Suggested improvements for patient and family engagement

Information for Patients/Families

- Patients/families should be better informed of the SAI review process. For example, there could be better quality information leaflets available, or a video or podcast explaining the process on the DoH or RQIA's website.
- The SAI process must be explained to patients/families before the process commences so they can have realistic expectations.

Communication with Patients/Families

- There must be clear standards of how a patient and family should be communicated with during the SAI process, with patients/families asked for formal feedback at the end of the process via a questionnaire or online survey tool. This should also accommodate requests for anonymity.
- The terms of reference/key lines of enquiry must be shared with patients/families prior to an SAI review commencing, and these must include the patient and family questions alongside technical clinical/process-based questions.

Patient and Family Engagement

- Trusts must demonstrate their commitment to the SAI process and to the patients/families affected by SAIs by ensuring senior management are actively involved in communications with families. This is particularly important at the start and end of the process.
- Staff must receive training from experienced advocates and families who have experienced the SAI review process so they know how to achieve and maintain positive engagement with a family.

SAI experience:

My SAI experience includes:

1997: Instituting reviews of all major complications and deaths at GRH and CGH as an inescapable routine

2009: Introducing the same process to the Surgical Division

2015: I have acted as a GMC performance assessor and as an IRM reviewer, involving extensive case note reviews.

Relationship to SHSCT

I have had no other engagement with any member of SHSCT, and specifically not with their Urology Services, prior to the events described in Section 1 above.

Specifically, I have had no previous experience in conducting SAI reviews at SHSCT, nor any involvement in any of their governance issues. I was entirely unaware of any concerns with any individual at SHSCT and have had no engagement with Mr O'Brien.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: H Gilbert

Date: 9th November 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 69 of 2022

Date of Notice: 14th September 2022

Witness Statement of: Dermot F C Hughes MB BCH BAO FRCPath Dip Med

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I, Dermot Francis Hughes, will say as follows:-

SCHEDULE [No 69 of 2022]

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

    - The narrative is provided as answers to the detailed questions below

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Please place any documents referred to in the body of your response as separate appendices set out in chronological order and properly indexed. If you are in any doubt about document provision, please do not hesitate to contact the Inquiry Solicitor.

    - All documents for the SAI Review were held on a secure system. The SHSCT provided access to "egress" containing all related documents to aid responses to these questions. I have requested the SHSCT to forward same documentation to the USI. I have referenced the documents from this file in my response, as advised.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions

Urology Services Inquiry

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: __ Personal Information redacted by the USI

____

Date: 17th October 2022

9. Outline and explain the circumstances in which you were asked to fulfill the role of Expert External Clinical Advisor of SAI reviews into the nine patients by the SHSCT in 2020.

- This is a question for Mr. Hugh Gilbert.

10. Outline what, if any written or oral briefing you received from the SHSCT before commencing the reviews. With regard to any briefing, you may have received, address the following:
    a. Who provided the briefing?

- The initial briefing and request to Chair the process, which was initially 5 Serious Adverse Incident Review came from Mr. Stephen Wallace Governance SHSCT and followed up by Dr Maria O'Kane, then Medical Director SHSCT.

b. What were you told about.

i. The circumstances giving rise to each individual case.

- I was informed that there were ongoing concerns about the care given to certain urological cancer patients by one professional. This initially focused on pharmaceutical prescribing for cancer patients. A local look-back exercise was progressing, and this in-house activity would forward cases that met the threshold for a Serious Adverse Incident as defined by the PHA Document "Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 version 1.1.". This would reflect relatively normal practice whereby incidents are assessed by service and governance departments before sharing with the PHA as a potential Serious Adverse Incident. The classification of the SAI process would be agreed between Trust and SAI.

ii. The reasons why the nine SAI reviews were necessary.

- It was deemed by the internal SHSCT governance triage process that all 9 cases met the threshold as defined by the PHA Document "Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 version 1.1." My understanding is that the nine cases also reflected a wider concern involving Prostate, Renal, Testicular, and penile cancer. It was indicated that the in-house governance process would continue but that the nine cases already identified should progress through a Serious Adverse Review process, not least because of responsibilities to patients and families. This I believed to be a pragmatic approach and discussions regarding subsequent cases meeting SAI threshold were not within my remit.

Qualifications:

1982-85	MB BChir (University of Cambridge)
1989	FRCS (England)
1989	FRCS (Edinburgh)
1994	MD (University of Bristol)
1996	FRCS (Urol)

Employment:

1996-2019	Consultant Urologist	Gloucestershire NHSFT
	A general urologist with a special interest in urological cancers. I provided the bulk of the cystectomy service Gloucestershire and Herefordshire. I was one of two surgeons providing the paediatric urology service.	
2019-date	Consultant Urologist	North Bristol NHST
	A general urologist with a special interest in prostate and bladder cancer diagnosis and management advice.	

Positions:

1997-04	Lead Gloucestershire Urology Research and Audit Group
2001-14	Chair 3CCN Urology Cancer MDT
2009-19	College Assessor, Royal College of Surgeons (Eng)
2009-14	Clinical Director for General Surgery and Urology
2014-17	Education Lead and member ARCP Committee
2015-	GMC Performance Assessor
2016-17	Clinical Lead for Urology
2019-	Urology Representative RCS IRM

that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

Your experience and relationship with the SHSCT

4. Please summarise your qualifications and your occupational history prior to your involvement in conducting a series of Serious Adverse Incident ("SAI") for or on behalf of the SHSCT in 2020-21. Set out all posts you held prior to commencing your involvement with the Trust on the series of SAI reviews in 2020.

   Qualifications – MB. BCH. BAO. FRCPath. Dip Med Ed

   Fellow of the Royal College of Pathologists

   Diploma in Medical Education (QUB)

- Associate HSC Leadership Centre 2020 –
- Visiting Professor Ulster University 2018 –
- Medical Director WHSCT 2015 – 2019
- Associate Medical Director WHSCT 2014 – 20125
- Clinical Director Diagnostics and Cancer Services WHSCT 2012 – 2015
- Medical Director Northern Ireland Cancer Network 2008 – 2011
- Lead Clinician / Clinical Director Diagnostics and Cancer Services WHSCT 2003 – 2008
- Honorary Senior Lecturer QUB 1998 – 2015
- Clinical Director Pathology Services WHSCT 1993 – 1997
- Consultant Pathologist WHSSB 1990 – 2019
- Pathology Travelling Fellow – George Washington University and National Institute of Health Bethesda USA 1987 -1988
- Northern Ireland Pathology Training Scheme 1983 – 1989
- Junior House Officer Mater Infirmorum Belfast 1982 - 1983

5. Set out what, if any, relevant experience you had of SAI processes and of involvement in conducting SAI reviews prior to your involvement with the SHSCT on the series of SAI reviews in 2020. It would be helpful if you detailed the approximate number of SAI review processes you have been involved with, and the capacity in which you were involved.

- I have formal training SAI processes and training as a Chair of SAI processes.

- As Medical Director of the Western Health and Social Care Trust, I was ultimately responsible for the SAI process and had oversight of all SAI Reports. This was approximately 80 – 90 per year. Each Serious Adverse incident report was reviewed, and quality assured at Director and Medical Director level within the Trust. I chaired this process over a 4-year period amounting approximately 350 cases between 2015 and 2019.

reflections really relate to how this can be prevented going forward. I had been fortunate to be in positions to alter how cancer was structured, delivered, and received. Lack of meaningful governance and assurance has resulted in care and experience of care varying from best practice and varying from what the patients had a right to expect.

- As a result of this and other governance work, I had the opportunity to become the Senior Responsible Owner for the Encompass Project in Northern Ireland. This is the largest implementation of an Electronic Patient Record in Europe covering all of health and social care. It is standardizing all patient and client pathways (benchmarked against international and national best practice) and embedding them digitally within the record. The record is visible to all healthcare staff and managerial staff throughout primary and secondary care. The system will provide real time data on care and will provide near-real time assurance. The system has a portal to allow patients / clients access to their own information. It will address some of the issues identified within the SAI process and hopefully will allow patients can become partners in their own care.

24.Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

The Governance of care delivered by teams, leadership and management by Medical Professionals is covered by GMC Guidance "Leadership and Management for all doctor Published January 2012." – I have used this guidance to benchmark how doctors with additional responsibilities perform in the management of governance of care delivered by teams they manage. The principles set out in this document have informed my clinical and managerial practice and informed the approach to the 10 Serious Adverse Review Reports. I was keen that expected actions of professionals aligned with the expectations of their professional body.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and 6

minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

Knowledge, skills and performance

- Make the care of your patient your first concern.
- Provide a good standard of practice and care.
    - Keep your professional knowledge and skills up to date.
    - Recognise and work within the limits of your competence.

Safety and quality

- Take prompt action if you think that patient safety, dignity or comfort is being compromised.
- Protect and promote the health of patients and the public.

Communication, partnership and teamwork

- Treat patients as individuals and respect their dignity.
    - Treat patients politely and considerately.
    - Respect patients' right to confidentiality.
- Work in partnership with patients.
    - Listen to, and respond to, their concerns and preferences.
    - Give patients the information they want or need in a way they can understand.
    - Respect patients' right to reach decisions with you about their treatment and care.
    - Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Leadership and management for all doctors

Working with doctors Working for patients

General
Medical
Council

About this guidance

Being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer.

This guidance sets out the wider management and leadership responsibilities of doctors in the workplace, including:

- responsibilities relating to employment issues
- teaching and training
- planning, using and managing resources
- raising and acting on concerns
- helping to develop and improve services.

The principles in this guidance apply to all doctors, whether they work directly with patients or have a formal management role.[1]

INQ-30235

Working with colleagues

Leadership

All doctors

3 Most doctors work in multidisciplinary teams. The work of these teams is primarily focused on the needs and safety of patients. The formal leader of the team is accountable for the performance of the team, but the responsibility for identifying problems, solving them and taking the appropriate action is shared by the team as a whole.

4 You must be willing to work with other people and teams to maintain and improve performance and change systems where this is necessary for the benefit of patients.

5 You should respect the leadership and management roles of other team members, including non-medical colleagues.

Doctors with extra responsibilities

9 You must actively advance equality and diversity by creating or maintaining a positive working environment free from discrimination, bullying and harassment. You must make sure that your organisation's policies on employment and equality and diversity are up to date and reflect the law.[3]

Communication within and between teams

10 Multidisciplinary teams can bring benefits to patient care when communication is timely and relevant, but problems can arise when communication is poor or responsibilities are unclear.

All doctors

11 You must make sure that you communicate relevant information clearly to:

- **a** colleagues in your team
- **b** colleagues in other services with which you work
- **c** patients and those close to them in a way that they can understand, including who to contact if they have questions or concerns. This is particularly important when patient care is shared between teams.

Doctors with extra responsibilities

18 If you are responsible for leading or managing a team, you must make sure that staff are clear about:

- **a** their individual and team roles and objectives
- **b** their personal and collective responsibilities for patient and public safety
- **c** their personal and collective responsibilities for honestly recording and discussing problems.

19 You should:

- **a** contribute to setting up and maintaining systems to identify and manage risks in the team’s area of responsibility
- **b** make sure that all team members have an opportunity to contribute to discussions
- **c** make sure that team members understand the decisions taken and the process for putting them into practice
- **d** make sure that each patient’s care is properly coordinated and managed.

Doctors with extra responsibilities

28 If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any such failure is dealt with quickly and effectively.

29 If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking, are in place to monitor, review and improve the quality of the team's work. You must work with others to collect and share information on patient experience and outcomes. You must make sure that teams you manage are appropriately supported and developed and are clear about their objectives.

Health and Social
Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;
- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;
- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;
- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;
- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;
- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;
- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;
- Maintain a high quality of information and documentation within a time bound process.

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:
- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

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[1] Source: DoH - How to classify adverse incidents and risk guidance 2006 http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

APPENDIX 7

Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

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

Organisation’s Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

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[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)

- Review of staff/witness statements (if available)

- Interviews with relevant staff concerned e.g.
    - Organisation-wide
    - Directorate Team
    - Ward/Team Managers and front line staff
    - Other staff involved
    - Other professionals (including Primary Care)

- Specific reports requested from and provided by staff

- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers

- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident

- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

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[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

September 2020, I agreed to perform these reviews myself and agreed the engagement terms on 24th September 2020 and signed a confidentially agreement on 4th October.

I understood that my role would be to review the clinical records of nine cases that had been deemed by SHSCT to have reached the threshold to trigger SAI reviews. As a General Urologist with 23 years' consultant experience in the diagnosis and management of urological cancers at a DGH, I felt that I was in a position to perform disinterested, and contextually realistic, case reports to inform the governance process at SHSCT. I was not informed of Structured Clinical Record Review as a formal and documented operational policy and modelled my reports on the Structured Junction Review process adopted by The Royal College of Surgeons.

