The Northern Ireland population is historically less ethnically diverse than the other areas of the UK apart from a long term Chinese community and a small long standing Asian population which is very well integrated and requires little additional accommodation. There is also a long standing Irish Traveller community. However, recent years have seen a rise in groups from Eastern Europe Countries. There are a large population of Portuguese speakers living in the south west of the Region.

For patients who have sensory, cognitive or language difficulties, bespoke information is arranged. A range of information in 17 languages is available from the Macmillan Information and Support Centre. Additionally, a regional interpreting service is offered with a trained health related interpreter. The Trust also has a contract with the 24 hour telephone interpreting service here to ensure that whether it is a planned or emergency situation, the patient has access to an interpreting service. Local groups such as the Chinese welfare association provide cultural advocacy and the trust has traveller liaison officers.

A working group within the Macmillan Information and Support Service, which includes representatives from the equality department, are developing accessible information for people affected by cancer who have learning difficulties.

e) **Patient Feedback** **(Measure 08-2G-222,224,226)**

Feedback from patients using the service is obtained utilising sources such as patient surveys, patient focus groups, patient conferences as well as through local qualitative research in conjunction with colleagues in the QUB Schools of Nursing and the University of Ulster's School of Life There is patient representation at NICAN meetings and the NICaN Patient Information Forum is used to quality assure the patient information produced for the MDT. The NICaN Generic Patient and Public Forum is also used for consultative purposes. This feedback is reviewed and discussed in the operational meetings of the MDT.

There have been a number of recent formal urology patient and user involvement initiatives to date including:

(i) A workshop on living with and beyond cancer

(ii) A Gain Survey and Audit into the information and support needs of patient with

Urological cancer treated at the BHSCT MDM.

(iii) A survey of patient information and support needs for those patients living in North Belfast.

(iv) Survey on patient experience measures as laid out by National Cancer Peer Review.

Details of these initiatives are discussed in the Annual Report of the MDT.

A Survey on patient experience measures as laid out by National Cancer Peer Review measures was undertaken in March on patients in the Bridgewater Suite, before and after the introduction of the peer review measures and the results will be fed back to the MDM and findings incorporated into the Annual Work Plan. The findings will be made available in the evidence file.

8. Data collection and Audit

Data Collection **(Measure 08-2G-241,242)**

Minimum Data Sets for urological cancer have been agreed by the Network. This dataset consists of the dataset required for BASO with additional items of data relevant to local circumstances and interests. This is collected on the CAPPS electronic system. See evidence file for more information.
The waiting times data is collected onto the CaPPS database.

It is the responsibility of the MDT coordinator and MDT lead to collect data from the CAPPS system and other sources as necessary for Urology audits.
The Urology MDT has agreed a minimum dataset (MDS) with other MDT's of the same cancer site across the network. The MDS includes cancer waiting times monitoring and the Cancer Registration Dataset as specified in the National Contract for Acute Services. Each MDT should specify when they began to record the MDS in compliance with the details of the measure **(Measure 08-2G-241& 242).**

Audit

The Urology clinical and medical oncology team has an active audit program, details of which are listed in the annual report. It is the responsibility of the Belfast Trust to provide audit support to enable data to be collected and analysed. Regular audits are undertaken by the Urology MDT and Cancer Management Team and the MDT participates in NICAN Urology Audits which are presented at the MDT and actions incorporated. See Annual Report and evidence file for further information.

The Urology MDT has agreed to participate in at least one network audit project agreed by the NSSG and in accordance to necessary funding. This auditing project has been agreed prior to commencement by the lead clinician of the Urology MDT **(Measure 08-2G-243).** The MDT has also agreed to annually review the progress of the network audit project and present the results of the completed audit to the NSSG to ensure further discussion at an MDT meeting **(Measure 08-2G-244).**

Appendix One: MDT LEAD CLINICIANS - JOB DESCRIPTION

Name: Professor. Joe O'Sullivan
Role: MDT Lead Clinician

(a) To meet the objectives of MDT working including:-

- To ensure that the designated specialists work effectively together within the multidisciplinary team.
- To ensure that decisions regarding diagnosis, treatment and care of individual patients are multidisciplinary.
- To ensure that the MDT's operational policies are decided upon by the team.
- To ensure that care is given according to recognised guidelines (including guidelines for onward referrals).
- To seek clinical co-operation with, and support for system improvement, that leads to patient pathways being improved. To escalate to the Trust Cancer Clinical Director if co-operation is unreasonably withheld.
- To ensure that appropriate information is collected to inform clinical decision making and support clinical governance/audit.

(b) Responsible for ensuring that the MDT meets peer review quality measures including:-

(i) To ensure that attendance levels of core members are maintained in line with the peer review quality measures.

(ii) To ensure that the target of 100% of cancer patients discussed at the MDT is met.

(c) To provide the link to the NICAN Urology Group either by attendance at meetings or by nominating another MDT member to attend.

(d) To lead on, or nominate the lead for, service improvement in liaison with the Cancer General Manager.

(e) To organise and chair an annual meeting.

(f) Ensure the MDTs activities are audited and the results documented.

(g) With support from members of the Lead Cancer Team ensure that the outcomes of the meeting are clearly recorded and clinically validated and data is appropriately collected.

_____

Urology MDT Lead Clinician

_____

Trust Lead Clinician

Appendix Two: Urology Care CNS Qualifications

Appendix Three: Belfast Trust Key Worker Policy January 2010

1. Definition:

The Key Worker is a "person who, with patient's consent and agreement, takes a key role in co-ordinating the patient's care and promoting continuity, ensuring the patient knows who to access for information and advice." **(NICE, 2004).** The Key Worker must be a core member of the MDT team. In most instances the Key Worker shall be a CNS, but where more appropriate, the Key Worker could be an Allied Health Professional or Medical Professional.

The key workers may change during the course of the patient's care pathway, and depending on the patient personal circumsatnces or clinical condition. Such changes should be kept to minimum and be documented in the patient notes. It should be communicated to the patient, and their carers or family along with other healcare professionals involved in their care and new contact details provided.

2. Role of the Key Worker:

- Contribute to the MDT discussion and decisions about the patient's plan of care.
- Work as an integral member of the MDT to ensure continuity of patient care.
- Initiate and participate in MDT discussion and case conferences with all professionals involved in the delivery of patient care.
- Act as a communication resource and co-ordinator for other members of the multi-professional team in the care of the key worker's patient caseload.
- Be present at any other key points in patient's journey. (Not possible)
- Act as key point of contact for patients and their carers
- Undertake a holistic assessment of patient's needs at key points in the pathways and ensure onward referral to other agencies and professionals as appropriate

- Lead on the assessment of patients information needs and provide verbal and written information with regard to their diagnosis, investigations, treatment options, information on living with cancer and guide patients with regard to locally avaibale help and support.
- Lead in patient communication issues and co-ordination of the patient pathway across speciaities, discipline and health and social care providers.
- Utilise specialist knowledge and skills regarding disclosure of information.
- Co-ordinate the onward referral of patient and/or family members to appropriate clinical or support services.
- Ensure accurate follow-up documentation is maintained including any changes in the named key worker.

3. Process for Identifying Key Worker:

The responsibility for ensuring that the Key Worker is identified should be that of the nurse MDT member(s). The key worker must be a core member of the Cancer multidisciplinary team.

The key worker should possess post basic education in cancer care and have undertaken training in advanced communication skills, breaking bad news and patient information giving and patient education. They should also possess an ability to verbally summarise patient information to facilitate understanding and to utilise support strategies and interventions available to care for patients with complex needs.

The Key Worker's name should be recorded in all relevant patient records and relevant health professionals informed of the name. (e.g., letters to GP's). (not enough specialist nurses to facilitate)

Documentation of Key Worker details

The patient should be informed of the name of their Key Worker verbally and be provided with written information containing their name and contact number, including what arrangements have been made for cover, after-hours, etc. (not enough specialist nurses to facilitate)

The recording of the Key Worker information should be documented in the patient notes.

Any changes to the key worker should be given to the patient with new contact details. This change should be documented in the notes and communicated to any relevant health care professionals involved in the patients care.

Appendix Four: MDT Outcomes Proforma

Appendix Five: Permanent Record Consultation

Urology Consultation Discussion Record

Patient Name:	DOB:	H&C Number:
Patient Address:		
Specialist Name:	Date:	Hospital Site:

Diagnosis:
Future Investigations:
Treatment Options / Follow Up:
If you or your carer have any queries or concerns about your diagnosis, treatment or condition please contact your Key Worker. Otherwise you can contact your GP.

Name of Key Worker:	**Role:**	**Tel:**

Specialist Signature: _____

Appendix Six: Patient Information Checklist

NAME OF KEY WORKER:		
CORE INFORMATION PACK GIVEN?	RECORD OF CONSULTATION OFFERED TO PATIENT? Y / N	KEY WORKER CONTACT DETAILS GIVEN TO PATIENT?
	ACCEPTED Y / N	
SIG_____	SIG_____	SIG_____

Appendix Seven: GP letter following MDM

UROLOGY MDM @ CANCER CENTRE

<GP CONTACT DETAILS>

RE: < PATIENT DETAIL >

Dear Dr <GP NAME>

This patient was discussed at the Urology MDM @ CANCER CENTRE on 12/02/2010.

Diagnosis: Testicular Cancer

MDM Update:

This 40 year old man presents with lump in lower outer left testes 2 cm lump palpable. Right testes is normal upon clinical examination.

MDM Plan:

For Left Testes Surgery
The patient is aware of diagnosis

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

Yours sincerely,

Mr
Consultant Surgeon

Aimee Crilly

From: Neilly, Claire [redacted]
Sent: 20 June 2012 09:42
To: McCorry, Monica
Cc: O'Brien, Aidan
Subject: [redacted]

Monica

Dr [redacted] phoned this morning wanting to leave a message for Mr O'Brien re the above patient. He is a patient with prostate ca, he has blocked ureters and he is not passing urine properly and he has stents in – apparently the stents were to be changed every 3 months and hasn't been changed from January 2012. He attended CU2 27/3/12 and was seen by Dr Sani Aminu.
His GP is concerned that he is very unwell his EGFR has dropped to 25. He was in CAH A&E couple of night ago and they say his kidneys are starting to fail.

Many thanks

Claire

From:	McCorry, Ann
To:	Akhtar, Mehmood; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; McKay, Damian; O"Brien, Aidan; Sloan, Samantha; Weir, Colin; Young, Michael; Yousaf, Muhammad
Cc:	Damani, Nizam
Subject:	Antibiotic ward rounds
Date:	02 July 2012 14:47:27

Hi All,

As you are aware the antibiotic ward rounds have restarted in CAH on 27th June, and I will be sending out monthly reports as before to show compliance with the guidelines.

I will send out the results for June with the July summary but just to let you know the compliance with the treatment guidelines last week was very good, any non-compliance was with the surgical prophylaxis guidelines. Looking at the prophylaxis given, 6/14 patients were non-compliant, receiving the penicillin allergy regimen (Teicoplanin in place of flucloxacillin or Benzylpenicillin) with no documented allergy or history of MRSA. Teicoplanin should be reserved for penicillin allergy or for patients with MRSA.

When I send out the monthly reports I can either send you all codes so the reports will be anonymous or if you are happy, I can just use Consultant names as I do for the reports for Daisy Hill. If you can let me know if you have any preference before I send out the 1st report at the end of July & I will go with what the majority prefer.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Craigavon Area Hospital
Southern Trust
Ext: Personal Information redacted by the USI
Tel: Personal Information redacted by the USI

Aimee Crilly

Subject: FW: Additional Urodynamics Saturday 15th Sept

-----Original Message-----
From: ONeill, Kate <Personal Information redacted by the USI>
Sent: 17 August 2012 16:21
To: Troughton, Elizabeth <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>
Cc: Corrigan, Martina <Personal Information redacted by the USI>; McCorry, Monica <Personal Information redacted by the USI>
Subject: RE: Additional Urodynamics Saturday 15th Sept

Liz,

Please note that we have been able to organise staff to perform UDS Saturday 15th September. While Mr O'Brien will see the patients they are to be appointed from Mr Akhtar's list.
I will forward you the times shortly.

Martina – can you put this onto PAS please?

Thanks,
Kate

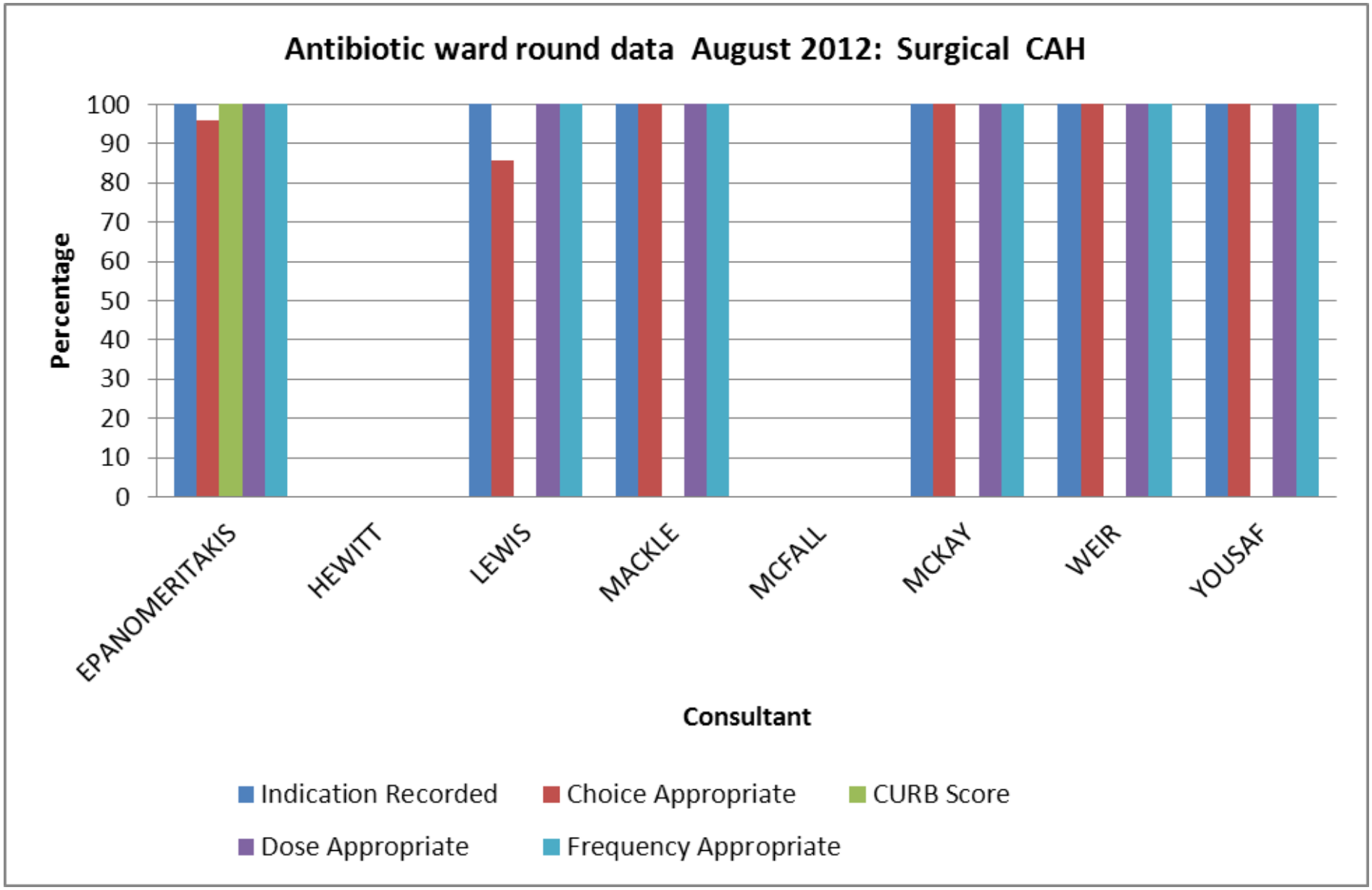
From:	McCorry, Ann
To:	Akhtar, Mehmood; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; McFall, Brendan; McKay, Damian; O"Brien, Aidan; Weir, Colin; Young, Michael; Yousaf, Muhammad
Cc:	Damani, Nizam; Rankin, Gillian
Subject:	For info: August ward round summary
Date:	30 August 2012 13:51:03
Attachments:	August Summary Surgery CAH.doc

Hi All,

Please find attached August ward round summary for information.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Craigavon Area Hospital
Southern Trust
Ext: Personal Information redacted by the USI
Tel:



SUMMARY: Ward rounds conducted 15th & 29th August.
47/117 patients on antibiotics (note patients who received surgical prophylaxis & also on active treatment included twice).

- Epanomeritakis: 25 patients. CURB score appropriate in 1 patient, **not recorded**.
    - **Choice inappropriate in 1 patient**:
        - 1 pt on IV tazocin 4.5g TID for CAP (originally started on IV co-amoxiclav 1.2g TID), IV amoxicillin 2g TID +/- IV/PO clarithromycin BD recommended.

- Hewitt: No patients.

- Lewis: 7 patients. CURB score n/a.
    - **Choice inappropriate in 1 patient**:
        - 1 pt given IV co-amoxiclav for appendectomy, IV benzylpenicillin, gentamicin and metronidazole recommended.

- Mackle: 1 patients. CURB score n/a.

- McFall: No patients.

- McKay: 5 patients. CURB score n/a.

- Weir: 1 patients, CURB score n/a.

- Yousaf: 8 patients. CURB score n/a.

Aimee Crilly

Subject: FW: Activity
Attachments: SKMBT_42312092414470.pdf

Importance: High

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 24 September 2012 16:08
To: Personal Information redacted by the USI) <Personal Information redacted by the USI>; Personal Information redacted by the USI <Personal Information redacted by the USI>; Personal Information redacted by the USI <Personal Information redacted by the USI>; AJay Pahuja (Personal Information redacted by the USI <Personal Information redacted by the USI>; David Connolly (Personal Information redacted by the USI <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Tony Glackin (Personal Information redacted by the USI
Cc: Brown, Robin <Personal Information redacted by the USI>
Subject: Activity
Importance: High

Dear all

Further to our meeting on Thursday, please find attached the volumes of activity that we will have to deliver once we have the 5 consultant team in place. So when planning clinics etc. these volumes have to be met.

Happy to discuss

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Martina.Corrigan Personal Information redacted by the USI <Personal Information redacted by the USI>
Sent: 24 September 2012 15:48
To: Corrigan, Martina
Subject: Message from KMBT_423

11) What are the Specific Outcomes of the preferred option
Quality, Timescales, Quantity (detailed in box 11)

The recommendations set out in the regional review of urology service could be implemented.

A sustainable service model for the urology service would be facilitated forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

2 additional consultants and associated support staff would be appointed;

The service would be expanded to encompass patients from the Fermanagh area;

The 62 day cancer target would be achieved for all patients.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

12) Activity Outcomes
Activity, contacts, placements, procedures etc, please identify

SBA Activity

	New OP[1]	Review OP[2]	FCEs	Day Cases/ 23 Hour Stays
Original Baseline Activity	1,014	2,390	1,596	1,239
Additional Baseline Activity	2,934	3,015	- 396	3,146
New Baseline Activity	3,948	5,405	1,200	4,385

1) New outpatient appointments comprise 2328 slots at consultant led clinics & 1,620 at support staff clinics.
2) Review outpatient appointments comprise 3,681 slots at consultant led clinics & 1,724 at support staff clinics.

If approved, activity will be added to Indicative volumes in Organisation's Service and Budget Agreement (if applicable)

The above table must be completed for each discreet element of the service in question, please replicate as required. If activity is for more than one LCG please detail separately.

13) Assess Risks and Uncertainties
Identify the main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers recognized risk scoring method

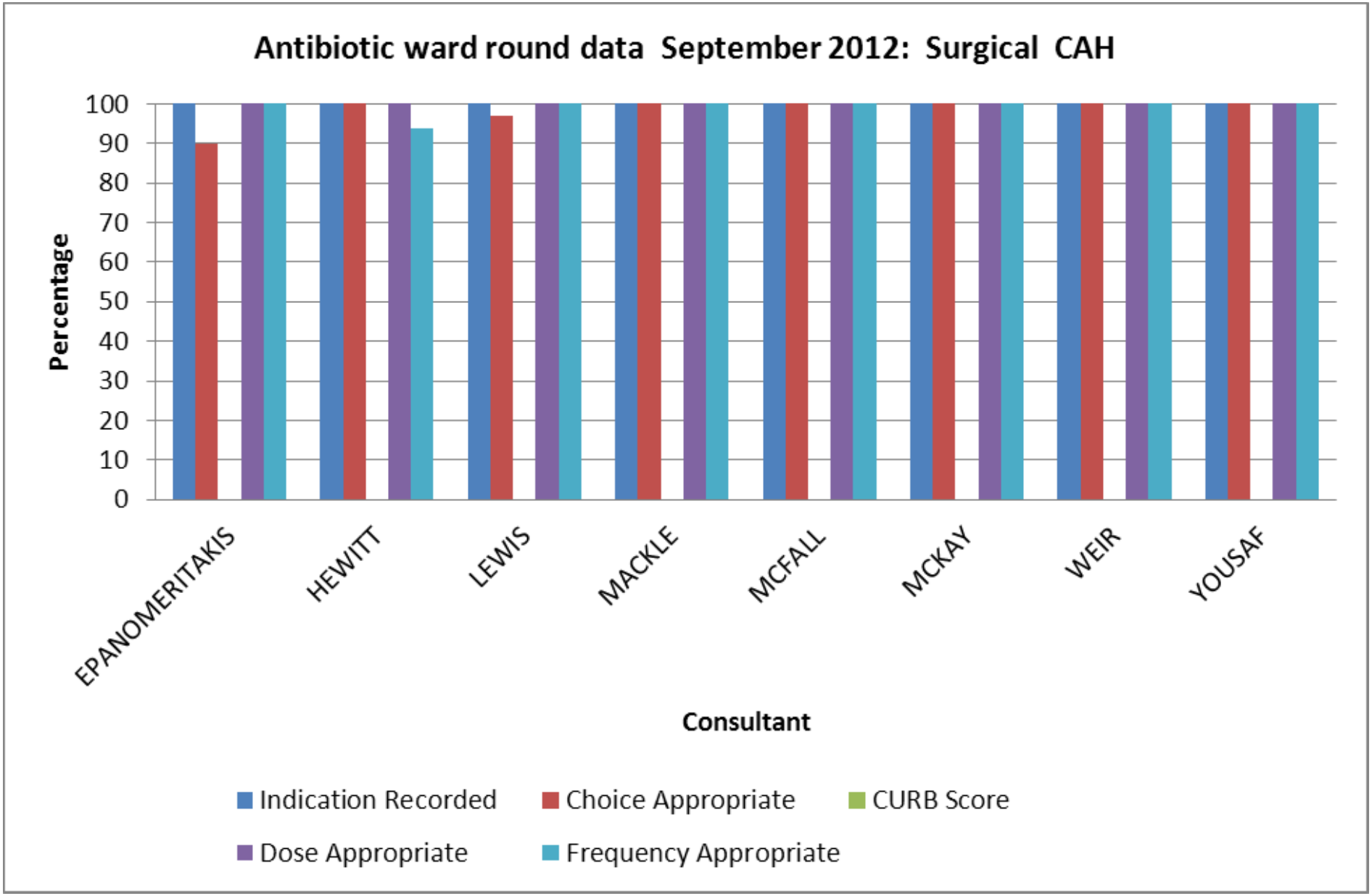
From:	McCorry, Ann
To:	Akhtar, Mehmood; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; McFall, Brendan; McKay, Damian; O"Brien, Aidan; Weir, Colin; Young, Michael; Yousaf, Muhammad
Cc:	Damani, Nizam; Rankin, Gillian; Boyce, Tracey
Subject:	For info: September ward round summary
Date:	27 September 2012 13:46:26
Attachments:	September Summary Surgery CAH.doc

Hi All,

Please find attached antibiotic ward round summary for September.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Craigavon Area Hospital
Southern Trust
Ext: Personal Information redacted by the USI
Tel: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted 5th, 19th & 26th September.
75/189 patients on antibiotics (note patients who received surgical prophylaxis & also on active treatment included twice).

- Epanomeritakis: 10 patients. CURB score n/a.
    - **Choice inappropriate in 1 patient**:
        - 1pt given IV Teicoplanin, gentamicin and metronidazole as prophylaxis for hepato-biliary surgery, IV benzylpenicillin, gentamicin and metronidazole recommended (no history of penicillin allergy or MRSA).

- Hewitt: 16 patients. CURB score n/a.
    - **Frequency inappropriate in 1 patient:**
        - 1pt on Iv Benzylpenicillin 1.2g QID (+ IV flucloxacillin) for cellulitis, 4 hourly dosing recommended.

- Lewis: 32 patients. CURB score n/a.
    - **Choice inappropriate in 1 patient**:
        - 1 pt given PO ciprofloxacin 500mg BD for cholecystitis (penicillin allergy), PO metronidazole also required for anaerobic cover.

- Mackle: 3 patients. CURB score n/a.

- McFall: 1 patient. CURB score n/a.

- McKay: 2 patients. CURB score n/a.

- Weir: 5 patients, CURB score n/a.

- Yousaf: 6 patients. CURB score n/a.

Aimee Crilly

Subject: FW: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"

Attachments: Letter from Christine Jendoubi to Board, Trust and PHA Chief Executives advising of launch of Who Care discussion document for consultation.DOCX

Importance: High

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 07 October 2012 17:45
To: Connolly, David <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; Farnan, Turlough <Personal Information redacted by the USI>; Korda, Marian <Personal Information redacted by the USI>; Leyden, Peter <Personal Information redacted by the USI>; Reddy, Ekambar <Personal Information redacted by the USI>; Hall, Sam <Personal Information redacted by the USI>; McNaboe, Ted <Personal Information redacted by the USI>
Subject: FW: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

Dear all

FYI

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Reid, Trudy
Sent: 04 October 2012 12:23
To: Nelson, Amie; Devlin, Louise; Corrigan, Martina; Henry, Gillian; Sharpe, Dorothy; Connolly, Connie
Subject: FW: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

For information and circulation

Trudy

From: Stinson, Emma M
Sent: 03 October 2012 16:04
To: Burke, Mary; Conway, Barry; Reid, Trudy; Trouton, Heather; Donaldson, Ruth
Cc: Graham, Michelle; Irwin, Laura J
Subject: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

Dear all

For any comments.

Emma

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Email: Personal Information redacted by the USI
P Please consider the environment before printing this email

From: Wright, Elaine
Sent: 28 September 2012 12:12
To: Donaghy, Kieran; Simpson, John; Rankin, Gillian; McNally, Stephen; McVeigh, Angela; Morgan, Paul; Clarke, Paula; Rice, Francis
Cc: Stinson, Emma M; Feely, Roisin; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Joyce, Barbara; White, Laura; Radcliffe, Sharon; Taylor, Karen
Subject: FW: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

Please see as below and attached.
Angela is leading the Trust response to this consultation.
Thanks e

From: McAlinden, Mairead
Sent: 27 September 2012 18:28
To: McVeigh, Angela
Cc: Wright, Elaine
Subject: FW: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

Angela, would you lead on Trust response to this consultation please.

Elaine please circulate to Directors and confirm Angela will lead response, and also print consultation document and covering letter for my post

Mairead

From: Reform Care and Support [mailto: Personal Information redacted by the USI
Sent: 17 September 2012 14:45
To: McAlinden, Mairead; sean.donaghy Personal Information redacted by the USI; colm.donaghy Personal Information redacted by the USI; elaine.way Personal Information redacted by the USI; hugh.mccaughey Personal Information redacted by the USI; john.compton Personal Information redacted by the USI; eddie.rooney Personal Information redacted by the USI
Cc: fionnuala.mcandrew Personal Information redacted by the USI; aidan.murray Personal Information redacted by the USI; kevin.keenan Personal Information redacted by the USI; seamus.logan Personal Information redacted by the USI; Jendoubi, Christine; Sweeney, Michael; Craughwell, Eva; Looney, Dean
Subject: Consultation on "Who Cares? The Future of Adult Care and Support in Northern Ireland"
Importance: High

Dear colleagues,

Please see attached letter sent on behalf of Christine Jendoubi, Director of Mental Health, Disability and Older People's Policy.

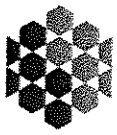
Regards,

Reform of Adult Care and Support Team
Department of Health, Social Services and Public Safety Room D3.7 Castle Buildings Stormont Estate Belfast BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Textphone: Personal Information redacted by the USI

Email: Personal Information redacted by the USI
Web: http://www.dhsspsni.gov.uk/index/hss/reform-cas.htm

Christine Jendoubi
Director of Mental Health, Disability and Older People's Policy



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

To:

Chief Executive, Health and Social Care Board
Chief Executive, Health and Social Care Trusts
Chief Executive, Public Health Agency

Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Tel: Personal Information redacted by the USI
Fax:
Email: Personal Information redacted by the USI

17 September 2012

Dear Colleagues,

CONSULTATION ON THE FUTURE OF ADULT CARE AND SUPPORT

I am writing to advise you that the Department of Health, Social Services and Public Safety is today launching for consultation the discussion document "Who Cares? The Future of Adult Care and Support in Northern Ireland." This is the first step in a three stage process intended to reform the provision and funding of adult care and support services.

As you will be aware, adult care and support provision is increasingly coming under pressure for range of reasons, such as for example; an ageing population, increased expectations and a difficult financial climate. Given this situation, it is widely believed that our current care and support system will be unable to cope with the demands of the future unless significant changes are made.

Many of the changes needed have already been outlined in the Transforming Your Care report. But to support that process, we need to undertake fundamental policy reform to ensure that a sustainable framework is in place to support people with care needs in the future.

As the first stage in this reform process, the purpose of the "Who Cares?" discussion document is to raise awareness among the general population about the pressures facing the care and support system, and to engage as many people as possible in a meaningful debate about the future provision and funding of these services.

The discussion document and response pro-forma can be accessed online at http://www.dhsspsni.gov.uk/showconsultations?txtid=58501. A shorter, more accessible version of the discussion document is also available via this link, and an Easy Read version will be made available shortly.

Further information on the consultation, including a link to an online questionnaire and a stakeholder pack, are available on the Reform webpage: http://www.dhsspsni.gov.uk/index/hss/reform-cas.htm.

The consultation will run for a period of six months. During that time we will be running a number of consultation events, details of which are provided on the

attached annex. It will be important that HSC staff both attend these events and encourage people who use services and carers to attend and participate in the debate. Where possible, it would be helpful if those interested could register with the Reform Team in advance, particularly for those attendees who have accessibility or dietary requirements.

If you have any questions about this consultation exercise or if you would like to request paper copies or alternative formats or languages, please contact the Reform Team using the contact details provided below:

Reform of Adult Care and Support Team
Dept. of Health, Social Services and Public Safety
Room D3.7
Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Textphone: Personal Information redacted by the USI

As the issues around adult care and support relate to all adult Programmes of Care, I would be grateful if you could cascade this letter to the relevant staff within your organisation.

Please note that all responses to the consultation exercise should be returned not later than **15 March 2013.**

I look forward to working closely with you during this process.

Yours sincerely,

Personal Information redacted by the USI

Christine Jendoubi
Director of Mental Health, Disability and Older People's Policy

CC: Fionnuala McAndrew, HSCB
Kevin Keenan, HSCB
Aidan Murray, HSCB
Seamus Logan, HSCB

Annex

Future of Adult Care and Support – List of Consultation Events

Location	Date	Time	Venue
Omagh	27/09/12	1.00pm – 4.15pm	Silverbirch Hotel 5 Gortin Road, Omagh
Newtownards	2/10/12	1.00pm – 4.15pm	Queen's Hall West Street, Newtownards
Ballymena	4/10/12	9.30am – 1.15pm	Tullyglass House Hotel Galgorm Road, Ballymena
Newry	11/10/12	9.30am – 1.15pm	Dromantine Retreat and Conference Centre 96 Glen Road, Newry
Cookstown	15/10/12	6.15pm – 8.15pm	The Burnavon Theatre Burn Road, Cookstown
Belfast	18/10/12	9.30am – 1.15pm	Grosvenor House 5 Glengall Street, Belfast
Enniskillen	22/10/12	1.00pm – 4.15pm	South West Acute Hospital 124 Irvinestown Road, Enniskillen
Downpatrick	25/10/12	9.30am – 1.15pm	Saint Patrick Centre 53A Market Street, Downpatrick
Newtownabbey	12/11/12	6.15pm – 8.15pm	Corrs Corner Hotel 315 Ballyclare Road, Newtownabbey
Craigavon	15/11/12	1.00pm – 4.15pm	Craigavon Civic and Conference Centre Lakeview Road, Craigavon
Londonderry	20/11/12	9.30am – 1.15pm	Clooney Hall 36 Clooney Terrace, L'derry (TBC*)
Lisburn	27/11/12	6.15pm – 8.20pm	Lagan Valley Island Civic Centre The Island, Lisburn
Portrush	29/11/12	1.00pm – 4.15pm	Magherabuoy House Hotel Magherabuoy Road, Portrush
Belfast	10/01/13	6.15pm – 8.20pm	Grosvenor House 5 Glengall Street, Belfast
Limavady	15/01/13	6.15pm – 8.20pm	Roe Valley Leisure Centre 9 Greystone Road, Limavady

*check website http://www.dhsspsni.gov.uk/index/hss/reform-cas.htm for further details

NB. Please register with the Reform Team in advance if you have any dietary or access requirements.

Aimee Crilly

Subject: FW: PS Enquiry545/12-13. Mr [redacted]
Attachments: [redacted]-consent form.PDF

Importance: High
Sensitivity: Confidential

-----Original Message-----
From: Corrigan, Martina <[redacted]>
Sent: 18 October 2012 14:33
To: O'Brien, Aidan <[redacted]>
Cc: Corr, Edel <[redacted]>; McCorry, Monica <[redacted]>; Reid, Trudy <[redacted]>
Subject: FW: PS Enquiry545/12-13. Mr [redacted]
Importance: High
Sensitivity: Confidential

Dear Aidan

I was wondering if there was any update on this patient and if he could perhaps be put on either Tony, David or Ajay's theatre list?

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: McAloran, Paula
Sent: 20 September 2012 13:57
To: Corrigan, Martina
Cc: Reid, Trudy; Corr, Edel
Subject: FW: PS Enquiry545/12-13. Mr [redacted]
Sensitivity: Confidential

Martina

Any update with this enquiry?

Regards
Paula

From: McAloran, Paula
Sent: 14 September 2012 11:35
To: Corrigan, Martina
Cc: Reid, Trudy [redacted]; Rankin, Gillian; Stinson, Emma M [redacted])
Subject: PS Enquiry545/12-13. Mr [redacted]
Sensitivity: Confidential

Re: Personal Information redacted by the USI

Martina

Please see email below from Colette Hart Patient & Client Council regarding Mr Personal Information redacted by the USI who is a patient of Mr O'Brien Consultant Urologist. Can you investigate and provide me with your response?

Regards
Paula

Paula McAloran
Patient Support Officer
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Tel. Craigavon Area Hospital Personal Information redacted by the USI
Tel: Daisy Hill Hospital Personal Information redacted by the USI (internal ext. Personal Information redacted by) Email Personal Information redacted by the USI

From: Colette Hart [mailto Personal Information redacted by the USI
Sent: 14 September 2012 10:37
To: Corr, Edel; McAloran, Paula
Subject: Mr Personal Information redacted by the USI
Sensitivity: Confidential

"This email is covered by the disclaimer found at the end of the message."

This email is covered by the disclaimer found at the end of the message.

Edel / Paula

I have been approached by the following patient who is waiting for a urology procedure:

Name: Personal Information redacted by the USI
Add:
DOB:
Hosp No:
Consultant: Mr O'Brien

Mr Personal began having problems with his left kidney about 14 years ago and had surgery for a PUJ obstruction (Mr Young). He has continued to have problems since, his most recent admission being in August 2012.

He advised that he is waiting for a ureteroscopy. He had been referred to 352 because of of the waiting list but was recently informed by Sinead in Appointments at CAH that they could not do it because they did not have the equipment. He spoke with Mr O'Brien's secretary Monica about 3 days ago and she told him to ring back on Monday(17 September) – but he is dubious about this as he contacted 352 on a number of occasions in response to their letter of 2 August offering him an appointment but was unable to confirm a date.

Mr Personal has had ureteroscopy / stretching on 4 occasions since 2005. The first provided him with relief from pain and nausea for about 18 months but on the last occasion, November 2011, he remained symptom free for only 3 months. He is concerned that repeating it will have no or very limited affect – he feels it would be pointless if he were to get only 2-3 months relief, and then go back to square one.

During his last admission in August 2012 he was given to understand that there would be a meeting to discuss the results of his scans. He is unclear if this took place and what the outcome was.

He is keen to clarify:

- Whether he still has a PUJ obstruction

- Whether he is on the waiting list for a ureteroscopy, his priority and when he will be seen
- Whether other options are being considered. He advised that Mr O'Brien had mentioned re-implantation of the tube at one stage.
- What the current view of his case is and what is proposed re way forward.

Would you look into this please? I attach form of consent.

Colette Hart
Patient & Client Support Officer
Patient & Client Council
Southern Area Office
Quaker Buildings
High Street
Lurgan
BT66 8BB

Tel: Personal Information redacted by the USI
Fax
Email: Personal Information redacted by the USI
Web: www.patientclientcouncil.hscni.net

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Join the Patient and Client Council Membership Scheme

"The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

FORM OF AUTHORISATION / CONSENT

I, [redacted] authorise the Patient & Client Council (PCC) to make representations to the Southern Health Health and Social Care Trust in connection with services I have received from the Trust. I authorise the Trust to provide the PCC with whatever information it requires. I understand that this may involve disclosure of confidential information and I consent to this.

Signed: [redacted]

Date: 13 9 12

Aimee Crilly

Subject: FW: transforming cancer follow up steering group (TCFU)
Attachments: transforming cancer follow up steering group tor 1.docx; TCFU PID Feb 2012 DRAFT 3 for Southern Trust.doc

-----Original Message-----
From: McKnight, Lesley Jane [Personal Information redacted by the USI]
Sent: 30 October 2012 09:23
To: O'Brien, Aidan [Personal Information redacted by the USI]
Cc: McCorry, Monica [Personal Information redacted by the USI]
Subject: FW: transforming cancer follow up steering group (TCFU)

I am really sorry- forgot to attach the Project initiation document- now attached

Lesley

From: McKnight, Lesley Jane
Sent: 29 October 2012 11:33
To: O'Brien, Aidan
Cc: McCorry, Monica
Subject: transforming cancer follow up steering group (TCFU)

Sent on behalf of Annie Treanor

Dr Mr O'Brien

Please find attached terms of reference for the transforming cancer follow up steering group which details the members of this group, as discussed with Annie Treanor last week.

Please also find attached the Project Initiation Document for your information.

I am hoping to have the next steering group meeting on 30th November at 3pm and I would be grateful if you would let me know if your availability.

Many thanks and kind regards

Lesley

Lesley McKnight
Clerical Support for Annie Treanor
Macmillan Cancer Review Project Manager.
[Personal Information redacted by the USI]

Southern Health and Social Care Trust

Cancer Services
Cancer Review Modernisation Steering Group
Terms of Reference

AIM.

The aim of the Cancer Review Modernisation Steering group is to ensure the implementation of the Cancer Review Modernisation Projects within the agreed project plan and to ensure it is achieved within the time frames whilst ensuring safe and quality patient care.

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5. Sub groups will be established to take forwards key work strands. These groups will provide feedback to the steering group and provide assurance that their aim/s and objectives are being met. Where aims and objective are not being meet appropriate actions will be agreed.
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MEMBERSHIP:

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- CD for CCS – Dr R Convery
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- AD for CCS- R Carroll
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- Gary Donaghy – Finance
- Sandra Waddell - planning
- LCG representative- Ms J McCulla
- Other representatives as required relevant to the agenda.

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The chair of the group will be the Director of Acute Services

REPORTING ARRANGEMENTS
The chair will report to the Chief Executive

MEETING FREQUENCY:
The meeting will be held on a quarterly basis

MEETING QUORUM:
50% + 1

REPORTS/DOCUMENT

- AGENDA
- REPORTS FROM SUB GROUPS TEAM

REPORTS *GENERATED*

- MEETING NOTES & ACTIONS

Southern Health and Social Care Trust

Transforming Cancer Follow Up (TCFU) Project

PROJECT INITIATION DOCUMENT

Author:	**Annie Treanor**
Directorate	**Acute Services**
Version:	**V3. 29.02.12**

Date:	

TABLE OF CONTENTS

1.0 Introduction & Background

Introduction

The Southern Trust's vision is to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them.

These services should be appropriate to patient needs and make best efficient use of resources. Consequently the Trust has signed up to the Cancer Review Modernisation Programme and will deliver on 3 projects for breast, colorectal and prostate cancers.

1.1 Purpose of Document

This Project Initiation Document (PID) sets out the Terms of Reference, Project Structure and Outline Plans for a two-year service improvement programme aimed at introducing and testing new models of cancer follow up within SHSCT, that will begin to transform how such services are delivered.

1.2 Approval of Document

The PID will be formally approved and signed off by the Cancer Review Modernisation steering group. It will act as a basis to measure project processes and management against, as well as delivery of acceptable outcomes.

2 BACKGROUND

Over 51,000 people are living with cancer in Northern Ireland and the number of survivors is likely to grow by 3% per year adding to an increased demand on NHS time and resource. Coupled with this is has become evident that cancer follow up is not as effective as it could be. Despite cancer increasingly becoming a chronic disease the current model of follow up is framed around acute illness. The emphasis is on surveillance and monitoring to detect recurrence and people often attend clinics simply to receive the results of follow up tests, a process repeated over many years, with duplication between oncology and surgery. There is no systematic approach to addressing their other health needs. Clinics are often rushed and many patients report unmet information and support needs. They may need to be referred onto other appropriate services. Services as currently configured will be unable to cope with the predicted increase in the number of people living with cancer or be able to address their survivorship needs.

2.1 Increasing number of cancer survivors

Currently within Northern Ireland there are an estimated 55,000 cancer survivors, a figure that reaches two million when taken across the UK. This number is growing by around 3.2% per annum, which means, if current trends continue, by 2030 there could be over four million cancer survivors in the UK; with breast, prostate and colorectal cancers accounting for over half.

Until recently, cancer has been viewed in simple terms; either people are cured and get back to normal or else they will have terminal cancer and die. However the cancer landscape is changing and the picture emerging is a more complex one. While some still die within a year of diagnosis, advances in treatment mean that those with incurable cancer can live for years, and experience similar illness patterns to those with long-term conditions, with many suffering from complex co-morbidities.

Even for people considered cured, returning to normality is fraught with difficulties, as the consequences of the disease and treatment, impact not only physically but also on an individual's psychological, financial and social functioning. The consequences of treatment can occur soon after treatment but serious effects can also be experienced years later.

2.2 Issues with the current system

Across the UK there is a growing recognition that cancer follow up is not as effective as it could be. Despite cancer increasingly becoming a chronic disease the current follow up model is framed around acute illness. The emphasis is on surveillance and monitoring to detect recurrence, yet there is evidence that up to 70% of recurrence is picked up outside clinics.

The system as currently organised will be unable to either cope with the projected increase in the number of people living with cancer or address their rehabilitation and secondary prevention needs. As people with cancer live longer they have a much poorer health profile than the remainder of the population and are likely to become greater users of the health service; however, if appropriate rehabilitative measures were available co-morbidities could be significantly reduced.

Considerable duplication in follow up practice exists, with many patients being seen by their surgeon and oncologist. Since each outpatient appointment costs around £106 there is an evident waste of resource.

Inefficiencies are exacerbated by the fact that many appointments add little or no value for either the patient or the doctor - so called "empty appointments".

There are indications that patients' needs are not being adequately addressed nor are they getting the help they need to get their lives back on track. They report

- Unmet information needs, feeling unprepared about what to expect after treatment, what to look out for, or whom they should contact.
- Feelings of abandonment at the end of treatment as the safety net provided by treatment routine is suddenly gone, some describing after care services as an after thought.

- A national survey found key issues of anxiety, depression, isolation, negative impacts on self-identity and self-image. Physical problems include fatigue, bowel problems, and loss of libido, impotence and infertility.
- Clinics are so rushed patients do not have the time to discuss concerns. Studies show that patients are selective in raising health and well being issues, as there is a reluctance to waste the doctor's time.
- Clinic appointment times are rarely on schedule incurring lengthy waits for patients, with some travelling long distances for short consultations.
- Signposting services and referral mechanisms are inadequate for patients to be appropriately referred to other Allied Health Professionals (AHP) and suitable charitable organisations.

2.3 Drivers for Change

In other parts of the UK considerable attention is being paid to the aftercare needs of cancer survivors under the auspices of the National Cancer Survivorship Initiative (NCSI). This is a partnership between the Department of Health and Macmillan Cancer Support facilitated by NHS Improvement. The NCSI has been charged with improving the quality of service and quality of life for those living with and beyond cancer.

The idea of survivorship is taken to include anyone from the point of a cancer diagnosis onwards, and recognises the impact of cancer on the person physically, psychologically and socially

The NCSI has identified 5 key shifts that are essential to ensuring service provision is fit for the future. The key shifts are:

- Cultural and attitudinal change from illness to focus on recovery, health and well-being
- Improved information delivered in an appropriate format and manner
- Individualised assessment and effective post treatment care plans
- Tailored after-care pathways based on risk of future problems associated with cancer type, treatment and individual circumstances
- Improved measurement through patient reported outcomes and experience measures.

The vision document can be found at www.ncsi.org.uk

Over the past two years, test communities across England and Wales have been testing elements and models of future care and support that are focused on addressing the needs of those living with and beyond cancer. They have collected baseline information about current service delivery and issues with this delivery to inform the development of new models.

Transforming Your Care – a review of health and social care in Northern Ireland:- The Compton Report, published in December 2011, acknowledges

the need for providing better patient centred care and a provision of the right care in the right place at the right time.

2.4 Project Principles

The following project principles for future practice have emerged which should be integral elements of all new cancer follow up models:

- *Risk Stratification*: Patients should be risk stratified into an appropriate pathway of care based on their individual needs, and the needs arising from their tumour and the treatment they have received
- *Personalised care plans*: These should be developed, and owned by the individual, which sets out how their needs will be met across care settings
- *Information to meet individual needs*: This should be available in a format easily accessible by the patient and promotes confidence, choice and control
- *Care Coordination* across care settings and non-statutory services which ensures consistency of service delivery with appropriate service commissioning
- *Rapid access* to appropriate health care professional when problems arise

2.5 Funding for Project

Funding has been received from the commissioners for a Project Manager Annie Treanor, a part-time Breast Care Nurse Eimer McGeown and part-time Administration Support Lesley McKnight, for the 2 year pilot period.

3. Terms of Reference

3.1 Aims

The aim of the Cancer Review Modernisation Steering group is to ensure the implementation of the Cancer Review Modernisation Projects within the agreed project plan and to ensure it is achieved within the time frames whilst ensuring safe and quality patient care. To improve the quality of cancer patients' after treatment experience, reduce inefficiencies in hospital follow-up and enhance service co-ordination and integration.

3.2 Objectives

- To be responsible for the direction, implementation and delivery of the project.
- To provide leadership and direction to the project teams.
- To ensure that the review is patient centred and fit for purpose involving patients and users in the development and evaluation of the service.
- Patient views and contributions will be sought from the current cancer services patient experience group
- To provide the opportunity for patients to have their say and to ensure that their voice is heard.

- To ensure that the concept of partnership working with the statutory and voluntary sectors is utilised to enhance the care for all patients and their families within the cancer pathways.
- To endeavour to embed the new models in care pathways prior to the end of the project period.
- To agree and present the requirements/recommendations for the Trust Cancer Services to the Cancer Review and Modernisation Steering Group and ultimately the Trust Board as identified in the key work strands by the sub groups.

Sub groups will be established to take forwards key work strands. These groups will provide feedback to the steering group and provide assurance that their aims and objectives are being met. Where aims and objective are not being met appropriate actions will be agreed.

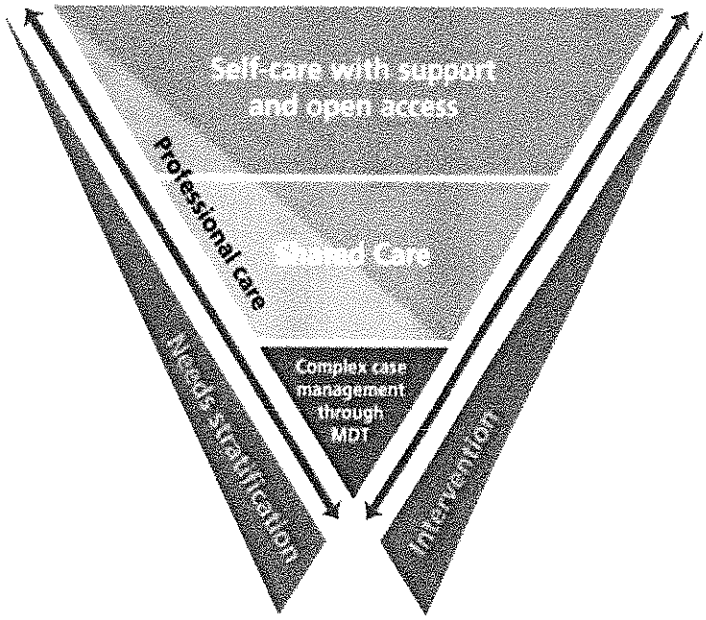
3.3 Desired Outcome

Anticipated benefits from the programme include:

- Improved patient satisfaction
- Effective resource utilisation
- Streamlined services
- Management of increased future workload

3.4 Proposed model

- A risk stratified model of aftercare arrangements is proposed, in line with the National Cancer Survivorship Initiative.
- This model is aligned with a chronic disease management approach, and the proportion of patients in each of the pathways will vary significantly depending on tumour site. For example, there will be more breast patients suitable for supported self- management with rapid access than lung cancer patients.



Risk Stratified Model of Care

3.5 Scope

This programme is applicable to the three projects in SHSCT which are Breast, Colorectal and Prostate.

The Breast project will include the implementation of a patient self-managed programme, having been discharged from the traditional routine medical review system, with an integrated mammography and Dexa screening programme, where appropriate.

The colorectal project will deliver a mechanism for the identification of patients with bowel cancer in the 'planned endoscopy' system to ensure that patients have timely endoscopy follow up as per the guidance.

The prostate project will deliver a rationalised approach to PSA testing and a more cohesive approach to PSA and cancer follow up.

Given the widespread collaboration required to make it successful, it will include members of the voluntary sector, community groups, local councils and educational facilities who will work in partnership with Trust and Primary Care to achieve the outcomes of the project. Patients who will be excluded from the self-management pathway include

- Patients on clinical trials.
- Patients with learning difficulties/mental health issues.
- Patients who presented very late initially
- Patients with metastatic/locally advanced disease.
- Patients with significant family history or proven BRCA1 or BRCA2 gene carrier risk. (*currently this group of patients are under discussion regionally for further clarification*)

Since this is a two-year programme each pilot project must address the issue of service sustainability beyond the lifespan of the project.

The judging criteria outlined below illustrate the scope of individual project: Each project must:

- Demonstrate cost effectiveness
- Be cost neutral recurrently
- Impact on significant numbers of patients
- Be deliverable and replicable
- Demonstrate a change in practice and not just additionality
- Have clear measures for success including measures to show improvements in the quality of patient experience
- Secure explicit support and or direct involvement from primary care
- Describe criteria for patient selection to new aftercare pathways
- Secure Trust Chief Executive support

4. DELIVERABLES / PRODUCTS

The overarching deliverable is a new model of follow up for risk stratified patients within each tumour site. However, elements of the programme include:

- Project initiation document
- Project plan
- Interim progress reports to Steering Group
- Stakeholder meetings
- Patient experience measurements
- Clearly identified aftercare pathways
- Agreed holistic assessment tool

- Agreed care plan record
- Agreed patient information
- Evidence of partnership working with voluntary and community services in the delivery of health and wellbeing programmes
- Evidence of effectiveness of new approaches

5. CONSTRAINTS

Time: The main constraint facing the programme is the short timescale. The Project Plan must take account of this. Monitoring of progress against agreed milestones must take place to ensure preparation and roll out are delivered in a timely fashion. Adopting learning from other parts of the UK and Northern Ireland will help to expedite development and implementation.

Governance: Identification of who is ultimately responsible for self- caring patients to be determined. Guidance from Clinicians and General Practitioners is to be sought. *(to be discussed with NICaN at regional level and agreed at SHSCT for each project)*

Service Capacity: Cancer services are presently under significant pressure with further growth anticipated year on year, and although the will to transform services appears to be there, the capacity to bring this about is limited. Service managers have flagged this up as a real concern.

Quality Assurance and Clinical Audit: Existing systems for the collection of clinical data and performance may need to be adapted to include additional information required by the Cancer Review and Modernisation Programme.

6. PROJECT ORGANISATION

6.1 Project Structure

A steering group, comprising key stakeholders, will oversee the programme of work. Steering Group meetings will take place quarterly as a minimum, but will ultimately be determined by the needs of the Project Plan. The Director of Acute Services will chair the Steering group.

Sub-groups have been established- Breast, Colorectal and Prostate to take forward the relevant work programmes led by the project manager.

7. EVALUATION

An evaluation programme will be established to inform the project outcomes. Each application for funding is required to identify service appropriate evaluation criteria within their bid.

This will include a baseline assessment of current services incorporating process activity and patient experience, which can subsequently be repeated.

7.1 Service Evaluation

- Activity figures, numbers of visits and clinic costs
- Patient focus group and patient questionnaires
- Economic Evaluation
- Planning and finance framework

7.2 Clinical Outcomes

A subsequent Clinical Outcomes evaluation strand will include:

- Patient reported outcome measures
- Clinical audit – initial discussions indicate that the pilot timeframe may be insufficient to facilitate an in-depth clinical outcome assessment. Therefore initial findings should be viewed with caution.

8. INTERFACES

This is a complex programme with a broad range of stakeholders across many organisations and specialities including surgery and oncology at the cancer centre and cancer units, primary care and cancer charities. In order to maintain engagement across the region, and to keep stakeholders involved, the following will be undertaken:

- Ensure appropriate representation of key stakeholders on the project steering group and relevant working groups
- Identify a project lead in each Trust who works through a Trust steering group
- Implement a robust communication plan
- Circulation of steering group minutes and regular updates of project plan
- vision of regular updates on NICaN website

Appendix 1

Southern Health and Social Care Trust

Cancer Services
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- REPORTS FROM SUB GROUPS TEAM

REPORTS *GENERATED*

- MEETING NOTES & ACTIONS

Appendix 1

Aimee Crilly

From: Haffey, Raymond <Personal Information redacted by the USI>
Sent: 30 October 2012 10:34
To: Ahmad, Munir; Akhtar, Mehmood; Amir, Adnan; Arava, Shiva; Blake, Geoffrey; Briggs, Gavin; Brown, Jeffrey; Brown, Robin; Browne, Gail; Bunn, Jonathon; Bunting, Helen; Carlisle, Robin; Campbell, Alastair; Carson, Anne; Clarke, Chris; Conlan, Enda; Cranley, Brian; Crockett, James; Daly, Cathy; Dignam, Paulette; Donnelly, Brian; Elliott, Hazel; Epanomeritakis, Manos; Farnon, Cathy; Fawzy, Mohamed; Feenan, Mark; Ferguson, Andrew; Gibson, Niall; Gilpin, David; Glackin, Anthony; Gracey, David; Gupta, Nidhi; Haffey, Raymond; Hall, Stephen; Hamill, Marion; Hampton, Gareth; Hannon, Robert; Harbinson, Laura; Heslip, Jennifer; Hewitt, Gareth; Hinds, John; Holmes, Erskine; Hopps, Caroline; Hughes, Paul; Johnston, Dr Linda; Kerr, Paul P; Kumar, Devendra; Kumar, Susim; Lennon, Pauline; Lewis, Alastair; Lichnovsky, Erik; Lindsay, Gail; Lowry, Darrell; Mackle, Eamon; Magowan, Hannah; Maguire, Peter; Marshall, Jacqueline; Marshall, Margaret; MAXWELL, Sharon; McAllister, Charlie; McCann, Michael; McClure, Mark; McConaghy, Paul; McConville, Richard; McCormick, Justin; McCorry, Monica; McCrory, Colin; McCrum, Gillian; McCullough, Pat; McDonald, Neil; McFall, Brendan; McGarry, Paul; McKay, Damian; McKee, Raymond; McKeown, Ronan; McStay, Sarah; Merjavy, Peter; Milligan, Aaron; Mockford, Brian; Morrow, Michael; Murnaghan, Mark; Murugan, Shanmugam; Neill, Adrian; Nicholl, Hilda; O'Brien, Aidan; OBrien, Joanne; OConnor, Kieran; O'Hare, John; OReilly, Janice; O'Reilly, Seamus; Orr, Des; O'Toole, Conor; Parks, Lorraine; patil, prashant; Patton, Sean; Porter, Simon; QUINN, Anne M; Rafferty, Lauri; Rainey, Gary; Rea, Margaret; Renney, Cathy; Rice, Paul; Richardson, Shirley; Rutherford-Jones, Neville; Scally, Nora; Scullion, Damian; Semple, Catriona; Simpson, John; Sobocinski, Dr Jacek; 'Streahorn, David'; Street, Julia; Tariq, S; Todd, Dr; Troughton, Elizabeth; Wilson, Lynn; Winter, Colin; Weir, Colin; Williams, Marc; Winter, Joanne; Wright, J; Yarr, Dr Julie; Young, Michael; Young, Thomas; Yousaf, Muhammad
Subject: Surgical list for M&M 16th November 2012
Attachments: (11) 28.09.12 to 26.10.12 for 16 November meeting.xls

Dear All,

Please see attached the list for Surgical M&M 16th November 2012.

Kind regards,

Raymond Haffey
Senior Effectiveness & Evaluation Facilitator Effectiveness & Evaluation Department
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI
e-mail Personal Information redacted by the USI

Casenote	Health & Care Number	Surname	Forenames	Method of Discharge	Date of Discharge Only	DOB	Consultant on Discharge - Name	Address Line 1	comment
Personal Information redacted by the USI				PM	01/10/2012	Personal Information redacted by the USI	Bunn J Mr	Personal Information redacted by the USI	Awaiting proformas
				No PM	05/10/2012		Cranley B. Mr.		Awaiting proformas
				No PM	22/10/2012		Epanomeritakis E Mr		Awaiting proformas
				No PM	13/10/2012		Epanomeritakis E Mr		Awaiting proformas
				No PM	12/10/2012		Epanomeritakis E Mr		Awaiting Dr proforma
				No PM	14/10/2012		Epanomeritakis E Mr		Awaiting proformas
				No PM	23/05/2012		Epanomeritakis E Mr		Doctor proforma received
				No PM	17/10/2012		Epanomeritakis / McAllister C Dr		Awaiting proformas
				No PM	22/09/2012		Gilpin D Mr		Awaiting proformas
				No PM	13/10/2012		Glackin A.J Mr		Awaiting proformas
				No PM	03/09/2012		Hannon R Mr		Awaiting Dr proforma
				No PM	30/07/2012		Hewitt G.R. Mr		Awaiting Dr proforma
				No PM	21/09/2012		Hewitt G.R. Mr		Awaiting proformas
				No PM	30/05/2012		Hewitt Mr/ McAllister C Dr		Awaiting proformas

Casenote	Health & Care Number	Surname	Forenames	Method of Discharge	Date of Discharge Only	DOB	Consultant on Discharge - Name	Address Line 1	*comment*
Personal Information redacted by the USI				No PM	20/09/2012	Personal Information redacted by the USI	Hewitt Mr/ McAllister C Dr	Personal Information redacted by the USI	*Awaiting proformas*
				No PM	23/09/2012		Hewitt Mr/ McAllister C Dr		*Awaiting proformas*
				No PM	17/07/2012		Ho K J Mr		*Awaiting proformas*
				No PM	09/05/2012		Lewis A Mr		*Awaiting proformas*
				No PM	26/06/2012		Lewis A Mr		*Awaiting proformas*
				PM	15/08/2012		Lewis A Mr		*Awaiting Dr proforma*
				No PM	05/09/2012		Lewis A Mr		*Awaiting proformas*
				No PM	05/09/2012		Lewis A Mr		*Awaiting proformas*
				No PM	25/09/2012		Lewis A Mr		*Awaiting proformas*
				No PM	19/10/2012		Lewis A Mr		*Awaiting proformas*
				PM	23/10/2012		Lewis A Mr		*Awaiting proformas*
				No PM	06/05/2012		Lewis Mr / McAllister C Dr		*Awaiting proformas*
				No PM	11/08/2012		McFall B Mr		***For presentation Nov 2012***
				No PM	09/09/2012		McKay D Mr		*Doctor proforma received*

Casenote	Health & Care Number	Surname	Forenames	Method of Discharge	Date of Discharge Only	DOB	Consultant on Discharge - Name	Address Line 1	comment
Personal Information redacted by the USI				No PM	22/08/2012	Personal Information redacted by the USI	McKay D Mr	Personal Information redacted by the USI	Doctor proforma received
				PM	10/10/2012		McKay D Mr		Awaiting proformas
				No PM	05/10/2012		McKay Dr / McAllister C Dr		Awaiting proformas
				No PM	15/10/2012		McKay Dr / McAllister C Dr		Awaiting proformas
				No PM	02/10/2012		Patton S Mr		Awaiting Dr proforma
				No PM	30/05/2012		Weir C.D. Mr		Doctor proforma received
				No PM	26/07/2012		Weir C.D. Mr		Doctor proforma received
				No PM	08/09/2012		Weir C.D. Mr		Doctor proforma received
				No PM	13/09/2012		Weir C.D. Mr		Doctor proforma received
				No PM	22/10/2012		Weir C.D. Mr		Awaiting proformas
				No PM	23/07/2012		Weir Mr/ McAllister C Dr		Doctor proforma received
				No PM	27/07/2012		Weir Mr/ McAllister C Dr		Doctor proforma received
				No PM	18/08/2012		Yousaf M Mr		Doctor proforma received
				No PM	18/08/2012		Yousaf M Mr		Doctor proforma received

Casenote	Health & Care Number	Surname	Forenames	Method of Discharge	Date of Discharge Only	DOB	Consultant on Discharge - Name	Address Line 1	comment
Personal Information redacted by the USI				PM	20/10/2012	Personal Information redacted by the USI	Yousaf M Mr	Personal Information redacted by the USI	*Awaiting proformas*
				No PM	09/10/2012		Yousaf M Mr		*Awaiting proformas*
				PM	22/08/2012		Yousaf Mr/ McAllister C Dr		*Doctor proforma received*
				No PM	15/10/2012		Yousaf Mr/ McAllister C Dr		*Awaiting proformas*
Please send proforma to			Personal Information redacted by the USI			**ASAP (if possible before 06/11/12. Thank You**			

Ward on Discharge
Cah Trauma Ward
Male Surgical
Emergency Surgical Ward
Emergency Surgical Ward
Progressive Care Ward, Level 4
Emergency Surgical Ward
Progressive Care Ward, Level 4
Intensive Care Unit
General High Dependency Unit
3 South Elective Ward
Male Surgical
Emergency Surgical Ward
Emergency Surgical Ward
Intensive Care Unit

Ward on Discharge
Intensive Care Unit
Intensive Care Unit
3 South Elective Ward
Emergency Surgical Ward
Progressive Care Ward, Level 4
Emergency Surgical Ward
Emergency Surgical Ward
Emergency Surgical Ward
Progressive Care Ward, Level 4
Emergency Surgical Ward
Progressive Care Ward, Level 4
Intensive Care Unit
Progressive Care Ward, Level 4
Progressive Care Ward, Level 4

Ward on Discharge
Emergency Surgical Ward
Main Theatre
Intensive Care Unit
Intensive Care Unit
Cah Trauma Ward
Emergency Surgical Ward
Progressive Care Ward, Level 4
Emergency Surgical Ward
Progressive Care Ward, Level 4
Progressive Care Ward, Level 4
Intensive Care Unit
Intensive Care Unit
Emergency Surgical Ward
Emergency Surgical Ward

Ward on Discharge
Progressive Care Ward, Level 4
Emergency Surgical Ward
Intensive Care Unit
Intensive Care Unit

Aimee Crilly

Subject: FW: **URGENT REQUIRING RESPONSE*** Red Flag patients requiring an urgent procedure

Importance: High

-----Original Message-----
From: Corrigan, Martina <[redacted]>
Sent: 02 November 2012 08:26
To: Ap[redacted]) <[redacted]>; Connolly, David <[redacted]>; Glackin, Anthony <[redacted]>; O'Brien, Aidan <[redacted]>; Young, Michael <[redacted]>
Cc: Clayton, Wendy <[redacted]>; Dignam, Paulette <[redacted]>; Hanvey, Leanne <[redacted]>; McCorry, Monica <[redacted]>; Troughton, Elizabeth <[redacted]>
Subject: **URGENT REQUIRING RESPONSE*** Red Flag patients requiring an urgent procedure
Importance: High

Dear all,

Please see below previous escalations that I had been advised were going to be given dates for beginning of November but to date have no dates. Can you please see if these can be scheduled as soon as possible as these patients are being reported to the Regional Board as breaches for their cancer targets. I would be grateful if you could advise as I have to let Wendy know in advance of their performance meeting next week:

Mr[redacted] – Added to waiting list on 28/09/12 for TURBT Ms[redacted] – added to waiting list on 30/08/12 for Cystoscopy, biopsy and diathermy of bladder Ms[redacted] – added to waiting list on 13/08/12 for TURBT Mr[redacted] – added to waiting list on 1/10/12 for Flexible Cystoscopy (AJG to do).

