UROLOGY SERVICES INQUIRY

Note: An addendum to this statement was received by the Inquiry on 5 May 2023 and can be found at WIT-94667 to WIT-94678. Annotated by the Urology Services Inquiry.

USI Ref: Section 21 Notice No. 80 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Vicki Graham

I, Vicki Graham, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

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 or by you, meetings you attended, 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.**

1.1 My first role was as a Cancer Tracker MDT Co-Ordinator from 18.02.2009 – 05.10.2014. My main duties were to proactively track the progress of suspected cancer patients along their pathway from the point of referral to diagnosis and first treatment. I was responsible for the co-ordination of weekly MDT's (Multi-Disciplinary Team Meetings or MDMs as we referred to them). When I commenced this role, and from my recollection my first tumour site to track (suspect/confirmed) was Gynaecology (April 09 – August 09), followed by Lung (July 09 – Sept 09) and Haematology (July

to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

44.1 After reviewing all of my responses, I feel that I have nothing further that I would like to add to my statement that would further assist the Inquiry.

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 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.

Statement of Truth

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

Signed: Vicki Graham

Date: 20/10/2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 80 of 2022

Date of Notice: 23rd September 2022

Addendum Witness Statement of: Ms Vicki Graham

I, Vicki Graham, wish to make amendments and an addition to my response to Section 21 Notice Number 80 of 2022. The amendments are as follows:-

1. At paragraph 1.2 (WIT- 60854), I have stated '*During my time as a Cancer Services Co-Ordinator Band 5 from 06.10.2014 to 09.08.2022 my main duties included supporting the Head of Services and OSL (Operational Support Leads), the performance management and commissioning functions within Cancer, the management of the Service and Budget Agreement (SBA) within Cancer Services and the management of the administrative staff within Cancer Services.'* This should state *'During my time as a Cancer Services Co-Ordinator Band 5 from 06.10.2014 to 09.08.**2020** my main duties included supporting the Head of Services and OSL (Operational Support Leads), the performance management and commissioning functions within Cancer, the management of the Service and Budget Agreement (SBA) within Cancer Services and the management of the administrative staff within Cancer Services'.*

2. At paragraph 7.1 (WIT-6086), I have stated '*Angela Muldrew, Cancer Services Co-Ordinator, would have held these meetings either ad-hocly if something had changed or needed to change following advice from Wendy Clayton/ Sharon Glenny, OSL (Operational Support Lead) to ensure that we were all aware of a change in practice*.' This should state '*Angela Muldrew, Cancer Services Co- Ordinator, would have held these meetings ~~either~~ ad-hocly if something had changed or needed to change*

Urology Services Inquiry

Signed: _Vicki Graham_____

Date: _04/05/2023_____

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

Job Title: Cancer Tracker MDT Co-ordinator Band 4 (Period 18.02.2009 – 05.10.2014)

4.1 The main duties and responsibilities were as listed below:

a) To proactively track the progress of suspected cancer patients along their pathway from the point of referral to diagnosis and first treatment.

b) Responsibility for the co-ordination of weekly MDTs (Multi-Disciplinary Team Meetings), relating to the tumour site I was tracking at that particular time. The tumour sites tracked in the Southern Trust are Gynaecology, Dermatology, Haematology, Breast Urology, Upper GI, Colorectal, Head, Neck, and Lung.

c) My role included attending the meeting for the Tumour site that I was tracking at the time and recording relevant information i.e. attendance record, brief notes of meeting and of any other discussions that took place and making a record of the management plan for each patient discussed to help facilitate the timely provision of care for patients.

d) To collect information relevant to each patient's clinical history from various systems i.e. NIPACS (Radiology System), NIECR (Northern Ireland Electronic Care Record), PAS (Patient Administration System) and to record this information into the CaPPs system (Cancer and Patient Pathway System) so that all relevant, and up to date information was available for discussion at the MDT.

Cancer Tracker / MDM Responsibilities

The Cancer Tracker has a pivotal role in ensuring the patients on the 31 and 62 day cancer pathways are fast tracked through all the above milestones, escalated and discussed at MDMs. Below is a list of the Cancer Tracker / MDM Co-ordinators core responsibilities:

- prospectively track all patients with cancer or suspected cancer in achieving the regional cancer access targets
- ensuring that all patients with cancer or suspected cancer have pre booked appointments and treatment in line with cancer access targets, and to raise delays with the MDT.
- ensuring all cancer patients are discussed at the MDT meeting
- ensuring all MDM management plans have been signed-off as being a correct record of the meeting's discussion. (This forms the main body of the MDT letter to GP)
- recording the MDT attendance for every meeting.
- adding any patient on the MDT list not discussed to the following week's list.
- For maintaining timely and accurate data collection, within CaPPs

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CANCER PERFORMANCE BRIEFING PAPER
December 2015

Introduction

The cancer access waiting times standards were implemented by the Department of Health in September 2005. The purpose of the waiting times was to ensure that patients presenting to their GP with symptoms suggestive of cancer or diagnosed to have cancer as an incidental finding or through the screening programmes were dealt with within the secondary care system along regionally agreed specific pathways. The Southern Health and Social Care Trust (SHSCT) is responsible for achieving 3 cancer access PfA targets plus an intra-trust transfer time of 28 days for those patients who will receive their first definitive treatment from the Belfast Health & Social care Trust :

- Suspected Breast Cancer Referrals – 100% to be seen within 14 days (commenced 2001)
- By March 2008 75% of GP suspected cancer referrals to be diagnosed and commence treatment within 62 days – to increase to 95% by March 2009 (Appendix 1)
- By March 2008 98% of patients diagnosed with cancer should begin treatment within 31 days of the decision to treat date.

Cancer services within SHSCT are provided for patients across sites, primarily Craigavon Area Hospital and Daisy Hill Hospital. Patients may be referred to Consultants/Specialties for example Breast, Lung, ENT, Haematology, Radiology and others. Co-ordination and centralisation of patient pathways and processes is essential to achieve the ministerial targets. Central to the success of managing the patients along the pathways and achieving the cancer access targets is the tracking/administrative function. This remainder of this briefing paper describes the ongoing and increasing risks and challenges associated with achieving the required cancer targets from the tracking perspective.

Modes of Referral rates

Receipt of Red Flags

In order for the Trust to meet the cancer access targets suspected cancer referrals have been categorised as being 'red flags' (RF). There are 2 main ways in which the Trust receives RFs:

1. Suspected cancer referrals (Red flag) are referred by GPs using the NICaN referral guidelines. The referrals are to be faxed to the 'red flag' central access referral fax machines (based in Daisy Hill Hospital and Craigavon Hospital).
   - **CAH Red Flag fax number:** Personal Information redacted by USI
   - **DHH Red Flag fax number:** Personal Information redacted by USI

   Or alternatively, referrals are received electronically via CCG (Clinical Communication Gateway)

2. General referrals from GPs to the acute Trust services have been centralised to a single referral and booking centre based at the Craigavon Hospital site, which can be triaged and upgraded to a RF by secondary care consultant

In order to ensure that patients are appointed and move to investigations and treatment as quickly as possible, a designated Cancer Tracking Team has been established. This

NI Tumour specific Cancer Waiting Times (CWTs) Guidance

Status: Draft

Version History
2nd Consultation: 1st April – 30th April 2015
1st Consultation: 21st November 2014 – 4th January 2015

Purpose:
This guidance provides supplementary tumour specific information to sections 4.11 – 4.26 of the NI Cancer Access Standards – A Guide, DHSSPS, 2008

Related Guidance:
This technical guidance should be viewed as supplementary guidance to the following document

- **HSCB PAS Technical Guidance for Recording Cancer Related Information issued March 2015**

11. Urological cancers (bladder, prostate, renal, testicular, upper tract transitional cell)

Patients included in /excluded from cancer waits
What cancers are included in/excluded from the cancer waits standards?

In Scope:

- ICD10 Codes: C66-C67 [Bladder]
- ICD10 Code: C61 [Prostate]
- ICD10 Codes: C64-C65 [Renal/Kidney]
- ICD10 Code: C60 [Penile]
- ICD10 Code: C62 [Testicular]
- ICD10 Code: C65-66 [Upper tract transitional cell carcinoma (renal pelvis or ureter)]

Out of Scope:

- pTa – transitional call carcinoma as regarded as non invasive [Bladder]

Treatments/Subsequent Treatments
What cannot be classed as first treatment for urological cancers (ie. ending the 62 day pathway)

- surgical biopsy for diagnostic purposes (unless the tumour is effectively removed by the procedure)
- palliative care for any patient who is fit for active treatment (unless they decline active treatment options and wish to have only palliative treatment)

Bladder
Can Transurethral resection (TUR) biopsy of a bladder be classed as first treatment?
Not unless the excised tissue was found to be malignant and the tumour had effectively been removed by the excision irrespective of whether the margins were clear

Prostate
Can PSA monitoring prior to diagnosis of prostate cancer be counted as first treatment?
In this scenario the patient has not received a confirmed diagnosis of cancer so active monitoring via PSA monitoring would not be a treatment option.

Prostate
Would TURP (TransUrethral Resection of the Prostate) be classed as a first treatment?
TURP can be classed as first treatment if performed to de-bulk a tumour or if carried out for benign disease and cancer is found incidentally and has, in effect, been treated by the TURP.

Could PSA monitoring prior to diagnosis of prostate cancer be counted as first treatment? repeat
No. If a patient has yet to have a prostate cancer diagnosis but is having repeat PSA then this is a case of clinical uncertainty and the PSA testing does not end a 62 day pathway.

When can active surveillance/monitoring be classed as a first treatment for prostate cancer?

Cancer Pathway Escalation Policy

1.0 Background

This policy is to inform Cancer Tracker/ Multi-Disciplinary Team (MDT) Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 100% date decision to treat to first definitive treatment
62 days – 98% date of receipt of referral to first definitive treatment

The purpose of this policy to illustrate the actions that may be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point. (Please see Table 1)

2.0 General Principles of Escalation

General principles of escalation are as follows:

(a) The earlier the better.
It is easier to stand people down once the problem is resolved than to catch up lost time
(b) Try everything you know to resolve the problem
(c) Recognise that you can't solve all of the problems – but by escalating it will give others a chance to help find a solution.
(d) Record on the escalation proforma the steps you have taken
(e) Take action in a timely manner
Be clear of the timescale of escalation
If a response is not received from Consultant/Clinician within outlined timescale for escalation the relevant Chair of the MDT is to be notified.

3.0 Trigger Points for Escalation

For a patient to progress along the pathway, the Cancer Trackers will start the tracking process and be responsible for escalations throughout the pathway. In order for the Trackers to track they have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility. While the Red Flag Appointments Team will escalate patients outside of expected 1st appointment timescales, the tracker will track the full cancer pathway.

In the event of delays in the patient pathway, as detailed in Appendix 1, the tracker will escalate to the Cancer Services Co-ordinator (CSC) or in her absence the Operational Support lead (OSL), who will in turn advise the Head of Cancer Service. The CSC will advise the relevant Head of Service (HOS) /OSL for that specialty, of any actions required to be taken or ongoing delays.

The HOS/OSL for the specialty will escalate patients who trigger key points on the pathways to the relevant Assistant Directors and Clinical leads as required.

Please see below escalations for your information.

Regards,

Vicki

From: rf.appointment
Sent: 24 December 2015 13:21
To: Graham, Vicki
Subject: UROLOGY ESCALATIONS

Hi Vicki the following patients are going to breach their first appointment deadline:

Personal Information redacted by USI
Personal Information redacted by USI
DNA'd appointment on 14.12.15 booked to CDMHTDU 06.01.15 (HAEMATURIA) D23
booked to CMDHTDU 06.01.15 D19

Regards Caroline

Red Flag Appointments.

Personal Information redacted by USI

DRAFT 10 – 2 January 2008

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

NORTHERN IRELAND CANCER ACCESS STANDARDS – A GUIDE

CONTENTS

Introduction

1. The NI Cancer Control Programme was published in November 2006. Within the Strategy there is a commitment to ensuring the timeliness of referral, diagnosis and treatment for suspected cancer patients. This document provides answers to some frequently asked questions about cancer access standards

- **2007/08 - '98% of patients diagnosed with cancer (decision to treat) should begin their treatment within a maximum of 31 days'**

- **2007/08 - '75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days. Where the performance of a tumour group currently exceeds this standard, performance should be sustained or improved against current levels'**

- **2008/09 - '95% of patients urgently referred as a suspected cancer should begin their first definitive treatment within a maximum of 62 days'.**

In addition there is also the existing two week waiting time standard for breast cancer patients:

- Maximum two week wait for referral for suspected breast cancer to date first seen from 1st August 2000.

This has been reinforced in Priorities for Action 2007/08.

- **"All breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within two weeks of the receipt of the GP referral"**

2. All these targets are being monitored through a regional cancer waiting times database tool offered to Trusts. The core data requirements will be circulated during December 2006.

4.3 The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control), which should be recorded for these purposes. In more detail:

First definitive treatment type	**Circumstances where this applies**
Surgery	♦ Complete excision of a tumour ♦ Partial excision/debulking of a tumour (but not just a biopsy for diagnostic or staging purposes) ♦ Palliative interventions (e.g. formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis)
Drug treatment: Chemotherapy, *Biological therapy*[+] OR Hormone therapy	♦ Chemotherapy (including cases where this is being given prior to planned surgery or radiotherapy)
	♦ Biological therapy includes treatments targeted against a specific molecular abnormality in the cancer cell (e.g. rituximab, trastusumab, glivec) and treatments which target the immune system (e.g. interferon, interleukin 2, BCG).
	♦ Hormone Treatments should count as first definitive treatment in two circumstances (1) Where hormone treatment is being given as the sole treatment modal ity (2) Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may for example be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy.
Radiotherapy	♦ Given either to the primary site or to treat metastatic disease. This should include cases where radiotherapy is being given prior to planned surgery or chemotherapy.
Specialist Palliative Care (SPC)	♦ Given via hospital SPC teams ♦ Given via community SPC teams ♦ Given via hospices (if known by the Trust)
Active monitoring	♦ When none of the other defined treatment types apply and the patient is receiving symptomatic support and is being monitored. The date of commencement of active monitoring should be the consultation date on which this plan of care is agreed with the patient, including the intervals between assessments (e.g. serial PSA measurements for prostate patients). This treatment type may be used for any tumour site if appropriate. ♦ For the purposes of waiting times the field active monitoring should also be used to record patients with advanced cancer who require general palliative care.

