Aimee Crilly

From: McVeigh, Shauna <[redacted]>
Sent: 14 August 2015 10:17
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[redacted]; 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 update list 13.08.15.

Update Report from Urology MDM @ The Southern Trust on 13/08/2015

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

[redacted]
DOB: [redacted] Age: [redacted]
Mr [redacted]
Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: [redacted] old man with a PSA of 21ng/ml in May 2015. He is asymptomatic. He gives no family history of prostate cancer. Following consent he had TRUS biopsies completed on the 3rd June 2015. His prostate volume was 25cc. For discussion of histology. Transrectal prostatic biopsy, 03.06.15 - Gleason score: 4+3=7, number of cores involved, 6/12. Overall tumour volume, 22%. Maximum length of tumour, 14 mm Lymphovascular invasion not seen Perineural invasion, yes. Discussed at Urology MDM 11.06.15. For review with Mr Glackin to arrange bone scan, MRI and will be for subsequent MDM discussion. Bone scan, 22.06.15 - The images presented for reporting are broadly unremarkable. There is slightly increased tracer uptake overlying the lateral aspect of the right humeral head. This may relate to degenerative change and plain film evaluation of this region should be considered. Uptake around the right ankle is also seen, this is more intense and may relate to previous trauma or degenerative change. Clinical correlation and plain film assessment of the ankle may also be worth considering. MRI, 17.07.15 - Appearance is suggestive of organ confined prostate carcinoma. Discussed at Urology MDM 30.07.15. This man was noted to have increased uptake of his right shoulder and his right ankle. Otherwise there was no evidence of any metastatic or extra capsular disease. For review by Mr Glackin to arrange plain x rays of his right shoulder and right ankle, before advising patient of management with curative intent. Mr [redacted] was reviewed in clinic on 3rd August 2015, he would prefer to have radiotherapy. He has been given written information regarding radiotherapy, hormone therapy and surgery. He has been commenced on Bicalutamide 50mgs once daily for the next month. I have advised the GP to please commence Decapeptyl SR 3mgs monthly by IM Injection once he has been established on Bicalutamide for 2 weeks. For central MDM discussion. Referral has been sent to Dr Houghton for consideration of EBRT.

MDMAction

Discussed at Urology MDM 13.08.15. For direct referral for consideration of brachytherapy.

Surgeon	Oncologist	Clinician	Palliative Medicine

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI Mr Personal Informatio	O'DONOGHUE J P MR (C8245) DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI	None	None	None Target Date

Diagnosis: TCC Bladder pTa Grade 2
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information old man was reviewed in clinic in May 2015, He had a history of PTaG2 RCC, and had right partial nephrectomy in 2007. Ultrasound scan was performed in April 2015, which had shown no upper tract lesions, however, within the bladder there was a 1.4cm solid lesion posteriorly to the left of the midline. Flexible cystscopy was performed and had shown a bladder tumour. CTU, 17.06.15 - 11 mm mass on the left side of urinary bladder. Partial nephrectomy right kidney and simple cysts left kidney. TURBT, 04.08.15 - Histology shows features of a WHO Grade II papillary transitional cell carcinoma with no invasion into the subepithelium (pTa). A fragment of muscle is represented.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information has a G2Ta urothelial cancer of the bladder (intermediate risk non invasive). For OP review with Mr O'Donoghue for flexible cystoscopy in 3/12.

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI Personal Information redacted by the USI Mr Personal Information	YOUNG M MR (C6861) DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI	None	None	None Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old man with left testicular pain. Right orchidectomy during childhood. To discuss USG scrotum. US Testes, 10.12.14 - Right orchidectomy. Heterogeneous left testicular echotexture. Small hypoechoic testicular foci measuring up to 3.5 mm ?significance. No previous imaging for comparison. Discussed @ Urology MDM 18.12.14. This gentleman has testicular heterogeneity on USS of uncertain significance. For review with Mr Suresh with results of testicular tumour markers and for clinical assessment, testosterone levels and consideration of a biopsy. US Testes 5.3.15: No significant interval change since 10/12/2014. Discussed @ Urology MDM 19.3.15. Mr Personal Information redacted by the USI s testicular tumour markers are normal. His follow-up USS of the testes is unchanged. He is azoospermic and has a slightly low serum testosterone and elevated LH / FSH indicative of primary testicular failure. For OP review with Mr Young to consider left testicular biopsy with USS guidance under general anaesthesia or ongoing interval USS scanning in 6 months. Patient was reviewed in clinic on 22nd May 2015, plan was to have ultrasound repeated in 3 months and review in clinic. Ultrasound testes, 25.06.15 - There has been no significant change in size or appearances of the few hypoechoic foci within the left testies, the largest measures 3.8mm. As previously reported there is a 2.8mm hyperechoic lesion superiorly within the testis. There is a small 2.5 x 4mm simple cyst noted on the left epididymis. No increase in scrotal fluid.

MDMAction

Discussed at MDM 13.08.15. Defer for radiology discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI Mr Personal	GLACKIN A.J MR (C8102) DOB Personal Information redacted by the USI Age: Personal Information redacted by the USI	None	None	None Target Date 11/09/2015

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old man presented to the clinic with an elevated PSA. It was 17.79 ng/ml on 1st June 2015. There is no family history of prostate cancer. Mr [redacted] proceeded to TRUSB on 4th August 2015. He had a prostate volume of 39.8cc. Transrectal prostatic biopsy, 04.08.15 - Prostatic adenocarcinoma of Gleason score 3+4 = 7, is present in four of eleven cores with a maximum histological length of 12.4 mm. The tumour occupies approximately 30% of the total tissue volume.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] has intermediate risk prostate cancer. For OP review with Mr Glackin and staging with ban isotope bone scan and MRI prostate and subsequent MDM discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
[redacted] Mrs [redacted]	DOB: [redacted]	Age: [redacted]		Target Date

Diagnosis: Renal clear cell carcinoma

Staging:

MDMUpdate

CONSULTANT MR HAYNES [redacted] old lady who was admitted via A&E on 2nd May, she had recurrent UTIs, presented feeling generally unwell for 3-4 weeks, multiple courses of antibiotics had no effect. Rigors, dysuria and frequency at home, background of poor appetite and decreased oral intake. US renal tract, 05.05.15 - Right renal mass, likely a renal cell carcinoma. CT, 13.05.15 - 1. 4.3 cm right renal tumour with right renal vein thrombosis. 2. 2.6 cm complex cyst / second tumour to the left kidney. MDT discussion is advised. 3. Probable solitary small lung metastasis. Discused at Urology MDM 28.05.15. Mrs [redacted] has a right renal tumour with a probable single right lung metastasis and a possible left renal mass. For review with Mr O'Donoghue to assess her fitness for possible right open nephrectomy +/- thrombectomy and to arrange DMSA and Bone Scan for further discussion at MDT. Renal DMSA, 09.06.15 - Severe reduction split renal function of the right kidney. Bone scan, 12.06.15 - No evidence of bony metastasis. Discussed at Urology MDM 18.06.15. Mrs [redacted] has a right renal mass which may represent a renal TCC or RCC with possible renal vein involvement, in addition there is a solitary right upper lobe lung lesion measuring 8mm. For review with O'Donoghue to organise an MRI renal and a right ureteroscopy. MRI renal, 06.07.15 - Right renal tumour extending into the renal vein. No extension into the IVC. The lesion of the left kidney appears to be a simple cyst. This patient attended for diagnostic right ureteroscopy in order to facilitate a renal biopsy of her right renal lesion. It is not known whether this is TCC or RCC. This was not possible at procedure today as her renal pelvis was full of clot. Renal pelvis washings were taken for cytology. Can the results of this and an MRI renal performed on 6th July, be presented at MDM on 16th July so further management plan can be arranged. It is proposed if her IVC is clear from thrombus then she will be considered for laparoscopic nephrectomy or nephroureterectomy. Mr Haynes will review to arrange surgery. Ureteric washings, 06.07.15 - Cytological examination shows the specimen to consist predominantly of blood and inflammatory cells including numerous neutrophils. Scattered within the specimen there are occasional individual and small clusters of epithelial cells which exhibit a degree of atypia but not obviously malignant features. In an instrumented sample, and particularly given the associated neutrophilic infiltrate, this atypia may be reactive. Definite malignancy has not been identified although given the clinical description of a mass, further investigation is advised. Discussed at Urology MDM 16.07.15. This lady has been shown to have a right renal tumour of uncertain nature. She also has a left renal lesion of uncertain nature. For review by Mr Haynes on 21st July 2015, to discuss arranging laparascopic right nephroureterectomy. This lady was admitted on 3rd August for her laparoscopic nephroureterectomy. For pathology review at MDM and subsequent outpatient follow up with Mr Haynes. Right laparascopic nephroureterectomy, 04.08.15 - Clear cell renal cell carcinoma. Furhman nuclear grade: IV. Tumour necrosis: present. Local invasion: tumour extends into the renal sinus fat. Lymphovascular invasion: yes. Tumour is identified within a segmental branch of the renal vein. Lymph nodes: none submitted. Margins: tumour is clear of the ureteric margin and tumour is confined to the renal capsule. pTNM STAGE: pT3aNxMx. Further comments - Histology shows a clear cell renal cell carcinoma predominantly showing features of Fuhrman nuclear grade IV with sarcomatoid change and necrosis. Only a small focus of conventional clear cell carcinoma is identified.

MDMAction

Discussed at Urology MDM 13.08.15. Mrs [redacted]'s laparoscopic nephroureterectomy pathology has demonstrated a Grade 4 T3a renal cell cancer. For OP review with Mr Haynes and early follow-up imaging with CT CAP in 3/12.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	SURESH K DR (C7766)	None	None	None
[redacted] Mr	DOB: [redacted]	Age: [redacted]		Target Date 01/09/2015

Diagnosis:
Staging:

MDMUpdate

CONSULTANT MR SURESH: This [redacted] old man attended clinic on 14th July 2015. His PSA was 10.4ng/ml in May 2015 but this has come down to 6.2ng/ml recently. On DRE the left lobe of prostate felt hard, we didnt proceed with TRUS biopsies as he had features of mild left epididymo-orchitis. MRI has been requested and he will be booked for TRUS biopsy of prostate following this. MRI, 03.08.15 - No definite prostate tumour is seen. Small area of indeterminate signal change within the lateral peripheral zone of the left mid gland. Dependent on the level of clinical suspicion, it would probably be worth considering targeted biopsies. Small indeterminate lesion within the lower pole of the left kidney for which further evaulation is recommended. I note the patient had a normal ultrasound of the kidney performed on 5th June 2015. In the first instance, a renal CT, with a view to a renal MRI, is recommended.

MDMAction

Discussed at Urology MDM 13.08.15. There is a left sided prostatic abnormality which is suitable for targeted TRUS biopsy. There is also a left renal abnormality which requires a CT renal in the first instance. For OP review with Mr Suresh.

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

Diagnosis: Bladder tumour
Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] old lady was admitted with abdominal pain and nausea. Recent CT showed bilateral hydronephrosis and ?bladder Cancer. Patient was unwell on admission and treated for sepsis with associated AKI. Her eGFR was 38 on 1st July 0215. TURBT, 27.07.15 - Part 1) Histology shows mostly necrotic fragments, some of which are lined by squamous cell epithelium. There are invasive structures of moderately differentiated squamous cell carcinoma. P40 is positive. Fragments of detrusor muscle are present with no evidence of invasion. Bladder biopsy, 27.07.15 - Part 2) Histology shows structures of moderately differentiated squamous cell carcinoma of the same appearance as part 1. Detrusor muscle is not present. pT1

MDMAction

Discussed at Urology MDM 13.08.15. Mrs [redacted] has been found to have a squamous cell carcinoma of the bladder. This is clinically invasive with a mass palpable on EUA. For OP review with Mr O'Brien to explore options of radical surgery if she is fit for this or alternatively symptomatic / supportive care.

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

Diagnosis:
Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This Personal Information redacted by the old man was reviewed in clinic in January 2015 for evaluation of his PSA. Mr Personal Information redacted by the has little in the way of lower urinary tract symptoms. There is no family history of prostate cancer. His current PSA is 11.42 ng/ml in June 2015. It was 8.87 in November 2014. We proceeded to TRUSB on 4th August 2015, he had a prostate volume of 38cc. Transrectal prostatic biopsy, 04.08.15 - await pathology.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information redacted by the has been found to have an intermediate risk prostate cancer (PSA 11.42, Gleason 3+3=6). For OP review with Mr Glackin, for MRI prostate and subsequent MDM discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
HAYNES M D MR (C8244)	None	None	None

Personal Information redacted by the USI Mr Personal Information redacted by the USI DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis: TCC Bladder invasive

Staging:

MDMUpdate

CONSULTANT MR HAYNES: This Personal Information redacted by the old gentleman presented with an episode of visible haematuria. He has a previous history of spinal surgery and is on medication for hypertension and asthma/COPD. He has also had previous surgery for a perforated duodenal ulcer. A CT urogram demonstrated a left sided bladder mass, pelvic and para-aortic lymphadenopathy and lesions within the liver consistent with metastatic deposits. He underwent a TURBT on 3rd August. At EUA he had a palpable mass within the bladder which was just about mobile giving a clinical staging of T3. His overall renal function is normal. His performance status is reasonable and aside from the first episode of haematuria he does not have any ongoing haematuria. For MDM discussion of pathology and radiology prior to outpatient clinic with Mr Haynes. TURBT, 03.08.15 - Histological examination shows fragments from a grade 3 papillary transitional cell carcinoma. There is invasion of the lamina propria (pT1). No muscularis propria is present within the examined material.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information has metastatic bladder cancer. For OP review with Mr Haynes to consider referral for palliative chemotherapy.

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

Personal Information redacted by the USI Mr Personal DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This Personal Information redacted by the old gentleman is asymptomatic from a urinary tract perspective. There is no family history of prostate cancer. He is not on any urinary tract medication. He gives no history of previous urological surgery. His PSA in March 2011 was 6.8ng/ml. When checked in December 2014 it was 9.6ng/ml. His U&E in December 2014 was normal. Digital rectal examination demonstrates a smooth enlarged prostate. Repeat PSA 10.2, prostate volume 43cc, 12 cores trus biopsy. TRUSB, 03.03.15 Histological examination of each specimen through levels shows benign prostatic parenchyma with no evidence of PIN or adenocarcinoma. Discussed @ Urology MDM 12.3.15. Mr Personal Information redacted by the prostate biopsies have shown no evidence of prostate cancer. For review with Mr Glackin to recommend MRI prostate. MRI, 24.06.15 - 1. Prostatic neoplasm - staging T2C N0 MX. 2. Abnormal bladder wall thickening posteriorly in the trigone - correlation with cystoscopy is suggested.

