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

Created	Type	Description	ID
12/04/2022	Form	Staff Inventory	Personal Information redacted by the USI
19/05/2021		Amended report	
22/04/2021		Final Report to HSCB 22.4.2021	
01/03/2021		Draft Report 121045 to HSCB & PHA 1.3.2021	
09/12/2020	Form	ToR and Membership	
27/10/2020		Amended notification to HSCB 27.10.2020	
18/08/2020		SAI Notification	

People Affected

	ID	Title	Forenames	Surname	Type	Current approval status
	Person		Patient 1		Patient/Client/Service User	Approved
	Person		Aidan	O'Brien	Staff - Medical and Dental	Approved

Employees

	ID	Title	Forenames	Surname	Type	Current approval status
	Person	Dr	Aidan	O'Brien	Staff - Medical and Dental	Approved
	Person	Dr	P...	Personal Information	Staff - Medical and Dental	Approved

Other Contacts

No Other Contacts

Corrigan, Martina

From: OKane, Maria <Personal Information redacted by the USI >
Sent: 30 September 2019 13:25
To: Haynes, Mark
Subject: FW: AOB concerns - escalation

Mark has this been shared with Ahmed and Siobhan yet please? thanks Maria

---

From: Haynes, Mark
Sent: 30 September 2019 13:04
To: OKane, Maria
Subject: RE: AOB concerns - escalation

Hi Maria
RE Concern 3
A query will be raised from the Belfast MDM regarding a patient who is in the patients who have not had clinic letters dictated and is at risk of missing a treatment window for adjuvant chemotherapy. The Chair of the central MDM will raise this in writing probably tomorrow.
In advance (and so you can factor it in to Monday), summary / timeline from ECR (HCN Patient 2);
Surgery (orchidectomy) 10/7/19, letter dictated 10/7/19, transcribed 11/7/19
Histopathology reported 24/7/19
MDM (CAH) 25/7/19
Review OP 23/8/19, Letter dictated 25/9/19 Transcribed 26/9/19, letter is a referral to oncology for adjuvant chemotherapy
MDM (BCH) 26/9/19 – Concern raised re 3 month treatment window for adjuvant chemotherapy (10/10/19)
I have also had raised to me by our Key worker team that there are other oncology referrals awaiting dictation but do not have patient details at present.
I will email to all once I have the formal query from the central MDM.
Mark

From: OKane, Maria
Sent: 30 September 2019 12:31
To: Khan, Ahmed; Hynds, Siobhan
Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: FW: AOB concerns - escalation

Dear Ahmed and Siobhan – any further updates on addressing the concerns raised by Martina please ? I am meeting with the GMC next Monday and I anticipate they will expect a description of what has occurred and how it has been addressed please? Many thanks Maria

Lauren bf for wed please

From: Weir, Lauren
Sent: 30 September 2019 09:00
To: OKane, Maria
Subject: AOB concerns - escalation

Dr O'Kane,
You asked me to bring this to your attention for today. I have it printed and on my desk for you

Lauren

Lauren Weir
PA to Dr Maria O'Kane – Medical Director's Office,
Southern Health & Social Care Trust
1st Floor, Trust Headquarters, CAH

My Hours of work are: Monday – Friday 9.00am – 5.00pm

☎ Please note my new contact number – External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by the USI

Personal Information redacted by the USI

From: OKane, Maria
Sent: 23 September 2019 13:27
To: Khan, Ahmed
Cc: Weir, Lauren; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Thank you.

Lauren bf 1 week please

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Cc: Weir, Lauren; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Maria, I and Siobhan discussed this case last week. She has already requested more information /clarification from Martina therefore we will wait for this information. Siobhan also informed me trust grievance progress is on hold due to Mr AOB's lengthy FOI requested in progress. I will reply to Grainne Lynn once all this information at hand before contacting her.
Thanks, Ahmed

From: Khan, Ahmed
Sent: 18 September 2019 11:52
To: OKane, Maria
Cc: Weir, Lauren
Subject: FW: AOB concerns - escalation

Maria, see update report & concerns from Martina as Mr OBrien have failed to adhere to 2 elements of agreed action plan. I have requested an urgent meeting with Siobhan and Simon to discuss this issue and other updates as I am unaware of any further progress on his case.
Regards,
Ahmed

From: Khan, Ahmed
Sent: 17 September 2019 09:52
To: Corrigan, Martina; Hynds, Siobhan; Gibson, Simon
Subject: RE: AOB concerns - escalation

Martina, thanks.

Siobhan & Simon, Can we meet to discuss this urgently please. I am can be available tomorrow am or pm.

Thanks,
Ahmed

From: Corrigan, Martina
Sent: 16 September 2019 16:37
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: AOB concerns - escalation

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

CONCERN 2 – adhered to – no notes are stored off premises nor in his office (this is only feasible to confirm as there have been NO issues raised regarding missing charts that Mr O'Brien had)

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Clinics in SWAH
EUROAOB – 22 July and 12 August all patients have letters on NIECR
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CAOBUO – 3 September – 8 booked to clinic – 0 letters on NIECR
I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Telephone:
Personal Information (Internal)
Personal Information redacted by the USI (external)
Personal Information redacted by the USI (mobile)

Stinson, Emma M

From: Haynes, Mark [redacted]
Sent: 11 October 2019 08:24
To: Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc: Carroll, Ronan; Corrigan, Martina
Subject: Emergency admissions of patients on waiting lists

Importance: High

Morning all

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trusts targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

Going forwards, can we each submit an IR1 form for any patient who has waited longer than a time we consider 'reasonable' for elective treatment and is subsequently admitted as emergencies, in particular those with positive gram negative blood cultures, but including any patient whose emergency admission would have been avoided if they had received timely elective surgery? This will clearly document to the trust and HSC the patient risk and harm.

What constitutes 'reasonable' is up for debate and has to be left to each of our clinical judgement. As an initial thought I suggest;

>1 month delay for planned change of long term stent or beyond planned timescale for ureteroscopy for stone in stented patient.
>3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.
>1 year wait for routine elective treatment

As onerous as it may be completing these forms, the documentation will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a speciality (not urology) in an NI trust has come in for criticism because it did not flag / document delays in cancer treatments which are felt to have resulted in patients coming to harm.

Hope this is OK with all. The IR1 form link is;

[redacted]

Mark

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 03 October 2019 14:50
To: Khan, Ahmed; Weir, Lauren
Cc: Gibson, Simon; Hynds, Siobhan; OKane, Maria
Subject: RE: AOB concerns - escalation

Follow Up Flag: Follow up
Flag Status: Flagged

Further update...

[redacted] (Male / [redacted])

IR1 going in from MDM today. Seen in OP on [redacted] after MDM on 27th June (outcome was for Mr O'Brien to review and arrange a renal biopsy. No dictation has been done from the OP appointment, no biopsy has happened. Multiple emails have been sent to Mr O'Brien and his secretary but no update has been provided and no biopsy has occurred. Brought back to MDM today to endeavour to clarify what is happening (has also had enquiry from GP which I contacted Mr O'Brien after to enquire if all was in hand).

Mark

From: Khan, Ahmed
Sent: 03 October 2019 11:13
To: Weir, Lauren
Cc: Gibson, Simon; Hynds, Siobhan; Haynes, Mark; OKane, Maria
Subject: RE: AOB concerns - escalation

Lauran, I would be available between 2-4pm.
Thanks, Ahmed

From: OKane, Maria
Sent: 03 October 2019 00:04
To: Haynes, Mark; Khan, Ahmed; Hynds, Siobhan
Cc: Gibson, Simon; Weir, Lauren
Subject: RE: AOB concerns - escalation

Lauren can you arrange a teleconference for this Friday afternoon from a time from 1pm onwards please to agree next steps please? Many thanks Maria

---

From: Haynes, Mark
Sent: 01 October 2019 19:00
To: Khan, Ahmed; OKane, Maria; Hynds, Siobhan
Cc: Gibson, Simon; Weir, Lauren
Subject: RE: AOB concerns - escalation

The details are at the start of this mail (pasted below)

From: Corrigan, Martina
Sent: 16 September 2019 16:37
To: Khan, Ahmed

Cc: Hynds, Siobhan
Subject: AOB concerns - escalation

Dear Dr Khan

As requested, please see below which I am escalating to you (emails attached showing where I have been asking him to address)

CONCERN 1 –not adhered to, please see escalated emails. As of today Monday 16 September, Mr O'Brien has 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals.

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I have asked Katherine Robinson to double-check that these are not in a backlog for typing and I will advise

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

From: Khan, Ahmed
Sent: 01 October 2019 16:13
To: OKane, Maria; Hynds, Siobhan
Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: RE: AOB concerns - escalation

Maria, I understand we are awaiting more details from Martina. Just spoke to Mark, he think number of non-adherence to agreed action plan.
Thanks, Ahmed

From: OKane, Maria
Sent: 30 September 2019 12:31
To: Khan, Ahmed; Hynds, Siobhan

Cc: Gibson, Simon; Haynes, Mark; Weir, Lauren
Subject: FW: AOB concerns - escalation

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Lauren Weir
PA to Dr Maria O'Kane – Medical Director's Office,
Southern Health & Social Care Trust
1st Floor, Trust Headquarters, CAH

Changed My Number

My Hours of work are: Monday – Friday 9.00am – 5.00pm

☎ Please note my new contact number – External - Personal Information redacted by the USI / Internal ext: Personal Information redacted by the USI

Personal Information redacted by the USI

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Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Telephone:
Personal Information redacted by the USI (Internal)
Personal Information redacted by the USI (external)
Personal Information redacted by the USI (mobile)

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 04 October 2019 14:01
To: Khan, Ahmed; Hynds, Siobhan; OKane, Maria
Cc: Gibson, Simon; Weir, Lauren
Subject: AOB exceptions

Afternoon

I have gone through two Mr O'Brien OP clinics from August – 16th and 20th. Below is a summary of Letters generated from the consultations, detailing, where letters have been done the date dictated and date typed. The summary is of 2- patient consultations, only 5 letters are available to date. Those that have been done were dictated a variable number of days after the clinic, ranging from 6 to 31. Outstanding dictations are up to 8 weeks since the consultation.

Mark

HCN	OP Date	Date Letter dictated	Date Letter typed
Personal Information redacted by the USI	16/8/19	16/9/19	18/9/19
	16/8/19	13/9/19	13/9/19
	16/8/19	No letter	
	16/8/19	No letter	
	16/8/19	No letter	
	16/8/19	27/8/19	29/8/19
	16/8/19	No letter	
	16/8/19	22/8/19	23/8/19
	16/8/19	No letter	
	20/8/19	No letter	
	20/8/19	19/9/19	20/9/19
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	
	20/8/19	No letter	

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 04 October 2019 16:53
To: OKane, Maria
Subject: FW: Action notes from meeting 24-4-19
Attachments: RE: Urology (176 KB); FW: Urology (11.2 KB)

From: Haynes, Mark
Sent: 31 May 2019 09:08
To: OKane, Maria; Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth
Subject: RE: Action notes from meeting 24-4-19

Morning

RE Job Plan;
Mr O'Brien does not have a signed off job plan. Discussion have occurred and the job plan has been 'awaiting doctor agreement' since November 2018. I am second sign off and so would not be requested to sign it off until he and his CD have signed it. I have requested an update on the process from the relevant CD.

RE 2017 action plan;
I am currently not in a position to provide the reassurances requested. I was not party to the action plan at it's inception and have only recently been made aware of it's contents. Having been made aware of it's contents, I am aware of instances where the actions regarding Concern 1 have not been met (see attached emails), specifically;

'…triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily.'

Given that I am aware of aspects of the action plan not being met, I am concerned to see the statement that there have been 'no exception reports flagged to case manager'. The implication being that either there has been an agreed deviation from the action plan and monitoring is now occurring against different standards, or that the monitoring and / or escalation process has not functioned as it should.
As I was not party to any of the previous discussions, if I am to become part of this I need an initial briefing with all and also some run through of monitoring to date. Through this briefing I need to understand the process as it is at present, and how, despite evidence that there appear to have been 'exceptions', the reporting process appears to have failed to flag these to the case manager.

Mark

From: OKane, Maria
Sent: 30 May 2019 18:06
To: Gibson, Simon
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth; Haynes, Mark
Subject: RE: Action notes from meeting 24-4-19

Thanks Simon.
- Ahmed or Mark as his AMD should seek regular assurance rather than me and then inform the MDO
- AOB is still undertaking assessments at private clinic at home as per the requests to sign off on transfers from private to public practice. I brought this to the attention of urology. We have asked for a rationale as to why the GMC has suggested this practice is stopped before this is progressed – please explore with them Simon.

Regards, Maria

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

From: Gibson, Simon
Sent: 30 May 2019 13:25
To: OKane, Maria
Cc: Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Montgomery, Ruth
Subject: RE: Action notes from meeting 24-4-19

- Conduct panel delayed pending grievance hearing

- Grievance hearing delayed pending further information being requested – **Siobhan Hynds to clarify from Vivienne Toal what this information is**
  Siobhan Hynds is gathering this information under the auspices of MHPS. It was noted that this will take significant time to gather.

- GMC have requested further information – response will be that we have no specific written information/document from AOB **Simon Gibson**
  Response was provided – GMC written again seeking clarification. Siobhan Hynds to draft response

- Working from home – clarification from Joanne Donnelly as to whether this is still required **Dr O'Kane**
  Dr O'Kane wasn't at the meeting to provide an update on this

- Discuss with Shane with regard to organisational review **Dr O'Kane**
  Dr O'Kane wasn't at the meeting to provide an update on this

- Need to seek assurance from Acute **(Dr O'Kane)**:
  - Is there an agreed job plan Simon to check with Mark Haynes on behalf of Dr O'Kane
  - Is the 2017 action plan being followed – and all monitoring arrangements in place Siobhan Hynds reported that Martina Corrigan is ensuring monitoring arrangements are still in place, with no exception reports flagged to case manager. It was agreed that the Case Manager should periodically seek this assurance.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 31 March 2019 10:52
To: OKane, Maria
Subject: RE: Urology
Attachments: Return to Work Action Plan February 2017 FINAL..docx.docx; FW: Urology ECR (10.9 KB); FW: Urology (11.0 KB); FW: REFS FOR TRIAGE (7.06 KB)

Morning.

Triage in Urology (and I think most other surgical specialities) is done by the on-call surgeon ('surgeon of the week'). The AOB return to work action plan (attached) concern 1 relates to this;

CONCERN 1

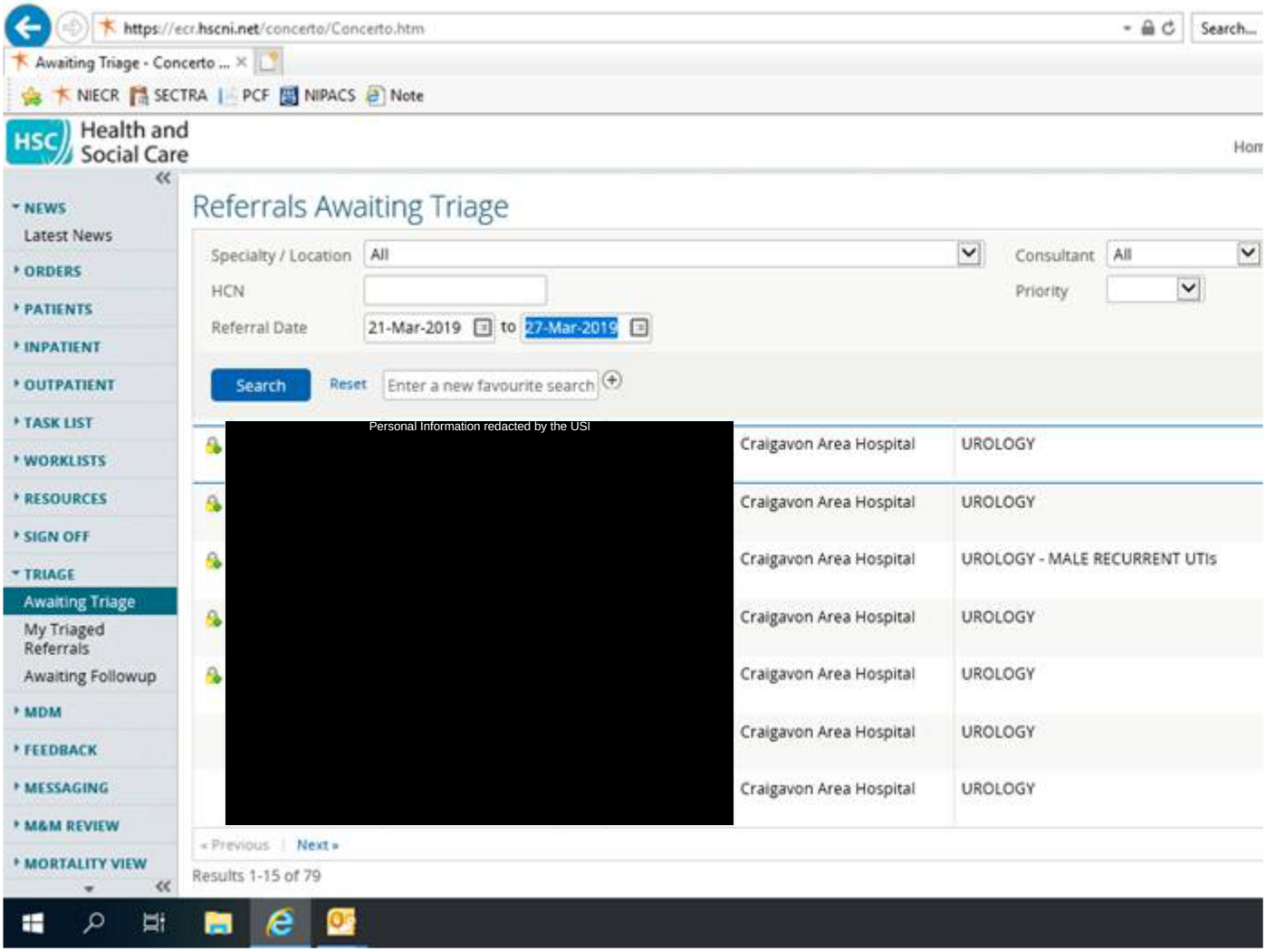
- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.
Red Flag referrals must be completed daily.
All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

Attached are a number of escalation emails pertaining to this from Vicki Graham. I would assume that this has been shared with the director of acute services and appropriately escalated to the MHPS case manager? Anecdotally certainly the e-triage is not completed by 4pm on the Friday of his on-call week, indeed looking now there are 79 referrals on e-triage, received between 21st March and 27th March (Mr O'Biren's recent on-call week) that have yet to be triaged, including 16 red flag referrals dating from 25/3 to 27/3 (see screenshot below).

