(Q 43)

313. No, there was no process to govern this. As indicated above, if an agreed pathway is recommended to a patient at review following MDM discussion, the patient may decline to comply with the recommendation, or wish to defer further consideration of doing so until a later date, or some variation of that nature. It may also be the case that the clinician and the patient may conclude at review that the recommended pathway is inappropriate for one or more of a multitude of reasons, as has been acknowledged in Guidelines and publications concerning MDTs and MDMs (such as Multi-disciplinary Team (MDT) Guidance for Managing Prostate Cancer, published by the British Uro-oncology Group and the British Association of Urological Surgeons' Section of Oncology in September 2013) [see supplemental October bundle pages 324 – 401].

314. Other members were not subsequently informed of a deviation from an agreed recommendation, as there was an understanding that the clinician and patient had the right, and indeed responsibility, to deviate from the agreed recommendation if the latter was declined by the patient, or if the recommendation was concluded by the clinician and patient to be inappropriate.

(Q 44)

315. I am unable to recall each specific instance where I did not implement a decision reached concerning recommended treatments or care pathways at MDM over a 10-year period, although I am sure there are examples of occasions when, following a decision made at MDM, and after reviewing the patient, a different approach was taken to that recommended by MDM. If the Inquiry is able to identify any such specific cases, I am happy to provide further details if required.

316. I can, however, refer to one example which has been provided in the disclosure by the Trust [see TRU-09828]. While I do not have the benefit of this patient's full clinical records, the details included in the emails exchanged

between myself and Ms McVeigh, Cancer Tracker, on 23 June 2019 [see supplemental October bundle pages 703 - 704], between myself and Dr Drake, Consultant Oncologist, on 15 August 2019 [see supplemental October bundle pages 705 - 706], between myself and Mr Haynes on 04 October 2019 [see supplemental October bundle pages 709 - 710] provide sufficient clinical detail for the purpose of addressing this particular issue. The patient presented to haematologists in March 2019 with lymph node enlargement and a biopsy in April 2019 confirmed follicular lymphoma. Staging of the lymphoma revealed the presence of a right renal lesion. While it was considered that this lesion was probably a primary renal cell carcinoma, it remained a differential possibility that the lesion may have represented lymphomatous infiltration of the kidney. If that was confirmed by percutaneous biopsy, that alone would have been an indication for treatment of the lymphoma. Percutaneous renal biopsy with prophylactic Factor VIII was recommended at Urology MDM on 27 June 2019.

317. When I subsequently reviewed the patient, I did not follow that recommendation as the patient had already begun chemotherapy for his lymphoma. Not only would a renal biopsy have been accompanied by risk of renal haemorrhage, it would have additional been accompanied by the risk of infective complication which would have exacerbated the risk of secondary renal haemorrhage. In any case, a provisional plan was for him to continue with chemotherapeutic management of his lymphoma followed by reappraisal prior to initiation of maintenance therapy. Accordingly, I made the decision to defer consideration of a kidney biopsy and I note that Mr Gilbert in his email of 13 December 2020 [TRU-09829] stated that this was a "*reasonable change of plan".*

318. It is of crucial importance to state that the MDM, while unquestionably useful, often did not have the full patient history when making recommendations. Situations did arise whereby a recommendation was made at MDM, and on review of the patient by the consultant it became clear that the MDM recommendation was not appropriate. Indeed, to slavishly follow the recommendations of the MDM in such circumstances would be to put patient

Thank you Hugh
This is very helpful
Glad you're feeling better. See you at 2pm

Kind regards
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital
Personal Information redacted by USI

From: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST) Personal Information redacted by USI
Sent: 13 December 2020 23:48
To: Kingsnorth, Patricia
Subject: Re: ENCRYPTION

Dear Patricia

Apologies for the delay; I think I am getting better now.

This case does not raise any alarms in my head.

The patient presented to the haematologists in March 2019 with LN enlargement and a biopsy (April 2019) confirmed a follicular lymphoma. As part of his assessment a CT had shown a renal lesion, which was further characterised by a PET CT and pointed to a coincidental kidney cancer. This was discussed at the urology MDT and a biopsy was recommended.

Significantly, the patient had low Factor VIII (haemophilia) and was about to start 6 cycles of chemotherapy for the lymphoma. He also had a cardiomyopathy and a past history of papillary thyroid cancer.

He was seen by AOB with the written plan to reassess after restaging. It is reasonable to assume he meant post chemo staging. The biopsy was, in my opinion, reasonably deferred; the potential complications infection, haematoma spread during immunosuppression, or even loss of the kidney outweighed any benefit in knowing the histology.

A letter describing this plan was not generated until October 2019. This caused unneccessary concern and work for AOB's colleagues.

Nephrectomy proceeded after the chemotherapy (successful) was completed.

There is a nodule in the lung fields, which may represent a metastasis. This must be discussed at a specialist MDT (Belfast) to consider the timing of adjuvant treatment.

My only observation is that the reasonable change of plan should have been discussed in the MDT in a timely fashion. I don't think the patient suffered any harm as a consequence of this omission. I don't think this amount to a SAI.

As an aside, I would be very interested in the histology of the kidney tumour. The combination of papillary thyroid cancer, renal neoplasia and follicular lymphoma points towards a genetic cause.

KR, Hugh

From: Kingsnorth, Patricia Personal Information redacted by USI
Sent: 03 December 2020 14:23
To: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST) Personal Information redacted by USI
Subject: ENCRYPTION

Dear Hugh
I have been asked if you could assist me some independent view regarding screening for this case. He will not be part of the SAI group but may need to have an SAI separately if required.
I apologise that I am adding to your busy workload and will understand if this is not appropriate to ask the question. Just delete the email if that is the case.

This is a gentleman has a renal carcinoma. He was also attending haematology with lymphoma and preparing for chemotherapy when a CT scan showed a renal lesion which required biopsy.
MDM made a recommendation to biopsy the kidney. This did not happen as the consultant (in his letter dated 16 August 2019) explained why this didn't happen in view of the patient currently undergoing chemo therapy and with his factor V111 condition. This was not fed back to MDM.
The question is given what appears to be a reasonable reason for the delay to action MDM outcome and not feedback to the MDM does that make this an SAI? However I will point out the letter was not written until October 2019.

There does not appear to be a proper process for feeding back to MDM and this will be one of the learning from SAI. Can you advise if this was a reasonable approach for this gentleman particularly if it had been with any other practitioner?

Kind regards
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
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Craigavon Area Hospital
Personal Information redacted by USI

many reports as possible, for the sake of the safety of patients so endangered by the Trust.

563. No concerns were ever raised during my tenure in respect of the use of Bicalutamide. The appropriateness or otherwise of this medication cannot be considered in isolation without reference to specific patients and their individual clinical situations.

564. In respect of MDMs, I do not believe that any failure on my part to follow MDM recommendations would have or did impact on patient care and safety. In any case where there may have been a departure from a MDM recommendation, a detailed review of the individual case would be required in order to comment on the rationale for departing as there can be many appropriate reasons to do so. For example, it would not be appropriate to follow such recommendation if, following discussion with the patient, the patient did not wish to follow the treatment recommended at MDM. That would be a more serious patient care and safety issue in that it would amount to providing medical treatment without the patient's consent.

(Q70 – 71)

565. I have provided comments under the heading "Concerns regarding your practice" (Questions 66 - 67) which refer to concerns that were raised and will not repeat the detail of same here.

566. As the Inquiry is aware, I had concerns regarding my practice addressed by the formal investigation initiated on 30 December 2016. I have commented on that process extensively elsewhere in this statement (see response to Questions 66 - 69) and in the grievance submitted in November 2018. I can only recall one occasion on which it was suggested that I deviated from an action plan that was put in place during that process and I will refer to that below.

