to be made available for both accredited and non-accredited Registrars and interested junior medical officers. They should be assigned to a specific member of the consultant group and encouraged throughout the year.

50. 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 from other Units within the Surgical Directorate.

BACKGROUND INFORMATION TO THE UROLOGY UNIT

Structure of the Unit

TCH

- 5 consultant urologists – All VMOS
- 2 accredited Urology trainees (registrars) – SET 3
- 1 non accredited registrar
- Hospital medical staff

- 1 prostate cancer nurse
- 1 bladder tumour nurse
- 1 urology Outpatient nurse
- 1 urology elective waiting list RN

Calvary

5 consultant urologists
SET 2 trainee

Unit activities

- Morbidity and Mortality meetings (M&M) weekly on Mondays
- Unit meeting – monthly after M&M meeting
- Multi disciplinary meeting MDT – every Thursday
- Unit Grand Round – monthly after MDT started in 2014
- Saturday morning Journal Club - monthly

Outpatient clinic roster

WEEK	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Week 1 AM	REG (H C E)			[redacted]	
PM					[redacted]
Week 2 AM		[redacted]			
PM					[redacted]
Week 3 AM			[redacted]		
PM			[redacted]		[redacted]
Week 4 AM					[redacted]
PM		[redacted]	[redacted]	[redacted]	

Operating theatre list

Elective List per month

[redacted]	**6 per month**
	4 per month
	8 per month
	8 per month
	4 per month

Informal Summary and observation of Urologists

[redacted]

[redacted]

Urology Ward 9A

This is a busy surgical ward and has co-located vascular surgical patients. There is a big difference in the Unit's style.

- The Urology Unit is described as somewhat 'laid back'.
- The Vascular Unit is very active. They have clear processes, clear plans, a very active team ward round, nursing staff are always clear as to what's happening with all of the patients and their documentation is excellent.
- In contrast the Urology Unit is described as 'laid back', have ad-hoc Consultants attend at varying times of the day and night to do ward rounds – often after 5 pm.
- In 2013 it was a source of great angst and frustration for the nursing staff. The Registrars in 2014 appear to have a better relationship with the nursing staff, but the nursing staff still feel they are not included in discussions and decisions in relation to the patients and their management. The Registrar documentation has improved a little in 2014.
- The ward receives feedback in relation to outcomes by the Quality Manager and these are by RiskMan incidences. They receive no other information in relation to urology patients or vascular patients.
- A unit meeting that occurs once a month with the Consultants. The Unit Manager attends "whether they want her to be there or not".
- It is a stable nursing workforce. The Nurse Unit Manager has, however, been in an acting position for over two years. The comment that *there's not been a Consultant on the ward for seven years*' is clearly not correct. [redacted] are often on the ward. [redacted] are on the ward as needed and [redacted] attends from time to time but does no on call, this is not seen as particularly unusual.
- Outliers are a not infrequent part of the Urology Unit reality. The day sample equals 23 patients listed as Urology, 10 were in 9A, 1 was in 5A, 1 was in 7B, 2 were EGS, 2 were in HDM and 7 were in theatre.

SECTION 1 – ACCOUNTABILITY

Review the structure of the Urological Department –

- ***Including the role of the Head of the Department, senior and junior staffing levels and staffing models.***

- ***Review lines of accountability and make recommendations to ensure that urological services are provided in an efficient and effective manner.***

- ***Ensure that the hospitals meet their OH & H obligations including fair equitable treatment for all staff.***

Areas for review –

- Clinical accountability
- Contractual accountability
- Financial accountability
- Supervisory accountability

TCH has a long history of placating medical staff to ensure that they would stay and deliver a service at the hospital. There is a chequered history of staff specialists (often from overseas) coming to broaden the medical base at Canberra often resulting in resignation or transfer to the "fee for service camp". Doctors remain differentiated by the manner of their remuneration – 'staffie' (staff specialist) or VMO rather than by their area of interest. This paradigm is a powerful influencer on much of the doctor –organisation relationship.