Many thanks for your help with this

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust

Telephone[redacted] (Direct Dial)
Mobile[redacted]
Email: [redacted]

Aimee Crilly

Subject: FW: ****URGENT****Theatres lists for December

Importance: High

-----Original Message-----
From: Dignam, Paulette <Personal Information redacted by the USI>
Sent: 19 November 2012 11:58
To: Connolly, David <Personal Information redacted by the USI>; Corrigan, Martina <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Cc: Elliott, Noleen <Personal Information redacted by the USI>; McCorry, Monica <Personal Information redacted by the USI>
Subject: RE: ****URGENT****Theatres lists for December
Importance: High

Hi David

My next available lists are on 21.12.12 and 28.12.12 – I could maybe take two for you if you give me names?

Thanks
Paulette

From: Connolly, David
Sent: 19 November 2012 11:52
To: Corrigan, Martina; O'Brien, Aidan; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; McCorry, Monica
Subject: RE: ****URGENT****Theatres lists for December

Aidan / Michael,

With the list on 18th being a GA list, I have no access to flexi lists in December. I have 4 patients who need a stent removed. Is there any possibility of taking some space from either of your flexi lists so that these people can get sorted out before January?

Thanks,

David

From: Corrigan, Martina
Sent: 15 November 2012 15:22
To: Personal Information redacted by the USI); Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: RE: ****URGENT****Theatres lists for December

Oops!!

Email should have read Tuesday 4th December NOT 1st!!

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 15 November 2012 14:04
To: Personal Information redacted by the USI; Connolly, David; Glackin, Anthony Personal Information redacted by the USI; 'O'Brien, Aidan'; Pahuja, Ajay; 'Young, Michael'
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: ****URGENT****Theatres lists for December
Importance: High

Dear all

I have been at our theatre meeting this morning and apologies but we can no longer get the following lists as the specialties that had given them up have actually covered them now with their own staff so we can no longer get these:

Tuesday 1 December 2012 – all day list for Mr Connolly we no longer have either of these lists Monday 10th December 2012 – AM CAH DSU list we no longer have either of these lists Friday 14th December 2012 – AM – we no longer have this list but we have been given the PM list instead. Mr Glackin is due in theatres all day, Mr Connolly was due all day but can do the PM only and then was going to see if Mr Pahuja can also do a PM list??
Tuesday 18th December AM – I had been asked if this list could be converted to an LA list for Mr Connolly and I have been advised that this has already got anaesthetic cover so therefore can GA's please be sent for.

Apologies for all of these changes but on this occasion it is outside my control.

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

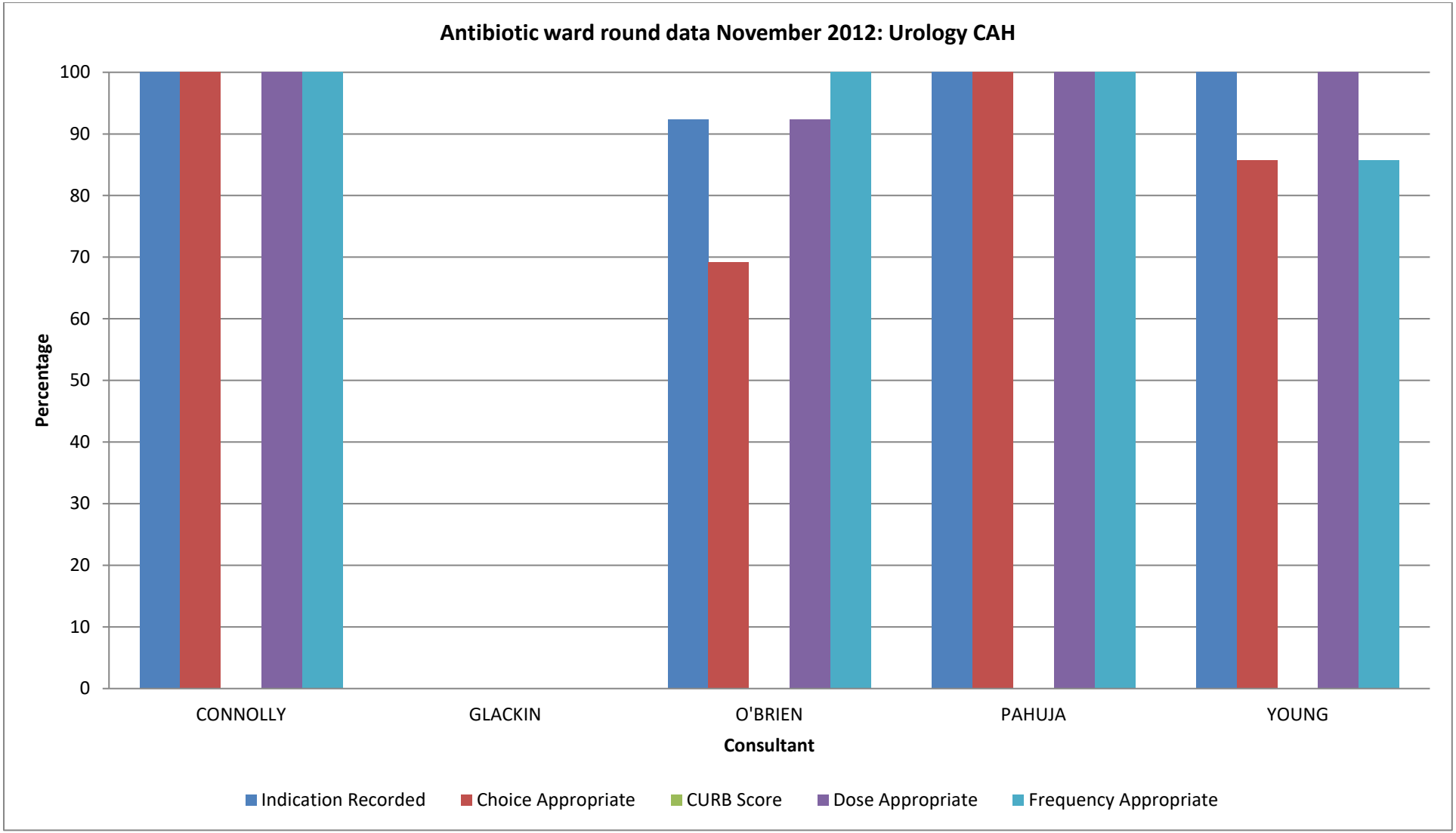
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Damani, Nizam; Rankin, Gillian; Boyce, Tracey
Subject:	For info: Antibiotic ward round summary
Date:	30 November 2012 14:47:52
Attachments:	November summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for November 2012.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 2nd and 29th November

41/80 patients on antibiotics (note patients who received surgical prophylaxis & also on active treatment included twice).

- Connolly: 1 patient. CURB score n/a.

- Glackin: No patients.

- O'Brien: 13 patients. CURB score n/a.
    - **Indication not recorded and choice and dose inappropriate in 1 patient**
        - 1pt given IV meropenem 500mg TID (1g TID recommended), switched form IV tazocin after 2 doses, no indication documented.
    - **Choice inappropriate in 3 patients**
        - 1pt given IV gentamicin 480mg OD + PO ofloxacin for epididymo-orchitis, PO ciprofloxacin recommended.
        - 1pt given IV co-amoxiclav 1.2g TID on elective admission for catheter removal, no evidence of infection. If prophylaxis for catheter change, 1 dose IV gentamicin recommended.
        - 1pt given PO trimethoprim 200mg BD for UTI, no clinical evidence of infection (patient had catheter in situ-may lead to resistance).

- Pahuja: 3 patients, CURB score n/a.

- Young: 7 patients. CURB score n/a.
    - **Choice and frequency inappropriate in 1 patient**
        - 1pt given IV co-amoxiclav 1.2g BD (TID recommended) post-surgery (uretic resection)-?need to continue antibiotics post-surgery, if required IV gentamicin recommended.

Aimee Crilly

From: Stinson, Emma M <[redacted]>
Sent: 04 December 2012 08:32
To: McFall, Brendan; McCracken, Geoff; Convery, Rory; Epanomeritakis, Manos; Neill, Adrian; O'Brien, Aidan; Eedy, David J; Boyd, Kathryn; McNaboe, Ted
Cc: Magee, Christine; McStay, Sarah; McCorry, Monica; Kerr, Karen
Subject: *for comment* Draft HSCB Cancer Commissioning Priorities 2013-14 : ACTION REQUIRED
Attachments: Draft Cancer Commissioning Team Priorities 2013-14_201112.pdf

Importance: High

Dear all

Please see attached for your comment by 7th December.

Gillian

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax:

Email: [redacted]
P Please consider the environment before printing this email

From: Stinson, Emma M
Sent: 03 December 2012 14:07
To: Clarke, Paula [redacted]; Hall, Stephen ([redacted]; Murphy, Philip; Mackle, Eamon; McAllister, Charlie; Hogan, Martina; McVey, Anne; Burke, Mary [redacted]; Conway, Barry; Carroll, Ronan; Reid, Trudy ([redacted]; Trouton, Heather
Cc: Radcliffe, Sharon; Lindsay, Gail; Smyth, Elizabeth; Renney, Cathy; Slaine, Delma; LauraAnne Ward; Graham, Michelle; Irwin, Laura J
Subject: *for comment* Draft HSCB Cancer Commissioning Priorities 2013-14 : ACTION REQUIRED
Importance: High

Dear all

Please see the Draft Cancer Commissioning Priorities for the next 2 years for comment by Friday 7th December.

Gillian

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Email: Personal Information redacted by the USI
P Please consider the environment before printing this email

From: Lisa McWilliams [mailto: Personal Information redacted by the USI
Sent: 30 November 2012 09:45
To: 'jennifer.welsh Personal Information redacted by the USI ; Geraldine Hillick; Seamus.McGoran setrust; Rankin, Gillian; Caroline Leonard; Colin Rodgers; Colin Rodgers1; diane.keown Personal Information redacted by the USI ; Eileen Deery; Elizabeth England; Fiona Beattie; Reddick, Fiona; Gillian Traub; Jim McGuigan; Jim McGuigan's diary secretary; Lisa McWilliams; Liz England PA; Liz Henderson; Michael Reilly; pat.mcclelland Personal Information redacted by the USI Robert McCormac; Carroll, Ronan; Convery, Rory; Sally Campalani; sarah williamson; Seamus McAleer; Stephen Kirk; tom.morton Personal Information redacted by the USI Wilma Boyd-Carson
Cc: Liz Henderson; Martin Eatock _Medical Director NICaN
Subject: Draft HSCB Cancer Commissioning Priorities 2013-14 : ACTION REQUIRED
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Dear Colleagues

Please find attached the drafted cancer commissioning priorities for inclusion in the HSCB Commissioning Plan for 2013-14.

The development timetable was such that it was not possible to arrange a meeting of the Local Lead Cancer Teams to help in drafting theses priorities but it has been agreed with the co-chairs of cancer commissioning that we can now circulate this to the NICaN Local Lead Cancer Teams Forum and Executive Directors to enable you to provide feedback. I have been advised to highlight that the format of the document may change during the editorial process.

Could you consider the content and return Trust submissions as to whether these are the appropriate priorities and whether any can be turned into SMARTer objectives.

The cancer commissioning team welcome your comments and submissions should be returned to myself by 12.00 noon on Friday 7 December in order that final priorities can be submitted to the agreed deadline.

Best regards

Lisa

Lisa McWilliams
Senior Manager
Northern Ireland Cancer Network
1st Floor - IT Department
Back Entrance - Knockbracken Clinic
Knockbracken Healthcare Park
Belfast BT8 8BH
Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI

www.cancerni.net

NICaN is part of the NI Health& Social Care Board

Draft Cancer Commissioning Team Priorities 2-13-14

[National Cancer Improving Outcomes; 1- Survival, 2 – Patient Experience, 3 – Safety & Quality, 4 – Productivity, 5 – Quality of Life]

1. **Transforming Cancer Follow Up (TYC SIP page 41; CSF Standard 46) [2,3,4 and 5]**
   Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative.
   Targets
   2013-14
   - Minimum of 30% of Breast Cancer Patients on self directed aftercare pathway
   - All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services
   - Introduction of risk stratified model of follow up across other tumour sites to address and prevent future backlog of review appointments

   2015
   - Findings of external evaluation to be incorporated into Trust action plans

2. **Radiotherapy Expansion (TYC SIP page 40; CSF Standard 24) [1,2,3,4,5]**
   HSCB in partnership with relevant Trusts will deliver a solution for the future provision of radiotherapy services in NI to include expansion in BHSCT and the creation of a radiotherapy unit in Altnagelvin.
   Targets
   2013-14
   - Trusts to work closely with HSCB to develop Oncology, Nursing and AHP Workforce Recruitment Plans
   - BHSCT and WHSCT to progress recruitment of radiotherapy physics and therapeutic radiography workforce in line with agreed Workforce Recruitment plans
   - BHSCT will commission 10th LinAc (Subject to business case approval) and continue with LinAc replacement programme as set out in PFI
   - Trusts to agree the cohort of patients to be treated at the Altnagelvin radiotherapy unit and to define the care pathways applicable for such patients

3. **Review of Non Surgical Oncology (TYC SIP Page 43; NICaN Chemotherapy Review 2010) [1,2,3,4,5]**
HSCB to develop a model of non surgical oncology service which best addresses acute oncology arrangements and makes most effective use of the multiprofessional workforce.

Targets
2013-14
- Trusts to introduce an Acute Oncology Service and to monitor activity as agreed with the HSCB .
- To monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis.
- Identification of model and quantified requirements
- Project plan for roll out of Acute Oncology Services

2015
- Mechanism for sustainability of Acute Oncology Services to be agreed

4. **Cancer Intelligence (TYC SIP Page 45) [3, 4]**
Trust should ensure participation in the development and implementation of systems (e.g RISOH, C-PORT, ECR) as well as contribute to national audit in order to benchmark outcomes and identify targeted improvement activity
Targets
2013-14
- Implementation of C-PORT
- Continued involvement in statement of requirement and development of RISOH
- Participation in national Lung, Bowel, UGI and Head and Neck audits

5. **Effective Cancer Multi-disciplinary Teams (CSF Standard 20) [1,2,3,4,5]**
Trusts will ensure that cancer MDTs are supported to undertake the NICaN Peer Review process and develop action improvement plans. HSCB will cognisant of peer review outcomes to inform future commissioning.
Targets
2013-14
- Peer review of Breast, Lung, Gynae, Colorectal, Upper GI, Urology and Haematology

2014 – 15

- Peer review of Skin, Head and Neck, Brain and CNS MDTs

2015-16

- Peer review of Sarcoma MDT

6. **Cancer Service Framework [1,2,3,4,5]**

Trusts should continue to implement the standards outlined within the DHSSPS Service Framework for Cancer Prevention, Treatment and Care and to provide HSCB with updates on adherence to key performance indicators on a bi-annual basis.

7. **Teenage and Young Adult Services (CSF Standard 32) [1,2,3,4,5]**

Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients.

Targets

2013-14

- Development of streamlined pathways

2015

- Enhanced multiprofessional multidisciplinary working e.g virtual MDMs

8. **Haematology Services (CSF Standards 39&40) [1,2,3,4,5]**

Targets

2013-14

- Trusts will implement virtual clinic arrangements and support agreed MDM configuration as determined by the HSCB working Group.
- Trusts to ensure maximisation of skills mix initiatives as determined by the HSCB working group
- Trusts will ensure clinical teams commence work on implementing a risk stratified model of follow up

2014-15

- Trusts will apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed CNS Job Planning

9. **Cancer Performance re: 62 day wait [1,2,4]**

Targets

2013-14

- Trusts will ensure all urgent suspected breast cancer referrals are seen within 14 days
- Trusts will ensure 95% of red flag suspect cancer patients referred with a suspected cancer will receive their first definitive treatment within 62 days.
- Trusts will ensure 98% of cancer patients commence their first definitive treatment within 31 days of their decision to treat.

2014-15

- Trusts will audit the Protocol for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer

Draft 3 - 20th November 2012

Aimee Crilly

Subject: FW: Switch to Saturday Lists January 2013

-----Original Message-----
From: Glackin, Anthony <[redacted]>
Sent: 06 December 2012 18:00
To: Troughton, Elizabeth <[redacted]>; McCorry, Monica <[redacted]>
Cc: O'Brien, Aidan <[redacted]>
Subject: Switch to Saturday Lists January 2013

Dear Liz & Monica,
Aidan & I have agreed to switch our Saturday extra lists, so as to avoid on call issues.
Mr Glackin will do 5th.
Mr O'Brien will do 12th.

Best wishes

Tony

Aimee Crilly

Subject: FW: NICaN Urology Group - Clinical Lead (Mr Aidan O'Brien)

Importance: High

From: Mary Jo Thompson <Personal Information redacted by the USI>
Sent: 07 December 2012 14:13
To: a.gavin Personal Information redacted by the USI O'Brien, Aidan <Personal Information redacted by the USI>; Brain Wilson <Personal Information redacted by the USI>; Brian Best (niecr) <Personal Information redacted by the USI>; Cherry Lynn <Personal Information redacted by the USI>; Chris Hagan <Personal Information redacted by the USI>; Colin Mulholland <Personal Information redacted by the USI>; Darren Mitchell (niecr) <Personal Information redacted by the USI>; Declan O'Rourke <Personal Information redacted by the USI>; Dr Alison Clayton <Personal Information redacted by the USI>; Dr Arther grey <Personal Information redacted by the USI>; Dr David Conkey <Personal Information redacted by the USI>; Dr Dermot Hughes <Personal Information redacted by the USI>; John Smyth (niecr) <Personal Information redacted by the USI>; Dr Johnny Brown <Personal Information redacted by the USI>; Edward O'Neill <Personal Information redacted by the USI>; Edna Wilson <Personal Information redacted by the USI>; Elizabeth England <Personal Information redacted by the USI>; Gerry McCarthy <Personal Information redacted by the USI>; McCusker, Grainne <Personal Information redacted by the USI>; Harry Lockhart (PPI) <Personal Information redacted by the USI>; Harry Lockhart (PPI) <Personal Information redacted by the USI>; Hugh Mullen <Personal Information redacted by the USI>; Jacqui Harney <Personal Information redacted by the USI>; Jenny Kelly (niecr) <Personal Information redacted by the USI>; Joe O'Sullivan <Personal Information redacted by the USI>; John McKinght (niecr) <Personal Information redacted by the USI>; Karen McClenaghan <Personal Information redacted by the USI>; Lady Joan Alderdice <Personal Information redacted by the USI>; Liz Henderson <Personal Information redacted by the USI>; Marie Vandrimmelen <Personal Information redacted by the USI>; Mark McClure <Personal Information redacted by the USI>; Martina Daly <Personal Information redacted by the USI>; Martina O'Brien <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; myles.nelson northerntrust <Personal Information redacted by the USI>; Nambi Rajan (niecr) <Personal Information redacted by the USI>; Niall.Mackenzie Personal Information redacted by the USI pat.mcclelland Personal Information redacted by the USI; Patricia Thompson <Personal Information redacted by the USI>; Patrick keane <Personal Information redacted by the USI>; Paula Grant <Personal Information redacted by the USI>; Peter.Ball setrust <Personal Information redacted by the USI>; Richard Fiala <Personal Information redacted by the USI>; Sharon Morgan <Personal Information redacted by the USI>; Sharon Uprichard <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; Stephen Stranex <Personal Information redacted by the USI>; Teresa (PPI rep) <Personal Information redacted by the USI>; Teresa (PPI) <Personal Information redacted by the USI>; Timothy (PPI) <Personal Information redacted by the USI>; ONeill, Kate <Personal Information redacted by the USI>; Barbara Harvey (Clinical trials Nurse) <Personal Information redacted by the USI>; Beth Malloy <Personal Information redacted by the USI>; Brolly, Dawn <Personal Information redacted by the USI>; Colin Mulholland <Personal Information redacted by the USI>; Dr Binu Thomas (Trust Grade) <Personal Information redacted by the USI>; Edel Aughey <Personal Information redacted by the USI>; Edgar, Arlene <Personal Information redacted by the USI>; Fiala, Richard <Personal Information redacted by the USI>; McClean, Gareth <Personal Information redacted by the USI>; Hazel Templeton (Uro-Oncology Specialist nurse) <Personal Information redacted by the USI>; Heather Kinnear - NICR <Personal Information redacted by the USI>; McMahon, Jenny <Personal Information redacted by the USI>; Jonathan McAleese (niecr) <Personal Information redacted by the USI>; Karen Johnston <Personal Information redacted by the USI>; Kerry Chambers (CNS) <Personal Information redacted by the USI>; Linton, Patricia <Personal Information redacted by the USI>; Lisa Ranaghan <Personal Information redacted by the USI>; Pat Shiels <Personal Information redacted by the USI>; a.gavin Personal Information redacted by the USI Patricia Linton <Personal Information redacted by the USI>; Patricia Sheppard <Personal Information redacted by the USI>; Paul Downey <Personal Information redacted by the USI>; Ricahrd middleton <Personal Information redacted by the USI>; Robby Nelson (Social Work) <Personal Information redacted by the USI>; Ruth Moore - AHP Rep <Personal Information redacted by the USI>; Sarah Williamson <Personal Information redacted by the USI>; Shane Breen <Personal Information redacted by the USI>; Sharon Hynds <Personal Information redacted by the USI>; Stacey Early <Personal Information redacted by the USI>; Teresa McEvoy (CNS)

< Personal Information redacted by the USI >; Wendy McPhee (niecr) < Personal Information redacted by the USI >; Wilma Boyd Carson < Personal Information redacted by the USI >; aidanpobrien Personal Information redacted by the USI ; McMahon, Jenny < Personal Information redacted by the USI >
Cc: Lisa McWilliams < Personal Information redacted by the USI >; McCorry, Monica < Personal Information redacted by the USI >; 'caroline.lynas Personal Information redacted by the USI <caroline.lynas Personal Information redacted by the USI >; Magee Martha - Cancer Survivorship Project Manager < Personal Information redacted by the USI Personal Information redacted by the USI ; Mills, Moyra < Personal Information redacted by the USI >; Treanor, Anne < Personal Information redacted by the USI >
Subject: NICaN Urology Group - Clinical Lead (Mr Aidan O'Brien)
Importance: High

"This email is covered by the disclaimer found at the end of the message."

Dear NICaN Urology Core Group members and Interested parties,

Following previous correspondence seeking expressions of interest for the position of Clinical Lead for NICaN Urology Group, we are delighted to announce Mr Aidan O'Brien from SHSCT will be taking over the role of Clinical Lead for the NICaN Urology Group taking effect from 1st January 2013.

Many thanks to Mr Nambi Rajan for his dedication and hard work over the last number of years and best wishes for the future.
Kind regards,

Mary Jo

Mary Jo Thompson
Macmillan Survivorship Programme Manager
Northern Ireland Cancer Network (NICaN)

Knockbracken Healthcare Park
Belfast BT8 8BH
Tel: Personal Information redacted by the USI Fax: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI
Email : Personal Information redacted by the USI
Web: http://www.cancerni.net/node/7336

Aimee Crilly

Subject: FW: return to work

-----Original Message-----
From: ajay pahuja <[redacted]
Sent: 26 December 2012 06:49
To: Glackin, Anthony <[redacted]
Cc: O'Brien, Aidan <[redacted]
Subject: FW: return to work

From: ajay_pahuja[redacted]
To: michael.young[redacted]
CC: martina.corrigan[redacted] djconn[redacted] aidanpobrien[redacted]
Subject: RE: return to work
Date: Wed, 26 Dec 2012 06:04:56 +0000

hi martina/michael
i am sorry i couldnt meet u when i was back at cah as i had to[redacted]

will be returning to work on 14th jan. i really appreciate all the support from each and every colleague in the department in these difficult times

thanks
ajay pahuja

From: Michael.Young[redacted]
To: Ajay_pahuja[redacted]
Date: Fri, 14 Dec 2012 10:52:38 +0000
Subject: RE: return to work

[redacted]

MY

From: Ajay Pahuja [mailto[redacted]]
Sent: 13 December 2012 18:25
To: Young, Michael
Subject: Re: return to work

[redacted]

On 13 Dec 2012, at 17:48, "Young, Michael" <[redacted]> wrote:

[redacted]

From: ajay pahuja [mailto[redacted]]
Sent: 13 December 2012 17:42
To: Young, Michael
Cc: Corrigan, Martina

Subject: return to work

hi martina/michael

just to keep you posted regarding my plans. sorry to have left at such short notice

Personal Information redacted by the USI

i intend to Personal Information redacted by the USI be in belfast on monday 17th late afternoon. i am happy to resume work back on 18th december tuesd.

apologies for all the disruption and appreciate the support from the whole team

thanks

ajay

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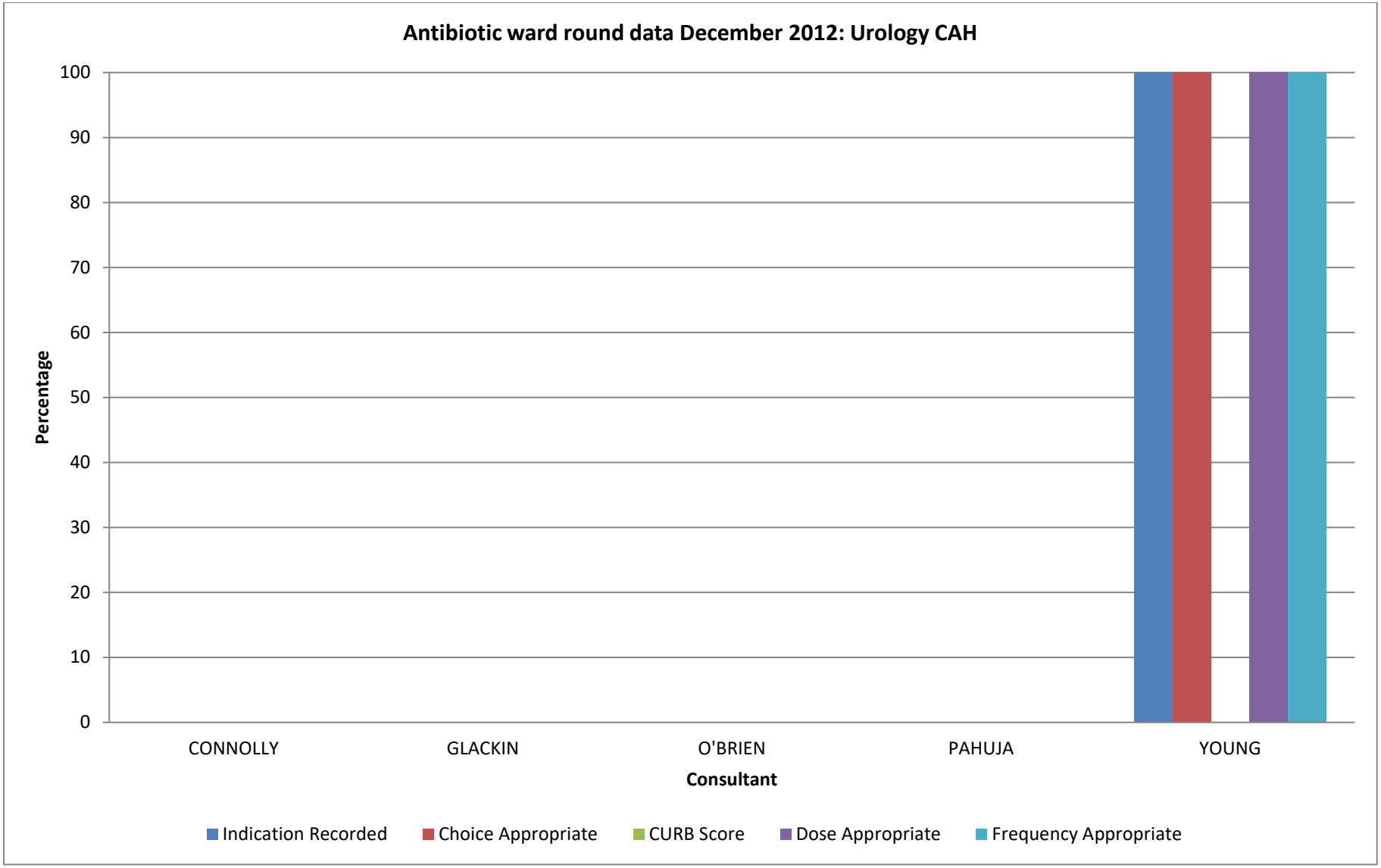
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Rankin, Gillian; Damani, Nizam; Boyce, Tracey
Subject:	For info: Antibiotic Ward round summary
Date:	27 December 2012 14:40:32
Attachments:	December summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for December.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 21st December

7/17 patients on antibiotics (note patients who received surgical prophylaxis & also on active treatment included twice).

- Connolly: No patients.
- Glackin: No patients.
- O’Brien: No patients.
- Pahuja: No patients.
- Young: 7 patients. CURB score n/a.

Aimee Crilly

Subject: FW: Mrs [redacted]

From: Young, Michael <[redacted]
Sent: 28 December 2012 12:30
To: O'Brien, Aidan <[redacted]>
Subject: FW: Mrs [redacted]

-----Original Message-----
From: Corrigan, Martina
Sent: 28 December 2012 12:09
To: Young, Michael
Subject: FW: Mrs [redacted]

Hi Michael

See update below - can you help with what she needed to have done yesterday as I checked and none of the nurses on today were on yesterday?

Thanks

Martina

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

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Carroll, Ronan
Sent: 28 December 2012 12:05
To: Robinson, Jeanette
Cc: Corrigan, Martina
Subject: RE: Mrs [redacted]

Tks - martina pls see update from Jeanette

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

-----Original Message-----
From: Robinson, Jeanette
Sent: 28 December 2012 12:04

To: Carroll, Ronan
Subject: FW: Mrs [redacted]
Importance: High

Hi Ronan

We have no outstanding requests for [redacted] An Appointment was made for a ankle joint injection on the 14th December this was confirmed on the 3 rd of December although Ms [redacted] did not turn up for her appointment. (this has not been reappointed An appointment as made to have a ultrasound guided nephrostomy this was cancelled in x-ray and carried by Mr Glacken in theatre between 10th-14th December.

There are no other outstanding requests for radiology.

jeanette
-----Original Message-----
From: Carroll, Ronan
Sent: 28 December 2012 11:19
To: Robinson, Jeanette
Subject: FW: Mrs [redacted]
Importance: High

Jeanette
Could I ask u to look into this today - i.e. why was the pt not cancelled by us & when can we do this investigation (does it required Richard only) Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

-----Original Message-----
From: Corrigan, Martina
Sent: 28 December 2012 11:19
To: Davidson, Alexis; Robinson, Jeanette
Cc: Carroll, Ronan
Subject: FW: Mrs [redacted]
Importance: High

Hi Alexis

I had spoken to Mr Young about this patient and apparently she was to get this done by Dr McConville. Ronan asked me to forward this to yourselves to see if there is anyone else who could do this and what is the timescale as Mairead's secretary has been on the phone about this already this morning

Thanks

Martina

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

Telephone: [redacted] (Direct Dial)
Mobile [redacted]

Email: Personal Information redacted by the USI

-----Original Message-----
From: Reid, Trudy
Sent: 28 December 2012 07:52
To: Corrigan, Martina
Subject: URGENTFw: Mrs Personal Information redacted by the USI

Martina could you please look into this please Regards Trudy

----- Original Message -----
From: McAlinden, Mairead
To: Complaints; Reid, Trudy
Sent: Thu Dec 27 18:52:36 2012
Subject: Mrs Personal Information redacted by the USI

I have been contacted today by Mrs Personal Information redacted by the (above, urology patient under Mr Glachan/Mr O'Brien previously urology inpatient in CAH before Christmas). She attended CAH 7.30 this morning for an elective cystogram. Mr Fernandes told her at 11am that she could not have the procedures as no one was booked to do it.

She enquired when she would have this procedure and was told 2-3 weeks. Mrs Personal Information redacted by the has apparently been told by her consultant she needs this done at the planned time and wants an urgent date for this procedure.

I would be grateful if you would look into this and contact Mrs Personal Information redacted by the (home Personal Information redacted by the USI mobile Personal Information redacted by the USI)

Mairead

Aimee Crilly

Subject: FW: Urology escalation

-----Original Message-----
From: Connolly, David <[redacted]>
Sent: 31 December 2012 16:30
To: Corrigan, Martina <[redacted]>; Glackin, Anthony <anthony.glackin[redacted]>; O'Brien, Aidan <[redacted]>; Pahuja, Ajay <[redacted]>; Young, Michael <[redacted]>
Cc: Graham, Vicki <[redacted]>; Reddick, Fiona <[redacted]>; Montgomery, Angela <[redacted]>; Carroll, Ronan <[redacted]>; Clayton, Wendy <[redacted]>; McMahon, Jenny <[redacted]>; ONeill, Kate <[redacted]>; Dignam, Paulette <[redacted]>; Elliott, Noleen <[redacted]>; Hanvey, Leanne <[redacted]>; McCorry, Monica <[redacted]>; Troughton, Elizabeth <[redacted]>
Subject: RE: Urology escalation

I have had a late cancellation for my DPU list on Wed PM. I will bring up the 2 haematuria patients to it. Mixing GAs and LAs but otherwise the slot is unlikely to be used.

David

From: Corrigan, Martina
Sent: 24 December 2012 12:05
To: Connolly, David; Glackin, Anthony; O'Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc: Graham, Vicki; Reddick, Fiona; Montgomery, Angela; Carroll, Ronan; Clayton, Wendy; McMahon, Jenny; ONeill, Kate; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth
Subject: RE: Urology escalation
Importance: High

Dear all

Please see below which I would be grateful if you could advise me on as soon as possible

Many thanks

Martina

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

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Clayton, Wendy
Sent: 24 December 2012 10:04
To: Corrigan, Martina
Cc: Graham, Vicki; Reddick, Fiona; Montgomery, Angela; Carroll, Ronan
Subject: FW: Urology escalation
Importance: High

Martina

Please see below escalations – can you have a look at them and advise action asap.

Many thanks

Wendy

From: Graham, Vicki
Sent: 21 December 2012 15:34
To: Clayton, Wendy
Subject: Urology escalation
Importance: High

Hi Wendy

Please see below urology escalations

Personal Information redacted by the USI - Bladder surgery outstanding- Target date 04.01.13 –Patient is now on day 17 of 31 target. Has been previously escalated.

Personal Information redacted by the USI - Haematuria appointment is outstanding- Now on Day 23

Personal Information redacted by the USI - Haematuria referral- Was seen on Day 20 for 1st OPD- TCC has been identified and was planned for surgery 21.12.12 but this was not scheduled, not sure as to reason but date for surgery is to be defined for TURBT – Target date is 14.01.13

Personal Information redacted by the USI Haematuria referral- Patient was offered appointment but cancelled and is now on day 22 and appointment is outstanding.

Regards

Vicki

Vicki Graham
Cancer Tracker/MDT Co-Ordinator
Urology
Direct Line Personal Information redacted by the USI
E-mail Personal Information redacted by the USI

From: McCorry, Ann
To: O"Brien, Aidan
Subject: Antibiotic Ward Round Data: annual summary
Date: 31 December 2012 15:48:00
Attachments: Dr O"Brien.docx

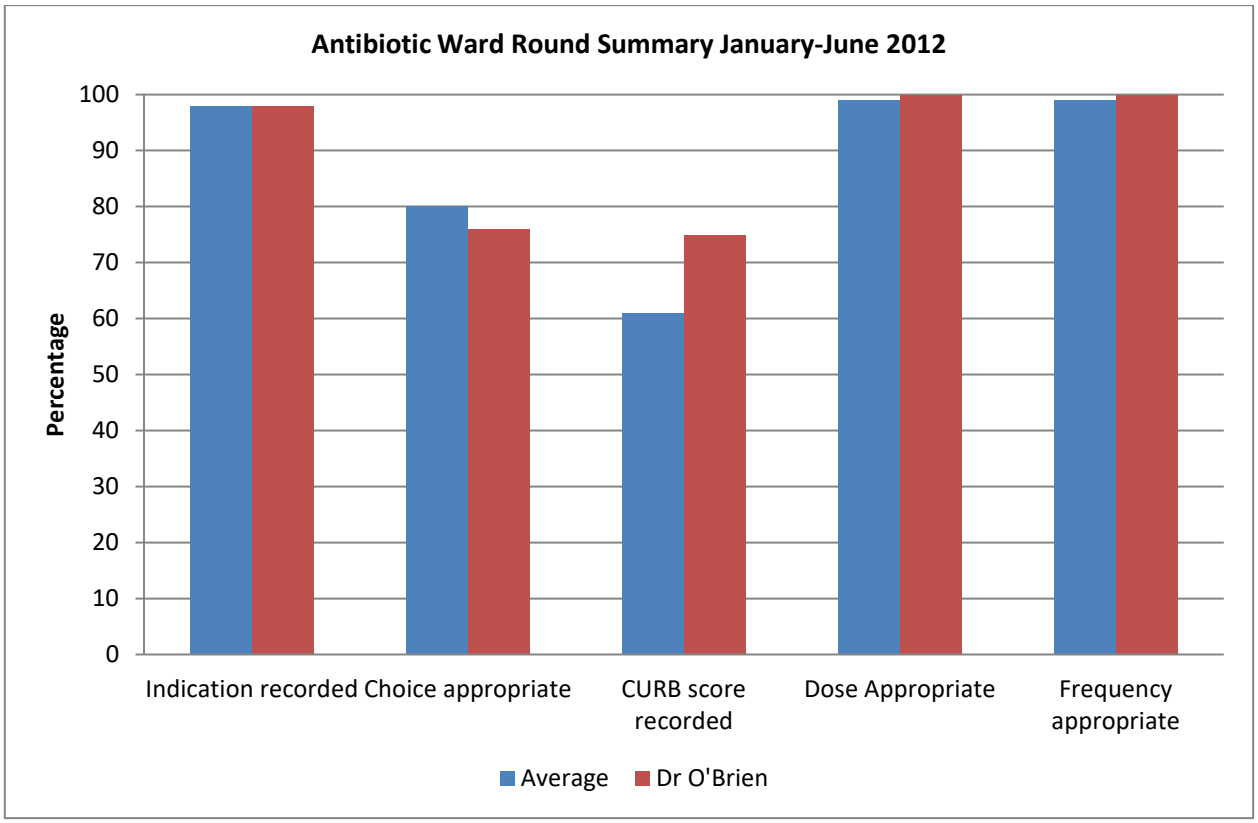
Hi Dr O'Brien,

Please find attached a summary of the antibiotic ward round data collected for your patients this year, with comparison against the average for all Consultants within that period.

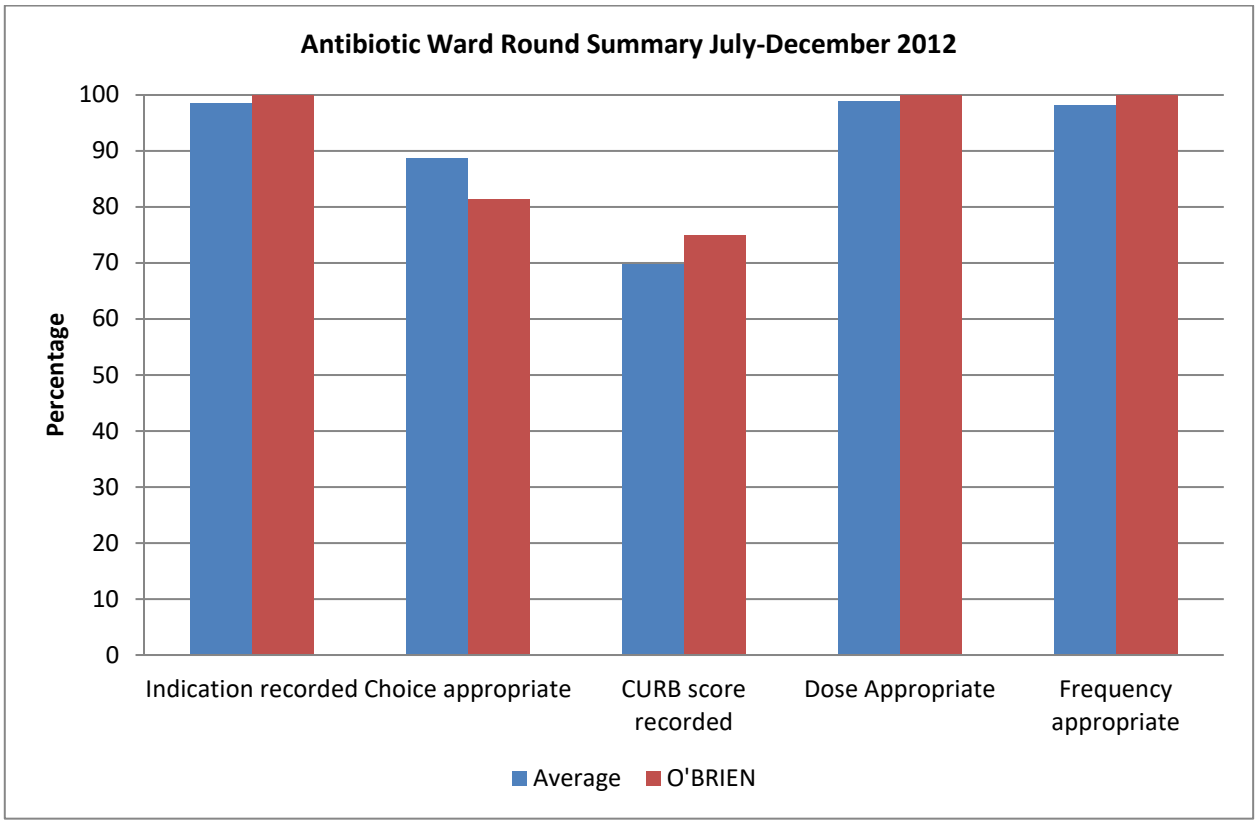
Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI

Antibiotic Ward round summary 2012



- January-June: 59 patients, CURB score appropriate for 16 patients, **recorded in 12**.
  - **Indication** not recorded in 1 patient and **choice** inappropriate in 14 patients.



- July-December: 32 patients, CURB score appropriate for 4 patients, **recorded in 3**.
  - **Choice** inappropriate in 6 patients.

From: McCorry, Ann
To: Boyce, Tracey; Rankin, Gillian
Cc: Simpson, John; Damani, Nizam; O"Brien, Aidan
Subject: For information: Antibiotic Ward Round Data DHH
Date: 31 December 2012 16:11:48
Attachments: 6 monthly summary Jul-Dec.xlsx
6 monthly Summary Jul-Dec.doc

Hi All,

Please find attached the 6 monthly ward round summary for DHH medical ward rounds from Jul-Dec 2012. The graphs show each Consultant percentages in comparison to the average for all Consultants; the word documents gives details of number of patients and if CURB score applicable etc.

I have sent each Consultant an individual report showing their data from Jan-Jun and Jul-Dec.

Let me know if you need any further info.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI

6 monthly antibiotic ward round summary DHH (July to December 2012)

- Dr Ahmed: 46 patients, CURB score appropriate for 15 patients, **recorded in 11**.
    - **Indication** not recorded in 4 patients, **choice** inappropriate in 6 patients, **dose** inappropriate in 2 patients and **frequency** inappropriate in 3 patients.

- Dr D Morgan: 37 patients, CURB score appropriate for 10 patients, **recorded in 6**.
    - **Choice** inappropriate in 8 patients and **frequency** inappropriate in 2 patients.

- Dr Harty: 5 patients, CURB score appropriate for 1 patient, **not recorded.**

- Dr Hayes: 9 patients, CURB score appropriate for 1 patient, **not recorded.**
    - **Choice** inappropriate in 1 patient.

- Dr Magee: 38 patients, CURB score appropriate for 10 patients, recorded.
    - **Choice** inappropriate in 2 patients and **dose** inappropriate in 1 patient.

- Dr McGleenon: 24 patients, CURB score appropriate for 6 patients, **recorded in 5**.
    - **Choice** inappropriate in 3 patients.

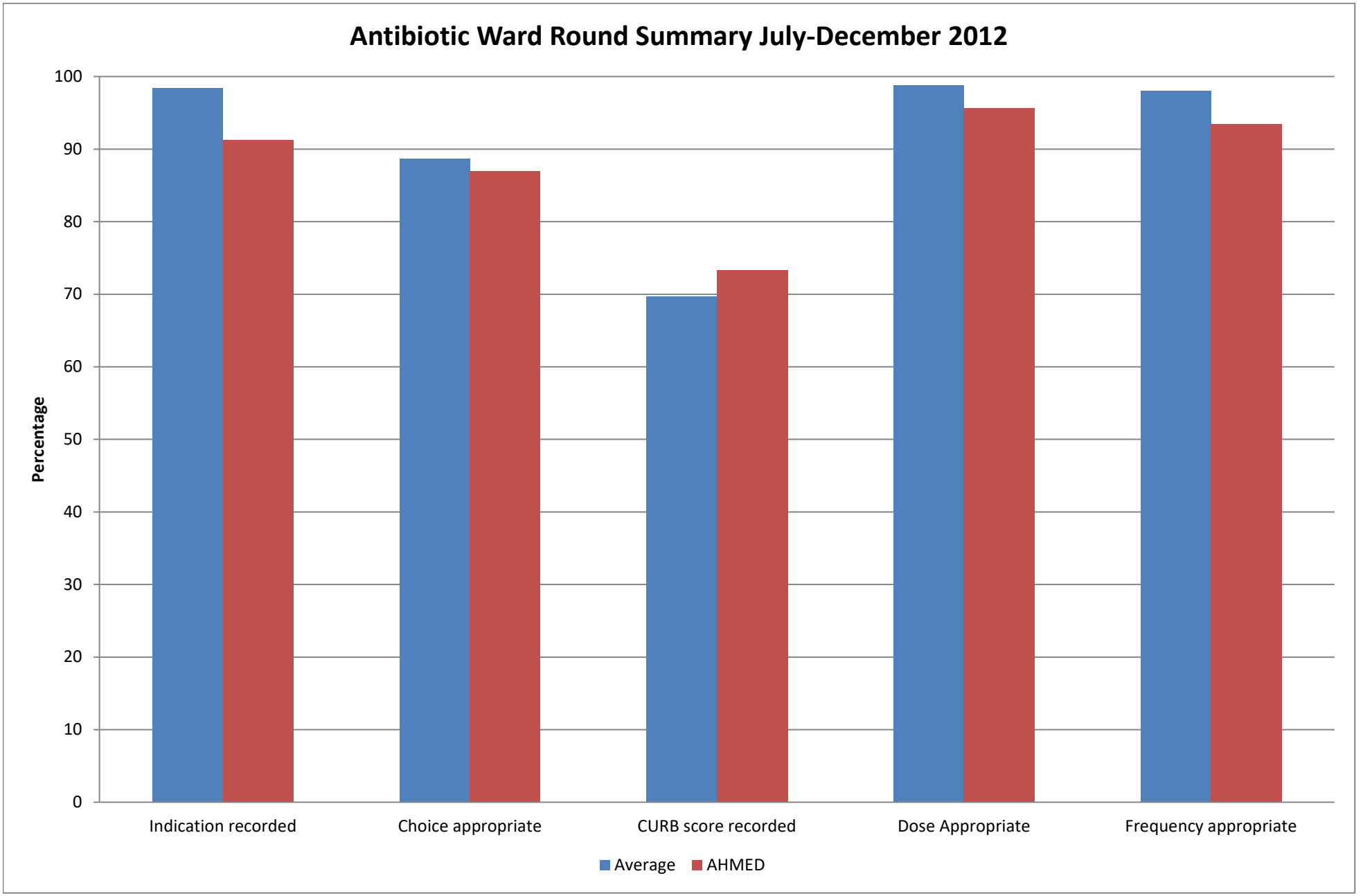
- Dr McKeveney: 6 patients, CURB score appropriate for 1 patient, **not recorded**.

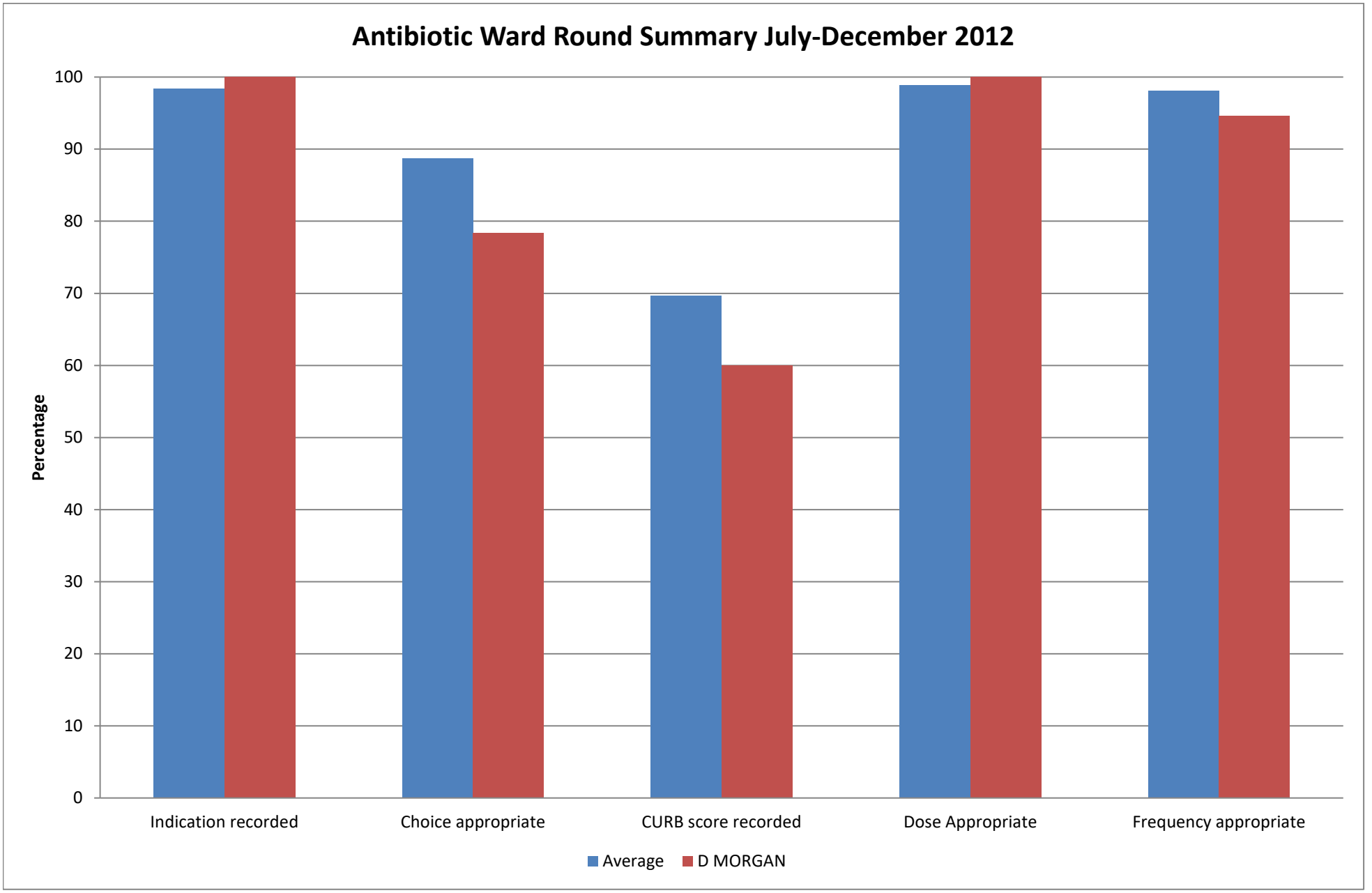
- Dr Moan: 28 patients, CURB score appropriate for 13 patients, **recorded in 7**.
    - **Choice** inappropriate in 2 patients.

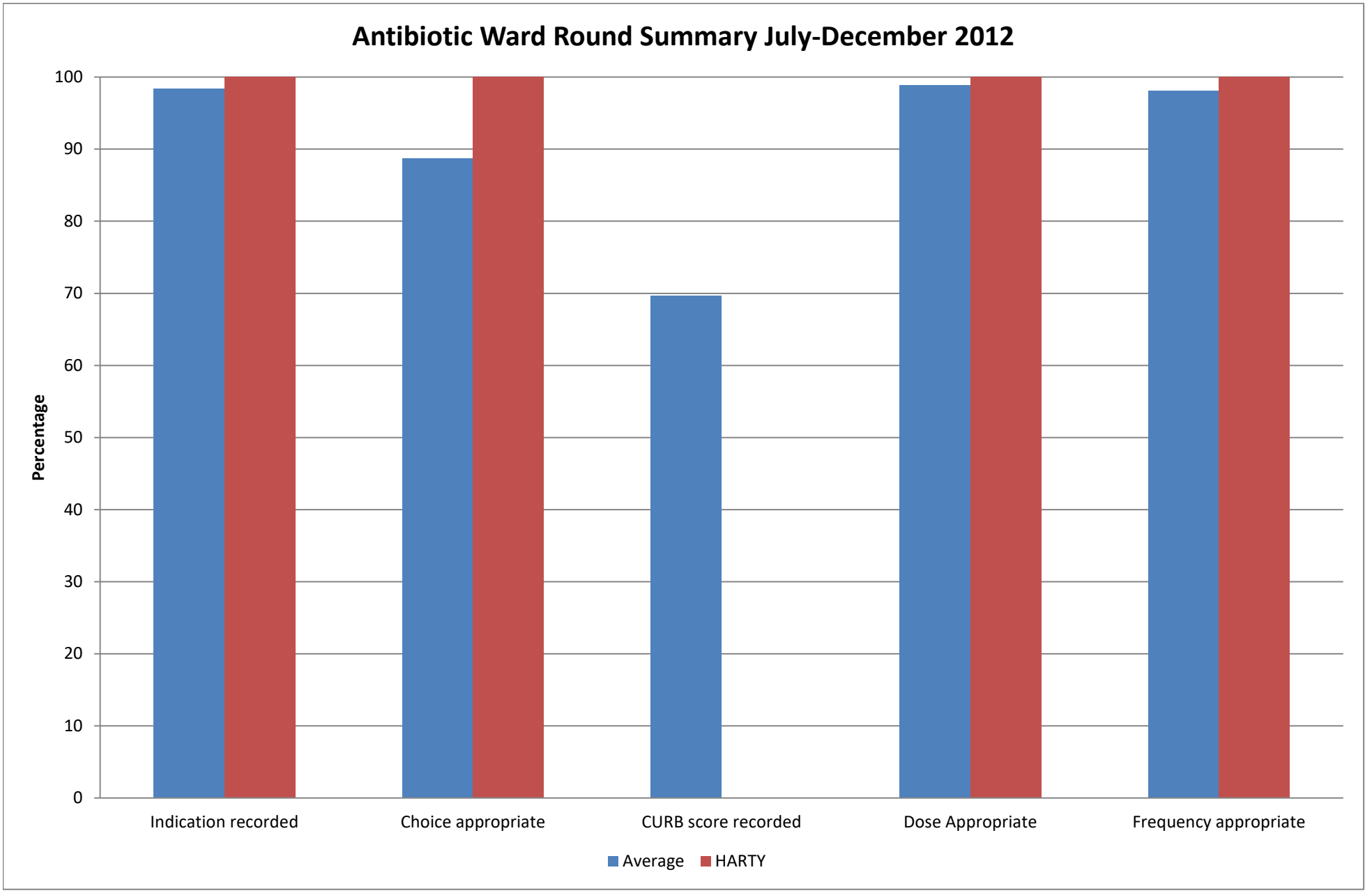
- Dr N Morgan: 2 patients, CURB score n/a.

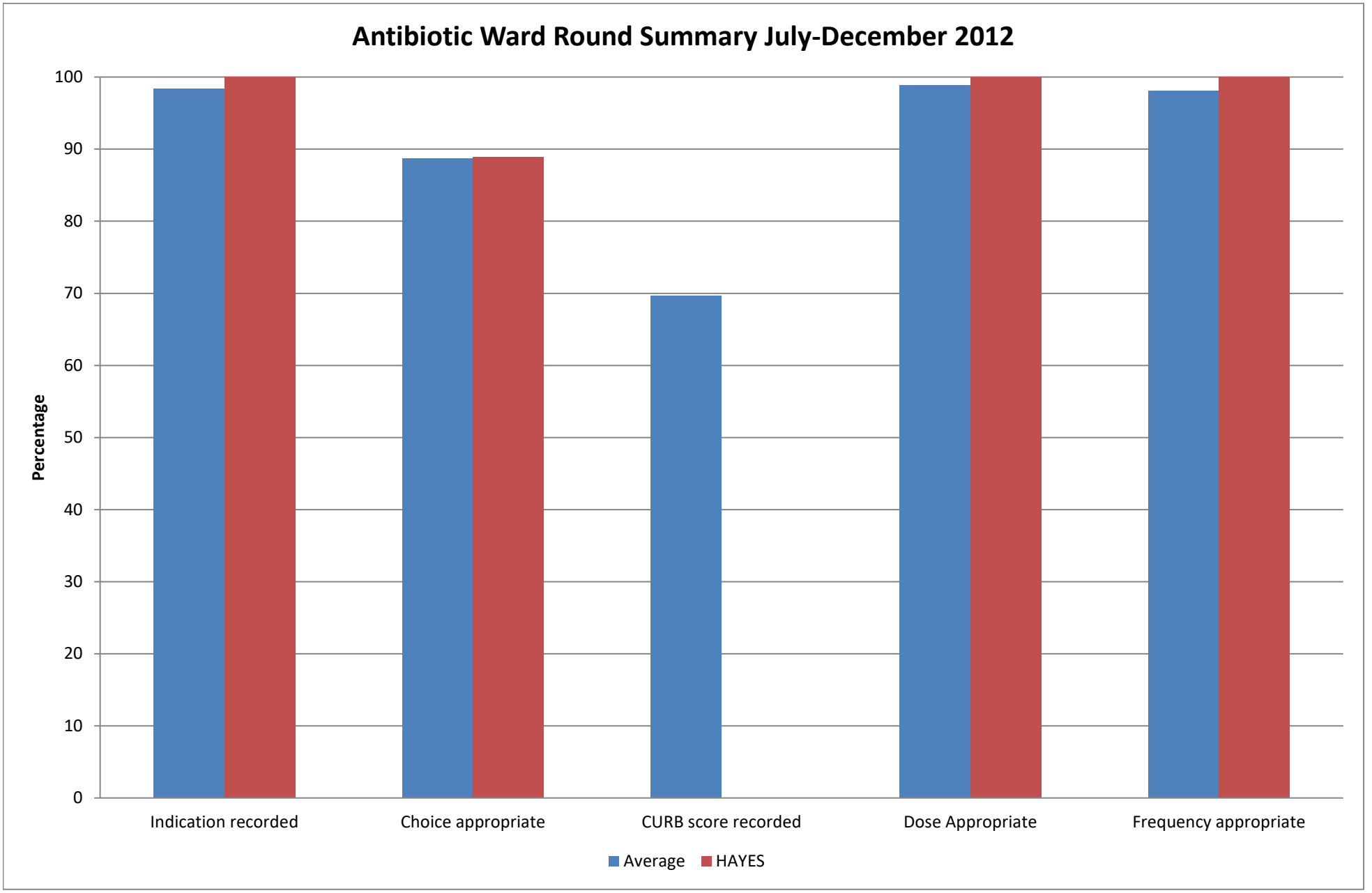
- Dr O'Brien: 32 patients, CURB score appropriate for 4 patients, **recorded in 3**.
    - **Choice** inappropriate in 6 patients.

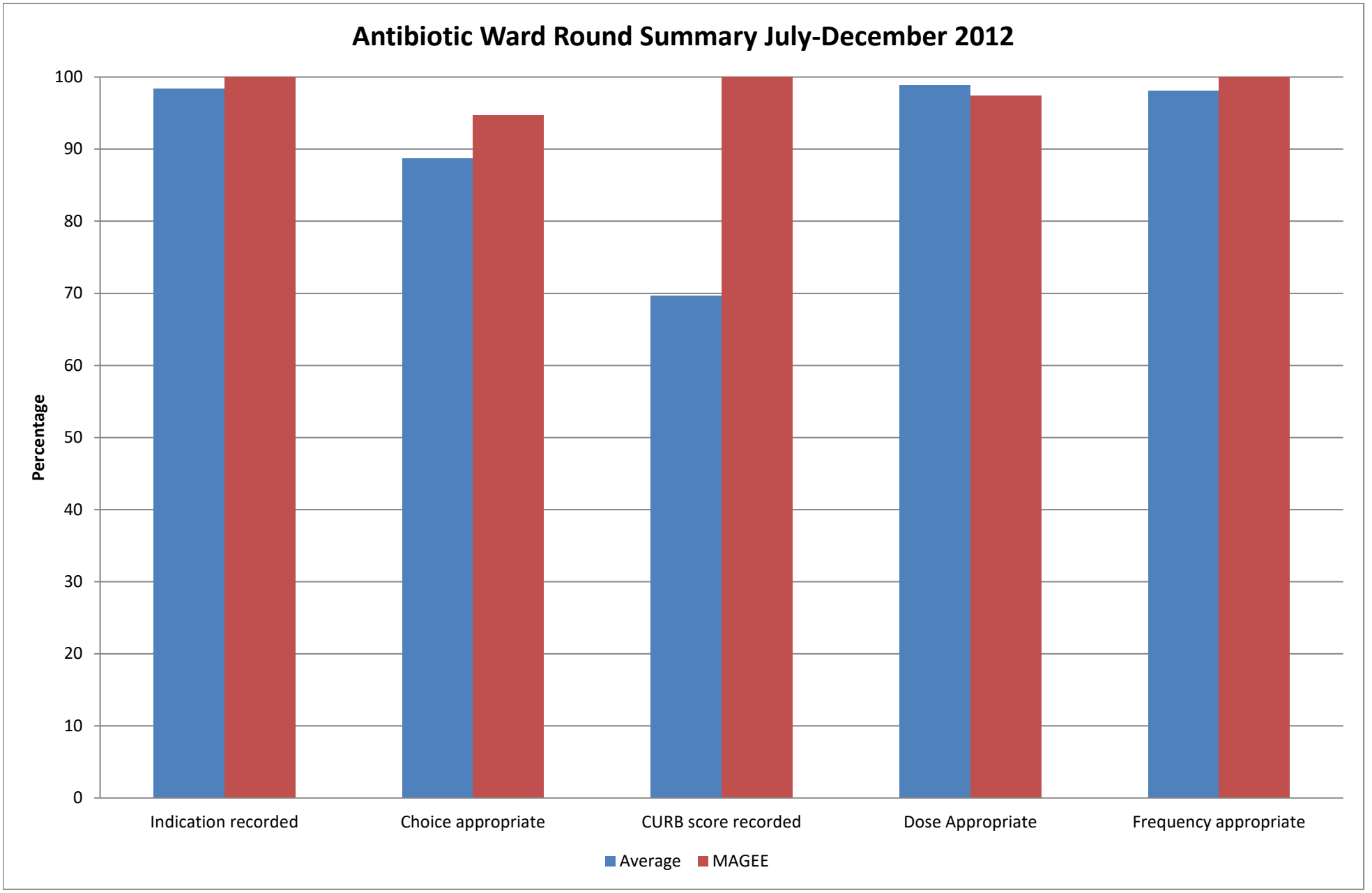
- Dr S Murphy: 29 patients, CURB score appropriate for 5 patients, **recorded in 4**.
    - **Choice** inappropriate in 1 patient.