I am not aware of the reporting and escalation that may have occurred of this following the return to work.

Mark



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

Has this happened in this way before?

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

From: Haynes, Mark
Sent: 30 March 2019 06:55
To: OKane, Maria
Subject: FW: Urology
Importance: High

This relates to one of the AOB issues. He has been on call since 22/3/19 and should have been doing the triage.

Mark

From: Graham, Vicki
Sent: 29 March 2019 16:09
To: O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark; Young, Michael; Glackin, Anthony; Tyson, Matthew
Subject: FW: Urology
Importance: High

Hi

The red flag team have advised that there are x 24 referrals on ECR to be triaged, dating back to 22.03.19. Would it be possible to get these triaged please?

Thank you

Vicki
Cancer Services Co-ordinator
Office 2
Level 2
MEC

From: rf.appointment
Sent: 29 March 2019 15:57
To: Graham, Vicki
Subject: Urology

Hey Vicki,

There are 24 referrals from 22/03/19 needing triage for Urology on ECR.
Can you escalate this please.

Best

Sinéad Catherine Joanne Lee
Higher Clerical Officer

✉ **Southern Health & Social Care Trust**
Red Flag Appointments Office
Ramone Buliding Ward 1, Ground floor
Craigavon Area Hospital
Lurgan Road, Portadown

☎ **Ext.** Personal Information redacted by the USI *(Red Flag Team Ext.* Personal Information redacted by the USI *)*

Corrigan, Martina

From: Graham, Vicki <Personal Information redacted by the USI>
Sent: 11 February 2019 17:00
To: O'Brien, Aidan; Young, Michael; ODonoghue, JohnP; Haynes, Mark; Glackin, Anthony; Corrigan, Martina
Cc: rf.appointment
Subject: FW: Urology ECR

Importance: High

Afternoon,

There are some red flag referrals on NIECR dating back from 07.02.19 - Would it be possible to get these triaged ?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

From: rf.appointment
Sent: 11 February 2019 16:24
To: Graham, Vicki
Subject: Urology ECR

Hey Vicki,

We have referrals on ECR from 07/02/19 for Urology. Can you escalate this through to get them triaged please.

Best

Sinéad Catherine Joanne Lee
Higher Clerical Officer

✉ **Southern Health & Social Care Trust**
Red Flag Appointments Office
Ramone Buliding Ward 1, Ground floor
Craigavon Area Hospital
Lurgan Road, Portadown

☎ **Ext.** Personal Information redacted by *(Red Flag Team Ext.* Personal Information redacted by *)*
Personal Information redacted by the USI

Corrigan, Martina

From: Graham, Vicki <[redacted]>
Sent: 29 March 2019 16:09
To: O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark; Young, Michael; Glackin, Anthony; Tyson, Matthew
Subject: FW: Urology

Importance: High

Hi

The red flag team have advised that there are x 24 referrals on ECR to be triaged, dating back to 22.03.19. Would it be possible to get these triaged please?

Thank you

Vicki
Cancer Services Co-ordinator
Office 2
Level 2
MEC

From: rf.appointment
Sent: 29 March 2019 15:57
To: Graham, Vicki
Subject: Urology

Hey Vicki,

There are 24 referrals from 22/03/19 needing triage for Urology on ECR.
Can you escalate this please.

Best

Sinéad Catherine Joanne Lee
Higher Clerical Officer

Southern Health & Social Care Trust
Red Flag Appointments Office
Ramone Buliding Ward 1, Ground floor
Craigavon Area Hospital
Lurgan Road, Portadown

Ext. [redacted] ***(Red Flag Team Ext.*** [redacted] ***)***
[redacted]

Corrigan, Martina

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

Importance: High

Hi

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

Many thanks

Vicki Graham
Cancer Services Co-ordinator
Office 10
Level 2
MEC
EXT Personal Information redacted by

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 30 March 2019 06:55
To: OKane, Maria
Subject: FW: Urology

Importance: High

This relates to one of the AOB issues. He has been on call since 22/3/19 and should have been doing the triage.
Mark

From: Graham, Vicki
Sent: 29 March 2019 16:09
To: O'Brien, Aidan; ODonoghue, JohnP; Haynes, Mark; Young, Michael; Glackin, Anthony; Tyson, Matthew
Subject: FW: Urology
Importance: High

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Cancer Services Co-ordinator
Office 2
Level 2
MEC

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Sent: 29 March 2019 15:57
To: Graham, Vicki
Subject: Urology

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Sinéad Catherine Joanne Lee
Higher Clerical Officer

✉ **Southern Health & Social Care Trust**
Red Flag Appointments Office
Ramone Buliding Ward 1, Ground floor
Craigavon Area Hospital
Lurgan Road, Portadown

Ext. Personal Information redacted by the USI (Red Flag Team Ext. Personal Information redacted by the USI)

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

- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

Meeting of consultants and senior nursing staff

In attendance:

Sr Caddell,
Sr McElvanna,
Sr Magill,
Sr Lockhart,
Sr Magee,
Sr O'Neill
Sr McMahon,
Sr McCourt,
Charge Nurse Young,
Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
Mr O'Donoghue

2.1 Ward issues:

1. Outlying of urology patients to facilitate medical inpatients.
2. Staff retention and vacancies.
3. Staff education program for Urology inpatient care.
4. Lack of medical support for medical inpatients on ward 3 South due to locum staff and a lack of continuity.
5. Interruptions to ward rounds.

2.2 Thorndale issues:

1. Too few cystoscopes.
2. Clinics overrunning.
3. Requests for inpatient flexible cystoscopy.
4. Introduction of endoscopy check list.
5. New patient clinic running problems due to time keeping and case mix.
6. Provision of intravesical chemotherapy service.

Sr Leanne McCourt tabled a prostate cancer option grid to be piloted within the Department.

Sr Jenny McMahon tabled the Southern Health and Social Care Trust endoscopy safety checklist.

ISSUES OF CONCERN FOR DISCUSSION
At
DEPARTMENTAL MEETING
On
24 SEPTEMBER 2018

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

UROLOGIST OF THE WEEK

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

TRIAGE

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, [redacted] year old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on [redacted] keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

SUMMARY

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.

Glackin, Anthony

From: Young, Michael
Sent: 12 September 2018 12:12
To: Glackin, Anthony; Corrigan, Martina
Subject: away day thoughts

It's disappointing to think that there is a question mark about the away day.
Yes agree that a formal structure is needed.
Our last 'blue sky thinking session' was good but I'm not sure that is fully what we are after.
As previously pointed out we have had the opportunity of a weekly departmental meeting time, which this last year has been poorly attended by some and if there were so many problems then there was a great opportunity lost.
Frankly I don't see why folk could not find the time to attend. – anyway this is an opportunity to all be there and take things forward thereafter.

Tony has wished to chair and that's great.
The ward and Thorndale wish to attend as they have issues and if not for any other reason, this is why the 'day' should occur.

After the last scheduling meeting I suggested that a pre-meeting meeting on the 13th departmental slot should help define an agenda and time slot.
So here are a few thoughts of mine

Thorndale –
scope issues
clinics not so big by spreading clinics out over the week more
partial reversion to specific clinic types eg a spec Dr only clinic for luts or routine patients that they may then do as DSU surgery

Outreach clinic on specific days – take the team ie BPC and STH Dr and specialist nurse clinic in tandem like the Erne
? create more space back in the thorndale.
How about we make a decision about the Erne ourselves

Ward
Discharge comment improvement for follow up arrangements
Phone answering

Drs
Our job plans have been defined – are they actually what we want personally or for the team
I think the focus for years has been oncology so some thought on this occasion about other issues.
I personally want a change to focus more on the STC role by dropping other things
Role of the STC
This includes overall dropping of sessions either on a Monday or Friday
I'm content with the triage arrangements but others may not be

Technology and principles
Scopes
Urolift , iris stent removal - all these things help with running
Winter pressure planning – still keep our theatre session but accept less inpt work and do day surgery blitz using these session and ensure elective ward is not abused
What does the Trust expect from us for all the defined areas of practice

MY

MY AOB MDH AOB.

① UoW.

AOB. Cons. provided IP care.
Ward rounds. Operating. Answering queries providing advice
Handover between cons. Thurs 9AM.
- privacy.
Conflict between operating/ward round.
Concern re: middle grade advice.
Incomplete discharge plans.
Unsupervised registrar operating.

Written agreement of what the trust expects of us.

MY. Communication between registrar + Consultants.
Practicalities.
Availability.
Handover of elective cases. Communication with elective operater/UoW.
Ownership at time of discharge.

MDH. Consultant present on ward round
Routine weekend working not in job plan.
Direct consultant involvement in referrals from elsewhere.

Evening ward round : form / structure.
implications for FY1 work pattern.
Continuity.

ASG. Personal input. On time.
Communication with other teams.
- advice sheet documented.
Primacy of handover meeting.
Handover of elective cases.
Senior Nurse on ward round.

Consensus.

Primacy of IP ward round,
consultant present.
Structure for referral + advice.
Definitive care.

Triage.

Expectation
Use of telephone.
Advice.
Scans.
Time constraints / commitment.
Mitigation of risk.
Decouple triage from UoW.

Draft a plan for a new way of doing triage.

Annual Leave.

define number away at any time.
Timing of discussion for Christmas / Summer Holidays.
Process for agreeing leave

Waiting List Management -

5. TURBT pathway:
- dedicated lists
- 2016 : 123 TURBTs 40 weeks x 3 cases.
- morning lists to facilitate day case surgery
- opportunity to move work out of main theatres
- shared bookable lists with proforma to identify suitable / unsuitable cases.

5&6. Bladder outlet Surgery Pathway.

AO'B.
Triage
UoW.
W/L.

List of recommendations

1. Develop a structured training curriculum for specialist urological nurses and establish accredited training departments.
2. Provide job planning for clinical nurse specialists and ensure appropriate skill mix.
3. Increase the provision of Urological Investigations Units (UIUs), providing a dedicated resource for urological outpatient care.
4. Review follow-up rates against a median of 1:2 first outpatient to follow-up.
5. Take further action to improve RTT performance for common conditions and pathways.
6. Address the potential adverse effects of existing cancer diagnostic and treatment standards.
7. Review guidance for urology cancer MDT working.
8. Reduce average length of stay across the specialty through enhanced recovery and increased use of day case pathways, while monitoring causes and rates of emergency readmissions.
9. Improve the secondary care pathway for patients with urinary tract stones.
10. Provide consultant-delivered emergency urology care in every trust by reducing elective commitments for consultants on call.
11. Review workloads of on-call consultants to ensure the sustainability of on-call arrangements.
12. Ensure high-quality emergency urological care is available in all areas seven days a week by focusing available resources at weekends on a smaller number of departments, while allowing some departments to operate on a five-day basis.
13. Review the approach to providing care for patients who require urgent surgery for urinary tract trauma and related conditions.
14. Establish urology area networks (UANs), comprising several urology departments that provide comprehensive coverage of urological services, beyond existing network arrangements, to optimise quality and efficiency.
15. Reduce the numbers of complex surgical procedures that are carried out in small volume centres, using networks as they develop.
16. Align data collection efforts across urology and ensure that data collected are relevant and have a value that is in proportion to the resources needed for its collection.
17. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and the spreading of best practice.
18. Reduce litigation costs by application of the GIRFT Programme's five-point plan.

Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Endoscopy Safety Checklist

Time Out (To be read Aloud)	Sign Out (To be Read aloud)
Before Commencement of Procedure (with Team Leader & Endoscopist- STOP all actions)	**Before Patient leaves Procedure Room**
Team introduction carried out Yes □ Patient's identity, procedure, consent & co-morbidities confirmed with Endoscopist? Yes □ Has all equipment used on the previous patient been removed from endoscopy room? Yes □	Specimen pots and pathology forms are correctly labelled (2 Nurses read specimen labels aloud, including patient name) Yes □ N/A □
Correct endoscope and all anticipated equipment needs available? Yes □ Has the correct endoscope been tracked to the correct patient? Yes □ Oxygen, suction, monitoring equipment & drugs available and checked? Yes □ Has Essential Imaging been reviewed All IRMER requirements met Yes □ N/A □	**Nurse Verbally Confirms with Endoscopist:** Any equipment problems to be addressed? Yes □ N/A □ Any complications during the procedure Yes □ N/A □ Recovery instructions documented in Endoscopy Care Pathway Yes □ N/A □ Follow up plans recorded in Endoscopy Report Yes □ N/A □ Recommencement of medication recorded on Unisoft report Yes □ N/A □
Confirmation of patient preference for sedation Yes □ Does the patient have a known allergy? Yes □ No □ Record of Last LMP Yes □ N/A □ Other hazard? E.g. MRSA/CJD Yes □ No □ Confirm any other risks e.g. Antiplatelets □ Anticoagulants □ Recent INR □ Is Antibiotic prophylaxis required? E.g. PEG insertion Yes □ No □	Enter details or affix label here Full name: Date of birth: Hospital/H&C number:
Emergency Bleeding Trolley available & fully stocked? Yes □ No □	Procedure:
Confirm late start /reason for delay with medical staff and record on TMS? Yes □ N/A □	
SIGNATURE: NAME: DATE:	SIGNATURE: NAME: DATE:

SHSCT Endoscopy Safety Checklist (January 2017 v0.8)

U.S. English

Prostate cancer (localized, low risk): treatment options

option grid

Use this decision aid to help you and your healthcare professional talk about how best to treat your low risk, localized prostate cancer.

Frequently Asked Questions ↓	Watch and wait	Active surveillance	Low dose brachytherapy	Radiotherapy and neoadjuvant hormones	Surgery
What does this treatment involve?	Treatment will aim to control symptoms. You will get regular checks and blood tests.	You will get regular checks with blood tests and prostate biopsies. If you change your mind or if the cancer changes, you will be offered treatment aimed at cure.	Small radioactive pellets are put into your prostate under general anesthetic.	Radiation beams and hormone therapy are used together for four to eight weeks, where you visit the hospital every weekday.	The prostate gland is removed under general anesthetic. You will stay in hospital for at least one night.
How will this treatment affect long-term survival?	After around 10 years, approximately 85 in every 100 men (85%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.	After around 10 years, approximately 90 in every 100 men (90%) will be alive.
Will I need additional treatment?	Perhaps. Other treatments may be needed to control your symptoms.	Perhaps. Around 30 in every 100 men (30%) will need additional treatment.	Perhaps. Some men benefit from using hormones to shrink the prostate before brachytherapy.	Yes, most patients have hormone treatment for at least three months before radiotherapy.	Perhaps. Radiotherapy might be offered to you after surgery.
What are the side effects associated with this treatment?	Does not apply	Symptoms generally occur in the first two weeks after biopsy, typically pain, and blood in sperm, urine or stools. 10 in every 100 men (10%) get a urine infection.	After the treatment, most men will pass urine frequently, and have bleeding. Some men will be unable to pass urine. After six months, around 30 in every 100 men (30%) will have problems with erections, and some men may pass urine more often than before.	After the treatment, most men will pass urine frequently, have diarrhea and tiredness. After six months or more, around 30 to 60 in every 100 men (30 to 60%) will have problems with erections. A few men will become incontinent and have bowel problems.	Most problems happen immediately after surgery. Most men will have some incontinence for the first three months. After six months or more, around 40 to 70 in every 100 men (40 to 70%) will have problems with erections. A few men will become incontinent.
How long before I return to usual daily activities?	Does not apply	2 days	2 weeks	6 weeks	12 weeks

Editors: Joseph Jelski (Lead Editor), Karen Gordon, Peter Alf Collins, Wendy Enticott, Emma Cording, Jon Mcfarlane, Marie-Anne Durand, Katy Marrin, Julia Pollard, Glyn Elwyn, Nick Burns-Cox
Editors have declared no conflicts of interest.
Publication date: 2015-05-29 **Expiry date:** 2017-05-29 **ISBN:** 978-0-9926733-5-2

Thorndale. KO'Neill JMcMahon LMcGurk Tolly.

* Cystoscopes : too few
additional 4 (we have 8).
(3 out of action)
at present.

Clinics. AM overrunning

DHH: 4 haematuria pts/week. potential for expansion.
do we need to shift work around?

IP flexis. staffing/scopes.
a place to do this activity.

SHSCT Endoscopy checklist.

New patient Clinic.
feedback
timekeeping.
preview to identify casemix.

Intravesical chemo. service.
arrange admission at present.
OP with procedure (would be better).
documentation onto NIECR.

G. Magill . C McElvanna . S Lockh...

Ward.

Sr. Caddell. ENT/UROL/MED. — 13 to 17.

* UROL pt. outlied to facilitate Medical.

Staff retention severe problem. 14 vacancies

Education programme cannot proceed at present.

Support from Medical Teams. Lalling.

Overrun from March 2018.

Regional Review: Urol. pt's on Urol. ward.

31 funded beds. 36 open.

Locum Staff Cons + SHO.

- lack continuity, insufficient numbers.
- pt's seen 5 days a week.

Ward Rounds.

interruptions

several specialties. doing simultaneous rounds.

Thorndale

prostate Ca. Options Grid.
pilot.

Corrigan, Martina

From: Carroll, Ronan <[redacted]>
Sent: 27 September 2018 14:08
To: Haynes, Mark; Weir, Colin
Subject: FW: Job Plan

Can we chat this though please – I am in cah tomorrow

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

From: Weir, Colin
Sent: 27 September 2018 12:08
To: O'Brien, Aidan; Carroll, Ronan
Subject: RE: Job Plan

Aidan

I have your job plan completed on Monday. I think it is a fair reflection of all the discussions and complexities of your working pattern we discussed.

If triage is to be increased from 6 hours that will have to be for all and done on an equal basis (I cant pay someone more for taking much longer for the same number of triages). That therefore will need an agreed position from all urologists and you as a group will need to decide that and approach me in due course
I cant see that 24 hours of Triaging would be sanctioned

If 3 hours fixed time each Sat and Sun for ward rounds is included again I would need written confirmation from all and all job plans will need rewritten

I expect if this was discussed on Monday then I await confirmation. It will require reopening of all job plans

Colin

From: O'Brien, Aidan
Sent: 27 September 2018 10:01
To: Weir, Colin
Subject: Job Plan

Colin,

Just to informally update you regarding two issues discussed at our departmental meeting on Monday 24 September 2018, and which relate to job planning:

- It was agreed that Consultants would undertake Ward Rounds on Saturday and Sunday mornings, when Urologist of the Week (UOW), provided doing so was included in Job Planning.
  While it was not specified or agreed, I believe that there may be agreement that 3 hours of predictable time be allowed for each rounds, but that may require further clarification.

