1 Executive Summary

1.1 Background

This report outlines the findings of the investigation into the missed diagnosis of breast cancer on two separate occasions when a patient, referred to in this report as Ms A, presented with symptomatic breast disease in 2005 and again in 2007. It includes a review of clinical and pathology services for the care and treatment of patients with symptomatic breast disease provided by University Hospital Galway (UHG), a hospital managed by the Health Service Executive (HSE).

Ms A initially presented to her general practitioner in September 2005 with symptoms suggesting breast disease and was referred to Barrington's Hospital, Limerick, a private hospital. At this hospital she underwent a biopsy (tissue sampling) of breast tissue. It was the general practice at that time that pathology specimens from Barrington's Hospital were examined and reported on by staff at UHG. On a second occasion, Ms A was seen again at Barrington's Hospital in March 2007, when further breast tissue was taken by Fine Needle Aspiration (FNA) and sent for analysis at UHG. These two samples, separated by eighteen months, were reported on at UHG by different consultant pathologists (known in this report as Dr B and Dr C) as benign. Subsequent biopsy of breast tissue in March 2007, performed at Barrington's Hospital and reported on at the Bon Secours Hospital, Cork, confirmed that breast cancer was present. Later in March 2007, Ms A was treated surgically for this at Barrington's Hospital and was subsequently managed and treated for ongoing oncology and radiotherapy care at the Mid Western Regional Hospital in Limerick.

In July 2007, following the discovery of these errors, the Health Service Executive (HSE) and the Health Information and Quality Authority (the Authority) discussed the Authority undertaking an investigation. Also in July 2007, the Authority was sent information about concerns relating to the quality of care received by ten patients with symptomatic breast disease at Barrington's Hospital. Ms A was one of these patients. These patients, and others who were treated at Barrington's Hospital from September 2003 to August 2007, were subsequently involved in a review undertaken by the Department of Health and Children and Barrington's Hospital. The findings of this review are published in the 'Report on the Independent Review of Symptomatic Breast Care Services at Barrington's Hospital, Limerick.'[1]

Subsequently, on 2 August 2007, the HSE formally requested that the Authority consider undertaking an investigation. On 9 August 2007, the Board of the Authority decided to instigate an investigation under Section 9(1) of the Health Act 2007. The scope of the investigation was to consider the aspects of Ms A's care as they related to the pathology service at UHG. This was also to incorporate the Symptomatic Breast Disease Service at UHG. The Authority appointed Dr Michael Durkin, Medical Director, South West Strategic Health Authority, England to lead a team of experts from within the Irish healthcare

system to conduct the investigation (Appendix 1). Additional external expert advice was sought from the UK in relation to specific aspects of the pathology review.

Under the Health Act 2007, the investigation powers of the Authority relate to services provided or funded by the HSE only, and so the terms of reference of this investigation did not include any aspect of Ms A's care in Barrington's Hospital.

The Authority's investigation entailed a review of documentation including relevant strategic plans, policies and procedures and evaluations at UHG and correspondence relevant to Ms A's experience. It involved site visits and interviews with clinical and non-clinical staff, Ms A, and other patients. The Investigation Team carried out reviews of patient records, imaging material and pathological specimens.

During the course of this investigation, key themes emerged that support the findings of this report. The Investigation Team recognises that there may be materials that it was not possible to review and that some individuals may interpret the issues under investigation differently. However, it is satisfied that it has presented a fair, balanced, objective and accurate account of the findings of this investigation in line with the terms of reference.

It is relevant to note that the aforementioned 'Independent Review of Symptomatic Breast Care Services at Barrington's Hospital, Limerick' was conducted into the care of Ms A and other patients at Barrington's Hospital. The findings of this were reported on 1 April 2008. At the Authority's suggestion, the pathology aspects of the Barrington's review were conducted by the Faculty of Pathology, of the Royal College of Physicians of Ireland, which had also been engaged to undertake the pathology aspects of the Authority's investigation. This was to avoid unnecessary overlap between the two investigations and to allow the Authority to place reliance on any pathology review carried out as part of the Barrington's review.

1.2 Pathology Services

In the course of the investigation, a review was undertaken of a sample of the work of consultant histopathologist Dr B who had been employed at UHG at the time of the initial misdiagnosis in September 2005. Dr B had reported on Ms A's breast tissue specimen and made the initial interpretive error.

