Minutes of Urology Service Development Day

Consultants Meeting

In attendance: Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
(Mr O'Donoghue joined later).

1.1 Urologist of the week working model.

This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay.

1.2 Triage of new referrals.

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the curent long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week.

1.3 Annual leave.

The team is define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to.

Other business:

Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings.

- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning

normal. However, his serum LDH level was markedly elevated at 1772 U/L. There was some prominence of para-aortic lymph nodes, up to 1 cm at the level of the left renal hilum, on CT scanning on 10 October 2017. He underwent a left radical orchiectomy on 18 October 2017. Histology shows features of a classical seminoma associated with foci of ITGCN. Areas of necrosis are also seen. The tumour is close to the rete testis but does not involve it. Discussed at Urology MDM 26.10.17. [redacted] pathology reveals a T1 Seminoma. His CT shows some indeterminate para-aortic nodes. Mr O'Brien to review in outpatients, obtain up to date tumour markers and refer for oncology review / testicular MDM discussion. [redacted] has been referred to Dr Oladipo in BCH.

MDMAction

Discussed at Urology MDM 09.11.17. Imaging of small retroperineal lymph nodes of uncertain significance. CT PET is recommended and for subsequent MDM discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	None	None
[redacted]	DOB: [redacted] Age: [redacted]	CAH [redacted]	[redacted]	Target Date

Diagnosis: Bladder tumour

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] year old lady had some visible haematuria. She underwent a CT urogram which showed a bladder tumour and a flexible cystoscopy confirmed this. On flexible cystoscopy the mass looked solid. On 27th October 2017 she underwent a EUA and transurethral resection of the bladder tumour. On EUA a palpable mobile mass was located on the left side of the pelvis. Cystoscopy revealed a solid mass in the left side of her bladder. This was resected in 2 parts with a superficial and then deep resection of tissue sent. Post TURBT no mass was found indicating that this could be a pT2 TCC of the bladder. Post operatively a catheter was left in and she was discharged home when her urine was clear. A CT and bone scan was requested and she will be listed for regional MDT discussion and will require review with Mr Glackin thereafter. TURBT, 27.10.17 - Histological examination of both specimens shows fragments of bladder mucosa and detrusor muscle extensively infiltrated by tumour demonstrating features in keeping with WHO grade III urothelial carcinoma. Extensive infiltration of detrusor muscle is noted. The tumour stage is therefore at least pT2. No CIS is noted. Bone scan 02.11.17 - No evidence of bony metastatic disease

MDMAction

Discussed at Urology MDM 09.11.17. [redacted] has muscle invasive bladder cancer with no evidence of metastases. For direct referral to BCH urological surgeons and oncologists for consideration of neoadjuvant chemotherapy and radical surgical management.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'BRIEN A MR (C6514)	None	None	None
Patient 205	DOB: [redacted] Age: [redacted]	CAHE [redacted]	[redacted]	Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] year old man has had lower urinary tract symptoms of a storage nature, due to bladder hypersensitivity, managed by anticholinergic drugs combined with hydrostatic dilation of his bladder in 2006 and in 2010, with limited success. He gained significant symptomatic relief lasting two years following intramural injection of Botulinum Toxin in January 2014. He was placed on the waiting list for further intramural injection of Botulinum Toxin when reviewed in December 2016. An ultrasound scan of his urinary tract was performed on 23 May 2017 in the investigation of intermittent, right renal colic accompanied by haematuria. He was reported to have gross right hydronephrosis and hydroureter, with gross loss of right renal cortex. His right upper tract had been normal on ultrasound scanning in 2012. A CT Urogram on 10 July 2017 found no excretory function from the right

Corrigan identified that a number of referrals had not been triaged by Mr O'Brien. The missing referrals were found in Mr O'Brien's office, triaged by the urology consultants (JODonoghue, AJ Glackin, M Haynes & M Young) and the patients needing urgent treatment seen in clinic quickly. Most of the referrals now for triage are on line so an issue like this is unlikely to occur again.

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within Urology Services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1 In my opinion, the main learning point is to make sure robust systems are in place to ensure all 7 pillars of clinical governance operate effectively. This would involve fully engaging with Clinical Effectiveness, Audit, Risk Management, Patient & Public Involvement, Staff Management, Information and Clinical Governance.

69. 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.

69.1 Yes, I think there was a failure to engage by Mr O'Brien with the Urology Service

69.2 Mr O'Brien failed to triage urology referrals and he failed to refer a patient from the uro-oncology MDM onto another clinician. With regard to his failure to triage, he should have let the Head of Service know that he was struggling to complete the triage. I am not sure if the failures to triage could have been picked up sooner as the referrals at the time were hard copies.

69.3 With regard to his failure to refer a patient for a biopsy from the uro-oncology MDM, he should have involved the cancer nurses to provide oversight that these referrals were done.

Trouton, this being passed to them, the delays having been noted by the Booking Office and Red Flag Team.