The VMOA (Visiting Medical Officers Association) is a longstanding and effective negotiator and remains very influential in relation to engagement with senior medical staff.

In a significant change, contracts for VMOs were introduced in 2007 with minimal accountability measures included. The 2007 contract explicitly omitted a performance component in order to ensure uptake by the senior staff. Subsequent revisions of the contract have attempted to include such requirements.

It is ten years since the Canberra Medical School provided the medical community with its first local graduates. There is anecdotal evidence of local graduates keen to return to work at TCH.

Many Sydney and Melbourne Hospitals have an over-supply of new Fellows (especially in anaesthetics and emergency medicine) who may consider Canberra as a viable site to relocate. This may mean that the longstanding difficulty in attracting "new blood" may change over the next few years.

Within the division of surgery and oral health, attempts to improve accountability have been largely futile. Practitioners are managed "by exception" and it is acknowledged that it is less than optimal.

Attempts to have regular meetings with Heads of Units have failed – due to non-attendance by those Heads of Units – and there has been no consequence for this passive/aggressive inaction.

There is a minimal Head of Unit position description; but no clear lines of accountability; no clear expectations. There is an allowance in the contract for payment for Head of Unit and some activities are outlined as part of this payment.

Individual surgeons work and engage within a local speciality environment; for example, it would appear that the Vascular Unit is cohesive, inclusive, very reliable and command respect from a number of those working internally.

In contrast, the Urology Unit is seen as being made up of five individuals, all with different styles and different ways of managing patients, colleagues and appears not to work cohesively as a group at all.

Urology Unit Clinical Accountability:

The core issue of who is in charge needs to be made clear. It would seem that the Clinical Director has ultimate responsibility for the management of the Urology Unit and that is actioned via the Head of the Unit. Since mid 2013, the Head of Unit position is much clearer and [redacted] is well regarded in this task.
He is not, however, particularly consultative with the nursing staff and there are a number of additional nursing staff, all of whom could contribute to the Unit being much more effective and productive if they all met together and were clear on what actions need to take place.

Outpatients have improved significantly in 2014 and complaints and cancellations are almost zero. Consultants now reliably attend Clinic, although [redacted] is noted to be late on a regular basis. This is in significant contrast to years of complaints, inefficiency and ineffectiveness in relation to the Outpatient Clinic.

As Head of Unit there has been no internal performance appraisal of his colleagues, no internal performance appraisal of himself, no performance appraisal by the Clinical Director of the Unit or the individual Urologists.

Interpersonal conflicts have been allowed to fester and this creates difficult professional relationships. [redacted] and [redacted] both have had their professional credentials queried significantly and formally by [redacted] almost immediately after they were appointed. This has led to quite passive behaviour by [redacted] and a somewhat resigned attitude of frustration by [redacted]

[redacted] corresponds regularly with the Clinical Director and the Head of the Unit in relation to various concerns. These are seen as particularly time consuming and very few of the issues that he has raised have been found to be of significance. They are bordering on vexatious.

The Unit meeting which takes place once a month has no structure, no minutes are taken, and there is no administration support and no regular data reviewed or

discussed. Follow up with incidents, complaints and concerns may or may not occur, as there is no record of what takes place.

The Unit is unable to assess itself as a result of lack of data and there is no process by which it can compare with its other surgical peers within the Canberra Hospital, let alone other Urological Units across the country. A suite of clear clinical indicators for all Surgical Units ought to be in place and there appears to be enough quality and safety staff observed within TCH for this to happen. This will assist the Clinical Director to better manage performance based on fact rather than hearsay and gossip in relation to performance. One of the real challenges for the Clinical Director is that he is working in a data and information vacuum. This makes it extraordinarily difficult to mange effectively and individual personalities and behaviours can have too much influence.

The British Association of Urologists has clinical audit data that can assist in comparing various cases for the urologists at similar levels within the United Kingdom. Health Round Table data will be discussed later as will MyHospital data, all of which provide information to reassure or raise concerns in relation to the quality of the urology service.

