Patie[redacted]ils
Nam[redacted]
D.O.E[redacted]
H&C [redacted]

Date of Clinic / Decision to list	14/05/20
Consultant	AO'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT UPPER TRACT OBSTRUCTION
Procedure:	REMOVAL OF STENT & RIGHT URETEROSCOPIC LITHOTRIPSY
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR UHC OR KINGSBRIDGE OR DHH

Urgency *Please tick appropriate box*	
Red Flag	
Urgent	✓
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	AS ABOVE
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☑ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐

- **Aspirin 300mg?** ☐

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:
a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

- **Clopidogrel** or **Prasugrel?** ☐

Please advise:
a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☑ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	[redacted]	**Print Name**	AO'BRIEN	**Date**	07.06.20
Countersigned (Consultant)				**Date**	

Patien	Personal Information redacted by the USI	details
Name:		
D.O.B.		
H&C N		

Date of Clinic / Decision to list	15.06.22
Consultant	A O'BRIEN
Specialty	UROLOGY

*** FOR URGENT BOOKABLE LIST ***

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	RIGHT URETERIC AND BLADDER INJURY
Procedure:	CYSTOSCOPY, REMOVAL OF STENT, RIGHT URETEROGRAPHY & CYSTOGRAM
Estimated Duration of Surgery:	1 HOUR
Additional Comments / Instructions:	FOR ADMISSION TO DHH

Urgency *Please tick appropriate box*	
Red Flag	
Urgent	✓
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	DHH
Specific Unit Requirement	LEVEL 4
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☑ ENOXAPARIN 60 MGS DAILY

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐
- **Aspirin 300mg?** ☐
- **Clopidogrel** or **Prasugrel?** ☐
- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

PLEASE TURN OVER & indicate the bleeding risk of the procedure.

Please advise whether the Patient should either:

a. Reduce to 75mg daily 7days prior to surgery ☐
b. Continue to take as normal ☐
c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐

Please advise:

a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
b. Patient should discontinue 7days prior to surgery ☐

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☑ Yes ☐ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Personal information redacted by USI	**Print Name**	ADAM O'BRIEN	**Date** 07.06.22
Countersigned (Cons				**Date**

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 07 July 2020 13:21
To: Carroll, Ronan
Subject: FW: Cases

FYI
Haven't circulated wider. Want to discuss with all later in this meeting. I have informally discussed with an oncologist who feels that both of these patients have been managed in a substandard manner and potentially their progression may not have occurred had they been investigated / managed in a standard manner.
Mark

From: Haynes, Mark
Sent: 07 July 2020 12:58
To: OKane, Maria
Subject: Cases

These two cases need a discussion and will need SAI completing. Can we cover them (perhaps without Irrelevant redacted by the USI at the end of todays call?

Personal Information redacted by the USI Patient 1 (Personal Information redacted by the USI)
MDM 31/10/20 'Review with Mr O'Brien as arranged. Patient 1 has intermidate risk prostate cancer to start ADT and refer for ERBT.' Commenced on bicalutamide 50mg (not full dose), was then increased to 100mg and subsequently 150mg (the appropriate dose, March 2020). Was not refered to oncology. Subsequently developed local progression of disease (retention) necessitating catheterisation and subsequent TURP. Re-staged and now metastatic.
Concerns;

1) MDM outcome not enacted and consequently management was below standard and outside of any guidance.
2) Patient developed local progression and metastatic disease. Evidence would suggest that had he been managed as per MDM outcome risk of local progression lower (ie would have potentially not gone into retention), and time to development of metastases would have been delayed.

Personal Information redacted by the USI Patient 9 (Personal Information redacted by the USI)
Referred urinary retention May 2019, abnormal prostate examination '… it was certainly my impression that Patient 9 had a malignant prostate gland, and that indeed it may have been locally advanced.'. Commenced on bicalutamide 50mg and TURP. TURP pathology benign. Planned for review (did not happen due to backlog). Represented May 2020 with urinary retention and now locally advanced (T4) prostate cancer with enlarged pelvic nodes, full staging not yet completed. Biopsies have shown prostate cancer.
Concerns;

1) Initial investigation was non-standard. In order to diagnose prostate cancer a specific prostate biopsy should be performed (not a TURP) preceeded by MRI imaging of the prostate (in the case of an abnormal prostate examination, biopsy should be recommended even if MRI normal).
2) Patient has subsequently presented with complications of local progression and may have metastatic disease. Evidence is that had diagnosis been made in May 2019 and appropriate management commenced (ADT and likely RT), this could have been prevented, additionally may have prevented / delayed metastases (if confirmed).