[+]*Biological therapy – For the purposes of the performance monitoring Biological Therapy should be recorded as "chemotherapy" in the field PLANNED CANCER TREATMENT TYPE as defined in Core Data Definitions document.*

Graph/Table 1 illustrates the referral pattern for all tumours per month

Table 1a
62 Day Suspect Referrals

	April	May	June	July	August	September	October	November	December	January	February	March	Total 62-day referrals	% increase
2008/09	8	15	17	34	44	261	577	412	378	373	536	437	**3,092**	
2009/10	550	604	653	555	577	515	583	550	472	507	573	485	**6,624**	114.2%
2010/11	587	594	728	622	662	746	667	646	473	670	728	599	**7,722**	16.6%
2011/12	677	649	740	630	632	751	669	645	547	681	737	655	**8,013**	3.8%
2012/13	635	733	684	700	778	770	865	814	621	823	801	861	**9,085**	13.4%
2013/14	766	865	856	874	815	874	944	905	821	967	829	1,079	**10,595**	16.6%
2014/15	844	925	1,080	1,000	922	1,068	1,067	1,013	944	1,027	1,193	1,019	**12,102**	14.2%
201516	1,096	1,022	1,333	1,204	1,080	1043							13556	12.0%

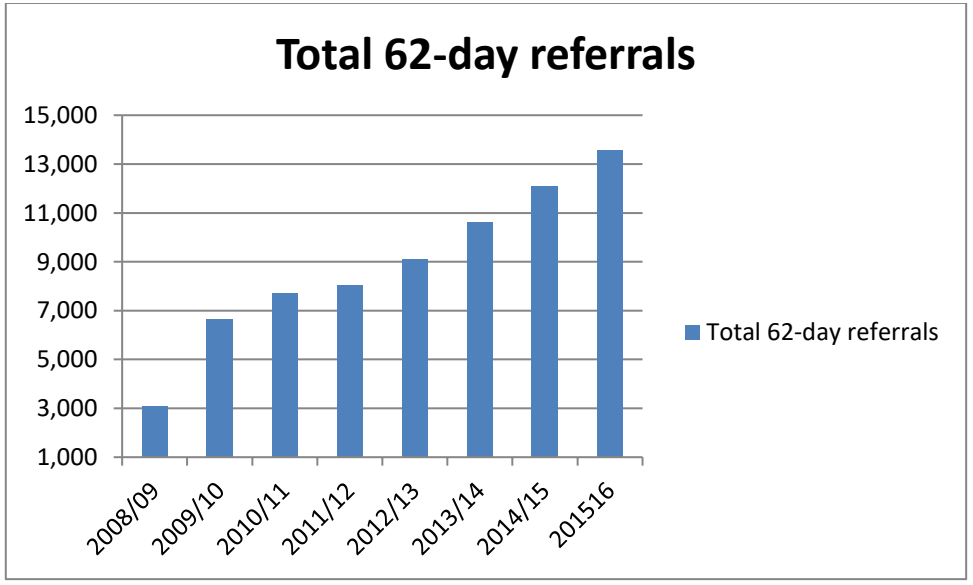
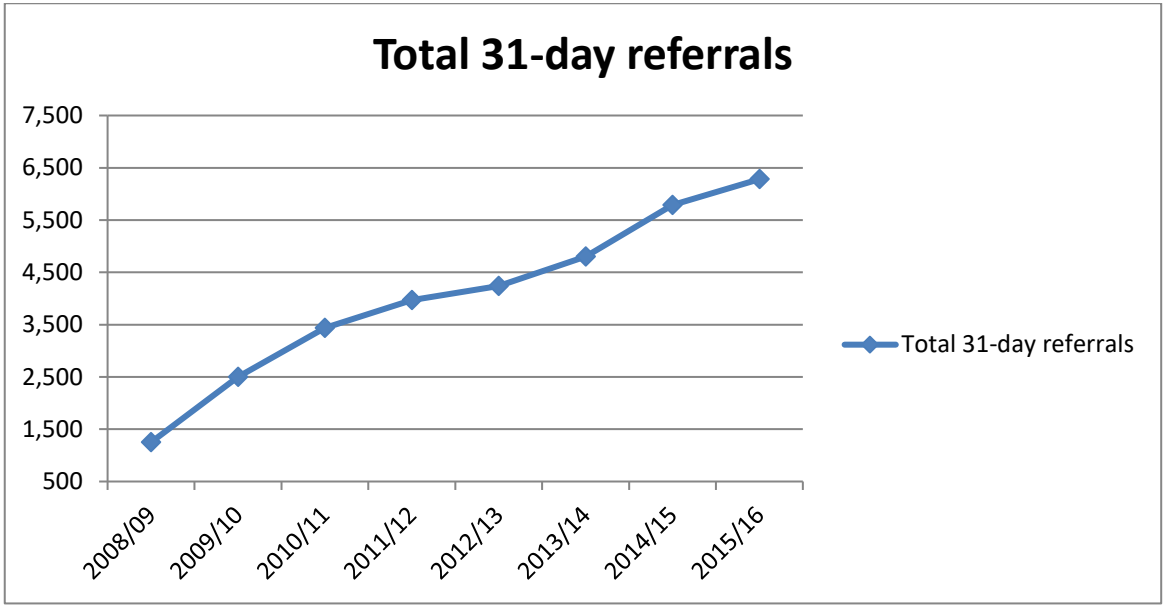


Table 1b
31 Day Suspect Referrals

	April	May	June	July	August	Sept	Oct	Nov	Dec	January	Feb	March	Total 31-day referrals	% increase
2008/09	12	26	32	44	43	70	142	169	140	185	204	183	1,250	
2009/10	147	159	223	161	221	254	265	227	211	225	225	179	2,497	99.8%
2010/11	265	238	281	285	245	305	306	309	261	300	342	298	3,435	37.6%
2011/12	290	325	350	297	311	359	324	337	318	338	342	381	3,972	15.6%
2012/13	309	454	358	338	329	376	334	316	306	381	349	387	4,237	6.7%
2013/14	343	383	395	398	396	387	456	412	413	393	376	448	4,800	13.3%
2014/15	392	436	478	520	399	523	553	494	459	489	548	498	5,789	20.6%
2015/16	543	479	609	491	521	498							6282	8.5%



Graham, Vicki

From: Graham, Vicki [redacted]
Sent: 03 September 2019 14:43
To: Glenny, Sharon
Subject: RE: Tracking Update W/E 30.08.19

Importance: High

Hi Sharon

Just wondering if an email has been sent out to the HoS's and AD's advising of current situation with tracking. I am just very worried about some sites, especially LGI as it has not hit over 1000+ patients – I never remember it as big as this, and skin is now up at 443, with Urology and UGI also in the 400's - these numbers are huge.

Many thanks,
Vicki

From: Graham, Vicki
Sent: 02 September 2019 16:29
To: Glenny, Sharon; Reddick, Fiona
Subject: RE: Tracking Update W/E 30.08.19
Importance: High

Afternoon,

Please see below tracking update as of Friday 30.08.19. The tracking team remain under a lot of pressure due to on-going sick and annual leave in the team. This has resulted in a lot of cross cover, with the focus solely being on MDM prep and then attending the MDM's and the MDM outcomes. Below is a rough guide as to where we are at now. No site at present is really fully up to date. Unfortunately I have no other staff members from any areas that could help out due to not being trained in this area. The tracker team as a whole is a risk area. This could impact on performance further as tracking will not be up to date.

Sick Leave – Personal Information redacted by the USI remains on sick leave, and her sick line is dated up until 16.09.19. Personal Information redacted by the USI returned from sick leave on Thursday 29.08.19.

Tracker MDT cover for over the next few weeks.

Day		Meeting to be covered	Cover	Comment
Monday	02/09/2019			Ann, Hilda & Sarah A/L - Personal Information redacted by sick
Tuesday	03/09/2019			Ann & Hilda A/L - Personal Information redacted by the USI
Wednesday	04/09/2019			Hilda A/L - Personal Information redacted by the USI
Thursday	05/09/2019	UGI & LGI	Wendy	Hilda & Shauna A/L - Personal Information redacted by the USI
Thursday	05/09/2019	Skin	Sarah	Hilda & Shauna A/L - Personal Information redacted by the USI
Thursday	05/09/2019	Urology	Sinead	Hilda & Shauna A/L - Personal Information redacted by the USI
Friday	06/09/2019			Hilda & Shauna A/L - Personal Information redacted by the USI
Monday	09/09/2019			Personal Information redacted by the USI
Tuesday	10/09/2019			
Wednesday	11/09/2019			
Thursday	12/09/2019	Skin	Sarah	
Friday	13/09/2019			
Monday	16/09/2019			Personal Information redacted by the USI &Wendy A/L
Tuesday	17/09/2019	Gynae		Wendy A/L
Wednesday	18/09/2019			Wendy A/L
Thursday	19/09/2019			Wendy A/L
Friday	20/09/2019			Wendy A/L

Tracking Update as of 02.09.19 as per tracking team.

Marie – Head & Neck – ENT - Tracking - About 60% up to date. Notifications – 5.5 pages to do.

Graham, Vicki

From: Muldrew, Angela [redacted]
Sent: 03 June 2016 11:37
To: Graham, Vicki
Subject: RE: Update from 1-1 yesterday

Come on down now

Angela Muldrew
RISOH Implementation Officer
Cancer Services
Tel. No. [redacted]

From: Graham, Vicki
Sent: 03 June 2016 11:37
To: Muldrew, Angela
Subject: RE: Update from 1-1 yesterday

Thanks Angela,

Yes I will call down surely and thanks for being so understanding I am just being honest, what time suits?

From: Muldrew, Angela
Sent: 03 June 2016 11:35
To: Graham, Vicki
Subject: RE: Update from 1-1 yesterday

Hi Vicki

I am glad that you have been honest and let me know how you are feeling. I completely understand how you are feeling like this as you have so much going on and so much is being expected of you at the minute. You were there to support me when I felt like this and I will certainly be there for you. You are definitely not failing as a manager & I do not think you are being awkward. Will you call down and see me to talk through this

Thanks

Angela Muldrew
RISOH Implementation Officer
Cancer Services
Tel. No. [redacted]

From: Graham, Vicki
Sent: 03 June 2016 10:40
To: Muldrew, Angela; Glenny, Sharon
Subject: Update from 1-1 yesterday
Importance: High

Hi Angela/Sharon

At the meeting when we were discussing the current situation I tried to explain that I have been feeling under extreme pressure due to the last few weeks, and found myself getting a bit teary, to the point where I feel I can no longer continue to do all that I have been doing. I know that the last few weeks have been very difficult and trying for everyone, and I am grateful for all the help and support, but I always say to the trackers to let me know if they

EXTERNAL VERIFICATION REPORT NICaN 2017

Organisation	Southern HSCT	
Team	Urology MDT	
Self-Assessment Compliance	70%	
Report Completed By	Clare Langslow	
Job Title	Interim Senior Quality Manager	
Date Completed	03 October 2017	
EV RAG rating (and EV % compliance)	**Red**	65%
Recommended Action for 2018	Repeat SA	

Structure and Function

EV comments

Core membership is complete although the named clinical oncologist is a locum. There is no cover for the oncologist or the radiologist.

Individual attendance of the surgeons, histopathologist and CNS is good. The greatest challenge for the MDT during the past year remains the inability to have a clinical oncologist and or radiologist at the MDT meetings. This is due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the posts where they are required both in the Trust and regionally. This has been escalated to trust senior management team and is being addressed with the appointment authorities.

With radiologists missing from 23 meetings and oncology from 35 meetings, only five MDT meetings were quorate in 2016 and this is a discernible deterioration from previous year's attendance. This raises concerns over the multidisciplinary discussion and decision making process at the MDT and by implication discussion and decisions must take place outside of the MDT meetings.

SA not agreed

Co-ordination of Care/Patient Pathways

EV comments

Network guidelines and pathways being followed. Nephron sparing surgery is no longer being undertaken locally as one of the SHSCT surgeons is providing support and undertakes nephron sparing surgery at Belfast City Hospital.

SA Agreed

Patient Experience

EV comments

As well as acting on the results of the national survey in 2015, a local patient survey was undertaken in 2016. Response rates were overall complimentary of the service provided. Results have been reviewed and discussed at an operational meeting and an action plan developed to address areas of weakness.

SA Agreed

Clinical Outcomes/Indicators

EV comments

Audit activity has been reviewed and two audits were presented in 2016; Audit on Bladder Cancer Access Standards for non-superficial disease and an Audit of Nurse Provided TRUS Biopsy Service in 2016.

Data was also submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database.

Urology clinical research activity is limited due to limited attendance of the clinical oncologist at the MDT meetings. 16 patients were recruited to trials in 2016.

Trust performance on the 62 day cancer waiting times targets was below the 95% required. The table in the annual report contained formatting errors in the total number of patient on the pathway. Verification showed that 81% of patients were treated within the target.