64.13 At the time, I was not aware of the meetings held by the Medical Director, Dr Wright, or Clinical Director, Mr Weir, with Mr O'Brien as mentioned in the subsequent correspondence of Mr Haynes. ***(Relevant document located at Relevant to Acute/Evidence after 4 November Acute/Document No 77/Mr M Young/ 20181018 Return to Work AP).***

64.14 It was appreciated that Mr O'Brien was vocal about saying he had difficulty in completing triage as he did not have enough time. I know he wished to perform the 'advanced' triage in a detailed fashion and did not have enough time allocated to do this work. However, he had not indicated the extent to which he was behind in his triaging either in the number of referrals or the timespan they dated back, having had plenty of opportunity to do so in departmental meetings and in his appraisals with me from 2011 to 2016. From recollection, his voiced concerns on triage were from after the time of the introduction of the Urologist of the Week. He raised his concerns at our departmental meetings, whether the topic was scripted for discussion or on an ad hoc basis. The quantum of consultants and the Head of Service at each of these departmental meetings over the years (2014 -18) did vary, however, we all were aware of his comments. It was pointed out that we felt the detail and depth he was aspiring to attain was above the necessary level to complete the totality of the triage for the week. Booking an investigation was the arrangement we had discussed initially when setting up the Urologist of the Week system. ***(Relevant document located at S21 No 55 of 2022, 139. Urol depart autumn 2018).*** I was not aware of anyone else that he had conversed with on this issue nor any correspondence he has produced other than in 2018 for the 'Developmental day' meeting.

64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, to my knowledge, at the meeting in January 2017 as part of the lookback exercise and I am unaware of further meetings on same.

64.16 The more recent concerns in reference to the SAIs in relation to delayed referral on to oncology and the prescribing of Casodex / Bicalutamide, I only became aware of around the time of Mr O'Brien's retirement.

Stinson, Emma M

From: Haynes, Mark [redacted]
Sent: 11 January 2017 12:45
To: Boyce, Tracey
Subject: FW: [redacted]

As discussed below is correspondence between Dr Beckett, Martina Corrigan and me regarding a patient who had no letters from previous consultations. The letter Dr Beckett refers to stating that the patient was to have her non functioning kidney removed was an e-discharge from 15/10/15. She had been seen in OP on 7/9/15 and 7/12/15.

I first saw her when admitted 12/4/16 and she had her surgery later that month.

Mark

-----Original Message-----
From: Haynes, Mark
Sent: 12 April 2016 13:28
To: Corrigan, Martina
Cc: 'Peter.Beckett [redacted]
Subject: RE: [redacted]

I saw this lady this morning on my ward round.

I have not been involved in her care to date, I have not received a referral, there are no letters on ECR and her notes detailing previous consultations were not available to me on the ward..

I have discussed a plan going forward that will depend upon how her current pain settles. If it does not settle she will get a nephrostomy, either way I will be looking to arrange an urgent lap nephrectomy. I cannot at present be certain of the date but would hope that it'll be before the end of May.

Mark

-----Original Message-----
From: Corrigan, Martina
Sent: 12 April 2016 08:08
To: Peter Beckett
Cc: Haynes, Mark
Subject: RE: [redacted]
Importance: High

Good morning,

This patient was admitted this morning via A&E under Mark Haynes. I have copied Mark into this email.

Thanks

Martina

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

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

-----Original Message-----
From: Peter Beckett Personal Information redacted by the USI
Sent: 11 April 2016 12:19
To: Corrigan, Martina
Subject: FW: Patient 103

Martina,
Just to update this girl was at ED in DHH and with me this AM.There was some suggestion of a further uss but I have defererd organising that until I hear what the IUROLOGISTS ARE DOING.

Thanks,
PB

_____
From: Peter Beckett
Sent: 08 April 2016 10:19
To: Corrigan, Martina Personal Information redacted by the USI
Subject: FW: Patient 103

_____
From: Peter Beckett
Sent: 08 April 2016 10:01
To: martina.cottigan Personal Information redacted by the USI
Subject: Patient 103

Martine
Sorry to ask you qabout this patient.I have a letter stating she is to have a non functioning kidney removed.However i am not sure if she is under the care on Mr Haynes or O'Brien and ECR does not help.Could you direct me twhoever might know if she is on a waiting list and if so which one and how long is the wait.
many thanks
PB

Corrigan, Martina

From: Young, Michael
Sent: 27 May 2015 21:36
To: Haynes, Mark; Corrigan, Martina
Subject: RE: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15

Internal email for those on this circulation only

Point taken
Agree
Play a straight honest game.
We are best placed defining our lists but at risk if above comments not taken on board.
Management not playing straight either by resetting patients clock.

But this is not the approach I want for the Dept

Few issues not prepared to put on paper about process = so discuss later.
Discussion required.