1e An initial meeting (on-line) took place on 12th October 2020. The scope and methodology of the review were agreed by those present; Dermot Hughes; Fiona Riddick; Patricia Thompson; and me. I confirmed that beyond my role as described above, I had no prior knowledge of any aspect of urological services at SHSCT. I was informed that SHSCT had significant concerns regarding the management of just nine patients seen and treated in their urology service. As an expert external reviewer, I was expected to provide a structured account of each patient's presentation, assessment, and management, together with a commentary on the rationale of any variation from standard practice as defined in commonly accepted local, National or international guidelines.

1f I was to review each case separately and provide comment on the management decisions including any variation from standard guideline practice; and offer a commentary agreed. I used the Royal College of Physicians Structured Judgment Review format, which has with modification been adopted my surgical services.

Ig In addition, I was asked to help construct a tenth report, which would describe common themes that emerged from the nine individual case reports.

Ig I was given electronic access to the entire clinical record in each case. These appeared to be complete.

iii. The process by which the nine patients were identified and selected for an SAI review.

- The process for triage of patients to meet the threshold for inclusion in an SAI process was performed in-house within Governance of the SHSCT. To my knowledge, this was in accordance with the document "Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 version 1.1.". Discussing with the PHA on the nature and grade of an SAI would be normal procedure. It would not be unusual in Trusts where a service raising a Serious Adverse Incident, would seek someone uninvolved with the issue to carry out a SAI review. This would be similar when the

  Ref No.1 SAI/PHA

  SHSCT were seeking an Independent Chair of the SAI and an independent external expert to act as clinical advisor to the SAI review.

iv. The existence of other cases of concern or potentially meeting the threshold for an SAI review.

- I was aware of an ongoing process to perform a "look-back exercise" and ongoing triage of cases as potential SAIs. This information became public knowledge as the SAI process was ongoing. It is also knowledge that I shared with families to ensure we were as open and transparent as possible. As Chair of the SAI process, I did not seek nor was I given any further details regarding outcomes of triage to SAI thresholds for subsequent patients, believing this would be inappropriate. The rationale for this was to maintain independence of the SAI process from ingoing triage of the care of other patients.

v. Previous concerns within Urology Services.

- I was initially unaware of the professional involved with the SAI process and was unaware of concerns within the Urology Services SHSCT. This however changed when meeting with professionals who referred to a previous Serious Adverse Incident Review involving the named professional. I believed this could be of importance to the ongoing 9 SAI reviews and to the learning and action plan resulting from that process. This was made available and is referenced in the overarching document. I was informed of the exitance of a past "Maintaining High Professional Standards" Investigation. I did not request this as it lay outside the terms of the SAI review process.

vi. Previous SAI reports and the findings of same.

- SAI HSC unique identifier S11471 was made available, after it was referred SHSCT professionals during interview. It related to triage of patients referred to Urology Cancer Services within the SHSCT for investigation and diagnosis of "Red Flag" symptoms of cancer. This issue first arose in 2016.

  Ref No.2 20210510

Ref No3. 2020522

11.With regard to the steps taken and processes adopted by the review team to complete its work. Further, outline, in broad terms,: to each of the nine cases subject to SAI review, generally describe

1. Your specific role in conducting the reviews and actions taken by yourself.

- I was the Independent Chair of the SAI Review process and was responsible for the SAI review, the Root cause analysis, patient timelines and leading on Family Engagement. The External Expert Clinical advisor to the SAI process provided the independent clinical opinion on each case, based on patient records, MDT records and feedback from families. This was benchmarked against regional and national standards declared to External Peer Review as the Standard of care by the SHSCT Urology Cancer Services. Variances from expected best practice were identified, formed the learning within each SAI and resulted in an overarching arching plan.

2. What documentation was made available to the review team?

- The review team had full access to the patient record of care. This included radiology scans, laboratory results and multidisciplinary meeting notes and agreed care pathways. Patient and family experience along with patients and family questions were included in this record as care was often delivered by a single professional without recourse to other members of the multidisciplinary team. The review team considered the clinical care and pathways for all 9 patients. The Investigation team wrote to Mr A O'B with specific questions for clarification. These questions were not responded to despite extension of deadlines.

  Ref No4. 20200211

3. What relevant personnel, including management staff, clinicians and nursing staff;

   i. Did the review team meet with?

- Associate Medical Director and Clinical lead for Cancer Services SHSCT
  Ref No5. 20210111
  Ref No6. 20210107

- Assistant Director for Surgical Services SHSCT
  Ref No7. 20210204

- Nursing Director SHSCT

about his practice but did not escalate the issue to the SHSCT – this is something both individuals regretted and reflected upon.

Ref No25. 20210106
Ref No26. 20210223
Ref No27. 20210222

4. Outline the engagement the review team had with each of the families affected and who took the lead for this aspect of the review team's work and provide a description of what steps they took.

- The Family Engagement process was led by me supported by the SHSCT Governance team and subsequently by the governance team and a specifically appointed family liaison officer. The families were met on three occasions – at the initiation of the SAI process to explain and contextualize the review. As findings evolved, they were met to get detailed feedback and receive apologies. This was followed by a further meeting to share interim findings and seek detailed family input regarding experience and concerns – by this stage it had become clear that the care received had been given in isolation from the multidisciplinary team, a unique situation in cancer care. Their stories, experiences, concerns, and questions then fed into the clinical questions and SAI process. The families were then met for a third time with their report and a redacted overarching report.

- The families were obviously upset but also angered by the fact the care provided to them was different to that received by others who accessed the SHSCT Urology Cancer Services. Many had believed that the deficits in their care and external support was due to ongoing pandemic and/or resource limitation. They were clearly shocked that their experience was determined by the practice of a single individual and that had been offered differing support and means of accessing services.

- The Family Liaison officer was appointed to provide ongoing support and some redress to ensure patients got immediate access to services that were previously not made available to them.

  Ref No28. 20211102
  Ref No29. 20210707

5. Outline how the review team assessed the performance of the MDT pathway for cancer management and who took the lead for this aspect of the review team's work and provide a description of what steps they took.

- As with all SAI processes the Review Team formed a patient cancer journey timeline from initial referral or presentation. The assessment of the MDT pathway was led by Mr Hugh Gilbert as external expert clinical advisor to the SAI process. The patient pathways were discussed at weekly / bi-weekly meetings and benchmarked against expected care as defined by NICAN Urology Cancer Guidelines, NICE Guidance, and Cancer Improving Outcomes. This review also included the local SHSCT Urology Cancer MDT recommendations. The findings were compiled into draft reports by myself and Mrs. Patricia Kingsnorth (Governance Lead on the Review). These were circulated for comment and sign off by the wider team. The assessment for the timeline of each patient was reviewed considering family comments during the family engagement process – this was deemed essential, as the patients were being treated by a single professional, without multiprofessional input.

- The patient pathways and outcomes were also benchmarked against the stated standards of care declared by SHSCT Urology Cancer Services to External Cancer Peer Review.

Ref No30. 20210125
Ref No31. 20210125
Ref No32. 20201230
Ref No33. 20201229
Ref No34. 202010910
Ref No35. 20200910
Ref No36. 20200202
Ref No37. 20200817

6. Outline how the review team conducted comparative analysis against regional and national guidance and who took the lead for this aspect of the review team's work, along with a description of what steps they took.

- The assessment was part of clinical care review and was led by Mr. Hugh Gilbert as external expert clinical advisor to the SAI process. The patient pathways were discussed at weekly meetings and benchmarked against expect care as defined by NICAN Urology Cancer Guidelines, NICE Guidance, and Cancer Improving Outcomes. This review also included the local SHSCT Urology Cancer MDT recommendations. The findings were compiled into draft reports by myself and Mrs. Patricia Kingsnorth (Governance Lead on the Review). These were circulated for comment and sign off by the wider team.

- Team review meetings were held on a weekly / 2 weekly basis and minutes of these are included in the shared evidence pack.

Ref No38. 20210105
Ref No39. 20210204
Ref No40. 20210223
Ref No41. 20201107

12.Outline who was responsible for formulating the findings and/or conclusions in each of the 9 SAI Reviews and the overarching report.

- I, as Independent Chair of the SAI process, was responsible for formulating findings and/or conclusions. These were solely based on the findings of the External Expert Clinical Advisor to the SAI Review and were defined by variance from expected best practice. The best practice standard was that as declared at Urology Cancer Services Peer review.

NICaN MDT Self-Assessment Report Proforma

Network	NICaN
Trust	Southern Health and Social Care Trust
MDT	Urology
MDT Lead Clinician	Anthony Glackin
Date	21st September 2017

Key Themes
Please provide comments including details of strengths, areas for development and overall effectiveness of the team. Any specific issues of concern or good practice should also be noted in the following sections. It is important to demonstrate any measurable change in performance compared to previous assessments.
Structure and function of the service
Comment in relation to leadership, membership, attendance and meeting arrangements, operational policies and workload.

The Urology MDT is held every Thursday from 2.15pm, with the exception of public holidays. There are video-conferencing facilities to Belfast Cancer Centre. Mr Anthony Glackin, Consultant Urologist, is the Lead Clinician of the MDT.
The Urology MDT is a well-structured MDT. Overall weekly attendance is good, however on some occasions this can be difficult due to competing demands.

The greatest challenge for the MDT during the past year has been the inadequacy of the availability of a clinical oncologist and or a radiologist at all MDMs. The inadequacy in both cases has essentially been due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the post where they are required. The inadequacies have been escalated to trust senior management team and are being addressed with the appointment authorities.

With increasing numbers of consultant urologists, the functions of Lead Clinician and of Chair of MDM have been separated to enhance active participation in and responsibility for MDM. The Chair of each MDM will have been decided when scheduling takes place at least one month previously. Scheduling has also ensured that time is allocated to the appointed Chair to preview in detail each Wednesday all of the cases to be discussed at MDM the following day. All of the required clinical summaries, results and reports of investigations will have been provided to the appointed Chair for preview. It also enables all multidisciplinary participants to preview cases and to prepare their contributions to the discussion of cases. This provision has greatly enhanced the quality of scrutiny and preparation for discussion of each case.

The quality of the conduct of MDM has been a singular achievement these past six years. The quality of participation has been enhanced by increasing the number of persons chairing, and by having time allocated for preview.

There had been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past few years, up from 2902 in 2013 to 4761 in 2015/16. The greatest increase was to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014. The increase has continued and in 2016 there were 1878 red flag referrals.

For 2016, the 31 day performance for the SHSCT was 100% and the 62 day performance was 81% - this reflects the marked increase in GP red flag referrals for the trust.

The diagnostic and operative activity has been reflected in an increase in the numbers of specimens received by the Cellular Pathology Laboratory at Craigavon Area Hospital. Tissue specimens increased from 874 in 2014 to 903 in 2016.

It is notable that there has been an increase in the numbers of Prostate biopsies which reflects the use of MRI to avoid unnecessary TRUS biopsy.

Progress is ongoing in relation to the full implementation of the Key Worker, Holistic Needs Assessments, Communication and ensuring all patients are offered a Permanent Record of Patient Management. 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.

Coordination of care/patient pathways
Comment on coordination and patient centred pathways of care, network guidelines and communication.

The MDT adheres to the regional Urology Clinical Reference Group guidelines & patient pathways and these have been agreed at an MDT meeting. There are clear pathways in place for the management of Urology cancers. The network has agreed a pathway for the management of Teenage and Young Adult (TYA) cancer patients. When TYA's are discussed at MDM, the cancer tracker will inform the Trust TYA nurse who will ensure appropriate onward support / referral to the TYA regional service.

Patient experience
Comment on patient experience and gaining feedback on patients' experience, communication with and information for patients and other patient support initiatives.

Patient feedback and experience is very important in planning service development. Patients' views are taken on board through compliments, complaints and feedback through patient surveys. These are considered by the MDT to identify areas for improvement.

MEETING PATIENTS' NEEDS

IMPROVING THE EFFECTIVENESS OF MULTIDISCIPLINARY TEAM MEETINGS IN CANCER SERVICES

CANCER
RESEARCH
UK

Multi-disciplinary Team (MDT) Guidance for Managing Prostate Cancer

September 2013

Produced by:

- **British Uro-oncology Group (BUG)**
- **British Association of Urological Surgeons (BAUS) Section of Oncology**

British Uro-oncology Group

BUG

BAUS

Section of Oncology

PLEASE NOTE: THIS GUIDANCE IS AN INTERIM PUBLICATION AND IS SCHEDULED FOR IMMEDIATE REVIEW IN 2014 WHEN IT WILL ADDRESS THE UPDATED NICE GUIDELINE AND THE OUTCOME OF OTHER RELEVANT TECHNOLOGY APPRAISALS

This guidance has been supported by educational grants from:
Astellas; AstraZeneca; Bayer; Ipsen; Janssen.