SA Agreed

Communications

EV comments

The consultant radiologist needs to undertake Advanced Communications Skills training as must be undertaking interventional procedures.

SA Agreed

Concerns raised at SA 2017

Immediate Risk at SA

None identified

Serious Concerns at SA

Identified: Yes

Updates on previous SCs raised, see below.

Not all Resolved

Risks raised at Peer Review Visit 2015 Resolved?

Immediate Risk

None identified.

Serious Concerns

1. There is now a single handed radiologist supporting the Urology MDT with no cover arrangements in place. Attendance at the MDT during 2015 is not consistent due to clinical commitments in order to deliver timely waits for patients. This could adversely affect the treatment planning decisions for patients.

Urology Services Inquiry

62 Day Cancer Performance Target = 95% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	83.93%	81.91%
2017/2018	74.29%	58.43%
2018/2019	74.33%	54.41%
2019/2020	65.92%	41.59%
2020/2021	60.75%	32.10%
2021/2022	49.75%	27.13%

31 Day Cancer Performance Target = 98% (Red denotes breach of target)		
Fiscal Year	Trust	Urology
2016/2017	99.00%	100.00%
2017/2018	97.14%	99.70%
2018/2019	99.50%	99.41%
2019/2020	98.17%	98.93%
2020/2021	92.42%	94.65%
2021/2022	85.67%	97.81%

10.10 Up until 4th January 2022, the Cancer Services Co-Ordinator was responsible for escalating all delays on the cancer pathway including first red flag appointments, delays with diagnostics, delays with first definitive treatment. When I came into post on 1st April 2016 the Cancer Services Co-Ordinator was Vicki Graham (to 9th August 2020), Sinead Lee (10th August 2020 to 25th October 2020 (temp)), Ciaran McCann (26th October 2020 to 31st March 2021 (temp)) and Sinead Lee (1st April 2021 to date). These escalations were sent to the Operational HOS who was charged with directing steps to address the concerns. However, it is recognised that at times minimal action could be taken due to ongoing capacity and demand difficulties within specific tumour sites, including urology With reference to Urology, there have been capacity and demand difficulties across the whole cancer pathway throughout my tenure as OSL for CCS, including delays with first appointment, delays with diagnostics i.e MRI, PET scan (Regional service provided in Belfast) and flexible cystoscopy, Transperineal (TP) biopsy, and delays with surgery. The actions that have been taken by HOS, including urology, around escalations of patients on cancer pathways include:

a) Increasing red flag out-patient capacity on clinic templates
b) Offering in-house additionality to increase overall out-patient capacity
c) Working with other Trusts to equalise waiting times, in particular for transperineal biopsy
d) Securing Independent Sector capacity in relation to out-patient capacity and flexible cystoscopy

Corrigan, Martina

From: Corrigan, Martina
Sent: 18 December 2014 10:36
To: Graham, Vicki
Cc: Glenny, Sharon; Davies, CarolineL
Subject: RE: UROLOGY REFERRALS THAT ARE STILL MISSING

Hi

I note that all of these patients have a date or plan except for [redacted]?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Graham, Vicki
Sent: 15 December 2014 15:20
To: Corrigan, Martina
Cc: Glenny, Sharon; Davies, Caroline L
Subject: FW: UROLOGY REFERRALS THAT ARE STILL MISSING
Importance: High

Martina,

Please see below patients who will not be seen by Day 14 due to referrals going missing the week that Mr O'Brien was triaging. I will ask Caroline to request these from GP surgery – should these be booked directly into next available or should these be sent to triage?

Many thanks,

Vicki

From: Davies, Caroline L
Sent: 15 December 2014 14:35
To: Graham, Vicki
Subject: UROLOGY REFERRALS THAT ARE STILL MISSING

Hi Vicki I have just been going through my Urology referrals and I had thought I had got all my referrals back on Friday but the 12 referrals below are still outstanding:

[redacted]

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

08/12/2014

09/12/2014

THORNDALE

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

PROSTATE

08/12/2014

09/12/2014

THORNDALE

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

PSA

08/12/2014

09/12/2014

THORNDALE

Personal Information redacted by USI

Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 19 January 2015 13:50
To: Graham, Vicki
Subject: RE: Missing urology referrals - Escalations

Vicki

I have emailed Mr O'Brien and I would assume that he is sorting but I will let you know

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Graham, Vicki
Sent: 19 January 2015 13:42
To: Corrigan, Martina
Subject: FW: Missing urology referrals - Escalations
Importance: High

Martina,

Please see below urology referrals that are outstanding. Do you think that it is safe to assume that Mr O'Brien has referrals and that we leave these until he gives referrals back?

Thanks,

Vicki Graham
Cancer Services Co-ordinator
Mandeville Unit
Personal Information redacted by USI
Email – Personal Information redacted by USI

From: Davies, Caroline L
Sent: 19 January 2015 10:24
To: Graham, Vicki
Subject: missing urology referrals

Hi Vicki just to let you know I am still missing these referrals now on d10/11. Mr O'Brien was on triage so I think he must still have them. There is nothing requested on Sectra for any of them except Personal Information redacted by USI and there are no appointments or TCI dates on PAS. Went to the Thiorndale unit this morning to see if they were there but they weren't.

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

TESTICULAR (AE REF)

08/01/2015

08/01/2015

A&E REFERRAL

Us testes 12.01.15

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

08/01/2015

08/01/2015

GP

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

UROLOGY

PROSTATE

08/01/2015

09/01/2015

GP

Personal Information redacted by USI

Personal Information redacted by USI

Clayton, Wendy

From: Clayton, Wendy
Sent: 14 May 2015 17:01
To: Graham, Vicki
Cc: Corrigan, Martina; Reddick, Fiona; Carroll, Ronan
Subject: AOB triage next week

Vicki

Martina has just advised that it is Mr O'Brien's turn to triage the RF urology referrals next week. If there is any delays with triage can you highlight to Martina within 48 hours and she will raise directly with Mr O'Brien.

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: Personal Information redacted by USI
Mob: Personal Information redacted by USI

Corrigan, Martina

From: Graham, Vicki [redacted]
Sent: 12 October 2018 09:53
To: ODonoghue, JohnP; Young, Michael; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Jacob, Thomas
Subject: FW: REFS FOR TRIAGE

Importance: High

Hi

I have been advised that there a quite a few Red Flag urology referrals on NIECR to be triaged, dating back to 4th October (36 in total) . Could these please be triaged ? There are also 10 OC referrals round in the Thorndale unit that also need to be triaged.

Many thanks

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT [redacted]

Importance: High

Wendy

We have still not been able to get an outcome for this patient can you please escalate to Martina & Sharon

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. Personal Information redacted by USI
From: Montgomery, Angela
Sent: 29 November 2011 12:52
To: Cunningham, Andrea Personal Information redacted by USI
Cc: Graham, Vicki
Subject: FW: Urology escalation- Personal Information redacted by USI
Importance: High

Hi Andrea

Personal Information redacted by USI attended Mr O'Brien's clinic on 18/11/11 but Vicki has been unable to get an outcome from this appointment as she cannot locate the chart. Can you please see if you could get us an outcome?

Vicki has advised that she has problems getting outcomes for patients who attend a day 4 clinic with Mr O'Brien as he takes the charts away with him and no one knows where he takes them to. Can you please raise this issue with Martina & Mr O'Brien.

Thanks

Angela

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. Personal Information redacted by USI

Angela Kerr

From: Graham, Vicki [redacted]
Sent: 07 March 2014 15:28
To: O'Brien, Aidan
Subject: [redacted] SWAH clinic

Importance: High

Mr O'Brien,

[redacted] was reviewed by yourself @ SWAH on 23.12.13- I have had no joy in getting an outcome. Could you provide me with management plan or advise if she can be removed from Capps? No further investigations have been requested.

Regards,

Vicki

Urology Cancer Tracker/MDT Co-Ordinator
[redacted]
Direct line [redacted]

v) Prescription of drugs – N/A

24.9 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

vi) Administration of drugs

24.10 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

vii) Private patient booking

24.11 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs

24.12 I attended these meetings on a weekly basis, as I was the Urology Cancer Tracker. It was my responsibility to compile the list of patients for discussion at the meeting, updating clinical information, Consultant, diagnostics to date, pathology results etc. I would have printed out paper copies for those in attendance. I updated this information into the CaPPs system, which I emailed out to the attendees of the meeting the day prior to the meeting to allow time for Consultant Urologists, Consultant Radiologists, Consultant Pathologists, and Consultant Oncologists to preview patients prior to discussion. I displayed the CaPPS System via a projector so that everyone who attended could clearly see what patient was being discussed. The Radiologist would also have been displaying radiology imaging relevant to that patient. I would have updated the management plan for each patient, during the MDM; this would have been a draft version, with the final version completed after the MDM, which was read over and checked by the chair or the MDM. Once the final version was signed by the Chair, I would have verified the letter on the CaPPs relating to that particular discussion (This process was completed by ticking a verified button aligned to each MDT discussion if there was more than one, as some patients would have had multiple MDT discussions). Once this letter was signed it was our governance check that the management plan was accurate. Once verified on CaPPs the letter would automatically upload onto NIECR making it instantly viewable by Consultants or GPs. The Cancer

Southern Health and Social Care Trust

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DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Urology Multi-disciplinary Administrative Process	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Vicki Graham	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by: OSL's**
Approved by		

Urology Multi-disciplinary Meeting (MDM) Administrative Process

The Breast MDM is held every Thursday at 2.15 pm in Tutorial Room 1, Medical Education Centre. The meeting membership consists of:

Consultant Urologist
Consultant Oncologists
Consultant Radiologists
Associate Specialists
Consultant Pathologist
Specialist Urology Nurse
GP with specialist interest
Palliative Care Nurse
MDT Co-Ordinator

It is the responsibility of the MDM Co-ordinator to undertake the following tasks to ensure the efficient and smooth running of the meeting:

Patients listed for MDM

There are 6 methods of patients being added to the Urology MDM:

1) Prostate Assessment Clinic: Kate O'Neill, Urology Nurse Specialist e-mails me through a list in advance of planned biopsies and details are added onto Capps if not a 62 day patient. I also receive a confirmation of biopsies performed on the day. Patients are then added to the correct MDM and pathology discussed.

2) Tracking: Whilst updating tracking if there are any patients who have had investigations performed and tracker is unsure of results, or if results are reported and are not normal name is added to MDT to clarify further management.

3) Haematuria clinic DHH: Clinic outcome from haematuria clinic are e-mailed through to tracker. This informs tracker if patient is being discharged or requires further investigations and if patient is needed to be discussed @ MDM.

4) Secretaries/ Audio typist: If typing up a clinic and Doctor has requested for case to be discussed @ MDM, the letter is either e-mailed or posted via internal mail to tracker. Information is then updated onto CaPPs so all relevant information is available for discussion.

5) Surgery lists: Paulette (Mr Young's Secretary) e-mails Tracker through a copy of the scheduled theatre list. This allows tracker to check and add any confirmed cases. Tracker is not included in any other Consultants Theatre list distribution list.
6) Consultants: To discuss change of management plans, results, radiology etc.

7) Mr O'Brien leaves down with Tracker all patient's with updated narrative on patients that he would like discussed. All information is to be copied onto Capps. (Narratives can be quite lengthy)

8) Radiology:-Tracker can be advised of radiology results and details are added so case can be discussed @ MDM as most of these tend to be incidental findings.

9) Cases that are deferred from the previous week's MDM.

Administrative process before MDM

1. Copy of the patient list emailed to Urology Distribution list on the Wednesday at 1.00pm. Cut off time for adding patients to MDM is Tuesday lunch time. Copy list of MDM patients is given to Band 2 to allow time for tracking and requesting charts.

2. List of patients who have to be discussed for radiology results is emailed to Radiologist including clinical background on the patient & why they need discussed. MDM Co-ordinator has a copy of Radiology rota & sends this email to whichever radiologist was on the Assessment clinic that week.

3. On Wednesday, the day before the MDM, Mr O'Brien has requested an MDM update report on every patient and pathology printed out and put into a folder to allow time for preparation prior to the meeting. Tracker prints off the individual MDM update.

4. 8 copies of the patient list are printed off prior to the MDM meeting. (Band 3 when available)

5. Band 2 pulls charts & tracks charts prior to MDM.

6. MDM Co-ordinator goes to Tutorial Room 1 MEC

Administrative process after MDM

1. Go through histopathology & radiological reports for each patient & type results into MDM outcome if these were not available prior to MDM.

2. Update MDM outcomes that has been dictated verbally and hand written down during MDM Copy all MDM discussions into diary.

3. Create Letters & MDM reports.

4. E-mail each Secretary each individual patient's MDM outcome if patient is to be reviewed, added to W/L etc. and advise them what is to be actioned following MDM.

   Mr Glackin: Liz Troughton EXT Personal Information redacted by USI
   Mr Young: Paulette Dignam EXT Personal Information redacted by USI
   Mr O'Brien: Monica McCorry EXT Personal Information redacted by USI

   E-Mail Leanne Hanvey, Urology Specialist Nurse Secretary any patient's names that require Day4 appointments. Leanne EXT Personal Information redacted by USI

   E-mail all DHH outcomes individually to Mr Brown's Secretary, Joanne Brown & advise of what is to be actioned post MDM.

   If there are any ward histologies to be cancelled / appointed I e-mail Sharon McDermott, Ward Clerk in 3ESU.

Southern Health and Social Care Trust

Operational Policy
Urology Cancer Service

MDT Clinical Lead	**Mr. A. O'Brien**
Clinical Director of Cancer Services	**Dr. R. Convery**
Trust Cancer Executive Lead	**Mrs. E. Gishkori**

April 2015

Updated September 2016

In the case of referral of a patient for MDM discussion by a radiologist or histopathologist, the MDM co-ordinator will request the Consultant Urologist who may have already cared for the patient to provide a clinical summary, or the Chair of the MDM to provide a clinical summary if the patient is new to the Urological Service.