One of the challenges in terms of clinical accountability is that the only information or evidence that appears to occur is that of letters written by [redacted] Unless there is a clear data basis for conversations, discussions and concerns, then the conversations remain just that, conversations based largely on hearsay.

We have sought routine quality and safety data and requested such since August 2014, but only received the data in mid October. It would appear that accessing such information is not easy and that may explain why it has been so difficult to manage the Unit in the absence of facts and evidence.

Hence, standard clinical process and outcome data is not provided to the Urologists to review about themselves and their audits have been infrequent. Interestingly, an audit of cystectomy was provided in August 2014, immediately after the external review was listed to occur.

Contractual Accountability:

The usual way in which to manage contracts[1] is to manage by the letter of the contract. The management of the contract must be seen as a direct responsibility of the Clinical Director, assisted by HR, assisted by the Pay Office, assisted by the Head of Unit.

It is acknowledged that this has been extremely difficult to undertake for a number of well-understood, historical reasons as alluded to in the introduction. It may also be difficult to undertake as the Clinical Director remains a VMO himself and these discussions may be better served by the HR or Finance Department.

Matters in relation to the contract in particular for discussion are:-

Definitions need to be enforced in relation to on call, recall and call back and be the only basis for payment. Any other claims would be seen as vexatious, even fraudulent.

Elements of the contact that are in place and should be enforced may assist in better management of clinicians include: Engagement in relation to 2.3 - Scope of Practice, 2.4 - Maintenance of Professional Standards, 2.5 - Corporal Polices & Procedures, 2.8 - Head of Unit, 2.9, 2.10 and 2.11,
Contract price and payment in Sections 6.3, 6.4, 6.5 and 6.6.
Meetings in relation to 11.1, 11.2 and 11.3 need to be enforced and additional meetings ought to be included in that list as is appropriate. These meetings ought to be renewed on an annual basis to ensure that they encourage good practice and are contemporary.

In relation to Section 14 - Teaching, section 14.1 outlines the responsibility of all VMOs in relation to this important task.

In relation to Section 15 - Performance & Quality Assurance, Section 15.2 sub-sections 1 to 14 are very clear as to what activities need to take place and this needs to be enforced.

In relation to Section 16 - ACT Health Policy, Section 16.1 is clear and needs to be enforced.

In relation to Section 17 - Annual review, sub-sections 1, 2 and 3 are quite clear and need to be enforced.

The enforcement of the VMO contract and the strategies for this need to be adopted, within the Directorate, for all specialties. There needs to be nothing special done about Urologists but this ought to be the situation for all of the clinical directorates.

[1] 2013 VMO Contract used for this Review

There needs to be agreement and support from the Chief Executive and the Deputy Director-General that these contract requirements are enforced. Failure to do so will put those people in breach into a standard industrial performance management situation – first verbal warning, second verbal warning with a letter, third and final warning and then dismissal. They will be in breach of their contract and consequences will occur.

The clarification of the need for ward rounds must occur. There are two extremes within the Unit. [redacted] does almost no ward rounds unless specifically requested; [redacted] does ward rounds on all patients, often after hours and often all weekend and at weekend penalty rates. Criteria for ward rounds need to be made clear to avoid over and under servicing.

Outpatient expectations and time of attendance needs to be made clear. This needs to be recorded and again, be part of performance management in relation to this element of service provision.

The Code of Conduct for the Medical Board of Australia and the Code of Conduct for the Royal Australasian College of Surgeons also need to be part of the framework by which professional activity and contractual obligations are made and these should be part of core expectations.

Financial Accountability:

In discussions with the Finance Department, the current system works efficiently and effectively for about 95 % of the VMOs. Most comply with reasonable requirements in relation to submission of forms for payment and turnaround of payment. There are clear organisational rules in relation to submissions for payment and these need to be actioned.