Mark

Datix

Carly Connolly

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal information redacted by USI
Submitted time (hh:mm)	12:59

Incident IR1 details

Notification email ID number	Personal information redacted by USI
Incident date (dd/MM/yyyy)	31/10/2019
Time (hh:mm)	16:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	No
Description Enter facts, not opinions. Do not enter names of people	Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged June 2020 and developed metastatic disease.
Action taken Enter action taken at the time of the incident	Patient and family have been seen in outpatients and the diagnosis and future management plan discussed. Family asked if earlier treatment with EBRT would have changed the course and I have advised them that the care would be looked into.
Learning Initial	Concern MDM outcome not followed and patient has subsequently developed progression of disease.
Reported (dd/MM/yyyy)	14/07/2020
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	14/07/2020
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 1

Location of Incident

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

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Burns, Sandra Mrs	Personal Information redacted by the USI	14/07/2020 13:00:36	Personal Information redacted by the USI		Senior Governance Officer- Nursing
Connolly, Connie		14/07/2020 13:00:35			Acting Acute Governance Co-Ordinator
Cardwell, David		14/07/2020 13:00:35			Clinical Governance Manager
Kingsnorth, Patricia Mrs		14/07/2020 13:00:35			Acute Governance Co-Ordinator
Connolly, Carly		14/07/2020 13:00:35			Clinical Governance Manager
Law, Anne Mrs		14/07/2020 13:00:34			Practice Education Facilitator
Corrigan, Martina		14/07/2020 13:00:34			Head of ENT and Urology
Carroll, Ronan		14/07/2020 13:00:34			Assistant Director of Acute Services
Young, Michael		14/07/2020 13:00:34			Consultant
Haynes, Mark Mr		14/07/2020 13:00:34			Consultant Urologist
ONeill, Kate		14/07/2020 13:00:33			Ward Sister, Thorndale
McMahon, Jenny		14/07/2020 13:00:33			Sister in Charge (Thorndale)
Ward, Sarah Sr		14/07/2020 13:00:33			Acting Lead Nurse

Management of Incident

Handler
Enter the manager who is handling the review of the incident

Additional/dual handler
If it is practice within your team for two managers to review incidents together use this field to record the second handler

Escalate

You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.

Date of final approval (closed date) (dd/MM/yyyy)

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category

Sub Category

Detail

Datix CCS2

Type

Category

Sub-Category

Detail

Is this a Haemovigilance /Blood Transfusion or Labs-related Incident? No

Is this an incident relating to confidentiality? No

This may include inappropriate access / disclosure, loss or theft of records etc

SAI / RIDDOR / NIAIC?

Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI?

Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

Is this incident RIDDOR reportable?

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):
1. Employee or self-employed person working on Trust premises is killed or suffers a major injury
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. Dangerous Occurence attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;
- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm Catastrophic

This has been populated by the reporter. To be quality assured by the investigating manager.

Risk grading

Click here
When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances.

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○

(Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:	Possible (Expected to occur monthly)	○	○	○	○	○
	Unlikely (Expected to occur annually)	○	○	○	○	○
	Rare (NOT expected to occur for years)	○	○	○	○	○
	Grade:					

Action taken on review

Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

Action Plan Required?

A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions.

Lessons learned

Lessons learned

If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any equipment involved in the incident? No

Notepad

Notes

Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information

Communication

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message
No messages			

Medication details

Stage

Prescriber Name

Medication error

Medication involved

If multiple medications involved enter the primary medication affecting the incident, and record the others in the description

Correct medication

Form administered

Correct form

Dose and strength involved

Correct dose

Route involved

Correct route

Falls Information

Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or Community Setting?

Specific Location of Fall

Exact location of Fall

Please describe in free-text exactly where the fall occurred

Injury Suspected?

Harm?

Buzzer / bell available within reach before fall?

Floor surface

Footwear suitable?

Walking aid in use / reach?

Mental State	
First fall this admission or repeat?	
Days since admission	
Was the patient receiving medication which may affect the risk of falling?	
Family informed of fall?	
Outcome of Bedrails Assessment	

Pressure Ulcers

Was this incident in respect of a Pressure Ulcer?	No

Equipment details

Product type	
Brand name	
Serial no	
Description of device	
Current location	
CE marking?	
Description of defect	
Model/size	

Documents added

No documents.