Mark's points very valid – I fully appreciate the questions raised

MY
Lead

From: Haynes, Mark
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man (Personal Information redacted by the USI) who went into retention on 16th March 2015, Failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to Surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[redacted] AOB
Referred Sept 2015, Seen OP ([redacted]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[redacted] AOB
Referred 28/10/15, Seen OP ([redacted]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Southern Health and Social Care Trust
Quality Care - for you, with you

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]

An addendum amending this statement was received by the Inquiry on 5 October 2023 and can be found at WIT-103266 to WIT-103269. Annotated by the Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 62 of 2022

Date of Notice: 7th June 2022

Witness Statement of: JOHN P. O'DONOGHUE

I, John P. O'Donoghue, will say as follows:-

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

1.1 I started as a Consultant Urologist in Craigavon Area Hospital on 4th August 2014. My role included inpatient and outpatient treatment, on call duties, teaching and supervision of junior doctors and administration associated with the position.

1.2 The first time I became aware of issues of concern was during Mr O'Brien's sick leave in mid-November 2016. Miss Martina Corrigan, Head of Service for Urology informed the consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) during our weekly departmental meeting that a lot of referral letters for triage had been found in Mr O'Brien's office. They had been found in a filing cabinet and had never been triaged. On his return to work in mid-2017, measures were put in place to enable him to do his triage in a more timely way. Most of the referrals for triage (except those from A + E) went online, He was given the Friday after on call off

to triage and the timeliness of his triage was looked at regularly by Miss Martina Corrigan, Head of Service. I had no involvement in monitoring the timeliness of his triage.

1.3 The failure of Mr O'Brien to triage the referrals for the above-mentioned group of patients was taken as a serious clinical issue. All four substantive consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) triaged the patients as quickly as possible and organised appropriate investigations and clinic appointments. I was not aware of any other clinical issues relating to Mr O'Brien's practice whilst he was working in the Southern Health and Social Care Trust (SHSCT). No person came to me expressing any concerns about Mr O'Brien's practice before he retired.

1.4 I submitted an IR1 on 03/10/2019 ***(relevant document located at S21 62 of 2022 Attachments 1. Datix 03102019)*** when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. The patient was seen in outpatients by Mr Haynes on the 7th October 2019. A plan was made for a nephrectomy and this was carried out in Belfast City Hospital on 9th January 2020. The patient concerned has no evidence of metastatic disease and his last urological review was on 5th April 2022 where he remained well. The datix is still under review in the Trust at present.

1.5 In relation to clinical governance issues, I understood that as a department, we were engaging with all seven pillars of Clinical Governance (Clinical Effectiveness, Risk Management, Audit, Staff Management, Education & Training, Information and Patient/Public Involvement Appraisals were kept up to date and there were no concerns in relation to my practice. I was aware of the Key Performance Indicators (KPI) presented to us at the departmental meeting every month and engaged with efforts to reduce waiting lists and improve performance ***(relevant documents located at S21 62 of 2022 Attachments 2. August 22 Urology Performance, 3. Urology Performance May 2015, 4. Review Backlog 2015).*** KPI included cancer wait times (31 and 62 day targets), red flag/urgent, routine wait times for inpatient, outpatients and day surgery). I engaged fully with the patient safety meeting (Combined and Speciality Specific). I kept up to date with all my patients' results, dictated letters and

TURP Audit (2019)

Introduction

Do we know whether AOB did, in fact, use the bipolar equipment or did he continue to use monopolar in glycine, as his emails at TRU-395976 and 395978 suggest was his intention?

The TURPS equipment was purchased for the Urology Department in January 2018 and put into circulation in April 2018. Therefore it was felt that the best period to look at, and determine did Mr O'Brien use this equipment was January – December 2019 and to ensure equity this audit included all consultant urologists.

Identifying Patients

The Trust's information Team were contacted, (reference 10629 -1023) to request patient details based on Inpatient Finished Consultant Episodes and Daycases (Elective and Non-Elective) that had a TURP procedure performed as either a primary or a secondary operation, using the following codes:

M65	**Endoscopic resection of outlet of male bladder**
	Includes: Endoscopic resection of lesion of outlet of male bladder
	Transurethral resection of prostate
	Note: It is not necessary to code additionally any mention of diagnostic endoscopic examination of bladder (M45.5, M45.9)
	Use a subsidiary code for robotic assisted minimal access approach to body cavity (Y76.5)
M65.1	Endoscopic resection of prostate using electrotome
M65.2	Endoscopic resection of prostate using punch
M65.3	Endoscopic resection of prostate NEC
M65.4	Endoscopic resection of prostate using laser
M65.5	Endoscopic resection of prostate using vapotrode
M65.6	Endoscopic ablation of prostate using steam
M65.8	Other specified
M65.9	Unspecified

The Trust's information Team sent a spreadsheet with this information on 9 October 2023. In total, 121 patients had a TURP done during 2019. 117 patients were done electively and 4 were done as an emergency. There were no daycase TURP's.

Totals for each Consultant and sample picked for audit (Mr O'Brien had the majority of the operations for TURP so double the sample looked at).