Urology Services Inquiry

Patients being unaware of care varying from above recommendations and unable to give informed consent

- Patients were not aware that the care given varied from Regional Standards and MDM recommendations. They could not have given informed consent to this.

Patients receiving care without input from a Cancer Nurse Specialist / Key worker

- All patients were not referred to Urology Cancer Nurse Specialists despite this resource being increased by the Southern Health and Social Care Trust. Peer Review 2017 was informed that this resource was available to all. Their contact numbers were not made available.

Lack of resource within the SHSCT to adequately track cancer patients through their journey

- The Urology MDM was under resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment (that is 31- and 62-day targets). It did not function as a whole system and whole pathway tacking process. This resulted in preventable delays and deficits in care.
- Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT tracking, Consultants and their Secretaries and Urology Specialist Nurses, in a Key Worker role. The Review found that these 9 patients were not referred to Specialist Nurses and contact telephone numbers were not given. Therefore, the CNS were not given the opportunity to provide support and discharge their duties to the 9 patients, who suffered as a consequence. The MDM tracking system was limited. The consultant / secretary led process was variable and resulted in deficits. The weakness of the latter component was known from previous review.

Non-Quorate Multidisciplinary Meetings

- The Urology MDM was under resourced and frequently non quorate due to lack of professionals. The MDM had quorate rates of 11% in 2017, 22% in 2018 0% in 2019 and 5% in 2020. This was usually due to lack of clinical oncology and medical oncology. Radiology had only one Urology Cancer Specialist Radiologist impacting on attendance but critically meaning there was no independent Quality Assurance of images by a second radiologist prior to MDM.

Lack of Assurance Audits within the MDT process

- Assurance audits of patient pathways within the Urology Cancer Services were limited between 2017 and 2020. They could not have provided assurance about the care delivered.
- Because of resource, the MDM was very focused on first presentation at MDM and did not have a role in tracking subsequent actions if it lay outside 31- and 62-day targets.

8.0 LESSONS LEARNED

- The MDM should be chaired by a named clinician with responsibility for ensuring adequate discussion of every patient.
- Consideration should be given to ensuring that all patients and their GP's receive a plain-English copy of the MDM discussion.
- A Key Worker, usually a cancer nurse specialist, should be independently assigned to each patient with a new cancer diagnosis.
- All patients and their families should be offered an out-patient or telephone consultation with their Key Worker to allow reflection on their options.
- Patients should be invited to a joint oncology outpatient appointment at which all the treatment options available should be explained by the most appropriate clinician.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

A MDM chair's responsibilities must include regular quality assurance activity.

Recommendation 2

The MDM should be quorate.

Recommendation 3

The rationale for any decision to diverge from the MDM plan must be explained to the patient, documented in the communication with their GP, and subsequently validated by further MDM discussion.

Recommendation 4

The MDM must have an open supportive culture allowing members to raise clinical concerns.

Recommendation 5

The Southern Health and Social Care Trust must develop cancer service governance processes to identify deficits in care and to escalate these appropriately.

Mr Glackin highlighted there are only 5 Cancer Nurse Specialist covering the services over a number of hospitals.

Dr Hughes advised he thought at the start it was geographical but asked why patients were not given contact details. He advised this is one of the questions he has asked MrO'B. He was concerned there was no multi-disciplinary support for these patients.

Mr Glackin advised the issue surrounding resources of nurses has only improved in the last 2 years.

Dr Hughes highlighted that renal patients needed Cancer Nurse Specialist.

Mr Glackin suggested there was an issue with resources at MDM. He recalled his experience in the West Midlands where MDM was better resourced. The follow up and tracking was more robust, more a priority and had admin support. He advised there were weekly trackers who would liaise with consultants enabling them to meet their timelines. Adding here they are never able to meet timely care.

Dr Hughes agreed with Mr Glackins points. He questioned if the issue was systematic and a problem for more than the 9 cases, if so this would need to be addressed. He added the recommendations will be able to review this through the recommended audits.

Mr Glackin referred to the proposed audits and advised at present they would not have the time or resources.

Dr Hughes advised consultants should have been doing audits and agreed there was a need for more resources. He advised other concerns raised were the appropriate onward referral to other professionals, oncology etc from MDM. He feels MDM focused on first diagnosis.

Mr Glackin suggested this was more or less unique to MrO'B. He added that the MDM chair is rotated among colleagues.

Dr Hughes advised he had raised this with Mr Gilbert and was advised this was a common way of working and feels it is beneficial to rotate the chair, they can review cases in advance and identify where there is care deficit. He said when patients progress they are not being taken back to MDM leading to uni-professional care, causing a problem.
He also said there were issues around flutamide.

Mr Glackin advised this was discussed at MDM. He referred to the specific dose of 150mg and suggested the evidence was weak in the criticism in the use of this treatment and said the scientific evidence was not so robust.

Dr Hughes said he was taking advice from Mr Gilbert. He feels in these cases it was inappropriate and said it would have been more appropriate for onward referral to oncology.

Mr Glackin suggested that generally consultants give other treatments and feels if the review is referring to the use of flutamide this needs to be scientific and not opinion.

Dr Hughes referred to the 5 prostate cancers. 1 being coincidental, 1 was potential prostate that didn't get a diagnosis for 15 months.

9.0 RECOMMENDATIONS AND ACTION PLANNING

treatment planning and completion and survivorship.

Recommendation 3

The Southern Health and Social Care Trust must develop cancer service governance processes to identify deficits in care and to escalate these appropriately.

Recommendation 4

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.

Recommendation 5

The Southern Health and Social Care Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals, especially as disease progresses.

Recommendation 6

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.

Recommendation 7

Each MDM requires a Chair responsible for the audit and quality assurance of all aspects of its primary function.

Recommendation 8

The multi-disciplinary team meeting should be quorate, and all participants must feel able to contribute to discussion.

Recommendation 9

The clinical record should include the reason for any deferments or variation in MDM management decisions.

10.0 DISTRIBUTION LIST

Mr Shane Devlin – Chief Executive SHSCT

7.0 CONCLUSIONS

The management of XX's renal tumour was exemplary. The abnormal findings on the post-operative review scan should have been noted and acted upon. It would be unusual for a renal cell carcinoma to produce a sclerotic metastatic bone deposit and other options should have been considered.

8.0 LESSONS LEARNED

- An acknowledgement mechanism for email alerts to adverse radiological reports should have been in place.
- The MDM tracking capacity was insufficient to provide an additional safety net for patient follow up.
- Absence of a Urology Cancer Nurse Specialist is an additional risk for successful patient follow up.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review. This must be supported by a Urology Cancer Nurse Specialist at an early point in their surveillance journey**.**

Recommendation 2

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals. In this case it would be essential to improve radiological resource.

Recommendation 3

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed. This should be supported by a clinical nurse specialist, a radiology alert system and the consultant.

Recommendation 4

All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance). This includes onward referral for appropriate advice

8.0 LESSONS LEARNED

- The MDM should be quorate.
- If the MDM is not quorate, an accountable Chair should ensure, through appropriate Quality Assurance (QA), that every patient's potential management options are fully discussed and that the MDM's decisions are documented as having been communicated with the patient, their family, and their GP.
- A MDM Chair should ensure appropriate and a comprehensive Quality Assurance (QA) programme, that ensures adequate compliance with the MDM's published guidelines.
- All patients should be independently assigned a Key Worker, usually a cancer nurse specialist, to guide and advise them of their options.
- The MDM should regularly revisit their guidelines and policies to ensure best practice continues to be followed.
- The MDM should agree and audit, as part of QA, the indicative timings for the stages in cancer management.
- All patients whose disease fits the criteria for referral to a specialist MDT should be referred for advice and management at the completion of staging.
- Specialist urological cancer interventions should be delivered by appropriately experienced clinicians, normally at a specialist centre, who continue to demonstrate audited outcomes.