People Affected

ID	Title	Forenames	Surname	Type	Current approval status
Personal Information redacted by the USI		Patient 1		Patient/Client/Service User	Unapproved
		Aidan	O'Brien	Staff - Medical and Dental	Unapproved

Employees

No Employees

Other Contacts

No Other Contacts

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION: **SHSCT**	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: 1 [Personal information redacted by USI]
3. HOSPITAL / FACILTY / COMMUNITY LOCATION S Craigavon Area Hospital	4. DATE OF INCIDENT: 31.10.2019
5. DEPARTMENT / WARD / LOCATION EXACT Urology Department	
6. CONTACT PERSON: Mrs Patricia Kingsnorth	7. PROGRAMME OF CARE: Acute

8. DESCRIPTION OF INCIDENT:

[Patient 1] was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). [Patient 1] was not referred for ERBT and his hormone treatment was not as per guidance. In March 2020 [Patien t 1]s PSA was rising and when restaged in June 2020 [Patient 1] had developed metastatic disease.

JOB: [Personal Information redacted by the USI] GENDER: M AGE: [Persona l Informat]

(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*
D1000	D10700	D10703

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: - Patient has been seen in outpatients and diagnosis and future management plan discussed.

11. CURRENT CONDITION OF SERVICE USER: - alive.

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*		NO	
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES		

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	X
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service	

Received from Mr Mark Haynes on 20/09/22. Annotated by the Urology Services Inquiry.

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM	
user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*		NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: 17/07/2020
		specify reason: To be informed when review team meet

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*		NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		
19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 2	

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: Patricia Kingsnorth Designation: Acting Acute Clinical & Social Care Governance Coordinator

Email: Personal Information redacted by the USI Telephone Personal Information redacted by the USI Date: 10/08/2020

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: Personal Information redacted by the USI

and (*where relevant*) Personal Information redacted by the USI

Patient: Patient 1
H&C: Personal Information redacted by the USI

Date/ Time	Summary Of Events	Staff
13/06/19	GP red flag referral for nocturia raised PSA	
14/06/19	Letter received	
17/06/19	Letter– reviewed by consultant plan for MRI scan and appointment arranged for 22 July 2019	AOB
21/06/19	MRI requested for Pelvis- Referred as rising PSA 19.81 on 12 June 2019 Previous MRI June 18 – prostatic enlargement.	
10 /07/19	MRI reported	
Personal Information redacted by USI	Attended OPD appointment in SWAH – advised possible malignancy of prostate, raised PSA. Arranged to have appointment in SWAH of scan of urinary tract in particular in relation to bladder voiding on micturition. Also requested appointment to attend Thorndale Unit in CAH Dictated 13/08/19 typed 03/09/19	
Personal Information redacted by USI	Thorndale Unit for trans biopsy of prostate under local anaesthetic.	Nurse Kate ONeill
29/08/19	MDT	
23/09/19	Attended OPD CAH advised no evidence of prostatic adenocarcinoma in any of the 9 cores taken from the right lateral lobe of the prostate gland. He was found to have Gleason 4+3 adenocarcinoma found in 7 of the 11 cores taken from the right lateral lobe of his prostate gland. The maximum tumour length was 6mm and tumour was considered to occupy approx. 8% of total core tissue volume. There was no evidence of perineural infiltration, lymphovascular infiltration or extracapsular invasion. Advised nature of adenocarcinoma to be high risk category particularly in relation to high PSA 20ng.ml even though he had been taking Finasteride since 2010. For this reason – initiated androgen blockade by prescribing Bicalutamide 150mgs daily in addition to tamoxifen 10mgs daily in order to minimise the risk of gynaecomastia arising as a consequence of androgen blockage. Requested radioisotope bone scan and CT CAP GP requested to prescribe Bicalutamide 50mgs daily. Letter to GP dictated 14/10/19 typed 15/10/19	AOB
14 /10/19	Patient 1 spoke to consultant secretary and subsequently consultant to advise that the combination of Bicalutamide and Tamoxifen had resulted in adverse toxicity which he found difficult to tolerate. Reported fuzzy head concerned unsafe to drive. Therefore discontinued until end of October. Will assess tolerance at clinic appointment on11 November 2019.	