It is also the responsibility of clinicians to provide appropriate textual updates to the MDT Co-ordinator at significant junctures in patients' assessments and management, such as when treatment is initiated or when referral for treatment has been made. In particular, it is the responsibility of urological surgeons to provide dated, succinct, textual descriptions of operative findings and procedures.

It is the responsibility of the MDT Co-ordinator to ensure that patients have been given appointments for investigations at appropriate times, and to schedule those patients for MDM discussion as previously agreed. It is the responsibility of the MDM Co-ordinator to upload on CaPPS the reports of those investigations, such as radiological and histopathological reports.

When all such information, provided in appropriate format, has been uploaded onto CaPPS, it is the responsibility of the MDT Co-ordinator to disseminate the uploaded information to all MDT members one day prior to each MDM so that optimal preparation can be undertaken.

It is also the policy of the Urology MDT that the MDT Co-ordinator will identify those patients who are furthest along on their timed pathway and at greatest risk of breaching. The identity of these patients is also disseminated one day prior to each MDM so that plans for their further management can be scheduled by the responsible urological surgeon and notified to the MDT at the commencement of each MDM.

9.3 Chairing of Meetings

The chairing of MDMs has been shared by Mr. O'Brien, Mr. Glackin and Mr. Haynes on a rotational basis. Mr. O'Donoghue will join in chairing on a rotational basis during 2016. The person appointed to chair each MDM is decided at least one month

the need for Holistic Needs Assessment, or provision for needs if an Assessment has already been conducted and needs identified.

9.6 MDM Documentation 14-2G-104

It is the responsibility of the MDM Co-ordinator to make a documentary record of the MDM, including a record of attendance, and it is the responsibility of the Chair to approve that record.

It is the responsibility of both the MDM Chair and the MDT Co-ordinator to ensure the accuracy of the completed textual record of Clinical Summaries, Updates and MDM Plans of all patients discussed at the MDM, and so that the documentation, in correspondence format, may be sent without delay to Family Doctors and to other clinicians to whom it had been agreed patients would be referred.

9.7 Protocol for Patient Management between Meetings

Whilst the purpose of a MDT discussing the assessment and management of patients at weekly MDMs is to ensure that both have been discussed and optimised in a considered manner, there will be occasions when the assessment and / or management of a patient cannot be deferred until the next MDM. It does remain the right and the responsibility of clinicians to ensure that deferral does not contravene the patient's best interest and outcome. In such cases, it is the Policy of the MDT to recommend that assessment and management of such patients in such circumstances be advanced in consultation with other MDT members, and on condition that the patient will be discussed at the next scheduled MDM.

9.8 Virtual MDM

In more recent years, the numbers of patients discussed at each MDM has increased. It has been necessary to limit the number discussed at each meeting to 40 in order to ensure and maintain the quality of discussion of each patient. On occasion when it has not been possible to have a MDM, that has resulted in such a backlog that may take a number of weeks to clear, resulting in delays in progressing

the investigation, diagnosis and management of patients in a timely manner. The MDT decided in 2015 to experiment with the concept of a Virtual MDM where an appointed Chair will preview all cases who would have been discussed on the date on which it was not possible to hold a MDM, arriving at considered MDM Outcomes, which are circulated by email, as soon as is possible thereafter, to all core members, seeking their comments and proposed amendments, before being recorded on CaPPS, the Northern Ireland Electronic Care Record and sent to Family Doctors. It was also the experience of the MDT that the availability of histopathological reports enabled the further assessment and management of many patients to be advanced without controversy or further delay. Dr. McClean has ensured that histopathological reports have been agreed and issued to the Chair of Virtual MDM. The MDT has since found this practice to be successful and it has been adopted as its routine practice on such occasions.

9.9 Membership and Attendance 14-2G-104

It is the policy and the practice of the MDT to maintain and update a record in its Operational Policy of the names and roles of all core and extended MDT members.
It is the responsibility of the MDT Lead Clinician to ensure the accuracy of these records.

It is also the policy and practice of the MDT to maintain a record of attendance of all members at MDM, so that a record of the attendance of each individual member can be calculated and included in the Annual Report, and the quoracy of each MDM can similarly be determined and included in the Annual Report.

10. MDM BUSINESS MEETINGS

As the Southern Trust Urological Service has increased in size and as referrals have increased in number, and as the resulting challenges and incapacities have emerged, it has become necessary for the Urology MDT to hold regular Business Meetings to address and resolve these issues. Issues discussed to date have included:

day or so but would always have been discussed at the MDT so that everyone was in agreement when it would be. From my recollection the meeting was on a Thursday afternoon, with the cut off point for patients being added for discussion being Tuesday at 2pm, with me circulating the patient preview list on a Wednesday morning to allow time for preparation for the Consultant Radiologist, Consultant Urologists, Consultant Pathologist and Consultant Oncologist attending the meetings. I kept an up to date record off all those who attended the meeting. The attendance list was noted in the brief notes, which were discussed after each MDM. Those in attendance were also recorded in the CaPPs system, which could be extracted into excel, which the clinicians used for their appraisals as they had a set number of MDMs to attend on a yearly basis. If it was noted that a Consultant Radiologist or a Consultant Oncologist was not attending on a regular basis, I would have escalated this to the Head of Cancer Services, Fiona Reddick, and it would have been tried to have this resolved at her level, or it would have been escalated further to Barry Conway, Assistant Director. I recorded the management plan for each patient listed for discussion. I then printed each individual outcome via CaPPs which was to be sent to the GP of the patient, and the chair of each MDM always read down through the MDM outcome to ensure all was correct before signing the letter, including that I had taken the management plan down correctly. Mr O'Brien always ensured that (MDM Outcomes, Oncology Referrals and GP letters) all clinical information included in the narrative was meaningful and that the management plan was correct before these would be signed and posted to the GP.

20.4 As Cancer Service Co-ordinator I would have liaised with multiple people, including staff members working in Cancer Services and the Urology team itself. The meetings that I would have attended that included Urology, but were not solely for Urology, were the monthly Cancer Performance Meetings, the Cancer Operational Meetings and staff meetings with the Red Flag Team and the Cancer Tracking Team.

20.5 For the monthly Cancer Performance Meetings I would have drafted up the Agenda, going by a previously agreed template that I updated on a

40.1 As previously mentioned I have no knowledge of the concerns within urology services, and very limited information in relation to the concerns involving Mr O'Brien in particular so I do not feel that I can honestly comment.

40.2 All that I can recall is that while Mr O'Brien was chair of the Urology MDM that he was so committed and dedicated to this role. Prior to Mr O'Brien taking on this role I, as Cancer Tracker, had to compile the clinical summary for each patient that was to be discussed. Mr O'Brien changed this so that each Clinician provided a more comprehensive clinical history. The reason for this change was that at times clinical information available for discussion was very limited, if I was not tracking these patients, so management plans could not always be made and patients would have been deferred to the next week. This change was a work around to stop this happening so that there was very clear and relevant information for discussion. Mr O'Brien provided me with a very clear and informative outcome plan for each patient. After each meeting, I would have commenced work immediately (5pm) on the outcomes for each patient, printing out each individual MDM plan for each patient discussed, along with a copy for the medical notes. Once I had these all printed out I would have telephoned/texted Mr O'Brien, who remained on hospital premises, to come down to my office to go through each outcome, along with all of the clinical information to ensure accuracy, so that these were all signed and verified on the CaPPs system before 8.30pm each Thursday night. The turnaround times for GP letters to be signed following MDM is 48 hours and Mr O'Brien always endeavoured to have these done immediately after the MDM.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

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.

PAT-001482

Urology MDM @ The Southern Trust

RE: Mr [redacted]

[redacted]

DOB: [redacted], Hospital Number: [redacted], HCN: [redacted]

Discussed at Urology MDM 31.10.19.
Review with Mr O'Brien as arranged.
Mr [redacted] has intermediate risk prostate cancer to start ADT and refer for ERBT.

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM
Mr John O'Donoghue
Consultant Urologist

- Patient 6 had a slow initial diagnostic pathway which was outside expected cancer care timeframes.
- Patient 5 had a delayed diagnosis of a metastatic prostate cancer following successful treatment of Renal Cancer. This was due to non-action on a follow-up CT scan report.
- Patient 8 had a delayed diagnosis of Prostate cancer due to non-action on a histopathology report at TURP.
- Patient 3 with penile cancer had a 5 week wait between referral and first appointment. Subsequent time to diagnosis and MDM were appropriate. He had a 17 week wait for a CT scan for staging.
- Patient 7 was on a renal mass surveillance programme - a recommendation at MDM to discuss his case with the regional small renal lesion team was not actioned and it is not known if they would have suggested earlier intervention.

Care that varied from Regional and National Best Practice Guidance

- The treatment provided to 8 out of 9 patients was contrary to the NICAN Urology Cancer Clinical Guidelines (2016). This Guidance was adopted by the Southern Health and Social Care Trust Urology Multidisciplinary Team and evidenced by them as their protocols for Cancer Peer review (2017). The Guidance was issued following Dr.1 & Chairmanship of the Northern Ireland Cancer Network Urology Cancer Clinical Reference Group.

  Ref No105. 20200202

  Ref No106. 20200910

  Ref No107. 20201229

Care that varied from SHSCT Urology Services Multidisciplinary Team Recommendations

- The MDM made appropriate recommendations for 8 of the 9 patients but there was no mechanism to check actions were implemented - this included, further investigations, staging, treatment, and appropriate onward referral.
- Dr 1 was present for the discussions and party to the recommendations, 8 of which were compliant with National and Regional Guidelines.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non-implementation of these MDM recommendations was unknown to others in the MDM. One patient D presented as an emergency and his care was changed to the MDM recommendation by another consultant.

Urology Services Inquiry

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

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

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

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

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

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

Non-Quorate Multidisciplinary Meetings

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

Lack of Assurance Audits within the MDT process

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

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

Lack of coherent escalation / governance structures

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

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

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

  Ref No108. 20210331
  Ref No109. 20210421

6.0	FINDINGS

support from their GP and where hence referred to the Emergency Department which the review team agree was not the best place for them. The review team are of the opinion that access to a specialist nurse could have offered support for these families and provide direction to the appropriate services.

Governance / Leadership

- The review team considered the treatment and care of 9 patients who were treated under the care of Dr 1 Consultant Urologist. Individual reviews were conducted on each patient. The review team identified a number of recurrent themes following each review.
- The treatment provided to 8 out of 9 patients was contrary to the NICAN Urology Cancer Clinical Guidelines (2016). This Guidance was adopted by the Southern Health and Social Care Trust Urology Multidisciplinary Team and evidenced by them as their protocols for Cancer Peer review (2017). The Guidance was issued following Dr.1 & Chairmanship of the Northern Ireland Cancer Network Urology Cancer Clinical Reference Group.
- The Urology MDM made recommendations that were deemed appropriate in 8 of 9 cases and were made with contribution and knowledge of Dr.1. Many of the recommendations were not actioned or alternative therapies given. There was no system to track if recommendations were appropriately completed.
- The MDT guidelines indicate “all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner”. None of the 9 patients had access to a Key Worker or Cancer Nurse Specialist. The use of a CNS is common for all other urologists in the SHSCT urology multidisciplinary team allowing any questions or concerns that patients’ have to be addressed. This did not happen.
- The review team considered if this was endemic within the Multidisciplinary Team and concluded that it was not. Patients booked under other consultant urologists had access to a specialist nurse to assist them with their cancer journey.
- Statements to Urology Cancer Peer Review (2017) indicated that all patients had access to a Key worker / Urology Cancer Nurse Specialist. This was not the case and was known to be so.
- The Urology Cancer Nurse Specialist play an integral role of the MDT and should be facilitated on all the MDM to advocate on patient’s best interest throughout the patient’s journey. This should include independently referring and discussing patients at MDT.
- The Review Team regard absence of Specialist Nurse from care to be a clinical risk which was not fully understood by Senior Service Managers and the Professional Leads. The Review team have heard differing reports around escalation of this issue but are clear that patients suffered significant deficit because of non inclusion of nurses in their care. While this is the primary responsibility of the referring consultant, there is a responsibility on the SHSCT

9.0 RECOMMENDATIONS AND ACTION PLANNING

This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

Timescale - Immediate and ongoing

Assurance - Comprehensive Cancer Pathway audit and Patient experience.

Recommendation 3.

TheSHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collatorative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated.

Timescale – Immediate and ongoing

Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, numbers of issues outstanding.

Recommendation 4.

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.

This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans.This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).

Timescale - 3 months and ongoing

Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology / Palliative Care etc.

Recommendation 5.

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

This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers. A report should

9.0 RECOMMENDATIONS AND ACTION PLANNING

be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit / assurance. It is essential that current limited clinical resource is focused on patient care.

Timescale - 3 months

Assurance - Comprehensive Cancer care Pathway audit - Exception Reporting and escalation

Recommendation 6.

The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.

This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources.This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.

Timescale - 3 months

Assurance - Cancer Pathway Audit outcomes with exception discussion and escalation. Data should be declared externally to Cancer Peer Review

Recommendation 7.

The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.

Timescale - 3 months

Recommendation 8.

All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).

This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.

Timescale – Immediate and ongoing

Assurance - Variance from accepted Care Guidelines and MDM recommendations

should form part of Cancer Pathway audit. Exception reporting and escalation would only apply to cases without appropriate peer discussion.

Martina Corrigan

SHSCT Adverse Incident Reporting (IR2) Form -December 2020

The new Regional CCS2 codes which will replace 'Type', 'Category', 'Subcategory', and 'Detail' have been updated.