References

1. EAU guidelines for penile cancer: section 6.2.1 (2019)
2. NICE improving outcomes in urological cancer (2002)
3. NICAN Urology Cancer Clinical Guidelines (March 2016), Penile Cancer treatment Section 9.3 (3).
4. Peer review Self-Assessment report for NICaN 2017.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

A MDM Chair should develop an appropriate and comprehensive Quality Assurance programme that ensures adequate compliance with the MDM's published guidelines.

Recommendation 2

The MDM should agree and audit, as part of QA, the indicative timings for the stages in cancer management.

Urology Services Inquiry

Tracking of patients was flawed by limitations within the MDM systems and the lack of Specialist Urology Nurses from their Key Worked role. Two of the three normal safety nets for patient pathway completion were, in essence absent. A collaborative approach did not appear to be actively encouraged within the MDT.

Lack of coherent escalation / governance structures

- Annual business meetings had an expressed role in identifying service deficits and drawing up an annual work plan to address them. Cancer Patient Pathway compliance audits were limited and did not identify the issues within this report.
- Governance of professionals within the MDT ran through their own directorates but there was no functioning process within Cancer Services to at least be aware of concerns - even if the responsibility for action lay elsewhere within the Southern Health and Social Care Trust. There was disconnect between the Urology MDT and Cancer Services Management. The MDT highlighted inaction by Cancer Services on Oncology and radiology attendance at MDM but did not escalate other issues.
- The Review team found that issues about prescribing, and the use of Clinical Nurse Specialists were of long standing. They were known internally and in the case of prescribing externally (Regional Oncology Services). The Northern Ireland Cancer Network drew up specific Guidance on Hormonal Therapy in Prostate Cancer in 2016 following concerns about this issue. The Guidance was not subject to audit within the Southern Health and Social Care Trust.

16.Outline what, if any, discussion of the review team's findings, conclusions, recommendations, and action plans took place between the review team and the SHSCT.

- Discussions with the SHSCT Cancer management Team were limited as the recommendation in the report mirror those outcomes that should be evidenced at External Peer Review of Urology Cancer Services. The underlying difference was the service required a comprehensive assurance mechanism to demonstrate the outcomes and to meet the expectations of the families who contributed to the process. I was keen to ensure the recommendations were externally validated, would meet national standards, and reflect the independent external aspect of the review process. Feedback was received from the Senior Cancer Management team, and I have included this correspondence with my response in Question 12.

  Ref No108. 20210331
  Ref No109. 20210421

Urodynamics as it was the specialist nurse who performed the test, however he didn't include the CNS when he was consulting with the patient after the test.

Martina advised that in her opinion she felt that one of Mr O'Brien's problems was that he took everything on himself and never involved none of the wider team and then because of this never had the time to see everything through.

Dr Hughes reiterated – "at no stage were specialist nurses allowed to share patient care with Mr O'Brien?

Martina confirmed that yes this was correct. She also confirmed that all of the other consultants see the benefits of using a CNS and that they include them in all of their clinics.

Dr Hughes – advised that care was excluded to all professionals and that Mr O'Brien was working outside his scope of practice.

Martina advised that during MDT on occasions there were issues raised about Mr O'Brien and at times these were escalated to the AD and AMD but as with other concerns regarding Mr O'Brien these never got anywhere as he either 'promised' that he would sort or else he gave a reason why he couldn't follow through. Martina advised that there was an ethos among many other staff "well sure that's just Aidan".

Dr Hughes agreed and said that staff appeared to have become habitualised by his bad practice.

He asked Martina if she had any questions.

Martina didn't but did say she questions herself had she done the right thing by escalating the concerns?

Dr Hughes assured her - absolutely!

Martina felt reassured by this and also advised she had been involved in the original admin look back of patients and through this piece of work had identified two of the current SAI during this process.

Dr Hughes advised that the review team will go back to families with a draft report and feedback on the learning. He advised any learning for the MDT would be systematic and constructive.

He thanked Martina for her assistance.

Southern Health and Social Care Trust

Acute Governance

Patient 5

Meeting Room, Trust HQ, CAH
Monday 11 January 2021

PRESENT: **Dr Dermot Hughes**
Mrs Patricia Kingsnorth
Personal Information redacted by USI **– Via Zoom**
Patient 5's Daughter
Patient 5's Daughter

Patricia introduced Dr Hughes to Patient 5's Daughters and thanked them both for taking the time to meet with us to discuss their father's story.
Dr Hughes explained who the team members were and what his role was. He is a former Medical Director of the Western Trust. Mr Hugh Gilbert is our expert opinion who is based in England and has is totally independent of urology services in Northern Ireland. Patricia Thompson is a specialist Nurse who is new to the Southern Trust and previously worked in the South Eastern Trust. She does not know the consultant involved and is independent from that aspect but can bring insight and clarity around specialist nurses roles. Fiona Reddick is the Head of Cancer Services and can provide clarity around the process of cancer services Patricia Kingsnorth – head of clinical and social care Governance.

Dr Hughes explained about the review and how it came about after the retirement of the said consultant and the identification of patients when other consultants took over their care. He explained that these 9 patient's care were reviewed and screened for SAI and deemed to reach the threshold for SAI review.
The review will involve the treatment and care of 9 patients – 5 prostate cancers, 2 renal cancers, 1 testicular cancer and 1 penile cancer. He advised that he doesn't believe these will be the only patients affected. He assured Patient 5's Daughters that the process will be open and honest and transparent and that the learning will be shared and made available to the independent enquiry. Dr Hughes confirmed Mr Hugh Gilbert will be reviewing all cases. He explained the public enquiry being done by the Department would be more in-depth and may take a longer period of time.
Patient 5's Daughter advised that she was well versed in the process and had reviewed Robin Swan's statement.
Patient 5's Daughter – Said it seems pretty clear given the back ground. She asked if the initial review was looking at stent procedures. She recalled hearing that a named consultant had retired and when he retired his cases were passed to other consultants and some came back with concerns. She asked was there any indication of his practice before he retired.
Dr Hughes advised he was contacted in August to review cases and when he started more cases came to light. He explained they will review their father's cancer care and assured the family the review would be open and transparent. He acknowledged their father suffered and apologised for this.
Patient 5's Daughter – stated an apology wasn't enough.

Daughter - agreed to send any queries they have from the timeline.

Dr Hughes asked why their father hadn't a PSA test done when he was in ED.

Patient 5's Daughter – advised her father was very happy with the care provided by Mr O'Brien until he got the call from Mr Haynes. She asked if the CT scan her father got was not viewed or actioned. (an audit search has shown the CT scan report was not viewed).
Dr Hughes advised he had requested clarification from Mr O'Brien and the request was going through his solicitor.

Patient 5's Daughter - recalled 3 years ago her father presenting to ED for an INR test. She recalled the doctor going through her father's past medical history and asked if he had been in contact with chemicals. She believes the doctor realised her father hadn't a simple infection as her father was obviously in pain, the family left feeling reassured as he was being referred to urology. Patient 5's Daughter advised that following their father's ED attendance, she rang Mr OB secretary requesting a private appointment for their father, but Mr OB initiated an urgent review and arranged for their father to be seen urgently in December 2018. The kidney tumour was diagnosed. Her father was sick and he put his faith in the Trust.