Patient: Patient 1
H&C: Personal Information redacted by the USI

Personal information redacted by USI	Seen at clinic in SWAH - able to tolerate lower dose. Bloods taken PSA. Seen at clinic. Letter states It would be ideal to have optimal biochemical response to androgen blockade or androgen deprivation prior to consideration for radical radiotherapy. If his PSA has not decreased further it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of Bicalutamide to 50mgs twice a day and hopefully subsequently to taking the higher dose of 150mgs once again. As I suspect that the addition of a LHRH agonist may be more intolerable. Dictated 2/1/20 typed 10/01/2020	
2/1/2020	Phone call from AOB to Patient 1 – PSA dropped to 3.84 Needs repeat bloods in preparation for clinic appointment in January.	
Personal information redacted by USI	Seen at OPD appointment Serum PSA down 2.23 by 7th January 2020. Noted to be doing well. Only problem nocturia (twice at night). Plan to increase Bicalutamide 100mgs daily.	
5/3/2020	Serum PSA increased 5.37ng/ml	
11/3/2020	Letter to GP asking to increase dose to Bicalutamide 150mgs daily indefinitely. Plan repeat PSA mid-April. Plan review in SWAH 27th April 2020.	
27/04/2020	Appointment cancelled in view of covid outbreak. PSA check on 14 April – 12.08ng	
1/06/2020	Consultant spoke with Patient 1 advised to commence Leuprorelin 3.75mgs to be administered subcutaneously. To commence 1st week in June and repeat bloods at the same time. Plan for TURP in DHH. Needs to have adenocarcinoma restaged by having radioisotope bone scan.	
Personal information redacted by USI	Admitted to DHH for TURP Complicated by urinary sepsis requiring iv antibiotics. Failed trial removal of catheter for repeat TROC in SWAH in two weeks.	
Personal information redacted by USI	Discharged from DHH	
	Pathology report Adenocarcinoma – perineural and lymphovascular invasion seen.	
22/6/2020	Letter to GP Noted further elevation of PSA from 27.22ng/ml on 3 June 2020 to 29.5ng/ml on 12 June 2020.	

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 06 October 2020 10:54
To: OKane, Maria; Gormley, Damian; Corrigan, Martina; Carroll, Ronan; McClements, Melanie; Toal, Vivienne; Kingsnorth, Patricia; Hynds, Siobhan
Cc: Wallace, Stephen
Subject: RE: A further case

Yes. I think this is the most significant case to date – MDM outcome not followed, inadequate treatment given, patient experienced complications of untreated disease necessitating surgery and an inpatient stay which potentially could have been avoided.

Will do the IR1 shortly.

Mark

From: OKane, Maria
Sent: 06 October 2020 10:51
To: Haynes, Mark; Gormley, Damian; Corrigan, Martina; Carroll, Ronan; McClements, Melanie; Toal, Vivienne; Kingsnorth, Patricia; Hynds, Siobhan
Cc: Wallace, Stephen
Subject: RE: A further case

Mark thanks. I think so. I am concerned that the advice of the MDM was not followed given that this would have been agreed, I am presuming that this was not communicated back to the MDM and the patient then was treated suboptimally and that this could have been avoided. Maria

---

From: Haynes, Mark
Sent: 06 October 2020 10:42
To: OKane, Maria; Gormley, Damian; Corrigan, Martina; Carroll, Ronan; McClements, Melanie; Toal, Vivienne; Kingsnorth, Patricia; Hynds, Siobhan
Subject: A further case
Importance: High

Morning

I am going through the AOB MDM outcomes. This man I believe requires an IR1.

Do you agree?

If yes, what should we do about contacting this mans family as he has passed away? I presume wait until public announcement next week?

Summary below;

Mark

Personal Information redacted by the USI	Prostate	Mr O'Brien	Discussed at Urology MDM 25.07. Patient 4 has a high grade prostate on his TURP pathology. There is n evidence of metastases on a CT a pelvis. Mr O¿Brien to review in ou commence an LHRHa, arrange a and bone scan and for subsequen review.

Datix

Carly Connolly

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal information redacted by
Submitted time (hh:mm)	14:08

Incident IR1 details

Notification email ID number	Personal information
Incident date (dd/MM/yyyy)	31/10/2019
Time (hh:mm)	15:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	No
Does this incident involve a Staff Member?	Yes
Description Enter facts, not opinions. Do not enter names of people	Initial assessment May 2019. Clinically felt to have a malignant prostate. Commenced on Bicalutamide 50mg OD, TURP arranged (Benign pathology). Reviewed in outpatients in July 2019. Planned for repeat PSA and further review. Emergency Department attendance May 2020 resulting in catheterization. Rectal mas investigated and diagnosed as locally advanced prostate cancer. Commenced on Hormone treatment July 2020 and staging investigations arranged.
Action taken Enter action taken at the time of the incident	Discussed at MDM and prompt Outpatient review and commencement of treatment arranged.
Learning Initial	Concern TURP is not a diagnostic investigation for suspected prostate cancer and no prostate biopsies were performed despite clinical suspicion of locally advanced prostate cancer. Dose of bicalutamide patient commenced on below dose for standard antiandrogen monotherapy and no plan to utilize at this dose as cover for commencement of LHRHa therapy. No additional staging investigations arranged despite clinical impression of locally advanced prostate cancer. Patient subsequently re-presented with complications of local progression of untreated prostate cancer.
Reported (dd/MM/yyyy)	28/07/2020
Reporter's full name	[redacted]
Reporter's SHSCT Email Address	[redacted]
Opened date (dd/MM/yyyy)	30/07/2020
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.	[redacted]

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

Management of Incident

Reasons for Rejection - History

Linked records

Coding

Datix Common Classification System (CCS)

Datix CCS2

SAI / RIDDOR / NIAIC?
Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI?

Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

Is this incident RIDDOR reportable?

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):
1. Employee or self-employed person working on Trust premises is killed or suffers a major injury
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including

weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. Dangerous Occurence attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;
- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm: Major

This has been populated by the reporter. To be quality assured by the investigating manager.

Risk grading

Click here
When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	O	O	O	O	O
Likely (Expected to occur weekly)	O	O	O	O	O
Possible (Expected to occur monthly)	O	O	O	O	O
Unlikely (Expected to occur annually)	O	O	O	O	O
Rare (NOT expected to occur for years)	O	O	O	O	O

Grade:

Action taken on review

Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

Action Plan Required?

A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions.

Lessons learned

Lessons learned

If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any person involved in the incident? No

Was any equipment involved in the incident? No

Notepad

Communication

Medication details

Falls Information
Please Quality Assure all information as part of your investigation

Pressure Ulcers

Equipment details

Documents added

People Affected

Employees

Other Contacts

Datix

Carly Connolly

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information
Submitted time (hh:mm)	06:25

Incident IR1 details

Notification email ID number	Personal information redacted by USI
Incident date (dd/MM/yyyy)	20/08/2019
Time (hh:mm)	12:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	No
Does this incident involve a Staff Member?	Yes
Description Enter facts, not opinions. Do not enter names of people	Diagnosed with high grade prostate cancer July 2019. MDM outcome '...commence an LHRHa, arrange a CT Chest and bone scan and for subsequent MDM review.' Seen in OP 20/08/19, commenced on 50mg bicalutamide, Radiological investigations requested on 4/10/19 (6.5 weeks after OP attendance), no subsequent MDM review. Admitted with local progression January 2020 requiring transurethral resection and ureteric stent / nephrostomy. During inpatient admission it was not recognized that he had not been started on an LHRHa and he subsequently started standard treatment for his locally advanced prostate cancer (Degeralex) February 2020.
Action taken Enter action taken at the time of the incident	Persona l ad been started on appropriate treatment at the time this was identified.
Learning Initial	Non standard treatment started for prostate cancer, at variance with MDM recommendation
Reported (dd/MM/yyyy)	12/11/2020
Reporter's full name	[redacted]
Reporter's SHSCT Email Address	[redacted]
Opened date (dd/MM/yyyy)	12/11/2020
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.	[redacted]

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

Management of Incident

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	Treatment, procedure
Sub Category	Male genital organs
Detail	Treatment / procedure - failed

Datix CCS2

Type	Patient Incidents
Category	Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)
Sub-Category	Monitoring/On-going Assessment of Patient Status
Detail	Failure/insufficient recognition of significant change in patient status
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an Incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?
Click here To Help you determine whether or not an Incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI? Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.	Yes
Is this incident RIDDOR reportable? **Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):** 1. Employee or self-employed person working on Trust premises is killed or suffers a major injury 2. A member of the public on Trust premises is killed or taken to hospital 3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work) 4. Dangerous Occurence attributable to the work of the Trust 5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease	No
Is this a NIAIC Incident NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable; - design or manufacturing problems - inadequate servicing and maintenance - inappropriate local modifications - unsuitable storage and use conditions - selection of the incorrect device for the purpose - inappropriate management procedures - poor user instructions or training (which may result in incorrect user practice	No

Investigation

Investigator [redacted]

Date started (dd/MM/yyyy)

Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Major [redacted]

Risk grading

Click here
When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential Impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	○	○
Unlikely (Expected to occur annually)	○	○	○	◉	○
Rare (NOT expected to occur for years)	○	○	○	○	○

Grade: High Risk

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	

Action Plan

No actions.

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	
Date investigation completed (dd/MM/yyyy)	
Was any person involved in the incident?	No
Was any equipment involved in the incident?	No

Notepad

Communication

Medication details

Falls Information
Please Quality Assure all information as part of your investigation

Pressure Ulcers

Equipment details

Documents added

People Affected

Employees

Other Contacts

Montgomery, Ruth

From: OKane, Maria
Sent: 31 March 2019 00:18
To: Haynes, Mark
Subject: RE: Urology backlogs Confidential

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Thanks Mark – I will try and ring you on Monday to discuss further as I think I don't fully understand the intricacies of the processes - thanks Maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 11 March 2019 17:03
To: OKane, Maria
Subject: FW: Urology backlogs Confidential

Scroll down for details – result not actioned.

From: Haynes, Mark
Sent: 15 December 2018 05:57
To: Robinson, Katherine; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Thanks Katherine.

The issue for me is not whether or not it was ever received.