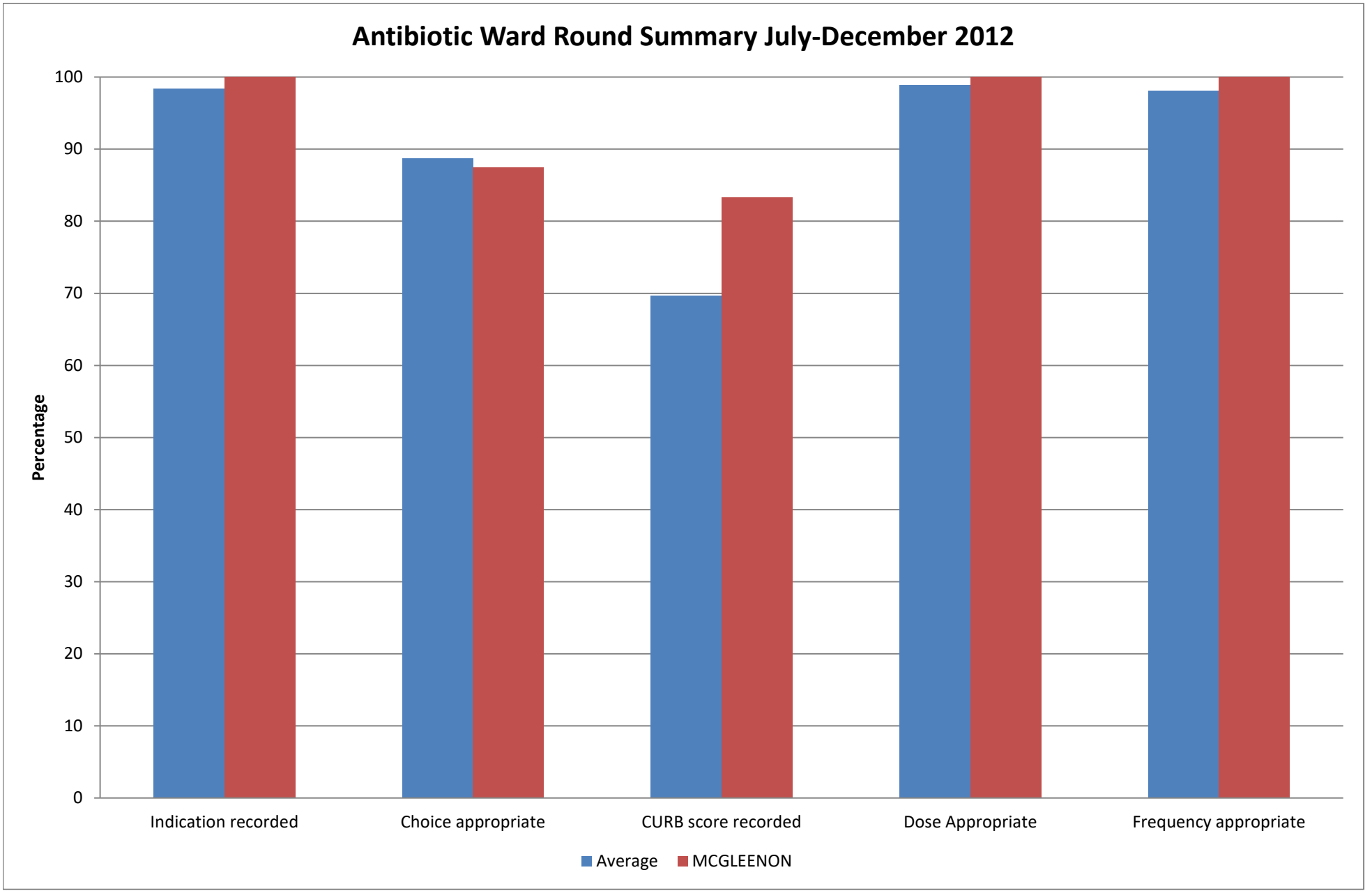


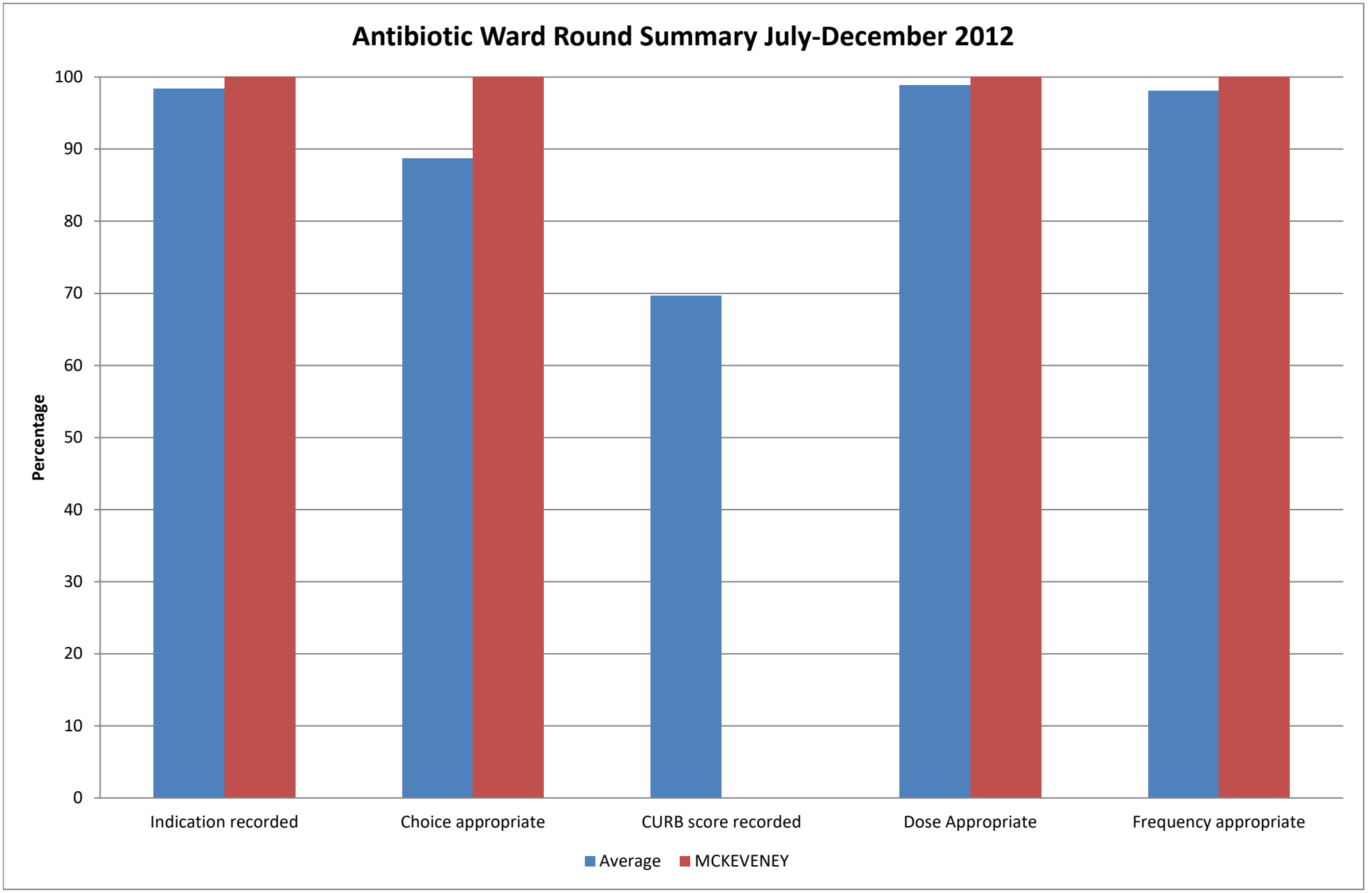


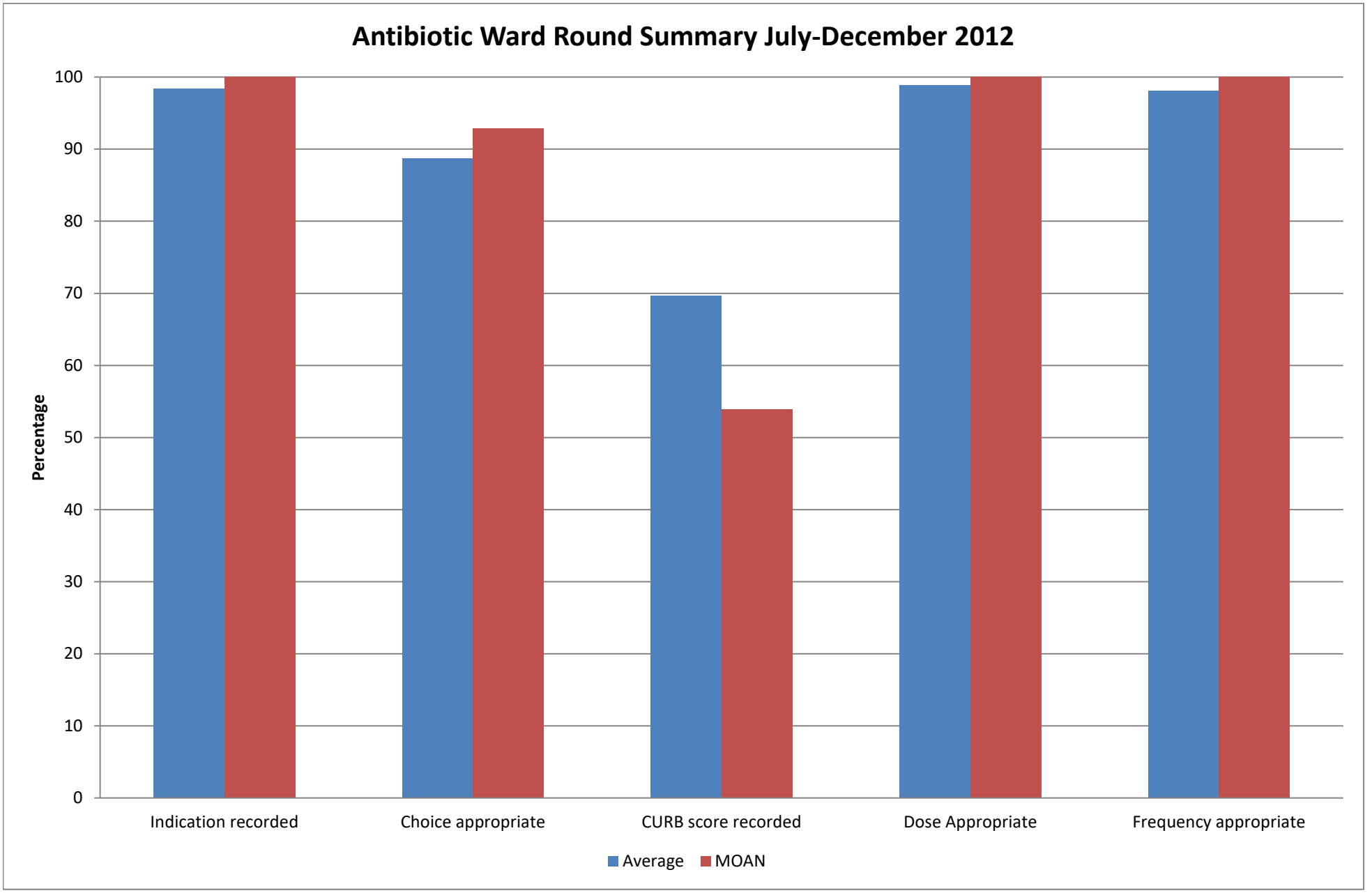


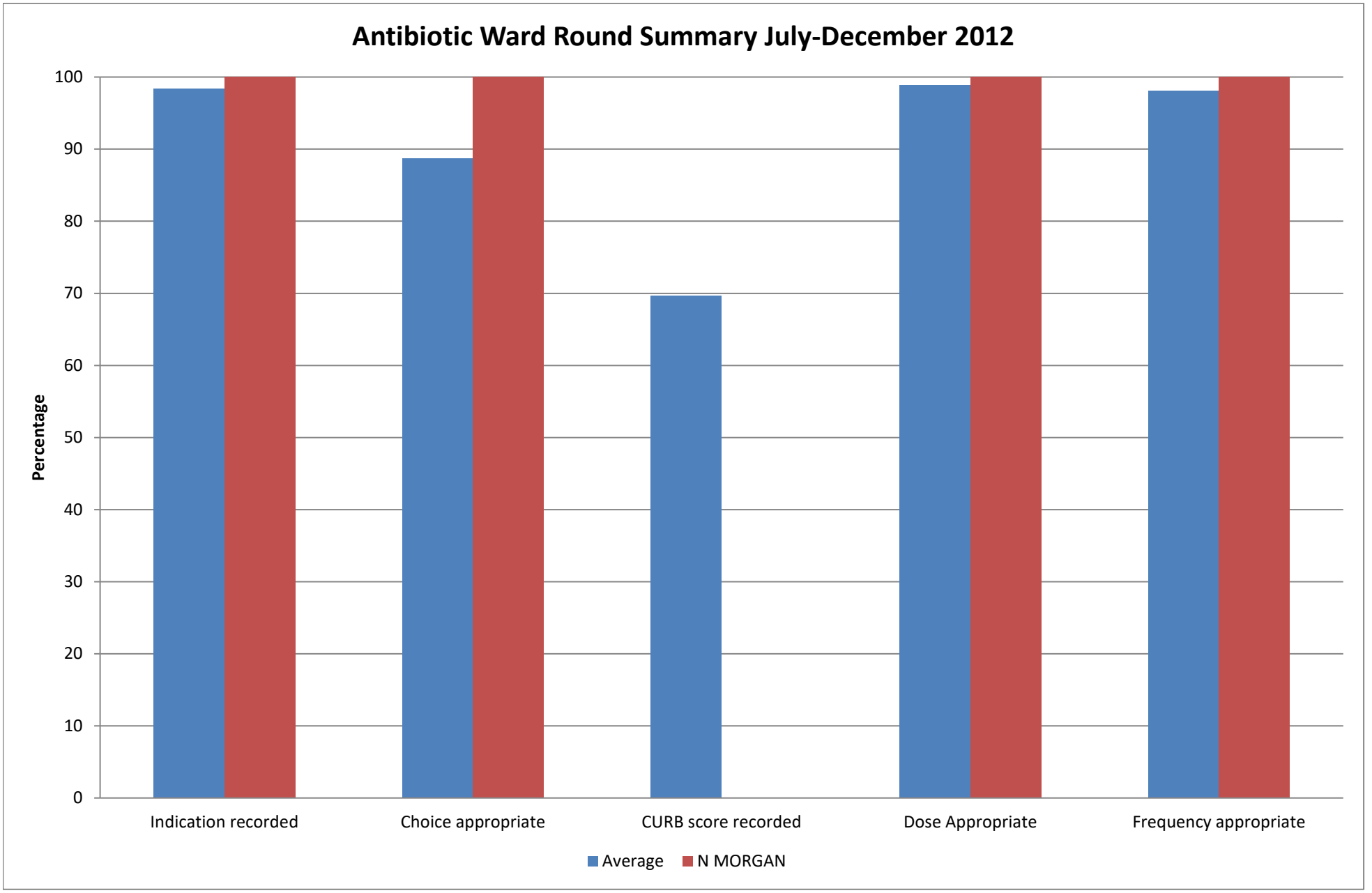


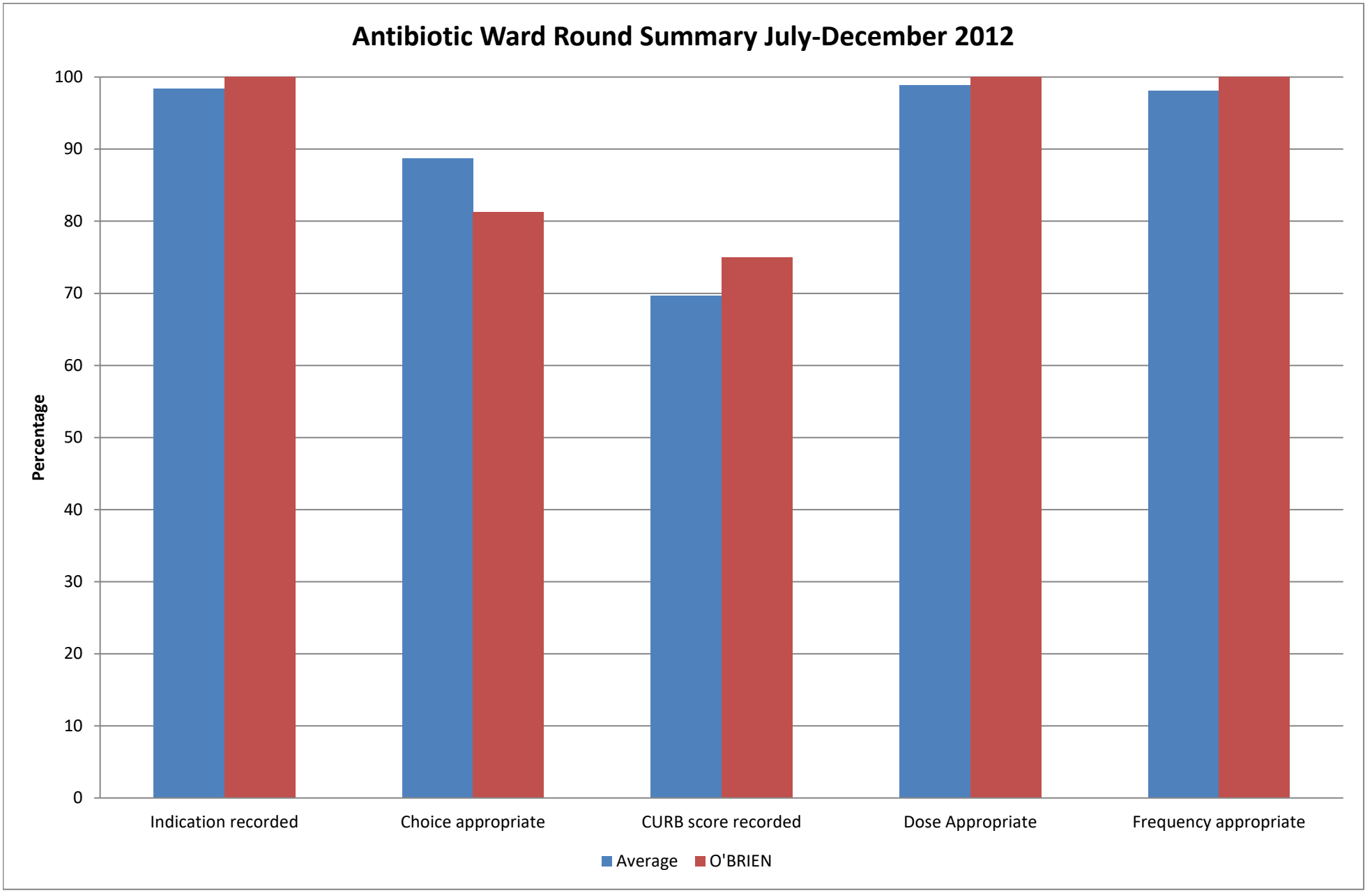


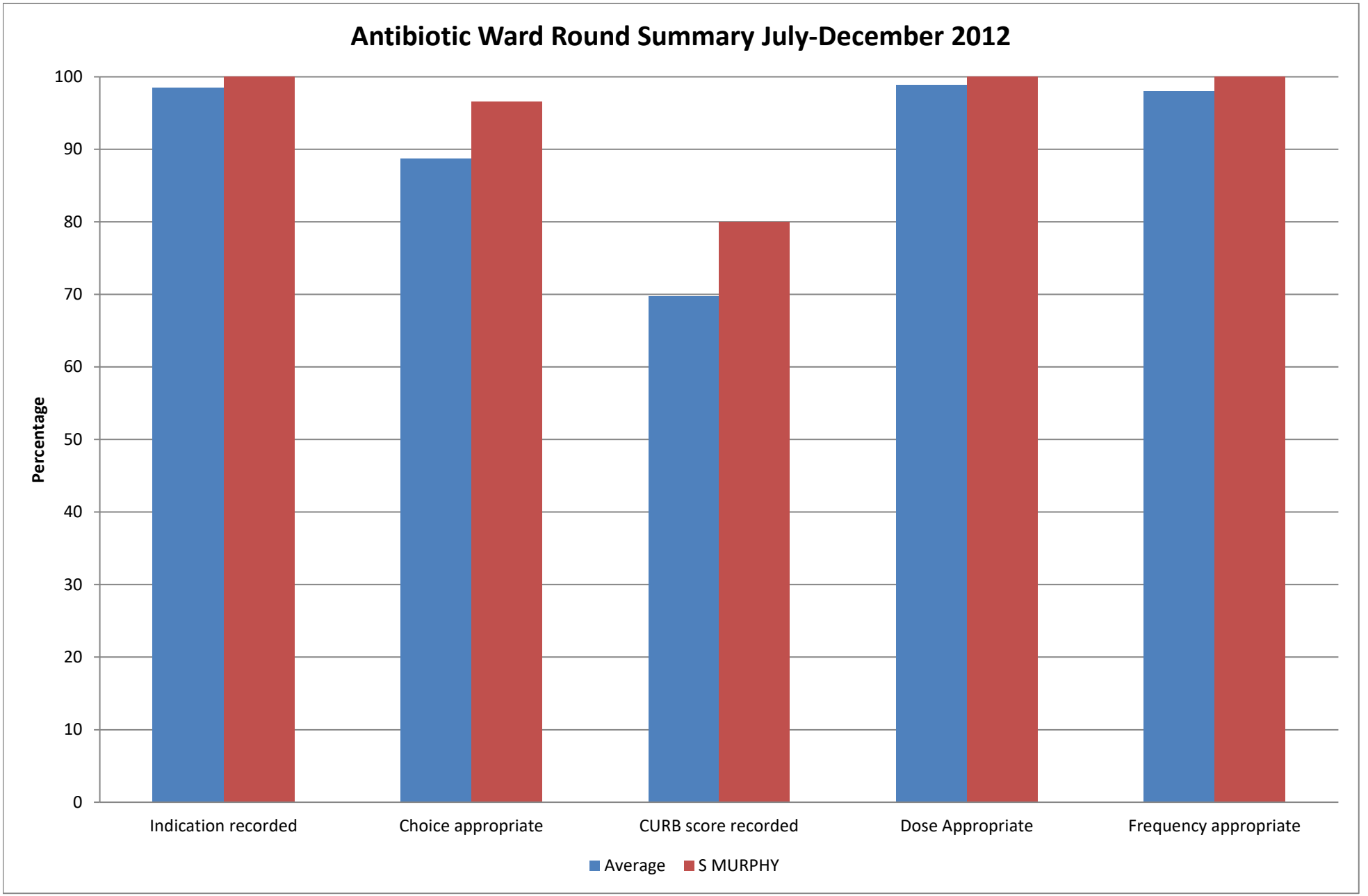












Aimee Crilly

Subject: FW: feb 13 provisional
Attachments: FEB 13.xls

-----Original Message-----
From: Michael Young <Personal Information redacted by the USI>
Sent: 06 January 2013 21:47
To: O'Brien, Aidan <Personal Information redacted by the USI>; aidano'brien <Personal Information redacted by the USI>; ajay_pahuja <Personal Information redacted by the USI>; aglackin <Personal Information redacted by the USI>; djconn <Personal Information redacted by the USI>
Cc: Dignam, Paulette <Personal Information redacted by the USI>
Subject: feb 13 provisional

provisional rota = filled in but I suspect others may have leave = some manipulation possible

MY

Paulette can you send this round the juniors Any junior picking up on the locum nights - please pass by me first with their requests

UROLOGY ROTA

FEBRUARY 2013

		Consultant	Registrar	daycover	
Fri	1	**Pahuja**	Locum	Tyson	Tyson
Sat	2	**Pahuja**	Tyson		
Sun	3	**Pahuja**	Tyson	Tyson	Tyson
Mon	4	**Pahuja**	Hirron	Hirron F	Hirron F
Tues	5	**Pahuja**	Hennessey	Hennessey	Hennessey
Weds	6	**Pahuja**	Tyson	Hirron F	Hirron F
Thurs	7	**Pahuja**	Maurice Fernando	Maurice	Hennessey
Fri	8	**O'Brien**	Locum		
Sat	9	**O'Brien**	Maurice Fernando		
Sun	10	**O'Brien**	Maurice Fernando	Tyson	Tyson
Mon	11	**O'Brien**	Hirron	Maurice	Maurice
Tues	12	**O'Brien**	Hennessey	Hennessey	Hennessey
Weds	13	**O'Brien**	Tyson	Hirron	Hirron
Thurs	14	**O'Brien**	Maurice Fernando	Maurice	Hennessey
Fri	15	**Glackin**	Locum		
Sat	16	**Glackin**	Hirron		
Sun	17	**Glackin**	Hirron	Tyson	Tyson
Mon	18	**Glackin**	Locum	Hirron F	Hirron F
Tues	19	**Glackin**	Hennessey	Hennessey	Hennessey
Weds	20	**Glackin**	Tyson	Hirron F	Maurice
Thurs	21	**Glackin**	Maurice Fernando	Maurice	Tyson
Fri	22	**Young**	Hirron		
Sat	23	**Young**	Locum		
Sun	24	**Young**	Locum	Hennessey	Hennessey
Mon	25	**Young**	Hirron	Maurice	Maurice
Tues	26	**Young**	Hennessey	Hennessey	Hennessey
Weds	27	**Young**	Tyson	Hirron	Hirron
Thurs	28	**Young**	Maurice Fernando		

	Annual	Study
Young	4 = 8	
O'Brien		
Glackin		
Connolly	4=5, 18=24	
Pahuja		
Hennessey		
Tyson	25 = 28	
Hirron		
Maurice		

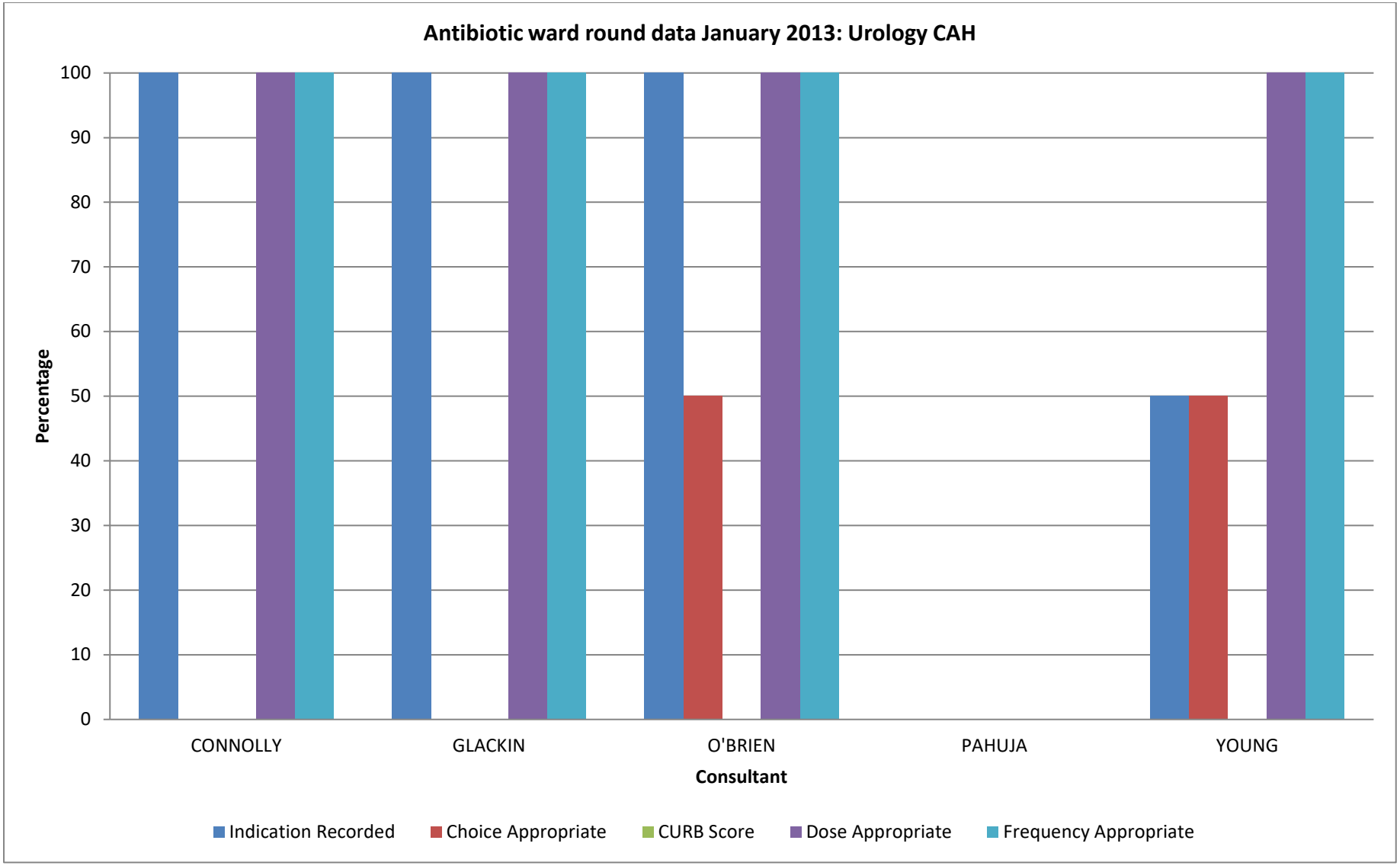
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Rankin, Gillian; Damani, Nizam; Boyce, Tracey
Subject:	For info: Antibiotic Ward round summary
Date:	01 February 2013 14:25:47
Attachments:	January summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for January.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 11th January
6/19 patients on antibiotics

- Connolly: 1 patient. CURB score n/a.
    - **Choice inappropriate in 1 patient:**
        - 1 pt on IV co-amoxiclav 1.2g TID post op, no documented evidence of infection.

- Glackin: 1 patient. CURB score n/a.
    - **Choice inappropriate in 1 patient:**
        - 1 pt on PO co-amoxiclav 625mg TID post op, no documented evidence of infection.

- O'Brien: 2 patients. CURB score n/a.
    - **Choice inappropriate in 1 patient:**
        - 1 pt on IV benzylpenicillin 1.8g BD for post op infection, IV gentamicin recommended.

- Pahuja: No patients.

- Young: 2 patients. CURB score n/a.
    - **No indication documented and choice inappropriate in 1 patient:**
        - 1 pt on PO co-amoxiclav 625mg TID, no documented indication or evidence of infection.

Aimee Crilly

Subject: FW: Mr O'Brien PTL still needing dates for end of March
Attachments: UROLOGY IP-DC PTL - 21 WKS BY 31-03-13 (POSITION AS AT 22-02-13).xlsx

From: Corrigan, Martina <Personal Information redacted by the USI
Sent: 27 February 2013 15:25
To: O'Brien, Aidan <Personal Information redacted by the USI>
Cc: McCorry, Monica <Personal Information redacted by the USI>
Subject: FW: Mr O'Brien PTL still needing dates for end of March

<<UROLOGY IP-DC PTL - 21 WKS BY 31-03-13 (POSITION AS AT 22-02-13).xlsx>> Dear Aidan

Please see attached updated PTL that we are still being monitored against. I was talking to David and Ajay this morning and they both advise that they have room on their lists for some of these patients if you would be kind enough to have a look at these and pass to them please.

Many thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Admission Reason	Casenote	Consultant Name	Original Date	Date Booked	Actual Weeks Waiting (Round
RESITING OF UROSTOMY	Personal Information redacted by the USI	O'Brien A Mr	08/11/2011		67.42857143
URETHROTOMY/URETHROPLASTY		O'Brien A Mr	04/02/2012		54.85714286
LEFT SELECTIVE RENAL EMBOLISATION		O'Brien A Mr	07/02/2012		54.42857143
BLADDER DIVERTICULECTOMY (WARFARIN)		O'Brien A Mr	13/02/2012		53.57142857
CIRCUMCISION		O'Brien A Mr	14/03/2012		49.28571429
RIGHT ? BILATERAL ORCHIDOPEXY GA		O'Brien A Mr	14/03/2012		49.28571429
RIGHT ORCHIOPEXY		O'Brien A Mr	27/03/2012		47.42857143
LEFT URETEROGRAPHY URETEROSCOPY ? f		O'Brien A Mr	03/04/2012		46.42857143
CIRCUMCISION		O'Brien A Mr	30/04/2012		42.57142857
RIGHT ORCHIDOPEXY GA		O'Brien A Mr	08/05/2012		41.42857143
RIGHT INGUINAL HERNIORRHAPHY DAY CAS		O'Brien A Mr	08/05/2012		41.42857143
TURP		O'Brien A Mr	15/06/2012		36
CYSTOSCOPY ? BLADDER NECK INCISION OR		O'Brien A Mr	15/06/2012		36
BLADDER NECK INCISION/TURP		O'Brien A Mr	25/06/2012		34.57142857
TURP		O'Brien A Mr	26/06/2012		34.42857143
DIVISION PREPUTIAL ADHESIONS ? CIRCUMC		O'Brien A Mr	27/06/2012		34.28571429
CIRCUMCISION		O'Brien A Mr	27/06/2012		34.28571429
GA CYSTOSCOPY AND RETROGRADE STUDIE		O'Brien A Mr	28/06/2012		34.14285714
ORCHIDOPEXY		O'Brien A Mr	14/08/2012		27.42857143
TURP/BLADDER NECK INCISION (BEFORE BE		O'Brien A Mr	17/08/2012		27
INTRADETRUSOR INJECTION OF BOTULINUM		O'Brien A Mr	31/08/2012		25
TURP GA		O'Brien A Mr	04/09/2012		24.42857143
CIRCUMCISION GA		O'Brien A Mr	04/09/2012		24.42857143
TURP		O'Brien A Mr	11/09/2012		23.42857143
RIGHT ORCHIDOPEXY GA		O'Brien A Mr	11/09/2012		23.42857143
VASECTOMY (DIABETES)		O'Brien A Mr	11/09/2012		23.42857143
CYSTOSCOPY AND HYDROSTATIC DILATATIO		O'Brien A Mr	11/09/2012		23.42857143
TURP		O'Brien A Mr	11/09/2012		23.42857143
BILATERAL ORCHIOPEXY		O'Brien A Mr	12/09/2012		23.28571429
REMOVAL OF URETERIC STENTS AND BILATE		O'Brien A Mr	13/09/2012		23.14285714
TURP AND?TURBT AFTER CHRISTMAS 2012 P		O'Brien A Mr	14/09/2012		23
HYDROSTATIC DILATATION OF BLADDER		O'Brien A Mr	14/09/2012		23
TURP Would prefer to be called January 2013		O'Brien A Mr	15/09/2012		22.85714286
TURP		O'Brien A Mr	15/09/2012		22.85714286
TURP		O'Brien A Mr	15/09/2012		22.85714286
RIGHT URETEROSCOPY		O'Brien A Mr	25/09/2012		21.42857143
CYSTOSCOPY AND MCUG		O'Brien A Mr	27/09/2012		21.14285714
FLEXIBLE CYSTOSOCPY PT REQUESTS ANAE		O'Brien A Mr	28/09/2012		21

TURP	O'Brien A Mr	28/09/2012	21
RIGHT HYDROCELE REPAIR	O'Brien A Mr	28/09/2012	21
INTRADETRUSOR INJECTION OF BOTULINUM T	O'Brien A Mr	29/09/2012	20.85714286

Personal Information redacted by the USI

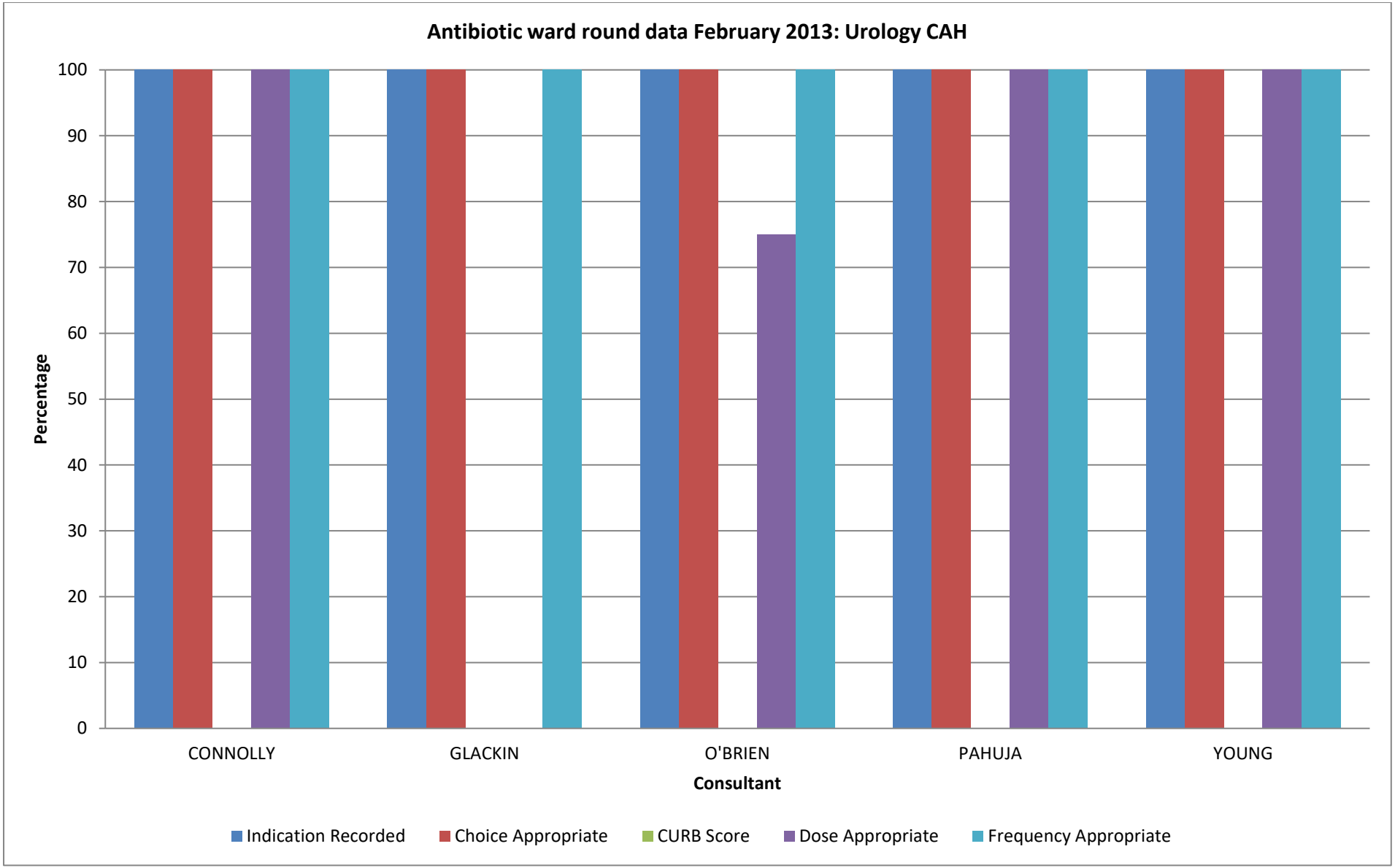
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Rankin, Gillian; Damani, Nizam; Boyce, Tracey; Muckian, Donna
Subject:	RE: For info: Antibiotic Ward round summary
Date:	28 February 2013 11:24:08
Attachments:	February summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for February.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 8th & 22nd February
14/34 patients on antibiotics

- Connolly: 1 patient. CURB score n/a.

- Glackin: 1 patient. CURB score n/a.
    - **Dose inappropriate in 1 patient:**
        - 1 pt on PO trimethoprim 200mg BD for UTI, eGFR 11, 100mg BD recommended.

- O'Brien: 4 patients. CURB score n/a.
    - **Dose inappropriate in 1 patient:**
        - 1 pt on PO fluconazole 50mg OD for treatment of fungal UTI, treatment dose of 400mg OD recommended if patient symptomatic and requiring treatment.

- Pahuja: 4 patients. CURB score n/a.

- Young: 4 patients. CURB score n/a.

From: Corrigan, Martina
To: (Aidanpobrien Personal Information ; (Personal Information redacted by the USI); AJay Pahuja (Personal Information redacted by the USI); Glackin, Anthony; Young, Michael; O"Brien, Aidan; Tony Glackin (Personal Information redacted by the USI)
Cc: Brown, Robin; Trouton, Heather; Mackle, Eamon
Subject: Urology team Job Plans
Date: 05 March 2013 14:51:11
Importance: High

Dear all

I have spoken with Robin this morning and in order to finalise and get sign-off for the job plans, I have included below the clinic templates as agreed with the Health and Social Care Board (HSCB) in order to meet the activity that is required to meet our Service Budget Agreements (SBA).

We have organised a meeting tomorrow on the Admin Floor with Robin, Michael, Heather and I to discuss these job plans and it would be good if any of the rest of you are available if you can attend, although I do appreciate your other clinical commitments.

I would be grateful if you could look at the assumptions below and advise me of any comments that you may have before tomorrow as it is important that once we sign off the job plans I will be setting up the clinics to see these volumes of patients.

ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE AGREED ACTIVITY

Stone Treatment clinics will be setup to see 6 New and 11 Review – there will be 1.5 clinics per week

Outreach (SWAH/STH/DHH/BAN/ARM) will be set up to see 5 New and 7 Review - there will be 2 outreach clinics per week

General at CAH will be set up to see 6 New and 8 Review which will mean PM clinic starting at 1:30pm - there will be 3 general clinic per week.

Oncology will be set up to see 3 red Flag and 4 Protective Review and 4 uro-oncology review – there will be 3.75 of these per week

D4 Clinics will be set up to see 4 patients (protective review) – there will be 1 of these per week

Prostate D1 will be set up to see 8 red flags and 2 News and there will be 1 of these per week

Inpatients – it is assumed that there will be 3 on a four hour session

Daycases – we have agreed 10 flexible cystoscopies on a list and 5 patients on a daycase list.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

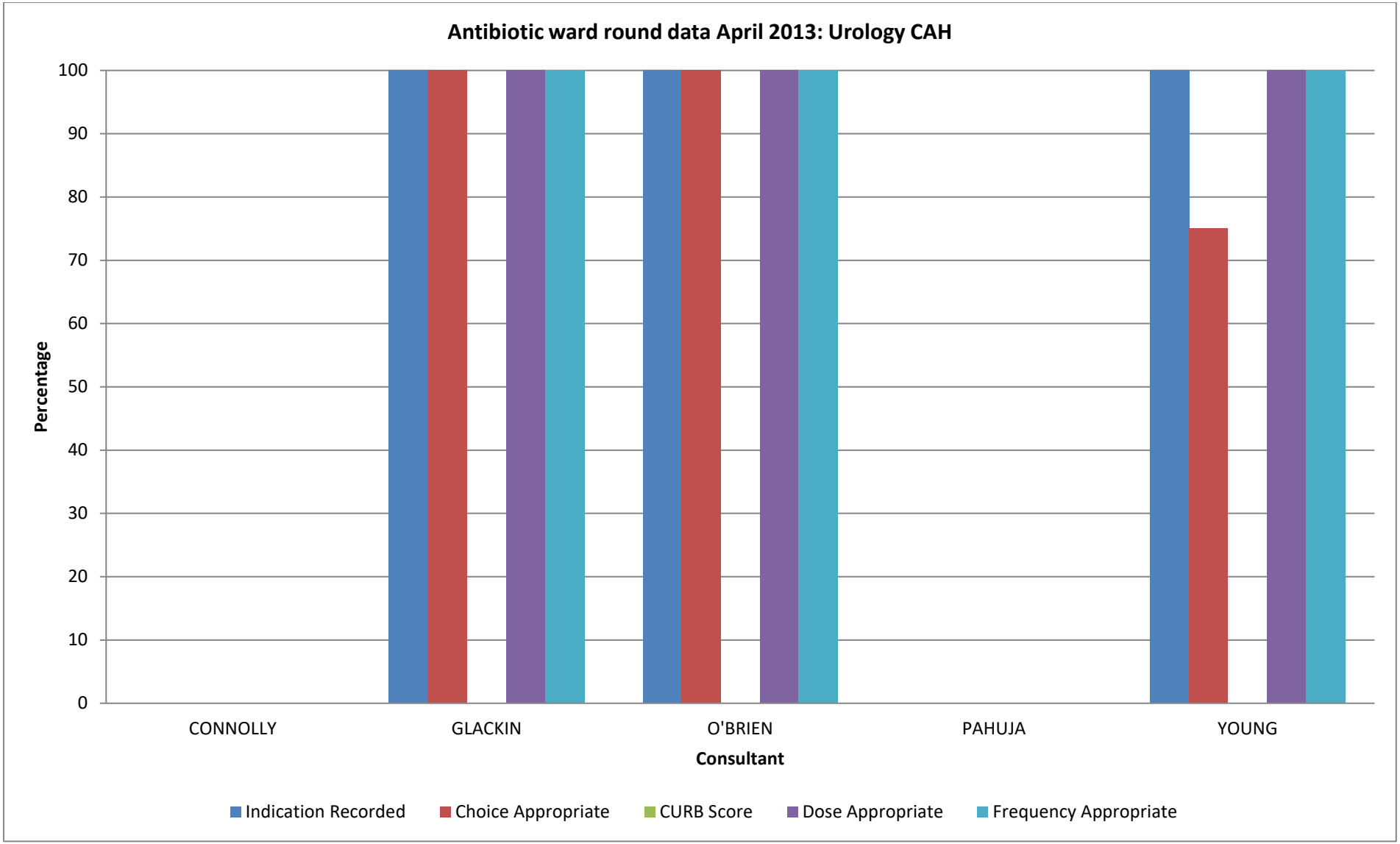
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Burns, Deborah; Damani, Nizam; Boyce, Tracey; Muckian, Donna
Subject:	For info: Antibiotic Ward round summary
Date:	03 May 2013 12:38:57
Attachments:	April summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for April.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 19th & 30th April.
10/25 patients on antibiotics

- Connolly: No patients.
- Glackin: 5 patients. CURB score n/a.
- O'Brien: 1 patient. CURB score n/a.
- Pahuja: No patients.
- Young: 4 patients. CURB score n/a.
    - **Choice non-compliant in 1 patient:**
        - 1pt on IV tazocin 4.5g TID + IV gentamicin + PO ciprofloxacin 500mg BD for UTI with kidney stones, patient on PO ciprofloxacin preadmission, not required while on IV tazocin & gentamicin.

Aimee Crilly

From: Corrigan, Martina <[redacted]
Sent: 13 May 2013 08:32
To: O'Brien, Aidan
Cc: McCorry, Monica
Subject: FW: Datix Incident Report Number W[redacted]

Importance: High

Dear Aidan,

Are you aware of this issue which I see was on Saturday. I will have to give a response to this IR1 and I would be grateful if you could advise.

Thanks

Martina

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

Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

-----Original Message-----
From: Nelson, Amie
Sent: 13 May 2013 08:24
To: Corrigan, Martina
Subject: FW: Datix Incident Report Number W[redacted]

fyi

-----Original Message-----
From: datix[redacted] [mailto:[redacted]
Sent: 11 May 2013 15:58
To: Nelson, Amie
Subject: Datix Incident Report Number [redacted]

An incident report has been submitted via the DATIX web form.

The details are:

Form number: [redacted]

Description:

after checking in apatient on the urology list I discovered she had no consent .her proceedure was discussed and patient confirmed the proceedure she was having was the same proceedure noted on the theatre list . Mr OBrien was to consent the patient in the anaesthetic room but as we walked down the corridor someone opened the main theatre doors said we were ready suggesting bringing the patient into theatre and i forgot the patient at that stage hadnt been formally consented .I was not the

anaesthetic nurse that day but one patient had to go to recovery as this patient arrived at theatre so I checked the patient in . lack of consent highlighted just as patient was having her anaesthetic .

Please go to http://vsrdatixweb/Datix/Development/index.php?action=incident&recordid=1 Personal information redacted by USI to view and approve it.

Southern Health and Social Care Trust

28 May 2013 **Our Ref:** AS64.13/14 **Your Ref:**

Private & Confidential

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

I refer to your complaint in respect of concerns raised by Mr Personal Information redacted by the USI in relation to the timeliness of his treatment plan. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

I have spoken with Mr O'Brien, Consultant Urologist regarding this patient. Mr Personal Information redacted by the had his original procedure on 19 April 2013 and his pathology came back to say that he has confirmed cancer. Mr Personal Information redacted by the USI was discussed at the urology Multi-Disciplinary Meeting on 2 May 2013 between the Southern and Belfast Trusts and they agreed that Mr Personal Information redacted by the required to have a Cystectomy which the Southern Trust no longer undertake following a Regional Urology Review led by commissioners when it was agreed that all major Pelvic Surgery was moved to Belfast City Hospital. An InterTrust Transferral (ITT) was completed on this same date and was sent through to Belfast. Mr O'Brien confirms that Mr Personal Information redacted by the USI has been sent out an outpatient appointment to see Mr Keane in Belfast City Hospital on Thursday 23 May 2013.

All of this was explained to the family when they have been in contact with Mr O'Brien's secretary. Even though Mr Personal Information redacted by the USI is now a patient with Belfast Trust Mr O'Brien agreed to see Mr Personal Information redacted by the USI last Friday 17 May 2013 so as to explain why he had been referred to Belfast and what the pathway would be from now on. Mr O'Brien advises that he has explained all of this again at the appointment with Mr Personal Information redacted by the USI and his family.

I trust that this letter addresses the issues you have raised.

If however you remain unhappy please do not hesitate to contact a member of the Clinical and Social Care Governance Team on Personal Information redacted by the USI who will discuss the options available to you.

Your Personal Information redacted by the USI

MRS DEBORAH BURNS
Interim Director of Acute Services
for Mairead McAlinden, Chief Executive

Clinical and Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by the USI

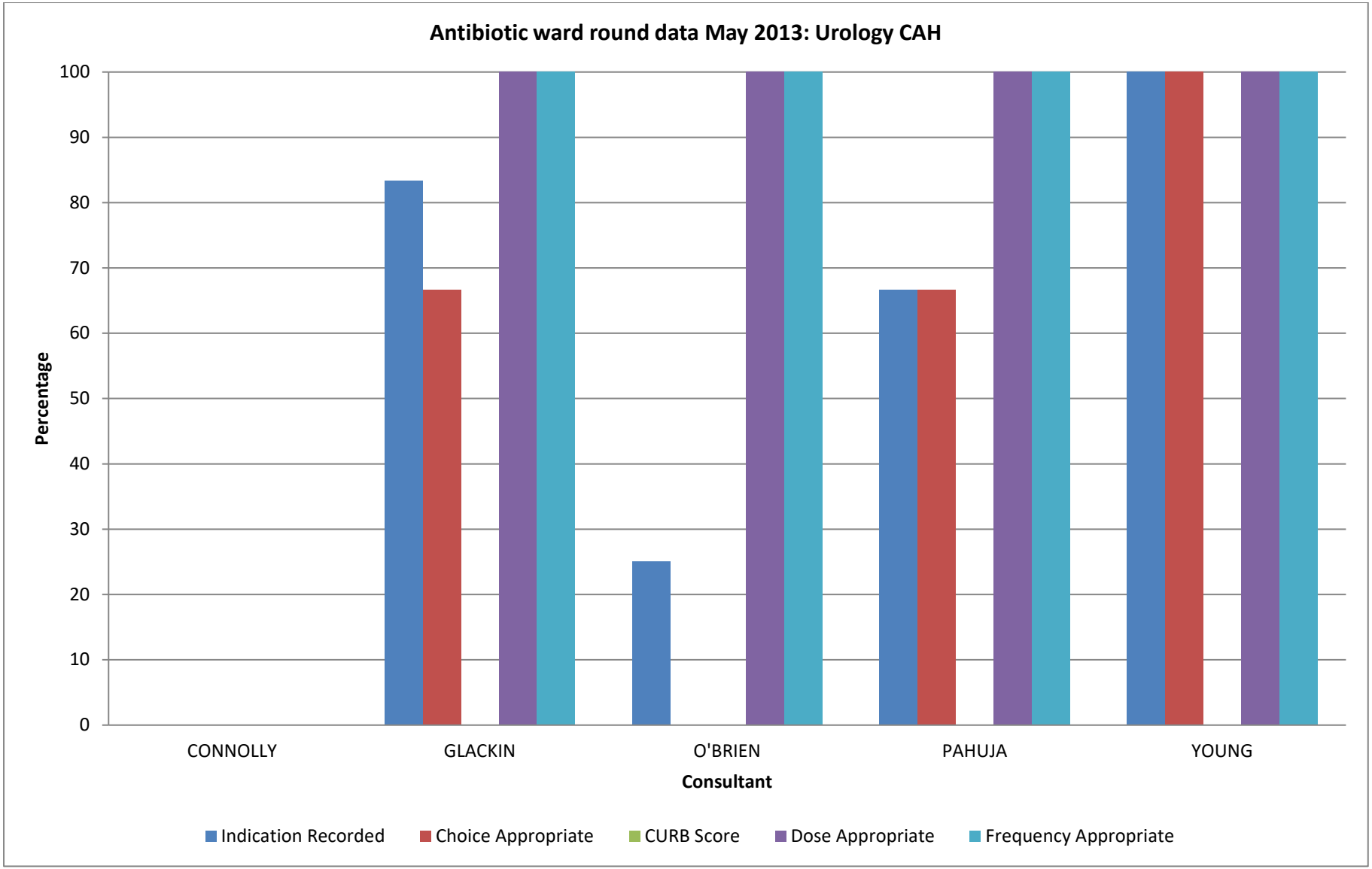
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Trouton, Heather; Damani, Nizam; Boyce, Tracey; Muckian, Donna; Collins, Cathal
Subject:	For info: Antibiotic Ward round summary
Date:	04 June 2013 12:54:00
Attachments:	May summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for May.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 17th & 28th May.
17/29 patients on antibiotics

- Connolly: No patients.

- Glackin: 6 patients. CURB score n/a.
    - **Indication not recorded and compliance not assessable in 1pt:**
        - 1pt on PO co-amoxiclav 625mg TID, no documentation of antibiotics in notes, no documented evidence of infection.
    - **Choice non-compliant in 1 patient:**
        - 1pt on PO nitrofurantoin 100mg QID + IV aztreonam 2g TID for urosepsis, PO nitrofurantoin not required.

- O'Brien: 4 patients. CURB score n/a.
    - **Indication not recorded and compliance not assessable in 3pts:**
        - 1pt on IV benzylpenicillin 1.2g BD, no documentation of antibiotics in notes, no documented evidence of infection.
        - 1pt on PO amoxicillin 500mg TID, no documentation of antibiotics in notes, no documented evidence of infection.
        - 1pt on IV tazocin 4.5g BD, no documentation of antibiotics in notes, no documented evidence of infection.
    - **Choice non-compliant in 1 patient:**
        - 1pt on IV gentamicin, admitted for IV fluids & antibiotics, no documented evidence of infection (note: most recent MSSU resistant to gentamicin).

- Pahuja: 3 patients. CURB score n/a.
    - **Indication not recorded and compliance not assessable in 1pt:**
        - 1pt on IV tazocin 4.5g TID, no documentation of antibiotics in notes, no documented evidence of infection.

- Young: 4 patients. CURB score n/a.

From: Feely, Roisin

To: - Dobbin Street, Community OT; adrian.east Personal Information redacted by the USI Ahmad, Munir; ahmedfaraz.khar Personal Information redacted by the USI Arava, Shiva; artohagan Personal Information redacted by the USI ; Bradley, Una; Brazil, Dr R; Browne, Gail; Campbell, Alastair; CreweBrown, Heather; Currie, Aoife; Daly, Cathy; Eltayeb, Mohamed; Farnan, Turlough; Hampton, Gareth; Hayes, Elaine; Hinds, John; Holmes, Erskine; Hull, Don; Hurreiz, Hisham; John, Alexander; Jones, Frank; juliem.anderson Personal Information redacted by the USI ; Kamath, Meeta; Kerr, Paul P; Korda, Marian; Kumar, Devendra; Lee, Jeff; Leyden, Peter; Lichnovsky, Erik; Liggett, Nathaniel; Loane, Katharine; Lowry, Darrell; Mackle, Eamon; Magee, Glynis; Martin, Laure; Mathers, Rachel; McCaffrey, Patricia; McClure, Mark; McConaghy, Paul; McConnell, Mae; McCusker, Grainne; McEneaney, David; McFall, Brendan; McGalie, Clare; McGarry, Paul; McGleenon, Bronagh; McGucken, Paul; McKay, Damian; McKeown, Gillian; McKnight, Karen; McMurray, David; McNaboe, Ted; McParland, Michael; Menown, Ian; Merjavy, Peter; Milligan, Aaron; Minay, Joanne; Morgan, David; Morgan, Neal; Morrow, Michael; Murdock, Andrew; Murnaghan, Mark; Neill, Adrian; Nicholl, Hilda; noelmcc Personal Information redacted by the USI o.morris Personal Information redacted by the USI ; O"Brien, Aidan; OConnor, Kieran; O"Hare, John; O"Reilly, Seamus; Orr, Des; O"Toole, Conor; Panuja, Ajay; Parks, Lorraine; Patton, Sean; peter.becket Personal Information redacted by the USI ; Phillips, Victoria; Polley, Liam; Quinn, Phil; Rafferty, Claire; Rea, Margaret; Reddy, Ekambar; Rice, Paul; Rutherford-Jones, Neville; Scullion, Damian; Shah, Rajeev; Shah, Shilpa; Sharpe, Peter; Sidhu, Harmini; Smew, Mansour; Sobocinski, Dr Jacek; Spedding, Ruth; stephanie.walker Personal Information redacted by the USI sulahmed Personal Information redacted by the USI ; Syme-Grant, Nicola; Thompson, Sam; Twaij, Suhair; Weir, Colin; Williams, Marian; Winter, Colin; Yarr, Dr Julie

Cc: Harty, John; Forbes, Raeburn; McKay, Damian; Sidhu, Harmini; DeCourcyWheeler, Richard; Grier, David; Aljarad, Bassam; Burns, Deborah; Crilly, Miceal; Morgan, Paul; Angela McVeigh; McVey, Anne; Carroll, Ronan; Gibson, Simon; Conway, Barry; Trouton, Heather; Carroll, Anita; Marshall, Margaret; Reid, Cathrine; Black, Tony; Johnston, Daphne; Parks, Zoe; Forde, Helen; QUINN, Anne M; Maguire, Geraldine; Boyce, Tracey; Chada, Neta; Damani, Nizam; Hall, Stephen; Hogan, Martina; Khan, Ahmed; McAllister, Charlie; Murphy, Philip; Brown, Robin; Cassidy, Lisheen; Convery, Rory; Epanomeritakis, Manos; Fawzy, Mohamed; Hall, Sam; Hughes, James; McGuinness, Dr Joan; McMahon, Dr; OBrien, Charles; Sim, David

Subject: FW: Re-launch of M & M Process

Date: 02 July 2013 16:51:00

Attachments: MMs memo_revised01july2013.pdf

Please find attached memo sent on behalf of Dr J Simpson.

Roisin

Roisin Feely
Medical Directorate Office
Clanrye House
Daisy Hill Hospital
(: Personal Information redacted by the USI / DHH Ext. Personal Information redacted by the USI
8: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

By email Memorandum

To: All Medical Staff

Cc: Associate Medical Directors / Clinical Directors / Chairs of M&Ms, Operational Directors, Assistant Directors & Heads of Services Acute, Non Acute Hospitals, CYP, Mrs M Marshall, Mrs C Reid, Mr T Black, Mrs D Johnston, Mrs Z Parks, Mrs H Forde, Mrs A Quinn, Effectiveness & Evaluation Manager

From: Dr J Simpson, Medical Director

Date: 01st July 2013

Subject **Re-launch of M & M Process**

Involvement in M&M meetings is one of the key activities that a doctor must engage in to assure patients that he/she is safe to practice. There is a responsibility on all of us not just to attend, but to actively participate and further develop a system that is more meaningful and produces outputs which improve patient outcomes. M&M meetings have made significant progress in that respect of late.

Enhancing the multidisciplinary input, as well as including the patient experience, will make the process more meaningful. M&M chairs will be inviting relevant nursing colleagues to the meetings to bring the nursing perspective and, where possible, the patient experience.

To improve patient outcomes the output from M&Ms will need to be more formally structured:

- learning points should directly link to our organisational education systems
- issues which require further investigation should determine topics for audit activity
- identification of action points to drive system-wide improvements.

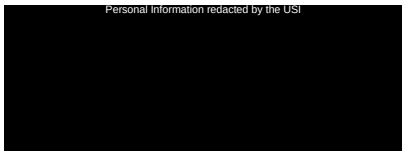
It is therefore imperative that our M&M meetings are brought together in a systematic way across the Trust. After lengthy discussions with medical and operational leads the Trust has decided to move all M&M meetings to a rolling audit calendar from September. The “surgical” and IMWH meetings are already held on these rolling audit dates. Medical M&Ms (CAH and DHH) and the cross-site paediatric M&M will now move to the rolling audit dates effective from September 2013. The Non Acute Hospitals will continue to participate in the Medical M&M on the CAH site

This shift to the rolling audit calendar will ensure there will now be cross-specialty clinical discussion at each of the monthly M&Ms e.g. ED, Diagnostics (including Labs), Paediatrics, Anaesthetics/ICU.

I would also wish to clarify that attendance at M&M is included as part of the weekly SPA personal allowance to each Consultant. An attendance rate of 66% is deemed the minimum accepted level for appraisal/revalidation (less than that will be acceptable if a reasonable explanation is put forward at the appraisal meeting). All doctors will be required to complete a structured reflective template to demonstrate how M&M has influenced their practice.

Junior doctors are expected to attend M&M as part of their on-going postgraduate training. Clinical Supervisors should ensure that their junior doctors are rostered to attend M&M meetings. Junior doctor attendance at the monthly M&M should then be monitored by the Educational Supervisors.

Thank you for your co-operation in implementing these revised arrangements. A separate correspondence for those doctors directly impacted by the revised dates will be issued.