Patient 5's Daughter - acknowledged her father is Personal years old and that this has had a phenomenal impact on him. Her father had come through a lot. She continued to advise that her father had lost his Personal information redacted by USI to cancer. Patient 5 sang Mr O'Brien's praises. Patient 5's Daughter advised their father had been shielded for 5 month due to COVID. They recall coming from an appointment in March 2019 thinking their father was cancer free. They didn't know he had prostate cancer until Mr Haynes phoned their father. This distressed them thinking that their father was fine and safe when he had cancer. They advised it was shocking news to receive. They questioned the governance processes in place. Who was monitoring Mr OB appraisals?
Dr Hughes agreed and advised these will be looked in a separate process with the GMC and external professionals.

Dr Hughes acknowledged the traumatic impact this had on the family. He advised Mr O'Brien is polite and personable but he gave the wrong advice, he seemed to work as an individual.

Patient 5's Daughter - recalled how their father was given a stress test by anaesthetics in preparation for their father's surgery. They put an Personal year old man with an Personal Information redacted by USI and asked why would you do that?
She advised that due to the anaesthetic risk the surgery was deemed too risky, but their father was willing to take the chance. Patient 5's Daughter said that each patient should be looked at as a holistic individual. She recounted that on two occasions, whilst in ED her, ECG leads were put on her father's Personal Information redacted by USI even though it was obvious.

Patient 5's Daughter recalled they were asked to attend a meeting with Mr Haynes. They attended the room to be told staff were meeting there and they had to move to another area in the hospital causing even more stress to their father. They felt this reflected poorly on the Trust. Patient 5's Daughter feels the meeting could have been moved and not the family. They described how their father is a very intelligent fully independent Personal year old.
Patient 5's Daughter said they never felt their father would have a second cancer.

Leanne McCourt doesn't feel he valued the Nurse Specialists. She recalled him asking her in the kitchen what the role of a Nurse Specialists was. He didn't understand the role if a Nurse Specialists.

Dr Hughes advised the Nurse Specialists was signed off in 2016. He advised the reason for Nurse Specialists are for patients. He advised he needs to know if it was a deficit because of work or this particular doctor.

Jenny McMahon said she had a very different experience. She advised she was not sure why MrO'B didn't invite CNS into the room and feels this is a question MrO'B needs to answer. She advised MrO'B spoke very highly of CNS. She recalls MrO'B having review oncology on Friday but she wasn't asked to attend.

Dr Hughes confirmed he had asked MrO'B this question. He asked if it is reasonable to say resources were made available.

Jenny McMahon said yes they would have been made available if support was need on the day but advised nurse specialists were not invited to attend appointments.

Kate O'Neill advised the period during 2019 MrO'B only seen reviews, she asked Martina Corrigan if this was decided.

Martina Corrigan advised no. MrO'B decided to do this himself.

Kate O'Neill advised reviews changed to Tuesdays. She recalled MrO'B contacting her to help with cath etc.

Leanne McCourt agreed MrO'B would approach her to arrange prostate appointments.

Kate O'Neill advised if there was no nurse available other staff was available to assist.

Dr Hughes advised referrals were not made and no numbers given out even though resources were available.

Jenny McMahon felt MrO'B was very supportive of Nurse Specialists.

Dr Hughes advised there are 9 patients in the review and they were not referred to Nurse Specialists and 3 have died. He advised families were not aware of Nurse Specialists. He feels Nurse Specialist should be imbedded.

Jenny McMahon agreed contact details should have been given. She conceded there may not have anyone available on the day but patients should have been given contact details.

Kate O'Neill advised at MDT Nurse Specialists should have been present or available. She advised there was an audit done from March 2019 to March 2020, 88% was given Nurse Specialist contacts.

Dr Hughes asked Kate if she would send the information to him. He advised he wants to be able to say resources were available but patients were not referred. He feels this is a patient's choice whether or not to avail of the support of Nurse Specialists.

Jason advised he worked with MrO'B and his experience was entirely different. He said he may not have been in the room but would have been introduced after but with MrO'B he would not have had as much input. He said MrO'B may have given contact details in the

Dr Hughes advised prostate cancer is very slow growing and does sometimes link with liver cancer. He advised the scan showed bony lesions but he is not sure if Mr O'Brien reviewed the scans but will checking the audit trail on NIECR.

Patient 5's Daughter - asked if Mr O'Brien went against MDT advice.
Dr Hughes said no regarding their father's renal tumour. This care was very good but Mr O'Brien didn't action the scan done in December.

Dr Hughes advised in terms of their father's care he needed surgical input to be at the MDT meeting, and oncology following his surgery. He acknowledged that oncology was not represented at the MDM. He said the Southern Trust were disadvantaged disproportionately regarding oncology services. That an oncologist was provided by Belfast for lung MDM which meets on a Thursday morning and urology is in the afternoon and often no oncologist is available to attend. There are known staffing issues within oncology and these will be addressed in the review.

Patient 5's Daughter - advised she has no confidence in the Trust.
Dr Hughes advised that the Trust has allowed him to conduct the review unhindered and have cooperated with him and are keen to identify learning to make it better for people going forward.
Dr Hughes will be asking why a specialist nurse wasn't aligned to Patient 5 and why MDT advise was not taken forward.

Patient 5's Daughter – asked was this issue localised to one profession?

Dr Hughes feels it is but he doesn't have the evidence to support that. This has been discussed with the cancer managers, going forward they will be running assurance audits on all staff. He said when reviewing Mr O'Brien the focus was around him as he had no nursing support.

Patient 5's Daughter - has spoken to her father and he had asked if it was all older people involved?
Dr Hughes advised there was one younger man and most patients are younger than Patient 5.
Patient 5's Daughter - believes most GP's dismiss older patients.
Dr Hughes believes the family have a valid point and questioned if it was ageism. He said it was a question around uni professional care given to patients.

Patient 5's Daughter - asked why would you want to do this and asked how Mr O'Brien got away with it?
Dr Hughes suggested it is better to share patient care and responsibility with other medics for both support and feedback. That is what the MDT is about.

Patient 5's Daughter - asked what the guidelines were audited.

Dr Hughes said the guidelines were for bladder cancer was regularly audit. But there was no audit on other urological cancers. He said there were a variety of issues, how people are diagnosed, prescriptions, support and referred back to MDT.

Patient 5's Daughter - recalled after her father's discharge there was no support the family had to care for his wound. She believes the doctor should have coordinated their father's care. She advised their father is not getting any better and his energy levels are low.
Dr Hughes suggested the family should have had named nurse to support the family.

Daughter - knew he wasn't getting any better so contacted the locum GP. They got a call to say he had fluid on the heart. He was referred to cardiology. The family arranged a private appointment with Dr McEneaney. Dr McEneaney sent their father to ED for assessment. They advised that at first the ED team didn't want to admit him. Patient 5's Daughter stated they felt hostility from ED and high to fight their father's corner.. ED then agreed to admit him; he got his kidney function up again. Patient 5 was referred back to urology.
Dr Hughes advised they would audit all referrals.

Patient 5's Daughter said- Mr O'Brien found out their father was in hospital and prescribed him folic acid. She recalls at a GP appointment their father was asked how "his flow" she questioned what kind of question is that to ask an Personal information year old man? What does that mean? Patient 5 advised he was "going to the toilet a wee bit more" and thought it was old age. Patient 5 had pain but he put it down to arthritis. She said their father is always sleeping.

Dr Hughes asked if Patient 5 got a PSA test done.
Patient 5's Daughter - advised he hadn't.
Mrs Kingsnorth check on the system, the first PSA was done 10 August 2020.
Dr Hughes suggested all older patients should get a PSA test done and is generally offered by GP's.