My concern that there are individuals who think that the reported 'results for dictation' data is robust. It isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the trust as robust it is seen as a monitoring tool within governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned significant results. I fear your team are at risk if we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigation reveals a large number of unactioned results. Your team would be open for criticism for reporting inaccurate information.

For Tony and me Liz / Leanne look at e-sign-off and the number outstanding on here, plus any sets of notes with hard copy reports and this is the number reported. Ironically although we are the most up to date with our admin, we regularly appear to be the ones who are most behind.

A question to all secretaries asking them how they get the numbers that they report would be a starting point, along with a meeting to highlight why this information is collected and the potential consequences of misreporting.

Mark

From: Robinson, Katherine
Sent: 14 December 2018 15:27
To: Haynes, Mark; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Mark

We have looked into this. We cannot establish if the result ever came back to AOB either hard copy or email. I thought Radiology flagged these up to be looked at , am I correct? We cannot find it in Noelene's office. That said the secretary has a huge issue with her management ie collette and I asking her questions etc and is extremely upset and feels we are harassing her. I am trying to get Trudy as I don't know how we can possibly get proper info without the secretary helping. The secretary does not want to be involved but I suspect like all of us there is no choice.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 06 December 2018 12:03
To: Robinson, Katherine; McCaul, Collette
Subject: RE: Urology backlogs

I should add that although this case is an individual who may have had concerns raised about previously, he is not alone.

From: Robinson, Katherine
Sent: 06 December 2018 12:02
To: Haynes, Mark; McCaul, Collette
Subject: RE: Urology backlogs

OK WE WILL GET back to you

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 06 December 2018 12:01
To: McCaul, Collette
Cc: Robinson, Katherine
Subject: RE: Urology backlogs

No problem.

An example; [redacted] Patient 92 (Female / [redacted] Personal Information)

FU CT done 13/3/18, reported 20/3/18. GP letter 17/7/18 brought it to my attention, renal cancer subsequently treated.

Happy to chat through with you. My concern is that there are individuals in the management structure who believe this data to be robust where I'm not certain it is.

Mark

From: McCaul, Collette
Sent: 06 December 2018 11:43
To: Haynes, Mark
Cc: Robinson, Katherine
Subject: RE: Urology backlogs

Mark

Apologies about the delay in getting back to you.

We are doing a bit of further looking into this request as we are taking this very seriously if this is the case.

IF you could I would be grateful of an example of patient who has come to your clinic but no result letter or action ever done that would be great so we can see what actually is going on .

Collette

Collette McCaul
Acting Service Administrator (SEC)
Ground Floor
Ramone Building
CAH
Ext [redacted] Personal Information

From: Haynes, Mark
Sent: 05 December 2018 06:32
To: McCaul, Collette; Corrigan, Martina
Subject: RE: Urology backlogs

Thanks Collette

Sorry if my next question sounds awkward and I appreciate I may have asked this before.

Could you describe the method by which the information is collated. I can see how you obtain the 'waiting to be typed' information. But for instance, how is the information on 'results to be dictated' collected? Is this based on e-sign off data (numbers of results not signed off on ECR) or some other method? I am concerned that the data presented doesn't fit with my impression of practices (I regularly see patients coming to OPA with scan results that have been performed often months earlier, requested by someone else, but no results letter or action ever done, and no sign off either on ECR or of the paper copy).

Similarly, how is the 'clinics awaiting dictation' data obtained?

I have copied Martina as I have spoken to her about this so she will be able to help if my question isn't clear.

Thanks

Mark

From: McCaul, Collette
Sent: 04 December 2018 16:16
To: Corrigan, Martina; Robinson, Katherine; Carroll, Ronan; Carroll, Anita; Scott, Jane M; Jacob, Thomas; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Urology backlogs

Hi all

Attached are the recent backlogs for Urology as of the 04.12.18.

No major outstanding backlog. The results to be dictated are the from the middle to end of November. Audio typist is currently on results to be typed area of backlog

Collette McCaul
Acting Service Administrator (SEC)
Ground Floor
Ramone Building
CAH
Ext Personal Information

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 17 June 2017 07:05
To: Evans, Marie; Corrigan, Martina; Robinson, Katherine
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Morning Marie / Martina / Katherine

Thanks for continuing to send this round, it is useful to have a clear picture of the pressures on our admin and clerical team. One minor point relates to the clinics to be dictated / clinics to be typed columns – I assume these should read clinic letters to be dictate / clinic letters to be typed?

However, I am concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'.