Dr J Simpson
Medical Director

Enc:
Rolling audit calendar 2013/14

Southern Health and Social Care Trust

Quality Care - for you, with you

Monthly Rolling Audit Calendar 2013 - 2014

Month	Date	Year	Time	Day
JANUARY	15th	2013	PM	TUESDAY
FEBRUARY	20th	2013	AM	WEDNESDAY
MARCH	20th	2013	PM	WEDNESDAY
APRIL	18th	2013	AM	THURSDAY
MAY	16th	2013	PM	THURSDAY
JUNE	21st	2013	AM	FRIDAY
JULY	19th	2013	PM	FRIDAY
AUGUST	20th	2013	AM	TUESDAY
SEPTEMBER	17th	2013	PM	TUESDAY
OCTOBER	16th	2013	AM	WEDNESDAY
NOVEMBER	20th	2013	PM	WEDNESDAY
DECEMBER	19th	2013	AM	THURSDAY

Month	Date	Year	Time	Day
JANUARY	16th	2014	PM	THURSDAY
FEBRUARY	21st	2014	AM	FRIDAY
MARCH	21st	2014	PM	FRIDAY
APRIL	15th	2014	AM	TUESDAY
MAY	20th	2014	PM	TUESDAY
JUNE	18th	2014	AM	WEDNESDAY
JULY	16th	2014	PM	WEDNESDAY
AUGUST	21st	2014	AM	THURSDAY
SEPTEMBER	18th	2014	PM	THURSDAY
OCTOBER	17th	2014	AM	FRIDAY
NOVEMBER	21st	2014	PM	FRIDAY
DECEMBER	16th	2014	AM	TUESDAY

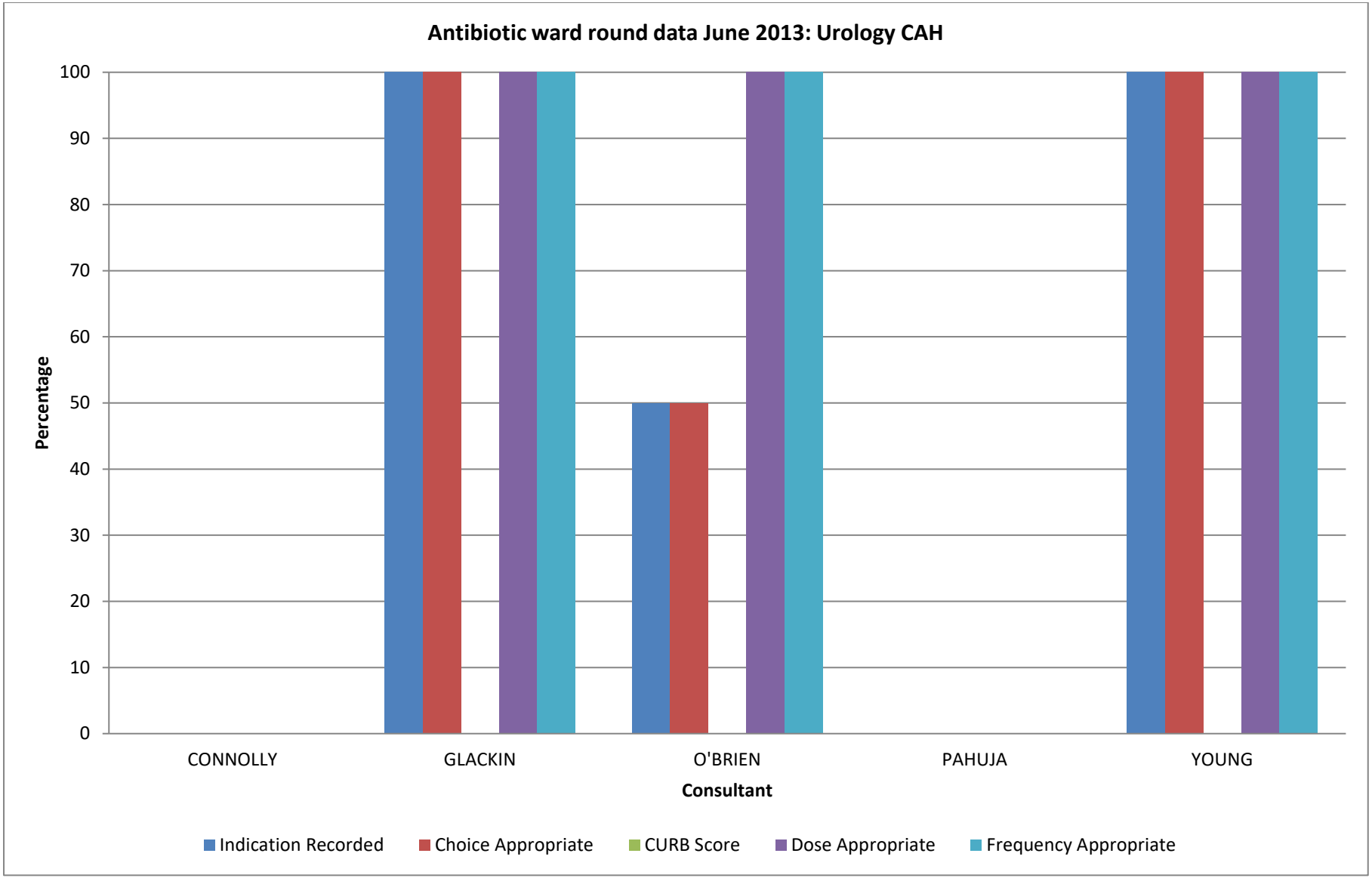
From:	McCorry, Ann
To:	Connolly, David; Glackin, Anthony; O"Brien, Aidan; Pahuja, Ajay; Young, Michael
Cc:	Corrigan, Martina; Trouton, Heather; Damani, Nizam; Boyce, Tracey; Muckian, Donna; Collins, Cathal
Subject:	For info: Antibiotic Ward round summary
Date:	05 July 2013 08:32:45
Attachments:	June summary UROLOGY.docx

Hi All,

Please find attached the antibiotic ward round summary for June.

Kind regards
Ann

Ann McCorry
Lead Antimicrobial Pharmacist
Southern Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI / Mobile: Personal Information redacted by the USI



SUMMARY: Ward rounds conducted on 11th & 25th June.
8/18 patients on antibiotics

- Connolly: No patients.

- Glackin: 1 patient. CURB score n/a.

- O'Brien: 2 patients. CURB score n/a.
    - **Indication not recorded and compliance not assessable in 1pt:**
        - 1pt on IV gentamicin 240mg OD, no documentation of antibiotics in notes, no documented evidence of infection.

- Pahuja: No patients.

- Young: 5 patients. CURB score n/a.

Personal Information redacted by the USI

10/09/1955

Tel: Personal Information redacted by the USI

Mr Personal Information redacted by the USI phoned complaints this morning. He advised that he underwent an operation in August and he was told that the Trust would provide him with a follow up appointment within 5 weeks.

To date, he said he has not been contacted. He wishes to lodge a formal complaint.

He wants to know why has he not been reviewed?
When can he expect a review of the procedure to take place?

Please can you action this matter accordingly.

Regards

Eileen
Corporate Complaints

Aimee Crilly

Subject: FW: Inpatient Urology PTL to meet 26 weeks
Attachments: Book1.xlsx

Importance: High

-----Original Message-----
From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 29 August 2013 13:57
To: Glackin, Anthony <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Pahuja, Ajay <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Cc: Robinson, Katherine <Personal Information redacted by the USI>; Cunningham, Andrea <Personal Information redacted by the USI>
Subject: Inpatient Urology PTL to meet 26 weeks
Importance: High

Dear all,

Please see attached the Inpatient PTL of all the patients that will be breaching 26 weeks at the end of August.

I would be grateful if when scheduling the September theatre lists that these long waiting patients are scheduled along with any Red Flags that you are scheduling.

I will forward a copy of the September PTL next week and also send through the Daycase one in a few minutes

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Admission Reason	Intended Primary Procedure Code	Casenote	Intended Management Description (R)	Consultant Name	Original Date	Actual Weeks Waiting (Rounded Up)
LEFT NEPHRECTOMY LITHUANIAN INTERPRETER	M02.5	Personal Information redacted by the USI	Normal Inpatient	Young M Mr	06/02/2012	69
URETHRAL MEATAL DILATATION & CYSTOSCOPY	M76.4		Normal Inpatient	O'Brien A Mr	07/07/2012	58.8571429
9-12/12 CHANGE OF STENT	M29.8		Normal Inpatient	Young M Mr	20/06/2012	53.5714286
RIGID CYSTOSCOPY BLADDER WASHOUT	M45.9		Normal Inpatient	Young M Mr	29/06/2012	52.2857143
TURP	M65.3		Normal Inpatient	O'Brien A Mr	13/07/2012	50.7142857
URETEROGRAM (LETTER IN B/F)	M30.1		Normal Inpatient	Young M Mr	07/07/2012	50.1428571
REDO PREPUTIOPLASTY	N30.1		Normal Inpatient	Young M Mr	07/09/2012	50
HYDROSTATIC AND URETHRAL DILATATION	M43.2		Normal Inpatient	O'Brien A Mr	23/07/2012	49.2857143
CIRCUMCISION & FLEXIBLE CYSTOSCOPY DIABETIC/ASPIRIN	N30.3		Normal Inpatient	Young M Mr	20/07/2012	49.2857143
TUR PROSTATE DIABETIC & WARFARIN	M65.3		Normal Inpatient	Young M Mr	17/09/2012	48.5714286
TURP - NEW LTR GP 13.02.13	M65.3		Normal Inpatient	Young M Mr	27/09/2012	47.1428571
RIGHT HYDROCELE REPAIR	N11.8		Normal Inpatient	O'Brien A Mr	28/09/2012	47
TURP	M65.3		Normal Inpatient	O'Brien A Mr	28/09/2012	47
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		Normal Inpatient	O'Brien A Mr	29/09/2012	46.8571429
TURP (WARFARIN)	M65.3		Normal Inpatient	O'Brien A Mr	01/10/2012	46.5714286
INSERTION OF URODYNAMIC CATHETER GA AND URODYNAMICS	M38.8		Normal Inpatient	O'Brien A Mr	02/10/2012	46.4285714
NESBITTS PROCEDURE ON CLOPIDOGREL, ASPIRIN, SIMVASTATIN	N32.8		Normal Inpatient	O'Brien A Mr	03/10/2012	46.2857143
cystoscopy & bladder lavage WHEELCHAIR USER - NEEDS HOISTED	M45.9		Normal Inpatient	Young M Mr	05/10/2012	46
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		Normal Inpatient	O'Brien A Mr	17/08/2012	45.7142857
TURP (CATHETER)	M65.3		Normal Inpatient	O'Brien A Mr	09/10/2012	45.4285714
RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4		Normal Inpatient	O'Brien A Mr	09/10/2012	45.4285714
GA URETHRAL DILATATION	M47.1		Normal Inpatient	O'Brien A Mr	12/10/2012	45
TURP	M65.3		Normal Inpatient	O'Brien A Mr	12/10/2012	45
TURP	M65.3		Normal Inpatient	O'Brien A Mr	25/07/2012	44.7142857
RIGHT URETEROSCOPIC LASERTRIPSY DEC 2012	M30.9		Normal Inpatient	Young M Mr	15/10/2012	44.5714286
CIRCUMCISION PER MR YOUNG 010313 WARFARIN	N30.3		Normal Inpatient	Young M Mr	15/10/2012	44.5714286

CIRCUMCISION AS INPATIENT ON WARFARIN	N30.3	Personal Information redacted by the USI	Normal Inpatient	Young M Mr	07/08/2012	44.4285714
HYDROSTATIC DILATATION OF BLADDER	M43.2		Normal Inpatient	O'Brien A Mr	28/08/2012	44.1428571
CIRCUMCISION AND BILATERAL ORCHIOPEXY	M30.2		Normal Inpatient	O'Brien A Mr	23/10/2012	43.4285714
CYSTOSCOPY & URETHRAL DILATATION	M45.9		Normal Inpatient	O'Brien A Mr	23/10/2012	43.4285714
CYSTOSCOPY AND SUPRAPUBIC CATHETERISATION	M45.9		Normal Inpatient	O'Brien A Mr	24/10/2012	43.2857143
TURP SATURDAY LIST IF POSSIBLE	M65.3		Normal Inpatient	O'Brien A Mr	24/10/2012	43.2857143
TURP -(SATURDAY LIST IF POSSIBLE)	M65.3		Normal Inpatient	O'Brien A Mr	24/10/2012	43.2857143
RIGHT URETEROSCOPY HIGH BMI	M30.9		Normal Inpatient	Young M Mr	23/01/2012	43.2857143
TURP	M65.3		Normal Inpatient	O'Brien A Mr	29/10/2012	42.5714286
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN			Normal Inpatient	O'Brien A Mr	30/10/2012	42.4285714
TURP	M65.3		Normal Inpatient	O'Brien A Mr	30/10/2012	42.4285714
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		Normal Inpatient	O'Brien A Mr	30/10/2012	42.4285714
TURP TCI WEEKEND	M65.3		Normal Inpatient	O'Brien A Mr	31/10/2012	42.2857143
TURP - HEARING IMPAIRED-TCI WEEKEND	M65.3		Normal Inpatient	O'Brien A Mr	31/10/2012	42.2857143
BLADDER LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	01/11/2012	42.1428571
CYSTOSCOPY AND CHANGE OF SUPRAPUBIC CATHETER	M45.9		Normal Inpatient	O'Brien A Mr	01/11/2012	42.1428571
BLADDER NECK INCISION/TURP	M65.3		Normal Inpatient	O'Brien A Mr	02/11/2012	42
CIRCUMCISION GA	N30.3		Normal Inpatient	O'Brien A Mr	06/11/2012	41.4285714
NESBITTS PROCEDURE MR PAHUJA	N28.8		Normal Inpatient	Pahuja A Mr	06/11/2012	41.4285714
OPEN SUPRAPUBIC CATHETER INSERTION	M38.2		Normal Inpatient	Young M Mr	09/11/2012	41
HYDROSTATIC DILATATION OF BLADDER	M43.2		Normal Inpatient	O'Brien A Mr	09/11/2012	41
INTRADETRUSOR BOTULINUM TOXIN (WARFARIN)	M43.4		Normal Inpatient	O'Brien A Mr	12/11/2012	40.5714286
RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4		Normal Inpatient	O'Brien A Mr	13/11/2012	40.4285714
CYSTOSCOPY/HYDRODISTENSION/BOTOX GA	M45.9		Normal Inpatient	O'Brien A Mr	13/11/2012	40.4285714
TURP	M65.3		Normal Inpatient	Young M Mr	13/11/2012	40.4285714
TURP 90G PROSTATE	M65.3		Normal Inpatient	Young M Mr	14/11/2012	40.2857143
INTERVAL TURP 163G PROSTATE WOULD LIKE WEEKEND LIST	M65.3		Normal Inpatient	Young M Mr	14/11/2012	40.2857143
REDO TURP/BLADDER NECK INCISION	M65.3		Normal Inpatient	O'Brien A Mr	14/11/2012	40.2857143
FLEXIBLE CYSTOSCOPY & PROSTATIC URETHRAL BIOPSY UNDER LA	M45.9		Normal Inpatient	Young M Mr	19/11/2012	39.5714286
TURP - PT PHON 12.03.13 ? DATE WILL TAKE CANCELLATION	M65.3		Normal Inpatient	Young M Mr	20/11/2012	39.4285714
TURP	M65.3		Normal Inpatient	O'Brien A Mr	23/11/2012	39
TURP	M65.3		Normal Inpatient	O'Brien A Mr	27/11/2012	38.4285714

		Personal Information redacted by the USI				
TURP	M65.3		Normal Inpatient	O'Brien A Mr	27/11/2012	38.4285714
LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY AND INTRADETRUSOR IN	M14.1		Normal Inpatient	O'Brien A Mr	27/11/2012	38.4285714
GA CYSTOSCOPY & MILD OPTICAL URETHROTOMY NIDDM TABLET	M45.9		Normal Inpatient	Young M Mr	14/09/2012	37.8571429
TURP	M65.3		Normal Inpatient	O'Brien A Mr	03/12/2012	37.5714286
HYDROSTATIC DILATATION OF BLADDER	M43.2		Normal Inpatient	O'Brien A Mr	03/12/2012	37.5714286
HYDROSTATIC DILATATION	M43.2		Normal Inpatient	O'Brien A Mr	04/12/2012	37.4285714
INTERNAL URETHROTOMY	M79.4		Normal Inpatient	O'Brien A Mr	04/12/2012	37.4285714
TURP	M65.3		Normal Inpatient	O'Brien A Mr	04/12/2012	37.4285714
CIRCUMCISION	N30.3		Normal Inpatient	O'Brien A Mr	05/12/2012	37.2857143
CIRCUMCISION	N30.3		Normal Inpatient	O'Brien A Mr	05/12/2012	37.2857143
TURP (ON TICAGRELOR)	M65.3		Normal Inpatient	O'Brien A Mr	05/12/2012	37.2857143
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M13.4		Normal Inpatient	O'Brien A Mr	07/12/2012	37
DRAINAGE OF LEFT RENAL CYST	M13.3		Normal Inpatient	O'Brien A Mr	10/12/2012	36.5714286
LEFT URETEROSCOPIC LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	10/12/2012	36.5714286
HYDROSTATIC DILATATION BLADDER	M43.2		Normal Inpatient	O'Brien A Mr	10/12/2012	36.5714286
BILATERAL EPIDIYMAL CYSTECTOMY	M34.3		Normal Inpatient	O'Brien A Mr	11/12/2012	36.4285714
TRANSLOCATION OF ILEAL CONDUIT	M19.1		Normal Inpatient	O'Brien A Mr	11/12/2012	36.4285714
FLEXIBLE CYSTOSCOPY & INSERTION SUPRAPUBIC CATHETER LA	M45.9		Normal Inpatient	Young M Mr	13/12/2012	36.1428571
NESBITTS PROCEDURE MR CONNOLLY LIST POLISH INTERPRETER REQ	N32.8		Normal Inpatient	Jathar H L Mr	14/12/2012	36
INTRADETRUSOR INJECTION BOTULINUM TOXIN	M43.4		Normal Inpatient	O'Brien A Mr	21/12/2012	35
TURP	M65.3		Normal Inpatient	Young M Mr	21/12/2012	35
TURP	M65.3		Normal Inpatient	O'Brien A Mr	27/12/2012	34.1428571
CORRECTION OF PEYRONIE'S CURVATURE & CIRCUMCISION nesbitt	N28.8		Normal Inpatient	O'Brien A Mr	24/01/2012	33
LEFT PARTIAL NEPHRECTOMY pt phon ? date	M02.5		Normal Inpatient	Young M Mr	04/01/2013	33
TURP	M65.3		Normal Inpatient	O'Brien A Mr	04/01/2013	33
LEFT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M30.9		Normal Inpatient	O'Brien A Mr	07/01/2013	32.5714286
CYSTOLITHOPAXY	M44.1		Normal Inpatient	O'Brien A Mr	08/01/2013	32.4285714
RIGHT EPIDIDYMAL CYSTECTOMY (PACEMAKER)	M34.3		Normal Inpatient	O'Brien A Mr	11/01/2013	32
FRENULOPLASTY	N28.4		Normal Inpatient	O'Brien A Mr	14/01/2013	31.5714286

TURP NEPHROSTOMY & CATHETER IN SITU NEEDS U&E ON ADM	M65.3	Personal Information redacted by the USI	Normal Inpatient	Young M Mr	15/01/2013	31.4285714
TURP	M65.3		Normal Inpatient	O'Brien A Mr	16/01/2013	31.2857143
LAPAROSCOPIC DEROOFING OF CYST	M04.1		Normal Inpatient	Glackin A.J Mr	17/01/2013	31.1428571
EXCISION OF RENAL SINUS/RIGHT NEPHRECTOMY	M02.5		Normal Inpatient	Young M Mr	18/01/2013	31
IV FLUIDS & IV GENTAMICIN	X29.8		Normal Inpatient	O'Brien A Mr	22/01/2013	30.4285714
RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	22/01/2013	30.4285714
LEFT URETEROSCOPIC LASER LITHOTRIPSY	M31.1		Normal Inpatient	O'Brien A Mr	22/01/2013	30.4285714
URETHROTOMY +/- TURP - NEW LTR CONT ADVISORS 05.08.13	M76.3		Normal Inpatient	Young M Mr	24/01/2013	30.1428571
CORRECTION OF PENILE ERECTILE DEFORMITY	X27.8		Normal Inpatient	O'Brien A Mr	28/01/2013	29.5714286
BILATERAL TESTICULAR FIXATION GA	N13.2		Normal Inpatient	O'Brien A Mr	29/01/2013	29.4285714
LEARNING INTERMITTENT SELF CATHETERISATION	M47.8		Normal Inpatient	O'Brien A Mr	29/01/2013	29.4285714
CT URINARY TRACT ? LEFT URETEROSCOPIC LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	29/01/2013	29.4285714
CYSTOSCOPY/BOTOX INJECTION/RETROGRADE STUDIES - GA	M45.9		Normal Inpatient	O'Brien A Mr	29/01/2013	29.4285714
MARSUPIALISATION OF RENAL CYST	M04.1		Normal Inpatient	Young M Mr	01/02/2013	29
MEATAL V-Y PLASTY	M81.2		Normal Inpatient	Young M Mr	01/02/2013	29
LEFT ORCHIECTOMY	N06.3		Normal Inpatient	O'Brien A Mr	01/02/2013	29
VASECTOMY UNDER LA	N17.1		Normal Inpatient	Jathar H L Mr	19/11/2012	28.5714286
TURP	M65.3		Normal Inpatient	Young M Mr	04/02/2013	28.5714286
TURP	M65.3		Normal Inpatient	O'Brien A Mr	04/02/2013	28.5714286
TURP	M65.3		Normal Inpatient	O'Brien A Mr	04/02/2013	28.5714286
CYSTOSCOPY	M45.9		Normal Inpatient	O'Brien A Mr	05/02/2013	28.4285714
RIGHT FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	05/02/2013	28.4285714
LEFT URETEROSCOPY	M30.8		Normal Inpatient	O'Brien A Mr	05/02/2013	28.4285714
GA FLEXIBLE CYSTOSCOPY/BLADDER WASHOUT/CHANGE OF SPC	M45.9		Normal Inpatient	O'Brien A Mr	05/02/2013	28.4285714
TURP	M65.3		Normal Inpatient	O'Brien A Mr	11/02/2013	27.5714286
TROC U/S AND CYSTOSCOPY ? TURP	M47.3		Normal Inpatient	O'Brien A Mr	12/02/2013	27.4285714
CIRCUMCISION	N30.3		Normal Inpatient	O'Brien A Mr	12/02/2013	27.4285714
REMOVAL OF STENT AND FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M76.7		Normal Inpatient	O'Brien A Mr	14/02/2013	27.1428571
CIRCUMCISION	N30.3		Normal Inpatient	Young M Mr	15/02/2013	27
CT URINARY TRACT, REMOVAL OF STENT URETEROSCOPIC LITHOTRIPSY	M27.5		Normal Inpatient	O'Brien A Mr	22/02/2013	26

CT URINARY TRACT CYSTOSCOPY SUPRAPUBIC CATHETERISATION	M45.9	Personal Information redacted by the USI	Normal Inpatient	O'Brien A Mr	26/02/2013	25.4285714
TURP	M65.3		Normal Inpatient	Young M Mr	27/02/2013	25.2857143
FLEXIBLE URETEROSCOPIC LITHOTRIPSY	M14.1		Normal Inpatient	O'Brien A Mr	27/02/2013	25.2857143
TURP	M65.1		Normal Inpatient	Young M Mr	27/07/2012	25.1428571
CYSTOSCOPY, MCUG, ?URETHROTOMY	M45.9		Normal Inpatient	O'Brien A Mr	01/03/2013	25

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

September 2013

Produced by:

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

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

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

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

Abbreviations

3D-CRT: three-dimensional conformal radiotherapy

ADT: androgen deprivation therapy

ASAP: atypical small acinar proliferation

BF: biochemical failure

BPFS: Biochemical progression free survival

BPH: benign prostatic hyperplasia

CAB: combined androgen blockade

CHHiP: Conventional or Hypofractionated High Dose IMRT for Prostate Cancer

CI: confidence interval

CPA: cyproterone acetate

CPFS: clinical progression free survival

CT: computed tomography

DES: diethylstilbestrol

DFS: disease-free survival

DRE: digital rectal examination

EBRT: external beam radiation therapy

EPC: Early Prostate Cancer

ERSPC: European Randomised Study of Screening for Prostate Cancer

FFF: freedom from failure

FSH: follicle stimulating hormonE

GnRH: gonadotrophin-releasing hormone

HDR: high dose rate

HIFU: high-intensity focused ultrasound

HR: hazard ratio

HRPC: hormone-refractory prostate cancer

HT: Hormone therapy

IAD: intermittent androgen blockade

IGRT: image guided radiotherapy

IMRT: intensity modulated radiotherapy

ISUP: International Society of Urologic Pathology

IPSS: International Prostate Symptom Score

LDR: low dose rate

LH: luteinising hormone

LHRH: luteinising hormone releasing hormone

LTAD: long-term androgen deprivation

MDT: multi-disciplinary team

MRC: Medical Research Council

MRI: magnetic resonance imaging

MRS: magnetic resonance spectroscopy

NCCN: National Comprehensive Cancer Network

NICE: National Institute for Health and Clinical Excellence

ONJ: osteonecrosis of the jaw

OS: overall survival

OR: Odds ratio

PET: positron emission tomography

PFS: progression-free survival

PLCO: Prostate, Lung, Colorectal and Ovarian

ProtecT: Prostate Testing for Cancer and Treatment

PSA: prostate-specific antigen

PSADT: prostate-specific antigen doubling time

RANK: Receptor activator of nuclear factor kappa-B

RCT: randomised controlled trial

RECIST: Response Evaluation Criteria in Solid Tumors

SRE: skeletal-related events

STAD: short-term androgen deprivation

TRUS: transrectal ultrasound

TURP: transurethral resection of the prostate

CRPC: castration resistant prostate cancer

mCRPC : metastatic castration resistant prostate cancer

Integrated Care and the Multi-disciplinary Team (MDT)

- The concept of integrated care is becoming increasingly accepted as a way to overcome fragmentation of patient management and to provide a consistent treatment strategy across the MDT. It also creates an optimal structure that facilitates audit and peer review.
- Integration within the MDT is essential for patients with prostate cancer because the collaboration between MDT members (Table 1) is central to the treatment strategy, with ongoing support from the wider team to manage pain and the adverse effects of therapy. By being familiar with the complete spectrum of management strategies, the MDT can assist patients in making treatment decisions that are specific for their individual disease state, co-morbid conditions, age and lifestyle.

Table 1: The make-up of the MDT in the prostate cancer setting

• Urological surgeons	• Oncology and urology nurse specialists
• Clinical and medical oncologists	• Palliative care specialist
• MDT co-ordinator and secretarial support	• Histopathologists
• Radiologists	

- Moves to true integrated practice can add value in the following ways: [Integrated Care Network 2004]
  - Changing the identity or branding of a service to create more positive user responses and staff allegiances, enabling a clear break with the past.
  - Securing organisational efficiencies, for example, in the shape of shared support services, integrated management, innovative administrative processes and emerging hybrid roles.
  - Defining a focus for action that includes clearer processes of accountability and is less prone to distraction by wider organisational concerns.
  - Introducing more robust arrangements for team-working and leadership-working in challenging times.
  - Creating new opportunities for investment, for example, in IT systems, and opening access to new sources of funding.
- The algorithms presented in this guidance provide a single framework that is adapted for each major category of prostate cancer: localised, locally advanced and advanced (Figure 1).
- The treatment algorithms presented in this document (Figures 2–4) represent a management structure that goes beyond a simple co-ordinated system and will work most efficiently when the MDT is functioning as a single integrated unit.

Integrated care and clinical governance

- The effective functioning of the MDT and tailored care pathways for patients will support the (now routine) clinical governance procedures implemented throughout the NHS. Traditionally, clinical governance relates to a single organisation or service and this can raise challenges, with the recognition that patients require management across different organisations and services. Therefore, it is appropriate to apply the principles of clinical governance to individual patients or groups of patients.
- The focus should be on optimum patient satisfaction and care, rather than on performance of the NHS institution. The MDT and development of organised pathways ensures that the patient's journey is monitored and assessed as a single entity.

Approach within the MDT

Key questions for the MDT – Localised Prostate Cancer

- TNM stage?
- Gleason grade?
- Prostate-specific antigen (PSA)/PSA kinetics?
- Performance Status?
- Co-morbidity/life expectancy?
- Symptoms:
  - bowel
  - urine (IPSS score)
  - bone
- Sexual Function?
- Social Situation?
- Family History?
- Clinical Trials?

Diagnostic Tests

- Digital rectal exam (DRE)
- PSA
- Transrectal ultrasound
- (TRUS)/biopsy
- MRI/CT pelvic scan*
- Bone scan*

(*Not mandatory for low-risk patients)

Key points for discussion with the patient

- Prognosis with and without radical treatment?
- Treatment options?
- Treatment side-effects?
- Impact on quality of life?
- Importance of:
  - Sexual function?
  - Urinary function?
  - Bowel function?
  - Physical strength, energy?
  - Level of activity?
  - Accessibility to prescribed drugs?
  - Psychosocial impact on them and their family?
- Family history?
- Clinical trials?

Approach within the MDT

Key questions for the MDT – Locally Advanced Prostate Cancer

- TNM stage?
- Gleason grade?
- Prostate-specific antigen (PSA)/PSA kinetics?
- Performance Status?
- Co-morbidity/life expectancy?
- Symptoms:
  - bowel
  - urine (IPSS score)
  - bone
- Sexual Function?
- Social Situation?
- Family History?
- Clinical Trials?

Diagnostic Tests

- DRE
- PSA
- TRUS
- TRUS biopsy/Transperineal biopsy
- MRI/CT pelvic scan
- Bone scan
- Specialist imaging where indicated e.g. choline PET
- Consider lymph node sampling (if this will determine changes in management approach)

Key points for discussion with the patient

- Survival prognosis?
- Treatment options?
- Treatment side-effects?
- Impact on quality of life?
- Importance of:
  - Sexual function?
  - Urinary function?
  - Bowel function?
  - Physical strength, energy?
  - Level of activity?
  - Accessibility to prescribed drugs?
  - Psychosocial impact on them and their family?
- Family history?
- Clinical trials?

Approach within the MDT

Key questions for the MDT – Advanced Prostate Cancer

- TNM stage?
- Gleason grade?
- Prostate-specific antigen (PSA)/PSA kinetics?
- Performance Status?
- Co-morbidity/life expectancy?
- Symptoms:
  - bowel
  - urine (IPSS score)
  - bone
- Sexual Function?
- Social Situation?
- Family History?
- Clinical Trials?
- Palliative Care Referral?

Diagnostic Tests

- DRE
- PSA
- Limited? TRUS biopsy (to confirm histological diagnosis for future therapies – e.g. entry into clinical studies)
- Biochemistry screen
- Full blood count
- Bone scan
- Consider CT Chest / Abdomen; CT/MRI pelvis if it may influence management decisions and entry into future clinical trials

Key points for discussion with the patient

- Survival prognosis?
- Treatment options?
- Treatment side-effects?
- Impact on quality of life?
- Importance of:
  - Sexual function?
  - Urinary function?
  - Bowel function?
  - Physical strength, energy?
  - Level of activity?
  - Accessibility to prescribed drugs?
  - Psychosocial impact on them and their family?
- Family history?
- Clinical trials?

The MDT ***Meeting*** is an essential part of cancer management. However, there are often difficulties in identifying which patients to discuss and whether time allows for presentation of relapsed patients as well as new diagnoses, ensuring that their details and diagnoses are available, and keeping a record of decisions made at the meetings.

- MDTs have repeatedly been endorsed as the principal mechanism for ensuring that all relevant disciplines and professional groups contribute to, and participate in, decisions regarding the clinical management of patients [NICE 2002].
- MDT-working is positively related to a range of measures of effectiveness, including the quality of clinical care.
- It is important to emphasise the distinction between management and administration.
- A central concept of integrated care is to reinforce the role of the MDT (working as a single unit), but with enough clinical freedom to tailor management strategies to the needs of individual patients.
- Treatment strategies are influenced by the stage of disease and by an interaction between the risk of disease progression, survival and key patient characteristics, such as age, lifestyle and general health. The discussion of these factors is of crucial importance in determining the most appropriate way forward. For example, age and the presence of co-morbidities may be a restrictive factor when considering surgery.
- The case notes, pathology reports, test results and radiology for each patient must be available to be discussed at the meeting. The MDT must also ensure that the patient has the fullest possible role in determining treatment – the importance of this cannot be overstated. Patient preference should be discussed within the MDT. Although the majority of men with prostate cancer want to be involved in treatment decisions, an estimated one in five of all patients does not raise, or really understand, the potential issues and associated side-effects of treatments and alternatives that may be available to them [House of Commons Committee of Public Accounts 2006].
- The possibility of including a patient in a relevant clinical trial should be highlighted.

Approach to the Patient

The patient's expectations

The patient should have the right to discuss their treatment with appropriately trained members of the MDT

- After a diagnosis of prostate cancer, most men will want to have some involvement in the decisions concerning their care. The following aspects have been found to be important [Davison BJ, *et al* 2004]:
  - Honesty about the severity of the cancer and their prognosis
  - Discussion of the best treatment options
  - The clinician being up-to-date on ongoing and recent research
  - Disclosing all treatment options
  - How cancer may affect their daily functioning
- It is essential that the patient and healthcare professionals discuss the likelihood of adverse events associated with each treatment option and implications for their future lifestyle when determining management strategies.
- The patient and his partner, family and/or other carers should be fully informed about care and treatment options and therefore able to make appropriate decisions based upon the choices offered by their healthcare professionals. For example, the choice between radical treatment and active surveillance may be influenced by a patient's desire to retain sexual activity, physical energy and quality of life.
- Patients should be informed and advised regarding the available treatment options and the potential effects of these on their lifestyle and quality of life.

Discussing evidence with patients

There is a lack of evidence to guide how healthcare professionals can most effectively share clinical data with those patients facing treatment decisions. However, basing recommendations largely on relevant clinical studies and expert opinion, it is possible to achieve five communication objectives when framing and communicating clinical evidence.

1. Understand the patient's experience, expectations and preferences
2. Build partnerships with the patient and carer
3. Provide evidence and discuss uncertainties and side-effects
4. Present recommendations
5. Check for understanding and agreement

Assessment and Diagnosis

Screening

PSA screening remains a relatively contentious subject in the field of prostate cancer. Assessment of the value of a test, which is so widely disseminated in clinical practice, is a particular challenge. There is conflicting evidence regarding whether screening results in a reduction in mortality from the disease. As a consequence available evidence must be used to minimize the risk of harms and maximize the benefits for an individual man.

- Three ongoing large, randomised, controlled clinical trials are evaluating the value of PSA screening for prostate cancer: the European Randomised Study of Screening for Prostate Cancer (ERSPC) [Schroder FH, *et al* 2012], the Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening trial in the US [Andriole GL, *et al* 2012] and the UK-based Prostate Testing for Cancer and Treatment (ProtecT) study [Rosario DJ, *et al* 2008]. The first reports from these trials have been published and have added further information to the PSA screening debate:
    - The PLCO study reported no mortality benefit with the combination of PSA screening and digital rectal examination (DRE) during a median follow-up of 13 years [Andriole GL, *et al* 2012]. However, this was not a trial of screening versus no screening, but rather of "systematic" versus "opportunistic" screening, and there were high rates of screening in the control group.
    - In contrast, the ERSPC trial found that PSA screening was associated with a 21% relative reduction in prostate cancer mortality at a median follow-up of 11 years, equivalent to the prevention of approximately 7 prostate cancer deaths per 10,000 men screened. This mortality benefit was associated with a high risk of overdiagnosis, with nearly 76% of men who underwent a biopsy following an elevated PSA value having no cancer detected on biopsy [Schroder FH, *et al* 2012].
    - ProtecT has demonstrated a benefit of repeat PSA testing in reducing the risk of high-grade prostate cancer in men with an initial PSA concentration of 3–20 ng/ml [Rosario DJ, *et al* 2008].
- Based on the results of these two large, randomised trials, the general consensus is that at present there is insufficient evidence for widespread mass screening for prostate cancer. However early detection (opportunistic screening) should be offered to the well-informed man Quality of life and cost-effectiveness analyses from the ERSPC and PLCO trials, along with mortality results from ProtecT are needed to help resolve the ongoing PSA screening debate.

Risk factors for prostate cancer

The risk factors for prostate cancer are generally well-documented, but are highlighted here for completeness of the Guidance.

- Age
    - Relatively rare in men under the age of 50 years.
    - Incidence increases in those over 60 years.
- Race
    - A higher incidence of the disease is seen in African-Caribbean, African-American and West African races. The UK PROCESS study demonstrated that black men in the UK have substantially greater risk of developing prostate cancer compared with white men [Ben-Shlomo Y, *et al* 2008]
    - Men of Chinese and Japanese origin have a lower incidence of disease [Delongchamps NB, *et al* 2006].

- Geography
  - The highest incidence of prostate cancer is currently seen in North America and Northern Europe.
- Family history
  - Men with a first-degree relative affected by prostate cancer have a relative risk of developing the disease themselves 2-fold greater than men with no relatives affected [Steinberg GD, *et al* 1990].
  - Those men with an affected second-degree relative have an increased relative risk of 1.7 of developing the disease.
  - Men with both a first- and second-degree relative affected have an increased relative risk of 8.8 of developing the disease.
  - A small subpopulation of individuals with prostate cancer (about 9%) has true hereditary prostate cancer. This is defined as three or more affected relatives or at least two relatives who have developed early onset disease, i.e. before age 55 [Hemminki K 2012].
  - There is also some evidence to show a link between an increased risk of prostate cancer where there is a family history of breast, ovarian, bladder or kidney cancer [Negri E, *et al* 2005].
  - The UK Familial Prostate Cancer Study is currently looking at the genetics of the disease with possible sites of interest lying on chromosomes 2, 5, Y and loss of heterozygosity at 10q and 16q.

Diagnostic tests

The main diagnostic tools for prostate cancer include digital rectal examination (DRE), serum prostate specific antigen (PSA), and transrectal ultrasound (TRUS). The definitive diagnosis depends on the histological verification of adenocarcinoma in prostate biopsy cores or operative specimens.

DRE

- The DRE remains valid as an initial method for assessing the prostate; however, DRE findings should not be regarded as a fail-safe test.

PSA

- PSA is a kallikrein-like serine protease produced almost exclusively by the epithelial cells of the prostate.
- As an independent variable, PSA concentrations are a better predictor of cancer than suspicious findings on DRE or TRUS [Catalona WJ, *et al* 1994;Elgamal A-AA, *et al* 1996].
- PSA is organ specific but not cancer-specific. Therefore, serum concentrations of PSA can be elevated in the presence of benign prostatic hyperplasia (BPH), prostatitis and other non-malignant conditions. Furthermore, there is, as yet, no recommendation for the optimal PSA threshold value that most effectively avoids the detection of insignificant cancers that are unlikely to be life-threatening [Aus G, *et al* 2003; Aus G, *et al* 2004].
- While PSA concentrations generally increase with advancing disease stage, the ability of PSA levels to accurately predict pathological stage in any one individual is low [Hudson MA, *et al* 1989; Brawer MK & Lange PH 1989; Partic AW, *et al* 1990].

- Asymptomatic patients who request a PSA test should be counselled before the procedure for the following reasons [Dearnaley DP, *et al* 1999]:
    - Although the test may detect a cancer at a stage where curative treatment can be offered, PSA will fail to detect some early tumours.
    - A PSA test may detect early prostate cancer in an estimated 5% of men aged 50–65 years.
    - Treatment of early prostate cancer can put the patient at some risk of toxicity and may not necessarily improve life expectancy

Factors affecting PSA concentrations are summarised below.

Age and race

Table 2: Age-specific PSA (ng/ml) reference ranges, by race [DeAntoni EP, *et al* 1996]

Age (years)	White	Black	Latino	Asian
40–49	0–2.3	0–2.7	0–2.1	0–2.0
50–59	0–3.8	0–4.4	0–4.3	0–4.5
60–69	0–5.6	0–6.7	0–6.0	0–5.5
70–79	0–6.9	0–7.7	0–6.6	0–6.8

Biopsy/Transurethral Resection of the Prostate (TURP) can cause an increase in PSA for a variable time period (4–12 weeks) [Xu ZQ, *et al* 2002].

Prostatitis can cause an increase in PSA concentration, which can be reduced to within a normal range with antibiotic treatment [Tchetgen MB, *et al* 1997; Gamé X, *et al* 2003].

Prostate size – a benignly enlarged gland can influence PSA concentrations.

Infection – elevated PSA levels can be sometimes be seen with febrile urinary tract infections.

Free and complexed PSA should be understood. Catalona *et al*. conclude that percentage free PSA is most useful in men with a PSA concentration in the range 2–15 ng/ml (Table 3); the higher the percentage of free PSA the lower the probability of cancer [Catalona WJ, *et al* 1998].

Table 3: Probability of prostate cancer based on total and percentage free PSA [Catalona WJ, *et al* 1998].

	Probability of cancer (%)
Total PSA (ng/ml)	
0–2	~1
2–4	15
4–10	25
>10	>50
Free PSA (%)	
0–10	56
10–15	28
15–20	20
20–25	16
>25	8

PSA density i.e. $\frac{\text{PSA level (ng/ml)}}{\text{TRUS-determined prostate volume (ml)}}$

May be helpful in differentiating BPH from prostate cancer in patients who have a normal DRE with a PSA 4–10ng/ml. A PSA density >0.15 may suggest prostate cancer.

PSA velocity can be valuable in the follow-up of men with a normal PSA but prior negative biopsies. Velocity is measured by a change in PSA concentration in three consecutive measurements taken at 6-monthly intervals. A change in PSA concentration of >0.75 ng/ml per year is more likely to indicate prostate cancer than BPH. The usefulness of PSA velocity in those with a PSA concentration >10 ng/ml is unknown [Smith DS & Catalona WJ 1994].

Transrectal Ultrasound (TRUS)

- TRUS detects 50% more patients with prostate cancer than physical examination alone [Gustafsson O *et al* 1992; Mettlin C, *et al* 1996], but the ultrasonic appearance of prostate cancer is variable and only a very small number of cancers are detected if a DRE and PSA test are normal [Mettlin C, *et al* 1996; Jones WT & Resnick MI 1990; Ellis WJ, *et al* 1994]. Therefore, TRUS is mainly used to aid biopsy.

Biopsy and tumour grading

- The first elevated PSA level should not prompt an immediate biopsy. The PSA level should be verified after a few weeks by the same assay under standardised conditions (i.e. no ejaculation and no manipulations).
- Prostate biopsies are traditionally guided by TRUS. The alternative is to use a transperineal approach with template biopsies.
- The National Institute for Health and Clinical Excellence (NICE) Prostate Cancer Guideline recommends that the serum PSA level alone should not automatically lead to a prostate biopsy [NICE 2008]. It states that to help men decide whether to have a prostate biopsy, healthcare professionals should discuss with them their PSA level, DRE findings (including an estimate of prostate size) and co-morbidities, together with their risk factors (including increasing age and black African and black Caribbean ethnicity) and any history of a previous negative prostate biopsy.
- NICE further highlights that men and their partners or carers should be given information, support and adequate time to decide whether or not they wish to undergo prostate biopsy [NICE 2008]. Men will need to comprehend the potential risks (such as potentially living with a diagnosis of prostate cancer that is deemed clinically insignificant) and the benefits of prostate biopsy.
- Where TRUS-guided biopsy is indicated, a minimum of 10 biopsies (as recommended by The British Prostate Testing for Cancer and Treatment Study) [Donovan J, *et al* 2003] should be obtained, according to the volume of the prostate. Biopsies should be performed under local anaesthetic and antibiotic cover [Eskicorapci SY, *et al* 2004].
- For each biopsy site, the number of biopsies positive for carcinoma and the International Society of Urologic Pathology (ISUP) 2005 Gleason score should be reported [Epstein JI, *et al* 2005]. The amount of cancer in each core should also be recorded either in terms of cancer core length (mm) or proportion of core involvement (%) as this correlates with tumour volume, extraprostatic extension, and prognosis after prostatectomy [Grossklaus DJ, *et al* 2002].
- The indications for a repeat biopsy if the first biopsy is negative include: rising and/or persistently elevated PSA; suspicious DRE; atypical small acinar proliferation (ASAP); extensive (multiple biopsy sites) prostatic intraepithelial neoplasia
- Magnetic Resonance Imaging (MRI) may be used to identify the possibility of an anterior located tumour and also allow targeted biopsies of any suspicious or abnormal area [Lemaitre L, *et al* 2009].
- A European study has reported that a prostate cancer detection rate for the first set of biopsies is 24% and for the second set of biopsies after a negative initial set as 13% [Djavan B, *et al* 2005].31
- Complications of transrectal biopsy include macrohaematuria and haematospermia. Severe infections were initially reported in <1% of cases, but this rate has increased in the last few years as a consequence of the evolution of antibiotic resistance strains with more post-biopsy hospitalisations for infectious complications while the rate of non-infectious complications has remained stable [Loeb S, *et al*. 2011].
- In some patients, prostate biopsy may be performed using a transperineal, template guided technique as the preferred approach. Possible reasons for this include: previous repeated negative TRUS biopsies; clinical or radiological suspicion of a large anterior tumour; more accurate characterization of tumour location and extent in order to guide management and assess eligibility for inclusion into focal therapy trials.
- In these patients, the prostate is divided into 20 anatomical zones and each zone is biopsied at 5mm intervals in a systematic manner using a template grid to guide the biopsy needle placement. Typically this results in between 40-70 biopsies depending on the size of the prostate gland.

- The biopsies are reported in a similar manner to TRUS-guided biopsies, with Gleason score, cancer core length (mm) and proportion of core involvement (%) recorded for each zone.
- This information can also be conveyed in a visual format by creating a 'map' of the prostate that illustrates the Gleason score and extent of tumour in each individual zone.

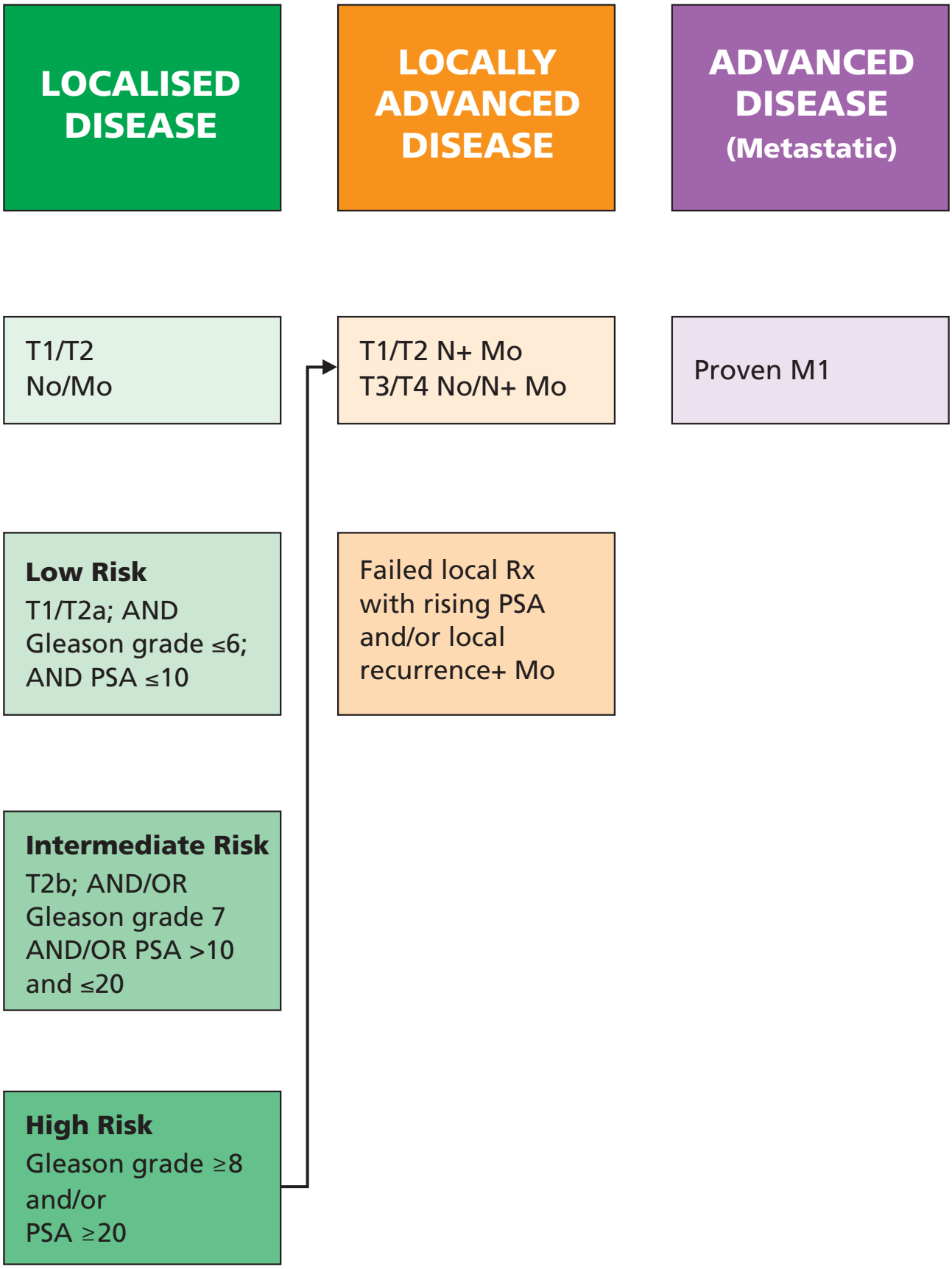
Magnetic Resonance Imaging (MRI)

- TNM staging, Gleason score, and PSA concentration facilitate estimation of the risk of extracapsular disease and lymph node metastases. Pelvic staging is required for those of high or intermediate risk (according to NCCN classification). MRI is the preferred option to stage pelvic lesions and where MRI is contraindicated, computed tomography (CT) should be used [NICE 2008].
- MRI is sensitive and specific in identifying extracapsular extension of prostate cancer in patients with high - or intermediate-risk disease [Allen DJ, *et al* 2004].
- NICE concludes [NICE 2008]:
    - MRI is now the most accurate and commonly-used imaging technique for tumour-staging men with prostate cancer. Many of the original publications on MRI technology are now considered to be outdated, and the accuracy reported for MRI is improving, typically with multiparametric, diffusion weighted scans
    - After transrectal prostate biopsy, intra-prostatic haematoma can affect image interpretation for at least 4-6 weeks.

Bone scans

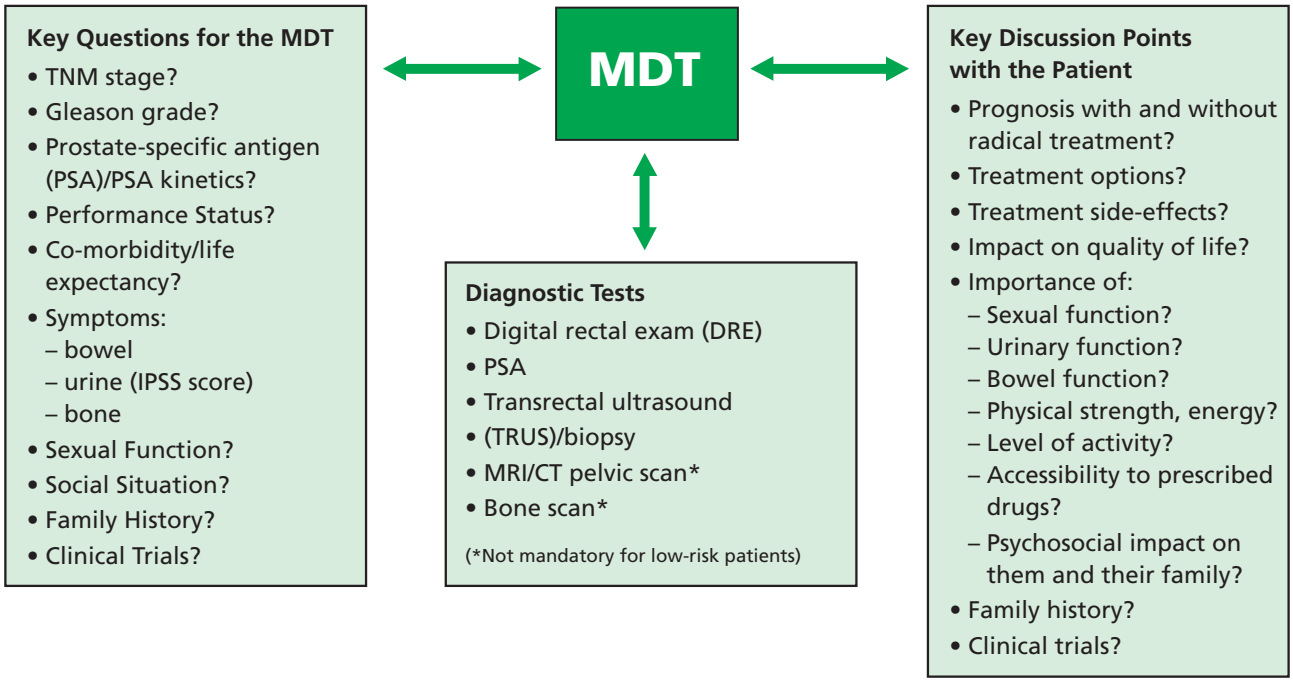
- Bone scans (particularly in patients with PSA concentration >20 ng/ml) are also important in the assessment process. A PSA concentration of <10 ng/ml is unlikely to indicate bone metastases at presentation. A PSA cut-off value of 10 ng/ml for men with Gleason grade ≤7 indicates a negative predictive value range of 91.5–100% [Gerber G & Chodak GW 1991].
- MRI can be an additional approach for distinguishing borderline metastases.

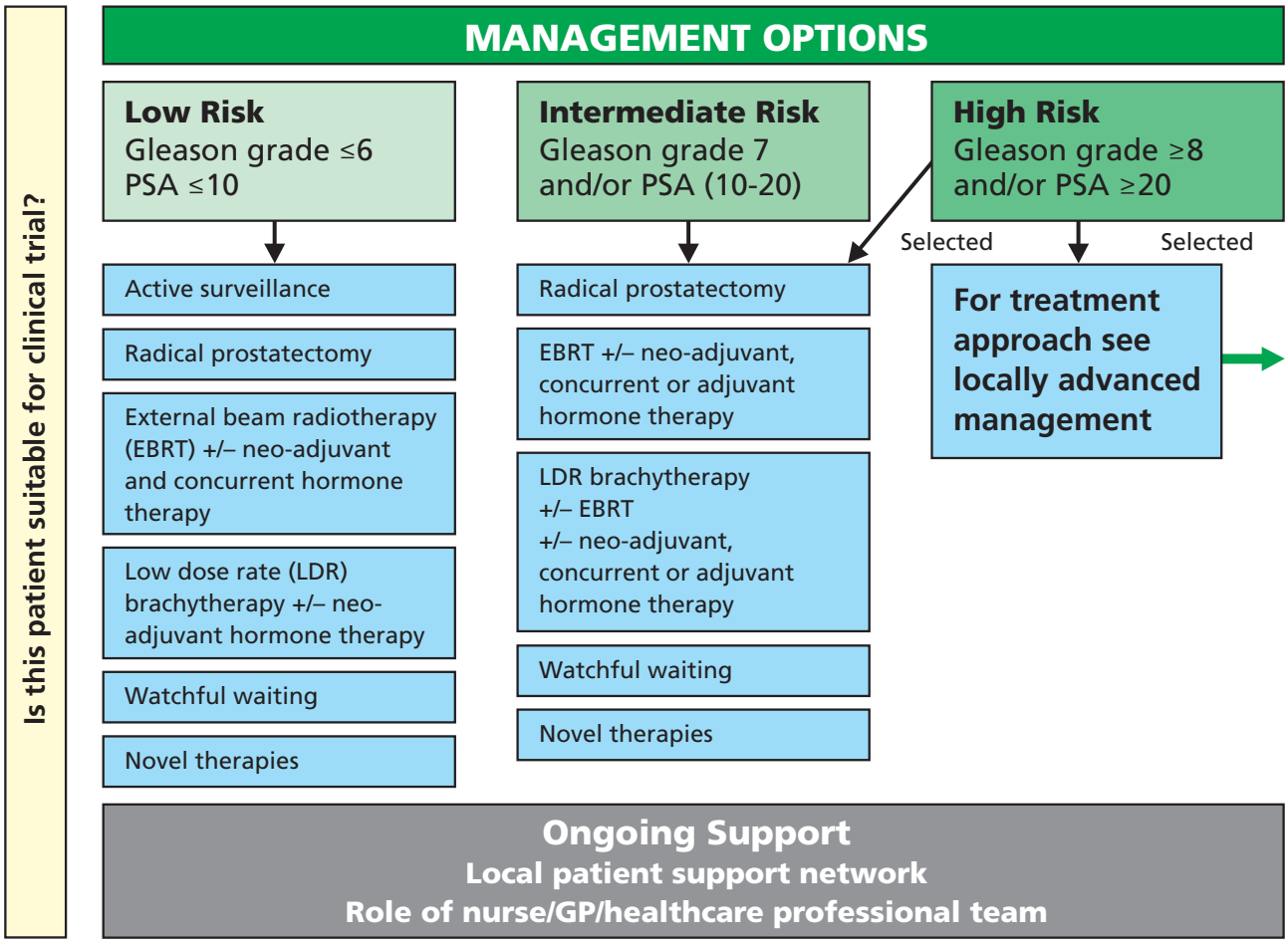
Figure 1: Summary of the definition of prostate cancer stages



Localised Disease: Management Options

Figure 2: Treatment algorithm for localised disease





The following guidance for managing localised prostate cancer focuses on low- and intermediate-risk categories, defined here as [D'Amico AV, *et al* 1998]:

- Low risk (T1/T2a; AND Gleason grade ≤6; AND PSA concentration ≤10 ng/ml)
- Intermediate risk (T2b; AND/OR Gleason grade 7 AND/OR PSA concentration: >10 and ≤20 ng/ml)

In the proposed management algorithms, high-risk localised disease falls more naturally into management of locally advanced disease.

Patient choice and the presence or absence of co-morbidities should be an essential component of management decisions in men with localised disease. Decisions concerning the choice of radical treatments need to be carefully balanced with the different options available and the impact of such treatments on a patient's co-morbidities.

In this section available evidence for the following management approaches is outlined:

- Active surveillance
- Watchful waiting
- Radical prostatectomy
- External Beam Radiation Therapy (EBRT)
- Low dose rate (LDR) brachytherapy
- Neoadjuvant/adjuvant hormone therapy
- Novel therapies

Active surveillance

Overview

- Active surveillance is an approach to the management of early prostate cancer in which the choice between curative treatment and observation is based on evidence of disease progression (PSA kinetics, repeat biopsy or MRI findings) during a period of close monitoring. The aim is to reduce the burden of treatment side-effects without compromising survival.
- Patients suitable for active surveillance are those with low-risk localised disease who are fit for radical treatment. Ongoing prospective studies of active surveillance have shown that 60–80% of such men will avoid the need for treatment, and that 99-100% prostate cancer-specific survival at 10 years is achievable [Selvadurai ED, *et al* 2013; van den Bergh RC, *et al* 2008].
- Active surveillance should be clearly distinguished from watchful waiting. Traditional watchful waiting involves relatively unstructured observation with late, palliative treatment for those who develop symptoms of progressive disease. In contrast, active surveillance involves close monitoring with early radical treatment in those with signs of disease progression.

Patient selection

- Low (or intermediate) risk, clinically localised prostate cancer
  - Clinical stage T1c/2a
  - Gleason grade ≤3+4
  - PSA concentration <15 ng/ml
  - Positive biopsies ≤50%
  - Age 50–80 years
  - Fit for radical treatment
- Active surveillance is particularly suitable for a subgroup of men with low-risk localised prostate cancer who have clinical stage T1c, a Gleason score of 3+3, a PSA density of <0.15 ng/ml per ml with <10 mm of any core involved [NICE 2008].

Side-effects

- Psychological uncertainty

Clinical evidence

- The case for active surveillance is based on the knowledge that PSA testing leads to significant overdiagnosis of prostate cancer. That is, approximately 50% of all cases detected as a result of PSA testing would never have been diagnosed in the absence of testing [Draisma G *et al* 2003]. It follows that treatment is 'unnecessary' in approximately half of all cases of PSA-detected prostate cancer.
- van den Bergh has reported the outcome of expectant management in 616 men who were diagnosed with prostate cancer between 1994 and 2007 at a mean age of 66.3 years in the ERSPC [van den Bergh RC, *et al* 2008]. All patients had low-risk disease with PSA <10 ng/ml, PSA density <0.2 ng/ml per ml, stage T1c/T2, Gleason score ≤3+3=6, and ≤2 positive biopsy cores. Median follow-up was 3.9 years. The 10-year prostate cancer-specific survival (21 patients at risk) was 100%, which sharply contrasted with 77% overall survival (OS), due to deaths from other causes.
- Selveduarai *et al*. reported the outcome of 471 men recruited to the Royal Marsden active surveillance study since 2002, at a median follow-up of 5.7 years [Selvadurai ED, *et al* 2013]. Median age was 66 years, and median initial PSA concentration 6.4 ng/ml. The 5-yr treatment-free probability was 70% (95% CI, 65–75%). There were two deaths from prostate cancer. Predictors of time to adverse histology were GS 7, PSAV >1 ng/ml per year, low ratio of free PSA to total PSA, and PPC >25%. There were two deaths from prostate cancer [Selvadurai ED, *et al* 2013].

Watchful waiting

Overview

- Watchful waiting is an approach to the management of localised prostate cancer that aims to avoid treatment, or delay it for as long as possible.
- Watchful waiting is particularly suitable for patients aged over 75 years or younger men with significant co-morbidities.
- Watchful waiting should be clearly distinguished from active surveillance. Conventional watchful waiting involves relatively unstructured observation with late, palliative treatment (usually hormone therapy) for those who develop symptoms of progressive disease. In contrast, active surveillance involves close monitoring with early, radical treatment in those with signs of progression.

Patient selection

- Asymptomatic clinically localised prostate cancer
  - Clinical stage T1–3 N0 M0
  - Gleason score ≤7
  - Any PSA concentration
  - Not suitable for radical treatment (usually by virtue of older age or co-morbidities)

Side-effects

- Uncertainty

Clinical evidence

- The NICE clinical guideline confirms a lack of evidence for watchful waiting and the Guideline Development Group reached a consensus that the recommendation from NICE would avoid unnecessary investigations [NICE 2008]:
  - Men with localised prostate cancer who have chosen a watchful waiting regimen and who have evidence of significant disease progression (rapidly rising PSA level or bone pain) should be reviewed by a member of the urological cancer MDT.

Radical Treatments

Radical Prostatectomy (RP)

Overview

- The procedure involves removal of the entire prostate gland between the urethra and bladder, and resection of both seminal vesicles, along with sufficient surrounding tissue to obtain a negative margin. This can be accompanied by bilateral pelvic lymph node dissection. There are now four approaches to performing a radical prostatectomy: retropubic, perineal, laparoscopic and robotic. Laparoscopic and robotic approaches have the potential advantage of reduced blood loss and shorter inpatient stays.
- Selley *et al*. reviewed a total of 17 studies (two randomised controlled trials [RCTs] and 15 observational studies involving a total of 5410 patients) to investigate the efficacy of radical prostatectomy for men with localised prostate cancer. Cancer-specific survival after 10 years of follow-up ranged from 86% to 91%, with clinical disease-free survival (DFS) ranging from 57% to 83% [Selley S, *et al* 1997].

Patient selection

- Anaesthetic fitness
- At least 10 years' life expectancy

Side-effects

- Based on the systematic review by Selley *et al*., the following side-effects should be considered [Selley S, *et al* 1997]:
  - Operative and post-operative mortality: 0.2–1.2%
  - Sexual dysfunction: 51–61%
  - Incontinence (mild stress): 4–21%
  - Incontinence (total): 0–7%

Clinical evidence

- Two randomised trials have compared radical prostatectomy with watchful waiting in localised prostate cancer [Bill-Axelson A, *et al* 2011].
    - After a follow-up of 15 years, the SPCG-4 trial showed that RP was associated with a reduction of all-cause mortality: RR=0.75 (0.61 to 0.92). According to a post hoc statistical sub-group analysis, the number to treat (NNT) to avert one death was 15 overall and 7 for men younger than 65 years of age. Radical prostatectomy was also associated with a reduction in prostate cancer-specific mortality: RR=0.62 (0.44 to 0.87).
- This OS and CSS benefit could not be reproduced in another prospective randomised study [Wilt TJ, *et al* 2012]. After a median follow-up of 10 years, the PIVOT trial showed that RP did not significantly reduce all cause mortality: HR=0.88 (0.71 to 1.08); p=0.22, nor did RP significantly reduce prostate cancer mortality: HR=0.63 (0.36 to 1.09); p=0.09. According to a preplanned sub-group analysis among men with low-risk prostate cancer (n=296), RP non-significantly increased all-cause mortality: HR=1.15 (0.80 to 1.66). For men with intermediate-risk tumours (n=249), RP significantly reduced all-cause mortality: HR=0.69 (0.49 to 0.98). Among men with high-risk tumours (n=157), RP non-significantly reduced all-cause mortality: HR=0.40 (0.16 to 1.00).Among men with PSA > 10, RP significantly reduced all cause mortality: HR=0.67 (0.48 to 0.94).
    - Faced with these figures, some patients would choose surgery, but should also be given the option of conservative management with active surveillance [Singer PA, *et al* 1991].