MDMAction

Discussed at Urology MDM 13.08.15. Defer for radiology discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date 27/09/2015
Mr Personal Informatio				

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR HAYNES: This Personal Information redacted by the old gentleman was found to have an incidentally raised PSA 8.87, rising to 9.85 on a repeat reading. He has no lower urinary tract symptoms or family history of prostate cancer. He is otherwise well, with previous history of hypertension only. He is a fit & active retired Personal Information living with his wife. His DRE demonstrated a small volume prostate with firm, hard right lobe clinically suspicious of prostate cancer. TRUS Biopsy was perfomed on 24th June 2015. Transrectal prostatic biopsy, 24.06.15 - Histological examination shows Gleason 4+3 prostatic adenocarcinoma, within nine of the 12 cores. Extensive pattern four is present. Tumour is present within all six cores from the right lobe where it occupies approximately 50% of the tissue examined. The left lobe is less involved with 15-20% of the tissue occupied. The longest confluent length of tumour is 12.5 mm. No perineural or lymphovascular invasion has been identified and neither is there evidence of extracapsular extension. Discussed at Urology MDM 16.07.15. This man has been found to have high risk, prostatic carcinoma, on recent prostatic biopsies. For review by Mr Haynes to arrange bone scan and MRI of prostate and for subsequent MDM discussion. Bone scan, 24.07.15 - While significant degenerative change could cause this appearance, a metastatic bony deposit cannot be excluded and plain film and/or cross-sectional evaluation of the pelvis is required. Lowgrade uptake at the lumbosacral junction may be degenerative in nature and there are features suggestive of degenerative change around the right hip, wrists, shoulders and at the base of the right first toe. Further degenerative features are suggested within the cervical spine. MRI, 06.08.15 - Bulky right apex to mid gland tumour with a wide capsular contact. No gross extracapsular extension is seen but the extent of capsular contact is significant. Prominent reduced T1 signal change in the region of the left hip joint which is probably degenerative. Plain film correlation is required.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information requires a plain X-Ray of this left Hip which Mr Haynes will arrange and subsequent MDM discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date
Personal Information redacted by the Mr	Personal Informatio			

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the old man attended Mr Mackle for investigation of altered bowel habit, bloating and weightloss. He had a CT chest, abdomen & pelvis arranged as part of this investigation which made an incidental diagnosis of a probable renal cell carcinoma on the upper pole of his right kidney – noted to be partially cystic and partially solid measuring 5 by 5 by 5cm in size. CT staging T1bN0M0. His past history includes hypertension and sleep apnoea and he is a lifelong smoker of 20 per day. Could he be discussed with regard to appropriate surgical management please.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information redacted by the has a right upper pole renal mass consistent with renal cancer. For OP review with Mr Haynes to discuss laparoscopic nephrectomy under the care of Mr Glackin.

Surgeon	Oncologist	Clinician	Palliative Medicine
None	None	None	None

Personal Information redacted by the USI Personal Information redacted by the USI Mrs DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis: TCC Bladder pTa Grade 2
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information old lady was referred with persistent microscopic haematuria. She is an ex-smoker. She had an ultrasound renal tract performed, this had shown the right kidney to measure 10.4cm and the left kidney to measure 9.6cm. The bladder was poorly filled but no gross abnormality was seen. Her post-micturition residual was 9ml. Flexible cystoscopy had shown a normal urethra and there was a patch of probable TCC at the back wall of the bladder below the dome. CT urogram was clear. TURBT, 04.08.15 - Histology shows features of a WHO grade II papillary transitional cell with no invasion into the subepithelium (pTa). No fragments of muscle are represented.

MDMAction

Discussed at Urology MDM 13.08.15. Mrs Personal Information has G2 Ta urothelial cancer of the bladder. For OP review with Mr O'Donoghue to arrange flexible cystoscopy surveillance in 3/12.

Surgeon	Oncologist	Clinician	Palliative Medicine
BROWN RJ MR (C6502)	None	None	None

Personal Information redacted by the USI Personal Information redacted by the USI Mrs DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR BROWN: Personal Information redacted by the old lady with a 10 year history of recurrent UTI's. These occur every 4 months with symptoms of urgency and dysuria. She has no frequency, frank haematuria and no abdominal pain. She was asymptomatic, ultrasound scan on 25th November showed a 1 cm cyst in her left kidney. Mr Brown has advised that Mrs Personal Information redacted by the USI has consented for cystoscopy and urethral dilatation. CT Renal, 18.11.14 - CT appearances are in keeping with simple cysts. The previously noted calcified septation in relation to one of the left sided cysts is not apparent but may not be appreciable given the small size. Ultrasound characteristics are those of IIf lesion therefore follow up ultrasound is recommended in 6 months. Discussion at urology MDT also advised. Discussed @ Urology MDM, 11.12.14. Mrs imaging has shown some small renal cysts which have no concerning features on CT. Mr Brown has arranged a FU USS in 6 months and if this is satisfactory she will be discharged. Ultrasound, 22.07.15 - Right kidney measures 10cm in bipolar diameter. Left kidney measures 10.5cm in bipolar diameter. The 1cm septated cyst in the left kidney appears the same as in the previous US scan. No calculi or hydronephrosis. The urinary bladder was not full.

MDMAction

Discussed at Urology MDM 13.08.15. Defer for radiology discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
HAYNES M D MR (C8244)	None	None	None

Personal Information redacted by the USI Mr Personal Information redacted DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis: TCC Bladder pTa Grade 2
Staging:
MDMUpdate

CONSULTANT MR HAYNES: This [redacted] old man had presented to Daisy Hill Hospital under the care of Mr Brown with visible haematuria. Flexible cystoscopy was satisfactory, however a CT urogram revealed a distal ureteric filling defect consistent with urothelial tumour of the distal ureter. He was subsequently admitted as an emergency under the care of Mr Haynes to Craigavon Area Hospital with significant pain most likely due to clot colic. He proceeded to a diagnostic ureteroscopy and left ureteric stent insertion. At ureteroscopy there was a papillary urothelial tumour within the distal ureter consistent with CT urogram findings. The tumour itself was of a size where laser ablation would not be feasible. Ureteric biopsies were taken and a stent inserted. A CT chest and DMSA renogram has also been arranged. For MDM review of all imaging along with pathology. Mr Haynes has placed Mr [redacted] on his red flag waiting list for a laparoscopic nephroureterectomy pending these results. Ureteric biopsy, 12.07.15 - Transitional cell carcinoma. Growth pattern, papillary. WHO Grade II. Local Invasion, pTa. Lymphovascular Invasion, no. Adjacent Mucosa, none represented, appears to be lesional tissue only. Muscularis propria: Not present. CT chest, 21.07.15 - No CT evidence of thoracic metastasis. Renal DMSA, 22.07.15 - No morphological abnormality identified in either kidney. Differential function is as follows: Left kidney 44%; right kidney 56% Discussed at Urology MDM 23.07.15. This man has been found to have TCC of his left ureter. He awaits a CT scan of his chest on 28th July 2015. Mr Haynes will arrange his admission for laparoscopic nephroureterectomy. Mr [redacted] was admitted on 3rd August 2015, for left Nephrouterectomy, following discovery of a left uteric lesion in July of this year. During the operation a retractor was noted to have broken but the fragments were removed from the patient as much as possible and no issues should arise following this. Left laparoscopic Nephrouterectomy, 03.08.15 - Transitional cell carcinoma. Growth pattern: Papillary. WHO Grade II. Local invasion: pTa (no invasion). Lymphovascular invasion: No. Lymph nodes: None submitted. Margins: The tumour is 110 mm from the distal margin of excision. FURTHER COMMENTS: Histology shows features of a WHO Grade II ureteric papillary transitional carcinoma with no invasion into the subepithelium (pTa). There is associated CIS immediately adjacent to the tumour.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] s laparoscopic nephroureterectomy pathology has shown a grade 2 Ta mid ureteric cancer. For OP review with Mr Haynes. To arrange flexible cystscopy in 6 months and upper tract surveillance imaging of his remaining right upper tract.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
[redacted] Mr	DOB: [redacted] Age: [redacted]			Target Date

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This [redacted] old man was seen at clinic with an elevated PSA. It was 7.1 ng/ml in March 2015 and most recently it was 5.33 in June 2015. He complains of mild LUTS. He has a past medical history of [redacted]. We proceeded with TRUSB on 03.08.15, his prostate was small and measured 17cc. 12 biopsies were taken 6 from the right and 6 from the left. Transrectal prostatic biopsy, 03.08.15 - Histology shows adenocarcinoma in 7 out of the 12 cores. Gleason score is 3+4=7. The longest continuous length of tumour is 4 mm. Overall tumour involves approximately 20% of the tissue. Perineural invasion is not identified. Prostatic intraepithelial neoplasia is present in one of the cores from part 4.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] has an intermediate risk prostate cancer. For OP review with Mr O'Donoghue to arrange an MRI of the prostate and subsequent MDM discussion.

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

Diagnosis: Benign
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old man was seen at clinic in June 2015 with a rising PSA. He gives no family history of prostate cancer. He reports no bothersome lower urinary tract symptoms. He has had a recent diagnosis of rheumatoid arthritis and has been started on treatment including steroids under the care of Dr Wright at the Ulster Independent Clinic. His PSA has been increasing it was 6.51 in March 2015, 8.10 in May and his most recent was 8.37 in June 2015. Mr [redacted] proceeded to TRUSB on 4th August 2015, his prostate volume was 41.4cc. Transrectal prostatic biopsy, 04.08.15 - Histological examination of all parts 1 to 6 through levels shows no evidence of prostatic adenocarcinoma. There are focal areas of atrophy and patchy chronic inflammation.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted]'s prostate biopsies have not shown prostate cancer. For OP review with Mr Glackin to arrange MRI prostate, repeat PSA and consider antibiotic treatemtn given prostatitis on biopsy.

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

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] old man was found to have an exophytic, globular lesion of 40 Hu arising from the lateral aspect of the upper pole of his left kidney when he had CT scanning in April 2015 in the assessment of his sarcoidosis. It was not possible to further characterise the lesion on ultrasound scanning in May 2015. Patient reported LUTS of a storage nature when reviewed on 26 May 2015. He was considered to have a small, clinically benign prostate gland on examination. PSA was 0.47 ngs/ml in March 2015. A Renal CT scan and Ultrasound scan of lower urinary tract were requested to be performed in July 2015. He was prescribed Oxybutynin MR 5 mgs daily. For MDM discussion with reports of scans. Ultrasound, 16.07.15 - Right kidney measures 10.4cm in bipolar diameter. There is a simple cortical cyst in the right kidney (9.7mm) Left kidney measures 11.1cm in bipolar diameter. The exophytic lesion on upper pole of left kidney measures 2cm. No renal calculi or hydronephrosis. CT renal, 28.07.15 - 1. The welldefined exophytic lesion in the left kidney show soft tissue density on the precontrast scan and reveal mild enhancment in the arterial phase. MDT discussion advised. 2. Punctate calcifications and two small hypodense lesions in te pancreas. Follow up in six months time suggested.

MDMAction

Discussed at Urology MDM 13.08.15. Defer for radiology discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	YOUNG M DR (C7585)	None	None	None
[redacted] Mr [redacted]	DOB: [redacted]	Age: [redacted]		Target Date

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR YOUNG: This [redacted] old man was reviewed following a diagnosis of prostate cancer made while in [redacted]. His PSA had been slightly elevated at 12 ng/ml. He was given a course of antibiotics and a repeat PSA was still high at 15 ng/ml. Prostate biopsy was perfomed, this confirmed a Gleason score of 3+4 = 7, in all seventeen samples that were taken. The only core free from tumour was the left base area. He had a bone scan and MRI performed, the images are not available, but it is to be uploaded onto our system. The bone scan is reading clear. He

was given an LHRH agonist injection and was at the stage of discussing treatment options. Can we review the MRI findings and discuss at MDT.