Patient 5's Daughter - asked how common is it to get two cancers?
Dr Hughes advised it is not uncommon but in certain family groups it can be more common.
Mrs Kingsnorth confirmed Patient 5's PSA was reported as normal.
Patient 5's Daughter - asked was it a qualified radiologist that reviewed the scans.
Mrs Kingsnorth confirmed it was.
Patient 5's Daughter asked if it was a staff member or locum who reviewed the scans.

Mrs Kingsnorth said it could have been a locum as this is most radiological investigations are outsourced by the Trust. (Patricia can confirm it was a consultant staff member who reported on the results)
Dr Hughes agreed to check.

Daughter - feels there was a deficit in their fathers care in December. She asked if her father could have had the cancer earlier.
Mrs Kingsnorth assured the family she would ask for a review of the previous scan reports to check if there was any abnormality detected. But assured them we were not defending anything that has happened. (We have had the radiology consultant lead to review and compare the previous scans. There was no evidence of metastases on the previous scans).

Patient 5's Daughter - expressed how angry she is. There were multiple failures in their father's care.

Dr Hughes said that the review expert would not agree with that and added that Mr Gilbert suggests that their father received very good care regarding his surgery and outcomes the problem was with the follow up of the scan result.

Dr Hughes advised he was ashamed as a health professional for what their father and the family have gone through. There is a clear pathway which wasn't followed.
Patient 5's Daughter said that her father was exhausted and the treatment has taken its toll on him. Dr Hughes advised that the hormone therapy does make you feel exhausted.

7.0 CONCLUSIONS

The Review Team would like to thank the patients and their families for their contribution to the report and their willingness to share their experiences. The process was difficult and at times traumatic for them.The review team acknowledge that this report may cause distress to the patient and their families, however the team has endeavoured to produce a complete and transparent account of each patient's journey.

The Review of nine patients has detailed significant healthcare deficits while under the care of one individual in a system. The learning and recommendations are focused on improving systems of multidisciplinary care and it's governance. It is designed to deliver what was asked of the Review Team by patients and families -" *to ensure that this does not happen again or that another patient suffers".*

The Patients in this review received uni-professional care despite a multidisciplinary resource being available to all others. Best Practice Guidance was not followed and recommendations from MDM were frequently not implemented or alternative treatments chosen. There was knowledge of that prescribing practice varied from regional and national guidelines in the Southern Health and Social care Trust, as well as more widely across the Cancer Network. This was challenged locally and regionally, but not effectively, to provide safe care for all patients. Inappropriate non referral of patients to oncology and palliative care was unknown.

The primary duty of all doctors, nurses and healthcare professionals is for the care and safety of patients. Whatever their role, they must raise and act on concerns about patient safety. This did not happen over a period of years resulting in MDM recommendations not being actioned, off guidance therapy being given and patients not being appropriately referred to specialists for care. Patients were unaware that their care varied form recommendations and guidance. They could not and did not give informed consent to this.

The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer review were not based on systematic audit of care given by all.

While it is of little solace to the patients and families in this review, The Review team sought and received assurances that care provided to others adhered to recommendations on MDM and Regional / National Guidance.

Four of the nine patients suffered serious and significant deficits in their care. All patients had sub-optimal care that varied from regional and national guidelines.

As part of the Serious Adverse Incident process, the Review Team had requested input fromDr 1. This related to the timelines of care, for the nine patients involved in the SAI reviews and specifically formed part of the root cause analysis. This fell under professional requirements to contribute to and comply with systems to protect patients and to respond to risks to safety. To date a response has not been received.

8.0 LESSONS LEARNED

The review identified Cancer Care given by Dr 1 that did not follow agreed MDM recommendations nor follow regional or national best practice guidance. It was care given without other input from Cancer Specialist Nurses, Oncology and palliative care. It was inappropriate, did not meet patient need and was the antithesis of quality multidisciplinary cancer care.

Ensure all patients receive appropriately supported high quality cancer care irrespective of the professional delivering care.

Ensure all cancer care is multidisciplinary and centred on patients physical and emotional need.

Have processes in place to provide assurances to patients and public that care meets these requirements.

That the role of the Multidisciplinary Meeting Chair is defined by a Job Description with specific reference to Governance, Safe Care and Quality Care. It should be resourced to provide this needed oversight.

9.0 RECOMMENDATIONS AND ACTION PLANNING

The recommendations represent an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialist appropriately in care. They are to address what was asked of the Review by families - "that this does not happen again".

Recommendation 1.

The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.

This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.

Timescale – Immediate and ongoing

Assurance - Comprehensive Pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review / External Service Review by Royal College.

Recommendation 2.

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.

- The Action Plan (which was included in the overarching report) was intended to provide evidence of a high-quality service going forward, that was externally quality assured and specifically met the expectations of the families who engaged at length with the SAI process (despite personal trauma). The recommendations were routine expectations of a functional high quality cancer service, but the required assurance mechanisms were new to the Urology Services teams and specifically new to the Clinical Cancer Management Team. This process would require additional resource, but I believe the augmented assurance and governance recommendations were perceived to be a criticism of the past. Irrespective of this, I believed that this level of assurance with appropriate external validation, was required to provide evidence to patients, families and the wider public that deficits in service had been addressed.

  Ref No91. 20210419

14.Were any updates provided to the SHSCT during the course of the review(s) conducted by the review team? Who was responsible for providing updates? If updates were provided, disclose the content of same, and explain why updates were provided before the review(s) were completed.

- I provided updates to professionals for separate and appropriate reasons. I had contact with Medical Director – then Dr Maria O'Kane to discuss early findings of importance that had the potential to adversely impact on ongoing patient care within Urology Cancer Services. This was to provide feedback on how ongoing services met expected care standards, while a review was in place.

  Ref No92. 20210419
  Ref No93. 20210121

- I met Mr. Stephen Wallace regarding timelines of work given that this was a high-profile review and that partners in the PHA and Department of Health required feedback on process.

- The SHSCT were given feedback regarding the patient feedback to help inform them of family concerns and allow them to deliver their responsibilities in terms of support and ongoing care for patients and families. As part of redress, the SAI team were able to expedite ongoing care including dates of surgery and access to community support for those with advanced disease.

- I became aware that SHSCT was receiving feedback through the governance lead within the SAI review via the Director Responsible for the Urology Cancer Services.

  Ref No94. 20201216

- The overarching Report and Action Plan was shared with the Cancer Management Team for information and discussion on how recommendations could be achieved. The Report was amended with tracked changes, by the SHSCT Clinical Lead for

Urology Services Inquiry

17.To the best of your knowledge and understanding, were the findings, conclusions, recommendations and action plans for each of the nine SAI reviews accepted by the SHSCT? Outline any disagreement or objection to any finding, conclusion, recommendations or action plan which was raised with you or any member of the review team.

- To the best of my knowledge the recommendations and action plans of the SAI process were accepted by the SHSCT and the SHSCT Urology Cancer Services. I was also contacted to be a “critical friend” to the implementation process and at a later date, contacted by the Urology Services Manager to help with implementation.

- The recommendations relate to expected best practice as defined by National and Regional Guidelines. These were shared and shaped by the Review team and families experience. My understanding of concerns from the Urology Cancer Services was the additional level of assurance placed on the service, the availability of resources to achieve this and the need to address staffing shortages. It represented a change in how patients were supported, managed, and tracked through the system but this was required to ensure patient safety and demonstrate change to service users. Members of the Urology MDT who had worked previously in the UK had requested enhanced MDT resource and appropriate recruitment to all professions contributing to patient care.

- The Senior Clinical and Managerial leadership of Cancer Services had a different view and regarded many of the assurance requirements within the recommendations were questioned based on commissioning and questionable benefit. My response to their concerns is included in question 12.