The development and content of this guidance has not been influenced in any way by the supporting companies.

Connolly, Carly

From: Dermot Hughes [redacted]
Sent: 30 December 2020 18:32
To: Kingsnorth, Patricia
Subject: Re: Urgent - SAI review - Urology

This is the 2020 SOP which has some wriggle room but would be regarded as non - confirmatory to NICAN guidance

Penile Cancer

Direct referral to the regional penile cancer service is the preferred option. In cases of clinical uncertainty initial assessment may be required by the designated local penile cancer lead (Mr Glackin, SHSCT) followed by referral to the regional penile cancer service in accordance with the NW Penile Cancer operational policy 2019- 2020.

NICAN guidance 2016

TREATMENT

Patients with penile cancer should be managed by specialist penile cancer teams working at the supra-network level. Such teams should serve up to four networks, with a combined population base of at least four million for penile cancer and expect to manage a minimum of 25 new patients each year. The team should include members of the specialist urological cancer team who work in the cancer centre within which it is based, and it should also have access to expertise in plastic surgery.

All penile cancer cases should be discussed with the supranetwork team prior to proposed treatment if not referred directly to that team.

Local care is classed as:
(i) The diagnostic process only.
Local care should be carried out by local teams for their catchment.

We are only looking at the care given by AOB - but there may be wider issues outwith our remit.

Penile cancer may well be a confused pathway but Hugh is very clear and his view the Regional guidance..

Hope this helps

Dermot

NICaN Urology Cancer Clinical Guidelines

March 2016

9.2 Prostate cancer

Epidemiology

Prostate cancer is the most common cancer in elderly males in Europe. It is a major health concern, especially in developed countries with their greater proportion of elderly men in the general population. The incidence is highest in Northern and Western Europe (> 200 per 100,000), while rates in Eastern and Southern Europe have showed a continuous increase. There is still a survival difference between men diagnosed in Eastern Europe and those in the rest of Europe. Overall, during the last decade, the 5-year relative survival percentages for prostate cancer steadily increased from 73.4% in 1999-2001 to 83.4% in 2005-2007.

There are three well-established risk factors for PCa:

- increasing age;
- ethnic origin;
- heredity

Genetics:

- If one first-line relative has PCa, the risk is at least doubled. If two or more first-line relatives are affected, the risk increases by 5-11-fold.
- A small subpopulation of individuals with PCa (about 9%) have true hereditary PCa. This is defined as three or more affected relatives, or at least two relatives who have developed early onset disease, i.e. before age 55.
- Patients with hereditary PCa usually have an onset six to seven years earlier than spontaneous cases, but do not differ in other ways.

Geography:

- The frequency of autopsy-detected cancers is roughly the same in different parts of the world.
- This finding is in sharp contrast to the incidence of clinical PCa, which differs widely between different geographical areas, being high in the USA and northern Europe and low in South-East Asia.
- However, if Japanese men move from Japan to Hawaii, their risk of PCa increases. If they move to California their risk increases even more, approaching that of American men.

- The National Institutes of Health (NIH) consensus statement in 1988 stated that external irradiation offers the same long-term survival results as surgery.
- EBRT provides a QoL at least as good as that following surgery. A recent systematic review has provided a more sophisticated overview of outcomes from trials that meet the criteria for stratifying patients by risk group, standard outcome measures, numbers of patients, and minimum median follow-up period.
- Radiotherapy continues to be an important and valid alternative to surgery alone for curative therapy.
- Intensity-modulated radiotherapy (IMRT), with or without image-guided radiotherapy (IGRT), is the gold standard for EBRT.
- All centres that do not yet offer IMRT should plan to introduce it as a routine method for the definitive treatment of PCa.
- Radiotherapy can be offered to men with intermediate-risk localised prostate cancer.
- Radiotherapy can be offered to men with high-risk localised prostate cancer when there is a realistic prospect of long-term disease control.
- Radiotherapy should be offered for localised prostate cancer a minimum dose of 74 Gy to the prostate at no more than 2 Gy per fraction.
- Men with intermediate- and high-risk localised prostate cancer should be offered a combination of radical radiotherapy and androgen deprivation therapy, rather than radical radiotherapy or androgen deprivation therapy alone.
- Men with intermediate- and high-risk localised prostate cancer should be offered 6 months of androgen deprivation therapy before, during or after radical external beam radiotherapy.
- Androgen deprivation therapy can be continued for up to 3 years for men with high-risk localised prostate cancer and the benefits and risks of this option should be discussed with them.
- Incidence of late toxicity and outcome by Radiation Therapy Oncology Group (RTOG) grade (from EORTC trial 22863):

Toxicity	Grade 2 %	Grade 3 %	Grade 4 %	Any significant toxicity (> grade 2)%
Cystitis	4.7	0.5	0	5.3
Haematuria	4.7	0	0	4.7
Urinary stricture	4.7	1.3	1	7.1
Urinary incontinence	4.7	0.5	0	5.3
Overall GU toxicity	12.4	2.3	1†	15.9

9.3 PENILE CANCER

Penile carcinoma is mostly a squamous cell carcinoma (SCC) but other types of carcinoma exist as well. It usually originates from the epithelium of the inner prepuce or the glans. Also, penile SCC occurs in several histological subtypes. Penile SCC shares similar pathology with SCC of the oropharynx, the female genitalia (cervix, vagina and vulva) and the anus and it is therefore assumed that it also shares to some extent the natural history.

EPIDEMIOLOGY

- In Western countries, primary penile cancer is uncommon, with an incidence of less than 1.00 per 100,000 males in Europe and the United States.

- Incidence is also affected by race and ethnicity in North America, with the highest incidence of penile cancer found in white Hispanics (1.01 per 100,000), followed by a lower incidence in Alaskan, Native American Indians (0.77 per 100,000), blacks (0.62 per 100,000) and white non-Hispanics (0.51 per 100,000), respectively.

- In contrast, in some other parts of the world such as South America, South East Asia and parts of Africa the incidence of penile cancer is much higher and can represent 1-2% of malignant diseases in men.

- Penile cancer is common in regions with a high prevalence of human papilloma virus (HPV). The annual age-adjusted incidence is 0.7-3.0 per 100,000 men in India, 8.3 per 100,000 men in Brazil and even higher in Uganda, where it is the most commonly diagnosed cancer in men.

- There are no data linking penile cancer to HIV or AIDS.

- In European countries, the overall incidence has been stable from the 1980s until today. Recently, an increased incidence has been reported from Denmark and the UK.

- A longitudinal study from the UK has confirmed a 21% increase in incidence over the period 1979-2009.

- The incidence of penile cancer increases with age, with an age peak during the sixth decade of life. However, the disease does occur in younger men.

TREATMENT

Patients with penile cancer should be managed by specialist penile cancer teams working at the supra-network level. Such teams should serve up to four networks, with a combined population base of at least four million for penile cancer and expect to manage a minimum of 25 new patients each year. The team should include members of the specialist urological cancer team who work in the cancer centre within which it is based, and it should also have access to expertise in plastic surgery.

All penile cancer cases should be discussed with the supranetwork team prior to proposed treatment if not referred directly to that team.

Local care is classed as:
(i) The diagnostic process only.
Local care should be carried out by local teams for their catchment.

It should also be carried out by specialist teams and supranetwork teams for the local catchment of their host locality.

Specialist care is classed as:
(i) Resection (except in cases needing penile reconstruction or lymph node resection).

All resections should be carried out in the host hospital of the team.

(ii) Radiotherapy and chemotherapy. The site(s) where this is carried out should be agreed in the
network guidelines.

Specialist care may be delivered by:

- A specialist urological team without a supranetwork interest in penile cancer provided this is agreed in the network guidelines and with the relevant supranetwork team. It should not be delivered by local urological teams.

- A supranetwork team for referring specialist teams provided this is agreed in the network guidelines.

- The supranetwork team for the local catchment of their host locality.

10.0 UROLOGICAL NURSING

It is well-documented that the CNS plays an essential role within the cancer multidisciplinary team (MDT) in providing high-quality care from diagnosis throughout the patient journey (National Peer Review Programme, 2014). The National Institute for Clinical Excellence (NICE) (2002) called for major changes in improving outcomes for patients with Urological Cancers. In particular they recommended that the CNS should have specific knowledge and expertise and should be trained in advanced communication skills. More recently, NICE (2014) emphasised that the CNS can ensure that patients have information that is tailored to their individual needs, therefore enhancing shared decision making. The CNS is also in an excellent position to provide individualised care following treatment which promotes cancer survivorship (National Cancer Survivorship Initiative, 2011). A recent Macmillan census on specialist nurses workforce in Northern Ireland (2014) has highlighted that cancer care teams of the future will need to have more flexibility working with people who are living with cancer. This census emphasised that the role of the CNS must be optimised to support those living in the community with a diagnosis of cancer.

The combination of improved life expectancy, advancements in diagnostics and treatment, and increased use of PSA testing in primary Care have all contributed to a significant rise in Urological cancer diagnosis. In Northern Ireland the number of new cases of Urological cancers diagnosed annually has increased and the associated workload creating significant challenges for Urological cancer teams and further demands on Uro-Oncology Clinical Nurse Specialists (CNS).

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

Position	Director of Acute Services
Name	Mrs Esther Gishkori
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by the USI

Position	Clinical Director Cancer Services
Name	Dr Rory Convery
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by the USI

Position	MDT Lead Clinician (on behalf of MDT members)
Name	Mr Anthony Glackin
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal Information redacted by the USI

The MDT members agreed this Operational Policy on:

Date Agreed	**1st September 2017**
Operational Policy Review Date	**1st September 2018**

1.5 Chairing of meetings

The chairing of MDMs has been shared by Mr Glackin, Mr O'Brien and Mr Haynes on a rotational basis. Mr O'Donoghue joined in chairing on a rotational basis during 2016. The person appointed to chair each MDM is decided at least one month previously, when a period of time equivalent to one session is allocated to the appointed Chair to preview all cases one day prior to the MDM. Adequate preparation time is included in Job Plans and in a pro rata, annualised, quantitative manner.

1.6 MDT Review (14-2G-103)

The MDM takes place every Thursday, unless otherwise notified, and begins promptly at 14:15 in the tutorial room, Medical Education Centre in Craigavon Area Hospital. The meeting takes place in a room with video conferencing facilities, enabling communication by video to Daisy Hill Hospital, Newry, and with the Specialist MDM in Belfast.

Video conferencing with the Specialist MDT is scheduled to take place at 3.30 pm, or as soon as is mutually convenient thereafter.
It is the policy of the Southern MDT that all MDMs should finish by 5 pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 40 in order to enable the MDM to finish by 5 pm.

All new cases of Urological cancer and those following Urological biopsy will be discussed. Patients with disease progression or treatment related complications will also be discussed and a treatment plan agreed. Patient's holistic needs will be taken into account as part of the multidisciplinary discussion. The Clinician who has dealt with the patient will represent the patient and family concerns and ensure the discussion is patient-centred.

All meetings are supported and organised by the MDT Coordinator. The MDT Coordinator is responsible for collating the information on all patients being discussed and ensuring that all the necessary information is available to enable clinical decisions to be made.

Responsibilities of the MDT Coordinator:

- Ensuring all cancer patients are discussed at the MDT meeting
- Inserting notes onto the pro forma and ensuring it has been signed-off as being a correct record of the meeting's discussion (this forms the main body of the MDT letter to GP)
- Insertion of clinical summaries and updates onto CaPPs
- Filing the pro forma into the relevant notes and forwarding a copy to the oncology department of those patients who need to be referred to the oncologists
- Posting a summary sheet or the pro forma to the referring General Practitioner within 24 hours of the MDT discussion taking place
- Recording the MDT attendance for every meeting
- Adding any patient on the MDT list not discussed (notes, films or results missing, lack of time), to the following week's list

SECTION 3: PATIENT EXPERIENCE

3.1 Key Worker (14-2G-113)

The identification of the Key Worker(s) will be the responsibility of the designated MDT Core Nurse member.

It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each Urology cancer patient has an identified Key Worker and that this is documented in the agreed Record of Patient Management. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6). It is the intent that all Key Workers will have attended the Advanced Communications Skills Course.

Patients and families should be informed of the role of the Key Worker. Contact details are given with written information, and in the Record of Patient Management.

As patients progress along the care pathway, the Key Worker may change. Where possible, these changes should be kept to a minimum. It is the responsibility of the Key Worker to identify the most appropriate healthcare professional to be the patient's next Key Worker. Any changes should be negotiated with the patient and carer prior to implementation, and a clear handover provided to the next Key Worker.

Urology Clinical Nurse Specialists and Practitioners should be present or available at all patient consultations where the patient is informed of a diagnosis of cancer, and should be available for the patient to have a further period of discussion and support following consultation with the clinician, if required or requested. They may also be present, and should be available, when patients attend for further consultations along their pathway.