A full list of these codes can be found here for review.

Incident Details
ID & Status

Incident Reference ID	Personal Information
Submitted time (hh:mm)	20:25

Incident IR1 details

Notification email ID number	Personal Information redacted by USI
Incident date (dd/MM/yyyy)	20/11/2014
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102 Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr H for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondance created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.
Action taken Enter action taken at the time of the incident	Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.
Learning Initial	
Reported (dd/MM/yyyy)	21/10/2015
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	18/11/2015
Last updated	David Cardwell 06/17/2016 09:17:40
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 102

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

discussed at MDM I would have printed off the GP Letter. When Mr O'Brien was chair of the MDM I would have phoned him on a Thursday evening to come down to my office, to review the plans and to sign letters, prior to these being posted to GPs for their record. Mr O'Brien also liked to get these all completed and signed off on the same day as the MDT. This also worked well because Mr O'Brien's post MDT review clinic for his patients to be informed of their management plan was the following day, which was on a Friday. This meant that Sarah McDonald, my admin support, was able to file the photocopy of the GP letter, along with the MDM outcome into the patient medical notes, prior to their appointment, which all ran very smoothly as the meeting had not taken place somewhat 24 hours prior. I was happy to work late on a Thursday evening (8.30pm) to get everything completed and all my outcomes done, letters signed, brief notes completed and circulated before I went home as this meant I could dedicate the whole of Friday to tracking. If Mr Glackin and or Mr Haynes were chairing the MDT, they would have signed these letters the next day. My clinical admin support (Sarah McDonald) would then have taken a photo copy of the signed letter and printed the MDM outcome sheet from CaPPs and kept this as a copy for the medical notes – this copy was kept for governance to show that a Consultant had signed management plan.

x) Onward referral of patients for further care and treatment

24.16 During my tenure as Cancer Tracker/MDT Co-ordinator (Urology), it was my responsibility to track a confirmed cancer patient up until they had received their first definitive treatment. This was in either the 31-Day pathway, or 62-Day pathway. If a patient did not have their first treatment in the Southern Trust, they would have been referred to another Trust for treatment. This transfer of care between Trusts is called an Inter Trust Transfer (ITT). If it had been decided at MDM that a patient was to be transferred to Belfast, and this was their first definitive treatment I would have generated an oncology referral letter via the CaPPs system for that patient. I then would have got the oncology letter signed by the Chair, after it had been checked to ensure the management plan was correct; the oncology letters had the same governance process which was followed for the GP Letters. The Oncology letter was emailed directly to the

relevant tracker in the Belfast Trust. My failsafe for this process was to highlight what patients required ITT to another Trust, by a highlighter pen and wrote ITT on the patient preview list. I then would have ticked that the referral had been sent, once I had emailed off the referral, and made a note of whom I had emailed, so that they were aware of the patient, as they would be tracking them from that point. The patient would then have been ITTd on the CaPPs system so that they were no longer for tracking in the Southern Trust. An onward oncology referral could have been generated in the form of a letter to the named Consultant Oncologist, but this was not normal practice, from my recollection. If a referral was done like this, without the ITT the Belfast Tracker would not have been aware of the patient, so would not have been able to chase up on appointments etc. *Please see:*

16. 20140702 Document 7 ITT Protocol 2014

51. 20142305 Document 20 (E) Oncology Referral

24.17 For patients who had already received their first definitive treatment and were closed off the CaPPs system as treatment complete, but were being referred to Oncology, an Oncology referral was not generated from the CaPPs system. The named Consultant would have generated a referral letter and sent this to the Oncologist. These patients would not have been actively tracked on the CaPPs system once first definitive treatment was completed.

24.18 I am sorry I do not have any copies of this process, as I have not been in this role from Oct 2014.

xi) Storage and management of health records

24.19 Not applicable in my role as Cancer Tracker or Cancer Services Co-ordinator.

xii) Operation of the Patient Administrative System (PAS)

24.20 During my tenure as Cancer Tracker/MDT Co-ordinator (Urology), I had a ‘look up’ function only for PAS, which I used for tracking purposes to see when

It's significance is uncertain but there is an apparent delay in the patients cancer care pathway, and without investigating we cannot draw a conclusion as it is possible that he has done something but simply not communicated to anyone. A date in the time line is wrong, I have highlighted / corrected below.

Mark

From: Carroll, Ronan
Sent: 04 October 2019 11:08
To: Haynes, Mark; Young, Michael
Cc: Clayton, Wendy; Corrigan, Martina
Subject: FW: Datix Incident Report Number [redacted]
Importance: High

Mark/Michael
Can I look to you both for guidance on the significance of this IR1 and the delay recorded
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

From: Clayton, Wendy
Sent: 04 October 2019 11:07
To: Carroll, Ronan
Subject: RE: Datix Incident Report Number [redacted]

I've just been on with Vicki to investigate.

[redacted] – The delay is not with the tracker but a delay in review with Mr O'Brien, and then once reviewed in clinic on 16.08.19 there has been no further movement or update on patients management. Tracker appears to have listed patient for MDM discussion on 03.10.19 to try and get an update on Management. Patient was informally discussed on 03.10.19 so there was no MDM outcome & then Datix was raised today.

patient was initially discussed at MDM on 28.06.19 (31D Patient) then patient waited 49 days for review with Mr O'Brien on 16.08.19.

Diary update on Capp's dates 09.08.19 – Appointment was then booked with Mr O'Brien on 16.08.19 following Mr Hayne's message to Mr O'Brien.

Edit	09-8-2019	[redacted]	Secretary advised - am not sure what is happening with this patient. Please see message below from Mr Haynes to Mr O'Brien regarding the most recent referral. Morning Aidan This man was discussed at MDM on 27th June regarding a renal lesion and the outcome was that your were going to organise a renal biopsy (with Factor VIII). A further referral has come in about his renal lesion which I am triaging as nil extra needed. Have you the biopsy in hand

No further update or clinic outcome was available from clinic on 16.08.19 – Mr O'Brien had been contacted regarding management updated.

Edit	04-10-2019	[redacted]	This man was discussed informally at MDM - time is passing for this patient and not sure what plan is in place for him. Mr Haynes to review in clinic. Chart not where it is tracked to. Have escalated to Vicki.	09-10-2019	No	Complete
Edit	03-10-2019	[redacted]	Have relisted this man for MDM as unsure as to what is happening with him, delays in his pathway.		Yes	Complete
Edit	25-9-2019	[redacted]	No reviews booked, no biopsy requested, clinic letter still not available	01-10-2019	Yes	Complete
Edit	19-9-2019	[redacted]	Response awaited from Mr O'Brien regarding this man - no biopsy has been requested, clinic letter not avialable	25-9-2019	Yes	Complete

Graham, Vicki

From: Graham, Vicki [redacted]
Sent: 04 October 2019 11:02
To: Clayton, Wendy
Subject: FW: [redacted] * POSSIBLE DATIX ** H&C [redacted]
Attachments: FW: Testicular MDM 26th Sept 19 (21.5 KB)

Importance: High

Hi Wendy,

Please see further patient that Shauna had brought to my attention due to a delay with this patients management as there is a good chance that another Datix could be raised as Belfast had queried the time delay with this patient.

[redacted] - Treatment was completed following surgery which was performed on 10.07.19 (Testicular Cancer) patient was discussed at MDM on 26.07.19 and was to be reviewed by Mr O'Brien which did take place on 23.08.19 but patient was not relisted for MDM discussion, nor was an outcome provided so Shauna. Shauna then listed the patient to be discussed at MDM on 26.09.19 as she was conscious of how much time had passed and patient had not been referred for chemotherapy. I have attached Shauna's emails that she sent to Mr O'Brien during the period of time.

Clinic outcome from 23.08.19 (Mr O'Brien) was dictated on 25.09.19 & typed on 26.09.19 – This was a referral to Oncology.

Patient was seen by Oncology on 01.10.19. Outcome not yet available on NIECR.

Edit	01-10-2019	[redacted]	BCH had queried the time delay with this patient - Mr Glackin was emailed by BCH.		No	Complete
Edit	01-10-2019	[redacted]	Discussed at Urology MDM 26.09.19. To be referred to Oncology for consideration of adjuvant chemotherapy.		No	Complete
Edit	05-9-2019	[redacted]	This man was reviewed 23.08.19 clinic letter awaited, will list for testicular MDM.		No	Complete
Edit	14-8-2019	[redacted]	Patient awaiting review slot, no response with regards to testicular MDM	19-8-2019	Yes	Complete
Edit	09-8-2019	[redacted]	Have asked Mr O'Brien does he want this man listed for testicular MDM patient awaiting review slot.	13-8-2019	Yes	Complete
Edit	02-8-2019	[redacted]	Review is to be booked post MDM - he needs listed for testicular MDM.	07-8-2019	Yes	Complete
Edit	26-7-2019	[redacted]	Discussed at Urology MDM 25.07.19. Mr [redacted] orchidectomy pathology shows a T1 classical seminoma with invasion of the rete testes. His CT shows no evidence of metastases and his tumour markers were normal pre-surgery. Mr O'Brien to review in outpatients and refer to oncology and the testes MDM.	01-8-2019	Yes	Complete

32.1 From my recollection if I, or others, while working as a Cancer Tracker/MDT Co-ordinator (Band 4), or as a Cancer Services Co-Ordinator (Band 5) raised any concerns that were identified as an SAI (Serious Adverse Incident), I do not recall being advised of the outcome of any investigation if it was logged onto the DATIX (Risk Management System). This was due to being a Band 4 or Band 5, and it was my understanding that we did not need to know. As a Band 5 and going by findings of my own investigation I would have updated the relevant team that a Datix had been raised. This was so that they were aware of what had happened, how it happened and what the learning was so that all relevant processes could be reviewed. By re-viewing, the processes this helped to identify what processes were maybe not fully followed, and if any fail-safes were to be developed to ensure that, the same thing did not happen. In some cases, from my recollection, we would only have been provided with limited information, due to my Banding (5). I would not have been privy to all information was my understanding. This information would have been shared with the higher banded staff, I think, but I cannot say with certainty that this happened.

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

33.1 No, I did not have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated, as necessary while I worked in Cancer Services. I was not aware of any ongoing issues or concerns within Urology Services. I was aware that referral numbers were on the increase for Urology and for all of the tumour sites. I was also aware that there were problems with tracking, and that this was not always possible to be kept up to date, due to the increase in referrals across all of the tumour sites, as previously mentioned and capacity issues for appointments, diagnostics and surgery. These issues were discussed at

the local Cancer Performance, and Regional Cancer Operational Meetings. The Assistant Director (Barry Conway) and the Heads of Services, along with Operational Support Leads, Head of Performance (Lynn Lappin) and Service Administrators would have been in attendance in these meetings so would have been aware of ongoing issues.

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

34.1 I cannot answer this question as I never attended any Governance meetings, and while I added some SAI (Serious Adverse Incidents), onto the Datix System, some relating to Urology patients and delays with referrals, not all of these SAIs were aligned to Urology. The DATIX system is a Risk Register for the Trust. I did not get feedback as to what the outcomes were following investigation. I am not sure who could help you answer this question. *Please see:*

22. 20172108 Document 10 (E) DATIX Missed Referral General Surgery

23. 2190502 Document 10A (E) DATIX Late upgrade at triage OC Referral

24. 20190410 Document 10B (E) DATIX Delay with Review with Mr O'Brien

25. 20190509 Document 10C (E) DATIX Delay with referral to Belfast- Mr O'Brien

26. 20190110 Document 10D (E) DATIX Delay with referral to Belfast Mr O'Brien

27. 20190908 Document 10E (E) DATIX Delay with referral to Belfast Mr O'Brien

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 71 of 2022
Date of Notice: 20th September 2022

Note: An addendum to this statement was received by the Inquiry on 10 May 2023 and can be found at WIT-94681 to WIT-94909. Annotated by the Urology Services Inquiry.

Witness Statement of: Kathleen (Kate) O'Neill

I, Kate O'Neill, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

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 or by you, meetings you attended, 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 Inquiry is aware that you have previously been provided with a questionnaire. If you replied and wish to rely on that questionnaire in reply to any question, please attach that questionnaire as an Appendix to your reply to this Notice and identify the section on which you rely. However, you are encouraged to provide answers that are as full as possible, including further details or information not contained in your questionnaire.**

This will include, for instance, correspondence, handwritten or typed notes, diary entries and 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.

Statement of Truth

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

Signed: ___ Personal Information redacted by the USI **_____**

Date: _____28.10.22_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.71 of 2022

Date of Notice: 22 September 2022

Addendum Witness Statement of: Kate O'Neill

I, Kate O'Neill, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 28th October 2022, to Section 21 Notice number 71 of 2022.

2. At paragraph 7.6 WIT 80909 I have stated *"The necessity for a Ward Manager was not fully resolved until 2021 when the Outpatient Department Ward Manager acquired managerial responsibility for Thorndale Unit, and the managerial responsibility for Band 3 to Band 7 nursing staff within the unit*", this should be changed to "*The necessity for a Ward Manager was not fully resolved until 2021 when the Outpatient Department Ward Manager acquired managerial responsibility for Thorndale Unit, and the managerial responsibility for Band 3 to Band ~~7~~6 nursing staff within the unit*".

3. At paragraph 17.2 WIT 80921, I have stated "*Weekly meetings with Head of Service*" This should be changed to "*Weekly meetings with the Head of Service is where any change in practice/procedure should have been discussed*".

4. I wish to remove the entire paragraph 35.2 which can be found at WIT 80951 "~~*Secured slots for patient discussions following MDT meetings."*~~

5. At paragraph 51.1 WIT 80964, I have stated "*I can only recall meeting resistance in relation to my role in performing prostate*." This should be changed to "*I can only recall meeting resistance in relation to my role in performing prostate biopsies*."