Could you advise me of the process whereby this data is collected? From recent experiences I would suggest that the data presented in this column is inaccurate. My concern relates to how this information would be used in the event of a significant issue arising due to a delayed / not acted on result – corporately are we kidding ourselves that all results are acted on / dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the information presented whereby some consultants seem to barely ever have any results to dictate is not untrue – not all of us dictate letters on results! An illustration of the inaccuracy of the data may be seen in last years data in relation to number of clinics to be dictated, which has been proven to be inaccurate.

As stated, I think collection of this information is important and I would like it to continue to be circulated to us but would like to ensure that the data collected is robust. I am happy to be involved in any discussion required.

Thanks

Mark

From: Evans, Marie
Sent: 30 May 2017 11:20
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Dear all

Please find attached the backlog reports for May 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

Corrigan, Martina

From: Robinson, Katherine <[redacted]>
Sent: 20 June 2017 11:03
To: Haynes, Mark; Evans, Marie; Corrigan, Martina
Cc: Carroll, Anita; Cunningham, Andrea; Cunningham, Lucia
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Mark

Thank you for your email. The first point does relate to clinic letters and not clinics, we will correct this.

You are correct in that the data collected last year was not accurate and this came to light in Dec 16 when a secretary advised that there were clinics not dictated on. This secretary was advised of the importance of highlighting this issue on the backlog report. Furthermore, I held a meeting with all secretaries and this was reiterated to everyone. The secretaries collect the data and it is our only way of knowing what is outstanding and what needs escalated further. Everyone is now fully aware of the need for this information and for it to be accurate.

I plan to do a walk about in the summer months of offices checking on data received to ensure everyone is completing honestly and accurately.

We will continue to strive to improve the risks associated with admin work not being completed or actioned correctly, any further thoughts, ideas are very welcome.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Haynes, Mark
Sent: 17 June 2017 07:05
To: Evans, Marie; Corrigan, Martina; Robinson, Katherine
Subject: RE: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Morning Marie / Martina / Katherine

Thanks for continuing to send this round, it is useful to have a clear picture of the pressures on our admin and clerical team. One minor point relates to the clinics to be dictated / clinics to be typed columns – I assume these should read clinic letters to be dictate / clinic letters to be typed?

However, I am concerned regarding the robustness of this data, particularly in relation to 'results to be dictated'.

Could you advise me of the process whereby this data is collected? From recent experiences I would suggest that the data presented in this column is inaccurate. My concern relates to how this information would be used in the

event of a significant issue arising due to a delayed / not acted on result – corporately are we kidding ourselves that all results are acted on / dictated on in a timely manner? That is the conclusion you could draw from the information, particularly in relation to some consultants. If a backlog were identified after an issue were to arise, are the staff who collect the data (I presume our secretaries) liable to be found culpable for not highlighting the backlog through this process? One could argue that the information presented whereby some consultants seem to barely ever have any results to dictate is not untrue – not all of us dictate letters on results! An illustration of the inaccuracy of the data may be seen in last years data in relation to number of clinics to be dictated, which has been proven to be inaccurate.

As stated, I think collection of this information is important and I would like it to continue to be circulated to us but would like to ensure that the data collected is robust. I am happy to be involved in any discussion required.

Thanks

Mark

From: Evans, Marie
Sent: 30 May 2017 11:20
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - MAY 17

Dear all

Please find attached the backlog reports for May 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 01 July 2017 07:04
To: Corrigan, Martina
Subject: FW: CLINICAL CORRESPONDANCE BACKLOG REPORT - JUNE 17
Attachments: UROLOGY.xlsx

Morning

My concerns re how the secretaries are reporting this persist – I'm sure you told me there were 95 sets of notes in AOB office, yet according to this he only has 4 sets of results to dictate!

Mark

From: Evans, Marie
Sent: 30 June 2017 13:28
To: Young, Michael; O'Brien, Aidan; Jacob, Thomas; Haynes, Mark; Glackin, Anthony; ODonoghue, JohnP
Cc: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Robinson, Katherine
Subject: CLINICAL CORRESPONDANCE BACKLOG REPORT - JUNE 17

Dear all

Please find attached the backlog reports for June 17.

Any queries let me know.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

E: Personal Information redacted by the USI
T: Personal Information redacted by the USI

Mr Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Informatio
Submitted time (hh:mm)	12:59

Incident IR1 details

Notification email ID number	Personal Information
Incident date (dd/MM/yyyy)	31/10/2019
Time (hh:mm)	16:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	No
Does this incident involve a Staff Member?	Yes
Description Enter facts, not opinions. Do not enter names of people	Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged June 2020 and developed metastatic disease.
Action taken Enter action taken at the time of the incident	Patient and family have been seen in outpatients and the diagnosis and future management plan discussed. Family asked if earlier treatment with EBRT would have changed the course and I have advised them that the care would be looked into.
Learning Initial	Concern MDM outcome not followed and patient has subsequently developed progression of disease.
Reported (dd/MM/yyyy)	14/07/2020
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	22/07/2020
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 1