Key responsibilities of the Key Worker:

- Act as the main contact person for the patient and carer at a specific point in the pathway
- Should be present when the cancer diagnosis is discussed and any other key points in the patients journey
- Offer support, advice and provide information for the patient and their carers, referring to Macmillan Information and Support Service as appropriate to enable access to services
- Ensure continuity of care along the patients pathway and that all relevant plans are communicated to all members of the MDT involved in the patients care
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patients care

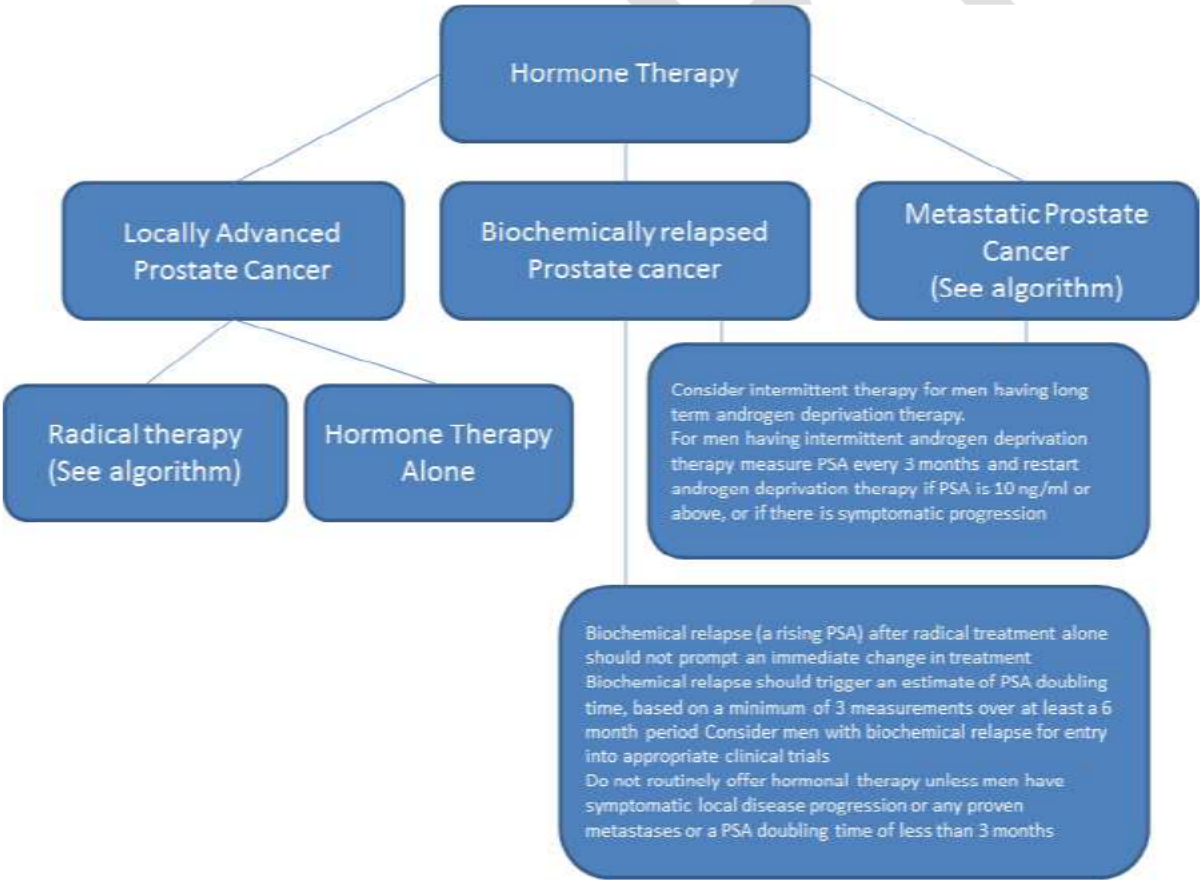
REGIONAL HORMONE THERAPY GUIDELINE

The regional guidelines on hormonal therapy for prostate cancer are drawn from the extensive research in this region and broadly adhere to the EAU guidelines (1) and NICE guidelines (2) on this topic.

The role of hormonal manipulation in men with prostate cancer is well established and fits within 3 broad groups.

1) Neo-adjuvant, concurrent and adjuvant hormone therapy with radical treatment.
2) Treatment of biochemical failure after radical treatment.
3) Treatment of metastatic disease.

Men within each group should be advised of the role of hormonal therapy in the management of their cancer and where appropriate PSA trigger points should be given.
Men should be advised of alert signs and symptoms of cancer progression which should be reported to the supervising clinical team and rapid access arrangements explained.



Consider intermittent therapy for men having long term androgen deprivation therapy.
For men having intermittent androgen deprivation therapy measure PSA every 3 months and restart androgen deprivation therapy if PSA is 10 ng/ml or above, or if there is symptomatic progression

Biochemical relapse (a rising PSA) after radical treatment alone should not prompt an immediate change in treatment
Biochemical relapse should trigger an estimate of PSA doubling time, based on a minimum of 3 measurements over at least a 6 month period Consider men with biochemical relapse for entry into appropriate clinical trials
Do not routinely offer hormonal therapy unless men have symptomatic local disease progression or any proven metastases or a PSA doubling time of less than 3 months

NEO-ADJUVANT, CONCURRENT AND ADJUVANT HORMONE THERAPY WITH RADICAL TREATMENT.

There is clear randomised evidence supporting the addition of hormone therapy to radical radiotherapy in men with non-metastatic prostate cancer. The majority of this evidence is for hormone therapy in men with an increased risk of systemic disease and is based on pre-treatment clinical and pathological features.

Men with intermediate or high risk prostate cancer should be offered neo-adjuvant hormone therapy for at least 3 months before the commencement of radical radiotherapy.
For very large prostate glands or patients with high risk prostate cancer or pelvic node positive prostate cancer a longer period of neo-adjuvant hormone therapy may be required (3, 4).
Cyto-reductive hormone therapy is also considered for men with large prostate's prior to their prostate brachytherapy volume study.

Men with intermediate or high risk prostate cancer should continue their hormone therapy through the course of radiotherapy.

Men with Intermediate risk prostate cancer should receive a total of 6 months of hormone therapy before, during and after their radiotherapy is complete (6-9)

Up to 3 years of adjuvant hormone therapy after radical radiotherapy should be considered for men with high risk prostate cancer. The benefits and risks of long term androgen deprivation therapy should be discussed. [NICE 2014] (5)

Hormone therapies options with radical radiotherapy include

LHRH agonists:-
Zoladex (goserelin) 3.6mg subcut every 4 weeks or
Prostap (leuproreline) 3.75 mg IM every 4 weeks or
Decapeptyl (triptorelin) 3mg IM every 4 weeks

Consider transferring to the 12weekly preparation of androgen deprivation therapy if the 4weekly preparation is tolerated and the intention is to proceed with longer term therapy.

In order to prevent testosterone flare, anti-androgen cover with Bicalutamide 50mg is given for 3 weeks in total with the first LHRHa given 1week after the start of the Bicalutamide.

The anti-androgen - Bicalutamide 150mg OD mono-therapy can be used as neo-adjuvant hormone therapy especially in men where preservation of physical capacity or sexual function is important or in those who may not tolerate hot flushes.

The cardiovascular and metabolic toxicities of LHRHa should be discussed and the patient advised to address cardiovascular risk factors with their GP.

The use of concurrent and adjuvant androgen deprivation with adjuvant and salvage radiotherapy post prostatectomy remains undefined. It is currently being assessed as part of the RADICALs study. Use is therefore at the discretion of the treating clinician.

Limited evidence suggested that the patients who may gain most benefit from the addition of hormone therapy to adjuvant post-prostatectomy radiotherapy have Gleason scores of ≥8 (13) or positive nodes at the circulated for comment and sign off by the wider team. The assessment for the timeline of each patient was reviewed considering family comments during the family engagement process – this was deemed essential, as the patients were being treated by a single professional, without multiprofessional input.

- The patient pathways and outcomes were also benchmarked against the stated standards of care declared by SHSCT Urology Cancer Services to External Cancer Peer Review.

Ref No30. 20210125
Ref No31. 20210125
Ref No32. 20201230
Ref No33. 20201229
Ref No34. 202010910
Ref No35. 20200910
Ref No36. 20200202
Ref No37. 20200817

6. Outline how the review team conducted comparative analysis against regional and national guidance and who took the lead for this aspect of the review team's work, along with a description of what steps they took.

- The assessment was part of clinical care review and was led by Mr. Hugh Gilbert as external expert clinical advisor to the SAI process. The patient pathways were discussed at weekly meetings and benchmarked against expect care as defined by NICAN Urology Cancer Guidelines, NICE Guidance, and Cancer Improving Outcomes. This review also included the local SHSCT Urology Cancer MDT recommendations. The findings were compiled into draft reports by myself and Mrs. Patricia Kingsnorth (Governance Lead on the Review). These were circulated for comment and sign off by the wider team.

- Team review meetings were held on a weekly / 2 weekly basis and minutes of these are included in the shared evidence pack.

Ref No38. 20210105
Ref No39. 20210204
Ref No40. 20210223
Ref No41. 20201107

12.Outline who was responsible for formulating the findings and/or conclusions in each of the 9 SAI Reviews and the overarching report.

- I, as Independent Chair of the SAI process, was responsible for formulating findings and/or conclusions. These were solely based on the findings of the External Expert Clinical Advisor to the SAI Review and were defined by variance from expected best practice. The best practice standard was that as declared at Urology Cancer Services Peer review.

4. Whether you had any prior engagement with Mr. O'Brien through your membership of the British Association of Urological Surgeons, or in any other capacity.

- This question relates to the External Independent Expert Clinical Advisor to the Serious Adverse Incident Process, Mr. Hugh Gilbert.

SAI Reviews

7. Outline what you understood to be the role of and duties associated with the role of Expert External Clinical Advisor to an SAI review and how this role related to all other individuals involved in the review. Explain how you performed the role of Expert External Clinical Advisor.

- I was the Independent Chair of the Serious Adverse Incident Review Process, and this question relates to Mr. Hugh Gilbert.

8. Specifically with regard to the other members of the review team, and without simply outlining their area of specialty, explain the role of and duties performed by the following individuals in conducting the SAI reviews:

   a. Mr. Hugh Gilbert: - Mr. Hugh Gilbert was the Expert External Clinical Advisor to the Serious Adverse Incident Review Process. He is a practicing Urological Surgeon working in an environment similar to the service provided at the Cancer Unit in the SHSCT. He gave independent expert clinical opinion on the care provided to the 9 patients benchmarking this against national best practice and recommendations of the local Multidisciplinary team within Urology Cancer Services SHSCT. Mr. Gilbert also reviewed care considering information and feedback from families.

   b. Mrs. Fiona Reddick: - Mrs. Fiona Reddick was the SHSCT Cancer Services Manager who provided local contextual information on how services were operated, supported, and resourced within the SHSCT Cancer Unit.

   c. Ms. Patricia Thompson – Ms. Patricia Thompson is a Urology Cancer Nurse Specialist who was recently appointed to the SHSCT and was independent of past care. She brought knowledge and experience of the role and expectations of a Urology Cancer Nurse Specialist from elsewhere in Northern Ireland.

   d. Mrs. Patricia Kingsnorth was the nominated SHSCT Governance Lead who supported the Review Process and was a link to governance structures within the SHSCT. She was nominated link person for the 9 families.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

- I believed that this approach would be constructive, providing patient and family engagement was adequately addressed.

  I have experience of this approach in another setting, and it can deliver high quality review of care – especially when there are expected care pathways to benchmark outcomes. It can be performed external to local service which provides greater public assurance and allows local service to continue for patients. The process of finding fact does not alter how a trust or professionals managing a service should interact with families and patients. My experience is that the Structured Review of notes should be only part of the process and the structure should include additional reviews considering patient and family stories. This can, to some degree, address the concerns that clinical notes, if incomplete, may result in flawed conclusions.

22.Since your participation in the series of SAI reviews in 2020, have you performed any additional work for the SHSCT in connection with Urology Services or governance generally, or have you been asked to do so? If applicable, outline what work you have undertaken or specify what work you have been asked to do.

- I had been asked by the SHSCT Governance Lead to be a critical Friend to the service and the Urology Cancer Service Manager did write to ask me to join the Urology Cancer Services team to help implement Recommendations. I considered this request but believed that if I took up such a role the recommendations might be viewed as “my recommendations” and not owned by the SHSCT. I decided not to undertake this role and explained my rationale to the Medical Director.

Learning & Reflections

23.Having had the opportunity to reflect upon the nine SAI reviews you were involved in, is there anything that would wish to say about the cases which you reviewed, the conduct of the review processes and the outcomes of the SAI reviews themselves, which is not already reflected in the respective reports?