- Triage was much more complicated.
  As has been my consistent view, it was agreed that it has been unfortunate that UOW and Triage have been so linked, particularly as it has been agreed that achieving triage while being UOW has only been possible by compromised quality of triage, and by compromised inpatient management.

It has been acknowledged that triaged actually replaced inpatient management.
With regard to the time expended on triage:

- Michael Young advised that he had been asked how long it took him to do triage, that he had advised that it took him at least six hours, but that it was an off the cuff remark, and that he did not have an accurate time requirement.
- Mark Haynes felt similarly… at least six hours, but he did not have a more accurate assessment of time required.
- Tony Glackin was more specific, advising that he spent two hours on each of the seven UOW days, a total of 14 hours.
- I advised that it took me 20 – 24 hours which when conducting advanced triage during my own time on the Friday, Saturday and Sunday after my UOW week.
- John O'Donoghue did not attend the meeting.

The amount of time required is entirely dependent on the kind of triage being conducted: the ordering of investigations and the initiation of treatment.
It was interesting to learn that the greatest disincentive to ordering investigation is having to deal with the results, requiring more unallocated time.
However, it was acknowledged that if, as we agreed, it would be mandatory for the UOW to conduct ward rounds on each of the seven days as UOW, and if it was the case that advanced triage was required in view of the waiting times for first outpatient consultation, it was impossible to complete triage whilst being UOW. We discussed possible solutions to that, the most attractive being that the specialty doctors, Saba and Laura, could possibly deal with cohorts of referrals in protected time to do so, etc.

I hope that this may be useful.

Aidan.

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 03 January 2020 14:47
To: Reid, Trudy; Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]
Attachments: Comments concerning the RCA Report on Review of SAI [redacted].docx; Assessment of Suspected Testicular Cancer.pptx

Within the document 'Comments concerning the RCA Report on Review of SAI [redacted].docx'nthe following statement (page 3) is included;

'…The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.'

I should highlight that this is not an accurate representation of the audit. The Audit was of red flag referrals for suspected testicular cancer with only 8 of 83 actually having a testicular tumour on US. This fact invalidates the point being made.

The powerpoint of the audit is attached.

Mark

From: Reid, Trudy
Sent: 18 December 2019 08:36
To: Carroll, Ronan; Haynes, Mark
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: CONFIDENTIAL: SAI [redacted]
Importance: High

Good morning please see attached comments on SAI and supporting documentation. I will be sharing this information with the chair of the SAI as this is the consultants response to the factual accuracy checks we ask for as part of the SAI process.
There appears to be suggestions that harm has come to patients. Mark and Ronan have these concerns been escalate within SEC prior to this and if so have they been investigated? If not can you review the content of the attached documents to ascertain what detail we require to allow us review and decide the next steps, e.g. SAI screening if required?

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile [redacted]

Comments concerning the RCA Report on Review of SAI [redacted]

In submitting this commentary regarding the RCA Report of SAI [redacted], I have reviewed all retained correspondence relating to the issue of triage, all retained documentation relating to other issues impacting upon triage and all retained documentation relating to other issues referred to by others interviewed during the course of the Root Cause Analysis. Having done so, I believe that the Recommendations outlined in the Report are its most important component, though I believe that at least one additional recommendation is required to ensure that the others could be effectively implemented. I have endeavoured to be concise.

Having been interviewed by Dr. Johnston and having read the above Report, I do believe that the singular and significant flaw of the Review has been to investigate the failure to triage urgent and routine referrals in isolation of other pressures and clinical priorities which I believe are evidently more important. As a clinician and a clinical department, I believe that these greater clinical priorities cannot be compromised for the sake of triage, as they have been and continue to be.

Urologist / Consultant of the Week

While agreeing that triage is indeed a serious issue and very important, I was concerned to being expected to agree that triage of referrals has 'number one ranking in the overall scheme of things'. I believe that it is vitally important to fully appreciate the significance of this claim, especially as triage has been aligned with the duties of the Urologist of the Week (UOW). If, as has been my experience during my last week as UOW, one does a ward round from 09.00 am to 11.30 am, prior to going to theatre to undertake seven emergency / urgent operations, is triage the most important concern that day, or the day after, if it is similar?

I most earnestly urge the Review Team to review the wording of Recommendation 6, urging the Trust to re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. I believe that it is important to appreciate that the Trust has never examined or assured itself in the first place, never mind do so again. I believe that it is crucially important that the duties and priorities of the CoW and the expectations of the Trust of the CoW in the conduct of those duties and priorities, be clearly agreed and expressed in a written Memorandum of Understanding, or similar. I do so as there has been an ambiguity since its inception as to those duties and priorities.

Following a long period of gestational discussion, the UOW came into existence in late 2014. The major reason for the length of that gestational discussion was the belief, particularly on the part of our Lead Clinician, that the duties of the UOW could not possibly take up a whole day. This belief was borne out of his perception that the UOW would essentially be on call. When subsequently persuaded and convinced that it would be a good for inpatient management that the UOW would conduct an ward round each morning, it was then proposed that we could then undertake a clinic in the afternoon each day, as the duties of UOW could be confined to the morning, as one would rarely be called to theatre in an emergency. When successfully disabused of that proposal which would have necessitated the disorderly cancellation of outpatient attendances, the proposal of

being able to undertake triage of all referrals while UOW was born, as it could be undertaken at any flexible time.

There is no doubt that the clinical and operative demands upon the UOW have evolved and increased during the past five years. Nevertheless, there persists a lack of clarity as to its very purpose, and I have no doubt that there persists a dichotomy of Urologist on Call and Urologist of the Week. It had been my understanding ab initio that its raison d'etre was to provide hands-on, clinical management of all inpatients within our department, whether acutely or electively admitted, to provide advice and management to patients attending and referred from other Departments at Craigavon Area, Daisy Hill and South West Acute Hospitals, and to undertake emergency and urgent surgical intervention so far as is possible. To do so effectively in pursuit of optimal clinical outcomes requires knowing patients, often with complex comorbidities, in detail, and that requires time. However, this has not always been the case.

I have experienced a patient being unnecessarily and inappropriately discharged when it would have been entirely possible for them to have had surgical intervention while inpatients, only to be acutely readmitted, sicker than previously and for another UOW to manage. I have witnessed patients undergoing surgery by Registrars (while the UOW triaged referrals) with outcomes inferior to those I believe would have been achieved had the UOW been operating, or at least attending in supervision. I have been requested by Nursing Staff to assess inpatients who had never been seen by a UOW. Indeed, the most frequently occurring practice which persists is that of the UOW not coming to the hospital at all, particularly over weekends, unless 'called' of course, or not undertaking ward rounds even if present in the hospital.

And while it has been and continues to be easier to undertake triage while being 'on call', I have also no doubt whatsoever that the expectation to undertake triage of all referrals lends itself to being Urologist on Call rather than UOW. Indeed, a senior executive manager of the Trust has written that UOW was introduced to facilitate triage! If that is one understanding, there certainly needs to be a discussion and an agreement in the first instance of the duties of the UOW.

In 2018, following discussion amongst our colleagues, it was agreed that we would set aside a whole day, Monday 24 September 2018, to meet with senior management to discuss this very issue, among others. We were requested to submit those issues which we wanted to have discussed (I have separately attached my submission). No clinical commitments were arranged for that day. The meeting was cancelled, with loss of all clinical activity that could have been scheduled. The meeting was rescheduled for Monday 03 December 2018, again with no clinical commitments scheduled. No senior management personnel could attend. I therefore have no confidence whatsoever that Recommendation 6 will be addressed.

Triage and Waiting Times

I also do contend that it is not possible to deal adequately with the very important issue of triage without consideration of waiting times, and how this could or should affect the nature of the triage conducted. Dr. Johnston was of the view that the Red Flag referrals were not an issue as they 'go straight into the system'. However, the recent waiting time for a first consultation for a patient suspected of having prostatic carcinoma is 107 days. We have recently been circulated with the details of twelve patients referred as, or upgraded to, Red Flags as they were suspected

of having prostatic carcinoma. They were triaged, without any consideration of any form of preliminary investigation being requested. It would have taken less than one minute to ascertain their Red Flag status, and 'they go straight into the system', and wait almost four months for a first consultation. The further ignominy is that, on attending almost four months later, some have waited all of that time just to have a serum PSA repeated, before deciding whether to proceed with Investigative imaging, such as MRI scanning, prior to prostatic biopsies. Lest there be any doubt, the reason for the conduct of triage in such a manner is the lack of time to do otherwise, coupled with a determination that triage will be completed on completion of the period of UOW. As indicated above, I have witnessed such minimalist triage being conducted instead of undertaking ward rounds.

In March 2015, I endeavoured as Lead Clinician of Urology MDT to have my colleagues agree to advanced / enhanced triage of Red Flag patients alone. The purpose of doing so was to facilitate patients progressing along the diagnostic and therapeutic pathway in the timeliest manner possible. I did not succeed, as they declined to commit to doing so, and the reason given then was the lack of adequate time while being UOW. I have retained a written record which can be provided if requested. As a persistent consequent, a patient recently referred with a renal tumour detected on ultrasound scanning, waited for a first consultation before having staging CT scanning performed, and which could have been requested if time had been taken or available to do so, to request the scan, informing the patient (and referrer) that it had been requested.

The issue of the referrals which are actually triaged as urgent and routine is even more pressing. It is worth asserting that a referral triaged as urgent may be as life threatening, except that it is presumed that it will not be threatened by a malignancy. However, as has been a recent experience, last year's pyelonephritis was actually a renal cell carcinoma, and she was not even referred, never mind triaged. The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.

Apart from the lack of adequate time to conduct optimal triage while UOW, an additional disincentive is that the UOW will be responsible for the receipt of any investigations requested, and without any additional administrative time allocated to do so. During my last period as UOW, I requested 47 scans. I did so, mainly in the days following completion of the period as UOW. Today, I have received the result of a CT Urogram indicating that the patient probably has pancreatic carcinoma with hepatic secondaries. I will arrange an outpatient consultation for this patient in coming days.

Yet, despite repeated claims to the contrary, the Trust does not have a policy regarding urological triage, and particularly in the context of such waiting times, and with respect to an ongoing expectation that triage will be conducted by the UOW while being the UOW. It remains the case that the Trust is happy with and prefers that the referral is triaged as quickly as possible, so that they are in the system, without investigation and irrespective of the periods of time waiting for a first consultation. It is now almost three years since I recommended in my report concerning the index case (Patient 10) that the Trust should meet with us to discuss and agree who should undertake triage, when it should be conducted, and the nature of the triage to be conducted. There has been

no response to date. Two attempts to arrange meetings with senior Trust management in late 2018 did not materialise. I have come to the view that the Trust is only interested in the avoidance of any shared responsibility for these issues, preferring instead that they will be the sole responsibility of the clinician, without provision of the time to do so.

To conclude this section, the Report implies that, irrespective of the difficulties and pressures which my colleagues did have in conducting triage while UOW, they did so, and that there were no negative consequences in there doing so. Inpatient care or the quality of triage suffered to varying degrees, and particularly in the context of long waiting times. I have personally experienced a number of cases of delayed diagnoses of cancer following triage by my colleagues since 2017.

Number One Ranking in the Overall Scheme of Things

Number one ranking in the overall scheme of things for any urological department should be the provision of acute care to those most urgently in need of it; hence, the concept of the UOW. Of course, triage is a method of selecting those patients who may next most urgently need such care. Meanwhile, patients languish on ever increasingly long lists awaiting elective admission, some 600 awaiting urgent elective admission for surgery, some now waiting over five years.

We collectively have over 640 patients awaiting admission for prostatic resection. At least 10% of these patients will be found to have prostatic carcinoma. A recent review has reported an incidence of 13.4% in men aged less than 65 years, and of 28.7% of men older than 65 years. One third of the younger patients required curative or palliative treatment. So, we have a situation where at least 64 patients are waiting for years to have a diagnosis of prostatic carcinoma found. Such a figure contrasts profoundly with the five cases found due to the failure to upgrade to Red Flag status, the subject of the Report. Yet, these patients have been assessed by our Department, placed on waiting lists, with a significant risk of having a cancer diagnosis, some requiring treatment with either curative or palliative intent. Which guidelines, goals, objectives, root cause analyses, SAIs apply to these patients? None, but for our concern for them.

Factual Inaccuracies

AMD1 reported that referrals were not triaged by me in the early 90s, that referrals were being kept in a ring binder and were not on any waiting list, that I stopped the practice when challenged, and would then slip back etc. This is untrue. I was a single handed urologist from 1992 to 1996. I triaged all referrals, sorting them into urgent, soon and routine. Each category had a ring binder of referrals. I had my secretary allocate appointments for patients from each category, in commensurate numbers, to every clinic. I continued to do so until the appointment of Mr. Michael Young in 1998 when it was more appropriate to have an appointments office make appointments.

I find it difficult to believe that patients were waiting 10 years for a first appointment., as claimed by DAS2. It has been my experience that the current waiting times are the longest we have ever had. Of course there were no serious clinical issues due to the effective triage that had been conducted.

DAS1 claimed that I struggled to adapt to the modernisation and change resulting from the Regional Transformation of Urology Services. This is particularly untrue. I can provide for you on request my written submission to the Regional Review Team in 2009, detailing my concerns regarding the future provision of urological services outside of Belfast, my views concerning the lack of a Urological Department at Antrim Area Hospital, and where radical prostatectomies and radical cystectomies should be undertaken in the future. I was particularly concerned regarding the 'centralisation' of radical cystectomies for bladder cancer to Belfast. Even then, I did not entirely appreciate the negative consequences of that centralisation, in that our Department continues to have patients suffering and dying due to their not having radical cystectomies performed.

I was particularly concerned at interview that HOS1 claimed that she had discovered over 700 untriaged referral letters in my filing cabinet, having gained permission to enter my office. I also found that Dr. Johnston appeared to struggle to accept that I had advised HOS1 of the whereabouts of the letters of referral, in the third drawer of the filing cabinet in my office. They were not discovered, or uncovered. Moreover, they were all copies of the originals, as the originals or copies were retained by the Appointments Office for appointment in chronological order in accordance with the Informal Default System (IDS) introduced in 2014.

The Report does acknowledge that I had advised colleagues and management that I had found it impossible to conduct non-Red Flag referrals while UOW, while continuing to triage Red Flag referrals, as detailed in my annual appraisal. It is inconceivable that a IDS was introduced to deal with the lack of triage of non-Red Flag referrals without management being aware that they were not being done, or claiming not to have been informed or aware. The Report implies that it was my sole responsibility, and that Trust management did not bear any responsibility for either their claimed lack of awareness, or its failure to address the issue in a constructive, agreed manner, and which it has still failed to do.

Recommendation 10

The Trust is recommended to set in place a robust system for highlighting and dealing with 'difficult colleagues' and 'difficult issues'. I entirely agree. I believe that it should be included in this Recommendation that any such systems should conform with and be implemented in compliance with national guidelines.

The Report is entirely silent on any Recommendation as to how clinicians, individually or collectively, are to deal with 'difficult management', and particularly management which has repeatedly and consisted failed to address issues of concern for clinicians. The absence of such a Recommendation implies an asymmetry unworthy of the Report.

Recommendations 11 and 12

Recommendation 11 advises that I review my chosen 'advanced' method and degree of triage, to align it more completely with that of my Consultant colleagues. This is itself inconsistent with the claim on Page 18 of the Report that other members of the consultant team were also 'ordering

investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons 1's advanced triage'.

Nevertheless, I believe that this recommendation should be amended. I believe that I should triage in the manner agreed with and expected by the Trust in a written policy for urological referral. That way, there will be no room for variance in how or when triage is conducted, and the trust will bear responsibility for any negative consequences, provided clinicians have conducted triage in accordance with the agreed policy. In doing so, Recommendation 12 will have been complied with.

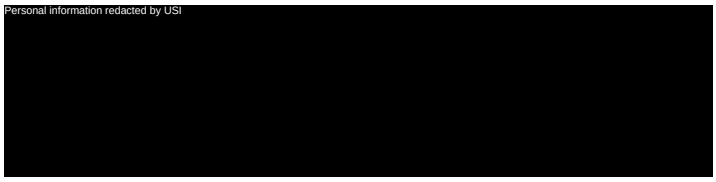
Conclusions

I do agree with the Recommendations contained in the Report, with a number of caveats. I do believe that it is crucially important that Recommendation be amended to ensure that the Trust develop a clear, agreed, written policy of its expectations, duties and performance of the Urologist of the Week, before it consider whether it is feasible to undertake triage while Urologist of the Week. Qualitatively and quantitatively defining and describing its expectations of the complexity of triage without firstly doing so for UOW will lead to a fudged failure.

I believe that no Consultant Urologist should be expected to concern him or herself with reviewing their conduct of triage to align themselves with his or her colleagues, especially when the colleagues claim to be conducting triage in a similar manner. That proposal wil be replaced by a clear, agreed, written policy of the Trust concerning the conduction of triage. Then each Consultant only has to comply with the policy, and not with conduct of his or her colleagues, real or imagined.

Lastly, the report should include a Recommendation concerning the establishment of systems enabling clinicians, and particularly clinical departments, deal with difficult or dysfunctional management.

I look forward to receiving a revised report in due course. I have little confidence that it will have been significantly amended. I have less confidence that any of its Recommendations will be implemented.