Urology Services Inquiry

Kingsnorth by email on 29 March 2021 *(please see 2. IMPORTANT - UROLOGY DRAFT SAI REPORTS and WIT 81548- 81552).*

6. I would also like to attach additional documents in relation to the following areas:-

Thorndale Notebook Entries and Minutes

Please see folder Thorndale Notebooks and Minutes

Cancer Figures

New Cancer Diagnosis Figures for Breast Cancer and Urological Cancer 2016 – *Please see RE New cancer diagnosis figures for 2016*

2016 WTE of Breast Care Specialist Nurses was 2.80 wte (aligned to C0343N C&CS Breast Care)– *please see 'FW Help with query - Breast CNS WTE'* and attachment *'Copy of 2016 Breast Urology Confirmed Cancers'.*

Datix Reports and Emails

Personal Information redacted by the USI – Please see *Datix* Personal Information redacted by the USI and *Datix Incident Report Number* Personal Information redacted by the USI *emails*

Statement of Truth

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

Personal Information redacted by the USI

Signed:

Date: 05.05.2023

247. It has been my greatest pleasure to work with very many, committed and caring nurses in the operating theatre suite, the theatre recovery ward and the intensive care unit during my tenure. I was always fully supported by them.

248. Following my appointment in 1992, I was fortunate in having the hospital fund the purchase of equipment to undertake urodynamic studies, and which was located in a room off Ward 2 South. A number of staff nurses keen to develop specialist skills became trained and accredited, experienced and skilled in the total, holistic assessment and management of lower urinary tract dysfunction in both male and female adults. One of these nurses, Ms Jenny McMahon, was appointed a Clinical Nurse Specialist (CNS) when the Thorndale Unit was opened in 2007. She has been an outstandingly competent CNS. She is one of the most experienced urodynamicists in Northern Ireland. She has augmented her competence by performing flexible cystoscopies and is an accredited prescriber. She conducts her own Lower Urinary Tract Symptom (LUTS) review clinics. I have always been supported by her. She has been a pleasure to work with.

249. The Department had the additional benefit of having a Urology Cancer CNS since 2007 with the appointment of Ms Kate O'Neill to that post, though she was a loss to inpatient management as she had been the Ward Manager until then. Kate was joined by a second Urology Cancer CNS, Ms Leanne McCourt, in or around 2016/17. Both were based in the Thorndale Unit.

250. Kate O'Neill has contributed significantly to the development of urological cancer services since her appointment in 2007. Since the establishment of the Urology MDT in 2010, she has attended most MDMs as the MDT Core Nurse Member. If unable to do so, she ensured that she was deputised. She was the author of the section regarding Urology Cancer CNS involvement in cancer services in the Clinical Management Guidelines which I commissioned in preparation for National Peer Review in 2015. She became competent in performing trans-rectal, ultrasound guided, prostatic biopsies, contributing significantly to diagnostic capacity. She ensured that all patients were reviewed

by consultants following MDM discussion and, as the MDT Core Nurse Member, she was responsible for ensuring that all newly diagnosed cancer patients had access to a Urology Cancer CNS for Holistic Needs Assessment, support and signposting, etc. She was assisted by Leanne McCourt. It is regrettable that there was no Urology Cancer CNS available to patients when attending for review at clinics at SWAH. Nevertheless, I found both Kate and Leanne to be supportive of me in my practice.

251. I had always felt that the urological medical and nursing staff had worked well together, enjoyed good relations with each other and were supportive of each other in endeavouring to provide the best care that they could provide to those in most need of it, even though a severely inadequate service had been commissioned and resourced, as described throughout this statement. However, I found it disappointing to learn that a colleague could initiate a SAI investigation concerning [redacted] in 2016 without ever being informed of it, and having it chaired by another colleague with ever having been consulted about it. Since then, I increasingly listened to criticisms of colleagues without those colleagues being aware of the criticisms. Since then, I found the absence of candour, honesty and integrity to be disappointing and most concerning.

(Q 38 – 39)

252. Even when providing the service as a single consultant from 1992 to 1996, Thursday morning was the only session free of any other elective commitment. Thursday mornings therefore lent themselves to being the time for a Grand Ward Round (GWR) of sorts, even though it did not merit the label with only one consultant, as the essential purpose of a GWR is for the management of inpatients by one consultant to be exposed to the scrutiny of another. Nevertheless, Thursday mornings were to become our multidisciplinary mornings and, with the eventual addition of Urology Cancer MDM every Thursday afternoon, Thursday became our department's multidisciplinary day.

11. The Inquiry has received information which references the following terms: Keyworker, Specialist Nurse, Cancer Nurse Specialist, Urologist Nurse Specialist.

Do these names refer to the same individuals/roles, as they appear to be used interchangeably, are they functions within one role, or are they all different individuals/roles? Please explain your answer so that the Inquiry has a complete picture of these individuals/roles and their relevance within the patient care pathway.

11.1. The use and meanings of these terms vary within healthcare and within regions and indeed Trusts.

11.2. I understand the terms urology nurse specialist, specialist nurse and clinical nurse specialist (CNS) to be generic titles that can be applied to any clinical setting.

11.3. In contrast, the terms cancer nurse specialist, uro-oncology nurse specialist and Macmillan cancer/clinical nurse specialist are often used interchangeably and refer to job titles where the main focus of the role is in cancer care.

11.4. During my employment as a 'urology nurse specialist', I would be more commonly referred to as a CNS within the SHSCT.

11.5. The term 'keyworker' is used to describe a function within the role of a CNS who is a core member of the cancer multi-disciplinary team (MDT).

Electronic systems for communication

12. The Inquiry is keen to understand how you and other staff communicate using electronic systems and how updates and next steps are communicated between staff. Please give a brief outline of your use of electronic systems in your role (naming any systems), such as the Patient Administration System, and how and

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

in the concerns raised in question 50 relating to the CNS not invited into the uro-oncology consultation, and I have provided a reply as to how Consultants managed this challenge differently.

54.4 I never felt that Mr O'Brien prevented/obstructed CNS involvement in his clinic, nor did my colleague Jenny McMahon or Staff Nurse Dolores Campbell who would both have deputised for me on occasions, ever raise this as an issue. My job plan meant that I was generally available for uro-oncology clinics with Mr Glackin, Mr O'Donoghue and Mr Haynes but to a lesser extent, Mr O'Brien and Mr Young. This meant that I would see much fewer patients with Mr O'Brien and Mr Young. I do recall Mr O'Brien introducing me to patients to either plan prostate biopsy for them, engage or signpost to other services (such as Palliative Care Team) or for the provision of information. On those occasions I felt that I was able to offer information, support and a contact number. On occasions I would have received phone calls from patients seeking clarity regarding their consultation with any of the Consultants. Had I not been present during the consultation the patient was referring to, I would have viewed the dictated letter from NIECR for clarity in relation to their questions, or sought clarity from their Consultant. For many years, I have worked a four-day week, Monday- Thursday, except with the occasional half day on a Friday. I would have spent this session preparing/organising the prostate biopsy service. In my absence for whatever reason, in the majority of these situations a colleague would have been available to support the clinic where necessary to provide documentation/contact numbers. There may have been a wait involved for the member of staff to become available, due to parallel activity, and this may have been a Staff Nurse. At no time did they ever raise a concern in relation to this activity.

54.5 Mr O'Brien was aware of the keyworker role given his involvement in Peer Review and MDT. He would have involved me in keyworker activity from time to time, but as stated previously it was not common for me to be available when his clinic took place. My job plan meant that I had much more keyworker activity with other Consultants. I contacted the entire Consultant team via email on several occasions explaining the role of the keyworker and the information to be provided

CNS Proforma

CANCER CNS PROFORMA

Form will be emailed to admin.cancersupportworkers@southerntrust.hscni.net

PATIENT DETAILS

Name: *

DOB: *

H+C: *

Tumour Site: Choose an Item *

Date of Referral:

Date of 1st Contact:

Date of MDM:

Type of Contact: Choose an Item.

Reason for Contact: Choose an Item.

CNS (Please choose your name): Choose an Item.

Consultant:

Hospital Site: Choose an Item.

Treatment Intent: Curative ☐ Palliative ☐

Patient Type: New ☐ Recurrence ☐ Benign ☐

CNS Email

Diagnosis:

Staging:

Treatment Received

Chemotherapy ☐ Radio ☐ Surgery ☐ Supportive Care ☐ A/S ☐ W/W ☐ Other:

Reason for referral to service

Breaking bad news: ☐

Pain Management: ☐

Other Symptom Management: ☐

Holistic Needs Assessment: ☐

Rapid Access: ☐

Inpatient: ☐

Newly Diagnosed: ☐

Disease Progression: ☐

Pathway (if applicable)

Shared Care: ☐

Consultant Led: ☐

Contact info given: Choose an Item.

Core info pack given: Choose an Item.

HNA

HNA Status: Choose an Item.

HNA to be booked: Yes ☐ No ☐

If yes, when:

Additional Info:

H+WB Event: Choose an Item.

Relevant Information:

Referrals to other services

Move more: ☐

Hospice: ☐

Charis: ☐

Community Macmillan Team: ☐

Smoking cessation: ☐

Counsellor/Psychologist: ☐

CAB referral: ☐

Macmillan Information Support Services: ☐

SDA Patients: ☐

Other, Please Specify:

CAPPS updated: Yes ☐ No ☐

Date of Death (if applicable):

Send to Admin Cancer Support Workers

6.0 FINDINGS

support from their GP and where hence referred to the Emergency Department which the review team agree was not the best place for them. The review team are of the opinion that access to a specialist nurse could have offered support for these families and provide direction to the appropriate services.

Governance / Leadership

- The review team considered the treatment and care of 9 patients who were treated under the care of Dr 1 Consultant Urologist. Individual reviews were conducted on each patient. The review team identified a number of recurrent themes following each review.
- The treatment provided to 8 out of 9 patients was contrary to the NICAN Urology Cancer Clinical Guidelines (2016). This Guidance was adopted by the Southern Health and Social Care Trust Urology Multidisciplinary Team and evidenced by them as their protocols for Cancer Peer review (2017). The Guidance was issued following Dr.1 & Chairmanship of the Northern Ireland Cancer Network Urology Cancer Clinical Reference Group.
- The Urology MDM made recommendations that were deemed appropriate in 8 of 9 cases and were made with contribution and knowledge of Dr.1. Many of the recommendations were not actioned or alternative therapies given. There was no system to track if recommendations were appropriately completed.
- The MDT guidelines indicate “all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner”. None of the 9 patients had access to a Key Worker or Cancer Nurse Specialist. The use of a CNS is common for all other urologists in the SHSCT urology multidisciplinary team allowing any questions or concerns that patients’ have to be addressed. This did not happen.
- The review team considered if this was endemic within the Multidisciplinary Team and concluded that it was not. Patients booked under other consultant urologists had access to a specialist nurse to assist them with their cancer journey.
- Statements to Urology Cancer Peer Review (2017) indicated that all patients had access to a Key worker / Urology Cancer Nurse Specialist. This was not the case and was known to be so.
- The Urology Cancer Nurse Specialist play an integral role of the MDT and should be facilitated on all the MDM to advocate on patient’s best interest throughout the patient’s journey. This should include independently referring and discussing patients at MDT.
- The Review Team regard absence of Specialist Nurse from care to be a clinical risk which was not fully understood by Senior Service Managers and the Professional Leads. The Review team have heard differing reports around escalation of this issue but are clear that patients suffered significant deficit because of non inclusion of nurses in their care. While this is the primary responsibility of the referring consultant, there is a responsibility on the SHSCT

6.0 FINDINGS

to know about the issue and address it.

- Assurance audits of patient pathways within the Urology Cancer Services were limited between 2017 and 2020. They could not have provided assurance about the care delivered.
- Because of resource, the MDM was very focused on first presentation at MDM and did not have a role in tracking subsequent actions if it lay outside 31 and 62 day targets. Tracking of patients was flawed by limitations within the MDM systems and the lack of Specialist Urology Nurses from their Key Worked role. Two of the three normal safety nets for patient pathway completion were,in essence absent. A collaborative approach did not appear to be actively encouraged within the MDT.
- Annual business meetings had an expressed role in identifying service deficits and drawing up an annual work plan to address them. Cancer Patient Pathway compliance audits were limited and did not identify the issues within this report.
- Governance of professionals within the MDT ran through their own directorates but there was no functioning process within Cancer Services to at least be aware of concerns - even if the responsibility for action lay elsewhere within the Southern Health and Social Care Trust. There was disconnect between the Urology MDT and Cancer Services Management. The MDT highlighted inaction by Cancer Services on Oncology and radiology attendance at MDM, but did not escalate other issues.
- The Review team found that issues around prescribing and the use of Clinical Nurse Specialists were of long standing. They were known internally and in the case of prescribing externally (Regional Oncology Services). The Northern Ireland Cancer Network drew up specific Guidance on Hormonal Therapy in Prostate Cancer in 2016 following concerns about this issue. The Guidance was not subject to audit within the Southern Health and Social Care Trust.
- The Review team were concerned that the leadership roles focused on service delivery while having a limited process to benchmark quality, identify deficiencies and escalate concerns as appropriate. Senior managers and clinical leaders in medicine and nursing were unaware of the issues detailed in this report.
- There had been a previous SAI signed off in May 2020 regarding adherence to Cancer Red Flag referral Pathways. The SAI process started in July 2016. The review team is concerned that, as part of early learning, assurances regarding other aspects of the cancer pathway were not sought. Clinical Leadership within Cancer Services were unaware of issues leading to the SAI in 2016.
- Patients in this review were not referred back appropriately to MDM as their diseased progressed. This meant there was no access to oncology and palliative care for many patients, when needed. Care needs within the community were unmet and patients left isolated.