- The Clinical and Managerial Leadership of Cancer services had no knowledge or insight into the problems identified within the SAI processes. There was lack of understanding of services how were delivered elsewhere and what constituted open and transparent governance in a complex multidisciplinary healthcare setting. Some of their concerns did not reflect views as expressed by the Urology Cancer MDT members and there was a disconnect between senior level clinical management and MDT teams. This was clearly evidenced by Statements made to External Peer Review of Urology Services.

  Ref No110. 20200202

- There seemed to be limited insight from the Senior Cancer management team that the recommendations were routine best practice, expected of all cancer services and reflected the care currently provided by the Urology Team, to a large degree. The assurance mechanisms were in place to address deficits (resource, MDT attendance, variance from expected practice, governance) and were required to provide external assurance. The patients and families were adamant that “words would not be enough”. They wanted evidence and the opportunity to be part of an assurance process. I believed this to an essential part of the process of redress.

Stinson, Emma M

From:	Wallace, Stephen
Sent:	16 March 2021 18:12
To:	Carroll, Ronan; Young, Michael; Glackin, Anthony; Haynes, Mark; Omer, Shawgi; ODonoghue, JohnP; Khan, Nasir; ONeill, Kate; McMahon, Jenny; McCourt, Leanne; Thompson, PatriciaA; Young, Jason; Corrigan, Martina; Conway, Barry; McCaul, David
Cc:	McClements, Melanie; Kingsnorth, Patricia; OKane, Maria
Subject:	IMPORTANT - UROLOGY DRAFT SAI REPORTS

Dear Colleagues,

As discussed with Martina Corrigan on 4th March you are aware that the Urology SAIs being conducted by Dr Dermot Hughes and his team relating to 9 patients were in their final stages. I would now like to confirm that these processes have concluded.

As agreed the draft copies of the SAI reports are now available for you to review via the Trust Egress system, you will receive a separate email with details of how to access these. Mr O'Brien has asked that a copy of correspondence he has issued to the Trust regarding this matter should be included with the draft reports. This can also be found in the draft report folder.

If you have any comments on the factual accuracy of any of the reports Dr Hughes would be grateful if you would provide these via Patricia Kingsnorth, Acute Governance coordinator Personal Information redacted by USI by the 30th March 2021.

Please note that the Egress files cannot be downloaded or saved and only viewed on the system**. I am ask that you do not share the draft reports further via any medium or platform due to the draft sensitive nature of the content.**

Regards
Dr Maria O'Kane
Medical Director

Dear Dermot and Hugh

Please see email below and comments in the report for discussion.

Kind regards

Patricia

Patricia Kingsnorth

Acting Acute Clinical Governance Coordinator

Governance Office

Room 53

The Rowans

Craigavon Area Hospital

Personal Information redacted by USI

From: Conway, Barry
Sent: 31 March 2021 09:11
To: Kingsnorth, Patricia
Cc: Tariq, S; McCaul, David; McClements, Melanie; Reddick, Fiona
Subject: feedback from Cancer and Clinical Services Division on the draft Overarching Urology SAI report

Dear Patricia,

Firstly on behalf of the Cancer and Clinical Services Division, we would like to note our sadness and regret in respect of the adverse impact on the nine patients and their families as outlined in the reports. Cancer and Clinical Services Division will work as a priority with other Divisions in Acute Services to implement agreed recommendations to improve our services.

We would also like to acknowledge the huge amount of work that you and the review team have put into all the draft reports. I have no doubt this has been a difficult process.

Dr Tariq, Dr McCaul and I have reviewed the reports and we have attached a tracked version of the Overarching report with our comments. Please note that we have not been able to involve Fiona Reddick in reviewing the draft reports as she is currently on a period of sick leave from late February.

As requested, our feedback is primarily focussed on comments from a factual accuracy perspective, however following recent discussions with Melanie and Maria, we have also included some of our thoughts in relation to how the current governance arrangements could be improved.

Yours sincerely.

Barry.

Mr Barry Conway

Assistant Director – Acute Services – Cancer & Clinical Services / Integrated Maternity & Women's Health

Email – Personal Information redacted by USI

Mobile number - Personal Information redacted by USI

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: 128057/127251/125819/127254/121851/121045/121877/124328/123988

Date of Incident/Event: Multiple dates

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: Male Age:

Responsible Lead Officer: Dr Dermot Hughes

Designation: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN)

Report Author: The Review Team

Date report signed off:

Date submitted to HSCB: 1 March 2021

1. EXECUTIVE SUMMARY

The purpose of the review is to consider the quality of treatment and the care provided by Doctor 1 to the patients identified and to understand if actual or potential harm occurred. The review findings will be used to promote learning, to understand system wide strengths and weaknesses and to improve the quality and safety of care and treatment provided. Nine patients have been identified as potentially suffering harm. This review will examine the timelines of each individual case and analyse if any deficits in treatment or care has occurred. As part of the review the cancer

The vast majority of the Urology MDMs within the Southern Trust are non-quorate due to the absence of an oncologist and does not meet the existing guidelines. (0% quorate for 2019). (There is a regional deficit of Oncology Consultants in NI and this is recognised by HSCB. During the past 2 years, HSCB have produced a stabilisation plan for Oncology / Haematology. Southern Trust has engaged in this process. A costed plan has been prepared and is currently being considered for funding. In the interim period, the Southern Trust has worked closely with Belfast Trust to secure as much Oncology cover for MDMs as possible, whilst recognising the regional pressures in this specialty. More recently Southern Trust has advertised a shared Oncology Consultant post with Belfast and this trawl has been successful with the post to be filed in the summer 2021. This will improve cover for MDMs but significant~~ome~~ gaps will remain.)

Whilst it was the primary responsibility for the consultant in charge to make the referral to oncology a failsafe mechanism to ensure agreed actions took place, such as an MDM administration tracker, was not in place. Cancer Services Division would welcome the establishment of an MDM administrator role; however it would be helpful if the report clarified that this is not yet a commissioned role in the Trust.

Alternatively, the allocation of a Urology Cancer Specialist Nurse as a Key Worker would have supported the patient on his journey as well as having ensured key actions had taken place. Service User E was not referred to a Urology Cancer Nurse Specialist nor was any contact details provided to him. The MDM guidelines indicate "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner"[4]. This did not happen. A Key Worker/ Urology Cancer Nurse Specialist would have prompted the oncology referral sooner.

Service User F

Service User F presented with possible prostate cancer and was commenced on bicalutamide 50mgs indefinitely or until biopsy results were available. The diagnosis of prostate cancer was confirmed by biopsy in July 2019. The patient was discussed at the MDM on 8 August 2020. The diagnosis of intermediate-risk organ confined prostate cancer was agreed. The plan was that Doctor 1 should review the patient and discuss management by surveillance or by active treatment with curative intent.

When Service User F was reviewed by a locum consultant in October 2020 the patient did not recall any conversation about the options of external beam radiotherapy (EBRT) as a radical treatment and Active Surveillance. A Urology Cancer Nurse Specialist was appointed as the Key Worker at this review, not having one at time of diagnosis.

Bicalutamide (50mg) is currently only indicated as a preliminary anti-flare agent and is only prescribed before definitive hormonal (LHRH analogue) treatment. Bicalutamide monotherapy (150mg) is not recommended for use as a continuing treatment for intermediate risk localised prostate cancer.

The presence of a Urology Cancer Nurse Specialist would support the patient on his journey as well as ensure key actions had taken place. Service User F was not

King, Dawn

From: Dermot Hughes [redacted]
Sent: 31 March 2021 20:41
To: Kingsnorth, Patricia
Subject: Fwd: feedback from Cancer and Clinical Services Division on the draft Overarching Urology SAI report
Attachments: image001.jpg

For info

Regards

Dermot
---------- Forwarded message ---------
From: **Dermot Hughes** [redacted]
Date: Wed, 31 Mar 2021, 20:34
Subject: Re: feedback from Cancer and Clinical Services Division on the draft Overarching Urology SAI report
To: McClements, Melanie [redacted]

Dear Melanie

No I had a good discussion with Maria.

