Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Quality Review of Symptomatic Breast Disease Services in Ireland

Report of the Focused Review at Waterford Regional Hospital 2010

To be read in conjunction with the Report of the Quality Review Assessment at Waterford Regional Hospital 2009

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within our social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing the quality and safety standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services).

Monitoring Healthcare Quality – Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment – Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

Health Information – Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services.

Social Services Inspectorate – Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services. Monitoring day and pre-school facilities*.

* Not all parts of the relevant legislation, the Health Act 2007, have been commenced.

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1. Introduction

The Health Information and Quality Authority (the Authority) carried out National Quality Review assessments at each of the designated centres, including Waterford Regional Hospital[1], over the period of October to December 2009. In February 2010, the Authority published individual reports of the findings of this National Quality Review of symptomatic breast disease services as they related to each of the eight designated centres and included local recommendations to be implemented by each centre.

In relation to Waterford Regional Hospital (WRH), the 2009 Quality Review concluded that the symptomatic breast disease service had in place some of the core requirements for quality and safety as set out in the National Quality Assurance Standards[2] (the Standards). However, there remained aspects of the service that were still being bedded down. The service's clinical and corporate governance structure, necessary to assure that the service was being effectively provided, managed and was sustainable, had recently been restructured and was in an early stage of development as were some data management and access arrangements. The Authority concluded that these arrangements would require a period of adjustment before a judgment on their effectiveness could be made and this would need to be re-assessed by the Authority.

In June 2010, the Authority carried out a focused review on those aspects of the service that had been identified as requiring re-assessment during the review of 2009. The Authority reviewed documentation and data submitted by the service and carried out interviews with the General Manager, Lead Clinician and Clinical Director.

This report is a report of the focused review at Waterford Regional Hospital and should be read in conjunction with the *Report of the Quality Review Assessment at Waterford Regional Hospital* [1], published in February 2010. This report provides an account of the Authority's findings in relation to the governance, data management and access arrangements in place at WRH, as of June 2010.

2. Findings - Focused Review 2010

2.1 Governance arrangements

At the time of the Quality Review in 2009, the corporate governance and clinical reporting arrangements at WRH were at an early stage of development. In June 2010, the Authority found that WRH had put revised structures in place to strengthen its corporate governance and clinical reporting arrangements. The SBD service was able to demonstrate a clear understanding of the operational functioning of the revised structures and the Authority confirmed this at interview. The Lead Clinician for the SBD service had been appointed and was reporting to the Clinical Director.

An Integrated Cancer Services Governance Group, chaired by the Clinical Director at WRH, had been established to oversee clinical governance of cancer services across

the four acute hospital sites in the HSE South East region[±], involved in, or making referrals to, the SBD service. The SBD Lead Clinician was also a member of this Group. This Group was reporting to the Network Cancer Service Steering Group which is jointly chaired by the National Cancer Control Programme (NCCP) and the HSE.

At a local level, monthly meetings were being held with the NCCP Cancer Network Manager, the Clinical Director, Lead Clinician and Hospital General Manager which include discussions pertaining to finance, human resources and key performance indicators for cancer services.

At the time of the focused review, the Authority confirmed that interim locum arrangements for radiology services were in place and a surgeon (the Lead Clinician) had been permanently transferred from Wexford General Hospital to Waterford Regional Hospital. The interview process for the second post of consultant radiologist had been completed. An interview date for the post of the third consultant breast surgeon was confirmed.

The Authority concluded that the SBD service at WRH had the necessary governance arrangements in place for the delivery of a high quality, safe symptomatic breast disease service.

2.2 Data management arrangements

At the time of the Review in 2009, the Authority concluded that the SBD service at Waterford Regional Hospital had most of the necessary data management arrangements in place. However, the Patient Analysis and Tracking System was not fully operational, data validation processes were not in place and audit processes were underdeveloped. It was identified that this would require re-assessment by the Authority.

In June 2010, the Patient Analysis and Tracking System was implemented and operating. The system had been configured to support the service's monitoring processes to ensure compliance with the Standards[(2)] and NCCP Key Performance Indicators[+].