MDMAction

Discussed at Urology MDM 13.08.15. Defer for radiology discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	None	None
Personal Information redacted by the USI Mr	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old man with a raised PSA of 18ng/ml. Mr Personal Information had been under surveillance having had a pTa Grade 2 TCC bladder resected in June 2013. With respect to his PSA it was 6.87ng/ml in May 2012, 18.9ng/ml in December 2014, 18.1ng/ml in January 2015 and 18.0ng/ml in May 2015. Mr Personal Information reports no family history of prostate cancer. He describes no bothersome lower urinary tract symptoms. Digital rectal exam demonstrates a very firm right lobe of prostate in keeping with your noted finding. He had 12 cores taken from his prostate which measured 30cc. Transrectal prostatic biopsy, 24.06.15 - Prostatic adenocarcinoma, Gleason sum score 4+3=7, is present in 7 of 12 cores (predominantly in the right, but also in the left). There is significantly more pattern 4 compared to pattern 3. The maximum tumour length is 3.5 mm and the tumour occupies 24% of the total tissue submitted. Discussed at Urology MDM 02.07.15. This gentleman has high risk, prostatic carcinoma, on recent biopsies. For review by Mr Glackin to arrange bone scan, MRI and further MDM discussion. Bone scan, 31.07.15 - No evidence of bony metastatic disease. MRI, 04.08.15 - Sizeable right sided peripheral zone tumour with a wide capsular contact. No gross extra-capsular extension is seen. Small area of non-specific reduced T2 signal in the peripheral zone of the right gland base which extends outside the capsule. This lesion is of indeterminate signifcance and is not convincing for tumour. No lymphadenopathy or bone metastasis. The appearances are best regarded as T2a N0 M0.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information redacted by has an organ confined, intermediate risk prostate cancer. For OP review with Mr Glackin to recommend radical treatment with surgery, radiotherapy or brachytherapy with external beam radiotherapy.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
Personal Information redacted by the USI Mr	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date 06/09/2015

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information old man who's PSA has been elevated for the last year. In May 2014 it was 5.14ng/ml, June 2014 it was 5.64ng/ml and in June 2015 it was 6.35ng/ml. He had a prostate biopsy performed at clinic, his prostate measured 21cc in volume. Transrectal prostatic biopsy, 03.08.15 - Prostatic adenocarcinoma of Gleason score 3 + 4 = 7, is present in 8 of 12 cores with a maximum tumour length of 7 mm. The tumour occupies approximately 25% of the total tissue submitted.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information has an intermediate risk prostate cancer with perineural invasion. For OP review with Mr O'Donoghue to arrange staging with an MRI prostate and subsequent MDM discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'DONOGHUE J P MR (C8245)	None	None	None

Personal Information redacted by the USI Mr Personal Information DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI

Target Date 27/08/2015

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the old man was seen at clinic, his PSA was 4.66ng/ml in May 2015 and he is on Dutasteride the real PSA is 9.32ng/ml. In June it was 4.80ng/ml and the real PSA is 9.6ng/ml. His most recent PSA was 5.19 in July 2015. He has had a left carotid endarterectomy in 2012 and he has an 8-% stenosis on the right hand side but is asymptomatic from this. He is on Plavix. He also has a history of type 2 diabetes mellitus and has recently had dobutamine stress echocardiography. On digital rectal examination he had a small prostate which measured about 30g and it felt somewhat firm. I am organising an MRI of his prostate. MRI, 04.08.15 - Bulky right sided peripheral zone tumour with extra- capsular extension at the mid to base of the gland. T3a N0.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information redacted by the USI has a likely prostate cancer on MRI. There would be an element of risk associated with stopping his antiplatelet medication for a biopsy. Additionally with his co-morbidities watchful waiting may be the most appropriate treatment option which could be commenced without a biopsy. For OP review with Mr O'Donoghue to discuss this and either arrange biopsy or commence watchful waiting dependent upon Mr Personal Information redacted by the USI preference.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'DONOGHUE J P MR (C8245)	None	None	None

Personal Information redacted by the USI Mr Personal DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI

Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the old man was seen at Urology clinic in December 2014, he has a history of lower urinary tract symptoms namely slow flow, nocturia x 2-3 with some hesitancy. He is very fit with a background history of a previous hip replacement and hypertension. Flexible cystoscopy in May 2015 revealed a normal urethra and a moderate sized prostate. On the left lateral wall of his bladder there was quite an inflamed area with some overlying mucus. CT A/P, 06.07.15 - Within the limitations of this examination, no evidence of a colo-vesicall fistula. Bladder biopsy, 23.06.15 - Histological examination through levels shows focal areas of carcinoma in-situ within both biopsies. Immunohistochemical staining supports this diagnosis. There is some inflammation and prominent vascularity in the sub-epithelial tissue. No invasive malignancy is seen.

MDMAction

Discussed at Urology MDM 13.08.15. Mr Personal Information redacted by the USI has been found to have CIS of the bladder. For OP review with Mr O'Donoghue to offer intravesical treatment (MMC or BCG dependent upon availability) and subsequent endoscopy surveillance.

Surgeon	Oncologist	Clinician	Palliative Medicine
HAYNES M D MR (C8244)	None	None	None

Personal Information redacted by the USI Personal Information redacted by the USI Mrs Personal Information DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI

Target Date 09/09/2015

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR HAYNES: This fit and well [redacted] old lady was found incidentally on ultrasound scan to have a 6.8x8.2cm right sided renal mass. This has been further assessed by a CT renal which has confirmed that is contrast enhancing. I have arranged completion of her staging with CT chest and CT pelvis and a DMSA renogram. Her overall renal function is normal with EGFR in excess of 60. I have also placed her on my waiting list for a laparoscopic right radical nephrectomy. Renal DMSA, 31.07.15 - Photopenia over the right kidney presumably represents the known renal mass. The left kidney appears normal. Differential function is as follows: Left kidney 63%; right kidney 37%. CT pelvis with contrast, 04.08.15 - The lungs are essentially clear, and there is no significant lymphadenopathy in the scan range, and no destructive osseous lesion or adnexal mass lesion. An IUCD is in satisfactory position. Incidental note is made of an aberrant right subclavian artery. Conclusion, no CT evidence of metastatic disease. This lady underwent a right laparoscopic radical nephrectomy on 5th August. For pathology review and subsequent review with myself. Await pathology.

MDMAction

Discussed at Urology MDM 13.08.15. Defer to next week, pathology not available.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'BRIEN A MR (C6514)	None	None	None

[redacted] Mr [redacted] DOB: [redacted] Age: [redacted] Target Date

Diagnosis: Carcinoma of penis

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] old resident of [redacted] was referred on 21 May 2014 with a pedunculated lesion of prepuce. On review on 27 May 2014, it was noted that he had had a diagnosis of benign prostatic hyperplasia in 2002, and that he had had his prostate resected on two occasions in 2004. The patient was of the understanding that he had prostatic carcinoma. On examination, he was found to have a lesion, characteristic of squamous cell carcinoma, protruding from a phimotic prepuce. Due to the phimosis, it was not possible to assess the extent of the lesion. Patient placed on waiting list for circumcision. Patient underwent circumcision on 01 July 2014. On examination under anaesthesia, he was found to have an exophytic tumour arising from the glandular aspect of the dorsal prepuce which was anatomically distorted by extensive adhesions to glans, chronic inflammation and phimosis. Most of the prepuce required sharp dissection from the glans to facilitate circumcision. Pathology reports squamous cell carcinoma, stage pT1. Discussed @ Urology MDM, 10.07.14. This gentleman had a squamous cell carcinoma of his penile prepuce recently resected by circumcision. For review by Mr O'Brien to consider on-going management including use of topical 5FU. Mr [redacted] was reviewed in clinic in July 2015, he has a known history of pT1a SCC of his penis that was removed on 1st July last year by Mr O'Brien. He presented with recurrence of that growth complaining of significant itching of his glans, although there was no bleeding and there is no problem with passing urine he has had a recent infection. Patient was reviewed on 17 July 2015 in order to clarify whether he required partial or total penectomy. On clinical reassessment, it was agreed that he would be better served by total penectomy. For admission on Tuesday 28 July for total penectomy on Wednesday 29 July 2015. Total penectomy and perineal urethrostomy performed on 29 July 2015 as planned. Total penectomy, 29.07.15 - Squamous cell carcinoma. Moderately differentiated, Growth pattern, predominantly exophytic Local invasion: Histology confirms tumour to invade into the corpus spongiosum (pT2) Lymphovascular Invasion: Unequivocal lymphovascular invasion is not identified Lymph nodes, no lymph nodes were submitted. Margins: Histology of sections taken from the proximal margin of the specimen, the urethral margin and prepuce margin confirms no tumour. pT2. Further Comments: Tumour is seen to abut the corpus spongiosum. It is difficult to determine whether or not there is definite invasion into it but the appearances are best regarded as pT2. Histology of the smaller tumour nodule adjacent to the main tumour shows a second squamous cell carcinoma with a more basaloid, less keratotic appearance. Histology of sections taken from the prepuce shows features of balanitis xerotica obliterans. Histology of sections taken from glans, adjacent to the tumour shows focal areas of dysplasia with carcinoma in situ.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted]'s penectomy pathology has shown a pT1 and a moderate grade pT2 SCC of the penis with negative margins. For OP review with Mr O'Brien, to offer bilateral modified inguinal lymph node dissection if deemed clinically appropriate.

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

[redacted] DOB: [redacted] Age: [redacted]

Mr

Target Date

Diagnosis: Benign

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: [redacted] old man referred with a PSA of 15.05ng/ml on 8th October 2013. Mr [redacted] has previously been complaining of bothersome lower urinary tract symptoms. Tamsulosin has been very beneficial for him. IPSS score was 1/35, his quality of life score was 1/6. He did not report any visible haematuria or dysuria. Flow rate - Q-max of 13.7mls/sec for a voided volume of 198mls. On examination the prostate gland was large and smooth. There was no nodularity. On ultrasound of his urinary tract on 17th December 2013, the kidneys appeared normal. There was a simple cyst measuring 2.6cm in the left kidney which was of no clinical concern. There was no evidence of stone disease or hydronephrosis. Pre micturition bladder volume was 191mls, residual volume 45mls. Prostate measured 86cc. PSA result from 24th January 2014 was 26.3ng/ml. Transrectal prostatic biopsy, 05.03.14 - The appearances are not sufficient for a diagnosis of adenocarcinoma. However, in view of this finding, close surveillance and follow-up is advised. Discussed @ Urology MDM, 13.03.14. Histology reports no evidence of prostate cancer. In view of elevated PSA for review at Histology clinic for ongoing PSA monitoring 3 monthly and consider a further prostate biopsy or MRI scan if PSA continues to rise. Mr [redacted] was reviewed in clinic in May 2015, his PSA is now 17ng/ml he wishes to have an MRI of prostate rather than proceeding to a second prostate biopsy. For discussion of MRI and further management. MRI, 04.07.15 - The prostatic hyperplasia.? Two foci of primary prostatic malignancy are noted in the mid gland level in the transitional zone.

MDMAction

Disuccsed at Urology MDM 13.08.15. Defer for radiology discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

[redacted] DOB: [redacted] Age: [redacted]

Mr

Target Date

Diagnosis: TCC Bladder pTa Grade 3

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: [redacted] old man with visible haematuria intermittently for the last 2 months. Past medical history TIA x2, Stroke in 2013, peripheral vascular disease, chronic kidney disease Stage 3. EGFR was 45ml/min on 14th January 2015. PSA was 1.65ng/ml. Haemoglobin 142g/L. Flexible cystoscopy showed large volume TCC on the on the left side of the bladder. CTU, 4.2.15 - Bladder tumour extending through the ureteral vesical junction into a dilated but not obstructed left ureter. TURBT 17/02/2015: Papillary and necrotic bladder tumour extending from bladder neck across trigone and onto left bladder wall in a confluent pattern. All resected to muscle. Left u/o uncapped, tumour within intra-mural left ureter. pT1 G3 with inflammation in detrusor muscle but no muscle invasion seen. For discussion of histology and further management. This man is not a good candidate for radical surgery in view of comorbid status. US Urinary Tract, 20.2.15 - The urinary bladder is collapsed around catheter balloon. Discussed @ Urology MDM 5.3.15. Mr [redacted] has high risk non-muscle invasive bladder cancer. For early repeat cystoscopy with Mr Glackin. For review with Mr Glackin Attended for 2nd TURBT 12 June 2015. Previous pT1G3 TCCB. Solid tumour involving dome and posterior wall resected. Tumour protruding from left u/o resected. For discussion of histology please. Histology shows structures of mostly solid, Grade 3 transitional cell

carcinoma invading into structures of detrusor muscle. pT2 Discussed at Urology MDM 25.06.15. Mr [redacted] has muscle invasive bladder cancer. For review with Mr Glackin to arrange CT C/A/P, for restaging and for central MDM discussion for consideration of EBRT if appropriate. CT C/A/P, 08.07.15 - 1. Multifocal bladder TCC without evidence of transmural disease. No evidence of nodal metastatic disease. 2. Occluded abdominal aorta. Both lower limbs are supplied by collateral vessels through the anterior abdominal wall. Vascular surgical opinion is warranted. Discussed at Urology MDM 23.07.15. This man has been found to have muscle invasive bladder carcinoma, without evidence of metastatic disease on recent CT scanning. For review by Mr Glackin to request bone scan and to discuss referral for palliative radiotherapy. Bone scan, 30.07.15 - There is no evidence of bony metastatic disease.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] has non metastatic invasive bladder cancer. For referral for consideration of radiotherapy.

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

Diagnosis: TCC Bladder invasive

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old man had a few episodes of frank haematuria. He doesn't smoke. DRE showed small benign feeling prostate. Flexible cystoscopy showed small but occlusive prostate. There was diffused papillary tumour in the trigone and this partly appeared high grade. CT Urogram, 28.02.14 - Within the limitations of this examination, no malignancy seen in the upper tracts. Electively admitted on 07.03.14 for TURBT +/-ureteric stenting. New bladder tumour resected from trigone and posterior wall. Mitomycin single shot prescribed. Pathology reported 1 - Superficial bladder tumour - Histology showed features of an invasive transitional cell carcinoma of WHO Grade III. Tumour was identified within the sub epithelial tissue but did not appear to infiltrate the detrusor muscle present (pT1). 2 - Deep biopsy bladder tumour - < gram of tissue was received. All of the tissue were processed for histological examination. Histology showed fragments of detrusor muscle; one fragment showed some superficial tumour and sub epithelial tissue. There was no evidence of invasion into the detrusor muscle present. Attended for flexible cystoscopy on 10.06.14 which showed a single solitary solid nodule at the junction of the prostatic urethra and bladder neck in the 12 o'clock position. The remainder of the bladder mucosa appeared satisfactory. His ureteric orifices were normal. Electively admitted on 15.08.14 for TUR of bladder lesion. He had an abnormal lesion resected from 12 o'clock position at the bladder neck/prostate. The histology has shown pTa grade 3 TCC. Discussed @ Urology MDM, 25.09.14. This gentleman has had high risk, superficial tumour recently resected. For review by Mr Glackin, to request a CT scan of chest, abdomen and pelvis, to arrange a course of BCG, to arrange readmission in January 2015 for endoscopic reassessment. CT Chest/Abdomen/Pelvis 8.10.14 - 1) Probable solitary significant aortocaval space lymph node, unchanged from previous. 2) No other definite metastatic disease. Electively admitted for TURBT 7.2.15 - Histology shows fragments lined by urothelium with the subepithelium exhibiting oedema, congestion, focal haemorrhage and patchy inflammation. There is no CIS or malignancy within the submitted tissue. Discussed @ Urology MDM 12.2.15. Mr [redacted] requires maintenance intravesical therapy. For review by Mr Glackin and to book CT CAP for follow up of aortocaval lymph node June 2015. CT C/A/P, 27.05.15 - The hypodense lesion in the aortocaval region show no interval change. Urinary bladder is mildly thick walled. Further to this gentleman's flexible cystoscopy in July which identified some red patches on posterior wall of his bladder he was admitted for a check cystoscopy and bladder biopsies on 24th July 2015, 4 biopsies were taken from the posterior wall. Histology shows markedly inflamed and reactive fragments of bladder mucosa. The subepithelial tissue contains numerous reactive stellate and multinucleate fibroblasts and occasional clusters of multinucleate type giant cells. The surface urothelium is denuded in many areas but, where focally present, it shows reactive changes only. There is no evidence of residual or recurrent invasive malignancy.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted]'s recent bladder biopsies have not shown any residual bladder cancer. For treatment with intravesical BCG and subsequent endoscopic surveillance with Mr Glackin.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'DONOGHUE J P MR (C8245)	None	None	None

[redacted] DOB [redacted] Age: [redacted]

Mr [redacted] Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This [redacted] old man has been under review with Mr Suresh for elevated PSA. He had a prostate biopsy in 2011 demonstrating BPH and has been under surveillance since. He describes no significant lower urinary tract symptoms with an IPSS of 3. Initially his PSA was attributed to chronic prostatitis, however his most recent PSA 9.86 had risen despite a course of ciprofloxacin. He is otherwise fit and well taking only simvastatin for cholesterol. Transrectal prostatic biopsy, 03.08.15 - await pathology.