Neoadjuvant and adjuvant hormone therapy with radical prostatectomy

- A review and meta-analysis of the role of Neoadjuvant Hormone Therapy (NHT) and RP has shown that this approach did not improve OS or DFS, but did significantly reduce positive margin rates [relative risk (RR): 0.49; 95% confidence interval (CI): 0.42-0.56, P < 0.00001), organ confinement (RR: 1.63; 95% CI: 1.37-1.95, P < 0.0001) and lymph node invasion (RR: 0.49; 95% CI: 0.42-0.56, P < 0.02) [Shelley MD, *et al* 2009]. Therefore, evidence suggests that the down-staging achieved with neoadjuvant hormone therapy does not translate into improved DFS, and therefore cannot be recommended outside of clinical trials [Bonney WW, *et al* 1999; Paul R, *et al* 2004; Selli C & Milesi C. 2004; Witjes WPJ, *et al* 1997].
- Similarly, there is currently no evidence that adjuvant hormone therapy provides a survival advantage for patients with pathologically proven localised disease [Hachiya T, *et al* 2002; Prayer-Galetti T, *et al* 2000]. A recent Cochrane review and meta-analysis studied the role of adjuvant HT following RP: the pooled data for 5-year OS demonstrated an odds ratio (OR) of 1.50 and 95% CI: 0.79-2.84 [Shelley MD, *et al* 2009]. Although this finding was not statistically significant, there was a trend favouring adjuvant HT. There was no survival advantage at 10 years.

Adjuvant radiotherapy after radical prostatectomy

- Extracapsular invasion (pT3), Gleason score > 7, and positive surgical margins (R1) can be associated with a risk of local recurrence and the role of adjuvant treatments for this high risk group is considered in the section of locally advanced prostate cancer and radical prostatectomy.

External Beam Radiotherapy (EBRT)

Overview

- Selley *et al*. reviewed 21 observational studies and one RCT involving radiotherapy and found that survival and recurrence rates are associated with grade and stage of the disease. The 5-year DFS for those with T1–T2 stage disease averaged 70–80%. Local progression was observed in 10–20% of these patients, while distant metastases were observed in 20–40% [Selley S, *et al* 1997].
- Nilsson *et al*. performed a systematic overview of radiotherapy in prostate cancer. Data from 26 non-randomised trials of conventional EBRT showed a 10-year DFS of 100%, 69% and 57% for T1a, T1b and T2 stage disease, respectively [Nilsson S, *et al* 2004].
- Long-term follow-up after EBRT continues to demonstrate an improvement in cause-specific survival. Improved selection and technical developments in radiotherapy leading to increased doses have shown better results.

Three-dimensional conformal radiotherapy (3D-CRT)

- There is evidence that increased radiation dose is associated with increased cancer cell kill for men with localised prostate cancer. However, the traditional two-dimensional technique of treatment planning and delivery is limited by the normal tissue toxicity of the surrounding structures (bladder, rectum and bowel), such that the dose that can be safely delivered to the prostate by EBRT is of the order of 64Gy in 2Gy per day fractions. Several technological advances over the last 20 years have enhanced the precision of EBRT, and have resulted in improved outcomes.
- The three-dimensional conformal radiotherapy (3D-CRT) approach reduces the dose-limiting late side-effect of proctitis [Dearnaley DP, *et al* 1999] and has allowed for dose escalation to the whole prostate to up to78 Gy.

Intensity Modulated Radiotherapy (IMRT)

- IMRT is an advanced technique which has superseded 3D-CRT. IMRT can modify the shape and intensity of the multiple radiotherapy beams. It is very precise in targeting the treatment area, sparing surrounding tissue and allowing dose escalation above 80Gy. IMRT is currently recommended, particularly for the irradiation of pelvic lymph nodes.

Dose escalation

- Several randomised studies have shown that dose escalation with 3D conformal radiotherapy and more recently with IMRT has a significant impact on the 5-year biochemical relapse free survival. However, no trials to date have shown an improvement in long term overall survival
- Evidence of the benefits of dose escalation has been demonstrated for T1–T3 prostate cancer by Pollack *et al*. in a phase III randomised study undertaken at the MD Anderson Hospital [Pollack A, *et al* 2002].
    - A total of 305 men were randomised between 1993 and 1998 to compare the efficacy of 70 Gy versus 78 Gy with a median follow-up of 60 months. The primary endpoint was freedom from failure (FFF), including biochemical failure, which was defined as three rises in PSA level.
    - The FFF rates for the 70 Gy and 78 Gy arms at 6 years were 64% and 70%, respectively (p=0.03). Dose escalation to 78 Gy preferentially benefited those with a pre-treatment PSA concentration >10 ng/ml; the FFF rate was 62% for the 78 Gy arm versus 43% for those who received 70 Gy (p=0.01). For patients with a pre-treatment PSA concentration ≤10 ng/ml, no significant dose-response relationship was found, with an average 6-year FFF rate of about 75%.
    - Although no difference in OS occurred, the freedom from distant metastasis rate was higher for those with PSA levels >10 ng/ml who were treated to 78 Gy (98% versus 88% at 6 years, p=0.056).
- Dearnaley and colleagues have reported their findings from the MRC RT01 study [Dearnaley DP, *et al* 2007].
    - In this 3D-CRT trial, 843 men were randomised to a standard dose of 64 Gy compared with an escalated dose of 74 Gy, with all men also receiving neoadjuvant hormone therapy.
    - Patients receiving the conventional dose had 5-year biochemical PFS rates of 60% compared to 71% in the dose-escalated arm. Advantages were also seen in terms of clinical PFS and the decreased use of androgen suppression.
    - An update of this study with 10 years of follow up has not shown any further benefit in biochemical PFS of 54% (172 events) versus 42% (224 events), HR 0.688 (0.56-0.84) p<0.0001 in favour of the dose escalated group [Dearnaley DP, *et al* 2011]. However, no overall survival benefit was demonstrated, with both the 64Gy and 74Gy arms having an overall survival of 70% HR 0.99 (0.77-1.28) p=0.337. The number of men requiring long term hormone therapy was reduced in the dose escalated arm HR 0.77 (0.59-1.00) p=0.05.
- Recently the long-term follow-up of the pilot study, which provided the initial safety and feasibility information for the national MRC RT01 trial have been published [Creak A, *et al* 2013].
    - In this study, 126 patients were randomised to a standard dose of 64 Gy compared with an escalated dose of 74 Gy after neoadjuvant androgen suppression.
    - After a follow up of 13.7 years, 49 of 126 patients restarted AS, 34 developed metastases and 28 developed CRPC. Median OS was 14.4 years.
    - Although escalated dose results were favourable, no statistically significant differences were seen between the randomised groups; PSA control (hazard ratio (HR): 0.77 (95% confidence interval (CI): 0.47–1.26)), development of CRPC (HR: 0.81 (95% CI: 0.40–1.65)), PC-specific survival (HR: 0.59 (95% CI:0.23–1.49)) and OS (HR: 0.81 (95% CI: 0.47–1.40)).
- The Dutch randomised phase III trial comparing 68 Gy with 78 Gy also demonstrated a significant increase in the 5-year rate of freedom from clinical or biochemical failure in patients treated with a higher dose of radiotherapy [Peeters ST, *et al* 2006]

- The phase III trial of the French Federation of Cancer Centres compared 70 Gy with 80 Gy in men with localised prostate cancer, in 306 patients with a low risk of pelvic lymph node involvement [Beckendorf V, *et al* 2011]. At a median follow up of 61 months, they demonstrated improved 5-year biological outcomes in favour of dose-escalated radiotherapy group. Using the Phoenix definition, the 5-year biochemical relapse rate was 32% and 23.5%, respectively (p = .09).
- Although these and other studies have shown benefits from dose escalation this has been offset to a degree by a reported increase in late rectal toxicity.
- Prospective non-randomised studies conducted at the Memorial Sloan Kettering cancer centre have compared the outcomes of 1100 men who received doses in the range of 64–70 Gy and 76–86 Gy using IMRT [Zelefsky MJ, *et al* 2001].
    - The results were evaluated within prognostic risk groups (using clinical stage, Gleason grade and presenting PSA concentration). They demonstrated that increasing the dose delivered beyond 70.2 Gy in men with intermediate- and high-risk disease improved the 5-year actuarial PSA relapse-free survival rate from 50% to 70% and 21% to 47%, respectively, in these two risk categories.
- IMRT has the potential to reduce late rectal toxicity as shown in a further study that reports 3-year actuarial ≥grade 2 gastrointestinal toxicity at 4% [Zelefsky MJ, *et al* 2002].
- A further development under investigation involves a change in the traditional fractionation schedules. Hypofractionation may improve cancer control for the same level of radiation-related toxicity and be a more effective treatment for prostate cancer with a predicted low alpha/beta ratio. Phase II dose escalation studies using shortened schedules of hypofractionated IMRT regimens have indicated acceptable early toxicity [Amer AM, *et al* 2003].
- The CHHiP (Conventional or Hypofractionated High Dose IMRT for Prostate Cancer) study is currently recruiting patients in the UK to compare standard fractionation IMRT (74 Gy in 37 fractions) to two hypofractionated IMRT regimens (60 Gy in 20 fractions or 57 Gy in 19 fractions) in combination with neoadjuvant hormone therapy [South CP, *et al* 2008]. There is no overall survival data available from this trial as yet but preliminary safety results have shown that hypofractionated high-dose radiotherapy seems equally well tolerated as conventionally fractionated treatment at 2 years

Image Guided Radiotherapy (IGRT)

- The advantages of dose escalation using IMRT means that organ movement becomes a critical issue, in terms of both tumour control and treatment toxicity to the bladder, rectum and bowel. Techniques should therefore combine IMRT with some form of IGRT (fiducial markers, imaging), in which organ movement can be visualised and corrected for in real time, although the optimum means of achieving this is still under investigation.

Patient selection

- EBRT can be unsuitable for patients with bilateral hip replacement, previous radiotherapy, severe proctitis or bowel morbidity (such as ulcerative colitis or Crohns' disease).

Side-effects

- Acute complications include cystitis, faecal frequency and urgency, proctitis and rectal bleeding.
- Late complications occurring 3 months or later after treatment include impotence, bleeding, proctitis and diarrhoea.

EBRT plus neoadjuvant hormone therapy

- Neoadjuvant hormone therapy with an LHRH agonist can reduce the prostate volume by up to 30–40% [Shearer RJ, *et al* 1992;Forman JD, *et al* 1995] This can allow smaller treatment fields and as a result the level of toxicity experienced.
- There are also reports of an additive or synergistic effect on tumour cell kill with combined therapy. Theories as to the mechanism of this include improved oxygenation by reducing tumour bulk and movement of hormone-responsive cells into a resting phase, which could reduce repopulation rate and enhance tumour cell death (increased apoptosis) [Hara I, *et al* 2002].
- The RTOG 86-10 trial randomised 471 men with T2–T4 prostate cancer to radiotherapy +/– 4 months of androgen deprivation therapy (ADT) before and during EBRT or to radiotherapy alone [Pilepich MV, *et al* 2001].
    - At median follow-up of 8.7 years, there was a trend to improved survival (8-year survival 53% versus 44%, p=0.1) for those treated by hormone therapy with radiotherapy, which was significant for the subgroup with Gleason grade 2–6 disease (70% versus 52%, p=0.015) [Pilepich MV, *et al* 2001]..
    - Ten-year OS estimates (43% versus 34%) and median survival times (8.7 versus 7.3 years) favoured combined therapy with hormones and radiation compared to radiation treatment alone; however, these differences did not reach statistical significance (p=0.12).
    - There was a statistically significant improvement in 10-year disease-specific mortality (23% versus 36%; p=0.01), distant metastases (35% versus 47%; p=0.006), DFS (11% versus 3%; p<0.0001) and biochemical failure (65% versus 80%; p<0.0001) with the addition of neoadjuvant hormone therapy, but no differences were observed in the risk of fatal cardiac events [Roach M 3rd, *et al* 2008].
- The TROG 96.01 trial has shown that in the intermediate-risk patient group a 6-month course of ADT has shown some benefit when compared with a 3-month course [Denham JW, *et al* 2008].
    - Relative to radiation alone, the HR of prostate cancer-specific mortality from randomisation was 0.95 (95%CI: 0.63–1.41; p=0.79) in the 3-month ADT treatment arm and 0.56 (95%CI: 0.36–0.88; p=0.01) in the 6-month arm.
- A separate 6-month study compared 3D-CRT plus ADT and 3D-CRT alone [D'Amico AV, *et al* 2004].
    - After a median follow-up of 4.52 years, patients receiving 3D-CRT + ADT demonstrated a significantly lower prostate cancer–specific mortality rate (p=0.02).
    - 5-year OS rates were estimated at 88% (95%CI: 80–95) in the 3D-CRT + ADT group versus 78% (95%CI: 68–88) in the 3D-CRT group (p=0.04).

EBRT plus adjuvant hormone therapy

- Refer to section "EBRT plus adjuvant hormonal therapy" on pp 40.

Low dose rate (LDR) brachytherapy

Overview

- In 2005, NICE reviewed the medical literature on LDR brachytherapy and concluded that, in the absence of randomised trials, the results of LDR brachytherapy are comparable to those achieved with surgery or EBRT in well-selected patients [NICE 2005].
- Suitable patients include those with localised disease (up to T2a) with a Gleason grade ≤6, and a PSA concentration ≤10 ng/ml. Patients with significant urinary symptoms or post-TURP may not be suitable.
- Brachytherapy is as effective as radical prostatectomy in patients with low-risk localised disease [Crook J, *et al* 2001; Grimm P, *et al* 2012].
- In intermediate-risk localised disease, the comparison is less clear, because many studies have added EBRT in combination [Merrick GS, *et al* 2001].
- Brachytherapy is a single-step day case procedure following a spinal or general anaesthetic.

Brachytherapy plus EBRT

- In a matched-pair analysis, the 5-year biochemical failure-free survival rate was 86% for patients treated with EBRT and LDR brachytherapy, and 72% for patients treated with EBRT alone (p=0.03). Both treatments were associated with comparable incidences of late genitourinary side-effects (18-19%). Late rectal toxicity decreased by 15% in patients treated with EBRT and brachytherapy (p=0.0003). [Singh AM, *et al* 2005].

Brachytherapy plus neoadjuvant hormone therapy

- The role of neoadjuvant hormone therapy with brachytherapy is controversial. It is used to reduce the prostate volume when it exceeds 50 ml, in order to facilitate brachytherapy. Volume reduction decreases the total isotope activity required, potentially improves implant dosimetry and decreases pubic arch interference. [Potters L, *et al* 2005].

Patient selection (exclusions)

- Prostate size >50 ml
- Recent TURP
- Significant urinary outflow obstruction
- Previous AP resection
- Previous high dose pelvic radiotherapy

Side-effects

- A review of 16 studies by Crook *et al*. showed acute adverse events as [Crook J, *et al* 2001]:
  - Irritant urinary symptoms: 46–54%
  - Acute urinary retention: 1–14%
  - Acute proctitis: 1–2%
  - Chronic adverse events (reinforced by Wills & Hailey, 1999 [Wills F & Hailey D. 1991]:
    - Incontinence: 5–6%
    - Haematuria: 1–2%
    - Strictures: 1–2%
    - Proctitis: 1–3%
    - Erectile dysfunction: 4–14% (or up to 38% in Wills & Hailey, 1999 [Wills F & Hailey D. 1991] and up to 50% at 5 years in Merrick *et al*., 2001 [Merrick GS, B, *et al* 2001]).

Clinical evidence

- Very few comparative studies to date have evaluated the results of treatment options for prostate cancer using the most sensitive measurement tools. PSA has been identified as the most sensitive tool for measuring treatment effectiveness. To date, comprehensive unbiased reviews of all the current literature are limited for prostate cancer. A large scale comprehensive review of the literature comparing risk stratified patients by treatment option and with long-term follow-up was carried out by Grimm *et al* 2012 [Grimm P, *et al* 2012]. The results of the studies were weighted, respecting the impact of larger studies on overall results. The review identified a lack of uniformity in reporting results amongst institutions and centres. A large number of studies had been conducted on the primary therapy of prostate cancer but very few randomised controlled trials had been conducted. The comparison of outcomes from individual studies involving surgery (radical prostatectomy or robotic radical prostatectomy), external beam radiation (EBRT) (conformal, intensity modulated radiotherapy, protons), brachytherapy, cryotherapy or high intensity focused ultrasound remains problematic due to the non-uniformity of reporting results and the use of varied disease outcome endpoints. Technical advances in these treatments have also made long-term comparisons difficult. This international group conducted a comprehensive literature review to identify all studies involving treatment of localised prostate cancer published during 2000-2010. Over 18,000 papers were identified and a further selection was made based on the following key criteria: minimum/median follow-up of 5 years; stratification into low-, intermediate- and high-risk groups; clinical and pathological staging; accepted standard definitions for prostate-specific antigen failure; minimum patient number of 100 in each risk group (50 for high-risk group). A statistical analysis of the study outcomes suggested that, in terms of biochemical-free progression, brachytherapy provided superior outcome in patients with low-risk disease. For intermediate-risk disease, the combination of EBRT and brachytherapy appears equivalent to brachytherapy alone. For high-risk patients, combination therapies involving EBRT and brachytherapy plus or minus androgen deprivation therapy appear superior to more localized treatments such as seed implant alone, surgery alone or EBRT.
- A significant correlation has been demonstrated between recurrence rates and the implanted dose [Stock RG, *et al* 1998]. It has been shown that men receiving a D90 of > 140 Gy had a significantly higher biochemical control rate (PSA < 1.0 ng/mL) at 4 years than those who received less than 140 Gy (92% vs. 68%).

- Kupelian *et al*. studied 2991 consecutive patients with T1/T2 tumours treated with radical prostatectomy, LDR brachytherapy, EBRT or a combination of EBRT and brachytherapy. Biochemical relapse-free survival was similar in all groups when EBRT <72 Gy was excluded [Kupelian PA, *et al* 2004].
- Potters *et al* studied 1,449 consecutive patients treated with permanent prostate brachytherapy between 1992 and 2000. The mean pre-treatment PSA of 10.1ng/ml and 55% presented with Gleason 6 prostate cancer and 28% Gleason 7 disease. 400 patients (27%) were treated with neoadjuvant hormones and 301 (20%) were treated with combination EBRT. At a median follow up of 82 months, the overall and disease specific survival at 12 years was 81% and 93%, respectively. The 12-year biochemical free recurrence rates varied between 77% and 81% depending on the method of reporting recurrence. They concluded from multivariate analyses that implant dosimetry remains an important predictor for biochemical recurrence and that the addition of adjuvant hormone therapy or external radiation had an insignificant effect. [Potters L, *et al* 2005].

Novel therapies

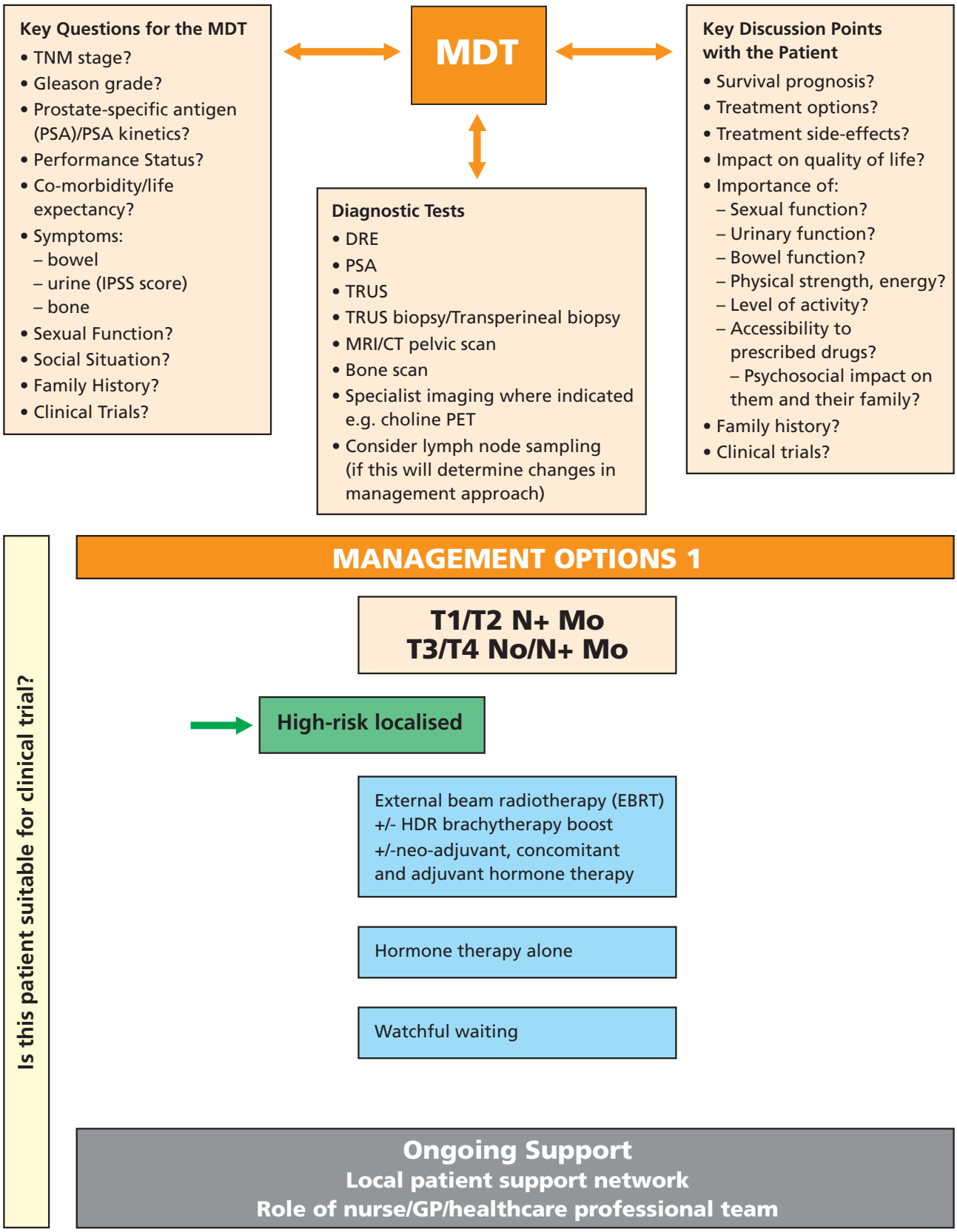
Cryotherapy/High-Intensity Focused Ultrasonography (HIFU)

The development of third-generation prostate cryotherapy has allowed the introduction of ultra-thin needles to deliver a minimally-invasive treatment for prostate cancer patients in the primary and salvage setting.

- Long *et al*. have performed a retrospective analysis of the multicentre, pooled, results of 975 patients treated with cryotherapy [Long JP, *et al* 2001]. The patients were stratified into three risk groups. Using PSA thresholds of 1.0 ng/mL and < 0.5 ng/mL and had a mean follow-up of 24 months. The 5-year actuarial biochemical disease free survival rates were:
    - 76% and 60%, respectively, for the low-risk group
    - 71% and 45%, respectively, for the intermediate-risk group
    - 61% and 36%, respectively, for the high-risk group
- Bahn *et al*. [Bahn DK, *et al* 2002], have reported the results of 7 year follow up on 590 patients treated with cryotherapy for clinically localised and locally advanced PCa. Using a PSA cut-off response level of < 0.5 ng/mL, the 7-year biochemical disease free survival for low-, medium- and high-risk groups was 61%, 68% and 61%, respectively.
- Longer-term follow-up series show biochemical DFS at 10 years of 80.56% for low-risk, 74.16% for moderate-risk and 45.54% for high-risk prostate cancer patients
- The toxicity from cryotherapy has reported erectile dysfunction in approximately 80% of patients and remains a consistent complication of the procedure, regardless of the generation of the system used. The complication rates described in third generation cryosurgery include tissue sloughing in about 3%, incontinence in 4.4%, pelvic pain in 1.4% and urinary retention in about 2% [De La Taille A, *et al* 2000]. Around 5% of all patients require transurethral resection of the prostate (TURP) for subvesical obstruction.
- This treatment has been approved by the American Urological Association and the European Association of Urology for treatment of patients with primary and radiation-failed prostate cancer
- In the NICE guidelines, the minimally-invasive treatments of cryosurgery and HIFU were considered to be experimental and for use only within the clinical trial setting [NICE 2008].
- Poissonnier reported on 227 patients with localised prostate cancer who were treated with HIFU at a single institution. The projected 5-year biochemical disease free survival rate was 66%, or 57% for patients with a pre-treatment PSA value of 4-10 ng/mL after a mean follow up of 27 months (range: 12-121) [Poissonnier L, *et al* 2007]
- Blana *et al*. have reported the results of 163 patients treated with HIFU for clinically organ confined prostate cancer. The actuarial disease free survival rate at 5 years was 66%, with salvage treatment initiated in 12% of patients [Blana A, *et al* 2008].
- In another study, 517 men with organ-confined or locally advanced PCa were treated with HIFU .Biochemical failure was defined as the PSA nadir + 2 ng/mL, After a median follow-up of 24 months, the biochemical disease free survival was 72% for the entire cohort. The biochemical disease free survival rates for low-, intermediate- and high-risk groups at 5 years was 84%, 64% and 45%, respectively (P < 0.0001) [Uchida T, *et al* 2009].
- Urinary retention appears to be one of the most common side effects of HIFU, with stress incontinence occurring in about 12% of patients. Subsequent TURP or bladder neck incision to treat subvesical obstruction can be used to treat these symptoms and is sometimes performed at the time of HIFU. Postoperative impotence has been reported in 55-70% of patients.

Locally Advanced Disease: Management Options

Figure 3: Treatment algorithm for locally advanced disease



The term 'locally advanced prostate' cancer can be used to encompass a spectrum of disease profiles that may include any of the following:

- Clinical stage T3, T4 or N1 cancers without evidence of distant metastases (M0)
- Clinical stages T1 and T2 ('localised') at diagnosis, where 'high-risk' features (PSA concentration ≥20 ng/ml or Gleason grade ≥8) indicate the likelihood of extraprostatic invasion or clinically undetectable metastatic disease.
- Pathological stage pT2 or pT3 disease with 'high-risk' features due to upstaging from additional pathological information after radical prostatectomy.

Men with locally advanced or high-risk prostate cancer generally have a significant risk of disease progression and cancer-related death if left untreated. These patients present two specific challenges. There is a need for local control and also a need to treat any microscopic metastases likely to be present but undetectable until disease progression. The optimal treatment approach will often therefore utilise multiple modalities. The exact combinations, timing and intensity of treatment continue to be strongly debated. Management decisions should be made after all treatments have been discussed by the MDT and the balance of benefits and side effects of each therapy modality have been considered by the patient with regard to their own individual circumstances.

Watchful waiting (deferred or immediate hormone therapy)

The waiting ('deferred treatment' or 'symptom-guided treatment') should be distinguished from active surveillance which involves close monitoring with early, radical treatment in those with signs of disease progression. Watchful waiting by contrast involves relatively unstructured observation with late, palliative treatment for those who develop symptoms of progressive disease.

Overview

- A pooled analysis of data from 2 RCTs involving 1036 men with locally advanced disease not suitable for curative treatment (T2–T4) suggested no survival benefit for immediate versus delayed hormone therapy at 1, 5 or 10 years [Wilt T, *et al* 2001].

Clinical evidence

- Adolfsson *et al*. prospectively followed 50 patients with locally advanced prostate cancer who were only treated upon patient request or when they became symptomatic. All patients were followed-up for more than 144 months, or had died before that point. OS and DFS at 5, 10 and 12 years was 68% and 90%, 34% and 74%, and 26% and 70%, respectively [Adolfsson J, *et al* 1999].
- Immediate versus deferred treatment for advanced prostate cancer was investigated by the MRC Prostate Working Party Investigators Group. An RCT of 943 men with asymptomatic metastases or locally advanced disease, not suitable for curative treatment, was undertaken, with randomisation to immediate or deferred hormone therapy [MRC Prostate Working Party Investigators Group 1997].
    - There was a significant advantage in the immediate treatment group in terms of distant progression. Mortality was only significantly changed by treating immediately in those with M0 disease (Table 5).
    - A modest but statistically significant increase in OS was seen in the immediate treatment group, but no significant difference in prostate cancer mortality or symptom-free survival was demonstrated.

- Due consideration must therefore be given to potential effects of long-term ADT versus the potential avoidance of such effects in patients if hormone therapy is deferred [Studer UE, *et al* 2008].

Table 5: Effect of immediate versus deferred hormonal treatment [MRC Prostate Working Party Investigators Group 1997]

		Immediate	Deferred
Distant progression		26%	45%
Mortality due to prostate cancer	M0 disease M1 disease	31.6% No significant difference	48.8% No significant difference

- A prospective randomised clinical phase III trial (EORTC 30981) by Studer UE *et al*, randomised 985 patients with T0-4 N0-2 M0 prostate cancer to immediate hormone or hormone treatment on the development of symptomatic disease progression [Studer UE, *et al* 2008]. After a median follow-up of 7.8 years, the overall survival hazard ratio was 1.25 (95% confidence interval [CI]: 1.05-1.48; non-inferiority $p > 0.1$) favouring immediate treatment. This appeared to be due to fewer deaths of non-prostatic cancer causes ($p = 0.06$). There was no difference in the time from randomisation to progression of hormone-refractory disease or prostate cancer-specific survival. The median time to the start of deferred treatment after study entry was 7 years. The conclusion suggested that immediate hormone therapy resulted in a modest but statistically significant increase in overall survival, but that there was no significant difference in prostate cancer mortality or symptom-free survival.
- The multicentre, International Early Prostate Cancer (EPC) study evaluated the efficacy and tolerability of adding the non-steroidal anti-androgen bicalutamide 150 mg once-daily to standard care (prostatectomy, radiotherapy or watchful waiting). 8,113 patients with localised or locally advanced non-metastatic prostate cancer were included [Iversen P, *et al* 2010].
  - Objective PFS and OS were defined as the primary endpoints. At a fourth analysis, the median follow-up was 9.7 years. Exploratory analyses were also conducted to determine the efficacy of bicalutamide in clinically relevant subgroups.
- A significant improvement in objective PFS in favour of bicalutamide 150 mg for all locally advanced disease patients was demonstrated. For those men with locally advanced disease who were managed by watchful waiting, there was a significant difference in PFS. The median time to progression was 6.6 years for those randomised to bicalutamide 150 mg compared to 3.7 years for those randomised to placebo. Patients in the watchful waiting subgroup showed a trend towards improved overall survival, this was statistically significant in sub-study 025 (carried out in Scandinavian in 1218 patients) HR=0.76 (0.59, 0.98) p=0.031 but did not reach significance in sub-study 24 (carried out in Europe, South Africa, Australia, Israel, and Mexico in 3603 patients) HR=1.03 (0.77, 1.37) p=0.844 [Iversen P, *et al* 2010].

Hormone therapy versus radiotherapy and hormone therapy

- A study by Widmark *et al* has shown that the addition of radiotherapy to hormone therapy for men with locally advanced or high-risk prostate cancer halves the 10-year prostate cancer-specific mortality and substantially decreases overall mortality [Widmark A, *et al* 2009].
    - This phase III study comparing endocrine therapy with and without local radiotherapy randomised 875 patients with locally advanced prostate cancer (T3; 78%; PSA concentration <70 ng/ml; N0; M0) to hormone therapy alone (3 months of total androgen blockade followed by continuous endocrine therapy using flutamide), or to the same hormone treatment combined with radiotherapy.
    - After a median follow-up of 7.6 years, 79 men in the hormone therapy group and 37 men in the hormone therapy plus radiotherapy group had died of prostate cancer. The cumulative incidence at 10 years for prostate cancer-specific mortality was 23.9% in the hormone alone group and 11.9% in the hormone therapy plus radiotherapy group (difference 12.0%; 95%CI: 4.9–19.1).
    - The 10-year cumulative incidence for overall mortality was 39.4% in the hormone therapy group and 29.6% in the hormone therapy plus radiotherapy group (difference 9.8%; 95%CI: 0.8–18.8).
    - The 10-year cumulative incidence for PSA recurrence was substantially higher in men in the hormone therapy group (74.7% versus 25.9%; HR 0.16; 95%CI: 0.12–0.20; p<0.0001).
    - After 5 years, urinary, rectal, and sexual problems were slightly more frequent in the hormone plus radiotherapy group.
- The National Cancer Institute of Canada (NCIC)/UK Medical Research Council (MRC)/Southwest Oncology Group (SWOG) intergroup PR3/PR07 study included 1,205 patients with stage T3-4 (n = 1057) or stage T2 with additional high risk features i.e. PSA > 40 ng/mL, or PSA > 20 ng in addition to Gleason Score > 8 and N0-X M0 prostate cancer [Warde, P, *et al* 2011]. These patients were randomly assigned to lifelong hormone therapy (bilateral orchidectomy or LHRH agonist), with or without radiotherapy (65-70 Gy to the prostate, with or without 45 Gy to the pelvic lymph nodes). The addition of radiotherapy to lifelong hormone treatment at a median follow up of 6 years demonstrated a reduced the risk of death from any cause by 23% (P = 0.03) and the risk of death due to prostate cancer by 46% (P = 0.0001) [Warde, P, *et al* 2011].

Side-effects of Hormone Therapy

- LHRH agonists: side-effects include erectile dysfunction and loss of libido, reduction in bone mineral density, hot flushes and sweating, and weight gain and metabolic effects.
- Bicalutamide (anti-androgens): side-effects include gynaecomastia and breast tenderness.
    - Mild to moderate gynaecomastia and breast pain are the most common adverse events described [McLeod DG, *et al* 2006].

External beam radiotherapy (EBRT) +/– neoadjuvant, concomitant and adjuvant hormone therapy

Radiotherapy Alone

- In locally advanced disease, EBRT alone has been shown to have a poorer outcome than in localised prostate cancer. Consequently, combination therapy with radiotherapy and hormone therapy is accepted as standard practice.
- Although it has been widely used, there are still many uncertainties associated with radical radiotherapy with regard to the optimum dose and field size (particularly to what extent the treatment volume should try to include pelvic lymph nodes). The advent of 3D Conformal radiotherapy (3D-CRT) and Intensity Modulated Radiotherapy (IMRT) in combination with Image Guided Radiotherapy (IGRT) has allowed the radiation field to be more precisely targeted to the tumour volume, thereby potentially reducing the side-effects of treatment and possibly allowing dose escalation that enhances its local efficacy.

Three-dimensional conformal radiotherapy (3D-CRT)

- There is evidence that increased radiation dose is associated with increased cancer cell kill for men with localised prostate cancer. However, the traditional two-dimensional technique of treatment planning and delivery is limited by the normal tissue toxicity of the surrounding structures (bladder, rectum and bowel), such that the dose that can be safely delivered to the prostate by EBRT is of the order of 64 Gy in 2 Gy per day fractions. Several technological advances over the last 20 years have enhanced the precision of EBRT, and have resulted in improved outcomes.
- The 3D-CRT approach reduces the dose-limiting late side-effect of proctitis [Dearnaley DP, *et al* 1999] and has allowed for dose escalation to the whole prostate to up to78 Gy.

Intensity Modulated Radiotherapy (IMRT)

- IMRT is an advanced technique which has superseded 3D-CRT. IMRT can modify the shape and intensity of the multiple radiotherapy beams. It is very precise in targeting the treatment area, sparing surrounding tissue and allowing dose escalation above 80 Gy. IMRT is currently recommended, particularly for the irradiation of pelvic lymph nodes.

Dose escalation

- Evidence suggests that patients treated with radiotherapy to the prostate have a significantly better outcome, because the dose to the gland is increased. The benefit is greatest in those patients with high-risk features.
- Debate remains over the best way of increasing the dose without significantly increasing normal tissue toxicity. 3D-CRT, IMRT and High Dose Rate (HDR) brachytherapy boost are methods currently under evaluation.
- Several randomised studies have shown that dose escalation with 3D-CRT and more recently with IMRT has a significant impact on the 5-year biochemical relapse free survival. However no trials to date have shown an improvement in long term overall survival.

- Evidence of the benefits of dose escalation has been demonstrated for T1–T3 prostate cancer by Pollack *et al*. in a phase III randomised study undertaken at the MD Anderson Hospital [Pollack A, *et al* 2002].
    - A total of 305 men were randomised between 1993 and 1998 to compare the efficacy of 70 Gy versus 78 Gy with a median follow-up of 60 months. The primary endpoint was freedom from failure (FFF), including biochemical failure, which was defined as three rises in PSA level.
    - The FFF rates for the 70 Gy and 78 Gy arms at 6 years were 64% and 70%, respectively (p=0.03). Dose escalation to 78 Gy preferentially benefited those with a pre-treatment PSA concentration >10 ng/ml; the FFF rate was 62% for the 78 Gy arm versus 43% for those who received 70 Gy (p=0.01). For patients with a pre-treatment PSA concentration ≤10 ng/ml, no significant dose-response relationship was found, with an average 6-year FFF rate of about 75%.
    - Although no difference in OS occurred, the freedom from distant metastasis rate was higher for those with PSA levels >10 ng/ml who were treated to 78 Gy (98% versus 88% at 6 years, p=0.056).
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    - Patients receiving the conventional dose had 5-year biochemical PFS rates of 60% compared to 71% in the dose-escalated arm. Advantages were also seen in terms of clinical PFS and the decreased use of androgen suppression.
    - An update of this study with 10 years of follow up has not shown an a further benefit in biochemical PFS of 54% (172 events) versus 42% (224 events) , HR 0.688 (0.56-0.84) p<0.0001 in favour of the dose escalated group. However, no overall survival benefit was demonstrated, with both the 64 Gy and 74 Gy arms having an overall survival of 70% HR 0.99 (0.77-1.28) p=0.337. The number of men requiring long term hormone therapy was reduced in the dose escalated arm HR 0.77 (0.59-1.00) p=0.05 [Dearnaley DP, *et al* 2011].
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    - In this study, 126 patients were randomised to a standard dose of 64 Gy compared with an escalated dose of 74 Gy after neoadjuvant androgen suppression.
    - After a follow up of 13.7 years, 49 of 126 patients restarted AS, 34 developed metastases and 28 developed CRPC. Median OS was 14.4 years.
- Although escalated dose results were favourable, no statistically significant differences were seen between the randomised groups; PSA control (hazard ratio (HR): 0.77 (95% confidence interval (CI): 0.47–1.26)), development of CRPC (HR: 0.81 (95% CI: 0.40–1.65)), PC-specific survival (HR: 0.59 (95% CI:0.23–1.49)) and OS (HR: 0.81 (95% CI: 0.47–1.40))
- The Dutch randomised phase III trial comparing 68 Gy with 78 Gy also demonstrated a significant increase in the 5-year rate of freedom from clinical or biochemical failure in patients treated with a higher dose of radiotherapy [Peeters ST, *et al* 2006].

- The phase III trial of the French Federation of Cancer Centres compared 70 Gy with 80 Gy in men with localised prostate cancer, in 306 patients with a low risk of pelvic lymph node involvement [Beckendorf V, *et al* 2011]. At a median follow up of 61 months, they demonstrated improved 5-year biological outcomes in favour of dose-escalated radiotherapy group. Using the Phoenix definition, the 5-year biochemical relapse rate was 32% and 23.5%, respectively (p = .09).
- Although these and other studies have shown benefits from dose escalation this has been offset to a degree by a reported increase in late rectal toxicity.
- Prospective non-randomised studies conducted at the Memorial Sloan Kettering cancer centre have compared the outcomes of 1100 men who received doses in the range of 64–70 Gy and 76–86 Gy using IMRT [Zelefsky MJ, *et al* 2001].
    - The results were evaluated within prognostic risk groups (using clinical stage, Gleason grade and presenting PSA concentration). They demonstrated that increasing the dose delivered beyond 70.2 Gy in men with intermediate- and high-risk disease improved the 5-year actuarial PSA relapse-free survival rate from 50% to 70% and 21% to 47%, respectively, in these two risk categories.
- IMRT has the potential to reduce late rectal toxicity as shown in a further study that reports 3-year actuarial ≥grade 2 gastrointestinal toxicity at 4% [Zelefsky MJ, *et al* 2002].
- A further development under investigation involves a change in the traditional fractionation schedules. Hypofractionation may improve cancer control for the same level of radiation-related toxicity and be a more effective treatment for prostate cancer with a predicted low alpha/beta ratio. Phase II dose escalation studies using shortened schedules of hypofractionated IMRT regimens have indicated acceptable early toxicity [Zelefsky MJ, *et al* 2001].
- The CHHiP (Conventional or Hypofractionated High Dose IMRT for Prostate Cancer) study is currently recruiting patients in the UK to compare standard fractionation IMRT (74 Gy in 37 fractions) to two hypofractionated IMRT regimens (60 Gy in 20 fractions or 57 Gy in 19 fractions) in combination with neoadjuvant hormone therapy [Zelefsky MJ, *et al* 2002]. There is no overall survival data available from this trial as yet but preliminary safety results have shown that hypofractionated high-dose radiotherapy seems equally well tolerated as conventionally fractionated treatment at 2 years
- Debate remains over the best way of increasing the dose without significantly increasing normal tissue toxicity. 3D-CRT, IMRT and HDR brachytherapy boost are methods currently under evaluation.

Image Guided Radiotherapy (IGRT)

The advantages of dose escalation using IMRT means that organ movement becomes a critical issue, in terms of both tumour control and treatment toxicity to the bladder, rectum and bowel. Techniques should therefore combine IMRT with some form of IGRT (fiducial markers, imaging), in which organ movement can be visualised and corrected for in real time, although the optimum means of achieving this is still under investigation.

Radiotherapy target volume/lymph nodes

- In high-risk patients the consensus is that the seminal vesicles should be included. There remains some debate for the benefit for prophylactic whole-pelvic irradiation, since randomised trials have failed to show conclusive advantages.
- The RTOG 9413 trial was designed to determine whether there was an advantage in terms of PFS with androgen deprivation therapy, whole pelvic radiotherapy followed by a prostate boost compared with androgen deprivation therapy and prostate-only radiotherapy. The trial also investigated the timing of hormone therapy with a further randomisation. One group received neoadjuvant hormone therapy followed by concurrent total androgen suppression and radiotherapy while the other group was treated with radiotherapy followed by adjuvant hormone therapy. Patients with non-metastatic disease but an estimated risk of lymph node involvement of >15% were randomised between the 4 arms [Lawton CA, *et al* 2007].
    - The difference in OS for the 4 arms was statistically significant (p=0.027).
    - However, no statistically significant differences were found in PFS or OS between neoadjuvant versus adjuvant hormone therapy and whole pelvis radiotherapy compared with prostate-only radiotherapy. A trend towards a difference was found in PFS (p=0.065) in favour of the whole pelvic radiotherapy + neoadjuvant hormone arm compared with the prostate-only radiotherapy + neoadjuvant hormones and whole pelvic radiotherapy + adjuvant hormone treatment arms.
    - These results have demonstrated that when neoadjuvant hormone therapy is used in conjunction with radiotherapy, whole pelvic treatment yields a better PFS than prostate-only radiotherapy. It also showed an improved OS when whole pelvic radiotherapy was combined with neoadjuvant rather than short-term adjuvant hormone therapy.

Patient selection

- EBRT can be unsuitable for patients with bilateral hip replacement, previous radiotherapy, severe proctitis or bowel morbidity.

Side-effects

- Acute complications include cystitis, faecal frequency and urgency, proctitis and rectal bleeding.
- Late complications occurring 3 months or later after treatment include impotence, bleeding, proctitis and diarrhoea.

HDR brachytherapy boost

- HDR brachytherapy using an iridium-92 temporary implant is a safe, reproducible and effective way of boosting conventional EBRT. There is published evidence for this approach demonstrating improved biochemical control and cause-specific survival without a significant increase in toxicity.
- Currently, HDR brachytherapy is mainly used as a boost treatment in combination with EBRT
- In a single randomised trial of EBRT vs. EBRT plus HDR brachytherapy boost, 220 patients with organ confined prostate cancer were randomised to EBRT alone with a dose of 55 Gy in 20 fractions, or EBRT with a dose of 35.75 Gy in 13 fractions, followed by HDR brachytherapy with a dose of 17 Gy in two fractions over 24 hours. In comparison with EBRT alone, the combination of EBRT and HDR brachytherapy showed a significant improvement in the biochemical relapse free survival (P = 0.03). There were no differences in the rates of late toxicity. Patients randomly assigned to EBRT plus brachytherapy had a significantly better QoL as measured by their Functional Assessment of Cancer Therapy-Prostate (FACT-P) score at 12 weeks. However, a very high, uncommon rate of early recurrences was observed in the EBRT arm alone, even after 2 years, possibly due to the uncommon fractionation used [Hoskin PJ, *et al* 2007].

- A further single centre study evaluated the 10-year outcomes for 472 intermediate- and high-risk prostate cancer patients treated with pelvic EBRT to a dose of 46 Gy in 23 fractions and a HDR brachytherapy boost. The HDR dose fractionation was divided into two dose levels. The prostate biologically equivalent dose (BED) low-dose-level group received <268 Gy, and the high-dose group received >268 Gy. Phoenix biochemical failure (BF) definition was used.At a median follow up of 8.2 years , the 10-year biochemical failure rate 43.1% vs. 18.9%, ($p < 0.001$), the clinical failure rate of 23.4% vs. 7.7%, ($p < 0.001$), and the distant metastasis of 12.4% vs. 5.7%, ($p = 0.028$) were all significantly better for the high-dose level group. Grade 3 genitourinary complications were 2% and 3%, respectively, and grade 3 gastrointestinal complication was <0.5%.This prospective trial using P-EBRT with HDR boost and hypofractionated dose escalation demonstrates a strong dose-response relationship for intermediate- and high-risk prostate cancer patients [Martinez AA, *et al* 2011].

EBRT plus neoadjuvant hormone therapy

- Neoadjuvant hormone therapy reduces prostate volume by 30–40% [Shearer RJ, *et al* 1992; Forman JD, *et al* 1995]. This can reduce the size of the treatment field and as a result the potential level of toxicity experienced.
- There are also reports of an additive or synergistic effect on tumour cell kill with combined therapy. Theories as to the mechanism of this include improved oxygenation by reducing tumour bulk and movement of hormone-responsive cells into a resting phase, which could reduce repopulation rate and enhance tumour cell death (increased apoptosis) [Hara I, *et al* 2002].
- The RTOG 86-10 trial randomised 471 men with T2–T4 prostate cancer to radiotherapy +/– 4 months of ADT (goserelin 3.6 mg depot once-monthly plus flutamide 250 mg tid) before and during EBRT or to radiotherapy alone. The median follow-up was 6.7 years for all patients and 8.6 years for surviving patients [Pilepich MV, *et al* 2001].
    - At median follow-up of 8.7 years for surviving patients, there was a trend to improved survival (8-year survival 53% versus 44%, p=0.1) for those treated by hormone therapy with radiotherapy, which was significant for the subgroup with Gleason grade 2–6 disease (70% versus 52%, p=0.015) [Pilepich MV, *et al* 2001].
    - Ten-year OS estimates (43% versus 34%) and median survival times (8.7 versus 7.3 years) favoured combined therapy with hormones and radiation compared to radiation treatment alone; however, these differences did not reach statistical significance (p=0.12) [Roach M, *et al* 2008].
    - There was a statistically significant improvement in 10-year disease-specific mortality (23% versus 36%; p=0.01), distant metastases (35% versus 47%; p=0.006), DFS (11% versus 3%; p<0.0001) and biochemical failure (65% versus 80%; p<0.0001) with the addition of neoadjuvant hormone therapy, but no differences were observed in the risk of fatal cardiac events [Roach M, *et al* 2008].

EBRT plus adjuvant hormonal therapy

- Long-term application of adjuvant androgen suppression should be seriously considered in prostate cancer patients with an unfavourable prognosis.
- A combination of radiotherapy and hormone therapy is superior to radiotherapy alone in patients with locally advanced disease. The combination is associated with better survival and increased time to progression.
- Optimal duration of adjuvant therapy is uncertain (6 months to indefinite) and the results of further studies are awaited.

Clinical evidence

- Adjuvant androgen suppression immediately after radical radiotherapy has been shown to significantly increase OS, PFS, and significantly reduce local progression, distant metastases and biochemical progression in several large randomised studies.
- Bolla *et al*. (EORTC 22863) randomised 415 patients with locally advanced prostate cancer (T1–4, Nx, M0) to receive either radiotherapy with immediate goserelin 3.6 mg therapy (every 4 weeks for 3 years) plus cyproterone acetate (CPA) during the first month of treatment for disease flare (n=207) or radiotherapy alone (n=208) [Bolla M, *et al* 2010].
    - After a mean follow-up of 9.1 years the 10-year clinical DFS was 22·7% (95% CI 16·3-29·7) in the radiotherapy-alone group and 47·7% (39·0-56·0) in the combined modality therapy group (HR= 0·42, 95% CI 0·33-0·55, p<0·0001). The 10-year OS was 39·8% (95% CI 31·9-47·5) in patients receiving radiotherapy alone and 58·1% (49·2-66·0) in those allocated combined treatment (HR 0·60, 95% CI 0·45-0·80, p=0·0004), and 10-year prostate-cancer mortality was 30·4% (95% CI 23·2-37·5) and 10·3% (5·1-15·4), respectively (HR 0·38, 95% CI 0·24-0·60, p<0·0001). No significant difference in cardiovascular mortality was noted between treatment groups.
- In the EORTC 22961 study, men with locally advanced prostate cancer who had all previously completed EBRT and 6 months of adjuvant ADT were randomised to receive either no further treatment (short-term ADT), or 2.5 years of further treatment with a LHRH agonist (long-term ADT) [Bolla M, *et al* 2009].
    - The 5-year overall mortality rates were 19.0% for short-term ADT versus 15.2% for long-term ADT (HR 1.42; p=0.65 for non-inferiority).
    - The 5-year prostate cancer-specific mortality rates were 4.7% for short-term ADT versus 3.2% for long-term ADT (HR 1.71; 95%CI: 1.14–2.57; p=0.002).
    - This study showed inferior survival for men treated with RT and 6 months of ADT compared with RT plus 3 years of ADT in the treatment of locally advanced prostate cancer.
- Pilepich *et al*. (RTOG 85-31) randomised 977 patients with locally advanced non-metastatic prostate cancer to receive either pelvic radiation plus goserelin 3.6 mg depot (started during the last week of radiotherapy, to be continued indefinitely every month or until relapse; n=488) or radiotherapy alone (n=489) [Pilepich MV, *et al* 2005].
    - A total of 945 patients remained appropriate for analysis: 477 in the adjuvant arm and 468 in the control arm. Thirty-two patients were retrospectively classified as ineligible. the most common reason was a T2 primary tumour with negative lymph nodes
    - Median follow-up was 7.6 years for all patients and 11 years for surviving patients.
    - The data clearly identified that the use of goserelin in combination with radiotherapy in this group of high-risk patients resulted in significant improvements in all endpoints.
    - Goserelin adjuvant therapy significantly (p<0.002) reduced the risk of dying by approximately 25%. The absolute 10-year survival rate compared with radiotherapy alone was 49% versus 39%. The improvement in survival appeared preferentially in patients with a Gleason grade of 7–10.
    - Goserelin treatment also resulted in a significant improvement in local control, freedom from distant metastasis, DFS and biochemical DFS.

- Horwitz *et al*. (RTOG 92-02) investigated the use of long-term androgen suppression following neoadjuvant hormonal cytoreduction and radiotherapy in locally advanced prostate cancer (T2c to T4 with no extra pelvic lymph node involvement and PSA <150 ng/ml) [Horwitz EM, *et al* 2008].
    - A total of 1554 patients were treated with goserelin and flutamide for 2 months prior to and 2 months during radiotherapy, and then randomised to 24 months of goserelin long-term (LTAD) or no further treatment short-term hormone therapy (STAD).
    - At 10 years, the LTAD and radiotherapy group showed significant improvement over the STAD + radiotherapy group for all endpoints except OS: DFS (13.2% versus 22.5%; p<0.0001), disease-specific survival (83.9% versus 88.7%; p=0.0042), local progression (22.2% versus 12.3%; p<0.0001), distant metastasis (22.8% versus 14.8%; p<0.0001), biochemical failure (68.1% versus 51.9%; p≤0.0001) and OS (51.6% versus 53.9%, p=0.36).
    - One subgroup analysed consisted of all cancers with a Gleason score of 8–10 cancers. An OS difference was observed (31.9% versus 45.1%; p= 0.0061), as well as in all other endpoints.
- As previously described, in the EPC study, exploratory analyses were conducted to determine the efficacy of bicalutamide in clinically relevant subgroups with a median follow-up of 9.7 years at the third analysis. The primary endpoints were objective PFS and OS [McLeod DG, *et al* 2006].
- Patients who derived benefit from bicalutamide in terms of PFS were those with locally advanced disease, with OS significantly favouring bicalutamide in patients with locally advanced disease undergoing radiotherapy (HR = 0.70 (CI 0.51 to 0.97), p=0.03). The overall tolerability of bicalutamide was consistent with previous analyses, with breast pain (73.7%) and gynaecomastia (68.8%) the most frequently reported adverse events in patients randomized to bicalutamide.

Radical Prostatectomy

There is debate about the role of radical prostatectomy for men with locally advanced or high risk prostate cancer. Surgical treatment of this stage has traditionally been discouraged because patients have an increased risk of positive surgical margins and lymph node metastases and/or distant relapse

Radical prostatectomy may be considered for selected cases with low volume tumour provided that the tumour is not fixed to the pelvic side wall, or that there is no invasion of the urethral sphincter. Management decisions should be made after all treatments have been discussed by the multidisciplinary team and after the balance of benefits and side effects of each therapy modality have been considered by the patients with regard to their own individual circumstances. It is essential that patients are counselled regarding the high risks of needing additional adjuvant and salvage therapies and understand that the surgery may be part of a multimodality approach.

It is recommended that lymph node dissection should be performed in all high-risk cases.

Clinical evidence

- The Mayo clinic have reported 15-year outcomes for 5662 men with locally advanced prostate cancer treated with radical prostatectomy [Ward JF, *et al* 2005].
    - Freedom from local or systemic disease at 5, 10, and 15 years after radical prostatectomy were reported as 85%, 73% and 67%; the respective cancer-specific survival rates were 95%, 90% and 79%. Significantly many men who did not receive neoadjuvant therapy (27%) were clinically over-staged (pT2) and most men with pT3 disease (78%) received adjuvant therapy. The mean time to adjuvant therapy after radical prostatectomy was 4.0 years. Pathological grade (> or =7), positive surgical margins, and nondiploid chromatin were all independently associated with a significant risk for clinical disease recurrence, while preoperative PSA level had little effect on outcome.
    - The authors also noted that many patients with clinically T3 prostate cancer are overstaged (pT2) (27% in this series who did not have neoadjuvant hormone therapy)
- In a further single institution series the 10-year outcomes of radical prostatectomy in 200 men with unilateral clinical T3a disease who had not received neoadjuvant hormone therapy, have been reported by Hsu [Hsu CY, *et al* 2007]. Clinical over-staging was again noted in 23.5% of cases who had a pathological stage of pT2. 56% of patients received adjuvant or salvage therapy. The overall survival at 5 and 10 years was 95.9% and 77.0%, respectively, and cancer specific survival was 98.7% and 91.6%. Biochemical progression free survival (BPFS) at 5 and 10 years was 59.5% and 51.1%, respectively, and clinical progression free survival (CPFS) was 95.9% and 85.4%. Margin status was a significant independent predictor in BPFS; cancer volume was a significant independent predictor in CPFS.

Radical Prostatectomy and Neoadjuvant/Adjuvant Hormone Therapy

- A review and meta-analysis of the role of NHT and prostatectomy has shown that NHT before prostatectomy did not improve OS or disease-free survival (DFS), but did significantly reduce positive margin rates [relative risk (RR): 0.49; 95% confidence interval (CI): 0.42-0.56, P < 0.00001), organ confinement (RR: 1.63; 95% CI: 1.37-1.95, P < 0.0001) and lymph node invasion (RR: 0.49; 95% CI: 0.42-0.56, P < 0.02) [Shelley MD, *et al* 2009]. Therefore, evidence suggests that the down-staging achieved with neoadjuvant hormone therapy does not translate into improved DFS, and therefore cannot be recommended outside of clinical trials [Bonney WW, *et al* 1999; Paul R, *et al* 2004; Selli C & Milesi C. 2004; Witjes WPJ, *et al* 1997].

- Similarly, there is currently no evidence that adjuvant hormone therapy provides a survival advantage for patients with pathologically proven localised disease [Hachiya T, *et al* 2002; Prayer-Galetti T, *et al* 2000]. A recent Cochrane review and metaanalysis studied the role of adjuvant HT following RP: the pooled data for 5-year OS demonstrated an odds ratio (OR) of 1.50 and 95% CI: 0.79-2.84 [Shelley MD, *et al* 2009]. Although this finding was not statistically significant, there was a trend favouring adjuvant HT. There was no survival advantage at 10 years. The pooled data for DFS gave an overall OR of 3.73 and 95% CI: 2.3-6.03. The overall effect estimate was highly significant (P < 0.00001) in favour of the HT arm.
- The ECOG 7887 trial compared adjuvant ADT after radical prostatectomy and deferred hormonal therapy in patients with nodal metastases [Messing EM, *et al* 2006]. A total of 98 patients with locally advanced prostate cancer (T1–T2, N+ disease) who had undergone pelvic lymphadenectomy were included in the study. These patients were randomised to receive adjuvant hormone ablation or followed until disease progression and then given hormone therapy [Messing EM, *et al* 2006].
    - At 11.9 years' median follow-up, adjuvant ADT increased survival by 2.6 years compared with surgery alone, in node-positive patients. Median survival in the adjuvant ADT and deferred treatment groups was 13.9 and 11.3 years, respectively. 64% of patients treated with adjuvant ADT were still alive at this time, compared with 45% of patients who received radical prostatectomy alone.
    - In this setting, adjuvant ADT reduced the risk of dying by approximately 46% compared with RP alone (HR 0.54; 95%CI: 0.99–0.30; p=0.04).

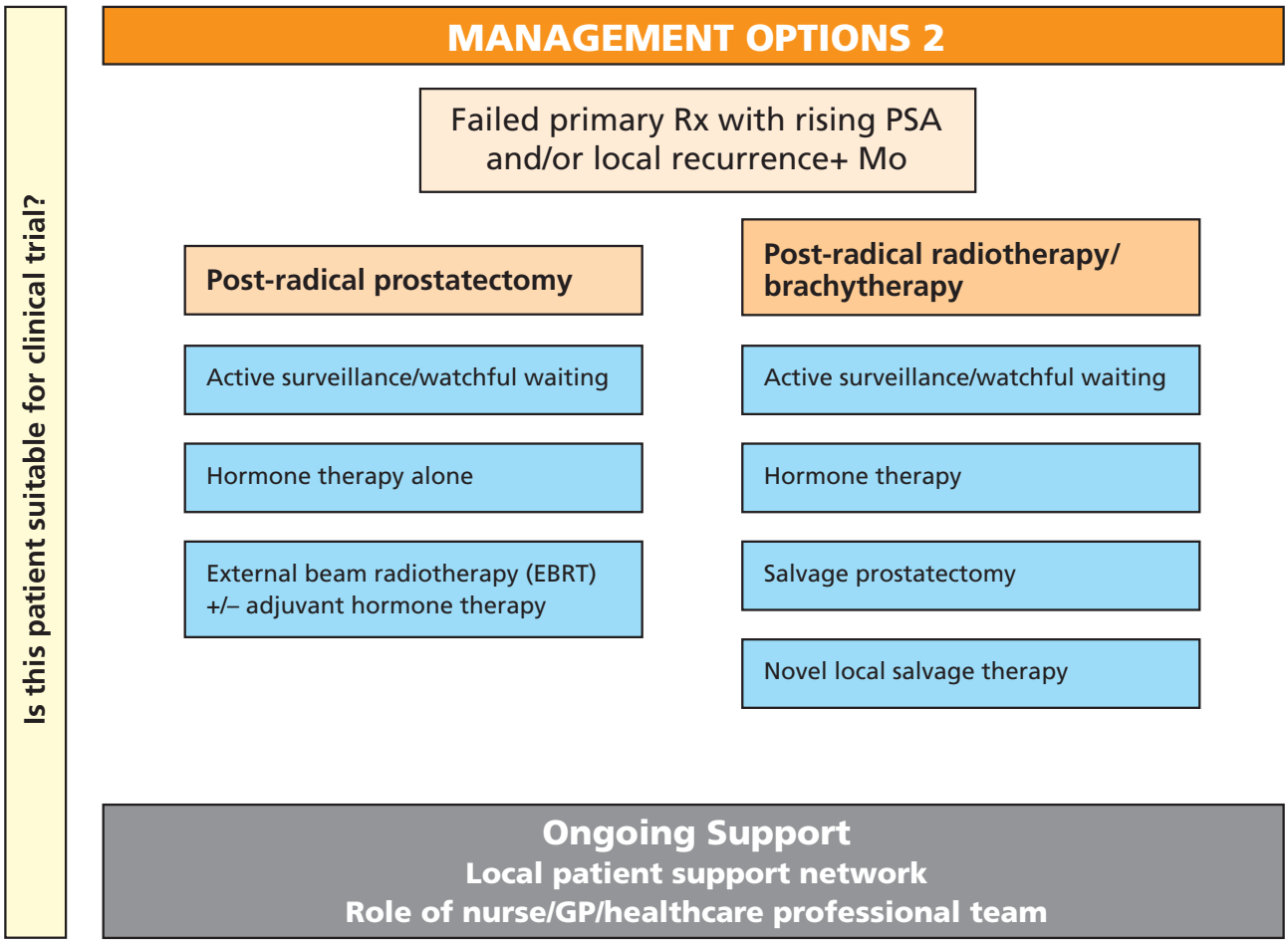
Radical Prostatectomy and Adjuvant Radiotherapy

- Extracapsular invasion (pT3), Gleason score > 7, and positive surgical margins (R1) can be associated with a risk of local recurrence [Hanks GE. E 1988]. Adjuvant radiotherapy has been assessed in three prospective randomised studies
- The EORTC 22911 study was designed to investigate benefit for immediate postoperative radiotherapy (60 Gy) in a target sample size of 1005 patients with pT3 disease or positive surgical margins as opposed to salvage radiotherapy offered for biochemical or clinical relapse [Bolla M, *et al* 2012].
    - After a median follow up of 10 years, overall survival did not differ significantly between the treatment arms. For patients younger than 70, the study concluded that adjuvant RT significantly improved the 10-year biological PFS: 60.6% vs. 41.1%. A previous reported difference in the clinical progression rates for the entire cohort that favoured adjuvant RT after 5 years of follow up was not sustained at 10 years, although locoregional control was improved after immediate irradiation (hazard ratio, HR = 0.45, P < 0.0001).
    - In terms of toxicity, adjuvant RT was well tolerated with no reported Grade 4 toxicity. The grade 3 genitourinary toxicity rate was 5.3%, in comparison with 2.5% in the observation group after 10 years.
- SWOG 8794 reported the results of 425 men with pT3 disease who were randomised to adjuvant radiotherapy to the prostate bed (60–64 Gy) or observation and subsequent salvage therapy [Swanson GP, *et al* 2008]. At a median follow up of more than 12 years, this study demonstrated a significant improvement in metastasis-free survival, with a 10-year metastasis-free survival of 71% vs. 61% (median prolongation of 1.8 years, P = 0.016) and a 10-year OS of 74% vs. 66% (median: 1.9 years prolongation; P = 0.023)

- The ARO trial 96-02 randomly assigned men with pT3 N0 tumours and an undetectable post operative PSA to immediate post operative radiotherapy (114 men) or a 'wait and see' policy (154 men). After a median follow-up period of 54 months, the radiotherapy group demonstrated a significant improvement in biochemical PFS of 72% vs. 54%, respectively (P = 0.0015). Further follow up is needed to assess metastases-free survival and overall survival. The rate of grade 3 to 4 late adverse effects was 0.3% [Wiegel T, *et al* 2009].
- The Medical Research Council (MRC) Radiotherapy and Androgen Deprivation In Combination After Local Surgery (RADICALS) study is investigating the timing of radiotherapy (immediate versus early salvage) and hormone duration and will be important in guiding future decision making.