(b) More often (though not always) I was invited in at the end of the encounter to provide information, support and a contact number. This was not unique to any single Consultant.

(c) If I had a biopsy clinic, patient notes would have been set on a work counter with a request for me to meet the patient (located in the waiting area) and provide keyworker support in the form of written information, support and a contact number as soon as I was free.

(d) On occasions when I had not met the patient, I would have received phone calls over the following days from patients seeking clarification of the diagnosis/treatment plan which had been provided by the Consultant.

(e) At no time was there an expectation that I would attend any satellite sites where cancer diagnosis may also have been discussed (Banbridge Polyclinic, Armagh Community Hospital, South Tyrone Hospital or South West Acute Hospital SWAH). In recent times we have been able to provide a CNS to support the clinic at Armagh Community Hospital

(f) Nor was there an expectation that the CNS/Keyworker had the responsibility to ensure that scans were requested or onward referrals completed

50.5 Consultants managed the above challenges differently. For example, if I were not available Mr Glackin may have given out the pack with the contact number himself, Mr Haynes generally requested that the patient wait until I was available, while Mr O'Brien may only have invited me into the room if the patient required nursing intervention for example a dressing change, or for referral onto other services such as the community continence team or the palliative team. I cannot determine if Mr O'Brien gave the pack or contact number to the patient in my absence. This meant that, on occasions, I would have been involved periodically throughout the clinic and on other occasions, I would not have been involved at all. I am unable to explain the reasons as to why the Consultants adopted various approaches to this particular clinic. The time constraints of a clinic and competing challenges for the Consultant (needing to undertake another clinic or theatre session) may have contributed to these various approaches. At no stage did any of the nursing team within Thorndale Unit recognise or raise a concern that CNSs

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. Patient 4, Patient 1 and Patient 3 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.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by USI
E-mail: Personal Information redacted by USI

Queries/ Comments in relation to SAI reports

1. Terms of Reference (TOR)

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

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

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

2. Roles & Responsibilities of CNS/Keyworker

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

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

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

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

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

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

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

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 7 of 2023

Date of Notice: 5 May 2023

Witness Statement of: Martina Corrigan

I, Martina Corrigan, will say as follows:-

1. **Please consider the following extracts from your "SAI Urology Review Interview", which took place with Dr Dermot Hughes and Patricia Kingsnorth on the 18 January 2021 at 12 Midday via zoom (see WIT 84355 – 84356) and address the questions following each section:**

<u>Extract 1:</u>

…

***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*. WIT 84355**

…

(a) Please set out, including names of any relevant individuals, details of anything said and dates (approximate if necessary), the basis on which you state that:

(i) For 11 years, Mr O'Brien never recognised the role of the Clinical Nurse Specialist.

1.1 When I began my tenure as Head of Service in September 2009, there were two Clinical Nurse Specialists in post, Kate O'Neill and Jenny McMahon. I would regularly have been in the Thorndale Unit, as often as once or twice a week in the earlier years of my tenure (2009-2015) and at least once per month from 2016-2019 (the reduction in frequency was due to my workload), when I would have called down to speak with either the CNS, the Consultants or other staff.

1.2 It was my impression that Mr O'Brien didn't recognise the potential value of having a nurse with him at clinics generally. I do not recall all the factors which led to me forming this impression of Mr O'Brien but I believe it was influenced by things like the following: when the two Clinical Nurse Specialists attended meetings and made suggestions about the services – examples could have been changing appointment slots for the clinics so that there were not too many people in the waiting room, equipment suggestions, suggestions regarding training for the other nurses in the Unit, and so on - Mr O'Brien, whilst he would have listened, never got involved in these conversations or showed any interest in taking forward their suggestions and I therefore personally felt that he didn't value the role that they held. This was not an impression formed, I believe, as a result of a single meeting but one that developed over time between approximately 2009 and 2015.

(i) That Mr O'Brien never involved them in his oncology clinics.

1.3 The CNS team expanded in about 2014 with two temporary Band 6s being appointed, Janice Holloway and Dolores Campbell (see my previous s.21 statement no.24 of 2022 at WIT-26197 to 26198). Kate and Jenny had plans and suggestions for these two new appointments including having additional staff to support all clinics. It was during conversations with both CNS (Kate and Jenny) that they would have mentioned that this was for all of the consultants although not as much for Mr O'Brien as he rarely had a nurse in attendance at his clinics.

1.4 I should emphasise in this regard that I do not ever recall, during any of my conversations with nurses in the Unit on this broad issue, any specific mention of oncology clinics or their cancer key worker role when they were mentioning Mr O'Brien's non-use of nurses. It was usually couched in much more general terms. I also note, in this regard, that the handwritten note of the 18 January 2021 meeting records me saying (1st page, 11th line of text *down* from the top of the page) that Mr O'Brien 'never involved them in clinics', with no specific reference to oncology. In this regard, the handwritten note better reflects what I believe I said at the 18 January 2021 meeting, during which I would have referenced my knowledge regarding Mr O'Brien's approach generally rather than in respect of any specific cancer or key worker role.

[The handwritten 18 January 2021 meeting notes were provided to me by the Trust on or about 11 May 2023, having recently been located, and I confirm that they are now attached to this Witness Statement.]

1.5 Of course, I now reflect and accept that, had I thought about the matter in more detail, I would likely have realised that this approach by Mr O'Brien might have included the nurses' cancer key worker roles. However, I believe I was perhaps less conscious or less sighted as to this aspect of their work for a number of reasons including, I believe, because I did not attend MDT meetings and because of Cancer (as opposed to Acute) Services' role in respect of these.

(b) Please identify to whom you are referring when you say "… *some of the Clinical Nurse specialists would have asked to be at clinics but Mr O'Brien never included them*", detailing how, when, and in what circumstances you came to be told or made aware of this information.

1.6 The nurses that I am referring to are Kate O'Neill, Jenny McMahon and, laterally, Leanne McCourt and Jason Young. I can confirm that I have no evidence of dates and times but I believe this would have been mentioned

to me occasionally during casual conversations about various aspects of the running of the Unit if I had, for example, just called in to see how things were with them and the staff.

2. **Extract 2**:

> **…**
>
> ***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*. WIT 84355**
>
> **…**

(a) Please name the two nurses to whom you refer in this paragraph.

2.1 The two nurses were Kate O'Neill and Leanne McCourt.

2.2 I should clarify in this regard that I do not recall the nurses saying they 'regularly' challenged Mr O'Brien. I note in this regard that this word does not appear in the relevant part of the handwritten meeting note – (1st page, 9th and 10th lines of text *up* from the bottom of the page).

(b) Please explain the details of how and when they reported the details you provide in this paragraph. If not to you, to whom did they report and how and when did you find this information out?

2.3 I can confirm that this was never formally reported to me. It was occasionally, but not regularly, mentioned to me conversationally and in passing and in the general terms referenced in my answer to Question 1

above. As Dr Hughes is recorded as observing in the notes, we all 'became habitualised' to Mr O'Brien's practice and, whilst we all periodically discussed the issue with each other, I can confirm that, to my knowledge, there was nothing formally raised in writing about the matter. I am therefore unable to provide dates or further details of these conversations.

(c) What, if anything, did you or anyone else do on receipt of this information?

2.4 I believe that I mentioned this matter during general conversations with Heather Trouton, Ronan Carroll, and Mr Mackle, as well as with the Clinical Directors, Mr Colin Weir and/or Mr Ted McNaboe, but did not do anything else with this information.

3. <u>Extract 3</u>:

…

***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*. WIT 84355 - 84356**

…

(a) Please explain your source for the statement that Mr O'Brien did include the CNS in urodynamics but that he did not do so when he was consulting the patient after the test.

3.1 I believe that the source of this information was from conversations that I would have had with Jenny McMahon (who did the urodynamics tests) between approximately 2014 and 2019.

(b) How and did you come to know this information and what, if anything, did you do on being told?

3.2 I do not believe that I did anything with this information.

4. <u>Extract 4</u>:

…

***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*.**
(*sic*) WIT 84356

…

(a) Please explain, detailing the source and all other relevant information, the basis on which you confirmed that at no stage were specialist nurses allowed to share patient care with Mr O'Brien.

4.1 I can confirm that I was aware from general conversations with the CNS (Kate and Leanne) that they would have occasionally mentioned in passing that most of the consultants used a nurse at their clinics (and this could have been any of the other Band 5s in the unit - Kate McCreesh, Dolores Campbell, or Janice Holloway - if Kate and Leanne were not available) but that this was not the case for Mr O'Brien's clinics. To be clear, I did not base this statement upon a review or audit of the files of patients of Mr O'Brien.

4.2 I should clarify in this regard that I believe that, when Dr Hughes asked, 'at no stage were specialist nurses allowed to share patient care with Mr

O'Brien?', and I replied 'yes' (second and third full paragraphs on WIT-84356), my response was in relation to what had come to light during the previous months, from approximately autumn 2020, when issues relating to MDT recommendations not being actioned were coming to light. I believe that this is supported by the handwritten note of the meeting which (on its 2nd page in the 6th line of text *down* from the top of the page) includes a reference to MDT recommendations not being followed through ('agreed MDT – not followed through') followed shortly thereafter (8th and 9th lines *down*) by Dr Hughes' question: 'no stage where (sic) specialist nurses allowed to share care with them?' I interpret the reference to 'them' at the end of this question to be a reference to the relevant MDT patients whose recommendations had not been actioned or followed through. In the typed version of the note, 'them' appears erroneously to have been replaced by 'Mr O'Brien'. My answer was, I believe, in respect of the relevant MDT patients.

(b) Please explain, detailing the source and all other relevant information, the basis on which you state that all other consultants see the benefit of using a CNS and that they include them in their clinic.

4.3 As was the case with the matter covered at paragraph (a) of this question, I did not base this statement upon a review or audit of the files of patients (in this case, of the other consultants). I believe that I based this statement upon a number of grounds. First, from speaking occasionally with the other consultants – Mr Haynes, Mr Glackin and Mr O'Donoghue - who would each have endorsed the value of having a CNS or nurse with them at clinic. Second, from the fact that nurses were not making comments to me in respect of the other consultants (as they had in respect of Mr O'Brien) about non-use of nurses and Clinical Nurse Specialists.

5. Given your statements above to Dr Hughes, please explain the following paragraph from your section 21 Notice 24 of 2022 dated the 29 April 2022, where you state that you did not become aware of the issues around Key

Workers until November 2020 and only as a result of the SAI investigations (at WIT 26268):

> ***54.1 Not providing oncology patients with access to a Key Worker (Clinical Nurse Specialist)***
> ***…***
> ***x. I became aware that Mr O'Brien did not permit the Clinical Nurse Specialists to provide support as key worker to his oncology patients. I only became aware of this in November 2020 from the outcome of the investigations into the most recent SAI patients. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these.***

5.1 I believe that two statements within my response to Section 21 Notice No.24 of 2022 are relevant here. They are:

Para 54.1.x (at WIT-26268)

> *x. I became aware that Mr O'Brien did not permit the Clinical Nurse Specialists to provide support as key worker to his oncology patients. I only became aware of this in November 2020 from the outcome of the investigations into the most recent SAI patients. This was never raised with me as a concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these.*

Para 66.1.c (at WIT-26298)

> *66.1 I can confirm that I am now aware of governance concerns arising out of the provision of urology services, which I was not aware of during my tenure. These are namely:*

…

c. Mr O'Brien did not follow the recommended process of having a Clinical Nurse Specialist for his oncology patients and, had affected patients had such a key worker, this may have reduced or prevented harm;

5.2 I believe, upon reflection and upon considering both the typed and handwritten copies of the 18 January 2021 notes, that both paragraphs are inaccurate and require revision as follows:

Para 54.1.x (at WIT-26268)

x. I became specifically and acutely aware that Mr O'Brien did not permit the Clinical Nurse Specialists to provide support as key worker to his oncology patients. I only became specifically and acutely aware of this ~~in November~~ from approximately autumn 2020 from the ~~outcome of the~~ investigations into the most recent SAI patients. I believe that this cancer key worker issue was never raised with me as a specific concern and, as the oncology multi-disciplinary meetings are part of the Head of Oncology Services' remit, I was never involved in these. However, as mentioned in my response to Section 21 Notice No.7 of 2023 (at Question 1 thereof), the broad issue of Mr O'Brien's non-use of nurses and Clinical Nurse Specialists was mentioned to me a number of times by nurses in the years prior to 2020 and I ought, upon reflection, to have appreciated the potential cancer key worker issue as a result.

Para 66.1.c (at WIT-26298)

66.1 I can confirm that I am now aware of governance concerns arising out of the provision of urology services, which I was not aware of during my tenure. These are namely:

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.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 8 of 2023
Date of Notice: 5th May 2023

Witness Statement of: Ronan Carroll

I, Ronan Carroll, will say as follows:-

1. Please consider the following extract from your SAI Urology Review discussion with Dr Dermot Hughes and Patricia Kingsnorth on the 18 January 2021 at 13:45 (see WIT 84342 – 84343) and address question 1 (a) and (b): …

> **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. …**

(a) Please explain the basis on which you stated that many of the CNS were afraid of Mr. O'Brien, to include the source of this information, the circumstances in which you became aware of this and what, if anything, you did in response to this knowledge?

1.1 In preparation for and in answering the questions asked of me in both my previous Sections 21 replies I have not referenced, referred to or considered my meeting with Dr Hughes and Mrs Kingsnorth.

1.2 I received the email communications with attachments including the notes of the meeting of the 18th January 2021 and Mrs Kingsnorth's hand written notes on Tuesday 9th May and 11th May 2023, I have reviewed the comments I made during this meeting, in particular the comment, "Many of the CNS were afraid of him".