Consultant	Elective	Emergency	Total	Total Charts requested
Mr Glackin	12	1	13	5
Mr Haynes	6	0	6	5
Mr O'Brien	57	1	58	10
Mr Tyson	4	0	4	4
Mr O'Donoghue	21	0	21	5
Mr Solt	4	1	5	5
Mr Young	13	1	14	5

Audit Methodology

Patient's Operation Notes, Theatre/Recovery Pathway and Theatre Fluid Balance notes were audited and comments recorded on a spreadsheet (Attached – 2019 TURP Audit Summary).

Findings

Consultant	Bipolar or Monopolar	Glycine or NaCl - Sodium Chloride	Comments
Mr Glackin	3 x bipolar 2 x Greenlight Laser	3 x sodium chloride 2 x n/a	
Mr Haynes	4 x bipolar 1 x monopolar	5 x sodium chloride	Mr D Hennessy was operator for one of Mr Haynes patients
Mr O'Brien	9 x monopolar 1 x bipolar (JOD)	7 x glycine 2 x monopolar had no fluid balance in notes 1 x sodium chloride (JOD operator)	Mr O'Donoghue was operator for one of Mr O'Brien's patients
Mr Tyson	4 x bipolar	4 x sodium chloride	
Mr O'Donoghue	5 x bipolar	5 x sodium chloride	
Mr Solt	4 x bipolar 1 not stated (AOB operator)	3 x sodium chloride 2 x no fluid balance in notes (1 x AOB)	Mr O'Brien was operator for one of Mr Solt's patients
Mr Young	3 x bipolar 2 waiting on notes	3 x sodium chloride 2 waiting on notes	Mr D Hennessy was operator for one of Mr Young's patients

Conclusion

All of the consultants moved to Bipolar with Sodium Chloride apart from Mr O'Brien who continued to use Monopolar and Glycine.

Clayton, Wendy

From: Haynes, Mark
Sent: 20 July 2022 07:45
To: ODonoghue, JohnP; Clayton, Wendy
Subject: Results

Morning John

As you are aware Wendy and I have started to receive weekly reports regarding radiology results sign-off (based upon NIECR signoff data). How we use this data is currently in development.

Below is the data for you for the past few weeks. The information presented only relates to radiology results only, up to 42 days after reporting (and so older results do not appear). I appreciate you have been off on annual leave and therefore results have built up a bit as a result and anticipate that you already plan to catch up with these (in particular those in the orange and red column as these are the longest since reporting) and so would anticipate seeing an improvement in next weeks report.

Mark

20/07/2022	Unsigned - Days since reported			total signed	total unsigned
	0-13	14-27	28+		
JOD	25	16	9	77	50

13/07/2022	Days since reported			total signed	total unsigned
	0-13	14-27	28+		
JOD	18	19	4	89	41

06/07/2022	0-14	14-28	28+	Total not signed off	Total signed off
JOD	20	8	0	28	105

6.0 FINDINGS

- XX case was appropriately discussed at the multidisciplinary meetings pre- and post-surgery.

- A urology review was planned for July 2019 following the CT scan report in June, but this did not happen. The review team note that XX appeared to be lost to follow up.

- In a letter to XX dated 30 November 2019, Dr.1 advised that he was arranging a further CT scan to be performed in December and to reviewing him at the urology clinic in January 2020.

- The review team note that the scan was performed on 17 December 2019 and reported by the radiology team on 4 January 2020, but no follow up occurred.

- The review team have identified that the MDM was not quorate as no oncologist present for the meetings.

- XX was not referred to a Cancer Nurse Specialist or Keyworker to support him with his diagnosis. Nor was any contact details given to him. The Northern Ireland Cancer Services recommendations for Peer Review include that "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"(1). This did not happen and was detrimental to the patient's experience.

- The review team are of the opinion that a specialist nurse would also have been a failsafe for identifying the delayed scan report and bringing it back to the MDM sooner.

  The review team are mindful that the family have concerns that when XX presented in ED with urinary symptoms a PSA was not undertaken. It would appear from the electronic records that a PSA test was never undertaken until August 2020.

- The CT scan, performed in January 2020, was not actioned until July 2020. Fortunately, no significant metastasis related event occurred in this 6 month period so will probably have no long-term effect on the disease's progress.

Irrespective of the guidelines and explanations, it would have been arguably optimal to have arranged a serum PSA level. It is evidently impossible to know what that level would have been in January 2019. It could have been normal then, particularly in view of the lack of any clinical suspicion of carcinoma in December 2018, the lack of any radiological evidence of metastatic disease in June 2019 and the rate of disease progression from December 2019 as indicated by the radiological evidence on CT scanning in December 2019 and August 2020.