The timing of fee for service bills needs to be clarified and a date after which they will not be paid needs to be made clear. Currently the fee for service model used by the Canberra Hospital is equivalent to the Commonwealth Medical Benefits Scheme (CMBS) and they have a two-year time after which claims will not be accepted. (Under Section 20B of the Health Insurance Act 1973, you are required to submit Medicare bulk bill claims within two years of the date of service) Ideally for accounting purposes, the Canberra Hospital should adopt a one-year time frame, either within the financial year the service occurred or a one-year time frame after which claims for payment should not be accepted.

With so many of the medical staff being on VMOs, it is difficult to imagine how accurate budgets can be projected and accounts signed off if there are so such large sums of money outstanding and cannot be accounted for in existing financial years.

Fee for service

A review of the fee for service should include the process by which invoices are paid for all VMOs. Definition of payment requirements needs to be clear and an FAQ about what will and what will not be paid would be helpful.

Medical record review of written notes and records should occur before payment is authorised.

Consideration should be given to MBS item numbers for written on the operating sheet at the time of operation and therefore payment can be expedited and the process made more efficient.

A clarification of what fee for service payment covers as per definition needs to be made clear; for example, bundling up of procedures into one item number rather than multiple single item numbers.

Payment when supervising a Registrar needs to be clarified. Within the MBS there is allowance for training and there is a scale of fees that includes the impact of training. This reduced payment to the VMO needs to be considered by TCH because a number of the procedures undertaken by trainees who are already being paid. The consultants are then also being paid a full fee for service for work that they have not actually undertaken.

A very clear and final process for invoice payment must be adhered to and any invoices from any doctors who do not comply with the Canberra Hospital application form and process requirements should be sent back and not paid until they come through in an authorised and appropriate manner.

Consideration should be given to doctors having to make a formal, signed, declaration at the end of the invoice that they believe it is true and correct.

[redacted]

[redacted]

Supervisory Accountability:

There are five Consultants and they have five very different styles of engaging in their supervision. The current Surgical Supervisor [redacted] takes his role very seriously but appears to do this on his own rather than in a collegiate manner with the other Consultants. The accredited Registrars are in SET 3 of a six-year training program -- so reasonably junior.

The obligations of supervision need to be made clear and they need to be consistent across the five Urologists.

The scope of practice for individual Registrars needs to be established at the start of the year and reviewed at six months in relation to what they can actually do in terms of particularly surgical and procedural activities. (NSOHS Standard 1)

The College of Surgeons does not have a formal supervisory scale while the one adopted by the RANZCOG has a 1 - 3 level supervision definition. It is suggested that this be adopted by the Canberra Hospital for all surgical supervision.

Level 1 – in room/ OT; level 2 on site ; level 3 off site.

Registrars need to have their scope clearly defined based on their SET 3 requirements in relation to their individual skills and this needs to be made clear. The current Clinical Director has no issue with supervision of Registrars taking place off site and in the individual consulting rooms. As they are both SET 3 trainees, this seems somewhat inappropriate for some larger cases and should be reconsidered. For small low level procedures (that would be clearly defined) the surgeon needs to be in the hospital but for certainly anything above minor procedures, given they are only SET 3, they need to be on site and available for advice and support within the operating theatre.

There needs to be attention to supervision of Registrar and HMO documentation. There is frustration from the nursing staff that unless they "nag" the Registrars and the juniors, the documentation in relation to patients' progress is not optimal.

We were unable to view more than one medical record as part of the on-site visit. The request to access twenty medical records appeared to have disappeared into the ether.

The Clinical Director needs to have a much more active role in ensuring that optimal supervision of the trainees is taking place. Clear expectations need to occur. It needs to be undertaken in the context of a supportive framework. Regular meetings

with all trainees probably should occur so that real feedback can take place so that the hospital can put systems in place to support their trainees.

Poor behaviour of trainees needs to be managed and it would be appear that the 2013 accredited Urology trainee had an extraordinary personality which appeared to have had an impact on many members of the nursing staff, the Unit in general and was poorly managed. This must not occur and vigilance in relation to the critical role of the Registrars needs to be assured by the Head of the Unit to the Clinical Director or the Clinical Director ought to make it his business to find out.