MDMAction

Discussed at Urology MDM 13.08.15. Pathology not available, defer to next week.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'BRIEN A MR (C6514)	None	None	None

[redacted] Mr [redacted] DOB: [redacted] Age: [redacted]

Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] old man underwent bilateral partial nephrectomies in 2007 for bilateral renal cell carcinoma detected coincidentally at that time in the assessment of prostatic carcinoma, managed by androgen blockade prior to radical radiotherapy in 2008. He has had an excellent oncological outcome to date. There was no evidence of recurrence of renal cell carcinoma on CT scanning in May 2014. His biochemical renal function has improved in recent years, with a GFR of 54 in April 2014. Patient had sustained fractures of several left ribs due to a fall in his home in March 2014. Concurrent with the fall, patient had reported that he had weight loss which was subsequently attributed to thyrotoxicosis, possibly induced by Amiodarone. Patient had had a subtotal thyroidectomy in 1978. His hyperthyroidism was successfully managed by decreasing doses of Carbimazole and Prednisolone. In view of weight loss and the history of exposure to asbestos, renal cell carcinoma and prostatic carcinoma, CT scanning in April 2014 had revealed a 12 mms, pleural based opacity in relation to lower lobe of right lung. He was reported to have a prostatic volume of 19 mls and a residual volume of 134 mls on ultrasound scanning in September 2014. The appearances of his chest were reported to remain unchanged on further CT scanning in December 2014 when patient remained well under review by Respiratory Physician. Patient then reported increasingly severe, right chest pain following a chest infection in April 2015. He was reported to have new, lobulated areas of right pleural thickening and a probable right pulmonary lesion on a Chest XRay in May 2015. On CT scanning on 18 July 2015, he was reported to have large, pleural based nodules, mediastinal lymphadenopathy, a large right pleural effusion, pulmonary collapse and right costal metastatic lesions. There was no evidence of abdominal or pelvic metastatic disease. He has an iron-deficiency anaemia, chronic renal functional compromise with a GFR of 48 mls/min and a serum PSA of 0.21 ngs/ml. Discussed at Urology MDM 30.07.15. This man has been found to have advanced progression of intrathoracic malignancy on recent CT scanning. For review by Mr O'Brien and for referral to Dr Convery consultant respiratory physician. Patient had evidently lost weight when reviewed on 31 July 2015. He was advised to discontinue Warfarin in advance of his admission on 05 August 2015 for drainage of right pleural effusion on 06 August 2015 and biopsies of chest wall lesions on 07 August 2015. Soft tissue biopsy, 06.08.15 - Histology through multiple levels shows fragments of skeletal muscle and fibrovascular connective tissue. There is no

evidence of malignancy within this limited submitted tissue. This specimen may not be entirely representative and given the clinical history, further biopsies may be considered.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted]'s recent chest lesion biopsies are non diagnostic. He remains an inpatient and his care is being discussed with the cardiothoracic team regarding a pleurex drain.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
[redacted] Mrs [redacted]	DOB: [redacted]	Age: [redacted]		Target Date

Diagnosis:
Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This [redacted] old lady was initally admitted to DHH in May 2015, with a urinary tract infection and severe acute kidney injury. At that time her creatinine was 515, EGFR was 7 and her baseline was 33. She has a history of cervical cancer and pelvic clearance. CT KUB had shown bilateral hydronephrosis and an ultrasound showed her to have a post-void residual of 222ml. Renal function on 30th July showed an EGFR of 32. Vaginal biopsy and bladder biopsy was performed on 24th July 2015. Part 1, Histology through levels shows detached and fragmented superficial surface squamous epithelium exhibiting full thickness dysplasia in keeping with vaginal intraepithelial neoplasia III (VAIN III). Very little, if any, subepithelium is represented and there is no unequivocal malignancy within this very limited submitted tissue. Discussion of this case at the Gynaecological MDT is advised. Part 2, Histology shows features of a WHO Grade III transitional cell carcinoma with some squamous differentiation. The adjacent surface urothelium exhibits dysplastic changes. No muscle is represented within the submitted tissue. The transitional cell carcinoma infiltrates into the subepithelium (at least pT1).

MDMAction

Discussed at Urology MDM 13.08.15. Mrs [redacted]'s vaginal biopsies have shown vaginal intraepithelial neoplasia while her bladder biopsies have shown high grade T1 urothelial cancer of the bladder. For OP review with Mr O'Donoghue to discuss urothelial cancer and suggest symptomatic treatment and she will need a change of ureteric stents arranging.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	None	None	None	None
[redacted] Mr [redacted]	DOB: [redacted]	Age: [redacted]		Target Date

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR GLACKIN: [redacted] old man with rising PSA now 10ng/ml April 2015. No family history of prostate cancer. Digital rectal examination demonstrated a very large but very firm prostate. He proceeded to TRUS biopsies, he had 12 cores taken from his prostate which measured 45cc. Transrectal prostatic biopsy, 27.05.15 - Adenocarcinoma Gleason score 3 + 3 = 6. Number of cores involved, 1 of 13. Tumour occupies 1.5 mm and approximately 2% of the tissue (overall less than 1% of the examined material). There is no perineural or lymphovascular invasion and no evidence of extracapsular extension. Discussed at Urology MDM 11.06.15. For review with Mr Glackin to arrange MRI and for subsequent MDM discussion. MRI, 03.08.15 - There is probable tumour anterolaterally at the left apex to mid gland. I note the history of Gleasion 6 carcinoma present only in one core from this area. Given the location of tumour, it is possible that the patient's disease has been undersampled. If active surveillance is being considered, would it be worthwhile considering targeted biopsies of the left apex?

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] has an area of abnormality at the left apex to mid prostate which may have been under sampled. For review with Mr Glackin to recommend targeted biopsy of this area.

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

[redacted] Mr [redacted] DOB: [redacted] Age: [redacted] Target Date 02/09/2015

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old gentleman reports no bothersome lower urinary tract symptoms. There is no family history of prostate cancer. He has had a single PSA test which is elevated 15ng/ml. He has significant co-morbidities. He has had a history of previous CVA. He has Type II diabetes, hypertension, Barrett's oesophagus and cystic renal disease. He is markedly short of breath on minimal exertion. He has central obesity. Examination of the scrotum reveals a right hemi-scrotal mass. Digital rectal examination finds a flat firm prostate. Repeat PSA 14.6 ng/ml. TRUS biopsy on 23 June 2015. To discuss histology and review US testes please. Transrectal prostatic biopsy, 23.06.15 - Gleason score: 4+3=7, number of cores involved: 9/11. Maximum length of tumour, 12 mm. Overall tumour volume: 53% Lymphovascular invasion: not seen Perineural invasion: not seen. Discussed at Urology MDM 02.07.15. This gentleman has been found to have prostatic carcinoma on recent prostatic biopsies. He has also been found to have a large right epididymal cyst. For review by Mr Glackin to arrange bone scan, MRI and subsequent MDM discussion. Bone scan, 23.07.15 - Tracer activity in relation to the mid dorsal region at the D7 level is highly suggestive of metastatic infiltration. Plain film correlation is required. There is also focal tracer uptake within the left third rib posteriorly and anteriorly in several of the lower right ribs which is again suspicious for metastatic disease. MRI, 05.08.15 - await results.

MDMAction

Discussed at Urology MDM 13.08.15. Defer for radiology discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
GLACKIN A.J MR (C8102)	None	None	None

[redacted] Mr [redacted] DOB: [redacted] Age: [redacted] Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old man was referred back to clinic due to a PSA of 13.15ng/ml. His previous PSA trend varied from 7-8ng/ml. He had a negative TRUS biopsy of prostate in 2013 complicated by bleeding and a prolonged hospital stay due to difficulty managing his anticoagulation for mechanical AVR. Prostate was previously estimated at 37cc. Following discussion with Mr [redacted] it was agreed to proceed to MRI prostate. MRI, 22.06.15 - Prostatic enlargement secondary to benign prostatic hyperplasia. Small indeterminate area of reduced T2 and ADC signal change in the left peripheral zone. No definite significant prostate tumour is seen.

MDMAction

Discussed at Urology MDM 13.08.15. Mr [redacted] 's MRI has not shown any radiological evidence of prostate cancer. Mr Glackin will contact Mr Wallace to reassure him and recommend PSA monitoring.

Aimee Crilly

From: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 28 August 2015 12:00
To: O'Brien, Aidan
Subject: Re: Personal Information redacted by the USI

Aidan,

The above patient's daughter was ringing regarding his review appointment. Mr Personal Information redacted by the USI attended you EURO clinic on 13/4/15 and was told he would b be reviewed in July 2015 however this has not been logged on PAS. She advised that her father is very tired, weak and has occasional sweats during the day. Can you please advise if he needs an PR appointment in SWAH.

Many thanks.

Noleen

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

MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING

19th AUGUST 2015

In attendance: Mr O'Donoghue, Chair, Mr Young, Minutes, Mr Haynes, Mr O'Brien, Dr Martin, Mr Tyson, Mr Mukhtar, Sister O'Neill & Martina Corrigan.

Apologies: Mr Glackin, Mr Suresh (holiday leave).

1. **HAND OVER** – This is proving an on-going issue; it is still recorded that this should be in person and in writing. It is recognised that the clinical governance committee are awaiting to report on this however in the interim our Registrar's will attend the surgical hand over in the morning at 8:40am. This will be the interim measure until it is defined what exactly will be the on-going arrangement. It is also appreciated that there is a hand over in the evening.

2. **LOCUM WORK** – It's not exactly clear when Locum's are commencing their shift time. There is an appreciation that they are working in other Trusts prior to commencing work for us in the evening. A more realistic start time may be recommended. Outcome is for Martina Corrigan to audit start time.

3. Where a patient is an inpatient and a urology consult is requested we are recommending that as much as possible from a urology investigative point of view should be performed as an inpatient rather than bringing the patient back as an outpatient.

4. The daytime Registrar cover of the urology unit was discussed with regards to the change noted in July where all day cover for a full week had been instigated; Dr Martin felt that there was good continuity of care. We are currently trialling the consistency of a single Registrar covering the morning sessions from Monday to Friday for two months. In October we will again trial the all day Monday to Friday approach.

5. There has been an adoption of one bleep only for the on-call urology Registrar i.e. the bleep is handed between Registrars' as opposed to switchboard etc. having to look at a rota for each session.

6. There are on-going training issues with regards to Immax (now called - Note). The M&M form data needs to be completed by the individual consultant and then at the audit meeting this will be completed by the audit members led by the chairman.

7. The Trust audit on fifty inpatients has had a poor uptake to date. It was hoped that 'google-doc' could be used but this has not been possible due to Trust computer blocking systems. Martina Corrigan will be addressing this with the IT Department but we have suggested that if this is not immediately correctable that a paper version would be undertaken. Plan to start 01st September 2015.

8. The stent register process is on-going. Mr Haynes has liaised with BAUS central office. Update for next meeting.

9. Audits for the incoming year:

    1. Partial nephrectomy – All partial nephrectomies undertaken from 2010 onwards to be reviewed by Jenny Martin.

    2. Outcome of invasive transitional cell carcinoma from 2000 – 2010. This is a pathology based audit to identify all outcomes of such patients. Mr Mukhtar to liaise with Mr O'Brien on this topic.

    3. Audit of hand over quality – Mr Tyson.

    4. On-line catheterisation teaching questionnaire for FY1's.
    These audits are in addition to the index control audit of TURBT and TURP.

10. Dr McAllister's comment on VTE prophylaxis was noted. The outcomes for each ward are recorded. Discussion on this topic did record that for 3 South the VTE risk assessment was only at 55%. Discussion also noted that our ward was a mix of ENT and urology. This led to a discussion around whether Clexane should be given to patients where bleeding is at risk, namely haematuria, TURBT and prostate surgery. It was concluded that all patients will be given the appropriate Clexane and TED stockings unless there is a specific default from same recommended by the consultant in charge. A focus at the daily ward round on the drug kardex is to be instigated.

11. **COMPLAINTS** – There is a general trend of complaints with regards to waiting times for outpatients and inpatients. No specific complaint with learning point has been recorded.

12. **CLINIC TIMES** – It is recorded that the afternoon clinics are overrunning often finishing well after 5:00pm and sometimes at 6:30pm. The afternoon clinics start at 1:30pm. The booking times towards the end of the clinic are to be readdressed by Martina Corrigan. It is recommended that last patient appointments should be at 4:00pm; this is to be trialled, actioned by Martina Corrigan.

13. No mortalities are recorded this month.

14. **MORBIDITY** – Case of bilateral flexible ureteroscopy with resultant acute renal failure from obstruction. The case presented with bilateral diagnostic flexible ureteroscopy with passage of urine for 48 hours post-procedure which then progressed to acute onset of anuria. Renal function blood tests then defined increasing creatinine. An ultrasound scan did not show any hydronephrosis. Patient then developed pain. Nephrology input requested as unusual presentation of obstruction. Proceeded with bilateral stent insertion; this resolved the renal function.