However, it is also possible that it may have been found to be elevated to varying degrees, and which may have resulted in a diagnosis of prostatic carcinoma in early 2019. Even if there had been no evidence of metastatic disease then, its staging and management may have curtailed him having a bleeding renal tumour resected. If there had been evidence of metastatic disease then, it would almost certainly have impacted upon the decision to proceed with radical nephrectomy at that time, or at all. He may have suffered even more if he had not had radical nephrectomy performed. The renal tumour itself would have metastasised, if it had not already occultly done so.

I do not believe that there is a compelling argument that he should have had a serum PSA level assessed in December 2018 or in January 2019. I can appreciate the argument that it may have been better if he did have. Equally well, I do believe that it may be argued that it was better that he did not have, as a probably elevated serum PSA level would have inevitably delayed, if not jeopardised, right radical nephrectomy being performed. I believe that XX derived significant benefit from having right radical nephrectomy performed, at least from a palliative perspective.

7.0 Conclusions

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

The conclusion above does not take account of the many administrative tasks and expectations which competed for inadequate time available, never mind provided, to act upon. By the time that I was able to act upon the reported finding, I was even more concerned with regard to the risk of this Personal Information redacted by the USI,

comorbid man who would have been particularly vulnerable had he been infected with the SARS Corona virus, as a consequence of attending for scans, as I believed that he was at grave risk of succumbing to Covid, if infected. It is evident that the risk of Covid infection was a concern for XX as his family have confirmed that he was being shielded from March 2020.

8.0 Lessons Learned

- *An acknowledgement mechanism for email alerts to adverse radiological reports should have been in place.*

  I do not have any record of having received any communication by email regarding the report of 11 January 2020 of the CT scan of December 2019.

  In an inadequately resourced service, such a system would have contributed significantly to the report having been notified earlier, and acted upon prior to the competing safety risks imposed by the Covid pandemic.

- *The MDM tracking capacity was insufficient to provide an additional safety net for patient follow up.*

  Agreed.

- *Absence of a Urology Cancer Nurse specialist is an additional risk for successful patient follow up.*

  Agreed.

9.0 Recommendations and Action Planning

I agree with all four recommendations made in the RCA Report.

Aidan O'Brien

Aimee Crilly

From: McVeigh, Shauna [redacted]
Sent: 21 November 2018 12:04
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Jacob, Thomas; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Hi,

Please see below email from BCH regarding regional cases and radiology.

Thanks
Shauna

From: Evans, Angelae [redacted]
Sent: 21 November 2018 12:02
To: McVeigh, Shauna
Subject: FW: radiology presence?

Hi Shauna,

Just to keep you informed -- please see response from our radiologist below

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: [redacted]
Email : [redacted]

From: Grey, Arthur
Sent: 21 November 2018 11:22
To: Vallely, Stephen [redacted]; Evans, Angelae [redacted]
Cc: Mitchell, Darren [redacted]; OKane, Hugh [redacted]
Lee, Davinia [redacted]
Subject: RE: radiology presence?

Hi all,

I have not reviewed these cases.

I would be happy to display the cases and read out the reports.

This whole situation is dangerous and unsatisfactory.

This issue has been raised numerous times before.

MDM Date	Mr Anthony Glackin	Mr Mark Haynes	Mr John O'Donoghue	Mr Matthew Tyson	Mr Nasir Khan	CONSULTANT UROLOGIST (x2)	Dr Gareth McClean	CONSULTANT PATHOLOGIST (x1)	Dr Marc Williams	Dr Richard McConville	Dr Ryan Connolly	CONSULTANT RADIOLOGIST (x1)	Dr Adam Uprichard	MEDICAL ONCOLOGIST (x1)	Dr Elizabeth Baird	CLINICAL ONCOLOGIST (x1)	Mrs Leanne McCourt	Mrs Kate O'Neill	Mrs Patricia Thompson	CLINICAL NURSE SPECIALIST (x1)	Miss Shauna McVeigh	Cover	MDT CO-ORDINATOR/TRACKER (x1	QUORATE	Reason for not being quorate
06/01/2022	1	1	1	1	1	Y	1	Y	1	0	0	Y	1	Y	0	N	1	0	0	Y	1	0	Y	No	No Clinical Oncologist
13/01/2022	No MDM																								
20/01/2022	1	1	1	1	0	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
27/01/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	1	1	Y	1	0	Y	No	No Radiologist
03/02/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
10/02/2022	1	0	1	0	0	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
17/02/2022	1	1	1	0	1	Y	1	Y	0	0	0	N	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
24/02/2022	1	0	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	0	1	Y	Yes	
03/03/2022	1	0	1	1	0	Y	1	Y	0	0	0	N	1	Y	0	N	1	0	1	Y	0	1	Y	No	No Radiologist or Clinical Oncologist
10/03/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Radiologist
17/03/2022	No MDM																								
24/03/2022	1	0	1	1	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
31/03/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
07/04/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	Yes	
14/04/2022	1	0	0	1	0	Y	1	Y	1	0	0	Y	0	N	0	N	1	0	1	Y	1	0	Y	No	No Clinical or Medical Oncologist
21/04/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
28/04/2022	No MDM																								
05/05/2022	1	1	1	0	1	Y	0	N	1	0	1	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
12/05/2022	1	0	0	1	1	Y	0	N	1	0	1	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
19/05/2022	1	1	1	1	0	Y	0	N	0	0	1	Y	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
26/05/2022	0	0	1	0	1	Y	0	Y	1	0	0	Y	0	Y	1	Y	1	1	0	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced

presented its own challenges such as poor broadband connection. If this occurs when the Chair is attempting to link into the regional meeting from an off-site location, a colleague will present the cases to avoid unnecessary delays.