There are some clear and less clear streams in relation to accountability within this Unit. The lines of accountability need to be made absolutely explicit and absolutely clear. Consequence of failure of accountability needs to be identified and acted on.

All five surgeons are committed to their craft and almost all have a level of interest in a system with the Registrars in the work that they do. They all take care of patients and provide a service for which some are reimbursed.

SECTION 2 – UTILISATION & PRODUCTIVITY

Review the staffing and management of the urological services including –

- ***Utilisation and productivity of the theatre, wards and Outpatients Clinics.***
- ***Make up of teams and how they function in communication, verbal and written documentation.***
- ***Issues to be covered***
    - ***a. Patient flow***
    - ***b. Patient record documentation***
    - ***c. Patient follows up***
    - ***d. Patient care review***
    - ***e. Communication re patient care***

Patient Flow

The urology patient journey typically starts with referral from their General Practitioner to the Outpatients clinics. It would appear in Canberra there has been a long tradition of GPs referring to the hospital for specialist opinion with minimal investigations prior to them attending the hospital. This has led to an extraordinary situation where over 10,000 outstanding patient referrals as of June 2014.

Outpatients: see Section 3

Operating Theatre:

There is an ongoing review of activities within the operating theatre being undertaken by incumbent operating theatre staff. About 50 % of the operating theatre that occurs at the Canberra Hospital is emergency that makes organising less very challenging and somewhat problematic.

The common view is that elective work is predictable and emergency work is unpredictable within the operating theatre. A considerable amount of research indicates that patterns do exist within emergency surgical caseload and so by exploring these patterns and incorporating these into the theatre template, much of the emergency work can be anticipated and managed better. This is where good data allows theatre to become more proactive instead of just reactive. Like any change in healthcare, it can be challenging to put into effect as certain individuals are 'programmed' to resist change but strong leadership can overcome this for the greater good.

A number of concerns were raised around the organisation of lists, theatre efficiency, management of elective and emergency bookings and overall governance of the theatre suite.

An attempt at establishing a theatre governance structure has been made with the theatre DDON, Head of Anaesthetics and the Clinical Director to meet weekly. This has not been well attended and suffers from a lack of structure and ownership of the issues raised. Establishment of a theatre operating group committee that met on a

monthly basis, with representation from not only theatre users but surgical bookings, pre-admission staff, day ward, surgical wards and CSSD and had an Executive present. It should be based upon review of a theatre dataset, would allow discussion of issues relevant to theatre and it's functioning and offer the opportunity for change and improvement. Examples: cancellation rates; on-start times; session utilisation; average case; cases done within category timeframes; turnover time; excess recovery minutes

The Urology theatre lists focus largely on the category 1 workload and has a current waiting list of over 200 patients, but we know that there is a 'hidden' burden of patients on the outpatient waiting list. The patients are placed on the waiting list of respective surgeons and are not shared. Some surgical units within TCH do share patients, to facilitate surgery based on need.

Registrars have some input into the booking of lists and the booking staff approach the surgeons for input as well but otherwise work from the waiting list. Few private patients are operated on under Urology.

Several staff commented on theatre efficiency on the day of surgery. These included delays to start time, finish time, turnover between cases, availability of radiology support (as shared between different units within theatre).An example of inefficiency was the disparity between doing flexible cystoscopies at Calvary versus TCH where Calvary can do 3 or 4 times as many as TCH in the same session because of equipment and sterilising facilities differences.

The issue of how much surgery was completed by the consultant surgeon and how much by the registrar was mentioned. Some surgeons were active in their supervision and management of the list while others were obvious in their decision not to scrub in. The issue of supervision and payment was also raised as the theatre nursing report (from which some data can be extracted around efficiency) only recorded the names of staff present in the operating theatre, yet the operation report recorded the name of the consultant surgeon. For finance staff reviewing Fee for Service claims, should payment be withheld where the surgeon is not listed as being present on the theatre nursing report or is there a clear understanding about what level of payment is made in relation to the level of supervision.

After hours the registrars often operated independently.