Outcome learning points:

1. Treat bilateral ureteroscopy with utmost respect with insertion of ureteric catheters or stenting.

2. A lack of hydronephrosis does not necessarily exclude obstruction – clinical judgement to take precedence.

15. **NEXT MEETING** – General hospital audit on 15th September 2015.
(post- script = this date is same as Regional Audit in the Ulster Hospital)

Aimee Crilly

Subject: FW:
Attachments: MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING 19 08 15.docx

-----Original Message-----
From: Glackin, Anthony <Personal Information redacted by the USI
Sent: 10 September 2015 11:21
To: Haffey, Raymond <Personal Information redacted by the USI
Cc: Cullen, Aidan <Personal Information redacted by the USI; Haynes, Mark <Personal Information redacted by the USI>;
O'Brien, Aidan <Personal Information redacted by the USI; ODonoghue, JohnP
<Personal Information redacted by the USI; Suresh, Ram <Personal Information redacted by the USI; Young, Michael
<Personal Information redacted by the USI; Martin, Jennifer <Personal Information redacted by the USI
Subject: FW:

Dear Raymond,
Please find attached the minutes of the last Urology meeting taken in my absence.
Please note apologies for the meeting 15th September 2015, all the Urologists will be attending Regional urology Audit at UHD.

Kind regards

Tony

From: Young, Michael
Sent: 10 September 2015 09:42
To: Glackin, Anthony
Cc: O'Brien, Aidan; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP; martin; 'Tyson, Matthew'; b.mukhtar@nhs.net; Corrigan, Martina
Subject:

Tony

Minutes of last meeting
Also just found out that next Audit for Hospital general meeting is same as the Regional urology.
Do you wish to liaise this with Aidan Cullen or what are we to do

MY

From: Medical Directors Office
To: O"Brien, Aidan
Cc: Mackle, Eamon; medical revalidation
Subject: CORRESPONDENCE FROM DR RICHARD WRIGHT, MEDICAL DIRECTOR - IMMEDIATE RESPONSE REQUIRED
Date: 30 November 2015 15:30:36
Importance: High

Dear Mr O'Brien, despite constant reminders as per the emails below, you have still not submitted appraisal documentation for the period January to December 2014 nor have you advised the Revalidation Team when you are planning to hold your appraisal meeting. As you are aware, the requirement to undertake an annual appraisal is a **contractual** one and it is also your **professional responsibility** to participate in the Trust's Medical Appraisal Scheme.

Therefore please advise by return the date of your appraisal meeting and ensure that your documentation is received by the Revalidation Team no later than Friday 18th December 2015.

Kind regards
Dr Richard Wright
Medical Director
(Responsible Officer)

From: medical revalidation
Sent: 17 November 2015 14:54
To: O'Brien, Aidan
Subject: RE: Appraisal 2014
Importance: High

Dear Aidan, just following up on the email below.

Regards,
Patrick

REVALIDATION TEAM

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation,

Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI)

From: medical revalidation
Sent: 03 November 2015 12:02
To: O'Brien, Aidan
Subject: Appraisal 2014

Dear Aidan, just following up on the email below. Can you complete your Paying Patients Declaration and scan it back to us. Also can you scan across your appraisal forms and ensure they include the following:

1. Front page completed;
2. Forms 1-7 completed and duly signed;
3. Appendixes 1, 2 & 3 completed.

Regards,
Patrick

REVALIDATION TEAM

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI)

From: medical revalidation
Sent: 19 October 2015 13:26
To: O'Brien, Aidan
Subject: Appraisal 2014

Hi Aidan, just following up on the email below, can you confirm that your appraisal is in progress or complete and if complete can you scan the following duly completed and signed off forms:-

1 Front page
2 Form 1-7
3 Appendices 1, 2 & 3

Many thanks for your assistance in this matter.

Regards
Katie

REVALIDATION TEAM

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI ***)***

From: medical revalidation
Sent: 05 October 2015 22:06
To: O'Brien, Aidan
Cc: Mackle, Eamon
Subject: FOR IMMEDIATE RESPONSE PLEASE

Hello Aidan, just following up on the emails below. We need a response as soon as you can please.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI ***)***

From: Thompson, Norma
Sent: 25 September 2015 11:15
To: O'Brien, Aidan
Subject: FOR IMMEDIATE RESPONSE PLEASE

Hello Aidan, can you please advise by return the date of your appraisal meeting as we have yet to receive a response to the reminder emails below. We have to produce regular reports for the Trust Board and Governance Committee as to who hasn't completed their medical appraisal as yet. However if you let us know a date we can record you as 'In Progress' on our database, rather than 'Not Complete'.

You will also have received emails about completing a Paying Patients

Declaration which we need submitted by the end of September 2015 in order to meet Internal Audit requirements (even if you do not undertaking Paying / Private Patient work, you still need to complete this form to say so). Can you complete the attached and return to this email address as soon as possible please.

Thanks for your assistance with this.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI *)*

From: medical revalidation
Sent: 14 September 2015 11:53
To: O'Brien, Aidan
Subject: FW: FOR REPLY / ACTION: YOUR OUTSTANDING 2014 APPRAISAL

Hello Aidan just following up on the email below.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI *)*

From: medical revalidation
Sent: 04 September 2015 13:45
To: 'O'Brien, Aidan'
Subject: FW: FOR REPLY / ACTION: YOUR OUTSTANDING 2014 APPRAISAL

Hello Aidan just following up on the email below.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
(Personal Information redacted by the USI)

From: medical revalidation
Sent: 27 August 2015 16:05
To: 'O'Brien, Aidan'
Subject: FW: FOR REPLY / ACTION: YOUR OUTSTANDING 2014 APPRAISAL

Hello Aidan just following up on the email below.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for information on Appraisal & Revalidation, Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
Personal Information redacted by the USI

From: medical revalidation
Sent: 20 August 2015 21:36
To: O'Brien, Aidan
Subject: FOR REPLY / ACTION: YOUR OUTSTANDING 2014 APPRAISAL

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

Medical Director's Office

CONFIDENTIAL VIA EMAIL

Dear Colleague

Further to the reminder email below, our records indicate that we have yet to receive confirmation that you have had an appraisal for the calendar year January to December 2014 or are in the process of arranging one. As you are aware, the requirement to undertake an annual appraisal is a contractual one and it is also your professional responsibility to participate in the Trust's Medical Appraisal Scheme.

Therefore, please confirm **by return** the date of your planned Appraisal meeting. Once your appraisal meeting has taken place, please ensure you forward all of your **original signed** appraisal documentation either to this email address or by post to Katie Shields, Medical Director's Office, Clanrye House, Daisy Hill Hospital, Newry in order that we may update our database. All Forms 1 to 7 and Appendix 1 (Training Matrix), Appendix 2 (Appraiser Feedback) and Appendix 3 (Appraisee Feedback) must be submitted along with the new front page checklist (current forms attached for ease of reference). The original Forms 1 to 7 will be returned to you once they have been saved electronically.

NB: It is <u>your</u> responsibility to organise your appraisal meeting and to submit your documentation to the Revalidation Team - click here for an up-to-date directory of trained Appraisers.

Please note your signed completed appraisal documentation must be submitted to us no later than the end of September 2015 in order to meet audit requirements.

If you have already completed your appraisal and believe you have submitted your documentation please let us know. In the meantime, if you have any queries or wish to discuss further please do not hesitate to contact us.

Kind regards
Revalidation Team

Visit the dedicated SouthernDocs website for

information on Appraisal & Revalidation,
Medical Training and Paying/Private Patients
www.southerndocs.hscni.net
Personal Information redacted by the USI
)

From: medical revalidation
Sent: 20 July 2015 17:43
To: **All Consultant and SAS Grades**
Subject: FOR ACTION: OUTSTANDING 2014 APPRAISALS
Importance: High

Dear Colleagues – just a reminder that all 2014 appraisal documentation should have been submitted to the Medical Director's Office by now. If you haven't already done so, can you please submit all signed originals and appendices (as per the email below) to Katie Shields, Revalidation Support Team, Clanrye House, DHH via internal mail or by scanning the originals and emailing them to this email address **no later than the end of August 2015.**

NB: If you have already submitted your 2014 appraisal documentation and have received confirmation of receipt from the Medical Director's office then please disregard this email.

Kind regards
Revalidation Support Team

From: medical revalidation
Sent: 05 January 2015 12:36
To: AMDs, CDs, Consultants, SAS Doctors
Subject: TRUST'S MEDICAL APPRAISAL FORMS

Dear Colleagues – there have been a few old versions of the Trust's Medical Appraisal Forms submitted recently with some of the appendices missing. Please note the forms were updated last April and there are now four appendices, along with Forms 1 to 7 as follows:-

Appendix 1 – Training Matrix (must be submitted)
Appendix 2 – Appraiser Feedback form (must be submitted)
Appendix 3 – Appraisee Feedback form (must be submitted)
Appendix 4 – Aide Memoire and Quality Assurance Tool (for own use as a checklist – does not need to be submitted).

The most up to date appraisal forms are attached but can also be downloaded from

the Southern Docs website by clicking on the link below ([Personal Information redacted by the USI] if asked)

http://www.southerndocs.hscni.net/appraisalscheme/

Please also ensure that the signed originals of all 7 Appraisal Forms are submitted via internal mail to the **Revalidation Support Team, Medical Director's Office, Clanrye House, DHH**. The forms will then be scanned in and saved electronically before being returned to you with an acknowledgement memo. Until all of the forms and required appendices have been submitted, your appraisal for that year will be recorded as incomplete.

Appraisals for the period January to December 2014 are due to be submitted by May 2015 therefore you should be commencing the process soon if you have not already done so. Please email the Revalidation Support Team for any information you require for your 2014 appraisal documentation.

In the meantime, if you have any other appraisal and / or revalidation queries, please do not hesitate to contact us.

Kind regards
Revalidation Support Team

A Guide to Job Planning

for Consultant Urologists

2016

www.baus.org.uk

British Association of Urological Surgeons

BAUS is a registered charity in England and Wales (1127044)

Email: admin@baus.org.uk

Website: www.baus.org.uk

Contents

1 Introduction

It is now 15 years since the document 'A Quality Urological Service for Patients in the New Millennium' with guidelines on workload, manpower and standards of care in urology was published by BAUS. Delivery of urological care has been transformed in the interim due to changes in the socio-political environment allied to advances in medical care. Examples include the introduction of new technology, the move away from open surgery, the development of rapid diagnostic services, increased public expectation and government targets on the timely delivery of health care.

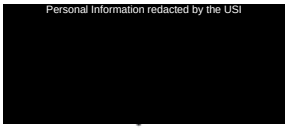
At present there are approximately 1000 consultant urologists working in the UK. The UK has one of the lowest rates of consultants per head of the population in Europe and consultant urologists have a challenging role delivering expert and timely clinical care.

Careful job planning is crucial to enable consultants to fulfil their role successfully and support them to deliver high quality safe patient care. At its most basic, job planning may include routine outpatients, diagnosis and management of complex cases, operating and contributing to the efficient running of the urology unit. In addition, all consultant urologists are expected to participate in quality improvement initiatives, as outlined in the GMC document 'Good Medical Practice'. For consultant urologists working in the UK, this entails a commitment to contribute to the Healthcare Quality Improvement Partnership (HQIP) Clinical Outcomes Publication (COP) Programme, which is supported by BAUS through its various national audits. It also involves spending time and effort reflecting on, and reviewing, patient care activities so that quality and safety improve continuously.

Hence, the roles of a consultant urologist are many and diverse; teaching, training, researching, managerial decision making, running departments and developing local services. It would not be expected that all consultants are involved in all these activities at the same time but rather that they are undertaken across a team of consultants at specialty/directorate level. The NHS depends on consultants being involved in the wider management and leadership of the organisations they work in, and the NHS generally.

A successful job plan should facilitate these activities and reflect the diverse roles that the consultant plays in shaping and developing services. It should also enable a healthy work-life balance, avoiding burnout.

This document details the essential components of a successful job plan and offers guidance on the activity that consultants might deliver on behalf of their trust, aiming to deliver safe timely care, focusing on the individual needs of the patient. Much of the source material can be accessed elsewhere and a comprehensive list of references is detailed in Appendix 6.



Kieran J. O'Flynn

President, BAUS

2 Making Job Planning a Success

2.1 What is a job plan?

Job plans are an annual agreement between the employer and the consultant setting out:

- the work that is done for the trust, reflecting a balance between operative work, outpatients and emergency care
- when and where the work is done
- how much time you are expected to be available for work
- what will be delivered for the employer, patients and the employee
- what resources are necessary for the work to be achieved
- what flexibility there is around the above

2.2 What are the hallmarks of a successful job plan?

Key to a successful job plan is a fit for purpose process. Job planning should be:

- undertaken in a spirit of collaboration and co-operation
- completed in good time
- reflective of the professionalism of being a doctor
- focused on measurable outcomes that benefit patients
- consistent with the objectives of the NHS, the employing organisation and the teams and individuals with whom the urologist will work

- clear about the supporting resources the trust will provide to ensure that objectives can be met
- transparent, fair and honest
- flexible and responsive to changing service needs during each job plan year
- fully agreed and not imposed
- focused on enhancing outcomes for patients whilst maintaining service efficiency

It is important that the support offered by non-medical personnel (e.g. surgical care practitioners, administrative staff, specialist nurses etc) is shared between all consultants in the department.

Agreement should also be sought on any action(s) the consultant and/or trust should take to reduce or remove potential organisational or systems barriers.

2.3 How might a job plan be constructed?

The services provided by a consultant fall into 4 broad categories:

- Direct Clinical Care (DCC)
- Supporting Professional Activities (SPAs)
- Additional responsibilities (Trust based)
- External duties (outside Trust)

Consultants remain accountable to their employer for the achievement of agreed objectives in both DCC and SPA time. While consultants receive an SPA allowance, this is generally to support CPD and other activities commensurate to the consultant grade and to the service objectives of the employer. This gives the employer the right to monitor the performance of the consultant during SPA time, looking at time spent and outcomes achieved.