48.4 In the main, communications were courteous in nature. Only on a few occasions have I ever felt a little ill at ease. One example I can recall was when Mr O'Donoghue was Chair of MDT. The meeting commenced a few minutes ahead of the agreed start time of 14:15pm. Mr O'Brien joined the meeting at the agreed time or a few minutes later, I cannot be sure. Mr O'Brien expressed his dissatisfaction that the meeting had commenced ahead of schedule. He directed his dissatisfaction toward the Chair, his voice was raised and tone forceful in nature. Mr O'Donoghue apologised that the meeting had commenced ahead of time, and after approximately five minutes during which time Mr O'Brien expressed his discontent, the MDT continued to a conclusion. As none of the content of the communication was directed towards me, I did not dwell on this encounter, though at the time I felt embarrassed for Mr O'Donoghue. I thought the encounter was unnecessary, as the discussion and outcomes up to that point could have been recapped. At no time did I feel that patient care or care planning were impacted upon.

49. Did you experience any other difficulties with MDT generally or clinician care and practice which may have impacted on your role, patient care and clinical risk?

49.1 From MDT commenced in 2010 until 2012, the meeting would have regularly overrun significantly, delaying the end of the working day for those present. Not all participants could remain for the entirety of the MDT on these occasions. Reasons for this would have included for example childcare responsibilities.

49.2 In 2022, an MDT proforma was introduced to ensure that the locally agreed minimum dataset is available for each patient being discussed at the MDT. The minimum dataset includes patient details, referring Consultant, clinical details,

I considered the practice to be concerning as I believed that it presented a very real risk that patients would not be reviewed at all. Since then, I had been contacted informally by a number of patients requesting that I review their management as they had not been reviewed for some time. It was as a consequence that I came to appreciate that Mr Haynes had effectively completely replaced holistic urological, clinical review of the patient with an ongoing monitoring of their pathology, based solely upon the results and reports of investigations. I became aware prior to the end of my employment that other colleagues were aware of this practice.

398. I believe that this is an important issue which requires consideration and discussion. I believe that it probably developed as a consequence of the service inadequacy. If that inadequacy contributed to the introduction of DARO, then DARO becomes self-perpetuating to the extent that review of the patient is completely replaced by the unidirectional communication of monitored results and reports, and can become the next, new standard of care. I believe that there is a place for both monitoring and communication of results and reports by staff provided with the time to do so, and review of the patient as well as their pathology. Regrettably, my employment was terminated prior to my having the opportunity of discussing this probably contentious issue with my colleagues.

399. Lastly, with regard to Mr Haynes, I have been most disappointed to learn since 2016 the extent to which he criticised me to others, formally and informally, without ever speaking to me regarding any concerns or criticisms which he did have. Needless to say, this disappointment reached its zenith when I realised that he was prepared to make an untrue allegation against me with regard to two out of ten patients not being on the Patient Administration System when they should have been (and were) in order to justify a Look Back review of my practice.

400. The only reason for my having any concern regarding the practice of my former colleague, Mr John O'Donoghue, was in his previewing of cases in

preparation for Urology MDMs which he chaired, and in the chairing of them. I had no doubt that he did not adequately preview cases for MDM. On enquiring why he had not adequately previewed a case while that case was being discussed, he explained that he did not have adequate time to do so. In that regard, he could hardly be faulted as we did not have adequate time to prepare for MDM as Chairs, if at all. The lack of adequate preview probably also contributed to the quality of his chairing, as his dictation of the outcomes of MDM discussions was often truncated, or incorrect, as in the case of Service User A (SUA) [see AOB-40064 – AOB-40074].

401. I did not have any reason for concern regarding the clinical practices of Mr Anthony Glackin or of Mr Mathew Tyson, Consultant Urologists, or of Mr Derek Hennessey or of Mr Thomas Jacob, Locum Consultant Urologists. However, the assessment and management of an inpatient by Mr Ram Suresh, Consultant Urologist, following the transfer of the patient from South West Acute Hospital in late 2015 with evidence of a significant intra-abdominal, secondary haemorrhage following an earlier partial nephrectomy did give rise to concern regarding his clinical acumen and ability to undertake emergency surgery in a life-threatening situation when UOW. This case was discussed with me and his remaining colleagues by Mr Mackle, then Associate Medical Director and Mrs Corrigan, Head of Service, in early 2016 when we were requested by them to provide back-up support for Mr Suresh when UOW. As can be seen from the email from Martina Corrigan dated 4 March 2016 [AOB-76726] a meeting took place on 17 December 2015 following the above incident and then a follow up meeting took place on 4 March 2016. I was not present at that meeting, but the email indicates that Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, and Ms Corrigan were present. The following support measures were agreed to be put in place to assist Mr Suresh:

RE: Personal Information redacted by the USI

Personal Information redacted by the USI Hospital Number: Personal Information redacted by the USI , HCN: Personal Information redacted by the USI

ONSULTANT MR O'BRIEN: This Personal Information redacted by the USI man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

An ultrasound scan of urinary tract and transrectal, ultrasound guided, prostatic biopsies were requested.