In line with NSQHS Standard 1, it is important for a scope of practice to be established for all surgical registrars, in a basic format of what procedures they can do independently and what procedures they need supervision for (i.e. a consultant in the operating theatre) covering both elective and emergency cases and updated 3 – 6 monthly. Through scopes of practice, the organisation delegates appropriate authority to trained individuals to open an operating theatre out of hours and empowers nursing staff to question registrars without the necessary scope of practice, to deliver appropriate patient care.

Taking a wider view of the operating theatre, better administration and management of theatre resources around the elective and emergency workload could be achieved with having a separate In Charge Anaesthetist to assist the senior nursing staff in the day to day theatre management. If this role was to be established, it needs a position description detailing the delegation and responsibilities of the position

There have been complaints by [redacted] in relation to urology pre-admission and Anaesthetic Clinic criteria. These criteria should be clear. Criteria for admission to any Anaesthetic Clinic should be based on the procedure being undertaken and the patient undertaking that procedure. It would not take too long for the urologists to decide on what investigations needs to take place for patients having TURP, radical prostatectomy, nephrectomy, cystectomy and PCNLs. This becomes very straightforward and no need for controversy.

The need for having blood available, either in the theatre or cross-matched needs to be discussed. A request to look at blood usage by the urologists has not been met for us and it would be of interest to look at their blood utilisation to determine best practice in relation to access to blood. Undertaking a review in line with NSQHS standard 7 : Blood and Blood products would improve and standardise TCH's blood management strategy.

List management is left with the Registrars and while, anecdotally [redacted] often changes his, lists about , which frustrates the Registrars, the rest appear quite happy with that process.

The level of supervision for the Registrars as noted earlier must be made very clear and what that supervision ought to be should be decided by the hospital, not individual consultants. The cases that go to Calgary ought need to be clarified and a supervision of the Set 2 trainee over there need similarly to be sorted out so that they have clear on site local and scrub support for all their procedures.

Clinical pathways are very common in urology surgery across Australia and internationally and there seems no reason why such processes ought not to be in place within this unit. A clear plan of post-operative management, documentation by exception, clear parameters for the nursing staff and clear reportable levels in terms of follow up should be relatively straightforward and should be implemented as soon as possible.

The operating theatre is one of the most expensive areas of the hospital but it is also one of the key areas of income for any healthcare organisation. Theatre needs to:

- Have a clear Governance structure
- Be effective at communicating change and be transparent in its decision making
- Meet and exceed key performance indicators
- Be appropriately resourced to meet both elective and emergency caseload
- Be responsive but not controlled by a single person or group

Healthcare organisations are often made up of many silos – units working alongside each other but rarely directly interacting. The operating theatre brings some of these silos close together and at times of reduced resources (e.g. equipment, limited nursing or anaesthetic staff etc.) conflict can arise. Anticipation of these conflicts will often prevent patient care being affected while strong leadership is required to manage disputes if they do arise.

Emergency:

Registrars are on call and are in regular communication with Urology Consultants after hours. There is no suggestion that the Urology Consultants are not available. [redacted] does little on call and [redacted] takes over his call. Registrars arrange theatre and undertake some procedures. As noted earlier, they currently do not have a defined scope of practice and it would appear that a decision is made between the Consultant and the Registrar as to whether or not the Consultant needs to come in to undertake a case. This needs to be rectified and formalised. (NSQHS Standard 1)

Elective Surgery:

Lists are undertaken by the Registrars. This appears to work reasonably well, although it is universally acknowledged that efficiency in the operating theatre could improve. There is often between 40 and 50 minutes of time between cases. This is often used productively by the surgeon, especially [redacted] giving tutorials to the Registrars and junior doctors, which they find extremely advantageous.

Review of patient follow up:

There is some frustration from the nursing staff that the plan of care for post-operative care for these patients is not as well articulated to nursing staff as it might be. From time to time, if the senior nurse is away, the documentation lapses and the acting Unit Manager feels the need to remind Registrars on a regular basis the need to document. This is in contrast to the Vascular Unit where their post-operative orders are very clear and the nursing staff are fully aware of what to do. (NSQHS Standard 6: Clinical Handover)

As noted earlier, ward rounds occur in an ad hoc fashion and at the request and need of the Registrar. There is no suggestion that Consultants do not come in when asked by the Registrar to attend.