2.4 When should the job plan be reviewed?

The job plan should be reviewed on an annual basis. All aspects of the job plan should be used to consider, amongst other possible issues:

- what factors affect the achievement, or otherwise, of objectives
- adequacy of resources to meet objectives
- any possible changes to duties or responsibilities, or the schedule of programmed activities
- ways of improving management of workload
- the planning and management of the consultant's career in the short and long term

3 Direct Clinical Care

For consultant urologists, this includes the following:

- outpatient activities
- operating sessions including pre-op and post-op care
- emergency duties (including emergency work carried out during or arising from on-call)
- clinical diagnostic work, other patient treatment
- multi-disciplinary team meetings about direct patient care
- administration directly related to the above

3.1 Outpatient activities

For most urologists, the majority of their clinical practice is based in outpatients. The conversion rate from outpatient activity to an inpatient stay has reduced in recent years with the greater use of outpatient diagnostics and day case facilities. Increasingly the model for the provision of outpatient services has shifted with more activity being delivered on a one-stop basis where the patient is discharged after a single comprehensive appointment that may include imaging (e.g. ultrasound and/or CT) and endoscopy. Where such a model is delivered it is anticipated that 60-70% patients can be safely discharged back to primary care.

BAUS' view is that enormous clinics are no longer appropriate. Patients deserve a full discussion where their concerns can be listened to and addressed. Recent clarification of the law concerning consent (Montgomery vs Lanarkshire Health Board, 2015) mandates that, in the event an intervention or operative procedure is planned, the urologist is required to share all relevant information with the patient to help him/her decide whether (or not) to proceed with an intervention or procedure. Not only must urologists carefully counsel the patient, they must also document the discussion as part of the consent process, or indeed the patient's reluctance to have a procedure performed. This inevitably takes

time and the proposed clinic templates, which are less onerous than previously published standards, reflect these changes in practice.

3.2 Weekend working

With increasing pressure towards 7-day working, trusts may request that urologists provide regular non-emergency Saturday working. At present this can only be done by mutual agreement. New consultant appointments by trusts may specify regular Saturday work and an individual who applies for a post on this basis would demonstrate their consent to the arrangements. Urologists should seek assurances that the same level of support and mentoring would be available on Saturdays as would be available to them, and other consultants in the department, during Monday to Friday. Without such support (e.g. administrative support, nursing input, post-operative care, radiology, pathology and support of medical doctors), a newly appointed consultant would find it difficult to meet the obligations in the Royal College of Surgeons of England's 'Good Surgical Practice'.

Table 1 BAUS recommendations for consultant clinical activity, based on 1PA (4 hours in England, 3.75 hours in Wales), including time for clinical supervision and dictation

Clinical Activity	*Suggested no. of patients per consultant*	*Comment*
New outpatients visit -generic	11	Based on consultation time of 20 minutes per patient with time for administration
Follow-up outpatient visit generic	15	Based on consultation time of 10-15 minutes per patient
Outpatients (combined new and review patients)	12	Based on 6 new consultations (6x20 minutes) and 6-8 reviews (6x15 minutes)
New outpatient visit - specialist		30-45 minutes. Number of patients seen will be dictated by the complexity of the patients seen, allowing sufficient time for counselling and consenting
Follow-up outpatient - specialist		15-45 minutes depending on nature of the problem
Outpatients (one-stop)	7-8	To include provision of flexible cystoscopy, imaging, TRUS and consent as applicable
Haematuria clinic (new patients only)	6-8	To include flexible cystoscopy
TRUS clinic	5-6	40-50 minutes per patient. Need to allow sufficient time for confirmation of consent and provision of antibiotic prophylaxis
Urodynamic clinic	4-5	40-50 minutes per patient
ESWL (am/pm session)	3-6	40-50 minutes depending on complexity of patient
Flexible cystoscopy	8-10	25-30 minutes. Need to allow sufficient time for confirmation of consent
Flexible cystoscopy and botox	4-6	40-60 minutes. Need to allow sufficient time for confirmation of consent
Multidisciplinary team meeting (oncology, stones, reconstruction etc)		General allocation 0.5-1PA direct clinical care depending on time
Theatre		For an all day list (8 hours/2PAs) an allocation of 2.5 PAs is desirable to cover pre- and post-op ward rounds

3.3 Emergency work

Survey evidence shows that urological emergencies account for approximately 20-25% of all surgical admissions. BAUS believes that consultant urologists should have reduced clinical commitments when on call, particularly in the morning, to allow all emergency admissions to be reviewed daily by the on-call consultant. There should be no scheduled private practice whilst on call. In larger units with a high emergency workload, and in the setting of an increasingly consultant led service, BAUS' view is that the urology team should be completely free of elective commitments to cover emergencies.

Emergency work will fall into two main categories:

i. Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work e.g. daily weekend ward rounds. This should be programmed into the working week as scheduled programmed activity (PA);

ii. Unpredictable emergency work arising from on-call duties: this is work done whilst on call and associated directly with the consultant's on-call duties e.g. recall to hospital to see urgent admissions or operate on an emergency basis. It will also include offering telephone advice to colleagues and remotely reviewing imaging and test results.

3.4 On-call availability

As an absolute minimum, all emergency surgical admissions must be discussed and documented with the responsible consultant urologist within 12 hours of admission. Where practicable, BAUS supports a daily consultant-supervised ward round/review, 7 days a week, to support ongoing decision making and to review the management plans and results.

While most urological admissions are not taken to theatre, BAUS' view is that the patient must be seen by the on-call consultant urologist within a maximum of 24 hours from admission, 7 days a week. Local

arrangements should be agreed for appropriate escalation of clinical involvement according to changes in clinical condition.

Urologists who need to attend their trust after 12am (midnight) should not be expected to attend for regular day time work on the following morning. On the rare occasion that the consultant has to work through the night, he/she should not be expected to work the following day. It is accepted that, in addition to providing on-call cover at their base hospital, urologists may also be required to provide advice to a number of units across the network. Under such circumstances, local arrangements will need to be made so that cover can be provided in the event the consultant urologist is busy on a different site.

A BAUS audit of emergency provision by urologists demonstrated that in teaching hospitals 25% of urologists are free of other duties and 85% are supported by a properly constituted mid-grade rota. In larger DGHs (population >350000), only 15% are free from other duties and only 55% have mid-grade support. For smaller DGHs, only 5% are free of other duties and only 15% have mid-grade cover. Many urologists support emergency care in smaller hospitals, with support from a 'hospital at night team' or FY1/FY2 cover. The provision of consultant urological cover in smaller DGHs is likely to become increasingly problematic for those consultants covering on a 1:4 basis or less, and innovative solutions will need to be identified to address the problem.

3.5 Acting down

The term 'acting down' is used to refer to situations where, as the result of an emergency or crisis, a consultant is required to undertake duties which would normally be performed by a non-consultant member of medical staff. It does not apply to duties that a consultant undertakes as part of his or her normal workload but which could also be undertaken by a non-consultant member of staff.

Acting down places an increased burden on consultants and should be the exception rather than the rule. All efforts should be made to avoid it through, for example, effective management of absences (including holidays and sickness) and absence cover for non-consultant career grades by comparable staff.

Consultants are not contractually obliged to act down or to be compulsorily resident on-call to cover the duties of non-consultant staff. In general, consultants are only requested to act down when there is a critical shortage of non-consultant staff and the only alternative would be to close the department. NHS Employers does not endorse any one approach and trust arrangements will be a matter for local discussion and agreement with the affected urologists.

3.6 Patient administration

All consultant urologists will need dedicated time to review referrals, outcomes from MDTs, results from investigations, queries from GPs and consultant colleagues, and dictate and sign off correspondence. This work is directly related to patient care and would normally attract an allowance of 1 PA, although an extra allowance should be allocated when the administrative burden is high.

3.7 On-call availability supplement

Most consultant urologists are required to participate in an on-call rota; the clinician will be paid a supplement in addition to basic salary, in recognition of his or her availability to work during on-call periods. The availability supplement will be paid at the appropriate rate set out in Table 2 below.

Table 2 Frequency of rota commitment and availability supplement

Frequency of rota commitment	*Value of availability supplement as a percentage of full-time basic salary for Category A duties*
1 in 1 to 1 in 4	8.0%
1 in 5 to 1 in 8	5.0%
1 in 9 or less	3.0%

The level of supplement will depend on both:

- the contribution of the consultant to the on-call rota, and
- the category of the consultant's on-call duties

Less than full-time consultants, whose contribution when on call is the same as that of full-time consultants on the same rota, should receive the appropriate percentage of the equivalent full-time salary.

While the employing trust will determine the category of the urologists on-call duties i.e. Category A or B, it is BAUS' strong view that Category A should apply to almost all urologists. The consultant is typically required to review emergency admissions and return immediately to the hospital when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, e.g. any emergency operative procedure.

3.8 Additional /extra programmed activities

Schedule 6 of the current consultant contract (2003) deals with extra programmed activities and spare professional capacity. Consultant urologists wishing to undertake private practice, and who wish to remain eligible for pay progression, are required to offer up the first portion of any spare professional capacity (up to a maximum of 1 PA per week).

Where a consultant intends to undertake such work, the employing organisation may (but is not obliged to) offer the consultant the opportunity to carry out up to 1 extra PA per week on top of the standard commitment set out in their contract of employment. In practice, many trusts are happy to do so, recognising that they get extra work from the consultant with little extra cost.

Schedule 6.2 of the terms and conditions of the current consultant contract sets out the provisions regarding offers to consultants and the periods of notice required. There is flexibility to agree a fixed number of extra PAs to be undertaken as required over the course of the year and trusts may find this provision particularly helpful in that arrangements can be tailored to reflect varying service needs.

One approach, for example, is to assess on a departmental basis how many extra PAs are likely to be required during the course of a year to temporarily increase capacity, for example for waiting list work, to cover clinics and lists, or to cover a vacancy.

4 Supporting Professional Activities (SPAs)

4.1 Categories of SPAs

The consultant contract (2003) defined categories of PAs. Within a full-time framework of 10 PAs, the contract states that a full-time consultant surgeon would normally devote on average 7.5 PAs per week to DCC and 2.5 to SPAs. However, over the past decade, many new consultant appointments have been made with a reduction in the number of SPAs and many urologists have found their SPA time reduced.

SPAs may include:

- continuing professional development (CPD)
- job planning
- appraisal
- participation in training
- medical education
- formal teaching
- audit (including the BAUS audits)
- research
- clinical management
- local clinical governance activities

CPD activities encompass clinical, personal, professional and academic activities. BAUS strongly supports the value of SPAs to ensure urologists have time to maintain and develop their skills, undertake CPD and contribute to the BAUS audits. Urologists are expected to gather evidence of audit and outcomes to support annual appraisal and revalidation.

BAUS concurs with the Academy of Medical Royal Colleges estimate that 1.5 SPAs per week is the minimum time required for a consultant to meet the needs for CPD for revalidation purposes. However, any job plan with only 1.5 SPAs leaves no time for teaching, undergraduate examination, research, trainee supervision, managerial input or clinical governance work outside of audit of personal practice. For these reasons, BAUS recommends the inclusion of a minimum of 2.5 SPAs in a 10 PA contract, enabling a consultant urologist to fulfil these commitments.

Expectations in relation to SPA allocation should be detailed in the job plan. Those consultants with less than full-time contracts will need to devote proportionately more of their time to supporting professional activities as they will have the same need as full-time colleagues to participate in continuing professional development.

Additional SPA time should be linked to the employing organisation's objectives, such as research, clinical management or specific medical education roles. Added SPAs should be evidenced by a commitment to training, teaching, research, governance etc. Individual urologists should be prepared to justify, through the job planning process, that their allocated SPA time is appropriate, or to negotiate for additional time as required. Table 3 illustrates some examples.

Table 3 *Suggested SPA allocations for additional Trust roles*

Activity	*Role*	*Duties*	*Allocation (SPA)*
Education	Specialty tutor (trainees and non-consultant hospital doctors)	Oversee job planning, educational development and yearly appraisal	0.5
	Assigned educational supervisor (per trainee)	Conduct PBAs, CEXs and CBDs Conduct interim and final review for ARCP	0.125-0.25
	Surgical tutor (RCS)	Support core surgical training and education within the hospital setting	1
	Undergraduate tutor (urology)	Range from occasional teaching events to co-ordinating student experience on a urology attachment	0.25-1
Audit and clinical governance	Unit governance lead	Oversee review of adverse incidents, complaints, risk register and SUIs	0.5-1
	Appraiser	Reading, critiquing, conducting and writing up appraisal	0.5-1 (depending on number of appraisals) or 4-6 hours per appraisal
	Audit	Overseeing and supporting unit strategy for audits and COP publications	0.25-0.5
Management	Clinical director (depending on size of department)	Developing and overseeing a complex range of strategic, operational and clinical responsibilities	1-2
	Clinical lead	Delivering strategic, operational and clinical responsibilities	1-2
	Rota co-ordinator	Developing a fair and equitable rota for consultant and junior colleagues	0.25-0.5
	Junior doctors' leads	May be responsible for day to day placement of junior doctors to meet both educational needs and department requirements	0.5-1
Research	e.g. NIHR funded studies	Recruitment to national trials	1-2

4.2 Additional responsibilities (Trust based)

These are special responsibilities agreed between a consultant and the employing organisation which cannot be absorbed within the time that would normally be set aside for SPAs. These activities will not be undertaken by the generality of consultants in the employing organisation.

Roles may include (the list is not exhaustive):

- Medical director
- Clinical director or lead clinician
- Clinical audit lead
- Clinical governance lead
- Undergraduate dean
- Postgraduate dean
- Clinical tutor
- Regional adviser

5 External Duties (Outside Trust)

In addition to DCC activity and SPAs, urologists often take on extra responsibilities outside the trust. Examples include (the list is not exhaustive):

- Medical Royal College work, including RCS England Invited Review Mechanism (IRM)
- Departments of Health
- BAUS work, including Trustees, Sections, Council
- Intercollegiate Board of Urology
- National Institute of Health Research (NIHR)
- National Institute for Health and Clinical Excellence (NICE)
- Regional Cancer Boards etc

Most of these types of work are not remunerated and consultants will need to work with their managers to determine what allocation of time may be appropriate. Trusts are not obliged to give a consultant in excess of 10 days per year (30 days per 3-year cycle) for study/professional leave, although some will choose to do so, recognising the wider benefits for the NHS. Where the work is regular, it should be set out and scheduled. Where it is irregular, an allocation of PAs can be agreed or there could be a substitution for other activities. The clinical director can approve up to 12 PAs of leave per annum to undertake external duties. Above this threshold, approval should be sought from the medical director. Where external duties beyond 12 PAs per year are carried out for another body (e.g. deanery/LETB/Departments of Health), agreement to substitute this activity for DCC activity is unlikely unless the full cost of the PA is recoverable from the other body. If the consultant and clinical director agree the consultant's clinical workload should remain the same, then additional PAs for DCC may be offered.