I was concerned about the use of the master copy as evidence editing rights and loss of independence of the process. The process will be subject to a range of external scrutiny.

I have copied you into my responses to what was described as matters of fact. I and Hugh as externals would disagree with this assertion given all 3 individuals had limited knowledge of any of the issues that formed the core of the SAIs and the deficits experienced by the 9 patients.

Our recommendations around tracking, which was referenced to my previous practice in WHSCT is actually normal standard in the UK, and in my previous cancer experience in Washington DC and the National Cancer Institute - these standards are what many Urology team members would welcome and had previously experienced in the UK.

In any event they are what are required to keep patients safe and provide assurances to patients families and the public.

10 "matters of fact" have been addressed in my response but am still concerned about a similar number of issues raised regarding the recommendations.

The recommendations have been shared with families and are regared by the external team as things that should be in place anyway. Assurance mechsnism could be scaled back with time but I am conscious of previous absence of meaningful audit and indeed incorrect declaration to peer review.

The recommendations are limited straight forward and an opportunity to adress staffing issues, improve care and move on.

1.“There is a regional deficit of Oncology Consultants in NI and this is recognised by HSCB. During the past 2 years, HSCB have produced a stabilisation plan for Oncology / Haematology. Southern Trust has engaged in this process. A costed plan has been prepared and is currently being considered for funding. In the interim period, the Southern Trust has worked closely with Belfast Trust to secure as much Oncology cover for MDMs as possible, whilst recognising the regional pressures in this specialty. More recently Southern Trust has advertised a shared Oncology Consultant post with Belfast and this trawl has been successful with the post to be filed in the summer 2021. This will improve cover for MDMs but significant gaps will remain.”

The review team does not accept a differential service for patients based on geography and the report is based on what should be present. It is expected that the out-workings of the SAI will result in better and appropriate resourcing for patients of the SHSCT.

2. “Cancer Services Division would welcome the establishment of an MDM administrator role; however it would be helpful if the report clarified that this is not yet a commissioned role in the Trust.”

This is not the experience of the external members of the review team elsewhere in NI and the UK. The review is based on what is best regional and national practice and that which results in the safest possible service for patients. Commissioning within trust resource or regional resource is not within the remit of a Serious Adverse Incident Review.

3 “Cancer Services can confirm that these reports would have been produced up to approx. 5 years ago by an experienced Biomedical Scientist in the Lab in CAH. These reports took a long time to produce and feedback from the MDMs was that they were of limited value. Cancer Services have confirmed that some labs in NI still produce these reports but not all do. Cancer Services believe that new Failsafe reports could be included with the scope of an MDM administrator role if this could be established”

This is not the experience of the external members of the SAI review team. The fail-safe cancer lists are generated by T site codes and M diagnosis codes for malignancy (xxxx3) weekly, by clerical staff who liaise with MDM trackers. It provides additional assurance and would have been of benefit in cases where patients are lost to follow. Critically it also ensures rapid referral of patients to MDM and better adherence to 31 and 62 day targets.

educational, therapeutic, and critical good cancer care experience. This is clearly stated in all Regional and National guidance, and I responded to their concerns

Ref No85. 210222
Ref No86. 202101028

- The overarching report was shared with a range of staff to explain the action plan and to ensure delivery of outcomes. The Clinical Lead for Cancer SHSCT, Dr Tariq, his deputy Mr. McCaul and Mr. Barry Conway Cancer Services, did take the opportunity to edit the report with tracked changes. As they were not members of the SAI team and did not have editing rights, I raised this with the SHSCT. There was a lack of understanding of how the SAI process was delivered and why SHSCT had sought external input. I was sensitive to this, as we had shared team member names and roles to families.

  I compiled the tracked changes into a document and provided responses to be shared with cancer team.

  Ref No87. 20210510
  Ref No88. 20210331

Response from Chair SAI Process to the Dr Tariq, Mr. McCaul and Mr. Barry Conway

1. *"There is a regional deficit of Oncology Consultants in NI and this is recognised by HSCB. During the past 2 years, HSCB have produced a stabilisation plan for Oncology / Haematology. Southern Trust has engaged in this process. A costed plan has been prepared and is currently being considered for funding. In the interim period, the Southern Trust has worked closely with Belfast Trust to secure as much Oncology cover for MDMs as possible, whilst recognising the regional pressures in this specialty. More recently Southern Trust has advertised a shared Oncology Consultant post with Belfast and this trawl has been successful with the post to be filed in the summer 2021. This will improve cover for MDMs but significant gaps will remain."*

Response

- *The review team does not accept a differential service for patients based on geography and the report is based on what should be present. It is expected that the out-workings of the SAI will result in better and appropriate resourcing for patients of the SHSCT.*

Ref – The costed Business plan was referred to by SHSCT staff but not submitted with their statement.

2. "Cancer Services Division would welcome the establishment of an MDM administrator role; however it would be helpful if the report clarified that this is not yet a commissioned role in the Trust."

Response

- *This is not the experience of the external members of the review team elsewhere in NI and the UK. The review is based on what is best regional and national practice and that which results in the safest possible service for patients. Commissioning within trust resource or regional resource is not within the remit of a Serious Adverse Incident Review.*

3 "Cancer Services can confirm that these reports would have been produced up to approx. 5 years ago by an experienced Biomedical Scientist in the Lab in CAH. These reports took a long time to produce and feedback from the MDMs was that they were of limited value. Cancer Services have confirmed that some labs in NI still produce these reports but not all do. Cancer Services believe that new Failsafe reports could be included with the scope of an MDM administrator role if this could be established"

Response

- *This is not the experience of the external members of the SAI review team. The fail-safe cancer lists are generated by T site codes and M diagnosis codes for malignancy (xxxx3) weekly, by clerical staff who liaise with MDM trackers. It provides additional assurance and would have been of benefit in cases where patients are lost to follow. Critically it also ensures rapid referral of patients to MDM and better adherence to 31- and 62-day targets.*

4."Cancer Services can confirm that the patient attend clinic on 25/05/2019 and it was noted that the CT was to be requested. The request was not raised until 08/07/2019 as an urgent referral (not Red Flag). The CT was completed 18 days after the CT was requested"

Response

- *The review included the overarching CT timeline, as the critical issue was that the patient had a potentially aggressive tumour and should have been on an appropriately timed pathway that was supported by tracking and assurance mechanisms. The 17week delay should not have happened and ideally systems would have been in place to prevent this.The recommendations in the over-arching SAI review propose patient pathways should be tracked in real time and prevent such delays.*

5."Cancer Trackers will track patients on the 31- and 62-day pathways in line with what has been commissioned. This is confirmed to be the case in other Trusts in NI with the exception of Western Trust. The responsibility for following up other actions sits with the clinician and his / her secretary."

Response

- *This is not the experience of the external members of the SAI review team in NI and UK. Critically the resource in SHSCT Urology MDM was unable to meet patient tacking need in these 9 SAIs and in a previous SAI of 2016. Patients came to harm. The review team believe it essential that enhanced resource is in place to improve MDM tracking, in concert with Key workers (usually Urology Cancer Nurse Specialists) and consultant secretaries. This has been shared with the Urology MDM and welcomed, given that several members had previous experience of this approach from the UK.*

6 and 7 "It would be helpful if the report stated who was aware of this issue."