Escalation:

Consultants take regular phone calls and provide timely phone advice. The junior staff and the Registrar staff appear well supported, although it can be said that this support is somewhat reactive rather than proactive and may suit an outgoing personality of a Registrar or Junior Officer rather than someone who may be quieter. A more proactive approach to management of the patients would be seen as advantageous.

Documentation:

It was intended that we review thirty cases. We accessed one case in an opportune manner, but were told that we required training to access the medical record system. This did not occur and, regrettably, we were unable to look at a suite of thirty medical records.

Clinician Pathology Communication:

The MDT (Multi Disciplinary Team) Meeting occurs on a Thursday morning at 7 am and is well attended by Urologists, by pathology staff and by diagnostic imaging staff. Medical students and junior staff are also in attendance. This meeting reviews cases and is minuted by the Urology nurse. I detected a sense of frustration that, despite plans being made at the meeting, they are not necessarily translated into practice. Work should be undertaken to improve patient follow-up and ensure clear plans are in place for patients, particularly who have positive histology and need a very active and time-critical of follow-up. The prostate cancer nurse is very keen for this to occur and has made numerous attempts to get them all together to better define this. Refer NSQHS Standard 6 : Clinical handover.

Follow-up Responsibility:

Follow up responsibility in the public system seems a little uncertain and the prostate cancer nurse has been somewhat frustrated in relation to this. This needs to be clear, streamlined and well-articulated for nursing staff, medical staff, and junior medical staff, GPs and of course patients.

There is little discussion about the private sector. Patients discussed at the MDT Meeting were discussed simply as patients and their insurance status was not commented on. Follow-up in the private system was not reviewed.

Patient Accountability:

Patients appear to have very little knowledge of what is going on and they would certainly benefit by having a clear pathway of care, a pamphlet outlining that care, and key names and numbers to discuss. Some of the challenges for the patient are in getting medical oncology appointments; radiation oncology appointments and the co-ordination of all of those, in addition to having some surgical follow up.

There appears to be no mechanism by which longer term urological complications such as impotence or urinary incontinence are actively sought out and managed and getting a review appointment for this becomes problematic for a patient, particularly if it happens after a few months and they're no longer seen in the immediate post-operative phase. This could be tightened and a clear service needs to be developed for these patients. There is currently no data in relation to these very important complications and this ought to change in line with the whole data collection system for the Urology Unit into the future.

The role of the clinician in relation to the follow up of a patient appears unclear. The role of the various nurses, the Registrars and the individual Consultants needs to be made very clear and a better classification of Outpatient appointments for this will assist in this process. (refer - NSQHS Standard 2: Consumer Engagement).

Patient Care review:

The Urology Unit Meeting occurs monthly after the Morbidity and Mortality Meeting, has no minutes, has no agenda, does not have any secretarial or admin support, despite almost all of the consultants having staff relatively close by who could assist in this process. Plans, issues and concerns may or may not be raised. The Nurse Unit Manager attends but is not actively invited and the Clinical Director does not attend. There appears to be no data information or evidence shared and discussed at that meeting.

The Urology MDT Meeting, as noted earlier, is very good. It is uncertain whether documentation in the patient's notes for that meeting takes place.

The Grand Round was instituted by [redacted] in early 2014. This is following on from the admired Vascular Unit grand round where all consultants' Registrars go through all of the patients is seen as a very important risk management initiative, patient's safety initiative and a communication initiative, as well as important for teaching.

It was decided this would occur after the MDT Meeting on a Thursday. This precludes three out of the five surgeons from attending and attempts to change that time have not been well received. [redacted] only regularly attends this round. The Head of Unit has attended one out of three over this year. The nursing staff were very keen for this to take place and are very disappointed that it's not quite what all had intended to do.