A similar review was undertaken of the work of Dr C who had been employed as a temporary consultant pathologist at UHG from September 2006 to March 2007. Dr C made the second interpretive error on Ms A's specimen in March 2007. Following this initial assessment, the review of Dr C's work was extended to include all breast cytology specimens that they reported on and all diagnostic cytology reported by them. In addition, a review of the gynaecological cytology reporting for which Dr C was responsible during their tenure at UHG was undertaken.

1.3 Findings

The main findings of the Investigation Team are outlined below.

1.3.1 Ms A's Diagnosis

Two significant errors were made in the examination and interpretation of Ms A's pathology specimens, one by Dr B and one by Dr C, both of whom were working within the Pathology Department of UHG. The first of these errors by Dr B in 2005, led to a diagnosis of a benign condition instead of breast cancer and contributed to a delay in commencing Ms A's treatment for breast cancer. The second error by Dr C occurred in March 2007. Ms A received a definitive diagnosis of malignancy shortly thereafter when a further biopsy of her breast tissue was reviewed and reported on at Bon Secours, Cork.

Ms A's clinical examinations, mammography tests and surgery were carried out at Barrington's Hospital. In addition, samples for pathology review were taken and the analysis of these was carried out at UHG, following which, the results were communicated back to Barrington's Hospital.

A small number of interpretive errors are a recognised feature of histopathology and cytopathology reporting. To mitigate the risk of such errors leading to a misdiagnosis there needs to be an effective system in place. This should allow for the diagnostic and clinical findings to be discussed by the relevant specialists (for example surgery, radiology, pathology) rather than individual results being relied upon in isolation. This is known as 'triple assessment' and is usually achieved through multidisciplinary team (MDT) meetings. MDTs provide a vital opportunity to identify discrepancies (known as 'discordant findings') so that further tests can be carried out if needed and the patient diagnosed and treated appropriately.

In Ms A's case there was no MDT meeting to discuss all of her triple assessment findings. The arrangement for reporting pathology specimens between Barrington's Hospital and UHG was informal in nature and was based on a long-standing private arrangement between individual clinicians.

The Investigation Team found that there had been no formal contract or agreement between UHG Pathology Department and Barrington's Hospital for reporting pathology specimens. There was no structured arrangement for consultant pathologists at UHG to participate in MDTs at Barrington's Hospital and as a result there was no opportunity to explore any discordant findings. This is not acceptable practice.

The Investigation Team believes that formal arrangements for referring surgeons, radiologists and reporting pathologists to discuss Ms A's diagnostic findings should have been in place. This is especially important in a situation where, as in Ms A's case, clinicians are based in different institutions. Putting in place this important safeguard for patients is a shared responsibility between individual clinicians and the institutions in which they work and the accountability for the oversight of the patient's care should be made explicit in such circumstances.

The Investigation Team concluded that, in Ms A's case, the absence of such arrangements was a significant contributory factor in her delayed diagnosis.

That Ms A experienced two interpretive errors, separated by 18 months, by different consultant pathologists serves to emphasise the importance of having fully functioning triple assessment and MDTs in place. Arrangements for MDTs should be in place, irrespective of whether patients are cared for in the public sector, private sector, or a combination of both.

1.3.2 The Response by UHG

In late June 2007, Ms A's oncology consultant (Dr D) asked UHG Pathology Department to review the original pathology samples of September 2005 and March 2007. This was completed in early July 2007. When the Pathology Department identified that errors had occurred (16 July 2007) they informed UHG senior managers. An adverse incident group was established by UHG (17 July 2007), which led to the request for an external independent review of symptomatic breast disease and related pathology services.

The UHG established a helpline for women who may have been concerned about their care as a result of Ms A's experience. In addition, they carried out their own internal review of a small sample of pathology reporting. This work was superseded subsequently by the Authority's investigation. The Hospital senior management, clinicians and administrative staff worked effectively together in setting up the helpline and managing the patients who came forward.

The Investigation Team is aware that the HSE is reviewing its procedures for responding to serious incidents and recommends that the approach adopted by UHG in setting up and managing a helpline are fed into this review. Hospital staff engaged in reviewing policies and procedures for services where adverse incidents or near misses have occurred, should be trained in carrying out root cause analysis and ways of achieving immediate changes in service re-design as a result of their analysis.