Aidan O'Brien

11 December 2019

Assessment of Suspected Testicular Cancer

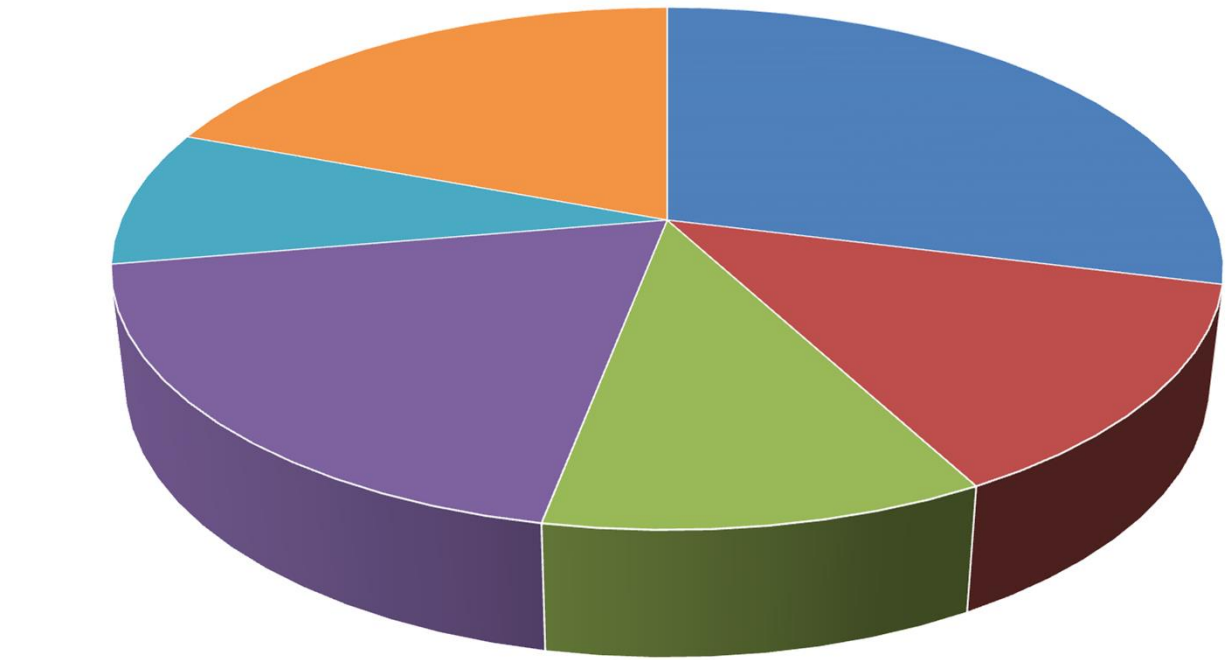
Aims of audit

- Can we change the way we investigate and refer for suspected testicular cancer
  - Fewer appointments in clinic
  - Faster results for patients
- Free up slots and decrease waiting times for other patient groups

The Referrals

- 83 referral for testicular ‘lumps’ and suspected cancer
- 8 Confirmed Cancers

Conditions seen in Clinic



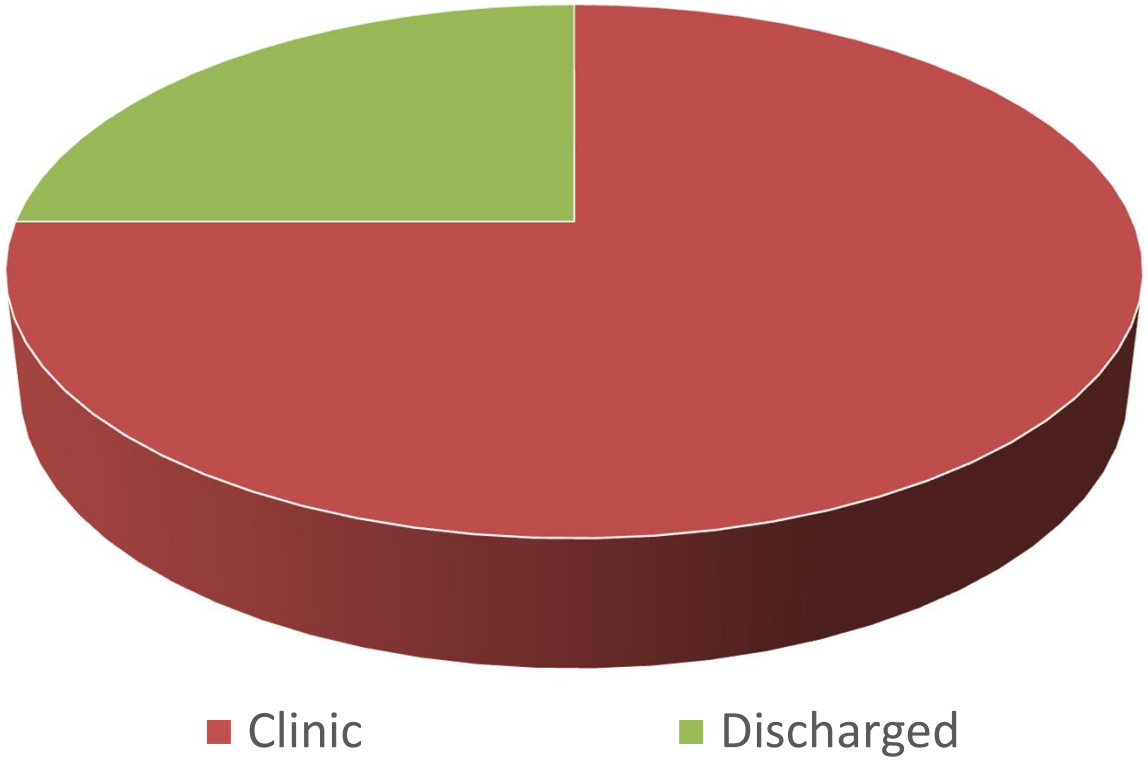
How were these diagnosed?

- US testes carried out in almost all patients
- Approx. half US requested by GP on RF basis
- Approx. half requested in clinic
- Could we have saved clinic appointments by having US scans carried out as part of the referral process?
- Could more patients be discharged on the basis of these scans before clinic review?

Results

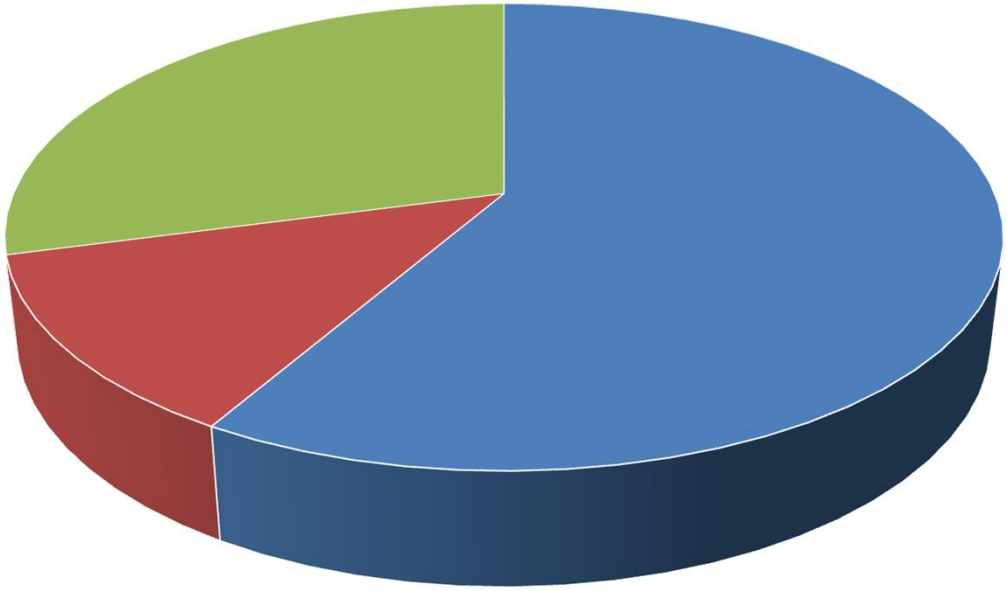
- Of the 83 referrals made, only 8 were confirmed cancers.
- Of the remaining 75 referrals, only 8 were discharged without a clinic appointment.
- The remaining 67 patients had either normal imaging or benign pathology, how many of these patients needed a slot in clinic?

Normal US Scan



¾ Seen in clinic before discharge

Cysts



¾ Discharged without intervention, the majority of which were seen in clinic

Proposed Changes

- Discharge a higher proportion of patients with normal or non concerning US scans without review in clinic
- Continue to offer review for patients with borderline US or benign findings which are amenable to intervention

Advantages

- More patients available for discharge before clinic review
- Minimal increase in US workload
- More information available in advance for any patients who have an appointment in clinic
- More effective triaging

Disadvantages

- Some patients may benefit from having a discussion with a urologist

Questions

Corrigan, Martina

From: Gibson, Simon <[redacted]>
Sent: 24 January 2020 12:57
To: OKane, Maria; Weir, Lauren
Cc: Carroll, Ronan; Haynes, Mark; Corrigan, Martina; Hynds, Siobhan; McNaboe, Ted; Khan, Ahmed; Carroll, Anita; McClements, Melanie; Toal, Vivienne
Subject: FW: For Response - Meeting Request - AOB

Dear Maria

As requested below, I co-ordinated and chaired this meeting. The purpose of the meeting was agreed as consideration of the below points laid out in your e-mail of 17th November, specifically:

1. describe in detail the management plan around the backlog report ,
2. the expectation re compliance
3. and the escalation

to assist a meeting with Mr O'Brien to discuss his deviation from the action plan

Present at the meeting were:

- Simon Gibson
- Ronan Carroll
- Martina Corrigan
- Mark Haynes
- Ahmed Khan

The Backlog Report

The Backlog Report was commenced in approximately 2016, (it existed before though detail and format may have been different) to quantify workload between secretarial and audio-typist staff and allow movement of work where necessary. Information was gathered by completion of a template by secretaries themselves on a monthly basis, when they were asked to quantify the level of work awaiting to be done either by their consultant or themselves.

This information was compiled into a report and circulated to consultant staff, and copied to relevant Heads of Service and Assistant Directors. It was not forwarded to medical staff acting in their capacity as CD or AMD. There appears to be variable consideration of this report by specialties within either patient safety meetings or specialty meetings. It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with individuals own recollection of behaviour or workload of colleagues. In essence, it was felt that there may have been inaccuracies in the data provided by staff. This data was never independently verified, and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology, and was not regularly discussed at the Urology specialty meeting.

Expectation re compliance

None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a gauge against reported performance.

Escalation

As there was some cynicism in relation to the validity of the data, combined with a lack of standards to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report.

It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges in taking forward this issue with Mr O'Brien

In concluding the discussion, those present felt that the best way to move this topic forward was for a group of interested staff to:

1. *Agree and describe why this information is being collated: for example, is it largely for resource / secretarial workload*
2. *Disaggregate into two areas those indicators for which clinicians are responsible and those indicators for which administrative staff are available*
3. *Agree and describe a consistent process for how this information is collated, and the method by which the information can be independently verified*
4. *Provide a Trust wide standard of performance in relation to these performance indicators which all clinical staff should be expected to adhere to*
5. *Agree the process for escalation for when monthly information indicates a deviation from this Trust wide standard of performance*

Considering the processes outlined above in the wider sense of supporting medical staff who have had issues identified, I feel there would be benefits in an urgent discussion regarding the day-to-day management of Mr O'Brien by his operational line management team to ensure that supervision of his administrative duties are being carried out as expected. This would allow an opportunity to identify if there are any concerns starting to emerge, so that appropriate supports can be offered to Mr O'Brien, to ensure that concerns do not continue.

Happy to discuss.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by USI

From: OKane, Maria
Sent: 17 November 2019 12:11
To: Hynds, Siobhan; Khan, Ahmed; Haynes, Mark; Carroll, Ronan; Gibson, Simon
Cc: Weir, Lauren
Subject: RE: FW: Backlog Report - October 2019

Thanks Siobhan.

Simon can I ask that you coordinate a meeting which I am asking you to minute please asap to

1. describe in detail the management plan around this ,
2. the expectation re compliance
3. and the escalation.

It will be important before all of you meet with Mr O'Brien that you have this process well described and documented – process mapping this might be the most useful approach.

While I appreciate that there is a divergence in views about the process we have in place to manage referrals, he is being asked to comply with this as is until it is collectively agreed that the system should be changed.

Lauren bf 2 weeks please

Thanks Maria

From: Hynds, Siobhan
Sent: 08 November 2019 10:10
To: OKane, Maria; Khan, Ahmed; Haynes, Mark; Carroll, Ronan
Subject: RE: FW: Backlog Report - October 2019
Importance: High

Maria

Mr O'Brien is clearly deviating from the action plan that was put in place as a safeguard to avoid this type of backlog and he is also an outlier in terms of his other Urology colleagues by some way.

Has there been any direct discussion with Mr O'Brien about this? Could I suggest a meeting of the case manager(Dr Khan) with Ronan and Mark to discuss the data and decide on the necessary next steps. As a matter of urgency there needs to be a clear plan in terms of clearing any outstanding work. Given some dictation is now going back to June 18 we need to understand if there is any impact on patients and we need to discuss the process for monitoring as this hasn't flagged.

Siobhan

From: OKane, Maria
Sent: 05 November 2019 08:33
To: Khan, Ahmed; Hynds, Siobhan; Haynes, Mark; Carroll, Ronan
Subject: Fwd: FW: Backlog Report - October 2019

Dear Ahmed / Siobhan you will have a view about this please ?

Ronan can you describe the systematic process in place please to capture the relevant information agreed with case managers please? Thanks Maria

---------- Forwarded message ----------
From: "Haynes, Mark" [redacted]
Date: Nov 5, 2019 6:37 AM
Subject: FW: Backlog Report - October 2019
To: "Khan, Ahmed" [redacted],"OKane, Maria" [redacted],"McClements, Melanie" [redacted],"Carroll, Ronan" [redacted]
Cc:

FYI re oversight.

Relevant info for oversight is highlighted below for October;

UROLOGY	Backlog - Number of charts with oldest dat							
Consultant	Discharges awaiting Dictation	oldest date	Discharges to be typed	oldest date	Clinic letters to be dictated	oldest date	Clinic letters to be typed	olde dat
Mr Tyson/ solt								
Mr Glackin	1	Aug-19	16	28.10.19	1	22.10.19	3	29.10
Mr Haynes	0	-	0	-	0	-	17	24.10
Mr O'Brien	35	27.06.17	0	-	45	23.09.19	11	20.09
Mr O'Donoghue	0	-	0	-	0	-	43	15.10
Mr Young	8	-	0	-	0	-	29	24.10
Sub Speciality Totals	44		16		46		103	

From: Evans, Marie
Sent: 04 November 2019 22:03
To: Carroll, Ronan; Robinson, Katherine; Carroll, Anita; Corrigan, Martina
Cc: Tyson, Matthew; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Backlog Report - October 2019

Dear All,

Please find attached Backlog Report for October 2019.

If you have any queries please don't hesitate to contact me.

(Mr Tyson/Solt blank [redacted])

Kind Regards

Marie Evans

Service Administrator (SEC)

Ground Floor

Ramone Building

T: Personal Information redacted by the USI

E: Personal Information redacted by the USI

Corrigan, Martina

From: Carroll, Ronan <Personal Information redacted by the USI>
Sent: 22 February 2020 11:26
To: Reid, Trudy
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; Haynes, Mark; McClements, Melanie; OKane, Maria; Corrigan, Martina
Subject: RE: CONFIDENTIAL: SAI Personal information redacted by
Attachments: RE: CONFIDENTIAL: SAI Personal information redacted by USI (135 KB)

Importance: High

Trudy,
I attached Mark's reply to your email of the 18th Dec. To date this investigation/ review of AOB's practice has not involved operational managers, in fact I only received the report on the 12/2/20. In Mark's email he suggests that the concerns expressed in AOB's letter should be review by Mr McNaboe or another AMD and as I have had no direct involvement to date I have not action Mark's suggestion.

No doubt you are already aware of 2 additional SAI/SEA's involving AOB
(1) Pati ent was presented at acute governance 14th Feb & (2) Personal Information redacted by the USI - Datix: Personal Information

1. Level 1 Report final for ACG Pati ent.docx

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by the USI

From: Reid, Trudy
Sent: 17 February 2020 16:16
To: Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; Haynes, Mark; McClements, Melanie; OKane, Maria
Subject: FW: CONFIDENTIAL: SAI Personal information redacted by USI

Ronan could you please provide an update on any review/screening of the concerns raised by Mr O'Brien in his correspondence

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

From: Reid, Trudy
Sent: 22 January 2020 12:37
To: Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; Haynes, Mark; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]

Dear Ronan I wonder if you could provide an update on any review/screening of the concerns raised by Mr O'Brien in his correspondence

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile [redacted]

From: Haynes, Mark [redacted]
Sent: 18 December 2019 11:12
To: Reid, Trudy; Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]

As one of his colleagues and therefore one of the individuals he may be accusing of harming patients, I cannot be part of any conversation regarding these comments alleging patient harm caused by his colleagues working practices, or any potential investigation. Mr McNaboe as CD can provide input and another AMD will need to input into any SAI screening if required in my place.

As a general comment, both items allege 'harm' that he has witnessed, yet give no detail. Without detail of patient ID's we cannot investigate any individual episode of patient care. If he is making an allegation that individual consultants working patterns, decision making and delivery of care are putting patients at risk of harm then we need to understand if he is bringing this to our attention for us to instigate an investigation into patient care by an individual / individuals. This needs ascertaining by means of a conversation with him.

The 'issues for concern for discussion' document was discussed at a departmental meeting. From memory I recall many disputed his perspective (eg weekend ward rounds, we are currently job planned to be on-call at weekend and therefore us acting as on-call consultants is what is expected, each of us will deliver this in the way we believe appropriate for the individual on-call at middle grade on the day. Personally I come in when needed but conduct a review of all patients results via ECR and have a telephone discussion about any the middle grade is concerned about, and any I have queries about based on ECR results, along with inpatient reviews when required). There should be minutes from this meeting (Mr Young as service lead should be able to provide these).

I agree with his issue that not all consultants conduct 'advanced triage' with some doing nothing other than ticking a box. I share his view that pre-investigating patients upon receipt of referral is the right thing to do. This was not accepted by all with concerns over the time required to do it and the time required to effectively manage the results. I continue to do it, as does he, in the most time efficient manner for me (I dictate letters to patients).

The concerns regarding patients at risk of harm on our waiting lists have certainly been raised by me before.

Mark

From: Reid, Trudy
Sent: 18 December 2019 08:36
To: Carroll, Ronan; Haynes, Mark
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: CONFIDENTIAL: SAI [redacted]
Importance: High

Good morning please see attached comments on SAI and supporting documentation. I will be sharing this information with the chair of the SAI as this is the consultants response to the factual accuracy checks we ask for as part of the SAI process.
There appears to be suggestions that harm has come to patients. Mark and Ronan have these concerns been escalate within SEC prior to this and if so have they been investigated? If not can you review the content of the attached documents to ascertain what detail we require to allow us review and decide the next steps, e.g. SAI screening if required?

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile Personal Information redacted by the USI

Corrigan, Martina

To: Haynes, Mark; Reid, Trudy
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]
Attachments: Comments concerning the RCA Report on Review of SAI [redacted].docx; ISSUES OF CONCERN FOR DISCUSSION.DOCX

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

From: Haynes, Mark
Sent: 18 December 2019 11:12
To: Reid, Trudy; Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]

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Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile [redacted]

Comments concerning the RCA Report on Review of SAI [redacted]

In submitting this commentary regarding the RCA Report of SAI [redacted], I have reviewed all retained correspondence relating to the issue of triage, all retained documentation relating to other issues impacting upon triage and all retained documentation relating to other issues referred to by others interviewed during the course of the Root Cause Analysis. Having done so, I believe that the Recommendations outlined in the Report are its most important component, though I believe that at least one additional recommendation is required to ensure that the others could be effectively implemented. I have endeavoured to be concise.