Quality Assurance Activities:

There appear to be no formal quality assurance activities within the urology Unit. Individual cases get reviewed to the CRC if there's been a significant morbidity or mortality, but very little other work takes place. Research is undertaken by Registrars, typically with [redacted] and this is presented and discussed at some meetings but rarely to the unit.

No formal clinical audits have been presented by the Urology Unit in 2010, 2011, 2012, 2013 .A review of cystectomies had been undertaken in 2014 and was shared in August 2014, but this is the first of any formal audit that appears to have taken place for some considerable time.

Management of incidents occurs via the Quality Manager and the Unit Manager and this is not shared with the doctors involved.

Communication re patient care

Clinical handover would appear to be reasonable between doctors but, as noted earlier, the nurses do not feel that they are particularly part of those conversations. Patient booking could be improved and work has been done to make sure category 1 patients have access to outpatients but, as noted earlier, cat 2s and 3s will probably be waiting a considerable time to ever be seen within the current system and the limited number of clinics that take place.

Communication in Relation to Care Escalation:

The hospital has an MET system. Patient care has escalated. In one case we looked at where the man had three individual episodes in intensive care certainly demonstrated that access to intensive care was not too difficult. The concern was that he was sent back to the ward and required not one, but two additional stints in intensive care before he ultimately died. This would indicate a useful review would be of patients who are sent out of intensive care and how well they progress once that level of care is no longer available to them. Refer: NSQHS Standard 9 : Recognising and Responding to Clinical deterioration in Acute health care.

Comparative length of stay data

There is no routine available tabulated or analysed length of stay data (LOS). We were provided with length of stay data for 2011, 2012, 2013 and half of 2014. The following table is a list of key procedures and the average length of stay based on this empirical data:

Average Length of Stay

Procedure	Average LOS (from three years of data)
Complete Unilateral Nephrectomy	7.08 days
Cystoscopy	0.56 days
Endoscopic Biopsy of Bladder	0.93 days
Laparoscopic Complete Unilateral Nephrectomy	5.4
Laparoscopic Nephro Ureterectomy	8.5
Laparoscopic Radical Nephrectomy	7.11
Nephro Ureterectomy	9.7
Partial Nephrectomy	6.2
Percutaneous of Removal of Calculi less than 2	6.03
Percutaneous Nephrectomy greater than 3 Calculi	11.3
Pyeloplasty	6.01
Radical Prostatectomy & Bladder Neck Obstruction	4.0
Radical Prostatectomy with Resection of Lymph Nodes	5.9
Radical Nephrectomy	9.1
Radical Prostatectomy	5.8
Total Excision of Bladder	17.7
TURP	2.89

Below is a table with the surgeon LOS marked as either above or below the ALOS. [redacted] has had his data averaged over the entire time he was working for completeness.

Average length of stay analysis

Data from 2011-2014

Procedure	Average LOS (from three years of data)	[redacted]	[redacted]			
Complete Unilateral Nephrectomy	7.1	6.3	11.1	5.1	5.7	7.2
Cystoscopy	0.56	0.5	0.6	0.4	0.8	0.4
Endoscopic Biopsy of Bladder	0.9	0.6	1.2	1.2	0.9	
Laparoscopic Complete Unilateral nephrectomy	5.4	4.2	6.1		4.2	5.6
Laparoscopic Nephro Ureterectomy	8.5	6.1	10.7	5.6	7.5	12.7
Laparoscopic Radical Nephrectomy	7.1	11.2	5.1	6.4	8.3	5.1
Nephro Ureterectomy	9.7	4.9	13.1	6.2	8.1	16.2
Partial Nephrectomy	6.2	8.1	5.7	6.5	5.5	5.3
Percutaneous of Removal of Calculi less than 2	6	3.7	3.5		6.3	8.1
Percutaneous Nephrectomy	11.3	8.7	12			
Pyeloplasty	6	5.4	3.2	10.7	4.9	
Radical Prostatectomy & Bladder Neck reconstruction	4	3.1	3.1	4.6		5.1