Locally Advanced Disease: Recurrence after Primary Treatment

Figure 3a: Treatment algorithm for locally advanced disease (cont.)



Rising PSA levels

- The PSA concentration at which to define treatment failure after prostatectomy varies in the literature. An international consensus states that recurrent cancer may be defined by two consecutive PSA values of > 0.2 ng/mL [Heidenreich A, *et al*. EAU guidelines 2013].

Definitions of recurrence

- The Phoenix definition of relapse after radiotherapy is PSA nadir plus 2 ng/ml [Roach M, *et al* 2006].
- Patients whose PSA never falls to an undetectable level in the post-operative period are generally considered to have systemic disease. However, some may have local disease amenable to salvage radiotherapy, and so need to be carefully assessed to determine the best management plan.
- A PSA concentration that rises rapidly in the post-operative setting may be indicative of metastatic disease, while a PSA that remains undetectable over a long period then gradually rises may be more likely to indicate local recurrence.

- Pound *et al*. carried out a retrospective review of 1997 men undergoing radical prostatectomy by a single surgeon for clinically localised disease with no neoadjuvant or adjuvant treatment [Pound CR, *et al* 1999]. A PSA ≥0.2 ng/ml was deemed evidence of recurrence.
    - At 15 years, 15% had PSA elevation and 34% of these had developed metastases.
    - The median time from PSA elevation to metastatic disease was 8 years.
    - After development of metastases, the median actuarial time to death was 5 years. In the survival analysis, time to biochemical progression, Gleason grade and PSA doubling time were predictive of the probability and time to the development of metastatic disease.
- After completion of radiotherapy and hormonal treatment, testosterone recovery usually occurs. This may cause some PSA elevation that is related to normal prostate tissue recovery and not disease recurrence.
- The definition of disease recurrence in the setting of combined therapy remains a matter of debate and consensus is awaited.
- Benign PSA rises (PSA bounce) occur in approximately 12% of patients following EBRT and 30% following LDR brachytherapy in the absence of neoadjuvant hormonal treatment (starting between 18 months and 2 years after treatment).

Local recurrence after radical prostatectomy

Overview

- Overall, approximately 40% of patients who have a radical prostatectomy have biochemical evidence of recurrence at some point.
- Determining whether relapse is local or distant is important in determining optimal treatment. However, post-prostatectomy imaging is often unhelpful. Other factors that may aid this distinction include:
  - Timing and pattern of PSA relapse (rapid rise post-operatively favours distant spread)
  - Involvement of seminal vesicles or lymph nodes
  - Margin status at surgery
  - Gleason grade
- Radical salvage treatment is usually via radiotherapy to the prostate bed +/– hormone therapy. The optimal time of treatment, i.e. immediate adjuvant or early salvage EBRT, is currently uncertain. The timing and duration of hormone therapy is also unclear.
- The RADICALS study is investigating the timing of radiotherapy (immediate versus early salvage) and hormone duration [Parker C, *et al* 2007].

Clinical evidence

- Extracapsular invasion (pT3), Gleason score > 7, and positive surgical margins (R1) can be associated with a risk of local recurrence [Hanks GE. 1988]. Adjuvant radiotherapy has been assessed in three prospective randomised studies.

Adjuvant radiotherapy

- The EORTC 22911 study was designed to investigate benefit for immediate postoperative radiotherapy (60Gy) in a target sample size of 1005 patients with pT3 disease or positive surgical margins as opposed to salvage radiotherapy offered for biochemical or clinical relapse [Bolla M, *et al* 2012].

  After a median follow up of 10 years, overall survival did not differ significantly between the treatment arms. For patients younger than 70, the study concluded that adjuvant RT significantly improved the 10-year biological PFS: 60.6% vs. 41.1%. A previous reported difference in the clinical progression rates for the entire cohort that favoured adjuvant RT after 5 years of follow up was not sustained at 10 years, although locoregional control was improved after immediate irradiation (hazard ratio, HR = 0.45, P < 0.0001).

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- Further results are awaited from a recently completed randomised controlled phase III study from the RTOG-96-01 in 771 men comparing salvage radiotherapy and placebo vs. a combination of salvage radiotherapy and bicalutamide 150 mg daily in the postoperative setting [Heney N *et al*, 2010]. At a median follow-up of 7.1 years, actuarial OS at 7 years was 91% for the RT and bicalutamide group and 86% for RT alone. Too few primary end-point events have occurred to allow a statistical comparison between groups. Freedom from PSA progression at 7 years was 57% for the combined modality group and 40% for RT alone (P < 0.0001) and for the 134 men with Gleason Score 8-10 was 56% and 26% (P < 0.0008). The 7-yr cumulative incidence of metastatic prostate cancer was less in the RT and bicalutamide arm, 7% vs. 13% in the RT alone arm (p<0.041). Late grade 3-4 toxicities were similar in both arms.

- The Medical Research Council (MRC) Radiotherapy and Androgen Deprivation In Combination After Local Surgery (RADICALS) study is investigating the timing of radiotherapy to a dose of 66Gy in 33 fractions (immediate versus early salvage) and hormone duration and will be important in guiding future decision making.

Salvage hormone therapy

- Systemic failure following radical prostatectomy is predicted with > 80% accuracy by a PSA relapse < 1 year, a PSADT of 4-6 months, Gleason score 8-10, and stage pT3b, pTx pN1. In this situation early hormone therapy may help delay progression in selected patients.
- A retrospective study including 1,352 patients with postoperative PSA recurrence showed no significant difference overall in the time to clinical metastases with early hormone therapy (after PSA recurrence, but before clinical metastases) vs. delayed hormone therapy (at the time of clinical metastases). However, for high risk patients (Gleason score > 7 and/or a PSA doubling time < 12 months) it was found that early hormone therapy delayed the time to clinical metastases although had no overall impact on prostate cancer specific mortality [Moul JW, *et al* 2004].

Recurrence after radical radiotherapy

Overview

- After radiotherapy, local failure is documented by a positive prostatic biopsy and negative imaging studies for systemic disease such as CT or MRI and bone scan.
- It must however be noted that most imaging studies are not sensitive enough to identify the anatomic location of relapsing PCa at PSA levels < 0.5-1.0 ng/mL. Prostatic biopsy after RT is only considered necessary if local procedures with curative intent, such as a salvage radical prostatectomy, are indicated in an individual patient.
- The therapeutic options for recurrence following radiotherapy include:
    - Salvage radical prostatectomy: associated with 5-year biochemical DFS rates of 55–69%, but the technique is associated with a significant incidence of complications, such as rectal injury, anastamotic stricture and urinary incontinence. In general, salvage radical prostatectomy should be considered only after multidisciplinary team and patient discussion with regards to potential benefits and toxicities. It should be limited to men with low comorbidity, a life expectancy of at least 10 years, an organ-confined prostate cancer with a Gleason score < 7, and preoperative PSA < 10 ng/mL.
    - Salvage cryotherapy: 5-year biochemical PFS ranges from 40% to 73%. The complications of salvage cryotherapy are erectile dysfunction, pelvic, rectal or perineal pain, recto-urethral fistula, bladder outlet obstruction and urethral stricture.
    - Salvage HIFU is currently under investigation.
    - Hormone therapy can be given in combination with local treatments or as monotherapy.

Clinical evidence

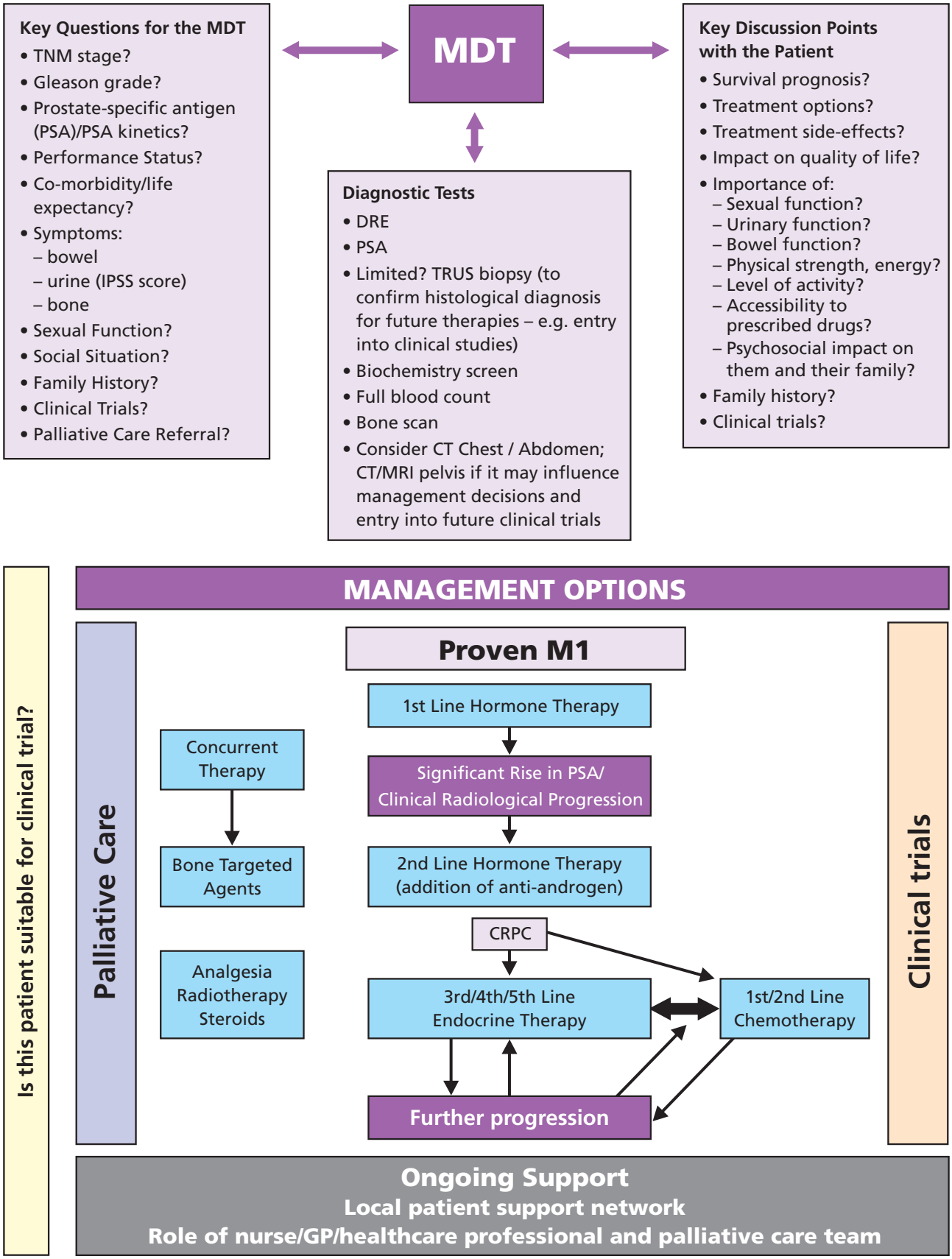
- In a recent systematic review of the literature, Chade *et al*. showed that salvage radical prostatectomy allowed 5-year and 10-year biochemical recurrence-free survival estimates ranging from 47% to 82% and from 28% to 53%, respectively. The 10-year cancer-specific and OS rates ranged from 70% to 83% and from 54 to 89%, respectively. The PSA value before salvage radical prostatectomy and prostate biopsy Gleason score were the strongest predictors of the presence of organ-confined disease, progression, and cancer specific survival [Chade DC, *et al* 2011]
- The four studies of salvage cryotherapy reviewed used varying definitions of recurrence. The 5-year biochemical PFS ranged from 40% when failure was defined as PSA 2 above nadir, to 62% and 73% when failure was defined as PSA greater than 2 and greater than 4, respectively.
    - The complications of salvage cryotherapy are erectile dysfunction, pelvic, rectal or perineal pain, rectourethral fistula, bladder outlet obstruction and urethral stricture.
- In a multicentre study reporting the current outcome of salvage cryotherapy in 279 patients, the 5-year biochemical -free survival estimate according to the Phoenix criteria was 54.5 ± 4.9%. Positive biopsies were observed in 15 of the 46 patients (32.6%) who underwent prostate biopsy following the procedure. The urinary incontinence rate was 4.4%. The rectal fistulae rate was 1.2%, and 3.2% of patients had to undergo transurethral resection of the prostate (TURP) for removal of sloughed tissue [Pisters LL, *et al* 2008].
- In 71 patients with localised disease following EBRT who were treated with salvage HIFU, 80% demonstrated negative biopsies and 61% had a nadir PSA concentration <0.5 ng/ml [Gelet A, *et al* 2004].
    - At a mean follow-up of 14.8 months, 44% of the patients had no evidence of disease progression.
    - Adverse events included recto-urethral fistula in 6%, grade 3 incontinence in 7%, and bladder neck stenosis in 17% of patients.

Salvage hormone therapy

- Patients with a PSA relapse who are not eligible for salvage therapy or who have high risk of systemic disease may be treated with immediate or delayed hormone therapy. Intermittent androgen deprivation for PSA elevation after radiotherapy may improve quality of life and theoretically delay hormone resistance. Overall survival rates of intermittent versus continuous androgen deprivation have been assessed in a noninferiority randomised trial.1386 patients with a PSA level greater than 3 ng/ml more than 1 year after primary or salvage radiotherapy for localised prostate cancer were randomised. Intermittent treatment was provided in 8-month cycles, with non-treatment periods determined according to the PSA level [Crook JM, *et al* 2012].
- At a median follow-up of 6.9 years, OS was 8.8 years in the intermittent-therapy group versus 9.1 years in the continuous-therapy group (hazard ratio for death, 1.02; 95% confidence interval, 0.86 to 1.21). The estimated 7-year cumulative rates of disease-related death were 18% and 15% in the two groups, respectively (P=0.24). Intermittent androgen deprivation was shown to be noninferior to continuous therapy in this setting with respect to OS. In the intermittent-therapy group, testosterone recovery to the trial-entry threshold occurred in 79%. Intermittent therapy provided potential benefits with respect to physical function, fatigue, urinary problems, hot flashes, libido, and erectile function.

Advanced (Metastatic) Prostate Cancer Management Options

Figure 4: Treatment algorithm for advanced (metastatic) disease



Based on MRC evidence, the majority of patients with advanced (metastatic) disease should be treated. Deferred treatment is acceptable only in highly selected, informed patients.

First line hormone therapy

Overview

- Androgen deprivation therapy (ADT) is standard first-line treatment for the management of patients with advanced disease. ADT can involve orchidectomy, LHRH agonists, and gonadotrophin-releasing hormone (GnRH) antagonists and anti-androgens
- Orchidectomy remains the gold-standard ADT against which all other treatments are compared because of its rapid effects on total testosterone concentrations [Tombal B.2007].
- The standard castrate level is <50 ng/dL. It was defined more than 40 years ago and current, more accurate methods of testosterone measurement have shown the mean value after surgical castration is 15 ng/dL(1.7 nmol/L) [Oefelein MG, *et al* 2000]. This has led to a revisiting of the current definition of castration, with many authors suggesting a more appropriate level is < 20 ng/dL
- Long-acting luteinising hormone-releasing hormone (LHRH) agonists have been used in advanced prostate cancer for more than 15 years. They are synthetic analogues of LHRH, generally delivered as depot injections on a 1-, 2-, 3-, 6-monthly, or yearly basis. After the first injection, they stimulate pituitary LHRH receptors, inducing a transient rise in LH and FSH release leading to a testosterone and potential clinic flare phenomenon, which begins 2-3 days after administration and lasts for about 1 week. The effects of the testosterone flare can be blocked by the co administration of an antiandrogen before and up to 2 weeks after the initial injection. Survival is generally considered equivalent with LHRH agonists and orchidectomy [Vogelzang NJ, *et al* 1995; Kaisary AV, *et al* 1995]. Although a meta-analysis has indicated that 2-year survival may be worse with medical treatment than with orchidectomy [Seidenfeld J, *et al* 2000].
- Patients, however, generally prefer medical treatment and in terms of usage, drug treatment represents the standard of care for advanced prostate cancer [Shahinian VB, *et al* 2005; Shahinian VB, *et al* 2006; Cassileth BR, *et al* 1992].
- In contrast to LHRH agonists, GnRH antagonists bind immediately and competitively to LHRH receptors in the pituitary gland. The effect is a rapid decrease in LH, FSH and testosterone levels without any testosterone flare. Now licensed on the evidence of phase III clinical trial data, degarelix demonstrates reduced testosterone concentrations to below castrate levels in 3 days (90% decrease in median testosterone compared with leuprolide group experiencing a 65% increase in median testosterone levels; p<0.001) [Klotz L, *et al* 2010].
    - Degarelix shows long term suppression of testosterone for up to 364 days. 97.2% of patients on degarelix maintained medical castrate levels (<50 ng/dl from day 28 to Day 364 (95% /CIS) compared to 96.4% with leuprolide.
    - PSA levels were lowered by 64% after 2 weeks, 85% after 1 month and 95% after 3 months and remained suppressed throughout the 1-year treatment.
    - An extended follow-up has been recently published (median 27.5 months), suggesting that degarelix might result in better progression-free survival compared to monthly leuprorelin [Crawford ED, *et al* 2011].
    - Ongoing research suggests that degarelix may reduce the risk of further cardiovascular events in men who have suffered an event prior to commencing hormone therapy [Smith MR, *et al* 2011].
    - Degarelix can cause local skin reactions after delivery of the initial injection but this isles common with subsequent treatments.

Immediate versus deferred hormonal treatment

- All symptomatic advanced prostate cancer patients should have immediate treatment with ADT.
- Immediate versus deferred treatment for advanced prostate cancer was investigated by the MRC Prostate Working Party Investigators Group. An RCT of 943 men with asymptomatic metastases or locally advanced disease, not suitable for curative treatment, was undertaken, with randomisation to immediate or deferred hormone therapy [MRC Prostate Working Party Investigators Group 1997].
    - There was a significant advantage in the immediate treatment group in terms of distant progression. Mortality was only significantly changed by treating immediately in those with M0 disease (Table 6).
    - A modest but statistically significant increase in OS was seen in the immediate treatment group, but not significant difference in prostate cancer mortality or symptom-free survival was demonstrated.
    - Due consideration must therefore be given to potential effects of long-term ADT versus the potential avoidance of such effects in patients if hormone therapy is deferred [Studer UE, *et al* 2008].

Table 6: Effect of immediate versus deferred hormonal treatment [MRC Prostate Working Party Investigators Group 1997].

		Immediate	Deferred
Distant progression		26%	45%
Mortality due to prostate cancer	M0 disease M1 disease	31.6% No significant difference	48.8% No significant difference

Combined androgen blockade (CAB)

- There is debate over the use of combined androgen blockade (CAB). In 2000, the Prostate Cancer Trialists' Collaborative Group published a meta-analysis of the available trials of CAB versus monotherapy. The analysis included 27 trials, which incorporated 8275 men, representing 98% of men ever randomised in trials of CAB versus monotherapy [Prostate Cancer Trialists' Collaborative Group 2000; Klotz L 2001].
    - The 5-year survival for all patients receiving CAB was 25.4%, compared with 23.6% for patients receiving monotherapy.
    - In subgroup analyses, patients treated with cypretone acetate (CPA) seemed to fare slightly worse than those treated with flutamide or nilutamide, mostly secondary to non-prostate cancer-related deaths.

- If the CPA studies were excluded, the results were as follows [Prostate Cancer Trialists' Collaborative Group 2000]:
    - CAB with flutamide alone was associated with an 8% reduction in the risk of death (95%CI: 0.86–0.98; p=0.02), which translates to a small but significant improvement in 5-year survival over castration alone.
    - CAB with flutamide plus nilutamide was associated with an 8% reduction in the risk of death (95%CI: 1.00–1.27; p=0.005), which translates to a small but significant improvement in 5-year survival of 2.9% over castration alone.
    - Conversely, CAB with CPA is associated with an increased risk of death of 13% (95%CI: 1.00–1.27; p=0.04), which translates to a small but significant reduction in 5-year survival of 2.8% over castration alone.
- It can be concluded that the choice of anti-androgen used for CAB has an impact on outcome, and that CAB with a non-steroidal anti-androgen may offer a small but significant survival benefit.

Intermittent versus Continuous Androgen Blockade

- The use of intermittent androgen blockade (IAD) has the advantage of potentially reducing the toxicities of therapy and improving quality of life in the periods of no treatment and also a potential theoretical advantage of delaying the emergence of the androgen-independent clone.
- A systematic review has concluded that intermittent IAD was feasible and accepted by patients [Abrahamsson PA 2010]. Results from ongoing randomised controlled trials are awaited although many studies had mixed advanced and locally advanced patients and used different criteria for starting and stopping ADT and the duration of therapy time.
- A study of 766 patients conducted by the South European Uroncological (SEUG) Group included 30% with advanced disease. After a median follow-up of 51 months, there was no difference in either time to progression (HR: 0.81; p = 0.11) or overall survival (HR: 0.99). No overall quality of life benefit was demonstrated but there was a clear benefit for improved sexual function in the IAD group, with 28% sexually active vs. 10% in the continuous group at 15 months after randomization, respectively [Calais da Silva FE, *et al* 2009].
- The FinnProstate Study VII, randomized 554 patients (50% with advanced disease) to intermittent versus continuous ADT. After a median follow-up of 65 months, no significant difference was observed in the median PFS (34.5 months in the IAD group vs. 30.2 months in the continuous group, p = 0.29) in either the total study population or in the N+ or M1 subgroup populations. The median OS was 45 months in both groups.
- Results are awaited from the SWOG trial 9346, which is the largest study to randomize patients with advanced prostate cancer (1134 men out of 3040) to intermittent and continuous ADT [Hussain M, *et al* 2012]. The presented abstract indicated that IAD was not 'non inferior' compared to continuous ADT (median OS 5.1 years for IAD compared to 5.8 years for the continuous treatment arm).
- Published results of this and other ongoing studies are awaited to determine the further benefits and safety of IAD in men with advanced disease.

Second line hormone therapy

- Some patients will respond to second-line hormone therapy with the addition of an anti-androgen, to achieve combined androgen blockade (CAB) With further progression anti-androgen withdrawal responses are seen in approximately 25% of cases who have been treated with first-line CAB or have had substantial (>1 year response) to second-line CAB.
- A common second-line treatment is the addition of an anti-androgen. A retrospective analysis of 122 patients who received the addition of bicalutamide 50 mg to goserelin for PSA and clinical progression showed a >50% decrease in PSA concentration in 30% of patients (responders) and a reduction in PSA concentration in 75% of all patients. The median duration of response from start of bicalutamide 50 mg was 291 days for responders and 193 days for the population as a whole. Those patients with a short duration of response to goserelin monotherapy (<1 year) appeared less likely to respond to CAB with the addition of bicalutamide 50 mg than those who had a longer response (1–2 years).
    - There are reports of PSA responses as a result of anti-androgen withdrawal in men whose disease is progressing on CAB. A recently reported multi-institutional, prospective study demonstrated PSA decreases of ≥50% in 21% (16% to 27%) of 210 men with progressive prostate cancer who discontinued the anti-androgen component of their CAB therapy [Sartor AO, *et al* 2008].
    - Median PFS was 3 months; however, 19% of responders had 12-month or greater progression-free intervals. Longer duration of initial anti-androgen use was shown to be a significant predictor of PSA response.

Side-effects of hormone therapy

- LHRH agonists and GnRH antagonists have a similar tolerability profile: side-effects include erectile dysfunction and loss of libido, reduction in bone mineral density, hot flushes and sweating, and weight gain and injection-site reactions (GnRH antagonists) and metabolic syndrome.
- Anti-androgen side-effects include gynaecomastia and breast tenderness. Mild to moderate gynaecomastia (68.8%) and breast pain (73.6%) are the most common adverse events described.

Castration Resistant Prostate Cancer: Management Options

Prostate cancers that progress despite castrate levels of testosterone are considered castration resistant and not hormone refractory. This is based on findings that the cancer is not uniformly refractory to further hormonal manipulation. Castration-resistant prostate cancer (CRPC), which is still hormone sensitive, has been clearly characterized, with new drugs targeting the androgen receptor, such as enzalutamide, or androgen biosynthesis, via CYP 17 inhibition, such as abiraterone acetate

There are a number of options for therapy for CRPC but the exact sequencing remains undetermined and will depend on both tumour characteristics (e.g. Gleason Score, PSA velocity) patient comorbidities and fitness for therapy and patient choice. The results of sequencing studies are awaited.

Further hormone therapies for CRPC

- Corticosteroids alone have definite activity against prostate cancer (approximately 20% response rate) and provide significant palliation in terms of anorexia, pain and depression. The optimal drug and dose have not been determined, but even prednisone at a dose of 5 mg bid resulted in subjective and PSA responses in one randomised trial [Tannock IF, *et al* 1996].
- Dexamethasone has been shown to be effective for men with progressive metastatic CRPC [Venkitaraman R, *et al* 2008]. In a study of 102 patients treated with oral dexamethasone (0.5 mg daily), 49% had a confirmed PSA response. The median time to PSA progression for the entire cohort was 7.4 (1-28) months and in responders, the median duration of the PSA response was 11.6 (1-24) months.
- Abiraterone acetate is a non-steroidal ester that selectively and irreversibly inhibits both 17α-hydroxylase and the C17, 20-lyase function of CYP17A1, a cytochrome involved in the production of dehydroepiandrosterone (DHEA) and androstenedione (precursors of testosterone). Abiraterone inhibits androgen biosynthesis at all three key sources in prostate cancer: the testes, adrenal glands and prostate tumour cells. It is administered in combination with glucocorticoids to prevent elevated levels of other steroid hormones and associated fluid balance abnormalities.
- Abiraterone in combination with prednisolone (5 mg twice daily) has been investigated in the pre-docetaxel setting in the COU 302 study in asymptomatic or minimally symptomatic men with a performance status of 0 to 1 and progressive castration resistant prostate cancer [Ryan CJ, *et al* 2013]. This multi-centre, double blind study randomised 1088 patients to abiraterone acetate 1000 mg daily and prednisolone versus placebo plus prednisolone. The study was unblinded after a planned interim analysis that was performed after 43% of the expected deaths had occurred. Results showed a significant improvement in radiographic progression-free survival with a median of 16.5 months with abiraterone-prednisone and 8.3 months with prednisone alone, HR 0.53; 95% CI 0.45 to 0.62; P<0.001). Over a median follow-up period of 22.2 months, overall survival was improved with abiraterone-prednisone (median not reached, vs. 27.2 months for prednisone alone; HR, 0.75; 95% CI, 0.61 to 0.93; P=0.01) but did not cross the efficacy boundary. Abiraterone-prednisone showed superiority over prednisone alone with respect to time to initiation of cytotoxic chemotherapy, opiate use for cancer-related pain, prostate-specific antigen progression, and decline in performance status. Toxicity included mineralocorticoid-related adverse events and abnormalities on liver-function testing were more common with abiraterone-prednisone, but mainly grade 1 or 2.
- Oestrogen therapy with DES demonstrated a comparable efficacy to castration in 1977 and was one of the first initial promising hormone manipulations. However the first Veterans studies showed that early treatment of advanced prostate cancer with DES 5 mg did not increase OS when compared to placebo, as the drug was associated with an increased incidence of cardiovascular deaths [Byar DP 1972].
- A second study compared the DES 5 mg dose to 1 mg and the results showed that this lower dose was equally effective but was associated with a much lower incidence of cardiovascular deaths. The risk of cardiovascular events may require the concomitant use of aspirin/anticoagulants [Robinson MR (a), *et al* 1995].
- Other new agents such as enzalutamide and orteronel are currently under evaluation in the prechemotherapy setting.
- There is now evidence for further use of hormone therapies after docetaxel (see below) The choice between these drugs or the use of second line chemotherapy remains unclear and sequencing studies are urgently awaited.

- Abiraterone has also been investigated in the COU 301 study [Fizazi K, *et al* 2012]. This was multicentre, prospective double blind randomised trial of 1195 patients with metastatic CRPC who were randomly assigned (ratio2:1) abiraterone acetate 1000 mg daily plus prednisolone (5 mg twice daily) or placebo and prednisolone (5 mg twice daily). All patients had progressive disease after docetaxel therapy (with a maximum of two previous chemotherapeutic regimens). After a median follow-up of 20.2 months, the median survival in the abiraterone group was 15.8 months compared to 11.2 months in the placebo arm (HR: 0.74, P < 0.001). The median time to PSA progression was 8·5 months, CI 8·3-11·1, in the abiraterone group vs. 6·6 months, 5·6-8·3, in the placebo group; HR 0·63, 0·52-0·78; p<0·0001), median radiologic progression-free survival (5·6 months, 5·6-6·5, vs. 3·6 months, 2·9-5·5; HR 0·66, 0·58-0·76; p<0·0001), and proportion of patients who had a PSA response (235 [29·5%] of 797 patients vs. 22 [5·5%] of 398; p<0·0001) were all improved in the abiraterone group compared with the placebo group. The most common grade 3-4 adverse events were fatigue (72 [9%] of 791 patients in the abiraterone group vs. 41 [10%] of 394 in the placebo group), anaemia (62 [8%] vs. 32 [8%]), back pain (56 [7%] vs. 40 [10%]), and bone pain (51 [6%] vs. 31 [8%]).The benefit was observed irrespective of age, baseline pain intensity, and type of progression.
- Enzalutamide is a novel oral antiandrogen that targets multiple steps in the androgen-receptor-signalling pathway and has shown a significant survival benefit for men with CRPC following docetaxel chemotherapy
- In the AFFFIRM study 1199 men with castration resistant prostate cancer after docetaxel chemotherapy were randomly assigned them, in a 2:1 ratio, to receive oral enzalutamide at a dose of 160 mg per day or placebo (399 patients) [Scher HI, *et al* 2012]. The study was stopped after a planned interim analysis at the time of 520 deaths. The median overall survival was 18.4 months (95% CI, 17.3 to not yet reached) in the enzalutamide group versus 13.6 months (95% CI, 11.3 to 15.8) in the placebo group (hazard ratio for death in the enzalutamide group, 0.63; 95% CI, 0.53 to 0.75; P<0.001). All the secondary objectives were in favour of enzalutamide. the proportion of patients with a reduction in the PSA level by 50% or more (54% vs. 2%, P<0.001), the soft-tissue response rate (29% vs. 4%, P<0.001), the quality-of-life response rate (43% vs. 18%, P<0.001), the time to PSA progression (8.3 vs. 3.0 months; hazard ratio, 0.25; P<0.001), radiographic progression-free survival (8.3 vs. 2.9 months; hazard ratio, 0.40; P<0.001), and the time to the first skeletal-related event (16.7 vs. 13.3 months; hazard ratio, 0.69; P<0.001). Rates of fatigue, diarrhoea, and hot flashes were higher in the enzalutamide group with a lower incidence of grade 3-4 side effects in the enzalutamide arm. Seizures were reported in five patients (0.6%) receiving enzalutamide.

Chemotherapy

An alternative treatment for advanced CRPC is chemotherapy. Docetaxel is now recommended as first line chemotherapy.

Side-effects of chemotherapy depend on the exact treatment regime, but usually include fatigue, nausea and vomiting, diarrhoea, hair loss and bone marrow suppression with increased susceptibility to infection. Specific therapies to handle these side-effects may be necessary to improve the patient's quality of life.

- A prospective study by Tannock in 1996 compared the benefits of mitoxantrone 12 mg/m² every 3 weeks plus prednisone 5 mg twice-daily with prednisone alone in 161 men with symptomatic HRPC [Tannock IF, *et al* 1996].
    - The primary endpoint was palliative response defined as a 2-point decrease in pain as assessed by a 6-point pain scale.
    - There was a significant advantage to the chemotherapy combination with a 29% pain response compared to 12% with steroids alone.
    - The duration of palliation was 43 weeks versus 18 weeks ($p<0.0001$) in favour of mitoxantrone and prednisone.
    - There was no difference in PSA or survival. It was therefore concluded that chemotherapy with mitoxantrone and prednisone provides palliation for some patients with symptomatic HRPC.
- The TAX 327 study randomised 1006 men with advanced prostate cancer to three treatment regimens [Tannock IF, *et al* 2004].
    - These were docetaxel 75 mg/m² administered every 3 weeks, docetaxel 30 mg/m² every week and mitoxantrone 12 mg/m² every 3 weeks, each with prednisone 5 mg twice-daily.
    - Initial results were published in 2004 and showed a significant improvement in median survival with 3-weekly docetaxel plus prednisolone (18.9 months), compared with the comparator arm of mitoxantrone plus prednisolone (16.5 months) ($p<0.001$).
    - A total of 45% of those in the docetaxel arm had a PSA reduction ≥50% compared to 32% of those having mitoxantrone ($p=0.0005$).
    - Increased benefits in pain response (35% versus 22%, $p=0.01$) were demonstrated in favour of docetaxel.
    - Quality of life was improved in 13% of patients receiving mitoxantrone, 22% of patients receiving 3-weekly docetaxel ($p=0.009$) and 23% of patients receiving weekly docetaxel ($p=0.005$).
- Further results have recently been reported and the survival benefit with 3-weekly docetaxel has persisted with extended follow-up [Berthold DR, *et al* 2008].
    - Median survival was 19.3 months for 3-weekly docetaxel versus 16.3 months in the mitoxantrone arm ($p=0.006$) with respective 3-year survival figures of 17.9% versus 13.7% in favour of docetaxel.
    - This study has confirmed the benefits of docetaxel chemotherapy.
    - The extended analysis of the TAX 327 study included subgroup analyses and demonstrated survival benefits for men both <65 years and >75 years of age.

- Cabazitaxel is a novel tubulin-binding taxane drug with antitumour activity in docetaxel-resistant prostate cancers. Positive results were seen for cabazitaxel from a large prospective randomised, phase III trial (TROPIC study) [de Bono JS, *et al* 2010]. In this study, 755 men with metastatic castration-resistant prostate cancer whose disease had progressed during or after treatment with a docetaxel-containing regimen were treated with 10 mg oral prednisone daily, and were randomly assigned to receive either 12 mg/m2 mitoxantrone intravenously or 25 mg/m2 cabazitaxel intravenously every 3 weeks. An overall survival benefit (15.1 vs. 12.7 months, P < 0.0001) was observed in the cabazitaxel arm. There was also a significant improvement in PFS (2.8 vs. 1.4 months, P < 0.0001), objective response rate according to RECIST criteria (14.4% vs. 4.4%, P <0.005), and PSA response rate (39.2% vs. 17.8%, P < 0.0002). The most common clinically significant grade 3 or higher adverse events were neutropenia (cabazitaxel, 303 [82%] patients vs mitoxantrone, 215 [58%]) and diarrhoea (23 [6%] vs. one [<1%]). 28 (8%) patients in the cabazitaxel group and five (1%) in the mitoxantrone group had febrile neutropenia.

Bone targeted agents

Bisphosphonates

- The benefits of zoledronic acid, in combination with hormone therapy have been investigated in a study by Saad in men with HRPC and bone metastases [Saad F, *et al* 2002]. This was a multicentre, randomised, placebo-controlled trial evaluating the efficacy of zoledronic acid 4 mg administered every 3 weeks in 422 patients with HRPC for 15 months, with an option to continue for an additional 9 months.
    - At the 2-year analysis, treatment with zoledronic acid was found to significantly reduce the percentage of patients with at least one skeletal-related event (SRE; defined as radiation for bone pain or to prevent pathological fracture/spinal cord compression; pathological fracture; spinal cord compression; surgery to bone; change in antineoplastic therapy) compared with placebo (38% versus 49%; p=0.028). All SREs were delayed.
    - Zoledronic acid also significantly delayed the time to first SRE by around 6 months (median 488 versus 321 days; p=0.009). Furthermore, patients in the zoledronic acid group had consistently lower incidences of all types of SRE than the placebo group. Pain scores were consistently lower in patients taking zoledronic acid 4 mg than placebo, and significantly at 3, 9, 18, 21 and 24 months (p<0.05).
- In the MRC PR05 and PR04 trials, men with advanced prostate cancer were randomised to sodium clodronate 2080 mg/day or placebo for up to 3 years (metastatic disease) or up to 5 years (non-metastatic disease) [Dearnaley DP, *et al* 2009].
    - A benefit of sodium clodronate versus placebo in men with metastatic disease was demonstrated for OS (HR: 0.77; 95%CI: 0.60–0.98; p=0.032).
    - However, no benefit of sodium clodronate versus placebo for OS in men with non-metastatic disease was demonstrated (HR: 1.12; 95%CI: 0.89–1.42; p=0.94).

Side-effects

- Bisphosphonates are generally well tolerated.
- Side-effects include: hypophosphataemia, anaemia, influenza-like symptoms, gastrointestinal effects, headache, conjunctivitis, very rarely osteonecrosis of jaw and renal impairment.
- To avoid this, patients on bisphosphonates should avoid dental surgery and extractions. If required this should be performed before starting treatment.
- In the study by Saad *et al*., zoledronic acid was generally well-tolerated [Saad F, *et al* 2002]:
    - Bone pain, nausea and constipation were reported most frequently both by patients receiving zoledronic acid and by those in the placebo group
    - In the zoledronic acid group, fatigue, anaemia, myalgia, fever and lower limb oedema occurred in at least 5% more patients than that observed in the placebo group
- In uncommon cases, patients treated with intravenous zoledronic acid have reported osteonecrosis of the jaw (ONJ) [Marx RE, *et al* 2005].
    - Risk factors associated with the development of ONJ include concomitant chemotherapy and corticosteroids, the patient's underlying disease, and other co-morbid risk factors (e.g. anaemia, local infection, pre-existing oral disease) [Zometa SPC].

RANK ligand inhibitors

- Denosumab is a fully human monoclonal antibody directed against RANKL and a key mediator of osteoclast formation, function, and survival.
- The efficacy and safety of denosumab (n = 950) compared with zoledronic acid (n=951) in patients with metastatic CRPC was assessed in a large randomised phase III trial [Fizazi K, *et al* 2011]. In this multicentre phase 3 study, 1904 men with CRPC and no previous exposure to intravenous bisphosphonate were randomised to receive 120 mg subcutaneous denosumab plus intravenous placebo, or 4 mg intravenous zoledronic acid plus subcutaneous placebo, every 4 weeks until the primary analysis cutoff date. Supplemental calcium and vitamin D were strongly recommended. Median duration on study at primary analysis cutoff date was 12·2 months (IQR 5·9-18·5) for patients on denosumab and 11·2 months (IQR 5·6-17·4) for those on zoledronic acid.
- Results showed that denosumab was superior to zoledronic acid in delaying or preventing SREs, as shown by time to first on-study SRE (pathological fracture, radiation or surgery to bone, or spinal cord compression) of 20.7 vs. 17.1 months, respectively (HR 0.82; P = 0.008). Denosumab also extended time to first and subsequent on-study SRE (HR 0.82; P = 0.008). Both urinary NTX and BAP were significantly suppressed in the denosumab arm compared with the zoledronic acid arm (P < 0.0001 for both). There was no overall survival benefit seen. Adverse events were recorded in 916 patients (97%) on denosumab and 918 patients (97%) on zoledronic acid, and serious adverse events were recorded in 594 patients (63%) on denosumab and 568 patients (60%) on zoledronic acid. More events of hypocalcaemia occurred in the denosumab group (121 [13%]) than in the zoledronic acid group (55 [6%]; p<0·0001). Osteonecrosis of the jaw occurred infrequently (22 [2%] vs. 12 [1%]; p = 0·09).

Systemic radionuclide therapy

Strontium

- Metastatic pain can be palliated effectively with systemic radionuclide therapy with strontium chloride.
- Relief of bone pain starts within 2 weeks. Possible initial bone pain flare may occur within 2 days, lasting 2–4 days.
    - Pain relief lasts 4–15 months.
    - 75–80% of patients experience significant palliation of pain.
- A Canadian collaborative study showed significant improvement in quality of life, increased time to further metastases, significant reduction in the amount of additional radiotherapy needed, and significant falls in PSA and alkaline phosphatise [Porter AT, *et al* 1993].
- Strontium is not associated with improvements in OS [Brundage MD, *et al* 1998].
- Four randomised clinical trials have reviewed the use of strontium [Robinson RG (b), *et al* 1995].
    - One trial reported significant improvement in pain control, two trials reported fewer new sites of pain.
    - One trial showed no significant difference in pain control compared to a placebo but an improved 2-year survival rate.
- A randomised clinical trial examining strontium versus placebo found a significant increase in median time to progression, but no significant effects on median OS or clinical response [Tu SM, *et al* 2001].

Side-effects

- The most notable side-effect of strontium is mild haematological suppression with a fall in circulating platelet and leukocyte counts recognised in most patients.
    - With usual therapeutic doses, platelets typically fall by 30% and leucocytes by 20%.
    - Clinically significant toxicity is rare, but its use is not recommended in patients with severely compromised bone marrow, platelet count <100, superscan prior to therapy, or impending spinal cord progression.

Radium 223

- Radium-223 dichloride (radium-223) is an alpha emitter which selectively targets bone metastases with alpha particles.
- The efficacy and safety of radium-223 was assessed in the ALSYMPCA study [Parker C, *et al* 2013]. In this multicentre, phase 3, randomized, double-blind, placebo-controlled study, 902 men , who had received, were not eligible to receive, or declined docetaxel, were randomly assigned in a 2:1 ratio, to receive six injections of radium-223 (at a dose of 50 kBq per kilogram of body weight intravenously) or matching placebo; one injection was administered every 4 weeks. In addition, all patients received the best standard of care. At the interim analysis, which involved 809 patients, radium-223, as compared with placebo, significantly improved overall survival (median, 14.0 months vs. 11.2 months; hazard ratio, 0.70; 95%CI, 0.55 to 0.88; two-sided P=0.002). The updated analysis involving 921 patients confirmed the radium-223 survival benefit (median, 14.9 months vs. 11.3 months; hazard ratio, 0.70; 95% CI, 0.58 to 0.83; P<0.001). Assessments of all main secondary efficacy end points also showed a benefit of radium-233 as compared with placebo. Radium-223 was associated with low myelosuppression rates and fewer adverse events.

Palliative Care

Overview

- Radiotherapy has been a mainstay in the palliation of painful metastatic bone lesions. Palliative radiotherapy can also aid other complications of metastatic disease, such as compression of the spinal cord or a nerve root, haematuria, ureteric obstruction, perineal discomfort caused by the local progression of prostate cancer, and symptomatic metastatic lymphadenopathy.

Clinical evidence

- Good evidence for the role of radiotherapy in palliation comes from McQuay *et al*. This systematic review covered 20 trials, which reported on 43 different radiotherapy fractionation schedules, and eight studies of radioisotopes [McQuay HJ, *et al* 1997].
    - Radiotherapy produced complete pain relief at 1 month in 395 out of 1580 (25%) patients, and at least 50% relief in 788 out of 1933 (41%) patients at some time during the trials.
    - In the largest trial, which included 759 patients, 52% achieved complete pain relief within 4 weeks and the median duration of complete relief was 12 weeks.
    - The study found no difference between the use of radioisotopes (such as strontium) and EBRT for generalised disease, a finding supported by the work of Quilty *et al* [Quilty PM, *et al* 1994].
    - In this latter study, 284 patients with prostate cancer and painful bone metastases were treated with local or hemi-body radiotherapy or strontium. Median survival was non-significantly different between groups (33 weeks with strontium versus 28 weeks with radiotherapy; p=0.1) [Quilty PM, *et al* 1994].
    - Both radiotherapy and strontium provided effective pain relief that was sustained for 3 months in 63.6% of patients after hemi-body radiotherapy compared with 66.1% of patients after strontium, and in 61% of patients after local radiotherapy compared with 65.9% of patients in the comparable strontium group.
    - Fewer patients reported new pain sites after strontium than after local or hemi-body radiotherapy ($p<0.05$) and radiotherapy to a new site was required by 12 patients in the local radiotherapy group compared with two receiving strontium ($p<0.01$).

Ongoing Support

The MDT team should ensure regular communication with the primary care team.

This may mean:

- Timely provision of detailed discharge or outpatient summaries
- Explanation of why a treatment route has been decided upon
- The patient's response to the chosen treatment
- Sharing of protocols
- Online educational resources
- Agreement on prescribing policies
- Provision of contact numbers for requests for information

The local patient support network, e.g. partner/family, must be included in the information/education process through the use of:

- Patient information materials
- Audio visual materials such as videos, DVDs and Web-based information

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Aimee Crilly

Subject: FW: URO DEC PLAN UPDATE AS AT 07.11.13.xls
Attachments: URO DEC PLAN UPDATE AS AT 07.11.13.xls

Importance: High

-----Original Message-----
From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 07 November 2013 15:15
To: Young, Michael <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Pahuja, Ajay <Personal Information redacted by the USI>
Cc: Troughton, Elizabeth <Personal Information redacted by the USI>; Dignam, Paulette <Personal Information redacted by the USI>; McCorry, Monica <Personal Information redacted by the USI>; Hanvey, Leanne <Personal Information redacted by the USI>; Elliott, Noleen <Personal Information redacted by the USI>; Corrigan, Martina <Personal Information redacted by the USI>
Subject: URO DEC PLAN UPDATE AS AT 07.11.13.xls
Importance: High

Good Afternoon

Please see attached report which lists the remaining patients who are still to be pre-admitted on PAS to meet the 58 week waiting time target by end of December to which we have committed. Could we please try to have as many patients pre-admitted on PAS as possible before Monday?

Many thanks.

Sharon

58 WEEKS DECEMBER

12 WITH NO DATES

Hospital	Casenote	Forename	Surname	Date of Birth	Age	Original Date	Current Date	Date Booked Y/N	Date Booked	Currently Suspended (Y/N)	Current Suspension End Date	Consultant	Intended Method of Adm	Urgency Code	Intended Management	Admission Reason	Intended Primary Procedure Code	Operation Description	Remarks	Weeks Waiting
CAH	Personal Information redacted by the USI [redacted]					20/06/2012	20/06/2012	N		Y	01/12/2013	MY	WL	2	N	9-12/12 CHANGE OF STENT	M29.8	9-12/12 CHANGE OF STENT MARCH/JUNE 2013	PER WARD DISCHARGE	62
CAH	[redacted]					27/09/2012	27/09/2012	N		N		MY	WL	4	N	TURP - NEW LTR GP 13.02.13-CANC 281013 RECENT CARDIAC STENT	M65.3	TURP HOLD(21.10.13)CD ON CLOPIDROGEL (HSQ JACQUI QUERY FILE)	PER WARD DISCHARGE	58
CAH	[redacted]					01/10/2012	01/10/2012	N		N		AOB	WL	4	N	TURP (WARFARIN)	M65.3	TURP ASTHMATIC ON WARFARIN HAS HEART SURGERY FIT(28.01.13)CD	SC OPD 011012 TCI PER AOB	57
CAH	[redacted]					23/10/2012	23/10/2012	N		N		AOB	WL	4	N	CYSTOSCOPY & URETHRAL DILATATION	M45.9	CYSTOSCOPY & URETHRAL DILATATION	PLA OPD 231012 WL PER REG	54
CAH	[redacted]					23/10/2012	23/10/2012	N		N		AOB	WL	4	N	CIRCUMCISION AND BILATERAL ORCHIOPEXY	M30.2	CIRCUMCISION AND BILATERAL ORCHIOPEXY		54
CAH	[redacted]					29/10/2012	29/10/2012	N		N		AOB	WL	4	N	TURP	M65.3	TURP		53
CAH	[redacted]					30/10/2012	30/10/2012	N		N		MY	WL	4	D	INSERTION OF SUPRAPUBIC CATHETER - NEW LTR GP 04.06.13	M49.8	INSERTION OF SUPRAPUBIC CATHETER - NEW LTR GP 04.06.13	PER DISCHARGE	53
CAH	[redacted]					30/10/2012	30/10/2012	N		N		AOB	WL	2	N	INTRADETRUSOR INJECTION OF BOTULINUM TOXIN	M43.4	INTRADETRUSOR INJECTION OF BOTULINUM TOXIN		53
CAH	[redacted]					31/10/2012	31/10/2012	N		N		AOB	WL	4	N	TURP - HEARING IMPAIRED-TCI WEEKEND	M65.3	TURP NEEDS INTREPRETER FOR DEAF. FIT(21.05.13)CD	ICSNULUT 311012 WL PER REG-PT HEARING IMPAIRED-TCI WEEKEND	53
CAH	[redacted]					02/11/2012	02/11/2012	N		N		AOB	WL	4	N	BLADDER NECK INCISION/TURP	M65.3	BLADDER NECK INCISION/TURP		53
CAH	[redacted]					06/11/2012	06/11/2012	N		N		AOB	WL	4	N	CIRCUMCISION GA	N30.3	CIRCUMCISION	PLA OPD 061112 WL PER REG	52
CAH	[redacted]					13/11/2012	13/11/2012	N		N		AOB	WL	2	N	RIGHT URETEROGRAPHY AND URETEROSCOPY	M30.4	RIGHT URETEROGRAPHY AND URETEROSCOPY		51

Aimee Crilly

Subject: FW: UROLOGY capacity/demand
Attachments: SKMBT_28313112315200.pdf

-----Original Message-----
From: Corrigan, Martina <
Sent: 24 November 2013 16:52
To: ONeill, Kate <; McMahon, Jenny <;
Glackin, Anthony <; O'Brien, Aidan <;
Pahuja, Ajay <; Young, Michael <
Cc: Dignam, Paulette <; Elliott, Noleen
<; Harvey, Leanne <; McCorry, Monica
<; Troughton, Elizabeth <
Subject: FW: UROLOGY capacity/demand

Dear all

Please see below for urgent discussion to try and address late upgrade triage and second how we can maintain the core capacity.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: (Direct Dial)
Mobile:
Email:

From: Clayton, Wendy
Sent: 22 November 2013 15:37
To: Corrigan, Martina; Glenny, Sharon
Cc: Muldrew, Angela; Reddick, Fiona; Carroll, Ronan; McQuaid, Julieann; Robinson, Jeanette
Subject: UROLOGY capacity/demand

Martina / Sharon

Please see below haematuria escalation. We received 2 upgraded haematuria referrals dated back from 30/10/13 (see attached).

Next available haematuria appointment as of today is the 12/12/13 – this will make these 2 patients D43. We will go head and book to avoid any delay.

Of note though if referral received and triaged today next available appointment will be D20 for haematuria, previously D14. Can you confirm if there are any more additional sessions.
We have on average:

- Demand = 46-50 RF haematuria referrals per month
- Capacity = 36 slots (this is 1.5 sessions per week)

Do you have any plans re ongoing additional sessions or increasing RF with core. If not the waiting time for haematuria is going to out again.
If we increase the core sessions to 2 haematuria sessions per week with current demand this should be enough (but dependent on demand staying the same)

Happy to discuss

Regards

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

Tel: Personal Information redacted by the USI
Mob

From: McQuaid, Julieann
Sent: 22 November 2013 15:06
To: Clayton, Wendy
Subject: FW: Delayed Urology triage

Please see below.

Julie Ann McQuaid
Clerical officer
Mandeville Unit
CAH
EXT : Personal Information redacted by the USI

From: McQuaid, Julieann
Sent: 22 November 2013 14:06
To: Muldrew, Angela
Cc: Brown, Lesley-Ann
Subject: Delayed Urology triage

Hi,

The following referrals have been received back from triage today to be booked for haematuria.

Personal Information redacted by the USI

Next available clinic is 12/12.

Kind regards,

Julie Ann.

From: Somerville, Nicola
To: O"Brien, Aidan
Cc: McCorry, Monica
Subject: R&S Training
Date: 09 January 2014 12:40:14
Importance: High

Mr O'Brien,

Your R&S Training has not been updated since 2007 and we have no record of you completing e-refresher training. Can I ask you to complete the refresher training before the interviews on Monday (panel members need to have completed this before they sit on panels). I have included the link below for your convenience. Thanks

http://www.hscelearning.com/southerntrust/

Mrs Nicola Somerville
Medical - Human Resources Officer
Southern Health and Social Care Trust
Hill Building
St Luke's Hospital Site
Loughgall Road
ARMAGH
BT61 7NQ

Tel: Personal Information redacted by the USI
e-mail: Personal Information redacted by the USI

Aimee Crilly

From: Brown, Robin <[redacted]>
Sent: 15 January 2014 11:18
To: Graham, Vicki; O'Brien, Aidan
Subject: RE: Urology MDM Update Report - 09.01.14

RE [redacted]
Sorry I could not attend last week and input to the discussion.
I think this man was previously being followed up in CAH by USS (MY, I think)and the only reason I was able to do a CT was because he was under GA for a Cystoscopy anyway.
Cystoscopy basically OK, some bleeding from around ureteric orifices was probably scope trauma.
He could not have a CT or MRI without GA.
He is significantly disabled
Is this realistic?

Robin

CONSULTANT MR BROWN: [redacted] old man with [redacted] History of tuberous sclerosis. Passed clots in urine, none since. Ultrasound â€“ nil significant. Cystoscopy - not performed. CT Urinary tract 31.12.13 - Multiple hyperdense lesions within the kidneys. These probably represent hyperdense cysts. MDMAction

Discussed @ Urology MDM, 09.01.14. Review of this gentleman's contrast enhanced CT demonstrates bilateral enhancing lesions without fat content, in both kidneys. Renal malignancy is a possibility. In addition, there is a lesion arising from lower pole of right kidney, which may represent an angiomyolipoma. For review by Mr Brown, to assess suitability for a renal MRI scan in first instance and if not suitable, to consider an interval CT scan in 3 months.

From: Graham, Vicki
Sent: 09 January 2014 19:00
To: Abogunrin, Funso; Brown, Lesley-Ann; Brown, Robin; Campbell, Dolores; Carser, Judith; connolly, maureen; Dabbous, Marie; Dignam, Paulette; Fionnuala Houghton; Glackin, Anthony; Graham, Vicki; Hamill, Joe; Hann, Gemma; Hanvey, Leanne; Jathar, Hemant; Kelly, Wendy; Larkin, Bronagh; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCorry, Monica; McCreesh, Kate; McMahon, Jenny; Muldrew, Angela; ONeill, Kate; Pahuja, Ajay; Paula McCloskey; Reid, Sharon; Reid, Stephanie; Shah, Rajeev; Shannon, Hilda; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; White, Deborah; Williams, Marc
Subject: Urology MDM Update Report - 09.01.14
Importance: High

Update Report from Urology MDM @ The Southern Trust on 09/01/2014

Surgeon

Oncologist

Clinician

Palliative Medicine

BROWN RJ MR (C6502)

None

None

None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

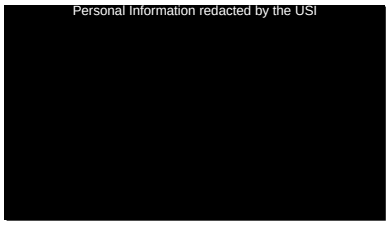
MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old lady with an incidental finding of 2cm right renal mass on CT scanning, October 2012. Discussed @ Urology MDM 13.12.12. This lady has been found to have a right renal lesion which had an unusual, concentric appearance. For review by Mr Glackin who will arrange for Renal MRI scan to be performed in April 2013 and subsequent review. MRI Abdomen, 01.05.13 - Solid enhancing lesion with a probable central scar in the lower pole of the right kidney. There was no significant change in size when compared with the CT of 19 January 2011, suggesting a benign or slow-growing lesion. The differential diagnosis was between an oncocytoma and a renal cell carcinoma. Imaging cannot differentiate. Discussed @ Urology MDM 02.05.13. On recent MRI scanning, this lady continued to have a small lesion within right kidney. For review by Mr Glackin to arrange continued active surveillance by having a further renal MRI scan performed in November 2013. Reviewed on 13.05.13, Mrs Personal Information continued to have right sided abdominal pain which was related to her bowel movements. She is under the care of Mr Brown, Consultant General Surgeon at Daisy Hill with regards to this complaint. MRI requested. MRI Renal 30.12.13: Solid enhancing 18.6 mm nodule lower pole cortex right kidney, with tiny central area of necrosis. This could represent a tiny RCC, but has not changed from previous CT dated 10/10/2012. MDMAction

Discussed @ Urology MDM, 09.01.14. Defer one week with MRI result.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None



Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man who had TURP performed on 10.09.2013 - Gleason score 3 + 4=7, in 0.7% of resected tissue. PSA of 1.2ng/ml on 5ARI, June 13. MRI has been requested but this has been cancelled. Discussed @ Urology MDM, 21.11.13. It is not possible for this gentleman to have his MRI at Craigavon due to shunt. Mr Young to refer to the Neurosurgical Department at the Royal Victoria Hospital for an MRI to be carried out in the Royal site. Results to be reviewed at MDM. MRI Prostate 06.01.14 @ RVH - Results awaited. MDMAction

Discussed @ Urology MDM, 09.01.14. Defer one week with MRI result.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder pTa Grade 2

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the USI old man previously diagnosed with pTa Grade 2 TCC bladder, June 2010, and recurrence August 2012. Flexible cystoscopy, 12.11.13 - multi-focal small volume papillary recurrences occurring on the right posterior wall and on the left side of the bladder near the ureteric orifice. Electively admitted on 20.12.13. Cystoscopy showed a small 1cm papillary growth near left ureteric orifice on left lateral wall. Several other carpet like suspicious areas on posterior wall - cold cup biopsies. Pathology reports 1- TURBT- Histology shows features of a WHO Grade II transitional cell carcinoma with no invasion into the subepithelium (pTa). There is no lymphovascular invasion. Fragments of muscle are represented and these are not infiltrated by tumour. 2 - Bladder mucosal biopsies - features of a WHO Grade II papillary transitional cell carcinoma with no invasion into the subepithelium (pTa). There is no lymphovascular invasion. Fragments of muscle are not represented within this specimen. Histology appointment booked for 13.01.14.MDMAction

Discussed @ Urology MDM, 09.01.14. For histology review on 13.01.14, CT Urogram to be requested and will be scheduled for Mitomycin x 6. For check cystoscopy following completion of Mitomycin C.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder invasive

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the USI old, referred to Haematuria Clinic, September 2013. Was also assessed at Lagan Valley Hospital where he had CT Urogram performed, 17.09.13 - No significant renal tract abnormality was seen. Flexible cystoscopy - although showing some cloudy urine, did show a vascular prostate, but the bladder mucosa was clear. Urine cytology - suspicious cells. Repeat urine cytology, 19.09.13 - carcinoma. Admitted, 05.11.13, for cystoscopy, biopsy and retrograde studies. Pathology - urine - malignant; washings from right ureter - negative; prostatic / bladder neck biopsies - Grade III transitional cell carcinoma. Discussed at Urology MDM, 14.11.13. This gentleman has been found to have poorly differentiated, transitional cell carcinoma of his bladder. For review by Mr Young, to arrange early admission for endoscopic reassessment. Electively admitted on 27.12.13 for deeper resection. 1- Bladder neck - the presence of extensive tumour in all of the tissue fragments and the features would be in keeping with a rather solid, high grade TCC of bladder. 2 - Prostate mucosal frond - the presence of extensive tumour, present within all of the tissue fragments, with invasion of fibromuscular stroma. 3 - Red patch fronds back wall - Atypical. Histology appointment booked for 03.02.14.
MDMAction

Discussed @ Urology MDM, 09.01.14. For histology review on 03.02.13, to have staging CT C/A/P and bone scanning requested and will be rediscussed @ MDM with results. Mr Young to consider whether further endoscopic assessment is required.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
HOUGHTON FIONNAULA DR (C7947)
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging: cT2 cN0 cM0

MDMUpdate

CONSULTANT MR O'BRIEN: Personal Information redacted by the USI old man. TURP 09.05.12, which reported Gleason 4+3= 7. Significant co-morbidities including CVA and multiple PEâ€™s on Warfarin. Discussed @ Urology MDM 28.06.12. This is a low volume, intermediate risk disease which will probably be managed by active surveillance. To be reviewed by Mr O'Brien in July 2012. Staging MRI to be requested. Will be rediscussed with results. Patient was unable to attend in July 2012 for review as intended due to hospitalisation for transfemoral closure of patent foramen ovale, complicated by development of large haematoma adjacent to femoral arterial puncture site. Haematoma has since resolved. Patient well at review on 28.09.12. LUTS completely resolved since TURP. Advised to discontinue Tolterodine and Dutasteride. PSA repeated. Ultrasound scan lower urinary tract requested. MRI Prostate requested. MRI, 09.10.12 - No evidence of bony metastases. Reviewed on 25.01.13. Very well, no LUTS. PSA 2.69 January 2013. To remain on active surveillance. Reviewed in August 2013. Patient remained satisfied with symptomatic improvement following TURP. PSA levels have increased from 2.69 in January to 5.97 in July 2013 (Dutasteride discontinued in September 2012). Patient keen to have prostatic biopsies performed using Bupivacaine or Levobupivicaine (both used in repair of rotator cuff in July 2013). To discontinue Warfarin on 02 November 2013, followed by self-administration of enoxaparin, and prostatic biopsies on 06 November 2013. PSA levels have been steadily increasing during 2013 from 2.69 in January 2013, to 4.13 in April 2013, 5.97 in July and to 8.19 in October 2013. Also reported the emergence of LUTS at review on 18.10.13, consisting of urgency and urge incontinence. Transrectal prostatic biopsy 06.11.13 - Prostate adenocarcinoma, Gleason score 4+3=7, present in 5/12 cores. 8% of tissue involved with a maximum tumour length of 5mm. Discussed @ Urology MDM 14.11.13. This gentleman has once again been found to have prostatic carcinoma of Gleason 7 on recent biopsies. For histology review, to request bone scan and MRI scanning and will be for subsequent MDM discussion. Bone scan, 26.11.13 - No evidence of bony metastasis. MRI, 08.01.14 - Small focus of tumour in the right mid gland. No definite evidence of extracapsular extension. T2 N0. MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman has been found to have organ confined, small volume, Gleason 4+3 adenocarcinoma, based on recent repeat biopsies, MRI and bone scanning. For review by Mr O'Brien, with a view to further referral to Oncology for consideration of radiotherapy.