- The SAI Review Team had an essential external component did include professionals from the SHSCT who discharged their duties in an exemplary manner. This was despite a potential perceived conflict of interest by some. I believe the local governance team were able to establish and maintain very positive relationships with patients and families, despite the traumatic nature of some of the findings. Although I met families on three occasions, the local team had ongoing interactions with patients and families ensuring details that would not otherwise have been known were included in the reports.

- Much of the SAI Reviews are framed in terms of what care and support patients did or did not receive. Patients with urological cancers often fall within the older age group and may be more often be passive recipients of decisions and advice. They may not have been able to seek independent information for themselves. They all had faith in the health service but were not given the opportunity to discuss their care or more importantly how their care varied from practice of others. Individual decisions of a single professional took precedence over patient’s rights to best care based on evidence and best supported care. This was not “patients as partners in care” and my

- 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

Wallace, Stephen

From:	Wallace, Stephen
Sent:	23 October 2020 14:58
To:	Wallace, Stephen
Subject:	MNOTES - 23.10.2020 11:30am SAI Dermot Hughes

9 cases to date.

Inappropriate androgen deprivation therapy – clear international regional guidance. Should be used with an anti RH drug. Not a lot of logic of prescribing, doesn't benchmark against local or national guidance. How was this not picked up. These are patients with metastatic prostate cancer. Only data is from 2016 – oncology attendance at the MDM is very poor – three different oncologists. May not be able to pick up a trend. One of the safety nets wasn't there. Primary care and pharmacists role in this. These were patients who weren't being given correct treatment. There may be good reason for consultants to act off guidance. MDM focused on initial appointments, less on review on going forward.

Inaction on results, one x-ray. Safety net via trackers required.

Young patient testicular cancer – first 6 weeks. MDM suggested a referral immediately, waited for 2 months. However did that happen. Have to forensically examine the MDM function. SME thinks one directly related to death and another linked wider. Link every patient with Prostate cancer with that consultants name. SME – letters are very full – patients don't seem to have a full understanding of their conditions. If this isn't reflected then this is not an informed decision, if deviation from the pathway informed decision making is crucial.

If full testosterone suppression your prognosis could be worse, this was related to death in one case. Wouldn't be sure it is only one drug, this may be wider for androgen deprivation drugs.

Kidney cancer, SME would have suggested earlier review, patient came to no harm. One case of cancer wasn't added to MDM, need a link with labs as a safety check to the tracker. How we are assured when referrals are to be made they are done esp in time critical cases. Lab attendance at MDM was excellent, though this should happen automatically, list goes to the tracker. There are always cases that will be forgotten about. Some patients didn't have appropriate diagnostic issues were completed. Diagnostic, pathway and prescribing issues. Alert letters have been issued re consultant.

MMcC in confidence – Dermot informed that weekly meetings with the HSCB. DoH and HSCB – may want to release information very soon. We have asked the DoH to consider holding the information release. Not sure if we will be given more time. MMcC aim to is synchronise releases with DoH timelines. MOK – other potential professionals who may be implicated in this – DH potentially 300 prostate cancer in SHSCT, not all metastatic, how many consultant saw. Some staff further downstream must have noted the therapy was bizarre. DH – delay to definitive treatments leading to poor outcomes. Wasn't a culture of bringing patients back to MDM following initial decision making. MMcC – is this different to what happens elsewhere, DH this is different. Usually the treatments are more complex for metastatic cancers, there wasn't ability to provide this in the SHSCT.

Each MDM timeline will have decisions, will detail who was present. MDM discussions for part of your journey, not for others. Everyone would assume that this would be along pre-agreed pathways. DH – initial thoughts that it should have been the oncologists who pick up on this. SHSCT has been poorly served with oncologists for a number of reasons and is a key part of the safety net not there. DH – need to have a discussion with the team to say where we are. MOK – potential of discussing with the urology team, the potential of stating there is a range of alerts among certain groups of patients.

Were the findings and/or conclusions reached on the basis of consensus amongst the review team?

- The SAI review team worked on a basis of consensus. The reports were drafted by me, as chair with support from Mrs Patricia Kingsnorth based on the clinical findings from Mr Hugh Gilbert. The reports were circulated as draft for comment, input and sign off. These reports went through several iterations following information and questions from patients and families. I do not recall any difficulty with this process though a member of the team (the SHSCT Cancer Manager) was absent for a period. The process was to review expected care considering Regional and National Urology Cancer care Guidelines and also in light of the recommendations from the SHSCT Urology Multidisciplinary Team meetings.

Do you recall any disagreement arising with regard to any finding and/or conclusion? If so, provide full details relating to the nature of the issue and how, if at all, it was resolved or reconciled. Your answer should include reference to any draft reviews and reports in advance of the final versions and copies of those should be provided.

- The SAI process was relatively straight forward in terms of the identified clinical variation from expected best practice. This aspect of the review was led by the External Expert Clinical Advisor to the SAI Mr. Hugh Gilbert. It identified variation from declared standards of care in the SHSCT, variations from Multidisciplinary Meeting recommendations, variations from normal specialist nurse support and variations in therapy. Discussions with SHSCT Urology MDT provided assurance that they followed expected practice as defined by the regional and national guidelines. This was an essential governance step to assure the SHSCT of ongoing care but did indicate that the care delivered by Mr. O'Brien was unique within the service.

- All nine reports went through multiple draft iterations – the reviews were held as live documents on a secure system. The reports evolved following initial delineation of patient timelines from clinical notes, MDT meeting notes and cancer tracking information. Critically further drafting of reports were required following family information of their experience – as they were not offered normal cancer care support structures (available within SHSCT) – their patient pathways were unusual, complex and at variance from expectations. The detail of this information evolved of a period during family engagement. All families were offered meetings on three occasions with myself and ongoing email / phone calls to address issues were managed by Mrs. Patricia Kingsnorth. This ongoing engagement fed into the weekly / biweekly SAI review meeting. Mr. Gilbert reviewed the patient's timeline of care provided in light of family comments and questions. Details are included within the information submitted on my behalf by SHSCT.

  Ref No42. 20200301[redacted]
  Ref No43. 20210222[redacted]
  Ref No44. 20210208[redacted]
  Ref No45. 20200903[redacted]
  Ref No46. 20210423[redacted]

  Ref No47. 20210930[redacted]
  Ref No48. 20210316[redacted]

September 2020, I agreed to perform these reviews myself and agreed the engagement terms on 24th September 2020 and signed a confidentially agreement on 4th October.

I understood that my role would be to review the clinical records of nine cases that had been deemed by SHSCT to have reached the threshold to trigger SAI reviews. As a General Urologist with 23 years' consultant experience in the diagnosis and management of urological cancers at a DGH, I felt that I was in a position to perform disinterested, and contextually realistic, case reports to inform the governance process at SHSCT. I was not informed of Structured Clinical Record Review as a formal and documented operational policy and modelled my reports on the Structured Junction Review process adopted by The Royal College of Surgeons.

1e An initial meeting (on-line) took place on 12th October 2020. The scope and methodology of the review were agreed by those present; Dermot Hughes; Fiona Riddick; Patricia Thompson; and me. I confirmed that beyond my role as described above, I had no prior knowledge of any aspect of urological services at SHSCT. I was informed that SHSCT had significant concerns regarding the management of just nine patients seen and treated in their urology service. As an expert external reviewer, I was expected to provide a structured account of each patient's presentation, assessment, and management, together with a commentary on the rationale of any variation from standard practice as defined in commonly accepted local, National or international guidelines.

1f I was to review each case separately and provide comment on the management decisions including any variation from standard guideline practice; and offer a commentary agreed. I used the Royal College of Physicians Structured Judgment Review format, which has with modification been adopted my surgical services.

Ig In addition, I was asked to help construct a tenth report, which would describe common themes that emerged from the nine individual case reports.

Ig I was given electronic access to the entire clinical record in each case. These appeared to be complete.

1h I did not have electronic access to any radiology, but where necessary these were sent on encrypted DVDs

1j I submitted the first draft of the reviews by email on 5th November 2020, anticipating that they would be used to inform the Clinical Governance processes of the Urology Service at SHSCT. I had no further contact with the review group but did indirectly respond to queries raised by the patients or their families. At no time have I had any contact with any other part of SHSCT, apart from with Stephen Wallace,

1k On 6th November, I was contacted by KS to provide contact details for MC.

1l The review group, which included Carly Connolly, met online on 30th November 2020 to discuss the first draft reports. The reports were reviewed.

1m On 3rd December, I was contacted by PK to comment on a case that might have amounted to a SAI. I was unaware of the source of this case and did not enquire as I wished to remain detached from any parallel investigation. On review (Att.1) I felt that the management had been reasonable and did not amount to a SAI.

1n I returned an annotated version of the tenth (overarching) report on 19th January.

1o I proofread my first drafts, which had been annotated by the members of the review group and returned the revised documents on 4th January 2021. The review group met on 24th January to consider the resulting second drafts. A common format was agreed, which would include a section on lessons learnt.

1p I was aware that members of the review group were actively and intensively involved in discussing the findings with some patients or members of their families. These discussions raised some specific questions or points for clarification. I responded to these as they arose, for example, on 18th February, I responded to a request by PK (Att. 2). At no time did I have any direct involvement with any of the patients or their families.

1q On the 23rd February, I submitted the third version according to the agreed format (see1o).

1r Over the ensuing weeks, some observations and questions were provided by patients or their relatives. I have my responses to each and will provide each on request. In summary, although requiring minor amendments to the reports' wording, none of which were amended in material terms.

1s My final versions of the reports were submitted on 19th April 2021. They are product of my own interpretation of the clinical record provided to me. The conclusions were discussed by the review group and any revisions were made by consensus. To my clear recollection, there were no disagreements. DH was exemplary in his chairing of each meeting, allowing sufficient time to discuss each case comprehensively by all attendees. The meetings were characterised by a courteous common purpose.

1t Since my involvement in this process, I have been asked to recruit a number (6-10) expert reviewers for approximately 64 patients' cases whose management has raised concerns. I understand these cases were revealed by a continuing audit by the Urology Service supported by KS. I have had no involvement in this work with all communication with this matter has been with Stephen Wallace alone at SHSCT.

2a The events given above are derived from my electronic records comprising emails and attachments. None exist outside those held by the SHSCT, which are part of their submission to the Inquiry. However, I can provide copies of those I hold.

2b The reports, in their various iterations, are held by SHSCT and should comprise part of their submission to the Inquiry. However, I can provide copies of these.

2c I neither hold, nor am I aware of, any other relevant record.

Level 3 SAI review

Introductory Meeting New Urology reviews.

Date and time: Thursday 10 September 2020 10:30 – 12:00
Venue: - Board Room Trust Headquarters CAH

Attendees:
External Chair – Dr Dermot Hughes.
Mrs Fiona Reddick – Head of Cancer Services
Ms Patricia Thompson – Clinical Nurse Specialist – urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Governance Coordinator

Welcome

Patricia Kingsnorth welcomed everyone to the first meeting and introductions were made.

Dr Hughes explained the process and rationale for review to look at the service and map the pathway of the patients being presented. There would be separate reports with one overall umbrella section.

The cases 6 presented (one more to follow) will include mapping the patient's journey and compare with the existing pathway to identify deviations from the pathway.

Cases discussed.

1. [redacted] a [redacted] old man referred in view of increased PSA and tumour markers. Noted he had an MRI pelvis and was referred for discussion with MDT prior to biopsy. MDT recommended radiotherapy in Belfast. No done. Fiona will check out, who was present at the MDT meeting, were the appropriate people at the meeting and was the referral made to Belfast. There was some discussion about a failsafe from cancer trackers if a referral is not made how did non beam radiotherapy not happen?

2. [redacted]- noted renal cell carcinoma. Noted the risks of surgery for this patient but patient wanted surgery. Following radiology investigation the result was not acted upon.
   There was some discussion around who follows the patient up – if surgeons then the review should be followed up in Thorndale unit, if oncology this would be done in Belfast. Patricia K will check with PACS manager if the MRI scan was viewed and by whom. Also she will check with Imran if the CT scan meets the definition of unexpected result.- index of suspicion.
   Need to map this patient's journey

3. [redacted] patient received TURP as clinically suspicious of prostate cancer. Need to ascertain if all the tissue was there was a clinical suspicion of cancer –

what would be expected in this case. Fiona to identify who attended the MDT meeting and what was the pathway of care – pathway appears not to have been followed. Patient not reviewed until his emergency attendance at ED 7 months later.

4. [redacted] – need to look at his entrance to the pathway. PK to provide a timeline and present to the team. Was his case discussed at MDT what was the decision making in his case. Who was present?

5. Is there a fail-safe coordinator for urology? There is for breast cancer services. We need to check with Martina Corrigan.