The Authority confirmed that the SBD service at WRH was reporting 11 of the NCCP indicators on a monthly basis.

The SBD service was actively engaging with the NCCP in relation to a national data dictionary and validation policy to support the Patient Analysis and Tracking System. A local policy had been developed for data inputting and validation for the South East Cancer Centre in the interim.

[±] Waterford Regional Hospital, Wexford General Hospital, South Tipperary General Hospital and St Luke's Hospital Kilkenny
[+] NCCP Key Performance Indicators are listed in Appendix 6 of the *Report of the Quality Review Assessment at Waterford Regional Hospital*[(1)]

At the time of the focused review, the SBD service at WRH was having monthly SBD Clinical Audit meetings chaired by the Lead Clinician and the Authority confirmed that all SBD clinical specialties, including radiation oncology, actively participated. The Authority reviewed the SBD audit activity and confirmed that there were clear reporting lines to the Clinical Director in the event that the audit activities identified any area of concern.

The Authority concluded that the SBD service at Waterford Regional Hospital had data management arrangements in place to enable monitoring and reporting of performance against the NCCP Key Performance Indicators and the Standards.

2.3 Access arrangements

At the time of the Quality Review in 2009, the SBD service at WRH did not have a consistent triage process in place. The service was challenged in meeting the access timelines for urgent and non-urgent patient referrals to the service and was putting controls in place to address these timelines.

In June 2010, the patient referral triage system had been reviewed and a consistent triage system had been put in place for the SBD service. This was confirmed by the service's SOP (standard operating procedure) for Primary Surgical Management. Triage was being conducted by a specialist breast care nurse, with quality control measures in place by the consultant surgeon. The Authority identified during interview that quarterly audits were being carried out by the service to measure the effectiveness of the revised triage system.

At the time of the focused review, the SBD service, for the preceding five months, had been consistently compliant in meeting the standard that all patients triaged as urgent were offered an appointment to be seen within 10 working days (Standard 2.8)[(2)] and on average, was 89% compliant for all patients triaged as non-urgent being offered an appointment within 12 weeks (KPI 1b)[(1)].

The service had identified a challenge in consistently meeting the urgent and non-urgent targets and had been scheduling additional clinics when required. However, the service acknowledged that the appointment of the third consultant breast surgeon was necessary to ensure the ongoing sustainability of meeting this target.

The Authority concluded that Waterford Regional Hospital had most of the necessary arrangements in place for the provision a safe high quality symptomatic breast disease service.

3. Quality Review 2009 recommendations[(1)]

During the focused review, the Authority reviewed the implementation plan against the recommendations contained in the 2009 Quality Review report[(1)], developed by Waterford Regional Hospital, in order to gain a clear assessment of their implementation. Findings specific to each of these recommendations are reported in Figure 1 below.

Figure 1: Recommendations of Quality Review Assessment at Waterford Regional Hospital [(1)] Focused Review Findings, June 2010

Recommendations of the report of the Quality Review Assessment[(1)]	Focused Review Findings, 2010
Governance	
G1. The role of the Lead Clinician should be formalised with specific responsibility for the symptomatic breast disease service.	This had been addressed nationally by the National Cancer Control Programme (NCCP). A formal role specification for symptomatic breast disease Lead Clinicians had been agreed and a National Lead Clinicians Network established. At the time of focused review, the Lead Clinician for the symptomatic breast disease (SBD) service at WRH had been formally appointed.
G2. The service must ensure the continuing sustainability of symptomatic breast disease services to effectively and efficiently manage the needs of its patients. Locum arrangements must be finalised while the permanent appointments of a consultant radiologist and consultant breast surgeon are ongoing.	The Authority confirmed interim locum arrangements in radiology were in place and a surgeon (the Lead Clinician) had permanently transferred from Wexford General Hospital to Waterford Regional Hospital. The recruitment process for the permanent appointment of a consultant radiologist and consultant breast surgeon were ongoing. The interview for the consultant radiologist had been conducted and contract signed with a start date to be confirmed. An interview date for the post of a third consultant breast surgeon was confirmed.
G3. The corporate governance and clinical reporting arrangements require ongoing evaluation by the Hospital and the	Since the 2009 Quality Review, WRH had put in place revised structures to strengthen its corporate governance