Having been interviewed by Dr. Johnston and having read the above Report, I do believe that the singular and significant flaw of the Review has been to investigate the failure to triage urgent and routine referrals in isolation of other pressures and clinical priorities which I believe are evidently more important. As a clinician and a clinical department, I believe that these greater clinical priorities cannot be compromised for the sake of triage, as they have been and continue to be.

Urologist / Consultant of the Week

While agreeing that triage is indeed a serious issue and very important, I was concerned to being expected to agree that triage of referrals has 'number one ranking in the overall scheme of things'. I believe that it is vitally important to fully appreciate the significance of this claim, especially as triage has been aligned with the duties of the Urologist of the Week (UOW). If, as has been my experience during my last week as UOW, one does a ward round from 09.00 am to 11.30 am, prior to going to theatre to undertake seven emergency / urgent operations, is triage the most important concern that day, or the day after, if it is similar?

I most earnestly urge the Review Team to review the wording of Recommendation 6, urging the Trust to re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. I believe that it is important to appreciate that the Trust has never examined or assured itself in the first place, never mind do so again. I believe that it is crucially important that the duties and priorities of the CoW and the expectations of the Trust of the CoW in the conduct of those duties and priorities, be clearly agreed and expressed in a written Memorandum of Understanding, or similar. I do so as there has been an ambiguity since its inception as to those duties and priorities.

Following a long period of gestational discussion, the UOW came into existence in late 2014. The major reason for the length of that gestational discussion was the belief, particularly on the part of our Lead Clinician, that the duties of the UOW could not possibly take up a whole day. This belief was borne out of his perception that the UOW would essentially be on call. When subsequently persuaded and convinced that it would be a good for inpatient management that the UOW would conduct an ward round each morning, it was then proposed that we could then undertake a clinic in the afternoon each day, as the duties of UOW could be confined to the morning, as one would rarely be called to theatre in an emergency. When successfully disabused of that proposal which would have necessitated the disorderly cancellation of outpatient attendances, the proposal of

being able to undertake triage of all referrals while UOW was born, as it could be undertaken at any flexible time.

There is no doubt that the clinical and operative demands upon the UOW have evolved and increased during the past five years. Nevertheless, there persists a lack of clarity as to its very purpose, and I have no doubt that there persists a dichotomy of Urologist on Call and Urologist of the Week. It had been my understanding ab initio that its raison d'etre was to provide hands-on, clinical management of all inpatients within our department, whether acutely or electively admitted, to provide advice and management to patients attending and referred from other Departments at Craigavon Area, Daisy Hill and South West Acute Hospitals, and to undertake emergency and urgent surgical intervention so far as is possible. To do so effectively in pursuit of optimal clinical outcomes requires knowing patients, often with complex comorbidities, in detail, and that requires time. However, this has not always been the case.

I have experienced a patient being unnecessarily and inappropriately discharged when it would have been entirely possible for them to have had surgical intervention while inpatients, only to be acutely readmitted, sicker than previously and for another UOW to manage. I have witnessed patients undergoing surgery by Registrars (while the UOW triaged referrals) with outcomes inferior to those I believe would have been achieved had the UOW been operating, or at least attending in supervision. I have been requested by Nursing Staff to assess inpatients who had never been seen by a UOW. Indeed, the most frequently occurring practice which persists is that of the UOW not coming to the hospital at all, particularly over weekends, unless 'called' of course, or not undertaking ward rounds even if present in the hospital.

And while it has been and continues to be easier to undertake triage while being 'on call', I have also no doubt whatsoever that the expectation to undertake triage of all referrals lends itself to being Urologist on Call rather than UOW. Indeed, a senior executive manager of the Trust has written that UOW was introduced to facilitate triage! If that is one understanding, there certainly needs to be a discussion and an agreement in the first instance of the duties of the UOW.

In 2018, following discussion amongst our colleagues, it was agreed that we would set aside a whole day, Monday 24 September 2018, to meet with senior management to discuss this very issue, among others. We were requested to submit those issues which we wanted to have discussed (I have separately attached my submission). No clinical commitments were arranged for that day. The meeting was cancelled, with loss of all clinical activity that could have been scheduled. The meeting was rescheduled for Monday 03 December 2018, again with no clinical commitments scheduled. No senior management personnel could attend. I therefore have no confidence whatsoever that Recommendation 6 will be addressed.

Triage and Waiting Times

I also do contend that it is not possible to deal adequately with the very important issue of triage without consideration of waiting times, and how this could or should affect the nature of the triage conducted. Dr. Johnston was of the view that the Red Flag referrals were not an issue as they 'go straight into the system'. However, the recent waiting time for a first consultation for a patient suspected of having prostatic carcinoma is 107 days. We have recently been circulated with the details of twelve patients referred as, or upgraded to, Red Flags as they were suspected

of having prostatic carcinoma. They were triaged, without any consideration of any form of preliminary investigation being requested. It would have taken less than one minute to ascertain their Red Flag status, and 'they go straight into the system', and wait almost four months for a first consultation. The further ignominy is that, on attending almost four months later, some have waited all of that time just to have a serum PSA repeated, before deciding whether to proceed with Investigative imaging, such as MRI scanning, prior to prostatic biopsies. Lest there be any doubt, the reason for the conduct of triage in such a manner is the lack of time to do otherwise, coupled with a determination that triage will be completed on completion of the period of UOW. As indicated above, I have witnessed such minimalist triage being conducted instead of undertaking ward rounds.

In March 2015, I endeavoured as Lead Clinician of Urology MDT to have my colleagues agree to advanced / enhanced triage of Red Flag patients alone. The purpose of doing so was to facilitate patients progressing along the diagnostic and therapeutic pathway in the timeliest manner possible. I did not succeed, as they declined to commit to doing so, and the reason given then was the lack of adequate time while being UOW. I have retained a written record which can be provided if requested. As a persistent consequent, a patient recently referred with a renal tumour detected on ultrasound scanning, waited for a first consultation before having staging CT scanning performed, and which could have been requested if time had been taken or available to do so, to request the scan, informing the patient (and referrer) that it had been requested.

The issue of the referrals which are actually triaged as urgent and routine is even more pressing. It is worth asserting that a referral triaged as urgent may be as life threatening, except that it is presumed that it will not be threatened by a malignancy. However, as has been a recent experience, last year's pyelonephritis was actually a renal cell carcinoma, and she was not even referred, never mind triaged. The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.

Apart from the lack of adequate time to conduct optimal triage while UOW, an additional disincentive is that the UOW will be responsible for the receipt of any investigations requested, and without any additional administrative time allocated to do so. During my last period as UOW, I requested 47 scans. I did so, mainly in the days following completion of the period as UOW. Today, I have received the result of a CT Urogram indicating that the patient probably has pancreatic carcinoma with hepatic secondaries. I will arrange an outpatient consultation for this patient in coming days.

Yet, despite repeated claims to the contrary, the Trust does not have a policy regarding urological triage, and particularly in the context of such waiting times, and with respect to an ongoing expectation that triage will be conducted by the UOW while being the UOW. It remains the case that the Trust is happy with and prefers that the referral is triaged as quickly as possible, so that they are in the system, without investigation and irrespective of the periods of time waiting for a first consultation. It is now almost three years since I recommended in my report concerning the index case (Patient 10) that the Trust should meet with us to discuss and agree who should undertake triage, when it should be conducted, and the nature of the triage to be conducted. There has been

no response to date. Two attempts to arrange meetings with senior Trust management in late 2018 did not materialise. I have come to the view that the Trust is only interested in the avoidance of any shared responsibility for these issues, preferring instead that they will be the sole responsibility of the clinician, without provision of the time to do so.

To conclude this section, the Report implies that, irrespective of the difficulties and pressures which my colleagues did have in conducting triage while UOW, they did so, and that there were no negative consequences in there doing so. Inpatient care or the quality of triage suffered to varying degrees, and particularly in the context of long waiting times. I have personally experienced a number of cases of delayed diagnoses of cancer following triage by my colleagues since 2017.

Number One Ranking in the Overall Scheme of Things

Number one ranking in the overall scheme of things for any urological department should be the provision of acute care to those most urgently in need of it; hence, the concept of the UOW. Of course, triage is a method of selecting those patients who may next most urgently need such care. Meanwhile, patients languish on ever increasingly long lists awaiting elective admission, some 600 awaiting urgent elective admission for surgery, some now waiting over five years.

We collectively have over 640 patients awaiting admission for prostatic resection. At least 10% of these patients will be found to have prostatic carcinoma. A recent review has reported an incidence of 13.4% in men aged less than 65 years, and of 28.7% of men older than 65 years. One third of the younger patients required curative or palliative treatment. So, we have a situation where at least 64 patients are waiting for years to have a diagnosis of prostatic carcinoma found. Such a figure contrasts profoundly with the five cases found due to the failure to upgrade to Red Flag status, the subject of the Report. Yet, these patients have been assessed by our Department, placed on waiting lists, with a significant risk of having a cancer diagnosis, some requiring treatment with either curative or palliative intent. Which guidelines, goals, objectives, root cause analyses, SAIs apply to these patients? None, but for our concern for them.

Factual Inaccuracies

AMD1 reported that referrals were not triaged by me in the early 90s, that referrals were being kept in a ring binder and were not on any waiting list, that I stopped the practice when challenged, and would then slip back etc. This is untrue. I was a single handed urologist from 1992 to 1996. I triaged all referrals, sorting them into urgent, soon and routine. Each category had a ring binder of referrals. I had my secretary allocate appointments for patients from each category, in commensurate numbers, to every clinic. I continued to do so until the appointment of Mr. Michael Young in 1998 when it was more appropriate to have an appointments office make appointments.

I find it difficult to believe that patients were waiting 10 years for a first appointment., as claimed by DAS2. It has been my experience that the current waiting times are the longest we have ever had. Of course there were no serious clinical issues due to the effective triage that had been conducted.

DAS1 claimed that I struggled to adapt to the modernisation and change resulting from the Regional Transformation of Urology Services. This is particularly untrue. I can provide for you on request my written submission to the Regional Review Team in 2009, detailing my concerns regarding the future provision of urological services outside of Belfast, my views concerning the lack of a Urological Department at Antrim Area Hospital, and where radical prostatectomies and radical cystectomies should be undertaken in the future. I was particularly concerned regarding the 'centralisation' of radical cystectomies for bladder cancer to Belfast. Even then, I did not entirely appreciate the negative consequences of that centralisation, in that our Department continues to have patients suffering and dying due to their not having radical cystectomies performed.

I was particularly concerned at interview that HOS1 claimed that she had discovered over 700 untriaged referral letters in my filing cabinet, having gained permission to enter my office. I also found that Dr. Johnston appeared to struggle to accept that I had advised HOS1 of the whereabouts of the letters of referral, in the third drawer of the filing cabinet in my office. They were not discovered, or uncovered. Moreover, they were all copies of the originals, as the originals or copies were retained by the Appointments Office for appointment in chronological order in accordance with the Informal Default System (IDS) introduced in 2014.

The Report does acknowledge that I had advised colleagues and management that I had found it impossible to conduct non-Red Flag referrals while UOW, while continuing to triage Red Flag referrals, as detailed in my annual appraisal. It is inconceivable that a IDS was introduced to deal with the lack of triage of non-Red Flag referrals without management being aware that they were not being done, or claiming not to have been informed or aware. The Report implies that it was my sole responsibility, and that Trust management did not bear any responsibility for either their claimed lack of awareness, or its failure to address the issue in a constructive, agreed manner, and which it has still failed to do.

Recommendation 10

The Trust is recommended to set in place a robust system for highlighting and dealing with 'difficult colleagues' and 'difficult issues'. I entirely agree. I believe that it should be included in this Recommendation that any such systems should conform with and be implemented in compliance with national guidelines.

The Report is entirely silent on any Recommendation as to how clinicians, individually or collectively, are to deal with 'difficult management', and particularly management which has repeatedly and consisted failed to address issues of concern for clinicians. The absence of such a Recommendation implies an asymmetry unworthy of the Report.

Recommendations 11 and 12

Recommendation 11 advises that I review my chosen 'advanced' method and degree of triage, to align it more completely with that of my Consultant colleagues. This is itself inconsistent with the claim on Page 18 of the Report that other members of the consultant team were also 'ordering

investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons 1's advanced triage'.

Nevertheless, I believe that this recommendation should be amended. I believe that I should triage in the manner agreed with and expected by the Trust in a written policy for urological referral. That way, there will be no room for variance in how or when triage is conducted, and the trust will bear responsibility for any negative consequences, provided clinicians have conducted triage in accordance with the agreed policy. In doing so, Recommendation 12 will have been complied with.

Conclusions

I do agree with the Recommendations contained in the Report, with a number of caveats. I do believe that it is crucially important that Recommendation be amended to ensure that the Trust develop a clear, agreed, written policy of its expectations, duties and performance of the Urologist of the Week, before it consider whether it is feasible to undertake triage while Urologist of the Week. Qualitatively and quantitatively defining and describing its expectations of the complexity of triage without firstly doing so for UOW will lead to a fudged failure.

I believe that no Consultant Urologist should be expected to concern him or herself with reviewing their conduct of triage to align themselves with his or her colleagues, especially when the colleagues claim to be conducting triage in a similar manner. That proposal wil be replaced by a clear, agreed, written policy of the Trust concerning the conduction of triage. Then each Consultant only has to comply with the policy, and not with conduct of his or her colleagues, real or imagined.

Lastly, the report should include a Recommendation concerning the establishment of systems enabling clinicians, and particularly clinical departments, deal with difficult or dysfunctional management.

I look forward to receiving a revised report in due course. I have little confidence that it will have been significantly amended. I have less confidence that any of its Recommendations will be implemented.

Aidan O'Brien

11 December 2019

ISSUES OF CONCERN FOR DISCUSSION
At
DEPARTMENTAL MEETING
On
24 SEPTEMBER 2018

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

UROLOGIST OF THE WEEK

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

TRIAGE

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, Personal Information old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on Personal information redacted by USI, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

SUMMARY

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.

CHKS
Insight for better healthcare

CHKS Consultant Level Indicator Programme

The Southern Trust

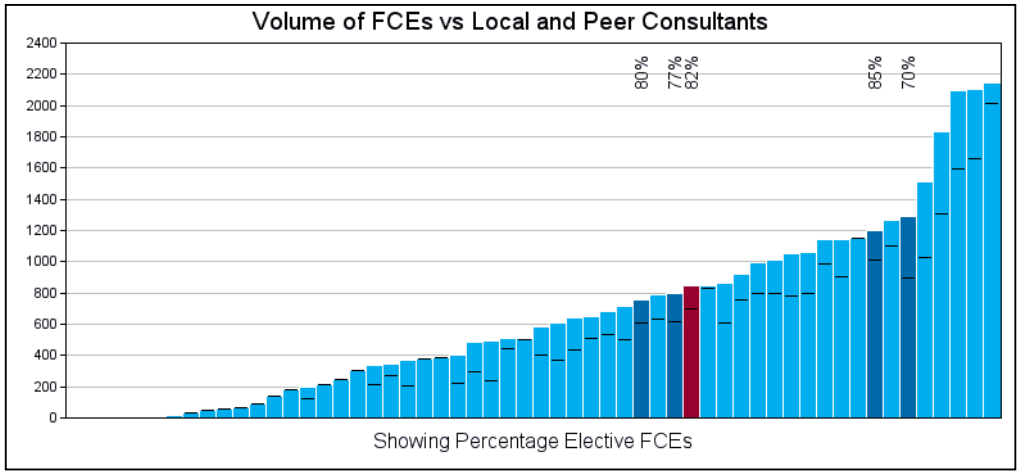
January 2016 to December 2016

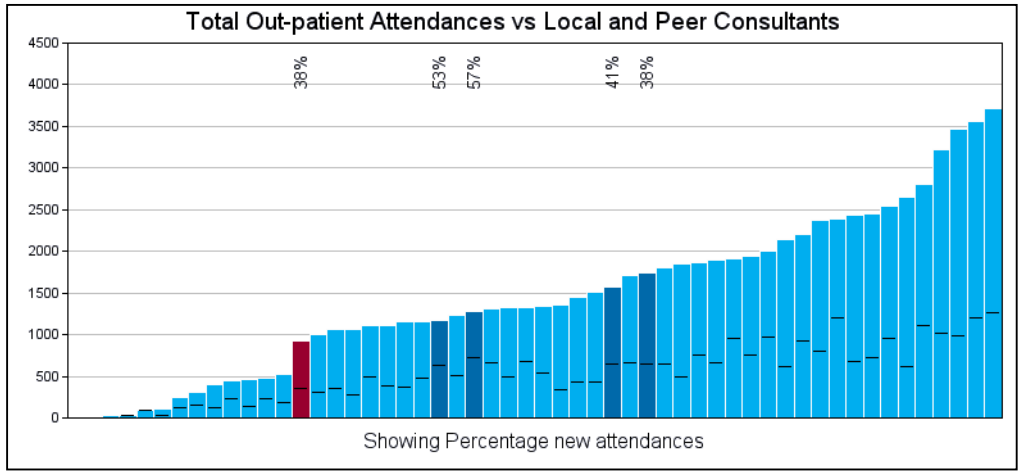
C6514 : Mr Aidan O'Brien

Urology

CHKS
Insight for better healthcare

The Southern Trust
C6514 : Mr Aidan O'Brien - Urology
January 2016 to December 2016





Workload Volumes	Consultant		Local	Peer
Total Number of FCEs	849			
Elective FCEs	698	82.2%	77.6%	79.6%
In-Patients	202	28.9%	15.4%	21.6%
Day Cases	496	71.1%	84.6%	78.4%
Emergency FCEs	121	14.3%	19.9%	19.7%
Other FCEs	30	3.5%	2.6%	0.7%
* Regular Attendances			6.7%	2.4%

In-Patient Details	Consultant		Local	Peer
FCEs - Male	526	62.0%	62.3%	68.9%
FCEs - Female	323	38.0	37.7	31.1
FCEs - Child (0-18)	27	3.2%	2.6%	5.1%
FCEs - Adult (19-74)	576	67.8%	72.6%	65.4%
FCEs - Elderly (75+)	246	29.0%	24.7%	29.5%

* Regular Attendances are counted **only** in this report line

They are expressed as a percentage of Elective FCEs (above) + Regular Attendances

They are NOT aggregated into any other data line or chart

Outpatient workload	Consultant		Local	Peer
Total Attendances	920		1440	1481
New Attendances	347	37.7%	46.0%	36.0%
Follow-up Attendances	573	62.3%	54.0%	64.0%
Attendances with Procedure	89	9.7%	2.4%	32.7%