1.3 I believe in the meeting I was attempting to describe to Dr. Hughes my experience of Mr O'Brien and how difficult it had been over many years to deal with him as a difficult colleague in a robust and consistent manner. While I am unable to provide specific evidence to substantiate the comment that "many of the CNS were afraid of him", it was my opinion and view that staff may have become influenced by his unique style which could be overbearing and somewhat intimidatory.

1.4 Revisiting my first S21, I referred to the starting dates of the 5 CNSs. Reviewing their commencement dates at the time of my meeting with Dr Hughes, 3 of the 5, namely, in hindsight: Ms McCourt would only have been in post approximately 10.5 months; Ms Thompson and Mr Young approximately 5.5 months and 4.5mths respectively. These were all limited durations of employment as CNSs within the Urology service at a time when the Trust was endeavouring to manage Covid19 with the CNSs (not only urology) being re-deployed to the wards. Therefore their exposure or contact with Mr O'Brien could have been very minimal. The 2 remaining CNSs were longer term staff members.

a. Jenny McMahon 04.07.2005
b. Kate O'Neill 04.07.2005
c. Leanne McCourt 01.03.2019
d. Patricia Thompson 03.08.2020
e. Jason Young 31.08.2020

1.5 In addition, at the time of the meeting with Dr Hughes I would have been aware of the four action plan issues identified at the end of 2016 and the start of 2017. I was engaged in the monitoring of this action plan and had been interviewed by Dr Chada in 2017 and was aware of the more recent issues identified by Mr Haynes in June 2020 which precipitated the Trust undertaking a 'look back' exercise. My awareness of the CNSs not undertaking the 'key worker' role was as a result of the SAI review chaired by Dr Hughes. There had to be a reason why the senior CNSs Ms McMahon and Ms O'Neill had not advised their Lead Nurse to whom they reported that they were not permitted to undertake their 'key worker' role for patients tracked and discussed at the urology MDT, which I suggested may have been fear on their part. I believe in the meeting I was attempting to describe to Dr. Hughes my experience of Mr O'Brien and how difficult it had been over many years to deal with him in a robust and consistent manner. I considered that that staff appeared to have come to passively accept AOB's behaviour".

(b) Please identify by name those among the CNS nurses who fall into the category of being afraid of Mr O'Brien, based on your knowledge and statement to Dr Hughes. If you do not know names, why did you not take steps to ascertain which CNS's fell into this category and the basis for their alleged fear?

1.6 I refer to my response to Q1a.

1.7 While none of the CNSs named in response to Q1a above, directly informed me that they were "afraid" of Mr. O'Brien to cause me to take further actions when Mr. O'Brien was employed as a Consultant Urologist, my comments relayed to Dr Hughes were based on my general perception of Mr. O'Brien's manner. He was imperious and had a propensity to instill anxiety and/or fear within the Urology team. Supporting this perception, Mr. Haynes, a fellow Consultant Urologist giving evidence to the Urology Services Inquiry, referred to Mr. O'Brien as "a challenge to challenge" and this is a view I also share.

Southern Health and Social Care Trust

Acute Governance
Cancer Nurse Specialists
22 February 2021 @ 11am
Zoom

PRESENT: **Dr Hughes (Chair)**
Patricia Kingsnorth Acute Clinical Governance Co-Ordinator
Roisin Farrell, Governance Officer
Patricia Thompson
Martina Corrigan
Kate O'Neill
Leanne McCourt
Jenny McMahon
Jason

Patricia Kingsnorth thanked all for attending, she explained she tried to arrange the meeting in January but it had to be cancelled due to COVID. She advised the meeting that the CNS care was not brought into question.

Dr Hughes advised he was asked to chair the review. He advised he was previously Medical Director in the NHSCT and Director of NI Cancer Network. He has a pathology background.
He explained there was a huge deficit with not having Nurse Specialist's involvement in the patients care.
He gave a background to patients involved in the SAI review.

Patient 1 – Prostate cancer patient. His disease progressed and was not referred back or provided palliative care. The patient has since died. He did not get best care pathway.

Patient 9 – Personal Information redacted by the USI old Biochemical, PSA & potential prostate care. TRP came back negative. Variety of reasons things were missed. He later attended ED with query rectal cancer but was diagnosed with prostate cancer. The disease has progressed.

Patient 5 – Had a large renal cancer, he was treated exemplary. He attended ED no PSA or scan, was missed for 8 months. PSA was over 100 he probable had prostate cancer from start. Never got CNS.
Kate O'Neill believes she had met this man late last summer with Mr Haynes.

Patient 4 – High grade cancer. Should have been referred to oncology, didn't happen. Disease progressed and spread. He wasn't referred back to MDM and no referral to palliative.
Dr Hughes believes issues with lack of onward referrals.

Patient 2 – Very good first time care. He has rheumatoid disease and arthritis. He has been diagnosed with testicular cancer, recommendation referral for treatment, was not referred for treatment and was identified by BHSCT. No CNS assigned.

Patient 6 – elderly with possibility of prostate cancer. MDM suggested active surveillance. No CNS for support. No LRH. Doing reasonably well.

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Patient 7 – Renal mass. Multiple consultants involved. No CNS assigned until tissue diagnosis. Did have surgery and doing well. Question is how to support these patients prior to diagnosis. This family are from a Personal Information redacted by USI and are very angst.

Dr Hughes advised another family has a Personal Information redacted by USI.

Jenny McMahon asked if patient should have got laparoscopy surgery.

Dr Hughes advised he was not sure. He believes a pathway should been drawn up. Then locums would be aware. There was no attendance at MDM.

Patient 3 – Penile cancer. He received local treatment, as a rare cancer should have been on regional and super regional pathway. There was a delay of 17 weeks from CT scan to diagnosis. Cancer very progressive and patient has died.

Patient 8 – Had TURP, small chippings. Wasn't referred back to MDM, missed for 8 months, don't feel he has come to any harm. Have issues with TURP and incontinence.

Dr Hughes feels the issues are
8 of 9 recommendations from MDM were perfect but none were put in place.
1 query of penile cancer.

- Patient 9 – early diagnosis – Referral
- Patient 4 – Referral to oncology
- Patient 2 – Oncology – missed
- Patient 6 – Oncology
- Patient 7 – Super regional network earlier.

All should have had input from Nurse Specialists.

Dr Hughes invited staff to speak.

Kate O'Neill asked if the review was from Jan 2019 to 2020.

Dr Hughes advised one started in 2016.

Kate O'Neill advised during that time staffing team consisted of 2 staff. January 2017 an additional 2 more staff was allocated. At interview job description was changed. Had to re-advertise for staff. This did add to the staff but was a management role.

Leanne McCourt advised she was one of the original clinical sisters. She started in April 2017 and was successful and joined CNS 2019.

Kate O'Neill advised they had established 1 staff clinic and had new clinics Monday to Thursday. She advised at the clinic you might have 1 consultant and 2 reg's with 15 – 21 patient to process along with other work in 3 ½ - 4 hours. There were issues with staffing levels, she advised she would work longer on a Thursday. Kate said if there were 21 patients Monday – Thursday and 6 reviews their first priority was the 21 patients.

Dr Hughes advised these were first review patients. He advised they weren't given phone numbers. He needs to know if MrO'B had an issue working with Nurse Specialists or was it a deficit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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room he doesn't know. He said MrO'B was supportive in other ways, he made him aware of other patients.

Dr Hughes advised families didn't know this service was available. Patients were unsupported and didn't have an understanding of their care.

Patricia Kingsnorth asked Jason if he followed up on patients results.

Jason said no patients were told to contact if needed.

Dr Hughes asked if they all get the opportunity to attend MDM.

Jenny McMahon advised no she hadn't linked for 1 year.

Dr Hughes asked if they can put patients on for discussion.

All said yes.

Kate O'Neill gave an example of contact from a patient. She was never questioned when she added to MDM.

Dr Hughes suggested they didn't have a seamless pathway.

Kate O'Neill asked if the SAI is to be closed at the end of the wee will be inclusive of MrO'B response.

Dr Hughes advised the draft report is to be completed to see if there is any early learning. He advised draft reports would be sent to the families. He advised families are more interested in how this happened. He added the report will include referrals not made and no contact details made available. He said this can't be done if referrals are not made.

Leanne McCourt advised in the year 19/20 they had 2016 patients. 14 from MrO'B. She advised they may have had a call later and took into process.

Dr Hughes asked staff to share their experiences.

Patricia Kingsnorth asked Leanne to clarify. Were those 14 from MrO'B.

Leanne McCourt advised these may not have been from MrO'B. She agreed to check for Patricia.

Dr Hughes asked if staff had any other questions.

Kate O'Neill advised it would be nice to work in an environment doing one job at a time. Reflected work load.

Dr Hughes acknowledged doctors have a work plan. He asked if they have a job plan.

Kate O'Neill advised it's to do what needs done on the day. If theatres need covered their day would change.

Dr Hughes advised there is no criticism of Nurse Specialists. The issues are with the person not refering patients which is best practice. He advised this review has highlighted the importance of Nurse Specialists. These issues are not of Nurse Specialists doing.

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Kate O'Neill asked if this will be reflected in the report.

Both Dr Hughes and Patricia Kingsnorth said yes.

Jenny McMahon said she feels much better supported now, but back years it took all consultants a while to engage. She added in 2019 all resources were there it is indefensible not to provide contact details.

Dr Hughes advised the report will be written without any criticism of Nurse Specialists but will highlight resource issues.

Jenny McMahon asked if the report could be share with CNS.

Patricia Kingsnorth advised not at this stage it is just shared with staff involved.

Dr Hughes agreed to share the part of the report that refers to Nurse Specialists.

Patricia Kingsnorth suggested Patricia Thompson could share that part of the report.

Dr Hughes read the part referring to CNS from the draft report. He advised he wants to say what happened is against regional guidelines and what the Trust signed up to.

Dr Hughes thanked staff for attending the meeting.

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

CNS COMMENTS

The CNS team believe the use of the word “failsafe” in reference to the CNS/keyworker role is inaccurate and there are numerous references to this term throughout the report (examples below). As identified above in both the NICAN guidelines and the SHSCT MDM operational policy, the ‘failsafe’ function is not described as a responsibility of the CNS/keyworker. Neither is the assertion that the keyworker has a role to ensure all key actions take place as is described in the overarching report ([redacted: Patients 2 and 6] The overarching report also refers to a 3 pronged approach to safe cancer patient care and pathway tracking involving MDM tracking, consultants and their secretaries and the urology nurse specialists. In point 10 of the governance findings, the review team again infer that the absence of a key worker equates to the absence of a safety net for patient pathway completion.

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

Example: Case [redacted: Personal Information redacted by USI]

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

Example: Case [redacted: Personal Information redacted by USI]

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

Example: Case [redacted: Personal Information redacted by USI]

the clinical activity we undertook, the current pressures/issues within the service, the priorities going forward in relation to service development and the educational needs of the team.

5.4 Prior to 2009, my line manager had both clinical and operational responsibility. From 2009 to present, the line manager for operational and clinical activity became separate entities, with formal separation between the Head of Service and the Lead Nurse. I did not consider that this separation of oversight caused any difficulties to my practice or for patient care and risk management. I considered the various skill sets that each individual brought to these encounters to be beneficial and indeed enhanced discussions. All three participants, the Head of Service, Lead Nurse and CNSs would have worked together to address issues of patient care and risk management.

5.5 One of the challenges within this setting was that on occasions, scheduled, planned meetings were cancelled at short notice. Martina Corrigan was the Head of Service (HoS) for four specialties, Urology, Ear Nose and Throat, Ophthalmology and Outpatients. Lead Nurses also had oversight of various areas outside of urology. This presented competing challenges on occasions. A recurring theme for cancellation of meetings were the annual winter bed pressures within the Trust. The input of the HoS and Lead Nurse was required to assist in the management of the staff compliment throughout the Trust. However, in their absence, for whatever reason, there was always accessibility to their colleagues such as another Lead Nurse or HoS for advice/guidance or resolution of any urgent issues, such as the need for sign off on an item of urgent equipment. On other occasions, queries with the HoS or Lead Nurse were resolved through email communication.

6. To whom did you report if you had any problems fulfilling your role or had concerns about patient care and safety?

6.1 I reported any problems fulfilling my role or concerns about patient care and safety directly to my line manager at that specific time. From 2009, when line management functions separated to operational and clinical activity, both

been located over many wards throughout the hospital. In-patient ward rounds occurred at least once a day. Emergency theatre space required negotiation. In addition urgent referrals within the ED or internal across specialty referrals in various ward settings in the Trust were to be assessed. This workload may have presented challenges to completing triage promptly.

58.6 The lookback exercise has highlighted the need for improvement to or extension of the cancer tracking role within the MDT setting as a means to determine have outcomes been actioned as agreed. If patients were tracked beyond the point of first intervention such as the prescribing of medication perhaps mechanisms could be built into this service to identify prescribing discrepancies in the future. In addition, a mechanism could be applied to check that onward referral has taken place.

58.7 In relation to learning, I would have several questions to which I do not have the answer. These include:

(a) Where investigations relating to Mr O'Brien's practice during his time within the SHSCT have taken place and action plans put in place, was there a robust process in place for dealing with non-compliance and to what level of senior management was this issue escalated and addressed?

(b) I am not familiar with the appraisal structure applied to medical staff. If appraisal was with a peer within the urology specialty was this appropriate, or should appraisal involve someone neutral to the specialty/ or indeed from outside the Trust?

59. Do you think there was a failure to engage fully with the problems within Urology Services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

59.1 As stated previously I do not work within the management structure, and therefore do not know the levels to which concerns were raised or discussed.