1.3.3 The Pathology Reviews

The Investigation Team reviewed a large number of pathology specimens reported on by Dr B and Dr C to identify whether there was a wider concern about their practice and to ensure, as far as possible, that other patients had not received incorrect or delayed diagnosis. Where this was the case, the Investigation Team sought to ensure that they were informed, given the offer of a follow up appointment, reviewed and where necessary treated promptly.

From the review of a representative sample of Dr B's breast histopathology reporting (200 patient cases), the Investigation Team concluded that Dr B made a significant error in the interpretation of the biopsy material of Ms A in September 2005. This had been reported as benign and should have been reported as malignant. Following the review of the representative sample, no further errors in diagnosis were identified.

The Investigation Team made an initial review of a representative sample of Dr C's cytology reporting which incorporated all their breast reporting and a random sample of other tissue types. From this review, the Investigation Team identified that Dr C made a significant error when reviewing material from a Fine Needle Aspiration (FNA) of breast tissue from Ms A. Dr C wrongly interpreted this specimen as benign. (FNA involves passing a thin needle through the skin to sample fluid or tissue from a cyst or mass.) As part of this initial review, other errors were identified. This led the Investigation Team to broaden the review of patient slides from Dr C's work to include all their diagnostic cytology work during their tenure at UHG. This review identified further errors.

Out of the total of 747 patient cases reviewed, 49 discrepancies were identified between the original report by Dr C and that of the Investigation Team. Where the discrepancies warranted patient follow-up, the Investigation Team liaised closely with UHG to ensure affected patients were reviewed and, where necessary, invited for follow up.

Of these 49 patients, the findings on follow-up were:

- *1 patient had a delayed diagnosis of thyroid cancer (9 month delay)*
- *1 patient had a delayed diagnosis of carcinoma in-situ of the bladder (16 month delay. Carcinoma in-situ means the cancer is non-invasive and has remained in the identified area)*
- *1 patient had a delayed diagnosis of carcinoma of the bladder (17 months)*
- *1 patient had a delayed diagnosis of a benign salivary gland tumour (1 month)*
- *1 patient experienced delayed management of their benign thyroid disease (8 month delay)*
- *7 patients experienced a delay in instigation of further urology investigations (ranging from 12–14 months)*
- *There was no change to the management of care or outcome in 37 other patients because they had received an accurate diagnosis through other tests or their condition was previously known*

These patients, and/or their relatives, have been contacted by the Investigation Team and UHG. UHG has informed the Investigation Team that all 49 patients, and/or their relatives, where appropriate, have subsequently had their findings explained to them either through correspondence or in one-to-one consultation.

Following the review of Dr C's cytology work, the error rate for Dr C's diagnostic cytology work was 6.5%, which is 5–6 times greater than the accepted range. The accepted error rate for diagnostic cytology work, according to international best practice, is 0.2–1.7%.[2-13] Evaluation of breast cytology against accepted performance criteria for Dr C indicated false negative (failure to identify malignancy) reporting of 40% which is more than six times the accepted threshold of 6%.[14(p50)]

The Investigation Team went on to review the gynaecological screening cytology workload for which Dr C was responsible. This included a selected slide review of cases reported on by Dr C. The arrangements for gynaecological screening cytology are different to diagnostic cytology. Gynaecology screening cytology cases are mainly reported by specially trained medical scientists under the supervision of a consultant pathologist. Slides that are negative or inadequate are screened and reported on by medical scientists. Slides that show any abnormality or uncertain findings on screening are referred to the consultant pathologist for review and reporting.

As the majority of cervical screening smears are negative, only a small proportion of slides are reviewed by the consultant. The slides that were reviewed by the Investigation Team were selected using a methodology designed by the Faculty of Pathology. To validate the methodology a review of quality assurance results and practices in gynaecological cytology was undertaken and this was found to be satisfactory.

During Dr C's tenure at UHG, 13,381 gynaecological cases were reported under their supervision. Of these, 9,877 cases were reported by the medical scientists as negative or inadequate and were therefore not reviewed by Dr C. Of the remaining 3,504 cases (which Dr C personally reviewed) there was agreement between their report and that of the medical scientists in 3,381 cases – that is 96.48% agreement. This left 123 cases where there was a difference between the medical scientists and Dr C's opinion. These were the cases selected for review by the Investigation Team.