National Cancer Control Programme to ensure that they are sustainable in order to effectively and efficiently manage the needs of its patients.	and clinical reporting arrangements. The service was able to demonstrate a clear understanding and operational functioning of the revised structures and this was confirmed by the Authority at interview. The lead consultant for the SBD service had been appointed and was reporting to the Clinical Director. An Integrated Cancer Services Governance Group, chaired by the Clinical Director at WRH, had been established to oversee clinical governance of cancer services across the four sites in the HSE South East region (Waterford Regional Hospital, Wexford General Hospital, South Tipperary General Hospital and St Luke's Hospital Kilkenny). The SBD Lead Clinician was also a member of this group. This group reports to the Network Cancer Service Steering Group which was jointly chaired by the NCCP and the Health Service Executive (HSE). At a local level, monthly meetings were being held with the NCCP Cancer Network Manager, the Clinical Director, Lead Clinician and Hospital General Manager which include discussions pertaining to finance, human resources and key performance indicators for cancer services.
G4. The service should ensure that the patient healthcare record is available for all symptomatic breast disease clinics and off-site symptomatic breast disease care.	The Integrated Cancer Services Governance Group had conducted a risk-assessment on the various options available to address this recommendation. The assessment concluded that that all clinics would be conducted at WRH to ensure safe patient care. At the time of the focused review, this decision had been implemented with all clinics being held in WRH. The SBD team verified that to date, there had been positive feedback from patients in relation to this revised arrangement and that no complaints had been received that would highlight it as an inconvenience to patients.

Multidisciplinary Approach	
MDT1. The service should put arrangements in place to ensure that all clinical findings and multidisciplinary team decisions are clearly recorded.	The Authority confirmed that the service had revised the processes for recording information at the multidisciplinary team (MDT) meeting. The Authority reviewed the SBD service's Multidisciplinary Team Conference Policy, and confirmed at interview that the SBD service had a range of evaluation activities to measure the success of the MDT meetings, including audit of the recording of decisions made. The annual audit for 2010 had not yet been conducted by the service at the time of the focused review, therefore the evidence of its findings were not available to the Authority.
MDT2. The centre should review practice around the documentation of patient notes so that all information pertaining to a patient's care is complete and easily accessible from a single source.	The Authority verified that, with the centralisation of SBD clinics, all patient healthcare records were available for the SBD team. In addition the centre reported that it had successfully implemented the HSE Code of Practice for Healthcare Records 2007 and there is ongoing engagement with the HSE and NCCP in relation to the development of an electronic patient record.
Skills, Education and Training	
SET1. The service should ensure that a formal policy is developed to support and monitor continuous professional development.	At the time of the focused review, the SBD service at WRH had a policy to support and monitor continuous professional development for its multidisciplinary team members.
Data Management	
DM1. The service should ensure that the Patient Analysis and Tracking System is configured and implemented fully.	At the time of the focused review, the Patient Analysis and Tracking System was implemented and operating. A local standard operating procedure (SOP) had been developed to support inputting and validation of data to the system.