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Consultant Total FCEs : 849 31,658 : Peer FCEs

Performance Indicators

	Consultant		Local	Peer
FCE Inpatient ALoS (DC trimmed)		4.0	3.3	2.1
Average Length of Stay (Zero trimmed)		4.7	3.8	3.0
Elective		3.7	2.6	2.4
Non-Elective		5.8	4.4	3.7
Risk Adjusted Length of Stay *		104.3	117.9	85.1
Day Case Rate	496	71.1%	84.6%	78.4%
Day Case Overstays	27	5.2%	5.2%	5.9%
Average Elective Pre-Operative LoS		0.2	0.1	0.1
Elective IP Spells with no Procedure	3	3.0	0.6	0.5
Elective Inpatient spells - procedure not carried out			1.6%	0.6%
Patient Cause				
Other Reason			1.6%	0.6%

High Volume Procedures

	Actual Day Cases						Day Case Overstays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
Day Case Procedures	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	186	278.0	163.8	95.9%	98.2%	96.5%	2	2.0	5.2	2.5	1.5	1.4
M49 - Other operations on bladder	146	72.0	108.8	99.3%	99.7%	99.5%	1		1.3	1.0		1.4
M43 - Endoscopic operations to increase capacity of bladder	36	11.0	13.8	87.8%	91.7%	91.9%	1	1.0	2.5	1.0	1.0	1.5
N30 - Operations on prepuce	8	18.8	24.2	61.5%	91.5%	92.8%		3.0	2.0		1.0	1.3
N11 - Operations on hydrocele sac	7	5.0	5.8	87.5%	88.2%	88.6%	1	1.0	1.7	2.0	1.0	1.1
M29 - Other therapeutic endoscopic operations on ureter	6	15.7	15.0	37.5%	71.2%	66.5%	2	2.3	4.8	2.0	1.0	1.5
U26 - Diagnostic testing of genitourinary system	4	1.0	34.0	100.0%	100.0%	100.0%						
M47 - Urethral catheterisation of bladder	3	3.0	25.3	100.0%	80.0%	96.4%			1.7			1.8
N06 - Other excision of testis	3	1.0	2.7	75.0%	33.3%	69.9%			1.4			1.2
M16 - Other operations on kidney	2	8.0	0.4	25.0%	69.6%	16.2%	1	1.0	1.0	2.0	1.0	3.0

	Number			Pre-Op Average LoS			IP Average LoS		
In-Patient Procedures	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M65 - Endoscopic resection of outlet of male bladder	36	11.0	21.9	0.8	0.1	0.1	4.3	3.0	2.6
M27 - Therapeutic ureteroscopic operations on ureter	20	15.0	7.2	1.0	0.5	0.3	2.5	3.0	1.5
M29 - Other therapeutic endoscopic operations on ureter	20	12.0	10.2	0.7	0.5	0.5	3.8	3.8	2.3
U21 - Diagnostic imaging procedures	18	24.8	12.3	2.0	6.9	3.0	6.5	3.4	2.3
M42 - Endoscopic extirpation of lesion of bladder	18	15.8	22.5	1.4	0.7	0.2	6.2	3.0	1.9
M45 - Diagnostic endoscopic examination of bladder	12	9.2	6.1	0.0	0.0	0.4	2.8	2.4	1.2
M16 - Other operations on kidney	8	2.0	1.3	1.2	1.0	0.6	4.4	12.2	3.7
M02 - Total excision of kidney	6	3.2	7.2	0.2	0.0	0.3	10.5	4.5	4.4
M76 - Therapeutic endoscopic operations on urethra	6	3.2	3.4	0.0	0.0	0.2	0.8	0.8	1.2
M79 - Other operations on urethra	6	0.5	0.3	0.0	0.0	0.1	0.7	1.5	0.6

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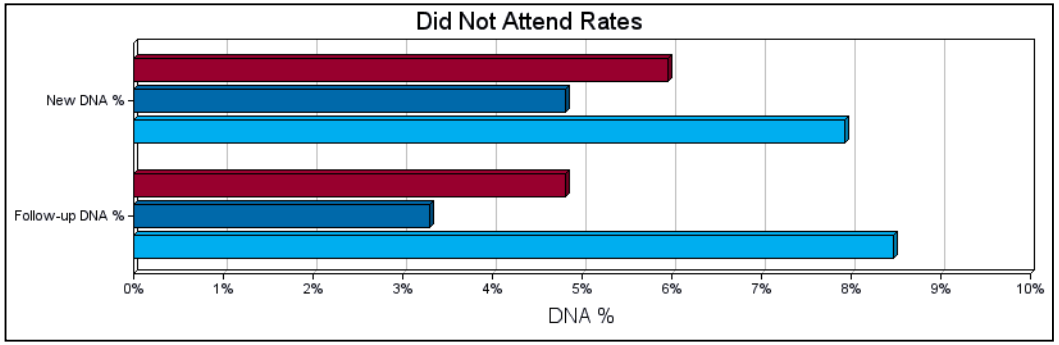
	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	920		1440		1481	
New Attendances	347	37.7%	663	46.0%	533	36.0%
Referred by General Practitioner	181	52.2%	478	72.1%	408	71.9%
With Procedures Recorded	80	23.1%	31	4.6%	165	29.2%
Average Procedure per coded attendance		1.1		1.0		1.1
Did Not Attend	22	6.0%	34	4.8%	49	7.9%
Follow-Up Attendances	573	62.3%	777	54.0%	949	64.0%
With Procedures Recorded	9	1.6%	4	0.5%	330	34.7%
Average Procedure per coded attendance		1.1		1.0		1.1
Did Not Attend	29	4.8%	26	3.3%	88	8.5%
New : Follow-Up Ratio	573	1 : 1.7	777	1 : 1.2	1010	1 : 1.8



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	89	29	8
M70 - Other operations on outlet of male bladder	0	6	13
M45 - Diagnostic endoscopic examination of bladder	0	0	119
U26 - Diagnostic testing of genitourinary system	0	0	4
X36 - Blood withdrawal	0	0	1
Q55 - Other examination of female genital tract	0	0	1
X38 - Subcutaneous injection	0	0	1
X62 - Assessment			274
U32 - Diagnostic blood tests			92
H62 - Other operations on bowel			7

CHKS
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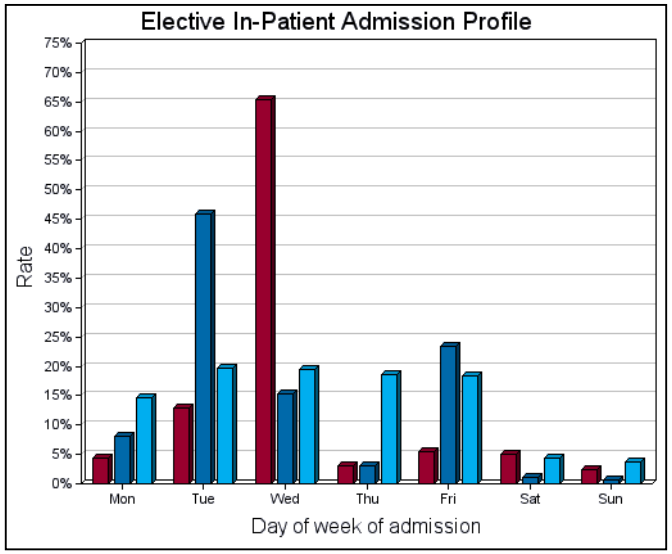

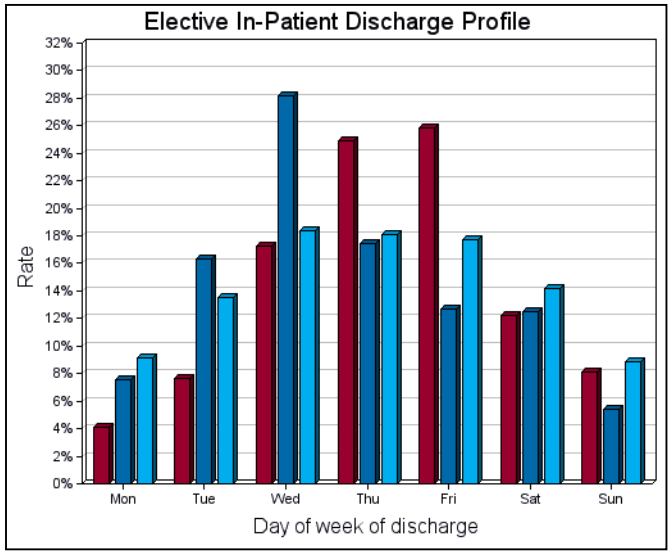

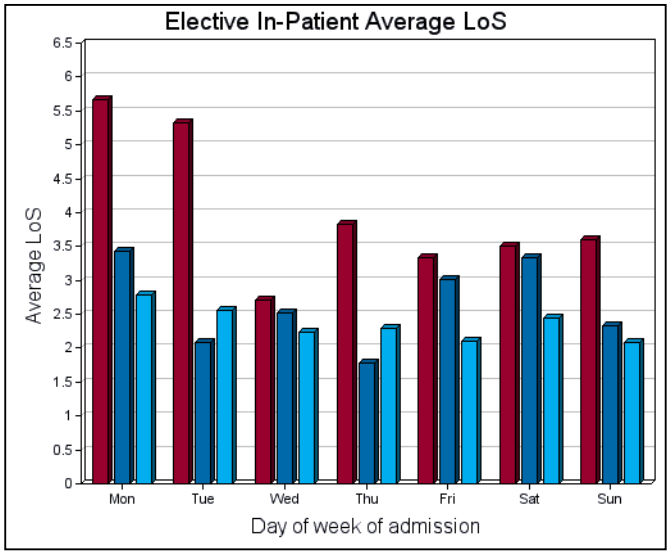

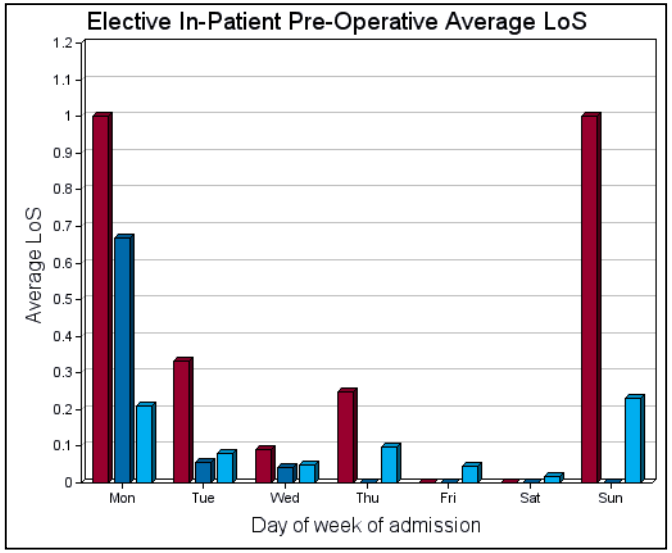

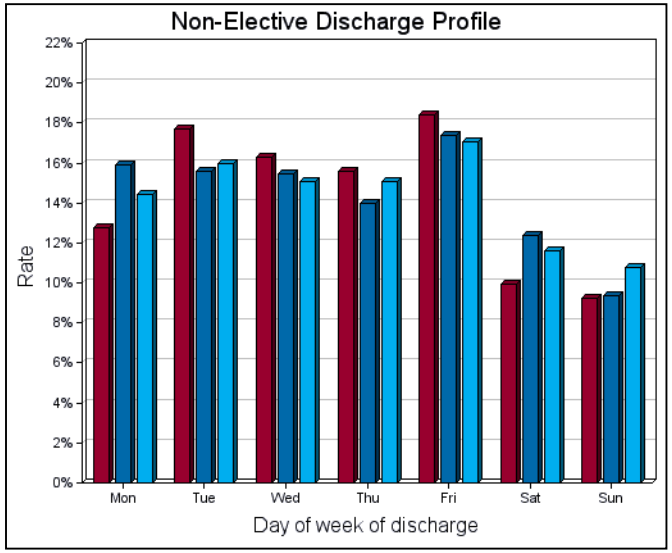

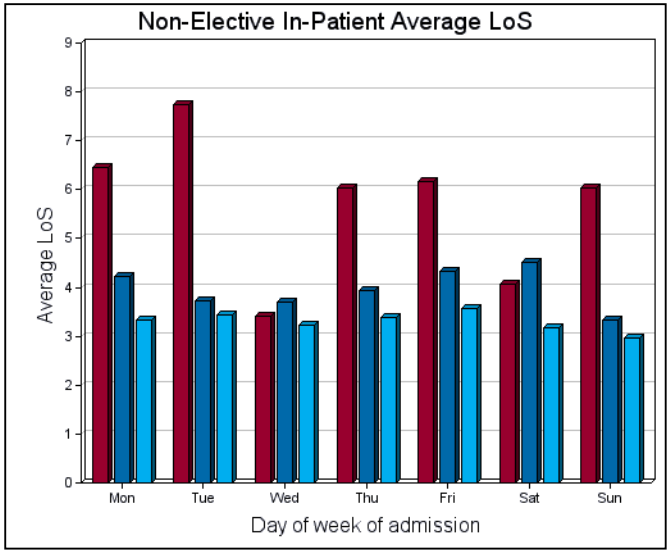

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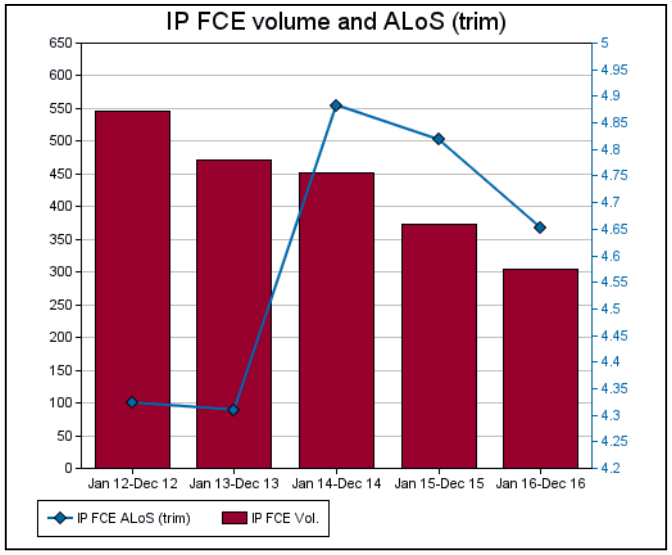

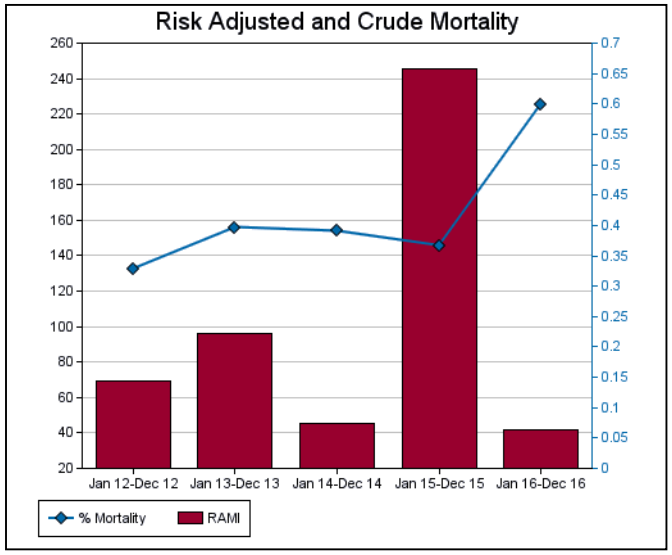

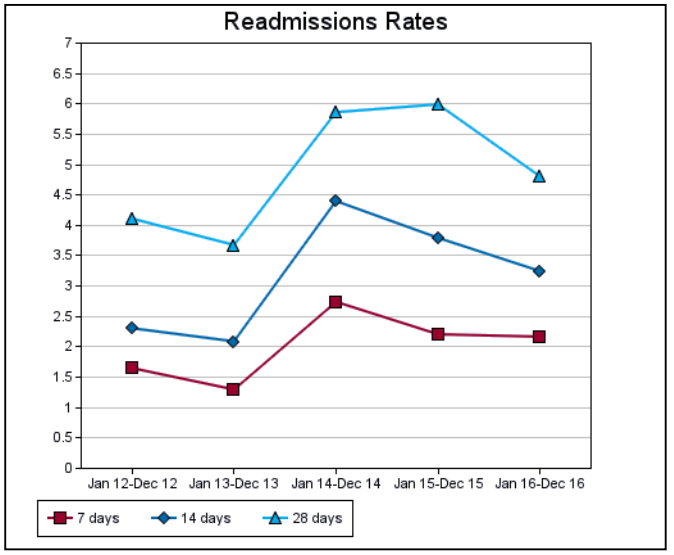

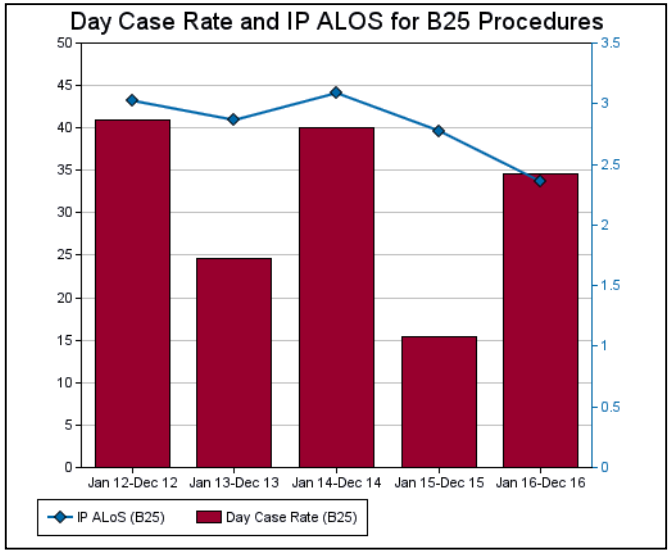

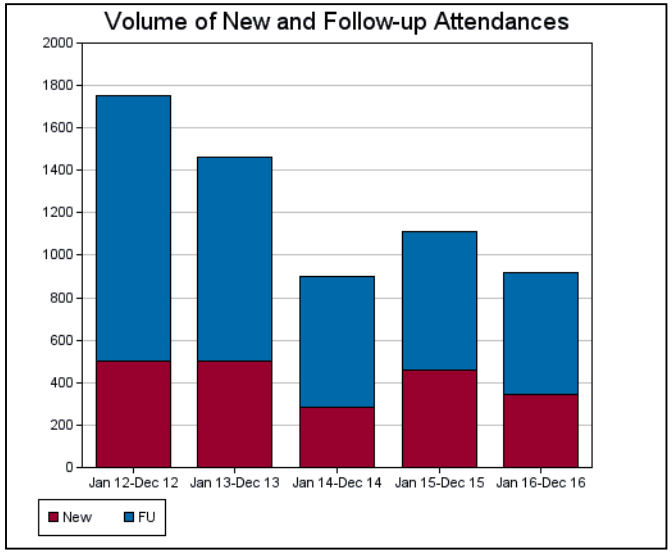

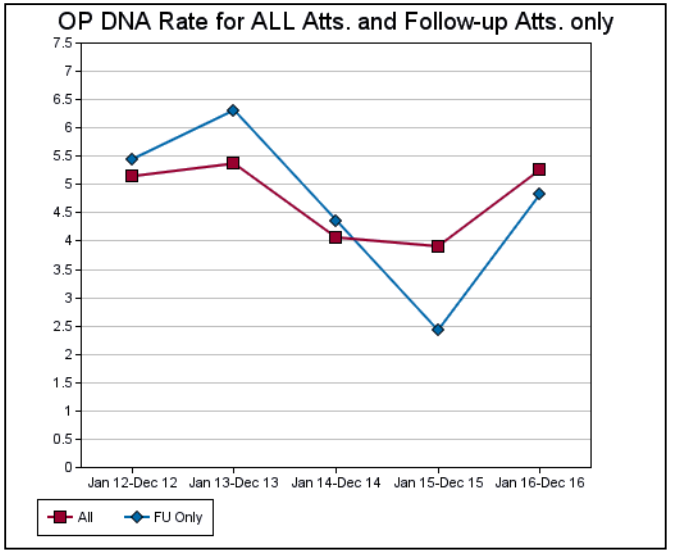

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CHKS CLIP Programme :- Indicator definitions

Report Indicator Definitions (Surgical)

Workload Volumes

Total FCEs

Numerator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

FCEs (incl. day cases) per inpatient DCC

Numerator: Count of FCEs / 52 (weeks in year)
Denominator: Number of inpatient direct clinical care (DCC) sessions
Exclusions: Well babies, regular attenders and renal dialysis patients

Elective FCEs

Numerator: Count of elective FCEs
Denominator: Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases
Denominator: Count of elective FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

Day Case Rate

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Emergency FCEs

Numerator: Count of emergency FCEs
Denominator: Total FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

Other FCEs

Numerator: Count of OTHER (not elective or emergency) FCEs
Denominator: Total FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

Regular attendances

Numerator: Count of regular attenders
Denominator: Total elective FCEs including regular attenders
Exclusions: Well babies

CHKS CLIP Programme :- Indicator definitions cont.