A review of any cytopathologist's gynaecological screening caseload will identify some differences between the original opinion and the reviewer's opinion. In this review of 123 cases there was agreement with Dr C's opinion in 78 cases and a difference of opinion in 45 cases. In light of these findings, the Investigation Team advised precautionary follow-up of these 45 women. 10 women have already been seen by a gynaecologist and the remaining 35 women are being followed up by UHG.

The Investigation Team concluded that there was a high level of agreement between medical scientists and Dr C. The differences of opinion between the reviewers and Dr C in 45 cases were largely around grading the degree of abnormality present and these women have therefore been advised to have precautionary follow-up.

The Investigation Team considered whether to review the work of other consultant pathologists at UHG. It decided that this was not necessary having confirmed that the breast histopathology service in UHG was incorporated into a well established multidisciplinary system. This provides an internal mechanism for identifying errors or concerns about the standard of pathology reporting in relation to breast disease. This conclusion was supported by the outcome of slide reviews conducted by the Faculty of Pathology of the Royal College of Physicians of Ireland, as part of the Barrington's Hospital Investigation, which concluded there was no concern about the general interpretive accuracy of the department. This included the work of a range of consultant pathologists at UHG.

1.3.4 The Pathology Service

At the time of the investigation, the Pathology Department had a newly appointed Clinical Director who participated in the Hospital's Management Team. Consultant pathologists with specialist interests were identified and there was evidence of their participation in, and contribution to, MDTs for breast and other conditions. Quality managers have been appointed and the Pathology Service is pursuing external accreditation. A programme of visits has been arranged and, in preparation for this, policies and procedures are being developed. The Investigation Team observed the challenging environment in which pathology staff work, with cramped and outdated working conditions.

There were sufficient external checks and balances for breast diseases by the pathology team's involvement in MDT. This was supported by some examples of diagnostic breast audit being undertaken, although there was limited evidence of this being used as part of an integrated clinical audit programme. Clearer direction, with a more structured approach, is required for standards development and quality assurance in diagnostic cytology. Clinical audit for gynaecological cytology is carried out to a high standard. Notwithstanding this, it was noted that the Information Technology (IT) systems to underpin data collection in the Pathology Service to facilitate clinical audit are poor.

The Pathology Service receives specimens from within the Hospital and from other facilities. The technical quality of histology slide preparation is adequate; that of diagnostic cytology material is variable. The variability of diagnostic cytology is due to a combination of specimen collection techniques and also the processes for preparing the slides for review.

1.3.5 The Symptomatic Breast Disease Service at UHG

The Symptomatic Breast Disease Service at UHG was found to be a well functioning service with evidence of good interdisciplinary collaboration. The service has grown significantly in recent years and innovative approaches have been used to reduce waiting times for the first attendance of patients at out-patient clinics and their initial assessment.

Multidisciplinary team meetings at UHG are held twice a week and attended by the surgeons, pathologists, radiologists, nurses and, where appropriate, oncologists. The MDT meeting is a central pillar to the work of the team in relation to patients and their symptomatic breast disease and the Investigation Team observed strong commitment to this approach. Latterly the MDTs had been extended to include clinical staff at Letterkenny and there were plans to extend this further to Castlebar and Sligo clinics. However, no such arrangements were in place with Barrington's Hospital.

There was evidence that the growth of the Symptomatic Breast Disease Service had, to some extent, run ahead of available capacity in other areas such as radiology and nursing. Whilst there is capacity amongst the surgical team to see patients, there were indications that this increase in patient attendance leads, on occasion, to long waiting times for patients on the day of their clinic appointments.

For example, not all urgent diagnostic tests are carried out on the same day and on occasion, patients were asked to return for tests and/or the results of their diagnostic imaging rather than this being made possible at the same visit. In some instances this may be appropriate but some patients and staff, who were spoken with during the investigation, considered that with some re-organisation of clinics this could be avoided.

It was found that FNA was occasionally being used as a diagnostic technique at UHG in line with the internally agreed protocol. The use of FNA cytology should only be used in clearly prescribed circumstances and within a quality assured cytology service.