TRUS Biopsy, 20.08.19 - Prostatic adenocarcinoma of overall Gleason sum score 4 + 3 = is present in 7 of 20 cores with a maximum tumour length of 6 mm. The tumour occupies approximately 8% of the total tissue volume.

Discussed at Urology MDM 29.08.19. Personal Information redacted by the USI has high risk prostate cancer. For review with O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at M with radiology results.

Personal Information redacted by the USI was advised of the histopathological diagnosis of prostatic carcinoma on 23 September 2019 when his serum PSA had increased to 21.8 ng/ml and his serum testosterone was 19.3 nmol/L. He was prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mg daily while awaiting completion of imaging. The medication was accompanied by intolerable adverse toxicity, mainly in the form of light headedness, and to the extent that he lost the confidence to drive. He was advised to discontinue taking both on 14 October 2019, and to resume taking Bicalutamide 50 mg daily alone on 01 November 2019. A bone scan and CT scan of chest, abdomen and pelvis were requested. A review on 11 November 2019 was arranged.

CT, 28.10.19 - No evidence of metastatic disease.

Bone scan, 31.10.19 - The bone scan appearances are considered to be unremarkable. Presumed degenerative change at L5. No convincing evidence to suggest a pattern of osteoblastic metastasis.

Discussed at Urology MDM 31.10.19. Review with Mr O'Brien as arranged. Personal Information redacted by the USI has intermidate risk prostate cancer to start ADT and refer for ERBT.

Personal Information redacted by the USI has review appointment with Mr O'Brien on 11.11.19.

(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.

(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?

(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

49.1 The only issue I raised was a SAI from the Uro-Oncology Meeting in 2019. I submitted an IR1 on 03/10/2019 when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. He was seen in clinic the following week and arrangements were made for him to have surgery in the next few months. He had a nephrectomy in early January 2020. His latest review in relation to this was in early 2022 and he has suffered no consequences as a result of the delay up to now. The investigation with regard to the circumstances of the delay is ongoing.

50. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether in your view these issues of concern were -

(a) Properly identified,

(b) Their extent and impact assessed properly, and

(c) The potential risk to patients properly considered?

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the
Submitted time (hh:mm)	16:25

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	03/10/2019
Time (hh:mm)	15:00
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	This patient was discussed at Uro-Oncology MDM 3/10/2019 and it would appear outcomes from previous Uro-Oncology MDM (27/06/2019) have not been actioned.
Action taken Enter action taken at the time of the incident	Agreement by multi-disciplinary team at MDM (3/10/2019) that chair should request review of process that has led to this apparent delay. Patient will be seen in clinic next week to expedite process.
Learning Initial	To be determined
Reported (dd/MM/yyyy)	03/10/2019
Reporter's full name	john P. O'Donoghue
Reporter's SHSCT Email Address	Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	21/10/2019
Last updated	Carly Connolly 09/11/2020 15:35:08
Has safeguarding been considered?	
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 112

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
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient	Recipient E-mail	Date/Time	Contact	Telephone	Job title	Originated

PATIENT PATHWAY	
Tumour Site	Urology
Name	Patient 112
Hospital Number	Personal Information redacted by the USI
HCN	Personal Information redacted by the USI
DAY	
	23/06/2019
	27/06/2019
	27/06/2019
	11/07/2019
	11/07/2019
	17/07/2019
	19/07/2019
	25/07/2019
	02/08/2019
	08/08/2019
	09/08/2019
	09/08/2019
	16/08/2019
	06/09/2019
	13/09/2019
	19/09/2019
	25/09/2019
	03/10/2019

Other referred to Craigavon
Diagnosis
MDM Action : Discussed at Urology MDM 27.06.19. Patient 112 has been found to have a right renal mass on recent CT scanning. For review by Mr O'Brien to advise a right renal biopsy with factor VIII.
Review to be booked post MDM with AOB.
Other referred to Belfast City
Other referred to Craigavon
AWAITING AN APPOINTMENT
Review post MDM is to be booked with AOB - awaiting slots.
Review remains to be booked following MDM - secretary has been emailed, no slots.
This man has been placed on an urgent WL for appointment have emailed secretary as not sure if this is related to review post MDM.
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
Secretary advised - Mr O?Brien is seeing this patient at his clinic on Friday the 16th of August 2019.
First Seen at Craigavon - Mr O'Brien
Clinic letter not dictated, don't see that a biopsy has been requested for this man. Will check with Mr O'Brien.
Response awaited from Mr O'Brien regarding this man - no biopsy has been requested.
Response awaited from Mr O'Brien regarding this man - no biopsy has been requested, clinic letter not avialable
No reviews booked, no biopsy requested, clinic letter still not available
Have relisted this man for MDM as unsure as to what is happening with him, delays in his pathway.