Any potential commitment to external duties is likely to impact on the service provided at trust level and this should be discussed with colleagues and management before applying for the post so that:

- the impact on service can be assessed and managed
- any potential benefits to the organisation can be identified
- there is fairness and transparency between team members at the outset

Opportunities to contribute in this way are likely to arise and vary during the course of a consultant urologist's career recognising that individuals may wish to take up additional responsibilities at different stages in their careers. Consultants and employers should agree outcomes for these activities and arrangements for reporting back to the employer and inclusion in the consultant's appraisal/revalidation folder.

6 Criteria for Pay Thresholds

Following the annual job plan review, the clinical manager who has conducted the review will report the outcome, via the medical director, to the chief executive. The report will be copied to the urologist, and to the chief executive of any other NHS organisation with which the consultant holds a contract of employment. For the purposes of decisions on pay thresholds, the report will set out whether the consultant has:

- made every reasonable effort to meet the time and service commitments in the job plan
- participated satisfactorily in the appraisal process
- participated satisfactorily in reviewing the job plan and setting personal objectives
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so
- worked towards any changes identified in the last job plan review as being necessary to support achievement of the employing organisation's objectives
- taken up any offer to undertake additional PAs that the employing organisation has made to the consultant in accordance with Schedule 6 of the consultant contract (2003)
- met the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 of the consultant contract (2003)

7 Leave Entitlements

7.1 Annual leave

A week's annual leave for a full time consultant is 5 days or 10 PAs. If the urologist has time out of the system during the week, he/she should not pro rata the week's annual leave.

The easiest way is to annualise the PA allocation for leave – 2 PAs per day of annual leave (for a consultant more than 7 years in post) = 64 PAs leave per annum. For time off that is less than a week, allocate the same number of PAs that a consultant would work in that day – e.g. 3 PA theatre day = 3 PAs of leave. This does not take into account the non-timetabled activity so a working week would always be equivalent to the number of PAs are worked in that given week, according to the job plan.

Consultants are entitled to annual leave at the following rates per year, exclusive of public holidays and extra statutory days:

Table 4 Annual leave entitlement against number of years of completed service as a consultant

Up to seven years	30 days
Seven or more years	32 days

The leave entitlements of consultants in regular appointment are additional to 8 public holidays and 2 statutory holidays or days in lieu thereof. The 2 statutory days may, by local agreement, be converted to a period of annual leave.

In addition a consultant who, in the course of his or her duty, was required to be present in hospital or other place of work between the hours of midnight and 9am on statutory or public holidays should receive a day off in lieu.

7.2 Professional and study leave

This includes:

- study, usually but not exclusively or necessarily on a course or programme, for CPD
- research
- teaching and assessment e.g. SAC in Urology etc
- examining or taking examinations eg undergraduate, MRCS, FRCS(Urol) etc
- visiting clinics and attending professional conferences for CPD
- training

The recommended standard for consultants is leave with pay and expenses within a maximum of 30 days (including off-duty days falling within the period of leave) in any period of 3 years for professional purposes within the United Kingdom.

8 Annualised Job Planning

Many consultants (those with senior managerial responsibility, single parents, clinical academics etc) do not have a working/domestic pattern that lends itself to preparing a job plan based on weekly activities. Both the consultant and the employing trust/health board (where applicable) may be best served by adopting a job plan that is wholly or partially annualised. A major advantage of an annualised job plan is that it will enable the trust to have a clear understanding of the activities a consultant will deliver on a yearly basis. Based on the numbers shown in the right hand columns of Appendix 4 (page 33), the yearly capacity of a unit to deliver urological services can be calculated along with the associated costs. In turn, this can inform the trust in its discussion with commissioners about the capacity and demands on the service.

Annualised job plans are likely to have some weekly fixed sessions and, in addition, will include the major responsibilities the individual will be expected to take on over the coming year and usually the relative amounts of time spent on each activity. The principles of job planning remain unchanged. The job plan should be a prospective document that sets out the requirements of the organisation and the priorities for the individual to meet those requirements. Like all other job plans it should include the objectives for the consultant, or team of consultants, and the support the organisation agrees to provide.

All, or part, of a job plan may need to be agreed on an annualised basis for the following reasons (the list is not exhaustive):

- where a consultant has a significant managerial role (e.g. a full time medical director)
- clinical variation
- social or domestic circumstances
- clinical academics

As an example - an individual and the organisation may agree that during 28 weeks of school term time, an individual works an 11 PA job plan. In the remaining weeks only 8 PAs are worked, with the total amount being averaged over the year to derive a 10 PA job plan. A description of working out an annualised job plan is detailed in Appendix 2 (pages 29-31).

9 Burnout Among Urologists in the Workplace

9.1 Rates of burnout in urologists and causative factors

The traditional characterisation of a consultant urologist/surgeon would include intense ambition, high intelligence, focus and organisation at work, and perfectionism. Such an achiever would be expected to thrive on stress rather than suffer burnout. Occupational burnout or job burnout is characterized by exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness, and also may have the dimension of frustration or cynicism. All these factors may contribute to reduced efficiency in the workplace. People experiencing burnout often do not see any hope of positive change in their situations. While clinicians are usually aware of being under a lot of stress, they do not always notice burnout when it happens. The same admirable personality traits of perfectionism and diligence actually predispose, rather than protect against, burnout.

In 2015, the British Association of Urological Surgeons and the Irish Society of Urology published their collaborative study in the BJUI revealing rates of self-reported burnout and causative factors among urologists. The study used an internationally accepted and reproducible research tool, the Maslach Burnout Inventory, which measures emotional exhaustion, depersonalisation and loss of personal achievement. Key findings from the cross sectional survey of 575 urologists were:

- 52% of respondents had high levels of emotional exhaustion and levels of depersonalisation
- 26% had moderate or high (29%) levels of emotional exhaustion
- 23% had moderate or high (27%) levels of depersonalisation
- 28% had moderate or high (31%) levels of loss of personal achievement

Self-reported burnout was more common in certain subgroups. Consultants reported higher levels than trainees, particularly those consultants under 44 years of age. Ethnicity was not a factor. While gender was not a factor overall, higher levels of emotional exhaustion were reported among females. Posts with responsibility or leadership were an adverse factor, whereas those with research commitments reported lower levels of burnout.

The top three reported stressors included:

- excessive administrative workload
- overall excessive work volume
- lack of institutional resources

The least three potential stressors reported included operating stress, clinical decision making and appointment status. It appears the old adage that a surgeon is happiest when left to operate in theatre applies.

8% of urologists reported seeking professional help for burnout and 7% had taken time off work. 1 1% reported taking prescription drugs to cope with burnout/depression/anxiety at work. A further 18% reported taking non-prescription drugs/alcohol to cope, more commonly amongst trainees (28%) than consultants (13%).

When asked, 80% of urologists considered medical staff should be evaluated in their workplace for symptoms of burnout. 60% reported they would avail themselves of workplace counselling if it was provided. 60% reported they would be happy to discuss burnout with their medical colleagues.

From a sociological viewpoint it may be uncomfortable to accept that consultant surgeons can suffer burnout but the findings do not surprise those in occupational health. Comparable rates are seen in non-medical high level positions. It is therefore important that the risk of workplace stress and burnout is now recognised and, where potential causes of breakdown are identified, these should be addressed and if possible avoided. It is also encouraging that urologists themselves feel there should be ongoing assessment for signs of burnout and they are willing to seek help in that eventuality. With the recent changes in pension arrangements, modern day consultants will be expected to work until

66-68 years of age or will face being penalised with their pension arrangements should they choose to retire early. Consultants in the latter stages of their careers are unlikely to have the same mental or physical reserves as their younger colleagues and new working arrangements will need to be developed to safeguard both the consultant staff and the service.

9.2 What help is currently available?

For any urologist suffering symptoms or signs that may be related to workplace stress, or in a burnout situation, there are agencies which offer help although services may vary in different locations. Hospital occupational health and GP services are available to all. Some trusts offer a specialist service for doctors in distress. Discussion with work colleagues can be most helpful. Advice may also be sought through the surgical Royal Colleges or the BMA Counselling Service (telephone: 0330 123 1245) which is staffed by professional telephone counsellors 24 hours a day, 7 days a week.

10 Appendices

Appendix 1 Specimen Consultant Urologist Job Plan

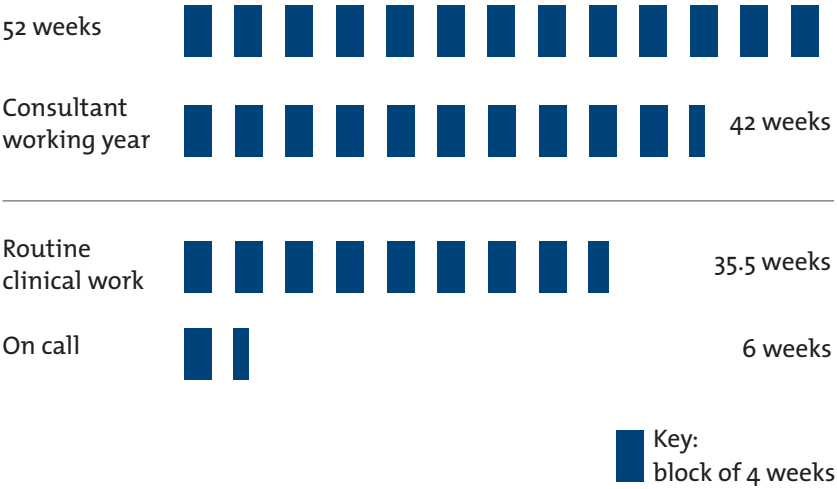
Based on an 11 PA contract with 1 extra PA of DCC activity, enabling the consultant to do private practice with 1:6 on call

Day Location	*Time*	*Work*	*Category*	*Number of PAs*
Monday	8am-9am	CPD	SPA	0.25
	9am-1pm	Flexi cystoscopy clinic	DCC	1
	1pm-3pm	Patient related admin	DCC	0.5
	3pm-5pm	Teaching	SPA	0.5
Tuesday	8am-12pm	One stop clinic	DCC	1
	12.30pm-1.30pm	Audit	SPA	0.25
	1.30pm-5.30pm	Urodynamic clinic	DCC	1
Wednesday	8am–12pm	Private practice		
	2pm-6pm	OPD	DCC	1
Thursday	7.30am-8.30am	Pre-op ward round	DCC	0.25
	8.30am-5.30pm	Theatre	DCC	2
	5.30pm-6.30pm	Management	SPA	0.25
Friday	9am-10am	Ward round	DCC	0.25
	10am-12pm	Patient related admin	DCC	0.5
	12pm-1pm	Journal club	SPA	0.25
	1.30pm-5.30pm	MDT	DCC	1
Predictable emergency on-call		Ward round on-call	DCC	0.75
Unpredictable emergency on-call		Emergency patient admissions	DCC	0.25
		Telephone consultations/advice		
Total				**DCC 9.5** **11 PA** **SPA 1.5**

Appendix 2 Working Out an Annualised Job Plan

The trust has a commitment to deliver elective and emergency urological services 52 weeks of the year. Most trusts recognise that consultants will work for 42 weeks of the year allowing for 6 weeks (30+ days, depending on seniority) annual leave, 2 weeks (10 days) professional/study leave and sundry bank holidays etc. Hence the cost to the trust of providing a designated session (PA) 52 weeks of the year is 52÷42 = 1.23.

Figure 1 Job plan for a consultant on a 1:8 with a 10 PA annualised job plan and no elective duties when on call



For a consultant on a 10 PA contract, 420 PAs of activity will need to be provided by the consultant annually. The precise nature of the PAs will depend on the requirements of the trust, frequency of on call and the services (clinical, managerial, educational etc) provided by the consultant.

Figure 2 ***Number of PAs of activity to be delivered based on type of contract***

Contract	*Annual number of PAs to be delivered based on 42 week working year*
12PA	504
11PA	462
10PA	420
9PA	378
8PA	336
7PA	294
6PA	252

For a consultant working in an 8 consultant unit, where all consultants take part in a dedicated on call rota, with no routine duties, each consultant will perform on call duties 6.5 weeks of the year, free of elective care. In a year:

- 35.5 weeks will be spent on routine activity
- 6.5 weeks will be spent on emergency care

Two elements need to be factored into provision of emergency care, namely routine clinical activity (ward rounds, urgent clinic reviews etc) and unpredictable activity in which a PA would be 3 hours ('premium time' - which for consultants is currently the hours between 7pm and 7am and all day Saturday and Sunday). For urology it is estimated that, when on call, there are 3 hours of unpredictable activity per day ie 21 hours or 7 PAs per week. When the consultant is on call, they are unlikely to be providing routine outpatient care and this is reflected in the reduced allocation of annualised PAs for a routine clinical session from 1PA to 0.845PAs. This is shown on the next page.

A consultant on a 1:8 rota will be engaged in routine clinical activity (i.e. not on call) for 35.5 weeks of the year. Annualised over a working year, each PA of activity can be calculated as follows - (35.5÷42) x1 = 0.845. As an example, a consultant doing a regular Tuesday clinic between 9am and 1pm will be working 0.845 PAs on an annual basis.

1 PA - 1 routine clinic 42 weeks per year

0.155 PA - No routine clinic when on call 6.5 weeks per year

0.845 PA - 1 routine clinic 35.5 weeks per year

The two right hand columns in Appendix 4 (page 33) show the true cost to the trust (in PAs) of providing elective and emergency care each week and on a yearly basis. This allows a trust to calculate its capacity to deliver outpatient care and the associated consultant costs. For a urology unit to see 8000 new patients per year, based on a one stop model with 8 new patients per clinic, 1000 single consultants' clinics (PAs) would need to be provided, recognising that a consultant on a 1:8 rota, with no elective commitments when on call, doing 2 new clinics per week, would be providing a total of 71 PAs and would see 568 patients.