Surgeon
Oncologist
Clinician
Palliative Medicine

None
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

Personal Information redacted by the USI old lady referred from Daisy Hill Hospital, admitted dehydrated with AKI and deranged LFT's. Ultrasound, 17.12.13 - multiple focal lesions in liver. CT C/A/P, 19.12.13 - mass in left kidney, tumour thrombus in renal vein extending into IVC. MDMAction

Discussed @ Urology MDM, 09.01.14. Patient deceased, Personal Information redacted by the USI

Surgeon
Oncologist
Clinician
Palliative Medicine

PAHUJA AJAY MR (C7882)
None
None

None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging: T3

MDMUpdate

CONSULTANT MR PAHUJA: Personal Information redacted by the USI old with a raised PSA of 19.6 ng/ml associated with some lower urinary tract symptoms in the form of frequency and nocturia. He has been commenced on Tamsulosin with little effect. He has past history of stroke from 2006 and possibly another one in 2010. He currently is on Clopidogrel, Simvastatin and Perindopril. He was only able to void 54mls with a q-max of 6.3 mls/sec and an average of 3mls. His bladder scan showed residual of 169mls. U&Es are satisfactory. His DRE revealed a very hard prostate, possibly T3 or even T4 disease. Bone scan, 24.12.13 - The increased uptake in thoracolumbar spine is more likely representing degenerative changes. The possibility of metastatic deposits in the spine is less likely. Correlation with plain x-ray, thoracolumbar spine may be required for further assessment. Otherwise, no evidence of bony metastasis.MDMAction

Discussed @ Urology MDM, 09.01.14. For review by Mr Suresh with a view to requesting a plain x-ray of lumbar spine, and to discuss the possibility of prostatic biopsies +/- androgen deprivation therapy.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Patient 166

Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging: T2 N0

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the USI old presented with elevated of 7.13ng/ml, September 2011. No LUTS. DRE - large BPE. TRUS volume 49mls. IPSS 0, QOL 1/6. Transrectal prostatic biopsy, 02.11.11 - no evidence of any atypical epithelial proliferation and no malignancy was seen. Discussed @ Urology MDM 10.11.11. Will be seen at Day 3 Histology clinic to be informed of negative pathology. Will be advised that they will be discharged from Urology Services and that GP is to check PSA level in 6 monthsâ€™ time. His PSA trend over the last 2-3 years has generally been upwards. His most recent PSA was 8.48ng/ml on 6th June 2013. His PSA range over the last three years has been between 5.6ng/ml and 8.9ng/ml. Transrectal prostatic biopsy, 05.11.13 - Tiny foci of prostatic adenocarcinoma of Gleason score of 3+3=6, identified in 2 of 12 cores with a maximum tumour length of 1 mm. The tumour occupied less than 1% of the total tissue volume. Discussed at Urology MDM 14.11.13. This gentleman has been found to have prostatic carcinoma of Gleason score 6. For histology review, to request MRI scan and will be for subsequent MDM discussion. MRI Prostate 08.01.14 - Tiny tumour nodule in the anterior left mid gland. No other significant tumour is demonstrated. No evidence of extracapsular extension. T2 N0 MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's MRI suggests he has small volume, localised, Gleason 6 adenocarcinoma of prostate. For review by Mr Young to advise that he is an ideal candidate for active surveillance.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man with a history of painless visible haematuria, who had a CT scan which showed approximately 5 small calculi in the left kidney, the largest measuring 5mm. There was an incidental finding of pulmonary nodules in the left lung base and given his history of smoking a CT scan in 6 month's time for follow up was recommended. There was also an old wedge compression fracture to T12. Urine cytology - atypia suspicious for malignancy. Cystoscopy, 15.11.13- Normal urethra and occlusive prostate with large medial lobe overlying the bladder. The bladder mucosa was trabeculated however there is no obvious pathology seen. M Personal Information redacted by the is not bothered with his lower urinary tract symptoms currently and only reported some intermittent nocturia. He will be reviewed at the Stone clinic in the New Year regarding his renal calculi. CT chest requested for April 2014. PSA of 2.9. Electively admitted on 03.01.14 for GA Cystoscopy & bladder biopsies +/- retrograde studies. Left RGP - normal. Flexible ureteroscopy and laser stone ablation and right RGP - normal. Random bladder biopsies, although bladder appeared entirely normal. Pathology reports fragments of normal urinary bladder mucosa lined by transitional cell epithelium with no evidence of dysplasia or invasive malignancy. TROC - 13.01.14.MDMAction

Discussed @ Urology MDM, 09.01.14. Pathology from recent bladder mucosal biopsies has been reported as benign. For histology review. For trial removal of catheter on 13.01.14.

Surgeon
Oncologist
Clinician
Palliative Medicine

None
None
None
None

Personal Information redacted by the USI

Target Date 15/01/2014

Diagnosis: Probable renal tumour

Staging:

MDMUpdate

CONSULTANT MR PAHUJA: Personal Information redacted by the old man with history of visible haematuria which lasted for about 36 hours. It was painless but his urine confirmed e-coli >100,000orgs/ml. He was given a course of antibiotics and a subsequent urine culture from 26th November came back clear. He denied any pre-existing urinary problems. Normal flexible cystoscopy. CT Urogram, 03.01.14 - Large enhancing mass lesion arising from cortex of lower pole left kidney, suspicious for RCC. MDMAction

Discussed @ Urology MDM, 09.01.14. For review by Mr Suresh, to request staging CT Thorax, DMSA and bone scanning for left lower pole renal tumour. For subsequent MDM discussion with results.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This Personal Information redacted by the old man initially presented with right testicular pain, without swelling, in September 2013. Pain recurred in November 2013 and again settled with antibiotic therapy. Since completion of antibiotic therapy, the right hemiscrotum has become increasingly painful and swollen. An ultrasound scan on 02 December 2013 revealed a grossly abnormal right testis. Pain became so severe by 08 December 2013 that he required admission to South West Acute Hospital. At review on 10.12.13, patient also reported dysuria and increased frequency of micturition. History of hypospadias repair and bilateral orchiopexy noted. Found to have urethral meatal stenosis and a tender, tense, hemi-scrotal swelling without any scrotal erythema. Advised continuation of Tazosin and Gentamicin. Advised repeat ultrasound scan of scrotal contents and of urinary tract. For review on 23.12.13. Discussed @ Urology MDM, 19.12.13. Review of recent scanning would indicate that this gentleman probably has a right testicular tumour. For review by Mr O'Brien on 23.12.13 as planned, to arrange testicular tumour markers and for early admission for right radical

orchiectomy. Patient was less painful at review on 23 December 2013. Still had a large, tense, right hemi-scrotal swelling which was no longer tender. Patient advised of probability of malignancy and of need for orchiectomy. Testicular tumour markers performed. For admission 03 January 2014 for right radical orchiectomy and insertion right testicular prosthesis. Alpha-fetoprotein 213.4 and Beta-HCG 420.4. No evidence of metastatic disease on CT Chest, Abdomen and Pelvis on 27 December 2013. Patient admitted for right radical orchiectomy on 03 January 2014. A right testicular prosthesis was inserted. Pathology reports MDMAction

Discussed @ Urology MDM, 09.01.14.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Patient 46
Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This Personal Information redacted by the old man developed acute urinary retention, requiring catheterisation, on 04 August 2013. He did not have any preceding LUTS. His prostate gland was considered to be firm and enlarged. GFR was > 60 mls/min. He was prescribed tamsulosin but was unable to pass urine following removal of catheter on 29 August 2013 when his PSA was 52.96. He was then prescribed dutasteride, but was again unable to pass urine on 10 October 2013 when PSA had decreased to 39.75 ng/ml. Underwent elective resection of large, trilobar prostate on 11 December 2013. Found to have adenocarcinoma of Gleason 3+4 involving 7% resected tissue. For review on 27 January 2014.MDMAction

Discussed @ Urology MDM, 09.01.14. For review by Mr O'Brien, to have PSA rechecked, and to have fitness assessed for consideration of external beam radiation.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Renal clear cell carcinoma

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old lady diagnosed with pT3a Fuhrman Grade 4 renal cell carcinoma. Right radical laparoscopic nephrectomy 11th September 2013. Discussed @ Urology MDM 19.09.13. This lady has been found to have a poorly differentiated, renal cell carcinoma of her right kidney removed by radical nephrectomy. For review by Mr Glackin on 07.10.13, to arrange a CT of chest, abdomen and pelvis in December 2013 and subsequent MDM discussion. Reviewed in October 2013 and has been doing very well. She has developed a small port site hernia at the camera port. On examination this was reducible. Her extraction wound in the right iliac fossa was healing well. CT chest, abdomen and pelvis requested. CT C/A/P 23.12.13 - Stable disease.MDMAction

Discussed @ Urology MDM, 09.01.14. Review of follow-up CT shows no evidence of disease recurrence or metastatic disease. For review by Mr Glackin.

Surgeon
Oncologist
Clinician
Palliative Medicine

PAHUJA AJAY MR (C7882)
None

None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Benign

Staging:

MDMUpdate

CONSULTANT MR PAHUJA: Personal Information redacted by the USI old lady with a past history of lichen planus and benign neoplasm of her colon in 1992. Type 2 diabetic and has a history of diverticular disease. History of frank haematuria. Mrs Personal Information redacted by the USI worked in a Personal Information redacted by the USI approximately 15 years ago. Flexible cystoscopy, 12.12.13 - normal urethra. There was a suspicious area beyond the trigone which will require a GA cystoscopy and biopsy. Electively admitted on 20.12.13 for GA cystoscopy and biopsy. Pathology reports no cytological atypia, dysplasia or carcinoma in-situ. There is focal congestion of submucosal vessels. There is no significant excess inflammatory cell infiltrate represented. Muscularis propria is present in this biopsy. Clinical-pathological correlation is required. There is no invasive malignancy. CT Urogram requested - This examination was cancelled by performing site. Patient was offered appointment but does not wish to travel to STH. She wants to wait until other tests are completed.MDMAction

Discussed @ Urology MDM, 09.01.14. This lady's bladder biopsies are benign. For review by Mr Suresh, to arrange a new date for CT Urogram at Craigavon Area Hospital as per patients request.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the USI old man investigated for frank haematuria in December 2011, again in April 2012 and in October 2013. All previous investigations including CT scan in March 2012 were all normal. Further CT scan in October 2013 shows thickening and stenosis of the left pelvi ureteric junction extending into the upper pole calyx with mild surrounding fat stranding. He is due for flexible cystoscopy shortly but perhaps ureteroscopy might be more appropriate. Discussed @ Urology MDM, 31.10.13. This gentleman has been found to have some mural thickening in the region of his left pelvi ureteric junction. For review by Mr Glackin to arrange left ureteroscopy. Reviewed on 18.11.13, name was added to waiting list for flexible ureteroscopy and urine cytology performed which has been reported as no malignant cell seen, acute inflammatory cells present. Electively admitted on 27.12.13 for left retrograde studies, NAD, splaying of calyces due to cyst. Left flexible ureteroscopy - just a few debris in renal pelvis. Good view of all calyces. No tumour seen. Urine - atypia. Histology appointment booked for 10.02.14.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's recent flexible ureteroscopy of left kidney was satisfactory. His cytology demonstrated atypia only. For histology review on 10.02.14, to be discharged back to the care of the GP.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This [Personal Information redacted by the USI] old man presented with a three month history of left flank pain and weight loss. Ultrasound and CT scanning in December 2013 revealed a large, nodular, left retroperitoneal mass, infiltrating the left kidney and surrounding left renal vessels. Appearances considered more typical of lymphoma than renal cell carcinoma. Referred to Dr Drake, Consultant Haematologist at Belfast City Hospital where patient had a biopsy of mass performed on 23 December 2013, pathology reports atypical lymphoproliferative disorder, suspicious for malignancy. At review on 27 December 2013, patient also reported mild LUTS while remaining on Combodart. PSA 0.9 June 2013. Ultrasound pelvis, 06.01.14 - Prostate volume 16cm3 approx. Bladder not very full. No obvious abnormality seen. Pre mict volume 90mls approx. Post mict residual volume 12mls approx.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman remains under the care of Dr Drake, Consultant Haematologist, at Belfast City Hospital with regards to possible lymphoma. From a urological prospective Mr [Personal Information redacted by] equires review at South West Acute Hospital in April 2014.

Surgeon
Oncologist
Clinician
Palliative Medicine

PAHUJA AJAY MR (C7882)
None
None
None

[Personal Information redacted by the USI]

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR PAHUJA Personal Information redacted by the old lady with a past history of superficial TCC bladder diagnosed in 2001. She remained clear for many years and was discharged back to her GP. She had recently presented with history of visible haematuria. On her flexible cystoscopy there was evidence of a red area. Her CT urogram was satisfactory but her chest CT suggested some indeterminate pulmonary lesions measuring only 4mm in size. She was brought in for cystoscopy which showed no obvious evidence of TCC recurrence in her bladder, bladder biopsies were taken. Bladder biopsy, 06.12.13 - Pathology reports bladder biopsies lined by urothelium which is focally artefacted with denudation of umbrella cells however where assessable there is no carcinoma in - situ. Muscularis propria is represented in one of the biopsies. The submucosal vessels are focally congested. There are minimal chronic inflammatory cells represented. There is no invasive malignancy. Attended Histology clinic on 06.01.14.MDMAction

Discussed @ Urology MDM, 09.01.14. Mrs Personal Information redacted by s recent bladder biopsies are benign. She is awaiting a CT of chest to further clarify the small, indeterminate pulmonary lesions noted on CT Urogram. For review by Mr Suresh, with a view to further flexible cystoscopy in six monthsâ€™ time.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Ureter

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old man diagnosed with pT3 Grade 3 TCC left ureter. Open left segmental ureterectomy performed, 9th July 2013. Discussed @ Urology MDM 18.07.13. This gentleman has had a muscle invasive, transitional cell carcinoma of the lower left ureter, probably completely resected in recent segmental ureterectomy. To return for a nephrostogram and cystogram on 24.07.13. For subsequent review with Mr Glackin. Presented with having haematuria in November 2013. Also had recent admission for a blood transfusion. He had an open segmental resection of his distal left ureter for TCC, 09.07.13. Attended for flexible cystoscopy 27.11.13, following removal of his catheter, cystoscopy showed a papillary tumour located on the left side of his bladder. The view was obscured by haematuria. This is related to his previous disease in the ureter. He also probably has TCC in the renal

pelvis according to the most recent ultrasound examination. Was advised that he will be scheduled for TURBT +/- left retrograde study. Electively admitted 20 December 2013 for TURBT and left ureteroscopy. At cystoscopy, 3 papillary bladder tumours were removed from region of reimplanted left ureteric orifice. Left retrograde study shows filling defects in ureter. Unable to negotiate wire beyond tortuous ureter in upper third. Ureteroscopy: 6Ch semi-rigid scope passed alongside safety wire. Obvious papillary tumour filling left ureteric lumen. 1 - Three new papillary bladder tumours - Histology shows tissue derived from a papillary transitional cell carcinoma of WHO grade III. Unequivocal invasion into the subepithelial tissue is not seen and the pathological stage is pTa. 2 - Part 2 - Deeper resection to check muscle - Histology shows a small fragment of papillary transitional cell carcinoma and two fragments of detrusor muscle. There is no evidence of tumour within the muscle. Staging CT and bone scan have been requested. Histology appointment booked for 03.02.14.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's histology demonstrates pTa G3 TCC of bladder. He is awaiting staging scans. He is a current inpatient. Mr Glackin to discuss with patient and family the possibility of a left nephroureterectomy.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder pTa Grade 2

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old man Previous CIS bladder, June 2012. Previous TCCB pTa G2 June 2010 and March 2011. BCG x 6 completed November 2012. Electively admitted on 06.12.13 for left ureteroscopy and biopsy of distal ureter. Indication - Abnormal urine cytology and filling defect left distal ureter on CTU. Electively admitted on 06.12.13. DRE very firm prostate, right lobe hard, moderate size gland. Left Ureteroscopy - Ragged area of mucosa in distal third, but no papillary tumour, ? CIS . Middle third and upper third appear clear. 4 flexible forceps biopsies taken for histology. Cytology taken. Will need a TRUS biopsy later. Pathology reports - Histological examination through levels shows small fragments of tissue, 2 of which contain tumour demonstrating features in keeping with WHO grade III

transitional cell carcinoma. In one tissue fragment infiltration of single cells into subepithelial connective tissues is noted. Within these biopsy fragments the tumour stage is therefore at least pT1. Ureteric washings, left ureter - malignant. Transrectal prostatic biopsy scheduled for 21.01.14.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's histology has confirmed pT1 G3 transitional cell carcinoma of left ureter. Mr [redacted] requires staging investigations, with a view to offering left nephroureterectomy at a later date if suitable.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

[redacted]
Target Date 21/01/2014

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR YOUNG: [redacted] old man who has a strong family history of [redacted] Recent difficulties with vaso-vagal episodes that are not completely explained. Ultrasound scan was performed and reported a 3cm mass lower pole of his left kidney. CT chest, abdomen and pelvis, bone scan and DMSA requested. He is on Ramipril for his cardiac status and his EGFR has dropped to 51. CT C/A/P, 10.12.13 - 3 cm left renal mass which is highly suspicious of tumour, likely RCC. There is no evidence of any metastatic disease or significant lymphadenopathy. DMSA, 11.12.13 - Normal size and shape of both kidneys. Normal split renal function on the right kidney is contributing about 49% of the total renal function while the left one contributes about 51%. Bone scan, 16.12.13 - No evidence of bony metastasis. Discussed @ Urology MDM, 19.12.13. This gentleman has a small left renal lesion, considered suitable for partial nephrectomy. For review by Mr Young to advise and arrange surgery. Attended for review 23.12.13, CT brain was requested due to family history of [redacted] and this was performed on 27.12.13. Reason for discussion as per Mr Young - Can we discuss this man again at MDT? I would be able to give a date at the end of February unless anybody can give a date earlier. MDMAction

Discussed @ Urology MDM, 09.01.14. NO GP LETTER. No date is available by any other Consultant before the end of February. Patient to remain on Mr Young's waiting list.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: Personal Information redacted by the old lady with sudden onset of pain and swelling in RUQ. USS showed a large solid mass in right kidney measuring 10cm. MRI Renal 18.11.13: Large 11 cm enhancing mass lesion arising from the interpolar region of the right kidney, devoid of fat content, with evidence of previous and recent haemorrhage. The MR appearances are nonspecific, but suggestive of, in the clinical context, of an angiomyolipoma, despite the absence of fat. CT Renal 19.11.13: Suitable for embolisation. The presence of calcification is concerning, making RCC more likely than AML. Discussed @ Urology MDM, 21.11.13. Review of this lady's CT and MRI investigations demonstrate an area of peripherally enhancing tissue suggestive of a renal tumour with evidence of haemorrhage. Fat is not demonstrated on MRI. The imaging is not conclusive and the lesion may represent a benign entity such as AML or alternatively it may represent a renal malignancy. Further to discussion between Consultant Urologists and radiology this lady will have a selective embolisation tomorrow as her initial management. Thereafter we will reassess the need for definitive surgery. Selective embolisation of right renal mass performed on 22.11.13. Embolisation resulted in pain and fever lasting several days. There was no evidence of any residual right renal function on renography and no evidence of skeletal metastatic disease on bone scanning. Patient required continued intravenous antibiotic therapy to suppress pyrexia. Right radical nephrectomy performed on 04.12.13. Extensive inter-aortocaval lymphadenopathy resected. Pathology report awaited. In view of this unusual differential this case has been sent to Dr Ashish Chandra, St Thomas' Hospital, London for expert opinion and a supplementary report will follow. This will include further comment on the separately submitted paracaval lymph nodes. **Supplementary report awaited**MDMAction

Discussed @ Urology MDM, 09.01.14. Supplementary pathology report not available. Defer one week.

Surgeon
Oncologist
Clinician
Palliative Medicine

BROWN RJ MR (C6502)
None
None
None

[redacted]

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR BROWN: [redacted] old man with [redacted]. History of tuberous sclerosis. Passed clots in urine, none since. Ultrasound ae" nil significant. Cystoscopy - not performed. CT Urinary tract 31.12.13 - Multiple hyperdense lesions within the kidneys. These probably represent hyperdense cysts. MDMAction

Discussed @ Urology MDM, 09.01.14. Review of this gentleman's contrast enhanced CT demonstrates bilateral enhancing lesions without fat content, in both kidneys. Renal malignancy is a possibility. In addition, there is a lesion arising from lower pole of right kidney, which may represent an angiomyolipoma. For review by Mr Brown, to assess suitability for a renal MRI scan in first instance and if not suitable, to consider an interval CT scan in 3 months.

Surgeon
Oncologist
Clinician
Palliative Medicine

None
None

None
None

Personal Information redacted by the USI

Target Date 03/03/2014

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR SURESH Personal Information redacted by the old lady with an incidental finding of a 2.2cm echogenic solid mass interpolar region right kidney on ultrasound scanning. CT Renal, 30.12.13 - Right renal tumour - likely a renal cell carcinoma. No metastatic disease. MDMAction

Discussed @ Urology MDM, 09.01.14. This lady's CT demonstrates a 2.8cm enhancing mass, arising from interpolar region right kidney. There is an indeterminate nodule near right renal hilum. Mrs Personal Information redacted by the USI requires a CT Thorax, bone scan and DMSA renogram to complete staging. For review by Mr Suresh.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date 16/01/2014

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old lady referred due to abdominal pain, which has been present for several months. Ultrasound scan reported an abnormal left kidney. CT scanning reported a Bosniak type 3 complex mass lesion. Discussed @ Urology MDM, 28.11.13. Review of this lady's investigations suggest that she has a solid lesion, mid pole, left kidney, in addition to multicystic kidney. For review by Mr Young, and if deemed fit for surgical treatment to arrange staging. DMSA 31.12.13: Normal size and shape of the right kidney. Normal size and shape of the left kidney with large photopenic area in its lower pole in keeping with a known left renal mass. Abnormal split renal function on the right kidney is contributing about 69% of the total renal function while the left one contributes about 31%. CT Chest 02.01.14: No lung metastasis seen. Bone scan 06.01.14 : Results awaited. MDMAction

Discussed @ Urology MDM, 09.01.14. This lady's staging investigations suggests she has no evidence of metastatic disease, although formal bone scan report is awaited. For review by Mr Young, with a view to offering radical nephrectomy.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Probable renal tumour

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man who attended ESWL treatment for his stones but this was clear but identified a left renal mass. CT scan with enhancement has confirmed enhancement and therefore a suspected tumour. Bone scan and DMSA requested. Mr Personal Information would be suitable for partial nephrectomy as he appears fairly fit. CT C/A/P, 16.12.13 - 1. Enhancing left lower pole renal mass, highly suspicious of a renal carcinoma. 2. No metastatic disease. DMSA, 27.12.13 - Normal size and shape of both kidneys. Split renal function is within normal limits as the right kidney is contributing about 46.5% in the left kidney contributes about 53.5%. Bone scan, 03.01.14 - No evidence of bony metastases. MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's staging investigations show no evidence of metastatic disease, related to small left renal tumour. He appears to be suitable for partial nephrectomy. For review by Mr Young.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging: T2 N0

MDMUpdate

CONSULTANT MR O'BRIEN: This Personal Information redacted by the old man was initially referred in 2007 with severe LUTS of a mixed nature, and with a PSA which had increased from 4.3 in 2005 to 10.78 on referral. He failed to attend. When referred again in 2009, his PSA had increased to 13.51. Prostatic volume was 37mls and residual volume was 138mls. PSA level fell to 10.49. There was no evidence of any prostatic carcinoma in 2009. Biopsies were performed again in 2010 when PSA was 11.67. There was no evidence of carcinoma found. PSA levels increased to 20.32 in 2011. Urodynamic studies then confirmed severe detrusor overactivity and bladder outlet obstruction. Intradetrusor injection of botulinum toxin and TURP performed 06.02.13. T.U.R.P, 06.02.13 - Histology reported prostatic chippings with structures of adenocarcinoma, Gleason 4+3=7. Perineural invasion was present but lymphovascular invasion was not seen. The tumour occupied

approximately 70% of submitted tissue. Discussed @ Urology MDM 14.02.13. This man has been found to have prostatic adenocarcinoma of Gleason 7 in prostatic tissue resected on February 6th 2013. For review by Mr O'Brien to arrange a bone scan and subsequent MDM discussion. Patient was appointed to be reviewed by Mr O'Brien 22.03.13. Unable to attend. Another appointment arranged for Friday 12.04.13. Patient well at review on 12.04.13. All LUTS resolved. PSA repeated. Bone scan requested. MRI scan to be performed in May 2013. For MDM discussion with reports of both scans. Bone scan, 02.05.13 - Multiple focal areas of abnormal increased uptake is seen in the lateral aspect of right mid ribs presumably representing rib injuries. MRI Prostate, 07.05.13 - The appearances were suggestive of cancer prostate stage T2 N0. Discussed @ Urology MDM 09.05.13. There were several foci of increased uptake of radioisotope in right ribs on recent bone scanning. For review by Mr O'Brien to arrange a CT of chest and subsequent MDM discussion. Patient did not attend for review on 14.06.13 (did not receive appointment). CT chest requested. For MDM discussion with report. CT Chest, 18.06.13 - There were almost completely healed fractures to the lateral aspects of the right lower ribs which would account for the uptake on the scintigram. Overall there was no convincing evidence of any bone metastasis. The gallbladder contained a couple of calcified stones at its' neck. There was no significant lymphadenopathy. Within the limitations of some respiratory movement artefact, the lungs were clear. Discussed @ Urology MDM 11.07.13. CT scanning has revealed that the foci of increased uptake of radio-isotope were due to healing rib fractures. For review by Mr O'Brien to advise androgen blockade prior to radical radiotherapy. When patient was reviewed on 02 August 2013, it was agreed with him, and with his son-in-law, that, in view of consecutive low serum PSA levels since TURP, serum PSA levels would be repeated in September 2013 and in December 2013, prior to review in January 2014, with a view to considering prostatic biopsies. It was the agreed intent to proceed with prostatic biopsies if PSA levels continued to increase, even if remaining at low levels. Patient then had a consultation independently arranged at the Cancer Centre in Belfast in 04 September 2013 when it was reported that the patient was not aware of the advice of MDM to proceed with hormone therapy followed by radical radiotherapy, that he was under the impression that his prostate cancer had been treated and that he required observation by his family doctor. It was explained to the patient that he had not had what would be deemed by the Cancer Centre to be oncological management of his prostate cancer. The patient was shocked, and agreed to proceed with neo-adjuvant androgen deprivation provided by monthly LHRH agonist (Goserelin) for six months followed by radical radiotherapy. On 29 September 2013, patient developed severe chest pain, accompanied by nausea and vomiting, due to myocardial infarction (Troponin 3465), resulting in broad complex tachycardia, requiring DC conversion. Coronary angiography confirmed native coronary arterial disease but good graft patency, and a left ventricular ejection fraction of 20-25%. Consideration given to implantation of pacemaker. For MDM discussion of future management. Should androgen blockade or deprivation be avoided in view of increased risk of further cardiovascular events? Should prostatic biopsies be performed in near future to assess histopathological status of prostate? Should further biopsies be deferred until there has been an increase in PSA levels?â€™ MDMAction

Discussed @ Urology MDM, 09.01.14. Mr O'Brien to liaise with Dr McCloskey directly. ** NO GP OR MDM REPORT **

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Benign

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man who has mixed lower urinary tract symptoms. He complained of urgency, occasional hesitancy and post micturition dribbling. He has been previously investigated for visible haematuria when he underwent a rigid cystoscopy and bladder biopsy in May 2012 - normal. He also had normal urine cytology and a normal CT urogram. His PSA from last year is 1.82ng/ml. He does have past medical history of Type II diabetes mellitus and subarachnoid haemorrhage in 2006. Post mict volume of 93ml and a prostate size of 31cc. He currently is on Solifenacin 5mgs for his storage type symptoms. Flexible cystoscopy showed a very suspicious looking red area in the posterior and left lateral walls. His prostate was of small to moderate size and did not particularly appear occlusive. Was scheduled for a repeat GA cystoscopy +/- a TURBT or cold cup biopsies. Electively admitted on 30.12.13 for cystoscopy - small red patches in posterior wall of bladder, biopsied. Bimanual examination - no mass. PSA normal. Pathology reports fragments of urinary bladder mucosa lined by transitional zone epithelium with no evidence of dysplasia. The stroma shows focal oedema and focal mild/moderate, both active and chronic inflammatory infiltrate.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's bladder biopsies are benign. Previous urine cytology x 2 has been negative. For review by Mr Young, to have lower urinary tract symptoms reassessed and managed.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Renal cell carcinoma

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: [redacted] old man who had a right radical nephrectomy performed in January 2007 for a renal cell carcinoma. As indicated by Mr Akhtar, Consultant Urologist, in his letter of 13 February 2012, [redacted] was found to have developed a small left renal tumour, measuring 2.2cm in diameter on review CT scanning performed prior to then. However, of even greater importance at that time was the diagnosis of a rectal adenocarcinoma, for which [redacted] had a laparoscopic anterior resection performed in February 2012 by Mr Hannon, Consultant General and Colorectal Surgeon at Daisy Hill Hospital in Newry. [redacted] had an entirely uncomplicated recovery following that surgery. Mr O'Brien reviewed [redacted] on 1 June 2012, he was found to be so well that it was agreed to proceed with left partial nephrectomy. The left kidney was approached by way of a left flank incision under general anaesthesia on 5 September 2012. The left kidney was enlarged, presumably having undergone compensatory hypertrophy since right nephrectomy in 2007. The kidney was completely mobilised, and the tumour was located within the cortex on the posteromedial aspect of the upper pole of the kidney. Prior to any renal dissection, [redacted] suddenly had an asystolic cardiac. Further surgery was abandoned, in order to facilitate immediate cardiopulmonary resuscitation, which was successful. He was transferred to Intensive Care Unit. He had a further episode of asystole on the 7 September 2012, when a temporary pacing wire was inserted. Following his adequate recovery, a permanent [redacted] was inserted on 18 September 2012 and [redacted] was fit for discharge on 20 September 2012. Mr O'Brien reviewed [redacted] on 26 October 2012, and was found to be keeping pretty well. When further reviewed by Dr Morgan on 12 November 2012, he too found him to remain well, and discharged him back to the care of Dr McEneaney with a view to further monitoring of his pacemaker. It has been my understanding that there has been no clinical grounds for suspicion of any coronary arterial disease, or that the asystole may have been caused by any ischemia. However, as we do need to embark upon further surgery at some stage in the coming months, I do feel that we would be more reassured in doing so by knowing that [redacted] does not have any significant coronary arterial disease. On speaking with Dr McEneaney, Consultant Cardiologist at Craigavon Area Hospital, I will arrange a further review for [redacted] following Dr McEneaneyâ€™s assessment. Staging CT C/A/P has been requested prior to embarking upon further surgery, in order to ensure particularly that there is no evidence of any progression of either the left renal carcinoma or of the rectal adenocarcinoma. CT Chest, abdomen & pelvis 24.04.13: Slight increase in size of the left renal tumour. No convincing evidence of metastatic disease. Discussed @ Urology MDM 09.05.13. There has been no change in the appearance of left renal tumour on recent CT scanning. Mr [redacted] is awaiting completion of cardiac assessment, and is being considered for right hemi-colectomy for a right colonic adenocarcinoma. For review by Mr O'Brien to arrange further follow up and management. Patient well at review on 27 December 2013 following right hemicolectomy in June 2013 for colonic adenocarcinoma infiltrative of posterior abdominal wall, for which he had adjuvant radiotherapy in October 2013. GFR 53 mls/min. CT renal requested. Patient keen to defer to consideration of left partial nephrectomy for as long as is safely possible. CT Renal 02.01.14 - Mild increase in the left renal mass which now measure 36 mm compared to the previous measurement 32 mm. Right kidney is surgically absent. MDMAction

Discussed @ Urology MDM, 09.01.14. The most recent CT shows this gentleman's left renal tumour is now 3.6cms. Given his history of two T4 bowel cancers, he is at risk of bowel cancer recurrence. For review by Mr O'Brien, to discuss the possibility of radiology frequency ablation versus surgical excision (extreme caution).

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Uncertain at present

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old lady with history of tuberous sclerosis. She was meant to have a follow up CT scan in January 2013 but unfortunately the Radiology report suggests that she was unwilling to have an IV cannula inserted. Follow up CT scan performed on 30.12.13. CT C/A/P 30.12.13 - Enhancing right upper pole mass which has increased in size. Multiple sclerotic lesions throughout the skeleton present since 2011, likely secondary to the known history of tuberous sclerosis. MDMAction

Discussed @ Urology MDM, 09.01.14. This lady requires to be reviewed by Mr Young, to arrange DMSA renogram. CT Chest shows no evidence of metastatic disease. For surgical excision of right upper pole renal mass.

Surgeon
Oncologist
Clinician
Palliative Medicine

None
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder invasive

Staging:

MDMUpdate

CONSULTANT MR SURESH: Personal Information redacted by the old man with no significant past medical history. He presented with one episode of frank haematuria in May. This was painless and not associated with any lower urinary tract symptoms. PSA on 4th November was 0.77ng/ml. Urine cytology that was sent by GP practice on 31st October was malignant. Flexible cystoscopy revealed a normal urethra, the prostate was mildly occlusive and certainly was quite vascular in nature. On entering the bladder there was a generally inflamed area particularly more so on the back wall at the left side, there was some raised suspicious looking areas in keeping with a likely TCC of the bladder. A DRE revealed a small, smooth benign feeling prostate. Electively admitted on 27.12.13 for GA cystoscopy- papillary tumour over extensive area in the anterior and right lateral wall of bladder. Most of the tumours resected. Base and adjacent area sent separately (Microscopically ? high grade non-invasive). Part 1 - Bladder tumour - Transitional cell carcinoma, pT1 GIII. Part 2 - Tumour base -Transitional cell carcinoma, pT1 GIII. Part 3 -Adjacent area - the appearances have been interpreted as Grade II Transitional cell carcinoma. There are a few splayed muscle fibres however there is no definite muscularis propria in part 3. There are prominent lymphoid aggregates. There is no invasive malignancy. MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's histology has confirmed pT1 G3 transitional cell carcinoma of bladder. For review by Mr Suresh, with a view to offering further cystoscopy +/- bladder tumour resection.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging: T2 N0

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man who has a history of Gleason 3+3 prostate carcinoma, diagnosed in 2008, and has been on active surveillance since then. He had a re-biopsy in 2012 which did not show any progression in his disease. PSA in October 2013 was 13.05ng/ml, which has increased from January 2013, when it was 10.51ng/ml, and in November 2012 was 11.16ng/ml. DRE, 12.12.13, revealed a smooth prostate but the left lobe was firmer than the right. Mr Personal Information redacted by the USI is not keen for further biopsy. PSA of 14.46ng/ml, 12.12.13.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's PSA was 14ng in 2007. It has fluctuated somewhat over the intervening period. Most recent PSA remains 14ng/ml, December 2013. Previous biopsies on two occasions have found small volume, 3+3 adenocarcinoma of prostate. Mr Personal Information redacted by does not wish to have further prostatic biopsies. Therefore we have agreed through MDM (Dr Hamill) that it is reasonable to have a further MRI of prostate. For review by Mr Young.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder pTa Grade1

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the USI old man who has a history of pTa GI TCC of his bladder and had a previous cystoscopy in 2011. Cystoscopy, 23.08.13, revealed a normal urethra. On the prostatic cavity on the right side there was small calcification with some surrounding abnormal looking tissue. The bladder itself was clear with no evidence of any recurrence. Electively admitted on 24.12.13 for GA cystoscopy and biopsy. There was an irregularity in the prostate; the mucosa looked fairly clear but there was a polyp on the right distal prostatic lobe and this was biopsied, the bladder was otherwise clear. Prostatic urethra mucosa 24.12.13 - The appearances are best regarded as those of polypoid urethritis / urethritis cystica. There is no CIS or invasive transitional cell carcinoma. MDMAction

Discussed @ Urology MDM, 09.01.14. Pathology from recent prostatic biopsy has been reported as benign. For histology review.

Surgeon
Oncologist
Clinician
Palliative Medicine

YOUNG M MR (C6861)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man with microscopic haematuria and continued urinary symptoms. Previous urine cytology - atypia. Cystoscopy and bilateral retrograde washings performed. Pathology reports 1 - Right ureteric washings - Cytological examination shows the specimen to be practically acellular. The specimen is therefore best regarded as insufficient for diagnosis. 2 - Left ureteric washings - Cytological examination shows a background of urothelial cells and debris along with several cohesive clusters of urothelial cells. No features suggesting CIS or high grade urothelial malignancy are seen. In the context of an instrumentation specimen the features of a regarded as within normal limits. Correlation with clinical, endoscopic and radiological findings is however recommended. 3 - Urine from bladder - Cytological examination shows urothelial cells, debris and several cohesive clusters of urothelial cells. If this is also an instrumentation sample the features may be regarded as within normal limits. No features suggestive of CIS or high grade urothelial malignancy are seen. Cohesive groups would however be an atypical finding in voided urine. Correlation with clinical findings is therefore recommended and discussion at MDT may prove helpful. Histology appointment booked for 13.01.14. MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's bladder urine cytology specimen taken at time of cystoscopy demonstrates atypia. The right ureteric sample was acellular and the left ureteric sample is consistent with an insufficent specimen with no obvious maligancy. For histology review on 13.01.14, to have a further sample of voided urine cytology performed.

Surgeon
Oncologist
Clinician
Palliative Medicine

O'BRIEN A MR (C6514)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: TCC Bladder pTa Grade 2

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: Personal Information redacted by the old with history of recurrent pTa GII TCC bladder from 1993 to 2000. Refractory to Epirubicin and Mitomycin C. Intravesical BCG in 2000. Recurrence in severely symptomatic, inflamed, ulcerated contracted bladder. Radical cystectomy and urinary diversion, 2002. Repair of parastomal hernia with translocation of stoma in 2009. Slowly progressive, pulmonary nodular disease since 2005. Referred to Oncology, 2008. For consideration of ? biopsy/?chemotherapy. Discussed at Urology MDM, 21.07.11. Slowly progressive pulmonary nodular disease since 2008 - no intervention was required. Patient remains asymptomatic. Mr O'Brien will organise a CT Guided biopsy. Patient remained well when reviewed in June 2011. Was referred then to Dr Houghton for further follow up. Patient referred again by GP in June 2013 because of peristomal pain similar to previous pain associated with parastomal hernia prior to relocation of urostomy. Pain had largely resolved by review on 23.08.13. No clinical evidence of herniation. CT scan of abdomen and pelvis requested. When CT Chest last performed in June 2013, there was no significant change in pulmonary lesions. For MDM discussion of appropriate time for biopsy and chemotherapy. Discussed at Urology MDM 19/09/13. For review by Mr O'Brien to discuss having a pulmonary nodule biopsied, to request a PET CT scan, and for subsequent MDM discussion. CT PET 26.11.13: There are multiple pulmonary nodules, some of which are FDG avid. The appearances are suspicious for pulmonary metastases. Discussed @ Urology MDM, 05.12.13. Recent PET CT scanning would indicate that the pulmonary lesions are metastases. For review by Mr O'Brien to discuss the possibility of biopsy. Personal Information redacted by remained asymptomatic of her pulmonary lesion at review on 17.12.13, in contrast to increasing pain related to left parastomal hernia. CT guided biopsy of right posterior pulmonary lesion requested. Reason for discussion - CT guided biopsy has been requested and no Consultant Radiologist agreed to perform procedure.MDMAction

Discussed @ Urology MDM, 09.01.14. This lady's case was reviewed at MDT. Dr Hamill has kindly agreed to perform CT guided biopsy of right lower lobe lung lesion. For rediscussion with histology.

Surgeon
Oncologist
Clinician
Palliative Medicine

GLACKIN A.J MR (C8102)
None
None
None

Personal Information redacted by the USI

Target Date

Diagnosis: Prostate cancer

Staging: T3b N0 MX

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the USI old man with a PSA 54.9ng/ml in May 2013. Past medical history that he has Personal Information redacted by the USI for which he attends Dr Boyd. He has a history of hypertension and has had 2 stokes 18 and 17 years ago respectively. This has left him with some right upper limb weakness. More recently he had developed back pain which radiates to both of his thighs. With regards to his urinary tract he reported suprapubic discomfort with occasional urgency and minor degree of urge incontinence. He passes urine more than 6 times per day and nocturia 2-3. He did not report any dysuria or haematuria. His EGFR was greater than 60. Ultrasound of urinary tract showed a normal sized right kidney with a 1.7cm simple cyst. Left kidney was also of normal size but has 2 complex cysts. Post micturition bladder volume was 8ml. His prostate volume was 36cc. Digital rectal examination showed a firm enlarged prostate. Transrectal prostatic biopsy 10.07.13: Histology reported prostatic adenocarcinoma, Gleason score 3+4=7, present in 6 out of 10 cores with maximum tumour length of 14mm. 15% of tissue involved. Discussed @ Urology MDM 18.07.13. This gentleman has been found to have prostatic adenocarcinoma of Gleason score 7 on recent prostatic biopsies. For review with histological report, to request radio-isotope bone scanning, to initiate androgen blockade, prior to subsequent MDM discussion. Bone scan 08.08.13: The abnormal uptake by the focal sclerotic lesion at T11 was highly suspicious for an osteoblastic metastasis. Further evaluation of the left knee and right ankle with plain radiographs was advised. Discussed @ Urology MDM 15.08.13. This gentleman's staging bone scan and SPECT demonstrate a solitary lesion at T11 which is suspicious for metastases. He requires a staging CT of chest, abdomen and pelvis which will be rediscussed at MDT. He will be reviewed by Mr Glackin. Reviewed by Mr Glackin on 02.09.13. He did not describe any new neurological findings. His walking is unchanged. He was however experiencing increasing pain in his pelvis and has had to increase his patch medication dosage. Mr Personal Information redacted by the received his first LH RH injection 10 days ago. He appeared to be tolerating this reasonably well. CT of his chest, abdomen and pelvis requested along with plain films of his right ankle and left knee as suggested by the radiologist. For 3 month review with a PSA. CT C/A/P 09.09.13: Probable metastatic deposit at T11. No other metastasis seen. Right ankle 09.09.13: Tibiotalar joint spaces maintained. No focal or acute bony abnormality seen. Right knee 09.09.13: No bony or joint space abnormality seen. Discussed @ Urology MDM 12.09.13. It would appear that this gentleman may have a metastatic lesion in the body of the 10th thoracic vertebrae. For review by Mr Glackin, to

request MRI scanning of thoracic-lumbar spine and prostate gland and subsequent MDM discussion. Reviewed on 23.09.13, he was tolerating his LH RH analogues pretty well. MRI of prostate was requested. MRI prostate 02.10.13: Bulky left-sided tumour probably extending into the left seminal vesicle. T3b N0 Mx. Discussed @ Urology MDM 17.10.13. Multiple scans would indicate that this gentleman has locally advanced, prostatic cancer associated with a single metastatic lesion in the 10th thoracic vertebrae. For review by Mr Glackin to advise to remain on androgen deprivation therapy. Reviewed again on 09.12.13. For discussion regarding management of pain relating to solitary metastasis. Discussed @ Urology MDM, 12.12.13. This gentleman has reported increasingly severe chest wall pain, radiating from his dorsal spine, on recent review. Mr Glackin to request an MRI scan of thoracic spine, and will be for subsequent MDM discussion. MRI Lumbar spine, 06.01.14 - 1. Multilevel disc degeneration, most marked at L4-L5 and L5-S1 where there are posterior annular fissures. 2. T11 lesion barely perceptible.MDMAction

Discussed @ Urology MDM, 09.01.14. This gentleman's most recent MRI scan suggests there has been some resolution in the lesion noted in T11. There is no evidence of spinal cord compression or cauda equina compression. For review by Mr Glackin and Dr Anderson, Palliative Care Consultant.

Aimee Crilly

From: Brown, Robin <[redacted]>
Sent: 27 January 2014 20:39
To: Graham, Vicki
Cc: O'Brien, Aidan
Subject: RE: MDM cases

Not very happy about this
If MDM is unable to discuss for 3 weeks, I will need to just get on with managing these cases operatively and ahead of presentation on 13 02 13

Robin

From: Graham, Vicki
Sent: 27 January 2014 10:21
To: Brown, Robin
Subject: RE: MDM cases
Importance: High

Thanks Mr Brown for list of patients to be discussed @ MDM. Just to advise you that unfortunately these patients will not be discussed @ MDM until 13.02.13. The reason for this being there are to be a maximum of 35 patients listed for MDM, and with missing one week of MDM due to audit the following 2 weeks MDM are full. I circulated the registration form last week, similar to the one used for Upper and Lower MDM on a Thursday, and this will be discussed again this week and hopefully if this new format is used it will speed up discussion of each patient so more can be added to list so not to delay cases being discussed @ MDM.

Regards,

Vicki

From: Brown, Robin
Sent: 26 January 2014 13:20
To: Graham, Vicki
Cc: O'Brien, Aidan
Subject: MDM cases

Some stuff for MDM, including 3 new testicular cancers presenting on the same day!

[redacted] Previously discussed 02 01 14. Planned for bone scan and further resection in February. Very frail elderly lady. Both of us are a little cautious about her fitness for surgery but in the end decided to book for February. Then got Bone scan report. Probable mets right posterior ribs 9 – 11. This, however, corresponds to area of recent trauma when she fell against a door handle and had severe persistent pain after. CXR – no obvious fracture. Email to M Fawzy – replied "I looked at the chest X ray. Did not show fracture or metastasis. The way the rib uptake looks more like metastasis." Is it appropriate to proceed to repeat TURBT?

[redacted] LEFT testicular lump 2 months. History of pain in left groin since hernia repair some years ago. O/E – small LEFT testis with small lump at lower pole, difficult to palpate. USS – 18x12mm mass in lower pole LEFT testis & second 4mm adjacent mass. Markers normal. Some question about fertility. May need sperm banking.

[redacted] history of left testicular pain. USS showed a 9mm tumour in the RIGHT testicle Markers sent.

[redacted] Always had a smaller RIGHT testicle. Noticed a lump 4 weeks ago. USS - 2cm mass upper pole RIGHT testis. Markers normal. Some question about fertility. May need sperm banking.

Robin Brown

Aimee Crilly

Subject: FW: SWAH clinic on 22nd September 2014

-----Original Message-----
From: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 17 September 2014 08:59
To: O'Brien, Aidan <Personal Information redacted by the USI>
Subject: SWAH clinic on 22nd September 2014

Aidan,

You had asked me to book Personal Information redacted by the USI onto your SWAH clinic on 22/9/14. Unfortunately I have already filled the PR slots on this clinic. Would you be happy to overbook this clinic by 1 and if so would you prefer it in the morning or afternoon?

Many thanks.

Noleen

Mrs Noleen Elliott
Urology Secretary
Tel No: Personal Information redacted by the USI

Aimee Crilly

From: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 05 November 2014 16:50
To: O'Brien, Aidan
Subject: Personal Information redacted by the USI

Aidan,

The above patient attended your SWAH clinic on 28th July 2014 and was told he would be reviewed in October 14. There was no outcomes logged on PAS therefore he is not on a w/l for review appointment.

Noleen

Mrs Noleen Elliott
Urology Secretary
Tel No: Personal Information redacted by the USI

Aimee Crilly

From: Haffey, Raymond <Personal Information redacted by the USI>
Sent: 15 December 2014 10:14
To: Ahmad, Munir; Akhtar, Mehmood; Amir, Adnan; Arava, Shiva; Best, Pauline T; Brown, Jeffrey; Boyd, Kathryn; Brown, Martin; Brown, Robin; Browne, Gail; Bunn, Jonathon; Bunting, Helen; Burke, Catherine; Carlisle, Robin; Campbell, Alastair; Carson, Anne; Clarke, Chris; Clarke, Rosemary; Collins, Cathal; Conlan, Enda; Cooke, Elaine; Crockett, James; Cullen, Aidan; Dignam, Paulette; Donnelly, Brian; Jennings, Leon; Doyle, Timothy; Elliott, Hazel; Elliott, Noleen; Epanomeritakis, Manos; Farnon, Cathy; Farnan, Turlough; Fawzy, Mohamed; Ferguson, Andrew; Ford, Ruth; Gibson, Niall; Gilpin, David; Glackin, Anthony; Gracey, David; Gudyma, Jaroslaw; Gupta, Nidhi; Haffey, Raymond; Hall, Pamela; Hall, Stephen; Hall, Sam; Hamill, Marion; Hamill, Joe; Hall, Pamela; Hanvey, Leanne; Harbinson, Laura; Harte, Terri; Haynes, Mark; Heslip, Jennifer; Hewitt, Gareth; Hinds, John; Hopps, Caroline; Hughes, Paul 2; Hull, Don; Hurreiz, Hisham; Jathar, Hemant; Johnston, Dr Linda; Korda, Marian; Kumar, Devendra; Kumar, Susim; Lennon, Pauline; Lewis, Alastair; Leyden, Peter; Lichnovsky, Erik; Lowry, Darrell; Mackle, Eamon; Magowan, Hannah; Maguire, Peter; Mansour, Ehab; Markey, Mary; Marshall, Margaret; Marmion, Catherine; Martin, Laure; Mathers, Helen; Mathers, Rachel; MAXWELL, Sharon; McAllister, Charlie; McArdle, Gerarde; McClean, Gareth; McClure, Mark; McConaghy, Paul; McConville, Richard; McConville, Yvonne; McCorry, Monica; McCrory, Colin; McCrum, Gillian; McCusker, Grainne; McCullough, Pat; McDonald, Neil; McFall, Brendan; McKay, Damian; McKee, Raymond; McKeown, Ronan; McKillop, Derek; McMurray, David; McNaboe, Ted; McStay, Sarah; Mansour, Ehab; Merjavy, Peter; Milligan, Aaron; Morrow, Michael; Murnaghan, Mark; Murugan, Shanmugam; Neill, Adrian; O'Brien, Aidan; OBrien, Joanne; OConnor, Kieran; ODonoghue, JohnP; OHagan, SineadM; O'Hare, John; OReilly, Janice; Orr, Des; Pahuja, Ajay; Parks, Lorraine; Patil, Prashant; Patton, Sean; Mallon, Peter; Porter, Simon; Rafferty, Lauri; Rainey, Gary; Rea, Margaret; Reddy, Ekambar; Renney, Cathy; Rice, Paul; Richardson, Shirley; Rutherford-Jones, Neville; Scally, Nora; Scullion, Damian; Shah, Rajeev; Sobocinski, Dr Jacek; Street, Julia; Sullivan, Claire; Suresh, Ram; Tariq, S; Troughton, Elizabeth; Wilson, Lynn; Winter, Colin; Weir, Colin; Williams, Marc; Wilkinson, Andrew; Winter, Joanne; Wright, Jayne; Yarr, Dr Julie; Young, Michael; Yousaf, Muhammad; McCaul, David; west ,caroline; Wilkinson, Andrew; Wortley, Heather
Subject: Surgical M&M meeting November 2014 - approved minutes
Attachments: 11) Approved Minutes 21st November 2014 Dr Hall.doc

Dear All

Please find attached the approved minutes for November's Surgical M&M meeting.

Regards

Raymond Haffey
Senior Effectiveness & Evaluation Facilitator Effectiveness & Evaluation Department
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI
e-mail Personal Information redacted by the USI

Minutes of Morbidity & Mortality Surgical, Anaesthetic, Radiology
Friday, 21 November 2014, at 2:00pm in the Lecture Theatre, MEC

Attendance

General Surgery		**Anaesthetics**	
Dr A Bell	F2	Dr S Arava	Consultant Anaesthetist
Mr R Brown	Consultant Surgeon	Dr J Brown	Consultant Anaesthetist
Mr E Epanomeritakis	Consultant Surgeon	Dr G V Browne	Consultant Anaesthetist
Mr D Gilpin	Consultant Surgeon	Dr H Bunting	Consultant Anaesthetist
Mr J Gudyma	Conslt Surgeon	Dr J Campbell	Consultant Anaesthetist
Mr M Haynes	Consultant Urologist	Dr C Clarke	Consultant Anaesthetist
Dr R Hutton	ST4	Dr L Clarke	ST6
Dr P Hughes	Associate Specialist	Dr J Cochrane	Specialty Doctor
Mr H Hurreiz	Consultant Surgeon	Dr A Cullen	Consultant Anaesthetist
Ms J Martin	Clinical Fellow Urology	Dr S Cullen	CT2
Dr J A McBrearty	ST5	Dr B Donnelly	Consultant Anaesthetist
Dr C McCrory	Associate Specialist	Dr A Ferguson	Consultant Anaesthetist
Mr D McKay	Consultant Surgeon	Dr N Gupta	Consultant Anaesthetist
Dr G McKevitt	ST3	Dr J Hinds	Consultant Anaesthetist
Dr S McParland	F2	Dr E Lichnovsky	Consultant Anaesthetist
Dr J O'Donoghue	Consultant Urologist	Dr D Lowry	Consultant Anaesthetist
Dr L O'Flaherty	LAT3	Dr E Mann	LAS
Dr R Spence	F2	Dr L Martin	Consultant Anaesthetist
Mr R Suresh	Consultant Urologist	Dr C McAllister	Consultant Anaesthetist
Mr M Young	Consultant Urologist	Dr N McDonald	Specialty Doctor
Mr M Yousaf	Consultant Surgeon	Dr N Melby	CT2
		Dr L Merjava	Staff Grade
Radiology		Dr J H Morrow	CT2
Dr S Hall (Chair)	Consultant Radiologist	Dr M Morrow	Consultant Anaesthetist
		Dr D Orr	Consultant Anaesthetist
Trauma & Orthopaedics		Dr L Parks	Consultant Anaesthetist
Dr M Connolly	Clinical Fellow	Dr M Rea	Consultant Anaesthetist
Mr T Doyle	Conslt Ortho Surgeon	Dr R Thorpe	Consultant Anaesthetist
Dr F Hassan	Specialty Doctor	Dr D Scullion	Consultant Anaesthetist
Dr D McMurray	Conslt Ortho Surgeon	Dr C Shevlin	ST7
Mr M Murnaghan	Conslt Ortho Surgeon	Dr N Siddique	Specialty Doctor
Dr G Pacha	SHO	Dr C B Winter	Consultant Anaesthetist
Dr G Rainey	Specialty Doctor	Dr J Wright	Consultant Anaesthetist
Ms L Wilson	Conslt Ortho Surgeon	Dr C Yap	CT1
Effectiveness & Evaluation			
Mr R Haffey	Senior Facilitator		
Apologies			
Dr J Adams	LAS ENT	Mr M Lesay	Staff Grade ENT
Dr S Anderson	LAS ENT	Mr P Leyden	ENT Consultant
Dr T Bennett	Consultant Anaesthetist	Mr D McCaul	ENT Consultant
Dr G Dobson	CT1 ENT	Dr P McConaghy	Consultant Anaesthetist
Mr T Farnon	ENT Consultant	Mr T McNaboe	ENT Consultant
Mr A Glackin	Consultant Urologist	Dr K O'Connor	Consultant Anaesthetist
Dr A Gomati	CT1 ENT	Mr Reddy	ENT Consultant
Dr G Gray	ST4 ENT	Dr S Russell	CT1 ENT
Mr S J Hall	ENT Consultant	Dr J Sobocinski	Consultant Anaesthetist
Mr M Korda	ENT Consultant	Dr A Taggart	Specialty Doctor ENT
Dr C Leonard	ST3 ENT		

	Lessons / educational points from the previous meeting
1393	Identify source of problem early.
Venflon	Cannulas inserted in ED need to be removed or replaced with 24 hours.
Results	Pathology and Radiology Results - Responsibility lies with the referrer to follow up reports with Radiology. All reports to be signed off by the Consultant.
1	**Updates**
1334	**GCS – Update from T Reid:** Discrepancy between the GCS recorded in ED and then in the ward. The ward assumed, as the patient had a previous CVA, the GCS could not have been 15 in ED and therefore did not escalate the drop in GCS. Trauma staff have been advised to escalate any drop in GCS to medical staff. The matter has been discussed with Mrs Burke and addressed with ED staff.
	Prescribing IV Fluids in children –Mr Mackle has discussed with the Medical Director and Dr Khan. Ongoing discussion still on whether IVF prescribing will be responsibility of Paediatrics or to remain as at present. No further update available.
1367	**Respiratory review requested** -Respiratory team did not take over care. Case presented at the Medical M&M meeting by Mr Yousaf.
1368	**Paediatric surgery** -Difficulty in getting the patient to be accepted in Belfast due to bed availability. Discussion needed around the regional and local Paediatric surgical policies. Local policy raised at Paediatric Governance. To be discussed at Acute Governance and for final sign off.
	Chair of Surgical M&M – Interviews to be undertaken shortly.
1385	**Surgical review** Delay in Surgical review requested by medical team. Case is subject to SAI.
1386	**Ward round** Ward round not undertaken as Consultant off site. Essential leave is covered at all levels.
1387	**Acute limb ischaemia** Presented to ED initially. CTA embolic occlusion 1 week later. ED to consider diagnosis of Arterial Embolism and CTS. Dr Hall has discussed the case with the AMD of ED who has agreed the case will be discussed at the ED M&M.
2	**Mortality with discussion**
1393	Extensive background of alcohol abuse. Emergency admission – haematemesis, collapse. Arrested in ambulance – CPR. Chest drain for ?haemopneumothorax – thought to be traumatic. CT 3 days after admission - Oesophageal leak, #L4 (incidental). Remained intubated in ICU. Issues – Boerhaave's Syndrome, Alcohol withdrawal, Sepsis. Persistent temps – multiple organisms from drains. Deterioration with left sided hospital acquired pneumonia. Decision made with family to withdraw care 17 days after admission. **Statement of management:** Review of imaging appropriate management. 1 (There were no areas of concern or for consideration in the management of this patient.) **Discussion** Haemopneumothorax thought to be traumatic however unsure if this was due to a fall or CPR. Fracture of L4 looked like acute in nature. The patient had a ruptured oesophagus which was not documented until day 3. Issues raised were who inserted the chest drain and NG tube. Case to be subject to SAI process. Case deferred to the next meeting for full discussion.

	Stated that insertion of NG tubes under image screening when appropriate should be available whenever appropriate as in this case. **Learning point** Identify source of problem early.
1396	Admitted. Fracture left hip. Past medical history: Recent LRTI, Angina, Previous MI 1996 200, MVR, CABG. Overnight ↓ BP. ECG changes and troponin rise. Ward round medical review requested. Not fit for surgery that day. Patient discussed with Medical registrar. Diagnosis acute coronary syndrome. Therapeutic enoxaparin and supported measures. Review by medical team. Renal dose Tazocin started for Chest infection. Family aware of condition and deterioration. DNAR discussed with son. Review by orthogeriatric staff grade. Diagnosis 1. LRTI. Diagnosis 2. NSTEMI. Diagnosis 3. AKI. Management – o2 nebs, Clexane, IV fluids. Patient discussed with cardiology and renal team. Condition continued to deteriorate. On call Dr reviewed– family informed that condition worsening. Cause of death • 1a Community Acquired pneumonia • 1b Fracture neck of femur • 1c Cardiovascular disease Medical team contacted morning. Attended next day. Didn't alter the overall outcome. Highlight the difficulty of getting a medical review (especially at weekends as was the case here). **Discussion:** Issues with medical and surgical assessment out of hours was discussed, this case to be highlighted to the Chair of medical M+M for information. **Statement of management:** 2 (There were areas for consideration but they made no difference to the eventual outcome.) No specific surgical issues, management appropriate.
3	**Morbidity** - no cases
4	**Inevitable deaths**
5	**HCAI / Infection Control / Antibiotic ward round**
(i)	**Antibiotic ward round September/October 2014** *(Full presentation available from E&E)* **<u>September summary</u>** **<u>Craigavon Area Hospital summary</u>** Ward rounds conducted on 12th & 26th September. 38/123 patients on antibiotics. Epanomeritakis: 2 patients. CURB score n/a. <u>Indication not recorded in 1patient:</u> 1 patient on IV Tazocin 4.5g TID (for HAP), not referenced in the notes. Hewitt: 4 patients. CURB score n/a. <u>Indication not recorded and compliance not assessable in 1 patient:</u> 1 patient on PO Trimethoprim 200mg BD, no documented indication in the notes, unable to assess compliance. Lewis: 2 patients. CURB score n/a.

Mackle: 3 patients. CURB score n/a.

Mallon: 1 patient. CURB score n/a. Choice non-compliant in 1 patient: 1 patient on IV Flucloxacillin 1g QID while drains in situ, no evidence of infection.

McKay: 11 patients. CURB score n/a. Indication not recorded in 3 patients: 1 patient on PO Co-amoxiclav 625mg TID (for cholecystitis), not referenced in the notes. 1patient on IV Tazocin 4.5g TID (for cholecystitis), not referenced in the notes. 1 patient on IV Tazocin 4.5g TID (for positive blood cultures), not referenced in the notes; Choice non-compliant in 1 patient: 1 patient on IV Tazocin 4.5g TID for buttock abscess, IV Co-amoxiclav recommended.

Neill: 13 patients. CURB score appropriate for 1 patient, not recorded. Indication not recorded and compliance not assessable in 1 patient: 1 patient on PO Co-amoxiclav 625mg TID, no documented indication in the notes, unable to assess compliance. Choice non-compliant in 3 patients: 1 patient on PO Flucloxacillin 1g QID post abscess drainage, if antibiotics are required, broader coverage needed. 1 patient on PO Amoxicillin 500mg TID + PO Clarithromycin 500mg BD for HAP, IV Tazocin 4.5g TID recommended (note patient treated as CAP, discharged 3 days previously following admission for >30days). 1 patient on PO Co-amoxiclav 625mg TID for CAP, PO Amoxicillin 1g TID recommended.

Weir: 2 patients. CURB score n/a. Choice non-compliant in 1 patient: 1 patient on IV Tazocin 4.5g TID for diabetic foot ulcer, no documentation of any severe criteria, IV Flucloxacillin 2g QID +/- IV Amoxicillin 1g TID +/- IV Metronidazole 500mg recommended.

Yousaf: No patients.

Daisy Hill Hospital Summary:
Ward rounds conducted on 1st, 15th, 22nd & 29th September. 27/97 patients on antibiotics.

Brown: 6 patients. CURB score appropriate for 1 patient, not recorded. Choice non-compliant in 2 patients: 1 patient on PO Amoxicillin 250mg TID for ?HAP (4 weeks admission), IV Tazocin 4.5g TID recommended. 1 patient on IV Tazocin 4.5g TID for HAP (<4days admission), IV Co-amoxiclav 1.2g TID recommended.

Gilpin: No patients.

Gudyma: 3 patients. CURB score n/a. Choice non-compliant in 1 patient: 1 patient on IV Tazocin 4.5g TID to be continued for ?HAP, developed while on course of IV Tazocin for IAS, escalation required if HAP confirmed.

Hurreiz: 8 patients. CURB score n/a. Indication not recorded and choice not assessable in 1 patient: 1 patient on IV Tazocin 4.5g TID, no indication recorded in the notes, unable to assess compliance.
Choice non-compliant in 1 patient: 1 patient on IV Ciprofloxacin 400mg BD for prophylaxis following GI bleed, IV Tazocin 4.5g TID recommended:

McArdle: 7 patients. CURB score n/a. Indication not recorded and choice not assessable in 1 patient: 1 patient on IV Teicoplanin OD + IV gentamicin OD + IV Metronidazole 500mg TID, no indication recorded in the notes, unable to assess compliance.

McKay: 2 patients. CURB score n/a.

Neill: No patients.

October summary

Craigavon Area Hospital summary

Summary: Ward rounds conducted on 10th & 24th October. 36/67 patients on antibiotics.

Epanomeritakis: 11 patients. CURB score n/a. Indication not recorded and compliance not assessable in 1 patient: 1 patient on Cefalexin 250mg QID, not referenced in the notes, unable to assess compliance. Choice non-compliant in 3 patients: 1 patient on IV Clindamycin 900mg TID, patient aged 75, IV Daptomycin recommended if penicillin allergic and >65yrs. 1 patient on PO Metronidazole 400mg TID for C Diff, patient had required PO Vancomycin/Fidaxomicin previously, PO Vancomycin recommended.

Hewitt: No patients.

Lewis: 1 patient. CURB score n/a.

Mackle: 2 patients. CURB score n/a.

Mallon: No patients.

McKay: No patients.

Neill: No patients.

Weir: 20 patients. CURB score n/a.

Indication not recorded and compliance not assessable in 2 patients: 2 patients on IV Tazocin 4.5g TID, no documented indication in the notes, unable to assess compliance.

Choice non-compliant in 1 patient: 1 patient on PO Co-amoxiclav 625mg TID for positive blood cultures (oral switch from IV Tazocin), ecoli resistant to Co-amoxiclav; 1 patient on IV Tazocin 4.5g TID for biliary colic, inflammatory markers normal, apyrexic, no documentation of infection; 1 patient on PO Co-amoxiclav 625mg TID for catheter UTI, IV Gentamicin recommended.

Frequency non-compliant in 1 patient: 1 patient on IV Tazocin 4.5g BD (eGFR 32, 23 on initiation), TID dosing recommended unless eGFR<20.

Yousaf: 2 patients. CURB score n/a. Indication not recorded and choice non-compliant in 1 patient: 1 patient on IV Tazocin 4.5g TID + IV Metronidazole 500mg TID (for abscess/collection), not referenced in the notes, IV Metronidazole not required; Indication not recorded and compliance not assessable in 1 patient: 1 patient on IV Tazocin 4.5g TID, no documented indication in the notes, unable to assess compliance.

Daisy Hill Hospital Summary:

Summary: Ward rounds conducted on 6th & 27th October. 17/73 patients on antibiotics.