	04/10/2019
	04/10/2019
0	**07/10/2019**
0	07/10/2019
0	**09/10/2019**
0	09/10/2019
0	09/10/2019
0	11/10/2019
0	11/10/2019
0	01/12/2019

Continue to escalate capacity problems and any dela

DATE

DATE

FOR THE SDU USE ONLY

FURTHER ACTION

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.
Update from Mr Haynes - following Datix - Personal Information redacted by the USI - Mr O?Brien has responded to me with an update regarding this patient (attached). In summary, Patient 112 is mid chemo and not able to proceed to management of his renal mass. He has also had an up to date CT. Aidan has listed him for MDM discussion next week. I am planned to see the patient next week and his renal management will be organised once he has completed, and recovered from his lymphoma chemotherapy.
Decision to Treat
Suspension Start : Suspension - Medical After chemo for lymphoma
Inter Trust Transfer referred from Craigavon to Cancer Centre
Mr Haynes reviewed this man 07.10.19 - Plan for laparoscopic radical nephrectomy early December 2019 Belfast City Hospital with factor 8 cover.
Have ITT this man to BCH surgery to be performed under Mr Haynes in December 2019.
undergoing chemotherapy for lymphoma and for Sx when chemo complete. Last cycle to commence 7.11.19 therefore
Sx - Hayes - For consideration of Sx in December after chemo for lymphoma.
Suspension End : Suspension - Medical After chemo for lymphoma

ys in the pathway and work closely with the team to try to avoid furthe

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

Kind regards
Patricia

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

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

Dear Patricia

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

This case does not raise any alarms in my head.

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

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

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

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

Nephrectomy proceeded after the chemotherapy (successful) was completed.

40.1 The only issue I raised was an SAI from the Uro-Oncology Meeting in 2019. I submitted an IR1 on 03/10/2019 when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. It is documented on an IR2 form ***(relevant document can be located at S21 62 of 2022 Attachments 1. Datix 03102019)***. This is an ongoing investigation.

41. What systems were in place for collecting patient data in Urology Services? How did those systems help identify concerns, if at all?

41.1 The head of Service identified KPI including 62 and 31 day cancer targets and waiting list targets (red flag, urgent and routine). Mortality is collected through the Clinical Governance Department and patient deaths and morbidity are discussed at the monthly patient safety meeting (PSM). Cancer trackers ensure that patients with cancer pass through the uro-oncology MDM in a timely manner. Issues with MDM patients are often only picked up when patients are discussed again at the MDM and this can be several months down the line from the original discussion.

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

42.1 KPI are accurate and discussed monthly allowing remedial action to be taken if necessary. In relation to the issue regarding the uro-oncology MDM, this is a much slower system to react and can potentially take weeks before issues are identified.

42.2 Patient mortality is picked up by the Clinical Governance Department from death certificates and put forward for discussion at the PSM. This is done on a monthly basis. The systems did not change during my tenure.

43. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any performance objectives relevant to Urology during your time (and identify the origin of

5.0 DESCRIPTION OF INCIDENT/CASE

than surveillance with PSA monitoring.

6.0 FINDINGS

Diagnosis and Staging

- 5 of the 9 patients in this review experienced significant delay in diagnosis of their cancer. This was related to patients with prostate cancer and reflected variable adherence to regionally agreed prostate cancer diagnostic pathways, NIACN Urology Cancer Clinical Guidelines (2016).
- Service User B had a delay of over 15 months from presentation.
- The review team could not find evidence of a Digital Rectal Examination in the notes of Service User D - potentially missing an opportunity to detect his high grade cancer earlier in his pathway.
- Service User F had a slow initial diagnostic pathway which was outside expected cancer care time-frames.
- Service User C 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 I had a delayed diagnosis of Prostate cancer due to non-action on a histopathology report at TURP.
- Patient H 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.
- Service User G 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.

Targets

- Three of the nine patients were said to have met one of their 31 / 62 day targets.
- Service User I was said to have met his diagnostic target for 31 days despite his tissue cancer diagnosis being missed and the patient suffering an 8 month delay.
- Service User H was said to have met his 62 day (1st treatment) target but had been referred down a pathway that did not meet the NICAN Urology Cancer Guidelines 2016. A regional Penile Cancer Pathway was agreed in January 2020.
- Service User B was said to have met his diagnostic target of 31 days despite having a delay from initial presentation of 15 months.