6. [redacted] – the datix doesn't provide enough information in this case to identify the issues. Need a timeline to share with the panel.

Other issues identified. – Service of oncology lung and urology MDT meet on the same day. Access to services problems?

Dr Hughes advises we conduct a systematic review of what is expected in the pathway, what has occurred in the patients journey and are the variants.

What should happen	What did happen	What are the variants

A draft terms of reference were discussed.
Agreed the following

Terms of Reference

The terms of reference for the review of the care and treatment provided to XX were:

- To carry out a systematic review in the process used in the diagnosis, MDT decision making and subsequent follow up provided, using a Root Cause Analysis (RCA) Methodology.
- To use a multidisciplinary team approach to the review.
- To identify those factors which may have had an influence, or may have contributed to the process.
- To agree the outcome of the review and subsequent recommendations.
- To action any recommendations and disseminate any lessons to be learnt.

- To report the findings and the recommendations of the review through the Director of Acute Services SHSCT, Medical Director of SHSCT and disseminate to the staff involved and XX.

Patricia advises that a urologist is being commissioned and we hope they will be available for the next meeting.

Actions

Patricia K will provide notes electronically for Dermot and Patricia T and hard copy for Fiona. Timelines are being written up and will be shared with the team for all patients.

Fiona will access the system to determine who was present at the MDT meetings and what was discussed. PK will forward the HCN to her separately.

Dermot will be on leave from next week.

PK to arrange the next meeting when the urology rep has been secured.

New Urology SAI Meeting 12.10.2020 @09:30.

Attendance: Dr Dermot Hughes (Chair); Mr Hugh Gilbert Consultant Urologist; Patricia Kingsnorth ; Fiona Reddick; Patricia Thompson

Round of introductions given

PK asked was the agenda received by all. All present confirmed they had received this. Patricia Kingsnorth asked for everyone to check the notes of last meeting for accuracy. Record of what was agreed. At previous meeting they discussed 6 cases at high level and 2 cases were removed Patient 101, Patient 112 following screening.

Dermot advised all cases are quite similar: 8 cases and it is important everyone has same information on each case to review.

Patricia Kingsnorth: Information can be accessed on Egress.

Patricia Kingsnorth advised there was one additional case for screening:

Dermot advised he was concerned he was asked to Chair the review in August and there are still cases added.

Patricia Kingsnorth advised will speak with directors re this.

Dermot advised everything that will be done will be scrutinised and advised it is important we take same approach to all cases. Asked to chair urology cases, quite similar, they have being independently triaged, currently 7 possibly with possibility of 8 cases. Dermot advised we can at the cases in 2 ways i.e. the processes in place and how the patients pathway progressed through.

Medical opinion: District general hospital consultant should be able to give peer opinion

Dermot explained the Urology services divided urology cancer MDTs, probably cover 400000 patients link together each week with regional MDT, there is a seamless flow of patients through the service,

Oncology services are separate; this is an outreach service that is variable throughout Trusts.

Patricia Kingsnorth advised previous introductory meeting prior to Hugh coming on board, looked at pathways briefly. The scope of the review and terms of reference, she advised we need to send draft TOR to HSCB and consider family involvement in TOR.

Patricia K read out TOR. Advised there will be separate individual reports and one overarching report with all information.

Dermot advised important we need to consider family expectation and involvement within the TOR. Normally would share TOR with family/ patient and ask them to review and contribute in some way. Usually family would have their concerns. Opportunity to express any concerns to be address in review.

Hugh advised If it is to be a multi-disciplinary review should there be an oncologist on review panel.

Patricia K advised 2 ways we could do this. Have one on the review team or ask for an oncology opinion this won't delay process getting oncologist.

Hugh: Need to have Oncologist for reviewing case, he will do primary case review, what urologist or oncologist would do, better and fairer way to complete review.

Patricia K advised we need to provide questions for clarity for the oncologist on what is required for the review.

Dermot advised not everything would be pertinent to oncologist, we should seek opinion now

Hugh advised he has gone through cases and knows what they are about, not entirely black and white, happy to provide questions for oncologist to consider.

Hughes: We need to know how MDT process works. How effective MDT is, it is important to have MDT input into review.

Patricia K advised she had provided papers and asked if all could you access Egress system.

Hugh: Given huge files and have gone through them, all a part [redacted].

Patricia K start going through cases, one step at a time, to see what we need from them. She will forward [redacted] papers to him.

Case 1 [redacted]

Hugh : [redacted] old presented with urinary retention in May 19, he was assessed 3 weeks later PSA moderately elevated difficult to know if accurate level, clinical point of view suspicion of disease, June 2019 seen consultant and listed for TURP, to start on hormone therapy straight away , bicalutamide 50mgs. This is an unconventional dose.

Hormone therapy- try to block of testosterone on cancer, stop its fuel source, in 90% cases prostate cancer will stop growing and shrink. LHRH analogue given intramuscular injection every 6 months, this is standard treatment, blocks testosterone receptors, bicalutamide 150mg is not recommended, trials proven patients survive less longer, still used as introductory treatment, couple of weeks before definitive injection treatment. OK to give 50 mgs if there was intention to move over to LHRH in short term. Operation (TURP) was completed only 3grams tissue of removed. Note TURP is not diagnostic test. Cancer can be missed with TURP most cancers occur in the peripheral zone therefore trans rectal biopsy is best practice, Cannot rely on TURP – this management was unconventional.

2nd July after operation reviewed and still had some symptoms, give antibiotic with plan to review 2 /12 later. This did not happy, not clear why, definite note in the letter to say should be seen.

iii. The process by which the nine patients were identified and selected for an SAI review.

- The process for triage of patients to meet the threshold for inclusion in an SAI process was performed in-house within Governance of the SHSCT. To my knowledge, this was in accordance with the document "Procedure for Reporting and Follow up of Serious Adverse Incidents November 2016 version 1.1.". Discussing with the PHA on the nature and grade of an SAI would be normal procedure. It would not be unusual in Trusts where a service raising a Serious Adverse Incident, would seek someone uninvolved with the issue to carry out a SAI review. This would be similar when the

  Ref No.1 SAI/PHA

  SHSCT were seeking an Independent Chair of the SAI and an independent external expert to act as clinical advisor to the SAI review.

iv. The existence of other cases of concern or potentially meeting the threshold for an SAI review.

- I was aware of an ongoing process to perform a "look-back exercise" and ongoing triage of cases as potential SAIs. This information became public knowledge as the SAI process was ongoing. It is also knowledge that I shared with families to ensure we were as open and transparent as possible. As Chair of the SAI process, I did not seek nor was I given any further details regarding outcomes of triage to SAI thresholds for subsequent patients, believing this would be inappropriate. The rationale for this was to maintain independence of the SAI process from ingoing triage of the care of other patients.

v. Previous concerns within Urology Services.

- I was initially unaware of the professional involved with the SAI process and was unaware of concerns within the Urology Services SHSCT. This however changed when meeting with professionals who referred to a previous Serious Adverse Incident Review involving the named professional. I believed this could be of importance to the ongoing 9 SAI reviews and to the learning and action plan resulting from that process. This was made available and is referenced in the overarching document. I was informed of the exitance of a past "Maintaining High Professional Standards" Investigation. I did not request this as it lay outside the terms of the SAI review process.

vi. Previous SAI reports and the findings of same.

- SAI HSC unique identifier S11471 was made available, after it was referred SHSCT professionals during interview. It related to triage of patients referred to Urology Cancer Services within the SHSCT for investigation and diagnosis of "Red Flag" symptoms of cancer. This issue first arose in 2016.

  Ref No.2 20210510

- I believed that this approach would be constructive, providing patient and family engagement was adequately addressed.

  I have experience of this approach in another setting, and it can deliver high quality review of care – especially when there are expected care pathways to benchmark outcomes. It can be performed external to local service which provides greater public assurance and allows local service to continue for patients. The process of finding fact does not alter how a trust or professionals managing a service should interact with families and patients. My experience is that the Structured Review of notes should be only part of the process and the structure should include additional reviews considering patient and family stories. This can, to some degree, address the concerns that clinical notes, if incomplete, may result in flawed conclusions.

22.Since your participation in the series of SAI reviews in 2020, have you performed any additional work for the SHSCT in connection with Urology Services or governance generally, or have you been asked to do so? If applicable, outline what work you have undertaken or specify what work you have been asked to do.

- I had been asked by the SHSCT Governance Lead to be a critical Friend to the service and the Urology Cancer Service Manager did write to ask me to join the Urology Cancer Services team to help implement Recommendations. I considered this request but believed that if I took up such a role the recommendations might be viewed as “my recommendations” and not owned by the SHSCT. I decided not to undertake this role and explained my rationale to the Medical Director.

Learning & Reflections

23.Having had the opportunity to reflect upon the nine SAI reviews you were involved in, is there anything that would wish to say about the cases which you reviewed, the conduct of the review processes and the outcomes of the SAI reviews themselves, which is not already reflected in the respective reports?

- The SAI Review Team had an essential external component did include professionals from the SHSCT who discharged their duties in an exemplary manner. This was despite a potential perceived conflict of interest by some. I believe the local governance team were able to establish and maintain very positive relationships with patients and families, despite the traumatic nature of some of the findings. Although I met families on three occasions, the local team had ongoing interactions with patients and families ensuring details that would not otherwise have been known were included in the reports.

- Much of the SAI Reviews are framed in terms of what care and support patients did or did not receive. Patients with urological cancers often fall within the older age group and may be more often be passive recipients of decisions and advice. They may not have been able to seek independent information for themselves. They all had faith in the health service but were not given the opportunity to discuss their care or more importantly how their care varied from practice of others. Individual decisions of a single professional took precedence over patient’s rights to best care based on evidence and best supported care. This was not “patients as partners in care” and my

Survey method

Postal surveys were sent to patients' home addresses following their discharge. Up to two reminders were sent to non-responders. A freepost envelope was included for their replies. Patients could call a free telephone line to ask questions, complete the questionnaire verbally, or to access an interpreting service. Survey packages were prepared by Quality Health, supplied to the Northern Ireland Health Service and dispatched to patients by them.

Response rate

A total of 5,388 patients who had received treatment for cancer during December 2013 to May 2014 were included in the sample for the Cancer Patient Experience Survey. These patients were allocated to 13 different cancer groups.

877 eligible patients from this Trust were sent a survey, and 451 questionnaires were returned completed. This represents a response rate of 53% once deceased patients and questionnaires returned undelivered had been accounted for. The response rate for Northern Ireland as a whole was 62% (3,217 respondents).

Percentage scores

The questions in the cancer survey have been summarised as the percentage of patients who reported a positive experience. For example, the percentage of patients who were given a complete explanation of their diagnostic tests or the percentage of patients who said that nurses did NOT talk in front of them as if they were not there. Neutral responses, such as "Don't know" and "I did not need an explanation" are not included in the denominator when computing the score.

The higher the score the better the Trust's performance. Some scores represent performance across a pathway involving primary and community care in addition to acute care but represent important parts of the patient experience along the pathway of care.

Most of the questions in the 2015 Cancer Patient Experience Survey for Northern Ireland are in the same format and have the same wording as in the 2014 CPES for England, and the scoring system for them is identical, thus enabling robust comparisons to be made.

Low numbers of respondents and data not reported

Some Trusts have relatively small numbers of cancer patients, so the total number of respondents to the survey may be lower despite the high response rate. Reports for these Trusts have been completed in the normal way, but the results for these Trusts need to be treated with caution. It is important to recognise however, that the low numbers of respondents in these Trusts for some tumour groups is simply the result of low numbers of cancer patients being treated, especially where there is low incidence of particular types of tumours.

Ref No3. 2020522

11.With regard to the steps taken and processes adopted by the review team to complete its work. Further, outline, in broad terms,: to each of the nine cases subject to SAI review, generally describe

1. Your specific role in conducting the reviews and actions taken by yourself.

- I was the Independent Chair of the SAI Review process and was responsible for the SAI review, the Root cause analysis, patient timelines and leading on Family Engagement. The External Expert Clinical advisor to the SAI process provided the independent clinical opinion on each case, based on patient records, MDT records and feedback from families. This was benchmarked against regional and national standards declared to External Peer Review as the Standard of care by the SHSCT Urology Cancer Services. Variances from expected best practice were identified, formed the learning within each SAI and resulted in an overarching arching plan.

2. What documentation was made available to the review team?

- The review team had full access to the patient record of care. This included radiology scans, laboratory results and multidisciplinary meeting notes and agreed care pathways. Patient and family experience along with patients and family questions were included in this record as care was often delivered by a single professional without recourse to other members of the multidisciplinary team. The review team considered the clinical care and pathways for all 9 patients. The Investigation team wrote to Mr A O'B with specific questions for clarification. These questions were not responded to despite extension of deadlines.

  Ref No4. 20200211

3. What relevant personnel, including management staff, clinicians and nursing staff;

   i. Did the review team meet with?