Brown: 12 patients. CURB score n/a. Choice non-compliant in 1 patient: 1 patient on IV Teicoplanin OD + IV Metronidazole 500mg TID for cholecystitis (penicillin allergy), IV Gentamicin also recommended.

Gilpin: 5 patients. CURB score n/a. Indication not recorded in 1 patient: 1 patient on IV Tazocin 4.5g TID (for HAP), not referenced in the notes.

Gudyma: No patients.

Hurreiz: No patients.

McArdle: No patients.

	McKay: No patients. Neill: No patients. **Discussion** These figures have also been circulated to each Consultant.
6	**Any other business**
(i)	**Memo from Dr Simpson.** Carbon monoxide poisoning memo was raised at the meeting for awareness.
(ii)	**SAI Report** Personal information redacted by USI **Description of case** Patient was referred to Craigavon Area Hospital by GP with a 4 day history of chest pain which was aggravated by exertion. The chest pain radiated to the arms and the patient had nausea and vomiting. The patient was triaged and seen in CAH ED. Blood results, Troponin results, Chest X-ray and ECG were all normal. The patient was discharged with a primary diagnosis of gastritis for which they received medication and was referred for GP follow up. In light of a strong family history of Personal information redacted the patient was also referred to the Rapid Access Chest Pain clinic for a follow up Exercise Treadmill test. Tragically the patient was found deceased in their own bed the following morning. **Conclusions** The review team have concluded that this patient presented with chest pain. The medical history indicated that the differential diagnosis of gastritis was reasonable. The review team concluded that all necessary investigations were carried out appropriately and in a timely manner and senior opinion was sought appropriately. The review team also concluded with Cardiologist specialist advice that a cardiology review of this patient in ED would still have resulted in discharge home for follow up via RACPC which aligns to the discharge plans that were put in place, and whilst consideration may have been given to cardiology review or admission they are unsure that this would have affected the unfortunate outcome for this patient. **Lessons learned** In patients with a strong family history AND a classic history of cardiac pain even with normal initial investigations (ECG/Bloods), consideration should be given to admission. The findings of the review will shared with the Chairs of Morbidity & Mortality Meetings for dissemination. **Recommendation** The findings of the review will shared with the Chairs of Morbidity & Mortality Meetings for dissemination. **Discussion** The clinical history of the patient did not indicate admission however did indicate referral to the Chest pain clinic as was the case.
7	**Audit Update**
(i)	**Rectal Cancer Resections Audit** - Presented by Dr Moore *(Full presentation available from E&E)* **Data Collection** All cases entered into a 'Colorectal Database' (patient, date, procedure, indication, surgical approach, operating surgeon, stoma formation, ERP, complications, LOS, resection margins, node count, histology). Patient notes. Electronic care record. **Case population** Total 54 cases in which rectum was resected. Encompassed the following 11 procedures…

1. Abdominoperineal resection
2. Anterior resection
3. Low anterior resection
4. Ultra-low anterior resection
5. Completion proctectomy
6. Panproctocolectomy
7. Restorative proctocolectomy
8. Restorative proctectomy
9. TAMIS
10. TEM
11. Hartmann's Procedure

Surgical indication: Neoplasia (36), IBD (8), other (10)
Choice of procedure: AR, APR, Other
Surgical approach: Laparoscopic (56%), Open (22%), Laparoscopic converted to Open (11%), Trans-anal (11%). 67% laparoscopic at outset versus 56% successfully competed laparoscopically.
Operating Surgeon: 36% of cases had two Consultants present

Stoma Formation
Rates compared to data from National Bowel Cancer Audit Annual Report 2013 for patients undergoing 'major resection' for rectal cancer

	AR	APER	Hartmann's	Other
Any stoma	47.6% (77.2%)	100% (100%)	100% (100%)	33.3% 65.8%
Ileostomy	42.8% (61.9%)	0.0% (5%)	0.0% (8.8%)	33.3% (45%)
Colostomy	4.8% (15.3%)	100% (95%)	100% (91.2%)	0.0% (20%)

Loop Ileostomy
- 9 in total
- Successful closure within 12 months: 4 (33.3%)
- Median time to closure: 7.5 months

(compared to 7 months as reported in National Bowel Cancer Audit 2013)
Reasons for non-closure:
1. Patient choice
2. Complicated post-operative period
3. Advanced disease
4. Co-morbidities
5. Unsuccessful attempted closure
6. Time

Enhanced Recovery
Guidelines for the Management of Colorectal Cancer 2007 (ACPGBI)...
"With the development of Enhance Recovery Programmes (ERP) optimising peri-operative care, there is a growing body of evidence which shows that hospital stays can be reduced without an increase in morbidity, deterioration in quality of life or increased cost"

Enhanced Recovery Programme
31of 36 cases documented use. Of those that did not: 4 cases: trans-anal, 1 case: no clear documentation. High Dependency. Two cases required ICU post-operatively

Complications
Overall: Wound infection rate: 8.3%. (10% for lap vs 8.3% for open).
Compares favourably with recommendations from ACPGBI that... "With modern antibiotic prophylaxis, the rates of wound infection (presence of wound discharge with positive microbiology) should be less than 10%"

Anastamotic leak rate: 4.5%. ACPGBI recommend that... "overall rate below 8% for anterior resections and below 4% for other types of resection should be the aim"

Average length of stay
Median length of stay: 5.5 days (for all procedures). Shortest stay: 1 day (trans-anal). Longest stay 40 days (complicated by social issues).

Resection Margins
32 cases: R0, 4 cases: R1. One case: margin involvement. Rate CRM +ve: 11.1% (over all)

Node Count
Overall: Mean number of nodes procured: 17.4. Mean number of nodes involved: 2

Mortality Data
Based on figures to date. 4 deaths recorded. Only one within 90 days of surgery -R1 resection, residual disease, post-op chemotherapy, elderly.

	DHH	NBCAAR
30 day mortality	0%	2.9%
90 day mortality	2.8%	4.5%
2 year mortality	-	24.5%

Conclusion
- Overall, outcomes are good
- Complication rates compare favourably to those from published data/audit
- Particularly low rates of post-op thrombo-embolism and LRTI
- Rate of CRM positive resections in AR is lower than data published for a number of studies
- 30 day mortality: 0
- Scope for re-audit

Discussion
The data on the incidence of APR undertaken, compares favourably with ACPGBI. The figure was 17% compared to < 30% as noted for ACPGBI. The median time to closure for patients who had reversal of Loop Ilesostomy after Anterior Resection also was similar to the data found in the national Bowel Cancer Audit 2013. The management of two cases of non- closure was discussed. In one case the patient had a complicated post-operative period and was not keen for reversal. In the other case there had been an unsuccessful closure - this was subsequently closed at 11 months.
Involvement of more than one consultant in procedures was raised. It was highlighted that when more than one consultant was involved in any procedure then this reflected the more complex cases.
The complication rate of patients was also raised. The rate 8.3% was reported and this compares favourably against the standard of < 10%.
Discussion was also held on considering offering laparoscopic surgery to all patients. It was suggested that laparoscopic surgery had a greater wound infection rate however this related to small numbers of patients. These are low rectal cancer patients who were on long course Chemotherapy and can have wound problems. The recovery times for laparoscopic versus open surgery is similar however the laparoscopic approach leads to less pain for patients.

(ii) **Current NCEPOD Studies**
Sepsis
- Data submitted for study period 6th-20th May 2014. Clinical questionnaires to be completed.
- Organisational questionnaire to be submitted following validation / approval.

8 **Dates of future meetings:** Tuesday 16th December 2014 at 2.00 pm.

Narrative report on the Stock-take for the Health and Social Care Board of Urology Services in Northern Ireland; February to May 2014

Introduction

Following the implementation of the "Review of Adult Urology Services in Northern Ireland – A modernisation and investment plan" of March 2009 the HSCB requested a stock-take of adult urology services in Northern Ireland to assess progress after the 5 years since the review. To provide external independent advice to the HSCB, Mark Fordham the consultant urologist from the Royal Liverpool University Hospital Trust who had provided support as a "critical friend" for the original 2009 review was invited to provide a similar service for this project.

Terms of reference

The terms of reference for this 2014 stock-take of urological services in Northern Ireland were prepared by the HSCB (A – H).

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full range of urology procedures

G) Review the service delivery to those acute hospitals sites that do not have an on-site urology team

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `Nice guidance CG175' [Prostate cancer management].

Plan for conducting the stock-take

A team consisting of Beth Malloy and David McCormick from the HSCB and Mark Fordham as the external advisor was established. Arrangements were made for:

1) Visits to be made to each of the hospital trusts which provide in-patient urological services to meet the urological clinical and management teams (Ulster Hospital, BCH, Craigavon, Causeway, Altnagelvin and Antrim Hospital)
2) To meet with clinicians who have a specific responsibility for providing regionally based administrative services for the organisation and planning of provision of urological care. This was to including meeting the regional BAUS representative (John McKnight), the training programme lead (Siobhan Woolsey), the urological cancer lead (Aidan O'Brien), the lead for audit in urology (Siobhan Woolsey), the RCS representative for Professional affairs in surgery (Terry Irwin) and the regional lead nurse consultant in the Public Health Agency(Siobhan McIntyre).
3) To have access to and review urological data reflecting the way the workforce is organised and the current level of the workload including the waiting list backlogs, together with an assessment of the current commissioning arrangements.
4) To review data germane to this work that is in the public domain relating to urological activity, care pathways, guidelines, contributions made by the urological staff, published audits and research.

1) Reports on the review meetings at Hospital Trusts

Present at all these meetings were Mark Fordham and Beth Malloy, with David McCormick at all except Antrim Hospital.

The aim of the meetings was to allow each Trust team to describe how they saw their current position and any challenges that existed, and what progress they had made since the 2009 Review. The HSCB did not offer any comments on the data presented.

Belfast Trust
Date: Tuesday 11th March
Present: Representative Urology consultants and management
Points raised by the Trust:
Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Increasing workload especially from increasing numbers of cancer referrals to its Cancer Centre
3. Consultant changes and increasing emergency work [especially acute stone cases] resulting in significant reduction in workforce capacity and in the skills base in particular surgical reconstruction services.
4. Recruitment of clinical staff remains difficult

5. Growing waiting lists especially for core urology and outpatient services
6. Primary care catchment areas overlapping with other providers making allocation of referrals challenging.
7. Limited space for day diagnostic services and limited theatre sessions, but helped by using the theatres at White Abbey Hospital to provide some diagnostics and day cases
8. The Trust raised the issue of the provision of Robotic Surgery
9. On ongoing problem with a small group of patients awaiting complex reconstructive surgery was described.

Achievements

1. Established Cancer Centre along Improving Outcome Guidance recommendations; weekly MDT with video links to cancer units;
2. Well-established training services for junior urologists

South Eastern Trust

Date: Wednesday 12th March

Present: Urology consultants and management representatives

Points raised by the Trust:

Challenges

1. Specific problems of the "Team East" arrangements that the 2009 Review had initiated, especially the on-call arrangements between the Ulster hospital and BCH.
2. Current 3 consultant team is overstretched: 4 peripheral sites covered as well as the main hospital; BCH provides clinical work at Lagan Valley
3. Rising demand for both cancer and core urology services

Achievements

1. Strong support from the 2 specialist nurses including delivering flexible cystoscopy and outpatient work
2. Activity delivered to contract but a growing waiting list
3. Target length of stay and day-case rates satisfactory
4. Potential for excellent training of junior urologists

Northern and Western Trusts (at Causeway Hospital)

Date: Thursday 13th March

Present: Representative urology consultants from Western Trust as well as consultant urologists from Northern Trust together with management teams from both Trusts.

Points raised by the Trusts :

1. The 2009 Review had recommended that the Northern Trust and the Western Trust urology services were amalgamated into a single team. A helpful document summarising the teams work towards this amalgamation was presented. The 2 teams have worked on and proposed a method for achieving this and have conducted an assessment of their proposals with the input of a senior and very well respected consultant urologist. To create a combined Northwest team the plan proposes continued cross team co-operation and development of working relationships, establishment of 2 new operating theatres on the Altnagelvin site to support increased urological activity, build a dedicated diagnostic and treatment facility on the Causeway site, increase within

Team NW numbers of consultant [to 6], staff grade [to 4], urology trainees/fellows [to 2] and specialist nurses. An analysis of capacity based on the recommended workload per clinician and current and likely increase in demand was presented to support the manpower and facility development proposals. It is recognised by the Trusts that investment will be needed to achieve these objectives.

Challenges

1. Waiting times for outpatients and surgical procedures remain high with significant numbers of patients on the operative waiting lists particularly for core urology procedures.
2. The arrangements for cross cover on-call arrangements between the two sites are not yet fully operational.
3. The 2 new operating theatres on the Altnagelvin site are not yet completed and do not have an agreed timescale for construction.
4. The loss of the defined cancer operations to the Cancer Centre has not been backed up with clear annual outcome data to assess whether improvements have resulted. The work to deliver these data is not within the scope of team NW.
5. The costing for some of the Team NW proposals are not yet fully worked out and no clear decision regarding possible funding has been taken.
6. Recruitment of clinical staff has remained difficult (both consultants and specialty doctors).

Achievements

1. A determined collaborative undertaking with external assessment to develop a plan to achieve the 2009 review recommendations.

Additional comments:

1. The clinical director for surgery pointed out that losing urological inpatient services from the Causeway Hospital Trust could have a negative effect on the functioning of the Trust, and he hoped that the service would remain as it is.

Northern Trust at Antrim Hospital

Date: Friday 14th March

Present: Consultants in general surgery and in gynaecology

Points raised by the Trust :

1. Patients with urological conditions are admitted via A&E under the care of the general surgeons. Although there is acute support from the urologists in the Northern Trust in Causeway Hospital and there are arrangements for urological input from the Belfast City Hospital team, in reality patients may not experience optimal care and may remain in hospital for longer than would be the case in hospitals with a urology directorate particularly for the patients who are undiagnosed or have medical type urology pathologies.
2. The 6 gynaecologists in Antrim Hospital would welcome the presence of a urological service to collaborate with providing functional urinary services as well as some operative procedures.
3. Operating theatre space is limited but facilities at Whiteabbey Hospital have traditionally been used by outreach urology services from Belfast Trust.

Southern Trust
Date: Thursday 3rd April
Present: Urology consultants and management staff
Points raised by the Trust:
A helpful document summarising the directorates progress on implementing the 2009 review recommendations was presented.

Challenges

1. The waiting lists particularly for outpatient services have very long waiting times.
2. Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases.
3. The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand.
4. Recruitment of clinical staff [consultants, juniors and specialist nurses] has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant.
5. Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site.
6. Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&E.
7. Administration time for consultants is significant and is not reflected in their job plans. There is a particular worry in delays in consultant to consultant referrals, MDT referrals and triage.

Achievements

1. An improved diagnostic and treatment outpatient facility has been completed which will enable one-stop services to be improved and developed.
2. Recent new consultant appointments are hoped will allow a significant improvement in waiting times and reduction in waiting lists.
3. An elective admission ward has helped improve day surgery numbers and improve theatre utilisation

Additional comments

1. General surgeons provide urological care at Daisy Hill Hospital and SWAH; vasectomy services at Craigavon Hospital are provided by the general surgeons.

2) Reports on the review meetings with regional leads

Regional BAUS representative; John McKnight
Date: Wednesday 5th March
Present: John McKnight and Mark Fordham
Points discussed

1. Regional meetings and updates
2. Regional audit
3. Sharing best practice
4. Supporting trainees
5. Ways to improve consultant recruitment
6. Managing competing needs of local hospital urology services while delivering regional urology services
7. Availability of Mark Fordham to meet and speak with the consultant urologists at any time about the stock-take.

Regional Programme director for urological trainees; Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Beth Malloy, David McCormick
Points discussed:

1. Training arrangements for juniors
2. Expansion of training posts and training accredited hospital locations
3. Opportunities for juniors to present research and audit studies

Regional Urology Audit lead: Siobhan Woolsey
Date: Monday 10th March
Present: Siobhan Woolsey, Mark Fordham, Beth Malloy, David McCormick
Points discussed:

1. Local and regional audit meetings
2. Opportunities for local and regional presentations of audited best practice
3. Development of care pathways and referral and treatment guidelines

Regional Urology Cancer Lead; Aiden O'Brien
Date: Thursday 3rd April
Present: Aiden O'Brien, Mark Fordham, Lisa McWilliams [NICaN Manager], Beth Malloy, David McCormick
Points discussed:

1. Annual meeting to review audited numbers and results, complications and outcomes from the regional urological cancer services teams to include reports from the regional radiotherapy, medical oncology and surgical urology cancer centre teams. This annual meeting has not yet happened.
2. Plans and preparations for the Urological Cancer Peer Review planned for July 2015
3. Recent changes in the urologist cancer lead.

4. Opportunities for sharing best practice
5. Developments in the roles of specialist urology nurse practitioners for diagnosis, treatment and follow up of urology cancer patients.
6. Preparation for the June NICaN meeting

Regional RCS representative for Professional affairs: Terry Irwin
Date: Friday 14th March
Present: Terry Irwin, Mark Fordham, Beth Malloy
Points discussed:

1. Emergency surgery services including urology
2. Consultant responsibilities between hospital and regional based services
3. Appraisal and Revalidation

PHA Regional lead nurse consultant: Siobhan McIntyre
Date: 2 April 2014
Present: Siobhan McIntyre [by video link], Mark Fordham, Beth Malloy
Points discussed:

1. Opportunities for training of specialist urology nurses
2. Specialist nursing skills recognition between hospital trusts
3. Numbers currently of specialist urology nurses
4. Numbers of Macmillan trained urology specialist nurses
5. Recognition of urology nursing associations [British and Irish]
6. Links with University training courses
7. Value of developing links with past president of BAUN [Jerome Marley] who works at University of Ulster and Craigavon Hospital Trust.
8. Appropriate use of specialist nurse workforce including robust job plans and recording of activities
9. The data below was kindly collected by questionnaire circulated by Siobhan McIntyre to the Trusts. The 0 to 4+ grading is approximate to give an indication of activity.

Clinical Nurse Urology Specialist data	Number of CNS in urology	Access to training and development [0 to 4+]	Community continence nurses	Community catheter care and change [0 to 4+]	Attendance at national and local meetings [0 to 4+]
Belfast Trust	2	++++	10	++++	++
Northern Trust	2	+++	4	++	++
SET	2	++++	4	+	+
Southern Trust	2	+	-	-	++
Western Trust	5	++++	7	++++	++++

3) Requests were made for data reflecting workload, waiting lists and waiting times, workforce numbers and workforce job planning, current methods and assumptions underpinning commissioning service level agreement contracts

3.1 The HSCB provided data on waiting lists and waiting times
3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.
3.3 Discussions took place with HSCB to understand the methods underpinning the way Service and Budget Agreements (SBA) are devised and commissioned.

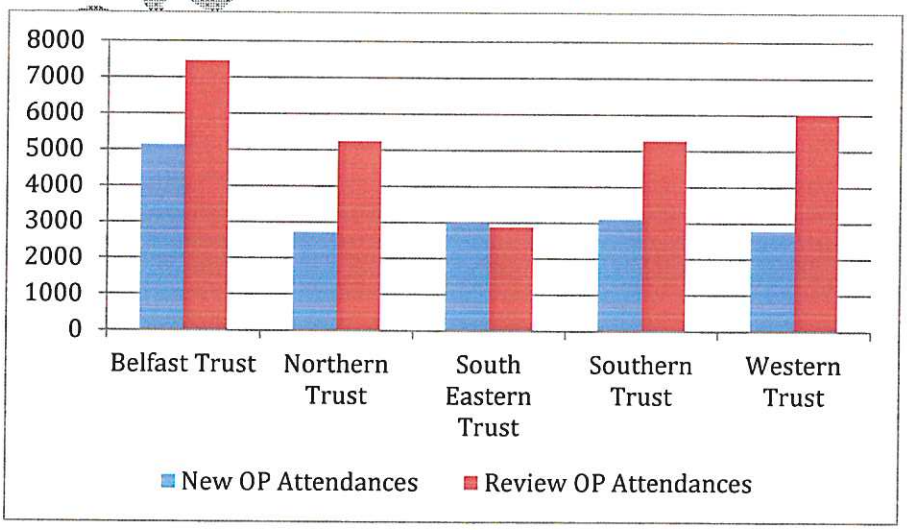
3.1 The HSCB provided data on waiting lists and waiting times

Reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The 2012/13 New : Review outpatient ratio is 1.6 (16,711:26,806) with DNA rates for first and review visits at 7.5% and 8.8% comparing favourably with the Dr Foster urology data for England. However this does not take into account for some units the very large numbers of patients waiting for out-patient appointments in particular review appointments.

The overall outpatient work for 2012/13 for the 5 Urology Directorates is shown in the table and histogram

2012/13	New OP Attendances	Review OP Attendances
Belfast Trust	5131	7447
Northern Trust	2717	5233
SET	2998	2870
Southern Trust	3095	5271
Western Trust	2770	5985

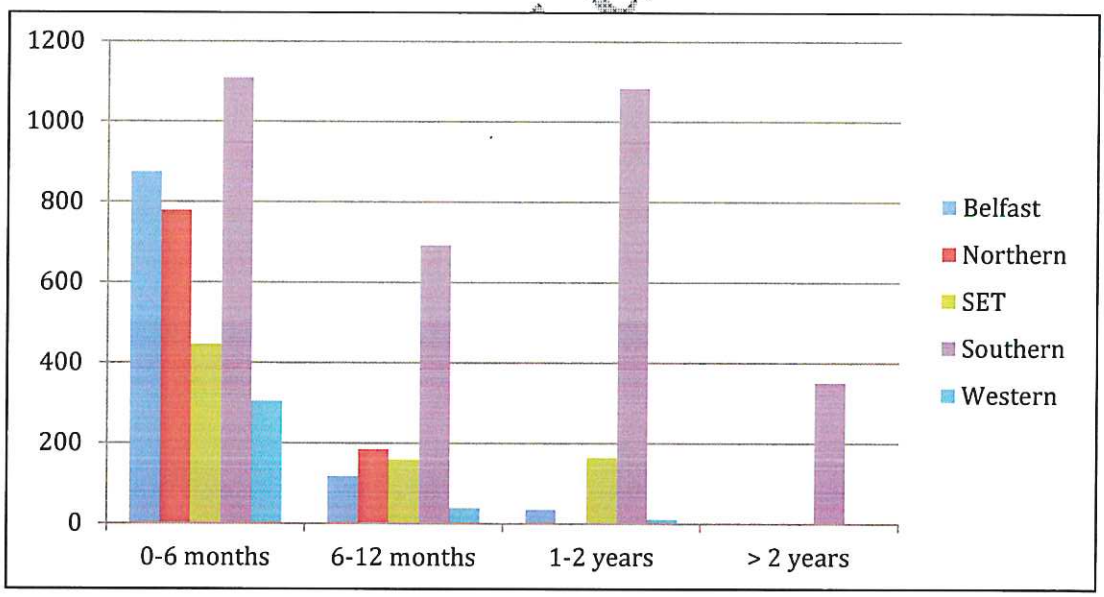


The waiting list and waiting times for patients booked for a review out-patient appointment are shown in the table and histogram below;-

Numbers of patients awaiting review out-patient appointments [time elapsed since the appointment was due is shown in the table below i.e. 'a backlog']. However it is also worth noting that in addition to these there are a number of patients currently still within their clinically indicated review appointment waiting time but yet to be seen are: BHSCT 3170; NHSCT 800; SET 1025; SHSCT 1300; WHSCT 1270. This represents a significant workload which may result in additions to the patients who breech their review clinic waiting time.

	0-6 months	6-12 months	1 – 2 years	> 2 years	Total
B HSCT	874	118	35	0	1027
NHSCT (Causeway)	778	185	0	0	981
SEHSCT	446	159	164	0	769
SHSCT	1109	692	1083	351	3235
WHSCT	304	39	11	0	354
Total	3529	1193	1293	351	6366

The same data is presented in a histogram



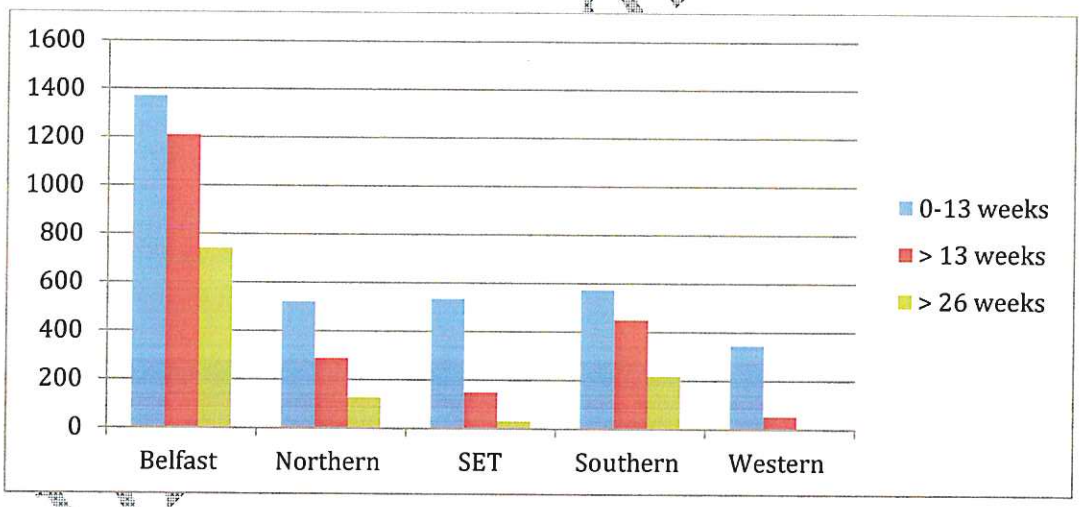
Despite the rising referral rate the in-patient operative activity shows overall stability with day case activity increasing gradually year on year and in-patient operative work largely stable.

In-patient bed usage appears satisfactory with average regional lengths of stay (LoS) at 2.71 days for elective and 5.24 days for non-elective cases, with little variation between the trusts.

Using data from the Theatre Management System [TMS] theatre utilisation shows almost no overruns throughout the region but each Trust has some theatre usage below 80%. This may in part result from the regional average operative cancellation rate of about 12% with a range from 7% to 25%. It should also be noted this utilisation is measured against available Trust reported capacity and not necessarily the capacity funded by the commissioner. This point was raised by several consultants who highlighted that theatre operating time was a key limiting factor.

The in-patient and day case waiting lists numbers (at 3/2/2014) are presented in this table and histogram below, these may increase when all the out-patient appointments have been completed:-

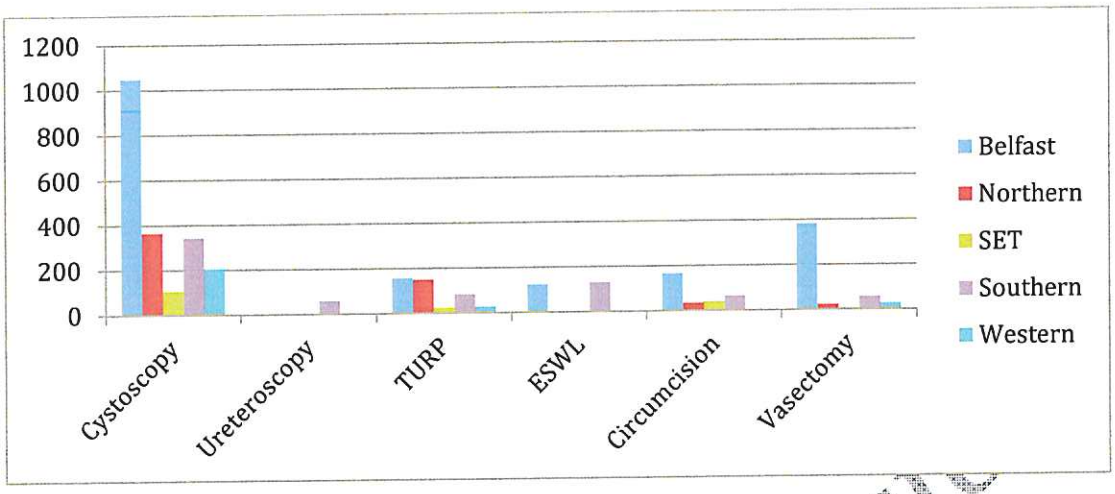
	0-13 weeks	>13 weeks	> 26 weeks
Belfast Trust	1368	1206	741
Northern Trust	521	267	126
SET	534	148	30
Southern Trust	573	449	217
Western Trust	345	52	4



The waiting list for operative procedures is shown in the table with the total number given together with 6 specific procedures with higher numbers of patients awaiting treatment.

	BCH	Northern	SET	Southern	Western
Total	2576	808	682	1022	398
Cystoscopy	1047	364	105	342	204
Ureteroscopy	0	0	0	58	0
TURP	155	150	24	83	27
ESWL	123	0	0	129	0
Circumcision	165	34	40	64	0
Vasectomy	381	22	7	56	27

The same data as above is presented in a histogram



3.2 Requests were made to hospital urology management teams for details of the urology workforce and their job plans.

The table below reflects the workforce (both staff in post and vacancies) in each Hospital Trust as accurately as can be assessed from the information provided.

Hospital	Consultants	Staff grades	Specialist urology nurses
BCH	9	2	2
Northern	3	2	2
SET	3	0	2
Southern	5	4 (inc 1 GPSI)	2
Western	3	1	5

Only a few complete job plans were submitted together with some tables representing the global clinical commitment of the urology teams within a hospital. From the information received it was possible to see that more imaginative ways of using the contracted time might be worth considering.

3.3 Discussions took place with HSCB to understand the methods underpinning the way SBA are devised and commissioned.

As part of the task of understanding the balance between the capacity of the urology service and the demand from both primary care referrals and emergency patient work Mark Fordham, Beth Malloy and David McCormick spent time establishing and examining the assumptions underpinning the calculation of the specific numbers of consultations, diagnostic procedures and therapeutic operations that are the basis of the commissioned service level agreements between the HSCB and the individual Trusts.

Three observations were made:-

1) The use of the BAUS workload numbers, particularly for outpatient work, do not fully reflect modern ways of providing patient centred services [one stop services including diagnostic tests] . Local estimates are needed based on patient referral types and modernised patient centred services and commissioned in a way which incentivises innovation.

2) This traditional method of commissioning clinical work has an inherent unintended consequence. By defining the work expected of the workforce [based on the BAUS recommendations], no cognisance is taken by the Trusts of the demand placed upon the system. Consequently any mismatch between capacity and demand will result in an excess workload that has not been costed or commissioned leading to a backlog of patients requiring treatment that will require additional extra-contractual arrangements and expenditure to always be funded by the Board.

3) Because the responsibility for dealing with demand over the service level agreement lies with the commissioners ie the HSCB, the clinical directorate and the Hospital management team are absolved from the responsibility of looking for imaginative and innovative ways of delivering the clinical service. It would seem this stifles any new or modern ways of delivering a better and more cost efficient service.

4) To review data germane to this work that is in the public domain relating to urological activity: care pathways; guidelines; contributions made by the urological staff; published audits and research; publications by public bodies and political committees

The impressive work that is undertaken by the urological consultants of Northern Ireland is easily available on the Internet on various sites where their work features. There are numerous publications, both academic and popular together with minutes of meetings and documents dealing with ways of improving services. In addition there are many documents published by the various health related public bodies and political committees that provide information regarding the best ways of delivering health care for patients, and in particular urological patients.

Research, audit, guidelines and care-pathways:-
A small sample of the contributions of the urological consultants include:-
Brian Duggan chaired the Northern Ireland urology clinical guidelines panel which produced draft guidelines for a range of urological conditions [lower urinary tract symptoms; haematuria; scrotal masses; raised PSA; renal colic; acute kidney obstruction; acute urinary retention] which have been accepted by the regions urologists. He has published papers on urethroplasty.
Paul Downey was part of the BAUS team that produced the nationally accepted guidelines for the management of patients with suspected kidney stones. He oversaw the safe introduction of laparoscopic renal surgery in UK urological practice through a national audit. He has published papers on flexible cystoscopy and reduced length of stay for TURP patients.
Aidan O'Brien is part of a national research project investigating a new drug for the treatment of angiomyolipoma disease.
Patrick Keane has been instrumental in developing the role of the specialist urology nurse, chairing the various regional urology cancer committees and co-authored the NHS guidelines on PSA testing; he has had a major role in aspects of training, education and examining trainees.
Siobhan Woolsey has published on stone disease, urodynamics, reconstructive and functional urology
Colin Mulholland has been responsible for developing a PSA tracker and its economic benefits.
Chris Hagan was part of the team that conducted a comparative audit on the care of prostate cancer patients in Northern Ireland in 1996, 2001 and 2006 and an audit on the prostate red flag referrals.

Cancer agenda:
The minutes of NICaN show what progress has been achieved under the various chairmen and members of the committee, in particular the work to make the 2009 Review become effective. More recently plans have been developed to make the MDTs effective, introduce patient representation and develop the regional annual plan.

Transforming Your Care:
This is a major review of Health and Social care in Northern Ireland produced at the Assembly's request incorporating comments from a large number of participating groups from the general public as well as professionals within the Health Service.
It covers topics that are relevant to urology such as:-
The ageing population [between 2009 and 2020 there will be a 40% increase in people> 75 years old] – no specific point are made about catheter care, but this will certainly impinge on urology services.
Long term conditions; this will include chronic conditions such as prostate and bladder cancer; incontinence; stone disease.
Patients with physical disabilities; the area of caring for adults who have required surgery as children eg spina bifida patients who may need treatment for stone disease, continence problems and renal impairment.
Acute care: the report makes the point that these are the sickest patients and they need the best informed clinical care.
Technology: the document endorses the best use of modern technology to offer both the best treatment for patients and in many cases the most cost efficient.

The Assembly's Committee for Health, Social Services and Public safety
This committee, chaired by Maeve McLaughlin [Sinn Fein]and vice chairman Jim Wells [DUP], has recently been hearing evidence from experts about the ways of improving patient care by managing waiting lists and waiting times. The video recordings and the Hansard records of the presentation and the discussion are all available on the Committee website:-
http://www.niassembly.gov.uk/Assembly-Business/Committees/Health-Social-Services-and-Public-Safety/Minutes-of-Evidence/

The evidence presented is of the highest quality and is worth looking at. There is much debate about recording Referral to Treatment Time [RTT].

Comments on the stock-takes findings related to the Terms of Reference

A) Undertake an initial 'stock-take' assessment of the implementation of each of the urology review recommendations

In summary the Review of Urology Services published in March 2009 looked at 2 main areas of concern:-

1. Specialisation within urology
2. Delivering timely urological care

1) Specialisation within urology;
In particular moving urological procedures from general surgery into urological practice and moving urological cancer services into line with the 2000 NHS cancer plan such that defined cancer operations as described by the Improving Outcomes Guidance [IoG] were performed in sufficient numbers in a cancer centre and for all defined cancer cases to be discussed at a regional MDT.

2) Delivering timely patient-centred urological care:
This was to cover new and review outpatient services, operative procedures and on call arrangements for the care of urological emergencies.

The review described 3 main proposals aimed to achieve these objectives:-

1) Referral patient pathways and care protocols to be agreed amongst the urological consultants so patients with urological symptoms would be seen by the right specialist first time and would have an agreed best care plan wherever they were seen in Northern Ireland.

2) To fund an increase in the urological consultant numbers [to 23 wte] and specialist urology nursing workforce [at least 5 cancer nurses] to allow the best redesign of diagnostic [one stop] and review clinics and day-case and in-patient operative capacity in line with the BAUS capacity recommendations to minimise delays in patient care supported by any necessary changes to the job plans of the clinical workforce

3) A regional urological clinical service model of 3 teams [NW; E and S] created by the amalgamation of the current urology directorates within the existing 5 acute hospital trusts, each team with responsibility for acute on call services and clinical support services for the hospitals within their defined area and where necessary support from management to negotiate new contractual and job plan arrangements.

Progress seen from the stock-take:-

1) Specialisation within urology:-

1. BCH has become the defined urology Cancer Centre and this has led to a net importing of complex work without any concomitant reduction in the core urology service.
2. The other urology cancer units no longer undertake the IOG defined cancer operations.
3. A weekly regional MDT takes place with video linkage from the cancer units to the cancer centre. The exact composition of this MDT is not yet clear and those attending should be reviewed.
4. An annual meeting to review audited data including numbers, complications and outcomes to be presented by the Cancer Centre team including the Radiotherapists, Medical Oncologists and Urological Surgeons to all users of the urology cancer service has not yet taken place.
5. A peer review is due in July 2015. This will need careful preparation.
6. As a consequence of specialisation for cancer surgery other urology units have begun to specialise in stone services
7. Female urology and andrology are poorly developed at present.

8. Some urological procedures [e.g. vasectomy] are still performed by general surgeons. If this ceases it will impact on the urology waiting lists and waiting times.

2 Delivering timely patient-centred urological care;

1. Investigation and treatment pathways have been developed but no regional audit has assessed how well they are used and whether they offer best practice
2. The total number of consultants has increased but recruitment has been difficult
3. There are significant waiting lists in the region with some very long waiting times for both out-patient and in-patient services.
4. Emergency care for urological patients is variable with some areas with a service that is not optimal.
5. The use of specialist urology nurses is variable, but where they are established they contribute a significant addition to the clinical workforce making an important contribution to timely and patient-centred care.
6. There are some areas of urological practice that cannot be provided within the current skill or technology base.
7. The number and distribution of urological teams favours some areas over others to the detriment of patient care.

B) Review the current three team model and advise the Board if the current model proposed in the Urology Review is sustainable across the Trusts

The amalgamation of the Belfast and Ulster Hospital urology teams for on-call services has been thoroughly assessed. It is clear that the area to be covered, the lack of continuity of care of acutely ill patients and each teams unfamiliarity with the other departments facilities may lead to the clinical care not being optimal. It would seem appropriate to accept that this model has not been ideal and for each Trust in Team East to consider managing their own on-call arrangements.

The amalgamation of the Northern and Western Trust urology teams has been looked at in detail, with external high quality urological assessment of the Team's proposal.

At present the two teams have not combined their on-call rotas and the proposed plans to make the amalgamation possible require significant investment. The two Trusts have reported their continued commitment to the concept of North West Team Urology, although there was little quantifiable evidence to support how the team functioned for acute on-call and sharing waiting lists on an on-going basis.

The Southern Trust urology team in Craigavon Hospital has several peripheral hospitals to serve but the plan did not involve them in amalgamating with another urology team.

C) Identify actions to improve clinical leadership and team dynamics, which may have been hampered by local issues such as junior doctor vacancies, on-call arrangements, sharing resources and governance/risk sharing across the teams.

It is helpful to recognise that the urology consultants have a dual role within their professional responsibilities. Clearly they are responsible for delivering their clinical commitments according to their job plan for their Trust, but in addition they have a responsibility to deliver a regionally coordinated service whereby they are able to share best practice through clinical audits, to review cancer services collectively and support patient-centred care-pathways, and to support the training of the specialist registrars.

Leadership is needed both locally in individual urology directorates to establish suitable job plans to make best use of the trust facilities as well as to encourage innovation and adopt best practice but also regionally to support those with regional responsibilities involving teaching, training, audit, research and cancer services.

The annual appraisal and the subsequent GMC revalidation require evidence that the consultant has contributed to these aspects of the service and have combined reflective practice as well as participation with the audits and meetings.

D) Identify key limiting factors [eg theatre access, equipment] which may be impacting on the delivery of full capacity

Without all the consultants complete job plans it is not possible to give an accurate assessment on any limitations to operating theatre access. However at each of the hospital visits the consultants said that they were limited in their access to theatre and needed more sessions to deliver the surgical work that was required.

Most urology teams seemed to feel that they had a satisfactory supply of theatre kit.

E) Review the expected case mix and activity assumptions of specialist verses core urology consultant posts, including the input of middle grade staff who operate independently

The evidence nationally and from speaking to the urologists in Northern Ireland is that suitable candidates for staff grade jobs are now virtually no longer available. This is the result of fewer subcontinent trainees coming to the UK as a result of EU rules and the changes in training for UK registrars.
For this reason, it would make sense to vire any current funding for unfilled staff grade posts and convert them into consultant posts. This would be in line with the NHS ambition for a consultant orientated service.

There has been a long standing difficulty in finding suitable candidates to appoint to vacant urology consultant posts in Northern Ireland. The training opportunities for urology HSTs are considerable and a short term increase in HST places in NI would act to increase the number of locally trained urologists who may be more likely to consider a consultant post in the Province. This is an area the regional BAUS representative and the Urology Programme Director may consider approaching the Urology Specialist Advisory Committee directly.

The current method of commissioning a service level agreement requires specific numbers of outpatient visits, diagnostic procedures and therapeutic operations. With changes in clinical practice aimed to deliver patient-centred care, the one-stop clinic visits, and the increasingly complex operations being performed. It will be necessary to consider a more sophisticated method of specifying and monitoring what work should be delivered for what budgetary agreement.

Alternatively, the commissioning contract [using historical levels of resources and funding as a guide] could aim to provide funding for a Trust management team so they are responsible for delivering the clinical service within the totality of budget. The measure of success and productivity being determined by achievement of waiting list targets as opposed to delivering of units of activity. In this way each team would be encouraged to develop innovative ways of delivering high quality cost effective clinical care. This has been demonstrated in England where outcome/target based budget contracts allowed hospital chief executives to vire funds towards the areas that are most needed. It was this environment that produced some of the most worthwhile patient-centred service developments during the Action on Urology project.

F) Assess the specialist operating requirements within the region, including increased utilisation of technology, to ensure delivery of the full ranges of urology procedures

One area of urology that benefits from state of the art theatre technology is stone surgery. As each acute centre will have to deal with its own share of acute stone patients having the appropriate kit would ensure high quality clinical care for patients wherever they presented in Northern Ireland. Such kit would include both rigid and flexible uretero-renoscopes and suitable laser technology to break up impacted stones. The specialist technique of percutaneous nephrolithotomy is generally best performed where there is interventional radiology support.

Two other areas that are worth considering:-

Flexible cystoscopies – using video style flexible cystoscopes has the advantage that teaching trainees is much easier, it is possible to make recordings of the examination if needed and there is less strain on the surgeon's neck. This technology would be an appropriate addition to the outpatient diagnostic services.

Robotic surgery – Robot assisted laparoscopic radical prostatectomy [RALP] is becoming the standard of care for surgically curable prostate cancer patients. Conventional laparoscopic surgery is recognised as a challenging procedure to perform and has a long learning curve.

It was little used in USA but with the introduction of RALP this is now standard practice. In the UK we have been slower to develop the use of robotic surgery, but it is clear that each region in the UK will be expected to deliver on this type of surgery.

Most regions have seen an increase in cases of surgically curable prostate cancer due both to PSA testing and following the regular review of all cases at the regional MDT.

In addition to prostatectomy, most robotic centres are using the robot for laparoscopic nephron sparing surgery, and are developing on the Scandinavian and USA experience of robot assisted cystectomy.

Northern Ireland should assess the need for access for its population to robot assisted laparoscopic radical prostatectomy. Recent studies and guidance provides greater clarity on the position in regard to the benefits and cost effectiveness of robotic assisted prostatectomy. The potential for this to be provided locally should be considered. The benefits of such a local service would demonstrate how forward looking the region is and could well result in increasing the quality and number of applicants for consultant posts.

Some urological conditions and procedures are rare or seldom performed. In a region of 1.8 million it is likely that some procedures will not be suitable for the regions skill set. This may include some reconstructive procedures, and some prosthetic devices. Arrangements for such patients to be treated elsewhere would seem appropriate.

G) Review the service delivery to those acute hospitals sites which do not have an on-site urology team

The initial review recommended that arrangements should be in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology units. The only major acute hospital trusts which have no urological team based on site is Antrim Hospital Trust and SWAH.

The discussion with the general surgeons and the gynaecologists at Antrim clearly showed their need to have urological services based there. Currently the patient care may not be optimal despite acute support from the Causeway urology team and visits from the Belfast urology team.

It would make sense to consider the enhancement of the urology services based at Antrim Hospital. The work would inevitably be mainly acute urology and core urology and initially the operative facilities may be based only at Whiteabbey

Hospital, although in time it is likely sessions would become available at the Antrim site, when the mobile Theatres are provided on the site or earlier if possible [much as was the case when the general surgeon Arthur McMurry was there].

The advantage of such a development is that some of the core urology cases that currently go to BCH would be redirected to Antrim taking some of the pressure off the regions urology Cancer Centre.

In the current stocktake South West Acute Hospital was not visited.

H) Assess the increased demand for urology services, especially the growth in suspect cancer referrals – including the potential impact from implementation of `NICE guidance CG175' [Prostate cancer management].

As stated earlier, reviewing the data over the last 5 years for primary care referral rate, hospital outpatient waiting times and operative procedure waiting lists for the 5 trusts providing urology care the primary referral rate has risen by ~10% year on year with red flag referrals rising by 25% year on year.

The audit headed up by Chris Hagan has shown that red flag referrals do not represent all the suspected cancer cases as demonstrated by reviewing the eventual outcome of the investigations. A more helpful statistic is that about 50% of men who undergo prostate biopsy are found to have a prostate cancer.

The evidence from England [and the USA and Europe] is that the numbers of patients having a localised prostate cancer identified are increasing significantly. This is reflected in the numbers of patients undergoing radical surgery.

The NICE guidance CG175 is a wide ranging series of recommendations for all aspects of referral, investigation and treatment of all stages and complications of prostate cancer. This document offers an excellent blueprint against which the regional cancer audit can compare itself and be able to present at their Peer review in 2015.

Some specific areas that the Cancer group may wish to look at would include information and decision support for men with prostate cancer, their partners and their carers; the management of post radical prostatectomy sexual dysfunction and the investigation and management of hormone therapy induced osteoporosis.

Comments and Conclusions

Many of these points have been made earlier in this narrative.

This section aims to summarise some of these points and add some comments that might be helpful in devising better ways of delivering excellent cost-efficient patient-centred services and to provide opportunities for regional planning.

In discussions at the hospitals with the consultant urologists and the management it was clear that all groups are keen to deliver an excellent clinical service. Most groups describe common types of difficulties including

- insufficient theatre capacity,
- the challenges of shared responsibility for clinical care especially those patients admitted as an emergency;
- increasing referrals from primary care,
- significant difficulties in recruiting suitable candidates to consultant posts

In discussions with those clinicians with regional responsibilities it is clear there is an untapped real opportunity to use the annual regional audit meetings, the annual regional cancer review meeting, and the regional representative report meetings to create regional cohesion amongst the urology teams. Each of these meetings would offer an opportunity to share best practice amongst the teams, provide an occasion for the trainees to present their research or audit projects [possibly with a prize for the best one], and to review the data from the BAUS complex operations audit. It is common practice in many other regions to combine the regional representative meetings with an evening meal giving the chance for consultants and trainees to meet socially.

To generate ideas for suitable patient-centred audit the technique of process mapping a service can be helpful and the work done during the Action on Urology project in England might offer some guidance.[see this pdf with a summary of some of the projects:-]
http://www.qualitasconsortium.com/index.cfm/publications/service-transformation/action-on-guides/action-on-urology-good-practice-guide/

There seem to be significant challenges in delivering the three team arrangement that the 2009 Review recommended. From a clinical governance perspective the Eastern Team has encountered problems and the NW Team development seems to be dependant on a significant financial input that has not yet been agreed. It seems that this three team recommendation should be reconsidered. This would impact on any new on-call arrangements, but would return them to the pre-review on-call arrangements.

It is not possible to form a complete picture of the current arrangements of the consultants job plans as so many were deemed confidential and were not released to the team undertaking the stocktake . Access to job plan information should be a prerequisite if future funding is to be approved. However there are ways of improving service delivery by suitable adjustment of job plans that can

also deliver an improved working practice for the consultant. It is for the Hospital Trusts and the HSCB to review this possibility.

There is a strong recommendation in Transforming Your Care for the best use of technology to improve patient care. Ensuring each urology unit can offer best practice acute renal stone services seems essential.
Video flexible cystoscopes have advantages over the eye-to-lens variety. These instruments would help train specialist nurses who wish to develop these skills as well as junior urologists.

It would seem ideal that the regions specialist urology nurses are encouraged to meet to discuss clinical topics perhaps supported by the consultant urologists. Their membership of either BAUN or IAUN and attendance at the national meetings would seem desirable [contacting a past president of BAUN, Jerome Marley who works at Craigavon and the University of Ulster, might help develop this]. Ensuring that community based nurses can provide both continence catheter care including catheter changes can reduce the numbers of A&E attendances.

There is a detailed commentary within the narrative regarding robotic assisted prostatectomy. It is likely that the colo-rectal surgeons and the gynaecologists would also need to be trained on this equipment if the purchase of the robot was to be a viable option.

A regular observation from both the urological surgeons and the hospital managers was that they did not have sufficient theatre capacity for the use of the surgeons. This is clearly part of a much bigger audit as so many different surgical specialities are dependent on access to theatres with appropriate anaesthetic and theatre staff support.

Although recruitment of suitable candidates for the consultant urology posts has been challenging, a worthwhile addition to the skill set for the regions urologists would be the appointment of an academic urologist. Such an appointee would have the opportunity to initiate audit and research with the trainees and to contribute to the regional leadership. Initially this may have to be a senior lecturer but in due time a chair of urology would add enormously to the development of the urology services in Northern Ireland.

As a long term strategy, aiming to increase the numbers of Higher Surgical Trainees within the Northern Ireland training circuit could bring benefits for locally trained urologists keen to apply for consultant post in Northern Ireland.

A SWOT analysis of the stock-take and ideas for a strategic way forward for urology services in Northern Ireland.

1. A SWOT analysis

One strength of a stock-take such as this is that it allows a small team to visit the whole of the regions urology providers and ask about their perceived challenges and what their aims are for delivering an improved and modern urology service. Individual trusts can present their plans allowing the team to draw conclusions about how well the service is integrated regionally and where the different Trusts could share best practice.

Another strength is that the team can critically assess the current commissioning methods that generate the SBA in an attempt to see what role this plays in dealing with waiting times and waiting lists. This includes reviewing the various numerical data and to review the workforce and how it is distributed.

One weakness of this stock-take is that it looks at the urology services over only a short period of time. However we have tried to ensure the narrative is reviewed by all the Trusts to correct any factual errors before it is finally circulated, and the hope is a longer term audit for the Region to assess different Trusts performance will be seen as helpful.

Very few organisations as complex as a Health Care System are perfect requiring no improvements. This stock-take has tried to identify opportunities to improve urology services aimed at a patient-centred guideline unified service. Various ideas have been presented in the text and are summarised in the second half of this section dealing with ideas for a strategic way forward.

Any stock-take or visit to assess a teams work patterns and productivity will represent a potential threat and challenge to the autonomy of the group. However, this stock-take has looked both at the clinical services and at the commissioning methods as well as how Trust management and clinical leadership are working to deliver a patient centred urology service. This has been done to give an overall regional picture and under pins the ideas in the next section.

2. Ideas for a strategic way forward for urology services in Northern Ireland

Below are three points of view based on how the challenges of delivering a clinical service are perceived:-

From a patients' perspective the long waiting times for new and review outpatient visits, the waiting times for diagnostic and operative procedures and the current imbalance in regional acute urology services would seem to be a major concern. A longer term patient anxiety would be to have easy access to the local clinical outcomes of treatments and procedures and know they are

satisfactory and that the inevitable occasional complications or adverse outcomes are at least within an acceptable range.

To achieve this level of service needs a constant reassessment of how audited processes are performing, to regularly introduce better diagnostic processes and better clinical methods that can be studied for their efficacy, and to maintain a regularly updated clinical outcome and complications data base that can be presented collectively to a regional meeting.

From a public health perspective, commissioning clinical services needs to be based on a clear understanding of the needs of the patient population, the assessment of the different types of work that are being funded while giving the providers freedom to develop value for money methods of delivering the clinical service without diminishing the service below an acceptable level.

From a providers' point of view the clinicians should have the kit and the access to operating and outpatient time that is needed to efficiently deliver the work during their contracted time. The trust management have the challenge of balancing the hospital's resources by wise deployment and appropriate use of their workforce.

What has this stock-take identified and what ideas might be worth examining to improve the clinical service for patients?

1) The current commissioning method for creating the SBA has within it two consequences that may have influenced the build up of waiting lists and long waiting times. Firstly by defining specific numbers of out patient clinic consultations and specific numbers of operative procedures but without recognising the wide variability of both types of clinical work the current method is guilty of a one-size-fits-all method and gives no allowance for innovative ways of managing patient care.

    a. For example the one stop service where a patient with haematuria will have an initial consultation, an ultrasound scan, a flexible cystoscopy and then a 'follow up' consultation where all the results are discussed and a management plan decided all at the same visit represents much more than a single outpatient attendance.

    b. Similarly a cystoscopy and biopsy under general anaesthetic to exclude a bladder lesion does not compare to a 30 gram bladder tumour resection or a 100 gram prostate resection.

The second inherent consequence is shown by the perceived imbalance between the clinical work commissioned and the actual numbers of patients referred to be investigated and treated. The responsibility to deal with the excess clinical work devolves straight back to the commissioners whose solution is to attempt to commission more clinical work from a urology service which already states itself to be a fully employed workforce and maximally utilising hospital facilities. This seems to also have the potential unintended consequence of removing the

responsibility for the Trust team to look for imaginative cost effective new ways to deliver the service such as those that were developed in the Action on Urology project [see website given earlier]. Many of the smarter ways of working involved better use of specialist urology nurses including stable hormone controlled prostate cancer patient clinics, telephone follow up clinics and pre-investigation consenting clinics for example.

How might this apparent anomaly be address? One method is to provide a historically calculated budget but with the expectation that the Trust will use it imaginatively to achieve the best value for money for the total referral cohort– a sort of 'consume your own smoke' model. This is different from the current commissioning arrangement whereby delivery of SBA units of activity are used as the key measure of productivity.

2) To best engage the whole clinical team in looking proactively for better ways of delivering a clinical service the process mapping technique ['patient journey'] proved very effective during the Action on Urology project. This would only be possible regionally if a project manger was funded to support the different teams in their work. For example:-
    - Different ways of addressing the challenges of processing new referral patients, dealing with review of patients' results, appropriate review clinic protocols and better ways of maximising theatre usage would all be worthwhile areas to investigate.

3) As part of each consultant developing their appraisal portfolio in readiness for their annual appraisal and eventually their reaccreditation, involvement in regional audit meetings, regional cancer outcome meetings and involvement with education and training of BST and HST doctors as well as urology specialist nurses would all pay dividends. There is a responsibility for those clinicians with a regional role to organise worthwhile meetings and for the management to support the urologists attendance.

4) A necessary part of the annual appraisal is reassessing each consultants job plan. This works both for the management who ensure the contractual hours are used efficiently and for the consultant to ensure that the resources necessary for him or her to carry out the work are available. There are several ways of using this job planning review for the benefit of both parties.

5) The idea of negotiating an increase in HST places in NI has been mentioned as a way of training some home grown potential consultants to ensure efficient succession planning.

6) An acute hospital such as Antrim without any urological team based within the hospital is not consistent with the delivery of high quality acute urological care. Ideally Antrim should have its own self contained urology consultants. As there are 6 gynaecologists working there with an

interest in functional urology such an interest would be ideal for urologists appointed there.

7) Northern Ireland urology could look much more attractive to prospective consultant applicants if it shows itself to be innovative and using the most modern technology. This would be one reason to consider supporting the local provision of RALP. Clearly the robot could be used for radical prostatectomy but also the general surgeons and the gynaecologists are increasingly developing its use. However recent studies may suggest that robotic prostatectomy might be a cost-effective alternative to open prostatectomy, if more than 150 cases were treated each year.

8) It is likely that NI urology will not be able to provide all aspects of urological procedures. To what extent reconstructive and prosthesis surgical procedures will need to be exported will depend on how closely the different teams are able to collaborate.

9) Any new consultant appointment could usefully reflect the regions urology skill needs as well as the Trusts needs. A reconstructive surgeon, an academic appointment or a robotically trained urologist would all add significantly to the regions skill base.

10) The recruitment of a regional urology improvement management, on a fixed term basis, could support Trusts develop innovative ways of delivering patient care. This would involve process mapping and identifying new ways of working to improve patient care and productivity within existing resources.

11) Finally, it seems paradoxical that a stock-take with a particular remit to look at operative procedures and waiting lists should find that hospital Trusts claim to have insufficient staffed operating theatre capacity to satisfy the needs of their surgical staff. Theatre usage will have peaks and troughs and some attempt is needed to average out demand to calculate what capacity is needed, however once the capital expenditure for an operating theatre has been paid the main expense is in staffing it. This could suggest that having over-capacity of theatre facilities would be at minimal cost when not in use, but allow immediate use of the facility when required.

Aimee Crilly

Subject: FW: Regional Cancer Peer Review Feed back Meeting 20.7.15.
Attachments: Regional Cancer Peer Review Feed back Meeting 20.7.15..docx.docx

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 20 July 2015 19:16
To: ODonoghue, JohnP <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Suresh, Ram <Personal Information redacted by the USI>
Subject: Fw: Regional Cancer Peer Review Feed back Meeting 20.7.15.

Dear all

Attached and below for your information.

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile Personal Information redacted by the USI

From: Carroll, Ronan
Sent: Monday, July 20, 2015 02:19 PM
To: Hall, Stephen; Convery, Rory; Trouton, Heather; Mackle, Eamon; Murphy, Philip; Gibson, Simon; Carroll, Kay; Corrigan, Martina; OHagan, Art; O'Brien, Aidan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: FW: Regional Cancer Peer Review Feed back Meeting 20.7.15.

Please find attached a quick update on today's regional peer review for the tumour sites recently assessed. In summary

1. CNS are being progressed via the HSCB working group chaired by Mary Jo
2. Waiting times being progressed regionally via OPD reform
3. Attendance at MDT being progressed via regional working group

We will be expected to nominate a clinical and management rep to these groups
Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by the USI

From: Clayton, Wendy
Sent: 20 July 2015 14:13
To: Carroll, Ronan
Subject: Regional Cancer Peer Review Feed back Meeting 20.7.15.

Regional Cancer Peer Review Meeting
Monday, 20 July 2015 at 1pm

Chair: Sara Long
Reps from each Trust, HSCB & NICaN
Southern Trust: Ronan Carroll, Fiona Reddick, Wendy Clayton

Issue	Discussion/Outcome	Action
SKIN		
Multiple operators / nature type of surgery operating	• To progress regional NICaN discussions. Level 5/6 surgeries • Scoping exercise of the pathway • 1 Task and finish group	Working group to be developed
Lack CNS	• Regionally developing CNS plan	Trust have submitted prioritisation plan for additional CNS
Core member of MDT/Quorm	• Need to do a separate piece of work – oncology, pathology, radiology, CNS in particular • Look at demand, current capacity and investments – outstanding requirements	Working group to be developed to ensure time is factored into all MDT's JPs
Community practitioners	• Ongoing project through pathology to identify GP's who are undertaking skin biopsies in the community • Link with Brendan O'Hare	
Mohs	• Belfast Trust discussion with commissioners	
Waiting times	• In with outpatient reform and Rogers piece of work	
UROLOGY		
Quorum	• Need to do a separate piece of work – oncology, pathology, radiology, CNS in particular • Look at demand, current capacity and investments – outstanding requirements	Working group to be developed
Routine waits	• Agree and progress through regional meetings no separate discussions required	Sara Long to discuss with Beth Malloy HSCB
Penile surgery / Nephron sparing Surgery	• Discussions to take place through the Regional Urology process / Beth Malloy	Sara Long to discuss with Beth Malloy HSCB
Length of the Regional MDT	• Develop an options appraisal for Specialist MDT	
CNS	• Regionally developing CNS plan	Trust have submitted prioritisation plan

Head & Neck (Specialist)		
Multiple sites operating / single handed consultant within BHSCT & in Southern Trust single handed surgeon	• Will have commissioner implications. • Address together – regional scoping exercise then develop working group	To discuss Southern Trust preliminary feedback with New Director for Acute Services
No core dietician	• Require commissioner discussion	
Specialist Brian		
Lack of CNS	• Regionally developing CNS plan	Trust have submitted prioritisation plan

HSCB Action: Short life working group nominations with view of 1st group in September 2015. Clinical and managerial representations required

Regional Review of Urology.

1. SUMMARY OF RECOMMENDATIONS

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. NICaN Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General

Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts should review their outpatient review practice, redesign other methods/staff where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

16. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

17. The NICaN Group in conjunction with each Trust should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

18. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

19. Trusts should ensure that surgeons carrying out small numbers (<5) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

20. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

21. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

22. At least 5 Clinical Nurse Specialists should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

23. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

24. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

Aimee Crilly

Subject: FW: UROLOGY ESCALATIONS

Importance: High

From: Corrigan, Martina <[redacted]>
Sent: 22 July 2015 06:57
To: Glackin, Anthony <[redacted]>; Haynes, Mark <[redacted]>; O'Brien, Aidan <aidan.o'brien@southerntrust.hscni.net>; ODonoghue, JohnP <[redacted]>; Suresh, Ram <[redacted]>; Young, Michael <[redacted]>
Subject: FW: UROLOGY ESCALATIONS
Importance: High

Dear all

This is to keep you in the loop as we are slipping in meeting the targets and this is for various reasons.

I am anticipating with annual leave over the summer this will get worse.

Regards

Martina

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

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

From: Graham, Vicki
Sent: 15 July 2015 12:13
To: Corrigan, Martina
Cc: Glenny, Sharon; Clayton, Wendy
Subject: FW: UROLOGY ESCALATIONS
Importance: High

Hi Martina,

Please see below Urology escalations. 2 of the escalations are late upgrades.

Regards,

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

From: Davies, Caroline L
Sent: 15 July 2015 11:36
To: Graham, Vicki
Subject: UROLOGY ESCALATIONS

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

Haematuria:
Personal Information redacted by the USI ref date: 08.07.15 (upgraded referral only received from booking centre today) next available: CJODTDU 18.08.15 D41
Personal Information redacted by the USI ref date: 10.07.15(upgraded referral only received from booking centre today) next available: CAOBTDU 18.08.15 D39
Personal Information redacted by the USI ref date: 14.07.15 CAOBTDU 18.08.15 D35
Personal Information redacted by the USI ref date: 14.07.15 CAOBTDU 18.08.15 D35

Should I go ahead and book?

Thanks Caroline.

Aimee Crilly

From: McVeigh, Shauna <[Personal Information redacted by the USI]>
Sent: 14 August 2015 10:16
To: Brown, Robin; Campbell, Dolores; Carser, Judith; connolly, maureen; Cummings, Ursula; Dabbous, Marie; Davies, Caroline L; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Fionnuala Houghton; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Hazel.Cantley[Personal Information redacted by the USI] keith rooney; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCreesh, Kate; McMahon, Jenny; McVeigh, Gerry; McVeigh, Shauna; Murphy, Linda; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; White, Deborah; Williams, Marc
Subject: Urology MDM minutes 13.08.15
Attachments: Urology MDM minutes 13.08.15.doc

Hi

Please find attached minutes of Urology meeting 13.08.15.

Thanks

Shauna

MDT UROLOGY CANCER MEETING
THURSDAY 6th August 2015
VENUE: TUTORIAL ROOM 1, MEC

PRESENT
Mr Glackin (Chair), Mr O'Donoghue, Mr Haynes, Dr Carser, Mr Brown, Dr McVeigh, Dr Rooney, Dolores Campbell, Donna Grier & Shauna McVeigh

MINUTES

1. **APOLOGIES**
   Mr O'Brien, Mr Suresh, Dr Williams, Mr Young.

2. **MINUTES OF LAST MEETING**
   E-mailed to the Urology MDM circulation list on 7th August 2015.

3. **PRESENTATION OF CASES**
   Meeting started @ 2:15pm Meeting finished @ 3:25pm
   32 cases were listed to be discussed.
   Belfast City did not need to link in.

4. **A.O.B**
   N/A

5. **DATE OF TIME OF NEXT MEETING**
   The next meeting is to take place at 2.15 pm on **Thursday 20th August 2015,** Tutorial Room 1, MEC, CAH, Ennis Room, Belfast & DHH.