1.3.6 Service and Workforce Planning

The Investigation Team found no evidence that the pathology errors relating to Ms A were as a result of a shortage of resources, although some of those interviewed believe this could have been a contributory factor. In exploring staff resources, the Investigation Team found that historically there had been debate about the staffing levels necessary to meet growing demand for the pathology service. In the years preceding the period covered by the terms of reference of the investigation, there had been a trend of increasing workload. This workload was a combination of public and private activity. Although additional staffing appointments were made, the comments of staff interviewed, and other evidence received by the Investigation Team, suggested that there could be a protracted process between national approval, regional planning and local service provision in relation to consultant staff recruitment. This had led to a time lag between the needs of the service and the appointment of additional staff. These long lead-in times to recruit, after approval of additional posts, coupled with the difficulty of recruiting to pathology services, increased the use of temporary consultant staff in UHG.

In relation to the use of temporary and locum staff within the Pathology Department for the period of the terms of reference for the investigation, January 2005 to May 2007, the Investigation Team established the following.

A second post for a consultant pathologist with a special interest in cytopathology had been advertised nationally on a number of occasions. Despite applications, at the time of the investigation, UHG had not been able to recruit to this post and as a consequence had been relying on the use of temporary and locum consultant staff.

The UHG Human Resources (HR) Department has a procedure for the recruitment of permanent staff and this was also used for the recruitment of temporary and locum consultant staff. The Commission for Public Service Appointments had issued some guidance regarding this type of recruitment.[15-16] The Investigation Team concluded that a specific procedure for the recruitment of temporary and locum consultant staff should be developed, particularly in relation to the take-up, validation and consideration of references, as well as the arrangements for working with specialist recruitment agencies. Since the investigation, the HSE has issued interim guidance on the recruitment of locum medical consultants.

Although not provided for by the consultant contract in place at the time covered by this investigation, the Investigation Team further concluded that arrangements for mitigating risk should also be strengthened in relation to temporary and locum consultant staff. This might include evidence of their existing technical competence being provided, as well as arrangements for their on-going development and support while in post. The new consultant contract should provide the basis for more explicit accountability of consultants through practice plans and a reporting relationship with clinical directors.

During the investigation, the team became aware that the HSE has established a Risk Sub-Committee which, among other things, is examining issues relating to recruitment, registration and competence assurance processes associated with the appointment of permanent, temporary and locum consultant staff. The Investigation Team suggests that the outcomes of this work should be made available as a priority as it believes that strategies, to mitigate risks associated with the appointment and on-going development of consultant staff, are required.

1.3.7 Leadership, Governance and Management

UHG has a clear framework for risk management with incident data beginning to be recorded and used for learning. UHG used the risk management framework appropriately when establishing the adverse incident group to investigate and respond to the pathology misdiagnosis of Ms A. However, the risk management arrangements in place had not identified the weaknesses in quality assurance systems highlighted by this investigation and therefore need to be strengthened.

There are clear plans for developing governance within UHG with the establishment of discrete units of clinical management known as Clinical Directorates; these are at an early stage in their development. There was a visible leadership style from the senior management team. This was valued by staff interviewed and was seen as particularly important when the initial review and helpline was found to be necessary. There was evidence of a culture of shared accountability in place between clinicians and managers.

1.3.8 Conclusion

In conclusion, two significant errors were made in the interpretation and review of Ms A's pathology specimens, one by Dr B and one by Dr C, both of whom were working within the Pathology Department of UHG. The first of these errors by Dr B in 2005, led to a diagnosis of a benign condition instead of breast cancer and contributed to a delay in commencing Ms A's treatment for breast cancer. The second error by Dr C occurred in March 2007 shortly before she received a definitive diagnosis from another hospital.

At the time, the clinical systems were not in place between UHG and Barrington's Hospital for multidisciplinary review of pathology findings. Neither were the explicit accountability and responsibility of individual clinicians evident in the pathway of care for Ms A. Consequently, in Ms A's case, the opportunity to identify and correct for these errors did not take place. The lack of MDT review meant that the interpretive errors in pathology were not identified. With the publication of the National Quality Assurance Standards for Symptomatic Breast Disease Services in May 2007, national mandated standards now stipulate that these diagnostic and treatment processes should not take place outside of an effective and well functioning multidisciplinary team environment, regardless of the care setting. The importance of clear multidisciplinary arrangements is even greater when more than one institution is involved in providing care and such arrangements should be governed by clear policies and service level agreements.

The Authority would regard adherence to these principles as an essential requirement of all centres and clinicians providing Symptomatic Breast Disease Services in Ireland whether in the public or private sectors.