- Associate Medical Director and Clinical lead for Cancer Services SHSCT
  Ref No5. 20210111
  Ref No6. 20210107

- Assistant Director for Surgical Services SHSCT
  Ref No7. 20210204

- Nursing Director SHSCT

- The conversations were at times difficult for staff as there was an undoubted concern that the SAI process was potentially detrimental to public perception of their service and their professional practice. There did appear to be an understanding of the variation in care regarding prescribing in prostate cancer and care delivered without specialist cancer nurse input. There was less knowledge of the other deficits identified by the External Expert Clinical Advisor to the SAI. This included failure to refer to oncologists and failure to further discuss patients at the multidisciplinary team meetings when disease progressed. The Senior Cancer Service management team had no knowledge of the above issues.

  Ref No15. 20210125
  Ref No16. 20210204
  Ref No17. 20210218

- A robust structure to quality assure care given by all within the Urology Services MDT did not exist and inappropriate declarations were made to External Peer Review. When discussing this issue some professionals and managers became defensive and believed that saying "did not know" was appropriate response. Three senior individuals subsequently amended the Overarching SAI report to include their views and concerns – this was raised with the SHSCT as they were not part of the SAI team, did not have editing rights and would have been a major concern for families. I responded to the individual amendments.

  Ref No18. 20210331
  Ref No19. 20210421
  Ref No20. 20210209
  Ref No21. 20210208

- The management team focused on delivery of 31 days to diagnose and 62 days to treat "cancer targets" which are ministerial returns. There was limited understanding how tracking of patients is used to support individuals in complex journeys, provide assurance and act as an evidence base for service improvement. Cancer Structures normally expect business meetings to discuss and improve functioning of the MDTs and service delivery. This should be based on data and evidence but was not in place. The Senior Cancer Management Team should have oversight of all Cancer MDTs learning from best practice and ensuring there is a commonality of approach to all receiving cancer care.

  Ref No22. 20210111
  Ref No23. 20210107
  Ref No24. 20201229

- The regional oncology staff were different and had knowledge of the variation from best practice regarding Prostate Cancer Prescribing. They explained steps taken to address issues. One professional initiated a regional protocol to standardize Androgen Deprivation Therapy for prostate cancer (signed off by Mr. O'Brien as the Regional Urology Cancer Lead for NICAN). They also had written to him directly

SAI Urology Review
30 November 2020 at 12:45
Telephone Conversation

Chair – Dr Dermot Hughes
Facilitator Mrs Patricia Kingsnorth – Acting Acute Clinical Governance and Social Care Coordinator (note taker).

Phone Conversation with Mr Anthony Glacken (AG) Consultant Urologist SHSCT

Notes of the Meeting.

Patricia and Dr Hughes thanked AG for taking the time to converse with the Chair of the SAI.

Dr Hughes (DH) advised that as part of the SAI review the panel had met with the families and they each said that they had not been involved with a Clinical Nurse Specialist in Urology was this unusual for one consultant.

Mr Glackin (AG)- advised that there were only two urology clinical specialist nurses in the Trust to support urology cancer patients and recently the trust have appointed a new clinical specialist nurse from the SET. The nurses are available for clinics held in the acute setting. However, there would be no nurse available to attend any clinics held off site –either in STH, Banbridge, ACH or SWAH.

DH advised that AOB prescribed off guidance which didn't adhere to NICAN guidelines. He appeared to ignore the recommendations from MDT in relation to the prescription of bicalutamide without patient informed consent?
AG – advised this would have been challenged at MDT. He advised the practice for presenting to MDT changed in last 6 years. The cases are discussed using NIECR for information. Each case is reviewed in advance by a Consultant Urologist who chairs the meeting on a rotational basis with colleagues. This was done to share the workload as opposed to monitor the practice of colleagues. The question around bicalutamide 50mgs use would have been challenged but not minuted. He went on to say that once a patient's care was discussed at MDT, this was left to the named consultant to continue the patient's care. No one was looking over the shoulders of others to check that the work was done.
DH advised that often the patients involved in the review were not represented to MDT when their conditions deteriorated.
AG – said he couldn't comment on that. If patients returned to theatre or had a deterioration- there was no way of capturing that if their case was not represented by their consultant.

DH advised the patients all described not being able to access appropriate care – 2 had died and 2 were palliative.
AG- can only speak for himself – his patients have access to CNS and are referred to palliative colleagues for support.
He went on to describe as AOB as "holistic physician/clinician" -
AG and other colleagues would work with multidisciplinary teams, they would deal with the surgical management but would refer to medical colleagues.

He described that AOB would have had a proportionate number of patients from the Western Trust and would have reviewed then in Enniskillen there were no CNS available to attend these clinics.

DH referred to the NICAN guidance and the annual business report. There was very limited audit reports.
Where there any issues with colleagues contributing to audit.

AG- both he and MH (Mark Haynes) were involved in the national audit from BAUS. In view of information control issues this audit was terminated by the HSCB. AG advised that Mr AOB didn't participate in audit and was not a member of BAUS.

DH – advised that the MDM was under resourced and under provided with oncology in SHSCT. There was a shortage of radiology and cover had to be obtained from medical oncology and clinical oncology.

DH – asked if any of the oncologist had any concerns about AOB?
AG- said he wasn't aware of any concerns raised. However he did advise that AOB was the chair of NICAN in previous years. Now chaired by MH and that AOB would have been involved in the drafting of the guidelines.

DH advised that a small number of patients were treated outside guidelines and this would normally be discussed with patients.
AG – one of the flaws with the MDM process is that clinicians who are present may be making a decision on patient care with incomplete information. A decision is reached indicating a course of action until you meet the patient in clinic and then have to revise the management.

DH – was it a functional MDT ?
AG – yes there was good involvement from the urologists, radiologists, pathologists specialist nurses and coordinator.

DH- What was the relationship like among the urologists?
AG- it was good up until December 2016 when AOB had a period of sick leave and the Trust took the opportunity to review his practice. After this working relationships became difficult, other issues came out of the woodwork.
Only the AMD was involved in the review – everyone else was left out of it.

AG- When AOB returned to work conversations were strained but got better. Relationships got back on an even keel. But they deteriorated again before AOB retired. There was a change in his demeanour towards the end of June.
MH would know more. One of the consultants Michael Young (MY) has worked with AOB for 20 years. I have known him since before I was a medical student. It is fair to say AOB was very helpful and supportive of me in my new role as consultant. The current investigation should be even handed and proportionate in manner. You should be aware of the good things he has done.

DH recognised the stress this process must be having on the urology team.

AG – described how he felt the minister had taken a disproportionate view and this was prejudicial.
DH provided an overall brief of what the SAI review will look like.

He mentioned the NICAN recommendations and this is what should happened and what didn't happen and why that was the case.
Why no specialist nurses were involved?
Why no oncologists referrals were made
Lack of follow up of radiological investigations?

AG – advised he was involved in the SET peer review process and noted how they were better resourced that the SHSCT.
DH – do you have any questions?
AG- the team would like to be briefed as and when it is appropriate as well as the CNS as they are all very stressed about the review.
DH- advised he thought this would be appropriate and ensure staff felt valued.
He would check with the medical director office to see when this could happen.

SAI Urology Review

Meeting with Barry Conway
Tuesday 29 December 2020 at 1pm

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
Barry Conway (BC)

Dr Hughes thanked Mr Conway for facilitating the meeting. He explained the overview of the SAI review in relation to the themes identified during the review. He advised that the NICAN peer review adapted by the Regional group was signed off by the Trust. Mr OB signed off the peer review; however, he did not adhere to the recommendations and standards.
He advised that some of the issues were in relation to the patients not having access to a specialist nurse/ key worker. Therefore when the patient's condition deteriorated there was no referral back to MDT

He advised the MDT was set up to keep patients safe and to provide challenge from the multidisciplinary teams. If there was challenge why did it not effect change and who knew about it.

BC advised that it would be down to the individual clinicians to bring patients back for discussion at MDT
BC advised that the structure of the cancer services would consist of him, HOS (Fiona Reddick) AMD (Dr Shahid Tariq) and CD (Mr David McCaul).
They would meet monthly to discuss operational issues regarding service delivery, workforce issues/ Pathways/ Incidents and Risk Registers and consider any pressures in the system.
They don't have a feed from the chairs of the MDM and would not be made aware of any individual's practices.
DH – what would happen when things go wrong?
BC – this would be managed by the specialist route.

BC advised that he has been employed by the Trust since 2005 and he was aware of some issues regarding Mr O'B in relation to back logs and dictation but not clinical concerns. BC said he was aware of a previous SAI on a higher level. He has been in this role as AD for clinical cancer services for 2.5 years and was not aware of any formal escalation relating to Mr O'B.

BC stated he wasn't aware that specialist nurses were not involved in the patients identified in the SAI review.

DH stated that there needs to be a corporate understanding of the MDM process with clear lines of accountability and governance processes. He advised that we need to understand were there any opportunities to identify concerns earlier?
DH give an example of the experiences of one of the patient's involved.

SAI Urology Review

Meeting with Dr Shahid Tariq
Tuesday 29 December 2020 at 1:45pm

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
Shahid Tariq (ST)

Dr Hughes thanked Dr Tariq for facilitating the meeting. He explained the overview of the SAI review in relation to the themes identified during the review. He advised that the NICAN peer review adapted by the Regional group was signed off by the Trust. Mr OB signed off the peer review; however, he did not adhere to the recommendations and standards.

He advised that some of the issues were in relation to the patients not having access to a specialist nurse/ key worker. Therefore when the patient's condition deteriorated there was no referral back to MDT

DH asked did the MDT know that Mr OB was not adhering to guidelines or the recommendations from the MDT. He advised that there was challenge but questioned who was it escalated to?
ST – he was not aware of any concerns mentioned. Any clinical concerns would go through the speciality management structure route.

ST did advise in 2019 he set up a cancer strategic forum which would meet twice a year.
This was to bring together different tumour site specialities under one umbrella, to look at good practice and to identify the need for additional resources for them.
They only had one meeting in 2019 and planned to meet in March 2020 but this was cancelled due to covid.

DH advised that some of the patients did not receive the appropriate drug therapy in relation to androgen deprivation therapy. Mr OB chose not to involve other professionals in the patients care. There are now 5 specialist nurses in post.

DH asked if the urology team asked for additional support. The specialist nurses were used by all the clinicians except one. The specialist nurse is a safety net for when things are missed. Do you know if there were any concerns raised by the specialist nurses?
ST – No. was not aware.

DH asked did the chair of the MDM have a pa in their job plan

ST advised that he believe they were given one PA but this would be for the MDT and their leadership to decide. He advised that the cancer service is responsible for cancer performance targets, tracking of patients on cancer pathways and to provide help and operational support to the tumour site teams if it is needed. Governance arrangements lay within the primary team management structure i.e. CD and AMD for the division.

DH acknowledged that people didn’t realise the deficits of care as the absence of a key worker impacted on the patient’s care.

ST advised that they were removed from that process because the primary team’s leadership is responsible for governance arrangements.
DH asked was that appropriate?
ST advised that cancer service would like to strengthen its links with the tumour site specialities to be able to provide better support for them..

Dr Hughes thanked Dr Tariq for his input.

SAI Urology Review

Discussion with Ronan Carroll (RC) AD for Surgical and Elective Care

Dr Dermot Hughes (DH) and Patricia Kingsnorth (PK)

Monday 18 January 2021 @ 13:45

Dr Hughes provided a summary of where we are regarding the SAI review and summarising the cases involved in the review. He explained that many of the patient's pathway did not follow the recommendations set out by the regional urology pathway. He explained that AOB was the Chair of the regional urology MDM up until 2016. He signed off the guidance for peer review in 2017 but did not adhere to the standards agreed.

DH described the issues regarding the lack of specialised nurse for AOB's patients and the impact this had on the patients and family when trying to access services. He advised that AOB use of ADT was highlighted by the oncologist in Belfast Trust who wrote to AOB to highlight issues. But this wasn't escalated further.

DH- asked how did AOB practice this way?

RC- believed everyone made excuses for AOB the consensus was that he was a very strong personality who could be spiteful and even vindictive. Many of the CNS were afraid of him. But RC was unaware that the CNS were excluded from seeing AOB's patients.

DH explained the SAI process that we are looking at the cancer pathway and benchmarking against the standards regarding diagnosis/ staging/ MDT. He explained that some of the patients were not referred on for palliative care when their disease progressed. AOB was referred to by one of his colleagues as a "holistic physician" who care for the patients in uni-professional manner, but really he was working outside of his scope of practice.

RC speculated about AOB that there was a sense of arrogance/ commanded respect almost "God like" when he walked the corridors.