In-patient Details

Male FCEs

Numerator: Count of Male FCEs
Denominator: Count of Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

Female FCEs

Numerator: Count of Female FCEs
Denominator: Count of Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

Children FCEs

Numerator: Count of Childrens FCEs - age on admission >= 0 and <=18
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

Adult FCEs

Numerator: Count of Adult FCEs - age on admission >= 19 and <= 74
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

Elderly FCEs

Numerator: Count of Elderly FCEs with age on admission 75+
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

Outpatient Workload

Total attendances

Count of outpatient attendances

Total attendances per out-patient DCC

Numerator: Count of outpatient attendances / 52 (weeks in year)
Denominator: Number of outpatient direct clinical care (DCC) sessions

New attendances

Numerator: Count of total new outpatient attendances
Denominator: Total outpatient attendances

Follow-up attendances

Numerator: Count of total follow-up attendances
Denominator: Total attendances

Attendances with a procedure

Numerator: Count of attendances with a valid OPCS4 procedure code
Denominator: Total attendances
Exclusions:
• OPCS4 codes shown in the Y and Z chapters and
• procedure code ‘X999-No outpatient procedure carried out’.

CHKS CLIP Programme :- Indicator definitions cont.

Performance Indicators

FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days
Denominator: Total IP FCEs
Exclusions:
- day cases
- Well babies, regular attenders and renal dialysis

ALoS (zero trimmed)

Numerator: Count of bed days
Denominator: Total FCEs with LoS > zero
Exclusions to numerator and denominator:
• Zero LoS FCE
• Well babies, regular attenders and renal dialysis

Elective ALoS (zero trimmed)

Numerator: Count of bed days - elective
Denominator: Elective FCEs and LoS > zero
Exclusions :
• Zero LoS FCEs
• Well babies, regular attenders and renal dialysis

Non-elective ALoS (zero trimmed)

Numerator: Count of bed days - non- elective
Denominator: Non-Elective FCEs and LoS > zero
Exclusions:
• Zero LoS FCEs
• Well babies, regular attenders and renal dialysis

Risk Adjusted ALoS

Numerator: observed spell bed days
Denominator: expected bed days
Exclusions: The following types of criteria are excluded from the risk adjusted Length of Stay model: Mental Health specialties , maternity admissions, other admissions, neonates who died < 2 days old, stillbirths, day cases, regular attenders, length of stay >100 , HRG defined exclusions, HRG's beginning with U and invalid primary diagnosis codes.

CHKS CLIP Programme :- Indicator definitions cont.

Day Case Rate

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Day case overstays

Numerator: Count of elective episodes intended to be a day case with a provider spell LoS > 0.
Denominator: Numerator + actual day cases
Exclusions: Well babies, regular attenders and renal dialysis

Elective inpatient pre-operative ALoS

For elective IP spells only –
Numerator: Total pre-operative bed days.
Denominator: Spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions: Well babies, regular attenders and renal dialysis

Elective inpatient spells with no procedure

Numerator: Coded elective IP spells with no procedure
Denominator: Coded elective IP spells
Exclusions:
• Well babies, regular attenders and renal dialysis
• Exclude spells where spell HRG = S22 – planned procedure not carried out

Elective inpatient spells - procedure not carried out

Numerator: Coded elective IP spells with diagnosis including Z53
Denominator: Coded elective IP spells
Exclusions:
• Well babies, regular attenders and renal dialysis

Procedure not carried out - patient cause

Numerator: Coded elective IP spells with diagnosis including Z531 or Z532
Denominator: Coded elective IP spells
Exclusions :
- Well babies, regular attenders and renal dialysis

Elective inpatient spells- Procedure not carried out - other reason

Numerator: Coded elective IP spells with diagnosis including Z530, Z538 or Z539
Denominator: Coded elective IP spells
Exclusions:
- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

Governance Indicators

Mortality Rate

Numerator: Spells with discharge method = death
Denominator: Total Spells
Exclusions :
• Well babies

Mortality Rate - Elective

Numerator: Elective spells that died
Denominator: Total elective spells
Exclusions :
• Well babies

Mortality Rate - Non-elective

Numerator: Non-elective spells that died
Denominator: Total non-elective spells
Exclusions:
• Well babies

Risk Adjusted Mortality Index

Numerator: observed deaths
Denominator: expected deaths (based on CHKS risk adjusted mortality model)
•Metholodgy Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Risk Adjusted Mortality Index - Elective

For elective spells only
Numerator: observed deaths
Denominator: expected deaths (based on CHKS risk adjusted mortality model)
•Metholodgy Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Risk Adjusted Mortality Index - Non-elective

For non-elective spells only
Numerator: observed deaths
Denominator: expected deaths (based on CHKS risk adjusted mortality model)
•Metholodgy Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

CHKS CLIP Programme :- Indicator definitions cont.

Attributed complication rate

Numerator: Count of Spells with an attributed complication based on ICD10 and OPCS4 criteria
Denominator: Total Spells
Exclusions:
• Well babies, regular attenders and renal dialysis

Misadventure rate

Numerator: FCE with ICD10 codes classified as misadventures reported
Denominator: Total FCEs
Exclusions:
• Well babies, regular attenders and renal dialysis

Readmission rate

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 28 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.
Denominator: Total spells discharged within the time period

CHKS CLIP Programme :- Indicator definitions cont.

High Volume Procedures

Day Case Rate

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Day case overstays

Numerator: Count of elective episodes intended to be a day case with a provider spell LoS > 0.
Denominator: Numerator + actual day cases
Exclusions: Well babies, regular attenders and renal dialysis

In-Patient Procedures

Top 10 elective Inpatient Procedures
(Total FCE's -Day Cases)

Inpatient pre-operative ALoS

Numerator: Total inpatient pre-operative bed days
Denominator: Inpatient spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions : Well babies, regular attenders and renal dialysis

FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days
Denominator: Total IP FCEs
Exclusions:
- day cases
- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

Outpatient Profile and Performance

New attendances

Numerator: Count of total new outpatient attendances
Denominator: Total outpatient attendances

New attendances referred by GP

Numerator = Total new outpatient attendances where the source of referral is GP
Denominator: Total new outpatient attendances

New attendances with a procedure

Numerator: Count of new attendances with a valid OPCS4 procedure code
Denominator: Total new attendances
Exclusions:
• OPCS4 codes shown in the Y and Z chapters and
• procedure code ‘X999-No outpatient procedure carried out’.

Average number of procedures - New attendances

Numerator: Count of valid OPCS4 procedure codes recorded for new attendances
Denominator: Total coded new attendances
Exclusions:
• OPCS4 codes shown in the Y and Z chapters recorded in procedure 1
• procedure code ‘X999-No outpatient procedure carried out’.

DNA rate - New attendances

Numerator: = DNAs - new attendances
Denominator = New attendances + DNAs for new attendances

Follow-up attendances

Numerator: Count of total follow-up attendances
Denominator: Total attendances

Follow-up attendances with a procedure

Numerator: Count of follow-up attendances with a valid OPCS4 procedure code
Denominator: Total follow-up attendances
Exclusions:
• OPCS4 codes shown in the Y and Z chapters and
• procedure code ‘X999-No outpatient procedure carried out’.

CHKS CLIP Programme :- Indicator definitions cont.

Average number of procedures - Follow-up attendances

Numerator: Count of valid OPCS4 procedure codes recorded for follow-up attendances
Denominator: Total coded follow-up attendances
Exclusions:
• OPCS4 codes shown in the Y and Z chapters recorded in procedure 1
• procedure code 'X999-No outpatient procedure carried out'.

DNA rate - Follow-up attendances

Numerator: = DNAs - follow-up attendances
Denominator = Follow-up attendances + DNAs for follow-up attendances

New : Follow-up ratio

New to follow-up ratio = 1:n (for every new attendance there are n follow-ups)
Numerator: Follow-up attendances
Denominator: New attendances

DNA Chart

DNA rate - All attendances

Numerator: = Total DNAs
Denominator = Total attendances + DNAs

CHKS CLIP Programme :- Indicator definitions cont.

Elective Admission Profile

Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases
Denominator: Count of elective FCEs
Exclusions: Well babies,regular attenders and renal dialysis patients

Elective In-patient Pre-operative ALoS by Admission Day

Elective inpatient pre-operative ALoS

For elective IP spells only –
Numerator: Total pre-operative bed days.
Denominator: Spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions: Well babies, regular attenders and renal dialysis

Discharge Profile - Elective In-Patient

Elective in-patient discharge profile

Numerator: Elective IP's by day of discharge
Exclusions:
• Well babies, regular attenders and renal dialysis

ALoS by Admission Day - Elective In-Patient

Elective ALoS (zero trimmed)

Numerator: Count of bed days - elective
Denominator: Elective FCEs and LoS > zero
Exclusions :
• Zero LoS FCEs
• Well babies, regular attenders and renal dialysis

Discharge Profile - Non-Elective

Non-elective in-patient discharge profile

Numerator: Non-elective IP's by day of discharge.
Exclusions:
• Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

ALoS by Admission Day - Non-Elective

Non-elective ALoS (zero trimmed)

Numerator: Count of bed days - non- elective
Denominator: Non-Elective FCEs and LoS > zero
Exclusions:
• Zero LoS FCEs
• Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

Revalidation Charts

IP FCE Volume and ALoS (trim)

In-patient FCEs

ALoS (zero trimmed)

Numerator: Count of bed days
Denominator: Total FCEs with LoS > zero
Exclusions to numerator and denominator:
• Zero LoS FCE
• Well babies, regular attenders and renal dialysis

Risk Adjusted and Crude Mortality

Risk Adjusted Mortality Index

Numerator: observed deaths
Denominator: expected deaths (based on CHKS risk adjusted mortality model)
•Methodgy Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Mortality Rate

Numerator: Spells with discharge method = death
Denominator: Total Spells
Exclusions :
• Well babies

Readmission Rates

Readmission rate within 7 days

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 7 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.
Denominator: Total spells discharged within the time period

Readmission rate within 14 days

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 14 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.
Denominator: Total spells discharged within the time period

CHKS CLIP Programme :- Indicator definitions cont.

Readmission rate

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 28 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.
Denominator: Total spells discharged within the time period

Day Case Rate and IP ALOS for B25 Procedures

Day case rate for B25 directory procedures

Numerator: Elective Day Case Spells (MoA = 11,12 or 13, Intended management = 2 and spell length of stay =0) AND AND procedure meets criteria fro inclusion in B25 (see appendix 1)
Denominator: Elective spells (MoA = 11,12 or 13) AND procedure meets criteria fro inclusion in B25 (see appendix 1)
Exclusions: None

IP ALoS for B25 directory procedures

Numerator: Elective in-patient spell bed days (MoA = 11,12 or 13 AND NOT day case (intended management = 2 and spell length of stay =0) AND procedure meets criteria fro inclusion in B25 (see appendix 1)
Denominator: Elective in-patient spells(MoA = 11,12 or 13 AND NOT day case (intended management = 2 and spell length of stay =0) AND procedure meets criteria fro inclusion in B25 (see appendix 1)
Exclusions: None

Volume of New and Follow-up Attendances

New attendances

Numerator: Count of total new outpatient attendances
Denominator: Total outpatient attendances

Follow-up attendances

Numerator: Count of total follow-up attendances
Denominator: Total attendances

OP DNA Rate for ALL Atts. and Follow-up Atts. only

DNA rate - All attendances

Numerator: = Total DNAs
Denominator = Total attendances + DNAs

DNA rate - Follow-up attendances

Numerator: = DNAs - follow-up attendances
Denominator = Follow-up attendances + DNAs for follow-up attendances

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 07 February 2019 06:25
To: OKane, Maria
Subject: FW: Patients awaiting results

Morning Maria

See below email regarding results from my colleague and my response FYI.

Mark

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI'; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; 'derek.hennessey Personal Information redacted by the USI'; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed.
I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by the USI lady who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for Personal Information redacted by USI tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

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

Corrigan, Martina

From: Haynes, Mark <[redacted]>
Sent: 16 November 2018 13:56
To: Khan, Ahmed; Gibson, Simon
Subject: FW: AOB

Hi Ahmed / Simon

Are you aware of this? Surely this behaviour (phone calls from wife and his son / legal advisor to Mr Young, below with Mr Weir) shouldn't happen?

How can we (his colleagues) be protected?

Mark

From: Weir, Colin
Sent: 15 November 2018 11:34
To: Carroll, Ronan; Hynds, Siobhan
Cc: Young, Michael; Gishkori, Esther; Haynes, Mark
Subject: RE: AOB

Can I put on record that last Thurs 8th Nov Mr O'Brien met me in my office from 08:50 to 09:15hrs. He requested the meeting

The conversation centred around his investigation. I was supportive to him as a colleague, and Clinical Director and I thought that was to be the focus of the conversation

He did ask me about evidence I had given to the investigation relating to meeting with Dr McAllister when he was AMD and prior to the investigation. I wasn't expecting this and tried to answer briefly my recollection.

I now feel that

1. he should not have made this approach
2. his questioning and my responses could undermine the investigation and action plan
3. he put me in a difficult and awkward position
4. having met Mr Young and knowing his experiences: I cannot meet or discuss anything with Mr O'Brien anything other than day to day activities in his work as a Urologist.

Can we please be protected from this as I suspect evidence is being gathered from us and make the Medical Director aware?

Colin

From: Carroll, Ronan
Sent: 15 November 2018 10:04
To: Hynds, Siobhan
Cc: Young, Michael; Weir, Colin; Gishkori, Esther
Subject: AOB
Importance: High

Siobhan,
Mr Young has advised me this morning that he received phone calls from Mrs O'Brien (Saturday evening) and [redacted] O'Brien (Monday Evening). Both these phone calls centred on the Mr Aidan O'Brien's investigation.
Give me a ring if you require anything further

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext Personal Informatio

From :*Dr Kathryn Boyd ,*
Medical Director, NICaN

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

By email
Primary Care Practice managers

Strategic Planning and Performance Group
HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 0300 555 0115
Email : nican.office@hscni.net

Date: 11 August 2022

Dear Practice Manager

We would be grateful if you could bring this letter and attached guideline to the attention of your practice GPs and colleagues.

Revised Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria Aug 2022

Please find attached updated NI Referral Guidance for Suspected Cancer- Red Flag Criteria. Changes have been made to two sections to align with NICE guidance (Overview | Suspected cancer: recognition and referral | Guidance | NICE); these are for suspect breast cancer and suspect prostate cancer only. No other changes have been made at this time.

- **Breast** – All breast criteria have been updated in line with NICE Suspected cancer: recognition and referral guidelines (NG12). The main change from previous NICaN guidance is for those aged under 30 with unexplained lump.
- **Urology- Prostate** – there has been a change to PSA thresholds by age group: updated in line with NICE NG12- 1.6.3.

These changes are effective immediately however recognising summer leave; secondary care will not return any referrals that do not meet referral criteria until 1st September 2022.

The Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria can be viewed on an ongoing basis along with other supporting resources at Primary Care – resources and education | Northern Ireland Cancer Network (hscni.net).