Response

- *"With the appointment of two more Nurses to the Thorndale Unit and Clerical Staff, all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner. It is intended that patients newly diagnosed as inpatients will also be included."*

- *The above statement was made on behalf of the SHSCT to Urology Cancer Peer Review 2017 – it has proven to be inaccurate and not based on an assurance audit process. The review team appreciated the candour of those who admitted to being aware that not all care was supported by Cancer Nurse Specialists. They do expect that governance processes are enhanced to ensure that no patients receive cancer care unsupported and without linkages to other critical services.*

8 "Additional capacity for targeted assurance audits would be useful for MDMs and for Cancer Services."

Response

- *The review team have considered this in the recommendations going forward. They believe prospective assurance audit must be supported by resource and infrastructure. However, between 2017 and 2020 assurance audit was limited in the Urology Service and much led by Urology Nurse Specialists. There was no evidence of targeted audit work in areas of known problems or concerns. Appropriate resourcing of audit should be within the remit of Cancer Service Management and Clinical leadership.*

9."It is important to state that the Cancer Trackers are commissioned to track patients on the 31 and 62 day pathways. It is incorrect to suggest that the scope of tracking was limited due to resources or due to the process being flawed. The Trackers perform this function in line with what has been commissioned and it is in line with other Trusts in NI with the exception of Western Trust. Changes to the scope of tracking should be agreed regionally through NICAN and be consistent across Trusts in NI"

Response

- *The 9 SAI reports detailed wide ranging delays and deficits in care that were not and could not be detected with the current tracking resource within SHSCT Urology Cancer MDT. The external members of the SAI review team have different experiences of cancer tracking, something which is shared by several consultant members of the Urology MDT with UK experience. Patients came to harm which*

Queries/ Comments in relation to SAI reports

1. Terms of Reference (TOR)

The SAI TOR makes reference to interviews with staff – just to clarify that the CNS team have not been interviewed at any stage throughout the process. We were however introduced to the review team via zoom meeting on 22.2.21.

Please note for proof reading, some TOR are repeated twice within individual case presentations and some also still include patient initials rather than XX.

Specialists Nurses were specifically represented on the SAI Review team with ongoing feedback throughout the process around details and specifics

2. Roles & Responsibilities of CNS/Keyworker

Regarding responsibilities of the Uro-oncology Specialist Nurses, NICaN Urology Cancer Clinical Guidelines March 2016 advise:

All patients should be assigned a key worker (usually a CNS) at the time of diagnosis, and appropriate arrangements should be in place to facilitate easy access to the key worker during working hours and an appropriate source of advice in his/her absence, as per National Cancer Peer Review standards.

All patients should be offered a holistic needs assessment (HNA) at diagnosis and subsequently if their disease status changes.

Patients should be offered advice and support to address any immediate concerns – physical, mental, spiritual or financial – on completion of the HNA with onward referrals made as necessary.

The responsibilities of the uro-oncology CNS include, ensuring patients undergoing investigations for suspected cancers have adequate information and support.

On diagnosis, the CNS has a supportive role and will help ensure that the patient and significant others are equipped to make informed decisions regarding their ongoing treatment and care.

The CNS may have a role in the review of patients following treatment for urological cancer. The CNS also has a key role in equipping the patient to live with and beyond the urological cancer, as advocated by the National Cancer Survivorship Initiative (2011). National Cancer Survivorship Initiative (2011) has also recommended the use of Holistic Needs Assessment (HNA) by the CNS to assess patient's needs for

review had the opportunity to avail of this. This was critical to the understanding of their care and awareness of the fact that care did not necessarily follow national or regional guidelines and indeed nor did it follow local MDT recommendations

CNS COMMENTS

The CNS team believe the use of the word “failsafe” in reference to the CNS/keyworker role is inaccurate and there are numerous references to this term throughout the report (examples below). As identified above in both the NICAN guidelines and the SHSCT MDM operational policy, the ‘failsafe’ function is not described as a responsibility of the CNS/keyworker. Neither is the assertion that the keyworker has a role to ensure all key actions take place as is described in the overarching report (service user E & F). The overarching report also refers to a 3 pronged approach to safe cancer patient care and pathway tracking involving MDM tracking, consultants and their secretaries and the urology nurse specialists. In point 10 of the governance findings, the review team again infer that the absence of a key worker equates to the absence of a safety net for patient pathway completion.

The review team fully accept that it is not the sole responsibility of Specialist nurses to ensure appropriate care is delivered – this is referenced in the overarching SAI where it emphasises the primary role of the consultant responsible for care. In normal practice patients care cared for through their cancer journey by a collegiate team of consultant, specialist nurses, consultant secretarial staff and appropriate MDT tracking. This is about everyone’s responsibility to ensure right care at the right time something the 9 patients missed out on.

Example: Case 125819

MDM not funded to provide appropriate tracking and focuses on 31 + 62 day targets. This combined with the absence of CNS represents a major risk. There was no effective “failsafe” mechanism.

Example: Case 121877

A Specialist Nurse would also have been a “failsafe” for identifying the delayed scan report and bringing it back to the MDM sooner.

Example: Case 127251

However the normal "failsafe" mechanism would include an administration tracker or keyworker to ensure agreed actions such as onward referral take place.

As a CNS team, we would view the role of keyworker to reflect the supportive role outlined in the above documents. If a patient contacted their keyworker/CNS to enquire as to date of scan / review appointment / onward referral that would be escalated to the consultant. We do not receive notification when scans are ordered / reported. It is the responsibility of the individual who requests a scan to action the findings. In addition and with recent expansion of the CNS team there is an increasing need for the CNS team to hold their own caseload of cancer patients. If the keyworker has a responsibility as a 'failsafe' for the Consultant, as the CNS team move more toward independent practice would they also be provided with a "failsafe mechanism?

The review team's experience is that specialist nurses would have an understanding of individual patient's pathways to provide supportive care. This means being aware of critical staging and treatment points in a pathway. Tracking of patients should be within the remit of an enhanced MDT tracking structure.

The CNS team in the SHSCT has increased in recent years as below:

- CNS X 2 in situ from July 2005
- 3rd CNS appointed March 2019 (Interviews for CNS X 2 planned January 2017 were changed on the day to Clinical Sister/Charge Nurse & this created a 2 year delay)
- 4th & 5th CNS appointed late summer 2020

Where a CNS was not available for a results clinic this task was delegated to either Clinical Sister/Charge Nurse/Experienced Staff Nurse. This service did not cover outreach clinics. As above there would not have been an expectation that the CNS/keyworker/delegated staff nurse would have a responsibility to follow up scan results / review appointments or ensure onward referral. The role has traditionally been viewed as a supportive role with the onus on the patient to make contact and re-engage as they needed.

The review team are aware of the limitations of support at outreach clinics – The issue was that the patients were not referred to this service for subsequent discussions – telephone numbers were not made available.

Connolly, Carly

From: Dermot Hughes [redacted]
Sent: 08 April 2021 11:39
To: Kingsnorth, Patricia; dermot hughes
Cc: OKane, Maria
Subject: CNS response
Attachments: Urology CSN responses.docx

Dear Patricia

I have drafted some thoughts in response

We can discuss on Monday but I am concerned that the CNS are not aware of critical posts in a patients pathway such as staging and initiation of treatments.

I am not sure how they can deliver on the responsibilities detailed in the letter if they are unaware of the critical points in a patient pathway.

I think there is a concern about about the term failsafe - it is a common reference for all professionals in cancer care - my lab staff and the secretaries acting in that role for me!

Perhaps we need to think about emphasizing everyone's responsibility to deliver right care right time.

Regards

Dermot

Dr Dermot F C Hughes MB BCH BAO FRCPath Dip Med Ed

[redacted]