RC said he wasn't aware of the issues identified by the SAI review and was quite shocked when the issues were identified by PK during the update of early learning from the SAI. He advised that the patients under the care of Mr OB were often elderly and held him in high esteem "the big doctor". He went on to say that staff appeared to be habitualised by AOB's behaviour, that they avoided challenge at MDT.

RC went on to describe a previous concern they had which was escalated to an SAI of a man who had a bladder tumour, his red flag referral was put in a drawer resulting in an extensive delay to review him. There was no remorse and AOB seemed to defer to everyone else's problem not his.

DH advised the language will be neutral describing what the standard of care should be and what it was. He advised that all the families found AOB to be very personable but his care fell below standard.

RC advised that AOB was known to be clinically sound and that any issues raised were regarding system and administration processes. He never thought of him as a poor surgeon. He wasn't aware there were any issues with drug prescription or failure to follow up or non-compliance with MDT recommendations.

DH advised the need for assurances through regular audits for all clinicians.

RC advised that the system is not resourced for re- referral to MDT.

DH said it should be and advised the cancer tracker's remit needs to be wider to include follow up of results and investigations.

DH thanked RC for assisting with the review.

SAI Urology Review

Interview with Mrs Martina Corrigan (MC) Head of Service for Urology

18 January 2021 at 12 Midday via zoom

Dr Dermot Hughes (DH)and Patricia Kingsnorth

Dr Hughes provided Martina with an update to date – he advised that there are 9 families involved in the process and that there are similar themes; one being that Mr O' Brien worked in isolation despite MDT involvement and being the Chair of the MDT for a number of years. Martina confirmed that Mr O'Brien never involved a specialist nurse and had always been the case from she had started in the Trust.

Martina advised that she worked in SHSCT for 11 years, and confirmed that during that time Mr O'Brien never recognised the role of the Clinical Nurse Specialists. She confirmed that he never involved them in his oncology clinics. She is aware that some of the Clinical Nurse Specialists would have asked to be at the clinics but Mr O'Brien never included them.

Dr Hughes advised that many of the patients that have been reviewed were given hormone therapy off licence and often without their knowledge and that this treatment was in variance to guidance. He also advised that some of the patients were not referred onwards to oncology when their disease progressed and they had no access to coordinated care. This meant that patient's had difficulty accessing care and the GPs couldn't help which resulted in patients having no option but to go to the Emergency Department during covid which was not appropriate.

Dr Hughes asked if anyone expressed concerns about excluding nurses from the clinics.

Martina advised that two of the Clinical Nurse Specialists did report that they did regularly challenge Mr O'Brien and asked him if he needed them to be in the clinic to assist with the follow-up of the patients but it got to the stage were staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change.

Martina advised that in her opinion that Mr O'Brien could be quite arrogant and that was a big part of the issues with his practice.

Dr Hughes advised that the Clinical Nurse Specialists are so important on the patient's journey.

Martina agreed and said that this support from the CNS was vital both for oncology and for benign conditions, and advised that Mr O'Brien did include the CNS in

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.

Meeting with Mr Mark Haynes AMD SEC and Dr Dermot Hughes Chair of Urology SAI Panel
Note Taker- Mrs Patricia Kingsnorth
Via zoom
18 January 2021 at 11:00

Dr Hughes thanked Mr Haynes for meeting with him a briefly outlined the SAI review and the issues to date.
He advised that Mr OB did not work with specialist nurses and patients did not feel supported in terms of knowledge of their disease. The patients deteriorated in the community with lack of support. In relation to ADT, Dr Hughes advised Mr Haynes that after speaking with the oncologist in Belfast who had known about Mr OB practice for 17 years. . He advised that this practice was off guidance and that patients were treated without informed consent.
Mr OB ignored the recommendations of the MDT and did not bring patients back for discussion.
Dr Hughes asked were there any concerns raised about this practice.
Mr Haynes – advised that he was the person who raised the concerns. He had taken over from AOB as chair of the urology cancer group approx. 3 years ago.
Mr Haynes advised that he works in a different system. He works in a more team based approach with 3 consultants and 5 specialist nurses) Mr AOB worked as more individual. There was non-involvement with any other members of the team which meant that his practice was not scrutinised.
Mr Haynes advised there were a number of concerns about how AOB practiced. But was not acutely aware about his lack of conformities to standard treatments. The benefit from covid is that it encouraged shared working practices.

Dr Hughes advised that cancer care is benchmarked – there is an agreed level of care which is peer reviewed.
Mr Haynes advised that AOB didn't use other people to assist him with his role. He took everything on himself. All queries came to him.
Mr Haynes advised that the MDT did disagree with Mr AOB decision making regarding ADT. He recalled a disagreement with AOB in relation to his use of ADT for a patient he said that Mr AOB became entrenched in his decision making and he never accepted their challenges.

Southern Health
and Social Care Trust

Acute Governance
Urology MDM
Thursday 18 February 2021 @ 12.30pm

PRESENT: **Mr Dr Dermot Hughes (Chair)**
Mrs Patricia Kingsnorth
Mr Michael Young
Mr Anthony Glackin
Jason Young
Jenny McMahon
Martina Corrigan
Kate O'Neill
Mr Mark Haynes
Mr Shawgi Omer
Roisin Farrell, note taker

Dr Hughes introduced himself to the meeting. He provided an update to the meeting. He advised he was asked to chair the Urology review in August. The review team have been working on the review from October 2020 and the draft report is expected to be ready for 28.2.2021. He has met with all 9 families once and is meeting with them between today and tomorrow (18 & 19 February 2021) for the second time and will meet with them for a third time to provide them with the draft report.
Cases in question were: 5 prostate cancers, 1 testicle cancer, 1 penile cancer and 2 renal cancers. He asked if anyone had any questions. – None. He advised in the instance of the prostate cancers there was no adherence to MDM and clinical guidelines of March 2016. Other issues of concern are the timeline for diagnosis, some delays and some were lost in the pathway to diagnosis and follow ups. He confirmed 3 patients have since died. [redacted], [redacted] and [redacted] and other patients are not so well. Dr Hughes advised the group that the external urology reviewer is Mr Hugh Gilbert he was nominated by the professional body that gives professional advice.

Dr Hughes explained that the Cancer Nurse Specialist was excluded from these patients care. 9 patients didn't have the supporting link leading to a greater risk of failsafe measures to ensure pathway is adhere to. Dr Hughes said he was not sure why this happened and he doesn't know if all at MDM were aware. He has been told MrO'B didn't refer patients to Cancer Nurse Specialist. He said these patients needed someone to manage their pathway. He advised he believed MDM was not appropriately resourced leading to a resource deficit in the recommendations referring back to the peer review of 2017. He asked if there were any questions.

Mr Glackin advised he was chair of Urology MDM, he took over from MrO'B. He confirmed nurses were excluded from MrO'B's practice. He doesn't believe there is an issue with other doctors.

Dr Hughes confirmed has been speaking to nurses and will be putting recommendations into the report to reflect this. He is not sure why patients didn't have access to Cancer Nurse Specialist which has caused issues in the community.

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.

Mr Glackin suggested TURP's was not a good diagnosis for prostate cancer.

Dr Hughes asked if there were any issues of concern raised outside MDM.

Mr Glackin advised management were aware of no nurses.

Dr Hughes advised he had spoken to AD in CCS who was not aware of issues.

Mr Glackin advised they did bring issues of concern a number of years ago. Their reaction was a shrug of shoulders and said "what do you want us to do".

Dr Hughes said he noted staff at MDM was generally locums and that oncology were not attending.

Mr Glackin said he had suggested suspending the Trust MDM due to attendance.

Dr Hughes advised one of the recommendations would be to provide resources for MDM.

Mr Haynes – AMD. He believes there is an enormous disconnection between services and feels consultants are blamed when they fail but at the same time CCS will take credit when they succeed. He referred to occasions where at MDM meetings issues were bounced back to urology. He asked what they can do.

Dr Hughes advised he attended a meeting and was stunned to hear staff was aware of the issues. He feels it's hard for staff if they feel isolated. He added when the report is complete staff need to feel supported.

Mr Glackin said there was no input from outside of MDM, no support from CCS.

Dr Hughes agrees staff do need support and feels supported to raise concerns. He suggested these concerns need minuted and actions taken. He advised he was going through the process of meeting families which has been quite upsetting to patients and their families.
Dr Hughes asked the meeting if they wanted to meet again or if they wanted to raise concerns directly they could contact him.
He advised he has struggled a little regarding the governance, he feels staff were told to sort out themselves which is not appropriate especially when people are paid. He questioned if there was the same issues in breast screening.

Mr Haynes advised breast screening was under the same remit; the same team CCS and they meet their targets.

Dr Hughes advised 8 or 9 recommendations from MDM were appropriate.
One of the safety checks to oncology, if had oncology been attending patient could have got referred.

Mr Glackin advised they use Belfast MDM. He suggested he doesn't feel comfortable making referrals to oncology. He added this has all been minuted at a governance meeting.

Dr Hughes advised them they focusing on the 9 patients.

Mr Glackin doesn't feel they are addressing any issues.

Dr Hughes suggested the trust needs a forum to address these issues.

Mr Glackin said their workload is another issue which needs to be recognised. He said they are "carrying more than their peers". Pressures causing risk with under resourcing of urologists and Cancer Nurse Specialist.

Dr Hughes agreed and asked to get data, he suggested if workload an issue causing underlying issues.

Mr Haynes advised here there is 1consultant per 90,000 of population, in England it is a lot lower.

Martina Corrigan advised the Western Trust has taken back their referrals from mid-September.

Mr Young advised the change in volume was only recently due to not being able to cope.

Dr Hughes advised he would share the draft report with MDM.

Kate O'Neill CNS advised she was astounded CNS had not been asked or been met with.

Martina Corrigan advised there was a meeting planned for Monday.

Dr Hughes said she had asked Patricia Thompson to speak with staff.

Kate O'Neill has only been made aware of meeting and thought it would have been formal.

Dr Hughes advised the issues were the absence of Cancer Nurse Specialist which was a deficit to the patients.

Kate O'Neill clarified it was not the fault of the nurses.

Dr Hughes agreed and advised when investigating the issues surrounding the Cancer Nurse Specialist he thought it was due to geographical but this was not the issue.

Martina Corrigan advised it was a fast process and the review team had to arrange to meet all the families involved. She advised both her and Patricia Kingsnorth liaised to arrange a meeting with Cancer Nurse Specialists.

Dr Hughes advised he needed to get the background of the cases before meeting with the Cancer Nurse Specialists. He apologised for the confusion and offered to chat more at the meeting arranged for Monday.

Jenny McMahon CNS said their role was central and provides a failsafe process that is benchmarked with other Trusts. She asked if other Trusts have the same issues as the Southern Trust.

Dr Hughes understands nurses meet patients with consultants or contact details are made available. He said one issue highlighted due to COVID was that patients were going to their GP or ED because they wouldn't know what to do. He advised where he worked Specialist Nurses would refer patients to MDM this would give patients better access to care.

Jenny McMahon didn't think it was unique to one consultant and suggested it was a resource issue.

Dr Hughes said it may be an issue and suggested it needs investigated to see if this is the issue. He said they need to know if there is a deficit, adding if the Trust is saying best care for everybody they need to have the resources available.

Dr Hughes asked if they would like him to come back to update them on the progress. He advised he has no involvement in the independent enquiry.

Patricia Kingsnorth advised there was no criticism of Cancer Nurse Specialists; it highlights how important their role is.

Mr Glackin believes it is criticism of other consultants.

Patricia Kingsnorth said it's not criticism just an acknowledgment of urology being under resourced.

Dr Hughes advised he was writing the report based in evidence and the only criticism of the Clinical Lead and Associate Medical Director was not being aware. He added 8 of the 9 recommendations by MDM were fine, but added these recommendations were not actioned. Another issue was patients not being referred back to MDM. He doesn't know if MDM were aware.

Martina Corrigan asked Dr Hughes to clarify was the AD and AMD for CCS.

Dr Hughes confirmed it was for CCS. He said there was an issue, CCS didn't seem to know.

Mr Young said he recalled MrO'B appearing very keen to have Nurse Specialists and was very vocal.

Dr Hughes said MrO'B was chair of the group and was aware of the rationale behind the need for Nurse Specialist. He said there was a clear role for these nurses. He said he needed to clarify if the Nurse Specialist were available or if it was a decision to leave them out, adding patients should have been given a phone number.

Mr Glackin asked from the discussions has anything become apparent from the 9 cases.

Dr Hughes said he was reluctant to add anything into the report that is hearsay.

Mr Glackin clarified the question, is there any need for immediate action.

Dr Hughes said there was a need for enhanced tracking, more oncology input with assurance audits. These need to be put in place. He said if staff feels there is anything else needs to be put in place to let him know, he said the public need to have confidence. The review team need to be able to go back to families and show them it's not the way it was. He highlighted the need for resources. He said there is a need