Yours sincerely

Personal information redacted by USI

Dr H Kathryn Boyd
Medical Director, NICaN

cc Dr Louise Herron (PHA)

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

Issue date: Aug 2022 (updates to Breast and Prostate PSA thresholds)

Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

BREAST CANCER	BRAIN AND CNS CANCER	COLORECTAL/LOWER GI CANCER
Red Flag referral, patients: • Refer as red flag for breast cancer if they are: - aged 30 and over and have an unexplained (*see note below*) breast lump with or without pain **or** - aged 50 and over with any of the following symptoms in one nipple only: - discharge - retraction - Other changes of concern. • Consider a red flag referral (for an appointment within 2 weeks) for breast cancer in people: - with skin changes that suggest breast cancer **or** - Aged 30 and over with an unexplained lump in the axilla. Consider non-urgent referral in people aged under 30 with an *unexplained breast lump with or without pain. *Note: Discussion with a specialist (e.g. by telephone or email) should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical* ***Unexplained** : Symptoms or signs that have not led to a diagnosis being made by the healthcare professional in primary care after initial assessment (including history, examination and any primary care investigations).	Red Flag referral, patients with: ▪ symptoms related to the CNS, including: - progressive neurological deficit - new-onset seizures - headaches - mental changes - cranial nerve palsy - unilateral sensorineural deafness in whom a brain tumour is suspected ▪ headaches of recent onset accompanied by features suggestive of raised intracranial pressure, for example: - vomiting - drowsiness - posture-related headache - pulse-synchronous tinnitus or by other focal or non-focal neurological symptoms, for example blackout, change in personality or memory ▪ a new, qualitatively different, unexplained headache that becomes progressively severe ▪ Suspected recent-onset seizures (refer to neurologist). Consider red flag referral (to an appropriate specialist) in patients with rapid progression of: ▪ subacute focal neurological deficit ▪ unexplained cognitive impairment, behavioural disturbance or slowness, or a combination of these ▪ Personality changes confirmed by a witness and for which there is no reasonable explanation even in the absence of the other symptoms and signs of a brain tumour. Non-urgent referral or discussion with specialist for: ▪ unexplained headaches or recent onset: - present for at least 1 month - not accompanied by features suggestive of raised intracranial pressure.	Please follow the NICaN Lower GI Suspected Cancer Pathway (appendix 1) and use qFIT to ensure appropriate prioritisation of your patient. We would request the following steps are taken against relevant symptoms after assessment and investigation in primary care. ▪ **Rectal, Abdominal or Anal Mass:** Refer as red flag, arrange qFIT, mention qFIT requested on referral. Result will be picked up by secondary care. ▪ **Proven Iron Deficiency Anaemia:** Refer as red flag, arrange qFIT, mention qFIT requested on referral. Result will be picked up by secondary care. ▪ **Persistent Change in bowel habit towards looser stool for >4 weeks:** Arrange qFIT, await result and when referring, attach result with red flag referral – this will ensure the patient is appropriately prioritised at triage. ▪ **Rectal Bleeding:** Arrange a qFIT and if result is positive refer red flag. If result is negative consider referral on an urgent basis or as appropriate undertake safety netting considering red flag referral if persistent or progressive symptoms exist on primary care review. ▪ **Abdominal pain with weight loss: (***Please also consider if Upper GI referral might be more appropriate*.) Arrange a qFIT and if result is positive refer red flag. If result is negative, undertake appropriate safety netting and consider red flag referral if persistent or progressive symptoms exist on primary care review. ▪ **Normocytic anaemia + lower abdominal symptoms:** Arrange a qFIT and if result is positive refer red flag**.** If result is negative, undertake appropriate safety netting and consider red flag referral if persistent or progressive results/symptoms exist on primary care review.

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

Issue date: Aug 2022 (updates to Breast and Prostate PSA thresholds)

GYNAECOLOGY CANCER

Red Flag referral, patients:

- with clinical features suggestive of cervical cancer on examination. A smear test is not required before referral, and a previous negative result should not delay referral
- not on hormone replacement therapy with postmenopausal bleeding
- on hormone replacement therapy with persistent or unexplained postmenopausal bleeding after cessation of hormone replacement therapy for 6 weeks
- taking tamoxifen with postmenopausal bleeding
- with an unexplained vulval lump
- with vulval bleeding due to ulceration.

Consider red flag referral for patients with persistent intermenstrual bleeding and negative pelvic examination

Red Flag referral for an ultrasound scan, patients:

- with a palpable abdominal or pelvic mass on examination that is not obviously uterine fibroids or not of gastrointestinal or urological origin. If the scan is suggestive of cancer, an urgent referral should be made. If urgent ultrasound is not available, an urgent referral should be made.

Ovarian Cancer

- Following clinical history and pelvic examination if ovarian cancer is suspected measure CA125. If ≥35 IU/ml arrange an ultrasound of pelvis and abdomen / refer as red flag.

[Please note: CA125 should not be ordered without a pelvic examination]

HAEMATOLOGY CANCER

Combinations of the following symptoms and signs warrant full examination, further investigation (including a blood count and film) and possible referral:

- fatigue
- drenching night sweats
- fever
- weight loss
- generalised itching
- breathlessness
- bruising
- bleeding
- recurrent infections
- bone pain
- alcohol-induced pain
- abdominal pain
- lymphadenopathy
- splenomegaly

The urgency of referral depends on the symptom severity and findings or investigations. [Please note lymphadenopathy as a single symptom does not normally need to be referred to haematology.

Immediate referral, patients with:

- a blood count/film reported as acute leukaemia
- spinal cord compression or renal failure suspected of being caused by myeloma.

Red Flag referral:

- patients with persistent unexplained splenomegaly.

HEAD AND NECK CANCER INCLUDING THYROID CANCER

Red Flag referral, patients with:

- an unexplained lump in the neck, of recent onset, or a previously undiagnosed lump that has changed over a period of 3 to 6 weeks
- an unexplained persistent swelling in the parotid or submandibular gland
- an unexplained persistent sore or painful throat
- unilateral unexplained pain in the head and neck area for more than 4 weeks, associated with otalgia (ear ache) but a normal otoscopy
- unexplained ulceration of the oral mucosa or mass persisting for more than 3 weeks
- unexplained red and white patches (including suspected lichen planus) of the oral mucosa that are painful or swollen or bleeding.

HEAD AND NECK CANCER INCLUDING THYROID CANCER CONT'D..

For patients with persistent symptoms or signs related to the oral cavity in whom a definitive diagnosis of a benign lesion cannot be made, refer to follow up until the symptoms and signs disappear. If the symptoms and signs have not disappeared after 6 weeks, make an urgent referral. Red Flag referral to a dentist:

- patients with unexplained tooth mobility persisting for more than 3 weeks – monitor for oral cancer patients with confirmed oral lichen planus, as part of routine dental examination. Advise all patients, including those with dentures, to have regular dental check-ups.

Red Flag referral for a Chest X-ray:

- patients with hoarseness persisting for more than 3 weeks, particularly smokers aged older than 50 years and heavy drinkers – if there is a positive finding, refer urgently to a team specialising in the management of lung cancer. If there is a negative finding, refer urgently to a team specialising in head and neck cancer.

Non-urgent referral:

- a patient with unexplained red and white patches of the oral mucosa that are not painful, swollen or bleeding (including suspected lichen planus).

Immediate referral (Thyroid Cancer):

- Patients with symptoms of tracheal compression including stridor due to thyroid swelling.

Red Flag referral (Thyroid Cancer):

- patients with a thyroid swelling associated with any of the following:

- a solitary nodule increasing in size
- a history of neck irradiation
- a family history of an endocrine tumour
- unexplained hoarseness or voice changes
- cervical lymphadenopathy
- very young (pre-pubertal) patient
- patient aged 65 years and older

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

Issue date: Aug 2022 (updates to Breast and Prostate PSA thresholds)

LUNG CANCER

Immediate referral, patients with:

- signs of superior vena caval obstruction (swelling of the face/neck with fixed elevation of jugular venous pressure)
- stridor

Red Flag referral, patients with:

- persistent haemoptysis (in smokers or ex-smokers aged 40 years and older)
- a chest X-ray suggestive of lung cancer (including pleural effusion and slowly resolving consolidation)
- a normal chest X-ray where there is a high suspicion of lung cancer
- a history of asbestos exposure and recent onset of chest pain, shortness of breath or unexplained systemic symptoms where a chest X-ray indicates pleural effusion, pleural mass or any suspicious lung pathology.

Urgent chest X-ray (the report should be returned within 5 days) for patients with any of the following:

- haemoptysis
- unexplained or persistent (longer than 3 weeks):
  - chest and/or shoulder pain
  - dyspnoea
  - weight loss
  - chest signs
  - hoarseness
  - finger clubbing
  - cervical or supraclavicular lymphadenopathy
  - cough
  - features suggestive of metastasis from a lung cancer (for example, secondaries in the brain, bone, liver, skin)
- underlying chronic respiratory problems with unexplained changes in existing symptoms.

SKIN CANCER

Red Flag referral (Melanoma), patients with:

- a lesion suspected to be melanoma. (Excision in primary care should be avoided.)

Red Flag referral (Squamous cell carcinomas), patients:

- with non-healing keratinizing or crusted tumours larger than 1 cm with significant induration on palpation. They are commonly found on the face, scalp or back of the hand with a documented expansion over 8 weeks.
- who have had an organ transplant and develop new or growing cutaneous lesions as squamous cell carcinoma is common with immunosuppression but may be atypical and aggressive
- with histological diagnosis of a squamous cell carcinoma

Non-urgent referral (Basal cell carcinomas):

- Basal cell carcinomas are slow growing, usually without significant expansion over 2 months, and usually occur on the face. If basal cell carcinoma is suspected, refer non-urgently.

UPPER GI

Red Flag referral for endoscopy/referral to specialist, patients of any age with dyspepsia and any of the following:

- chronic gastrointestinal bleeding
- dysphagia
- progressive unintentional weight loss
- persistent vomiting
- iron deficiency anaemia
- epigastric mass
- suspicious barium meal results

Red Flag referral for patients presenting with:

- dysphagia
- unexplained upper abdominal pain and weight loss, with or without back pain
- upper abdominal mass without dyspepsia
- obstructive jaundice (depending on clinical state) – consider urgent ultrasound if available

Consider red flag referral for patients presenting with:

- persistent vomiting and weight loss in the absence of dyspepsia
- unexplained weight loss or iron deficiency anaemia in the absence of dyspepsia
- unexplained worsening of dyspepsia and:
  - Barrett's oesophagus
  - Known dysplasia, atrophic gastritis or intestinal metaplasia
  - Peptic ulcer surgery over 20 years ago

Urgent endoscopy:

Patients aged 55 years and older with unexplained and persistent recent-onset dyspepsia alone.

UROLOGY

Consider a prostate specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with;

- Any lower urinary tract symptoms such as nocturia, urinary frequency, hesitancy, urgency, or retention OR
- Erectile dysfunction OR
- Visible haematuria

Do NOT do a PSA in men with a suspected or confirmed urinary tract infection(UTI)

Red Flag referral (Prostate), patients:

- Refer as suspect cancer if the prostate feels malignant on digital rectal examination.
- Refer as suspect cancer on the basis of a single PSA result if the level is >20 µg /L
- Refer as a suspected cancer (for an appointment within 2 weeks) if PSA levels are above the referral range (as detailed below), at both initial testing and when repeated again at between 2-4 weeks later.

Age	PSA Referral Range
Below 40yrs	Use clinical judgement
40 – 49	More than 2.5µg/L
50 - 69	More than 3.5 µg/L
60-69	More than 4.5 µg/L
70 - 79	More than 6.5µg/L
Above 79 years	: use clinical judgement

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

Issue date: Aug 2022 (updates to Breast and Prostate PSA thresholds)

UROLOGY CONTINUED	UROLOGY CONTINUED	CANCER IN CHILDREN AND YOUNG PEOPLE
Please note, a PSA may be raised in the presence of urinary infection, prostatitis or benign prostatic hypertrophy. It may also be raised following vigorous exercise, ejaculation or prostate stimulation (e.g. prostate biopsy, digital rectal examination, anal intercourse). Please wait six weeks to do a PSA test if a patient has had an active urinary infection, prostate biopsy, TURP, or prostatitis. PSA testing should only be carried out after full advice and provision of information. Red Flag referral (Bladder): ▪ aged 45 and over and have: - unexplained visible haematuria without urinary tract infection or - visible haematuria that persists or recurs after successful treatment of urinary tract infection, or ▪ aged 60 and over and have unexplained non-visible haematuria and either dysuria or a raised white cell count on a blood test. Red Flag referral (Renal): If they are aged 45 and over and have: ▪ unexplained visible haematuria without urinary tract infection or ▪ visible haematuria that persists or recurs after successful treatment of urinary tract infection. Of any age with abdominal mass identified on imaging that is thought to arise from the urinary tract.	Non Red Flag (Bladder and Renal) Consider non-urgent referral for • Patients aged 60 and over with recurrent or persistent unexplained urinary tract infection. ▪ Patients under 60 years of age with persistent microscopic haematuria. ▪ Patients with proteinuria raised serum Creatinine should be referred to a renal physician. If there is no proteinuria and serum creatinine is normal, a non-urgent referral to an urologist should be made. Red Flag referral (Testicular), patients: ▪ with a swelling or mass in the body of the testis. Red Flag referral (Penile), patients: ▪ with symptoms or signs of penile cancer. These include progressive ulceration or a mass in the glans or prepuce particularly, but can involve the skin of the penile shaft. (Lumps within the corpora cavernosa can indicate Peyronie's disease, which does not require urgent referral.)	▪ Consider referral when a child or young person presents with persistent back pain (an examination is needed and a full blood count and blood film). Persistent parental anxiety is sufficient reason for referral, even where a benign cause is considered most likely. Take into account parental insight and knowledge when considering urgent referral. ▪ Refer urgently when a child or young person presents several times (for example, three or more times) with the same problem, but with no clear diagnosis (investigations should also be carried out). There are associations between Down's syndrome and leukaemia, between neurofibromatosis and CNS tumours, and between other rare syndromes and some cancers. Be alert to the potential significance of unexplained symptoms in children with such syndromes. **Leukaemia (children of all ages)** Immediate referral, children or young people with either: ▪ Unexplained petechiae, or ▪ Hepatosplenomegaly **Lymphomas** Immediate referral, children or young people with either: ▪ Hepatosplenomegaly, or ▪ Mediastinal or hilar mass on chest X-ray Red flag referral, children or young people: With one or more of the following (particularly if there is no evidence of local infection): ▪ non-tender, firm or hard lymph nodes ▪ lymph nodes greater than 2 cm in size ▪ lymph nodes progressively enlarging ▪ other features of general ill-health, fever or weight loss ▪ axillary node involvement (in the absence of local infection or dermatitis) ▪ supraclavicular node involvement ▪ with shortness of breath and unexplained petechiae or hepatosplenomegaly (particularly if not responding to bronchodilators).

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

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CANCER IN CHILDREN AND YOUNG PEOPLE CONT'D	CANCER IN CHILDREN AND YOUNG PEOPLE CONT'D	
Brain and CNS tumours Immediate referral, children or young people with: ▪ a reduced level of consciousness ▪ headache and vomiting that cause early morning waking or occur on waking as these are classical signs of raised intracranial pressure. Immediate referral, children aged younger than 2 years with any of the following symptoms: ▪ new-onset seizures ▪ bulging fontanelle ▪ extensor attacks ▪ persistent vomiting Red flag or immediate referral, children with any of the following neurological symptoms and signs: ▪ new-onset seizures ▪ cranial nerve abnormalities ▪ visual disturbances ▪ gait abnormalities ▪ motor or sensory signs ▪ unexplained deteriorating school performance or developmental milestones ▪ unexplained behavioural and/or mood changes. Red flag referral, children aged 2 years and older, and young people, with: Persistent headache where you cannot carry out an adequate neurological examination in primary care. Red flag referral, children aged younger than 2 years with any of the following symptoms suggestive of CNS cancer: ▪ abnormal increase in head size ▪ arrest or regression of motor development ▪ altered behaviour ▪ abnormal eye movements ▪ lack of visual following ▪ poor feeding/failure to thrive ▪ squint, urgency dependent on other factors.	**Neuroblastoma** (all ages) Red flag referral, children with: ▪ proptosis ▪ unexplained back pain ▪ leg weakness ▪ unexplained urinary retention **Wilms' tumour** (all ages) Red flag referral: ▪ a child or young person presenting with haematuria **Soft tissue sarcoma** (all ages) Red flag referral, a child or young person: ▪ presenting with an unexplained mass at almost any site that has one or more of the following features. The mass is: - deep to the fascia - non-tender - progressively enlarging - associated with a regional lymph node that is enlarging - greater than 2 cm in diameter in size **Bone sarcomas** (all ages) Referral, children or young people with: ▪ rest pain, back pain and unexplained limp (a discussion with a paediatrician or X-ray should be considered before or as well as referral) ▪ persistent localised bone pain and/or swelling, and X-ray showing signs of cancer. In this case refer urgently. **Retinoblastoma** (mostly children less than 2 years) Red flag referral, children with: ▪ a white pupillary reflex (leukocoria). Pay attention to parents reporting an odd appearance in their child's eye ▪ a new squint or change in visual acuity if cancer is suspected. (Refer non-urgently if cancer is not suspected.) a family history of retinoblastoma and visual problems. (Screening should be offered soon after birth.)	

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria

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Source: NICE Referral Guidelines for Suspected Cancer; 2005 (CG27) and (NG12) 2015 .

Appendix 1

NICaN Lower GI Suspected Cancer Pathway

Symptoms of suspected Lower Gastrontestinal Cancer

•Abdominal and Rectal examination

Request qFIT and include result with referral

Key test in prioritising patients for colonoscopy

•For rectal/anal/abdominal /mass or proven iron deficiency anaemia qFIT result can follow referral.

Recommended Investigations

•Full Blood Count, U&E, Iron Profile (including Ferritin)

•Coeliac Profile (if Iron Deficiency anaemia , weight loss or diarrhoea)

Document fitness for investigation

Patient has been advised that further investigation may be required and appears agreeable to straight to test

High Risk Lower GI Symptoms – Based on NICE NG12/Scottish Guidance

Rectal, Anal or Abdominal Mass	Proven Iron Deficiency Anaemia (IDA)	Persistent Change in bowel habit towards looser motions for >4 weeks	Rectal Bleeding	Abdominal pain with weight loss (Upper GI referral might be more appropriate)	Normocytic anaemia +LOWER GI symptoms
Arrange qFIT	Arrange qFIT	ATTACH qFIT result			

Please **check qFIT result before referral** for any of these symptoms

If qFIT positive ≥7 µgHb/g	If qFIT negative <7 µgHb/g

Refer as RED FLAG Gastro/colorectal/general surgery depending on clinical judgement/individual Trust

IMPORTANT: Please state qFIT result on the referral or for rectal/anal/abdominal mass or proven iron deficiency anaemia indicate that it has been requested (secondary care will be able to access on ECR)

SAFETY NETTING - If persistent or progressive symptoms exist on primary care review consider RED FLAG referral. Secondary care may downgrade to URGENT upon triage.

Notes

- If patient unable to provide qFIT where requested, please make this clear in referral
- If patient does not return qFIT where requested, please reassess and safety netting
- For further guidance please refer to associated supporting documentation on NICaN website: qFIT for lower GI symptoms | Northern Ireland Cancer Network (hscni.net)

Version 22.6.21 – Pathway subject to review at 18 months following evaluation