The Investigation Team was appreciative of the full cooperation of UHG staff in relation to the provision of timely documentation and materials for all elements of the investigation. They responded promptly to all requests from the Investigation Team and provided additional information to assist with its enquiries. This was particularly evident in relation to the review of gynaecological cytology which entailed extensive sourcing of reports and materials. Their commitment to ensuring that patients affected by the ongoing outcomes of the investigation, particularly the pathology review, were informed and where appropriate treated, was evident throughout.

The Investigation Team would like to pay tribute to Ms A for allowing her story to provide a window into how services for others can be improved and for showing such courage in sharing her experiences with the Investigation Team for the future benefit of others. Her hope is that the findings and recommendations of this report are implemented by all those organisations who have a responsibility for symptomatic breast disease services.

A series of recommendations are made as a result of these findings. These are set out below.

2 Summary of Recommendations

Recommendation 1

The National Standards for Symptomatic Breast Disease Services (2007) should be applied to all centres providing Symptomatic Breast Disease Services irrespective of whether they are in the public, private or voluntary sectors.[17]

Where the care of patients is shared across more than one facility or institution, arrangements must be in place to ensure effective governance, management and review. Regular multidisciplinary team meetings must be held (at least weekly) and in particular, clear leadership of care planning must be maintained.

Implementation of these standards should be subject to a co-ordinated process of quality review.

Recommendation 2

Where diagnostic services are provided by a third party facility (for example a HSE laboratory providing services for a private hospital), such an arrangement should be subject to a formal Service Level Agreement, or contract, which is effectively managed and regularly monitored to ensure appropriate governance and quality assurance of the service.

The HSE and voluntary hospitals should undertake a review of all such arrangements to ensure appropriate service agreements and monitoring are in place. Equally, private sector providers are strongly encouraged to review all relevant arrangements where care of their patients is shared between organisations.

Recommendation 3

UHG's experience in responding to this incident, including the process adopted for patient management, should be captured and used to inform the development and implementation of national guidelines for handling adverse incidents.

Recommendation 4

Units using breast Fine Needle Aspiration (FNA) as a diagnostic modality should do so only in an appropriate triple assessment context and with robust quality-assurance. This should include:

- *Clarifying the role of FNA cytology in the investigation of breast disease and applying agreed patient selection criteria*
- *Auditing the service against the minimum standards set by the United Kingdom NHS Breast Screening Programme (BSP). Audit should calculate sensitivity, specificity, positive predictive value of C5, false negative rate, false positive rate, inadequate rate, inadequate rate from cancers and suspicious rates*
- *Using the C1-C5 classification system to ensure reports are clear and unambiguous*[14]

Recommendation 5

A clearer direction is needed for the development and quality assurance of the diagnostic cytology service in UHG Pathology Department.

Recommendation 6

All pathology departments should implement the recommendations of the Faculty of Pathology's guidelines on histopathology quality assurance programmes in pathology laboratories.[18] This incorporates, among other things:

- *Intra-departmental consultation/peer review*
- *multidisciplinary case discussion*
- *Incident reporting*
- *Vertical case review/audit*
- *Cytology quality assurance*

Implementation of these recommendations must be supported by appropriate Information Technology systems.

Recommendation 7

The HSE should review workforce planning at national and local levels to ensure that recruitment of consultants is more responsive to changing service needs and reliance on temporary staff is minimised. This should include measures to reduce the time-lag between authorisation to appoint and staff taking up post.

Recommendation 8

It is recommended that the HSE Risk Sub-Committee progress and publish their work on mitigating risks associated with the employment of permanent and locum consultant staff. In the meantime, all local service providers should review recruitment policies and procedures to ensure robust verification and assessment processes are in place.

Recommendation 9

A formal policy for the recruitment of locum and temporary consultant staff should be established and implemented nationally to ensure more robust and effective arrangements and quality assurance mechanisms. This should include:

- *Formalised agreements with specialist recruitment agencies which will include; their role, responsibility and area of accountability in the recruitment process. These agreements should be regularly monitored*
- *The provision for appointment panels to view and discuss all written references as part of the assessment process and before recommendation for appointment*
- *Account to be taken of existing competency levels of applicants as well as arrangements for their on-going development and support as temporary employees*
- *An agreed programme of audit against compliance*