DM2. The service should ensure that all data fields required for the National Quality Assurance Standards and National Cancer Control Programme Key Performance Indicators (KPIs) are configured in the Patient Analysis and Tracking System.	The Patient Analysis and Tracking System had been configured to support the service's monitoring processes to ensure compliance with the Standards and the NCCP Key Performance Indicators (KPIs). The Authority confirmed that the SBD service at WRH is currently reporting 11 of the NCCP indicators on a monthly basis.
DM3. The service should ensure that a robust data validation process for accuracy, auditing and validation of data is finalised.	The SBD service was actively engaging with the NCCP in relation to the development of a national policy for data validation. A local policy had been developed for data inputting and validation for the South East Cancer Centre in the interim.
Access	
A1. The service should develop and implement a consistent triage system for the SBD service.	At the time of the focused review, the patient referral triage system had been reviewed and a standardised triage system had been put in place for the SBD service. This was confirmed by the service's SOP for Primary Surgical Management. Triage was conducted by a specialist breast care nurse, with quality control measures in place by the consultant surgeon. The Authority identified during interview that quarterly audits were being carried out by the service to measure the effectiveness of the revised triage system.
A2. The service should put a targeted programme of action in place to ensure that all patients triaged as non-urgent are offered an appointment within 12 weeks, with this target being met in more than 95% of patients.	At the time of the focused review, the SBD service (for the preceding five months) had been consistently compliant in meeting the standard that all patients triaged as urgent are offered an appointment to be seen within 10 working days (Standard 2.8)[(2)] and on average, was 89% compliant for all patients triaged as non-urgent being offered an appointment within 12 weeks (KPI 1b)[(1)]. The service had identified a challenge in

	consistently meeting the urgent and non-urgent targets and had been scheduling additional clinics when required. However, the service acknowledged that the appointment of the third consultant breast surgeon was necessary to ensure the ongoing sustainability of meeting this target.
A3. The service should ensure that chemotherapy completion dates for patients are communicated to the third-party provider of radiation oncology services.	The local policy for data inputting and validation includes a policy for the collection of radiotherapy KPIs. This includes the formal communication of treatment start and completion dates to the third-party provider of radiation oncology services. The Authority confirmed through audit findings that all patients requiring radiotherapy received their appointments and accessed treatment within the NCCP KPI access timelines for radiation oncology.
A4. The service should ensure that turnaround times for FISH (fluorescence in situ hybridisation) specimens and pathology reporting continue to be monitored and improved.	The SBD service at WRH continues to monitor the turnaround times for FISH (fluorescence in situ hybridisation) specimens and pathology reporting. Pathology turnaround times are audited on a monthly basis. However, there continues to be ongoing variances in the turnaround time for FISH specimens. The service identified that this was a national issue and that the service was in discussions with the NCCP regarding this.
Clinical Effectiveness	
CE1. The service should incorporate specific symptomatic breast disease clinical audit activities within the clinical governance structure to systematically and critically analyse the quality of care provided.	At the time of the focused review, the SBD service at WRH was having monthly SBD clinical audit meetings chaired by the Lead Clinician. The team confirmed that all SBD clinical specialties, including radiation oncology, actively participate. The Authority reviewed the SBD audit activity reports and confirmed that there were clear reporting lines to the Clinical Director in the event that the audit activities had identified any area of concern.

4. Conclusion

At the time of the focused review, the SBD service had the necessary governance and data management arrangements in place. A consistent triage system had been put in place and the service had put controls in place to enable it to monitor the access targets for urgent and non-urgent referrals. However, the service acknowledged that the appointment of the third consultant breast surgeon was necessary to ensure the ongoing sustainability of meeting this target.

The service had a framework to address the Authority's recommendations of the 2009 Quality Review[(1)].

Overall, based on the evidence of the focused review, the Authority concluded that while there remained opportunities for improvement, the symptomatic breast disease service at Waterford Regional Hospital was meeting the key quality and safety requirements as set out in the Standards.

5. Next steps

The Authority, under section 8 of the Health Act 2007, continues to have the remit to monitor compliance with national standards. The Authority will liaise with the Director of the NCCP as delegated by the HSE, to be responsible for developing and monitoring an implementation plan for the recommendations of the National Quality Review of Symptomatic Breast Disease Services in Ireland.

6. References

(1) Health Information and Quality Authority. *National Quality Review of Symptomatic Breast Disease Services, Report of the Quality Review Assessment at Waterford Regional Hospital*. Dublin: Health Information and Quality Authority; 2010.

(2) Health Information and Quality Authority. *National Quality Assurance Standards for Symptomatic Breast Disease Services – Developing Quality Care for Breast Services in Ireland*. Dublin: Health Information and Quality Authority; 2007.