Location of Incident

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

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Burns, Sandra Mrs	Personal Information redacted by the USI	14/07/2020 13:00:36	Personal Information redacted by the USI		Clinical Governance Manager
Connolly, Connie		14/07/2020 13:00:35			Acting Acute Governance Co-Ordinator
Cardwell, David		14/07/2020 13:00:35			Clinical Governance Manager
Kingsnorth, Patricia Mrs		14/07/2020 13:00:35			Risk Midwife
Connolly, Carly		14/07/2020 13:00:35			Clinical Governance Manager
Law, Anne Mrs		14/07/2020 13:00:34			Practice Education Facilitator
Corrigan, Martina		14/07/2020 13:00:34			Head of ENT and Urology
Carroll, Ronan MR		14/07/2020 13:00:34			Assistant Director of Acute Services
Young, Michael		14/07/2020 13:00:34			Consultant
Haynes, Mark Mr		14/07/2020 13:00:34			Consultant Urologist
ONeill, Kate		14/07/2020 13:00:33			Ward Sister, Thorndale
McMahon, Jenny		14/07/2020 13:00:33			Sister in Charge (Thorndale)
Ward, Sarah Sr		14/07/2020 13:00:33			Acting Lead Nurse

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler	

If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	
Date Notification Sent to External Agency	18/08/2020
Date Terms of Reference Due	
Date SAI Report Due	31/03/2021
SAI Level (1,2 or 3)	3.00
External Agency SAI Ref No.	Personal informatio
Date SAI Report Sent to External Agency	01/03/2021
Date SAI Report Shared with Family/NOK	
Date HSCB/RQIA/Coroner Queries Received	

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	Treatment, procedure
Sub Category	
Detail	

Datix CCS2

Type	Patient Incidents
Category	Administrative Processes (Excluding Documentation)
Sub-Category	Referrals
Detail	Referral delayed
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?

Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI?

Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

Is this incident RIDDOR reportable?

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):
1. Employee or self-employed person working on Trust premises is killed or suffers a major injury
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. Dangerous Occurence attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;
- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm

This has been populated by the reporter. To be quality assured by the investigating manager.

Catastrophic

Risk grading

Click here
When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	○	○
Unlikely (Expected to occur annually)	○	○	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○
	Grade:				

Action taken on review

Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

Action Plan Required?

A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions.

Lessons learned

Lessons learned

If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any person involved in the incident? No

Was any equipment involved in the incident? No

Notepad

Notes

Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information

CGO 18/08/2020 - SAI notification submitted to HSCB
ToR & Membership - 15 September 2020
RCA Report 10 November 2020
The DRO for this SAI is Anne-Marie Phillips.

CGO 20/08/2020 HSCB have asked for additional information on section 10

CGO 25/08/2020 - Response to section 10 - There was no immediate action however, as soon as incident was recognised an appointment was arranged for this patient and discussion at clinic re: further management was carried out.
This gentleman has subsequently passed away due to cancer.

CGO 02/10/2020 HSCB chasing tor

CGO 20/10/2020 ToR and Membership sent to HSCB

CGO 27/10/2020 - Amended SAI notification sumbitted to HSCB

CGO 09/12/2020 HSCB acknowlege receipt of ToR The DRO is content to agree these terms of reference and membership with a minor change in the first paragraph should read "within which" rather than just "within". The DRO is also content with the 4 month timescale outlined in the TOR, therefore RCA Due is 12 March 2021.

CGO 17/12/2020 Following discussion at Acute SAI Review Team Meeting on 8 December 2020, DRO agreed timescale for completion of review is 31 March 2021.

CGO 01/03/21 Draft SAI report sent to HSCB pending family engagement

CGO 03/03/21 HSCB ack receipt of draft report

CGO 11/03/2021 HSCB emailed asking permission to share report with NICAN

CGO 15/03/2021 Acute team advised that the reports are in draft and awaiting factual accuracy checks. We are happy to share when the finalised reports are ready.

CGO 30/03/2021 HSCB emailed asking - Can you advise if we would be able to share the overarching report as a minimum at this stage?

CGO 22/04/2021 SAI Report Issued to HSCB

CGO 27/04/2021 HSCB response - We had been advised to wait until final reports were received before we could share them with NICAN. Can you advise if the Trust are now content we share the attached reports with NICAN.

CGO 28/05/2021 - Trust is happy for the report to be shared with NICAN

CGO 09/06/2021 - HSCB came back to advise that Patient name was on report on page 6.
Patient name removed and report reissued.

Communication

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message
No messages			