With respect to emergency care, a trust would need to make provision for 827 PAs of DCC per year (52 weeks). This would allow for predictable on-call (ward rounds etc), unpredictable care (emergency review and theatre) and the provision of emergency/review clinics 5 days per week.

Appendix 3 Specimen Timetable for a Less Than Full-time Urologist with a Standard or Annualised Job Plan.*

Based on a consultant doing a 1:12 on call with 6 PAs per week

Day	*Time*	*Work*	*PAs*	*Number of annualised PA (based on 37.7 weeks routine work) and no routine work on call*
Monday	AM	OPD	1	0.897
	PM	Flexible cystoscopy	1	0.897
Tuesday	AM	One stop clinic	1	0.897
	PM	Revalidation / governance / AES /teaching	1	0.897
		On call (1:12)	0.5	0.5
Wednesday	All day	**Week 1** Operating list (with pre-op and post-op round)	2.5	2.24
		Week 2 Admin/ward rounds etc am	1	0.897
		TRUS/urodynamics pm	1	0.897
Total			6.25 PAs (average)	5.95

*A consultant wishing to work a 6PA week might prefer to work a standard 42 week year delivering care on a weekly basis. Alternatively, the consultant and the trust may be better served by a contract that reflects the constraints and demands on the service and/or family and domestic considerations. On an annualised contract the consultant would deliver 252 PAs of care during a 42 week working year across the spectrum of urological care.

Appendix 4 Time Allocation and Assigned PAs on an Annualised Contract

Activity	*Time allocation*	*PAs allocated*	*Total number of PAs per annum (working 42 weeks a year)*	*Trust requirements per week (52 week year)*	*Per year (PAs)*
Outpatient session	4 hour session	**0.845 PA**	**35.49 PAs**	(52X1)/42= **1.23 PAs**	1.23X52= **63.96 PAs**
Urodynamics/ flexi/TRUS	4 hour session	**0.845 PA**	**35.49 PAs**	(52X1)/42= **1.23 PAs**	1.23X52= **63.96 PAs**
Administration/ ward round/ meeting patients	1.5PA (allocation)	**1.5 PA**	**63 PAs**	**1.5 PAs**	1.5X52= **78 PAs**
MDT	0.5PA (allocation)	**0.5 PA**	**21 PAs**	**0.5 PA**	0.5 X52= **26 PAs**
Undergraduate teaching	2 hours (0.5 PA) 16 weeks per year	(0.5X16)/42 = **0.19 PA**	**7.98 PAs**		
SPA (audit, governance, training etc)	1.5 PA (allocation)	**1.5 PA**	**63 PAs**	**1.5 PA**	1.5X52= **78 PAs**
Theatre list	9 hours +1.5 hours pre- and post-op	2.625 **PAs**	110.25 **PAs**	(52x2.625)/42= **3.25 PAs**	3.25X52= **169 PAs**
On-call (based on 1:8)					
Predictable on-call (ward round etc)	2 hours, 7 days per on call week	0.5X6.5/42= **0.08 PA**	**3.36 PAs**	0.5X7= **3.5 PAs**	3.5X52= **182 PAs**
Emergency clinic (3 hours)	0.75 (3 hours)	(3.73X6.5) /42= **0.58PA**	**24.36 PAs**	0.75X5 days= **3.75 PAs**	3.75X52= **195 PAs**
Unpredictable on-call (3 hours per day)	7X3=21 hours/week or **7PA**	(7X6.5)/42= **1.08PAs**	**45.36 PAs**	7X52/42= **8.66 PAs**	8.66X52= **450.3 PAs**
Total			**362.72 PAs**		

Appendix 5 Specimen Timetable and Urologist Annualised Job Plan 10 PAs

Based on a consultant doing a 1:8 on call with 35.5 weeks devoted to routine clinical care and 6.5 weeks of emergency care

Day	*Time*	*Work*	*Category*	*Number of annualised PAs*
Monday	AM	OPD	DCC	0.845
	PM	Private practice		
Tuesday	AM	One stop clinic/urodynamic clinic	DCC	0.845
	PM	Operating list (16.5 weeks/year)	DCC	0.392 (16.5/42)
Wednesday	All day	Operating list (2.5 PAs)	DCC	2.113
Thursday	AM	MDT (stone/oncology) meeting	DCC	0.5
	PM	Research	SPA	0.845
Friday	AM	Clinical governance Benign firm weekly meeting	SPA	1
	PM	Clinic (18 weeks/year)	DCC	0.42 (18/42)
		Total		**4.615**

Annualised Job Plan		
Annualised clinical sessions	DCC	4.615
Admin/ward rounds etc	DCC	1.5
Urgent access sessions	DCC	1
On-call	DCC	0.875
Clinical meetings (MDT)	DCC	0.5
Research	SPA	0.875
Revalidation/governance etc	SPA	1
Assigned educational supervisor to 4 trainees; FRCS(Urol) examiner, MB examiner/medical student teaching	SPA	0.5
Total		**10.865**
Rounded Total		**10.5**

Appendix 6 Additional Reading

GMC. Good Medical Practice. Published 25 March 2013. Came into effect 22 April 2013.
http://www.gmc-uk.org/guidance/good_medical_practice.asp

NHS Employers. Consultant Contract [Terms and Conditions – Consultants (England) 2003]
http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/Consultant_Contract_V9_Revised_Terms_and_Conditions_300813_bt.pdfConsultant

The Academy of Medical Royal Colleges. Advice on SPAs in Consultant Job Planning. AOMRC, 8 February 2010.
http://www.aomrc.org.uk/wp-content/uploads/2016/05/AOMRC_Statement_2010-02-08_Advice_on_SPAs.pdf

The Royal College of Surgeons of England. Emergency Surgery: Standards for unscheduled care. Guidance for providers, commissioners and service planners. February 2011.
https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/emergency-surgery-standards-for-unscheduled-care/

BMA. Information on job planning – including detailed guides on job planning (via the link below). Includes A Guide to Consultant Job Planning (July 2011).
http://www.bma.org.uk/support-at-work/contracts/job-planning

Medical Protection Society. New Judgment on Patient Consent. 20 March 2015.
http://www.medicalprotection.org/uk/for-members/news/news/2015/03/20/new-judgment-on-patient-consent

The Supreme Court. Judgement: Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland). 11 March 2015.
https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf

Position Statement on the Management of Emergency Surgery at the General, Paediatric and Urological Surgery Interface. Association of Surgeons of Great Britain and Ireland, British Association of Paediatric Surgeons, British Association of Urological Surgeons, SAC in General Surgery, SAC in Paediatric Surgery, SAC in Urology. 2015.
https://fssa2015.files.wordpress.com/2015/03/fssa_interface_egs.pdf

ISCP Core Surgical Training. 2015.
https://www.iscp.ac.uk/curriculum/surgical/specialty_year_syllabus.aspx?enc=vVY4XFLbRSZIHhnkUDQyVoJGVh3MGYxzpEoYSpfvyok=

'Rates of Self-reported 'burnout' and causative factors amongst urologists in Ireland and the UK; a comparative cross sectional study'. O'Kelly, Fardod et al. BJUI Int, 2016; 117 (Issue 2):363-372.

Helpguide.org. Burnout Prevention and Recovery. Signs, symptoms and coping strategies for mental exhaustion.
http://www.helpguide.org/articles/stress/preventing-burnout.htm

British Association of
Urological Surgeons

Email: admin@baus.org.uk
Website: www.baus.org.uk

Aimee Crilly

Subject: FW:
Attachments: GP Access Times Update - January 2016.pdf

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 15 January 2016 10:45
To: Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Suresh, Ram <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>; McCaul, David <Personal Information redacted by the USI>; Reddy, Ekambar <Personal Information redacted by the USI>; Sam.Hall <Personal Information redacted by the USI>; Ted McNaboe <Personal Information redacted by the USI>; Burke, Catherine <Personal Information redacted by the USI>; Cooke, Elaine <Personal Information redacted by the USI>; Cowan, Anne <Personal Information redacted by the USI>; Hall, Pamela <Personal Information redacted by the USI>; Mulholland, Angela <Personal Information redacted by the USI>; Wortley, Heather <Personal Information redacted by the USI>; bagnal, Louise <Personal Information redacted by the USI>; Brenda McCartan <Personal Information redacted by the USI>; McKenna, Margaret <Personal Information redacted by the USI>; Nugent, Carol <Personal Information redacted by the USI>; Dignam, Paulette <Personal Information redacted by the USI>; Elliott, Noleen <Personal Information redacted by the USI>; Hanvey, Leanne <Personal Information redacted by the USI>; Loughran, Teresa <Personal Information redacted by the USI>; Robinson, NicolaJ <Personal Information redacted by the USI>; Troughton, Elizabeth <Personal Information redacted by the USI>
Subject:

Good morning,

Outpatient and inpatient waiting times that have been shared with GP's for your information.

Regards

Martina

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern Health and Social Care Trust
Access Times

Updated 11 January 2016

For queries in respect of current / projected access times please contact:

Maria Conway / Judith Anderson

Telephone: Personal Information redacted by the USI

OUT-PATIENTS

SPECIALTY	Access Standard/ Backstop	Maximum waiting time @ 31/12/15	End of January 2016 position	Access Target / Backstop will be met at end of January 2016
Symptomatic Breast Clinic	9-weeks	Red Flag & Urgents = 2-weeks Routine = 16-weeks	Red Flag & Urgents = 2 weeks Routine = 15 weeks	x
Breast Family History Clinic	9-weeks	11-weeks	13 weeks	x
Cardiology	9-weeks	49-weeks	46 weeks	x
Cardiology ICATS	9-weeks	35-weeks		
Cardiology - Rapid Access Chest Pain	2-weeks	3-weeks	3 weeks	x
Chemical Pathology	9-weeks	18-weeks	18 weeks	x
Colposcopy	9-weeks	6-weeks	6 weeks	✓
Dermatology	18-weeks	29-weeks	18 weeks	✓
Dermatology ICATS	18-weeks	34-weeks		
Endo-Diabetes	9-weeks	Endo = 66-weeks Diab = 48 weeks	Endo = 70 weeks Diabetes = 49 weeks	x x
ENT	9-weeks	42-weeks	44-weeks	x
ENT ICATS	9-weeks	13-weeks		
Gastroenterology	9-weeks	54-weeks	54 weeks	x
General Medicine	9-weeks	10-weeks	10 weeks	x
General Surgery	9-weeks	34-weeks	37-weeks	x
Geriatric Medicine	9-weeks	29-weeks	Acute = 9 weeks DHH Non-Acute = 28 weeks	✓ x
Geriatric Medicine: Ortho-Geriatric	9-weeks	64-weeks	64 weeks	x
Gynaecology	9-weeks	27-weeks	27 weeks	x
Haematology	9-weeks	41-weeks	45 weeks	x
Nephrology	9-weeks	11-weeks	9 weeks	✓
Neurology	9-weeks	51-weeks	51 weeks	x
Orthopaedics	13-weeks	56-weeks	60-weeks	x
Orthopaedic ICATS	9-weeks	32-weeks	30-weeks	x
Paediatrics	9-weeks	31-weeks	34-weeks	x
Pain Management	9-weeks	40-weeks	42 weeks	x
Thoracic Medicine	9-weeks	41-weeks	42 weeks	x
Rheumatology	18-weeks	59-weeks	62 weeks	x
Urology	9-weeks	77-weeks	81-weeks	x
Urology ICATS	9-weeks	64-weeks		

Notes

1. Oral Surgery Services are Managed by South Eastern Health & Social Care Trust

2. Ophthalmology & Paediatric Cardiology Services are managed by Belfast Health & Social Care Trust

IN-PATIENTS / DAY CASES

SPECIALTY	Access Standard/ Backstop	Maximum waiting time @ 31/12/15	End of January 2016 position	Access Target / Backstop will be met at end of January 2016
Breast Surgery	26-weeks	IP = 61 weeks DC = 27 weeks	IP = 65 weeks DC = 31 weeks	x x
Cardiology	13-weeks	46-weeks	44 weeks	x
Community Dentistry	13-weeks	<13-weeks	12-weeks	✓
Dermatology	13-weeks	22-weeks	25 weeks	x
ENT	13-weeks	IP = 23-weeks DC = 26-weeks	27 weeks	x
General Surgery	26-weeks	IP = 80-weeks DC = 80-weeks	84 weeks	x
Gynaecology	13-weeks	IP = 36-weeks DC = 19 weeks	IP = 37-weeks DC = 13 weeks	x ✓
Haematology	13-weeks	13-weeks	13 weeks	✓
Neurology	13-weeks	12-weeks	12 weeks	✓
Orthopaedics	26-weeks	IP = 83-weeks DC = 84-weeks	87 weeks	x
Pain Management	26-weeks	76-weeks	72 weeks	x
Rheumatology	26-weeks	22-weeks	21 weeks	✓
Urology	26-weeks	IP = 124-weeks DC = 125-weeks	128 weeks	x

DIAGNOSTICS

DIAGNOSTIC	Access Standard/ Backstop	Maximum waiting time @ 31/12/15	End of January 2016 position	Access Target / Backstop will be met at end of January 2016
Cardiac Investigations	9-weeks	27-weeks	29 weeks	x
Imaging	9-weeks	CT = 18-weeks	19 weeks	x
		USS = 23-weeks	23 weeks	x
		DEXA = 18 weeks	17 weeks	x
		MRI = 19-weeks	20 weeks	x
Neurophysiology	9-weeks	9-weeks	9 weeks	✓
Endoscopy	9-weeks	50-weeks	53-weeks	x
Audiology	9-weeks	8-weeks	9 weeks	✓
Sleep Studies	9-weeks	14-weeks	14 weeks	x
Urodynamics (Urology)	9-weeks	65-weeks	69-weeks	x

MENTAL HEALTH AND DISABILITY

Mental Health and Disability	Access Standard/ Backstop	Maximum waiting time @ 08/01/16	End of January 2016 position	Access Target / Backstop will be met at end of January 2016
Psychiatry of Old Age	9-weeks	18-weeks	16-weeks	x
Autism	13-weeks	14-weeks	13-weeks	✓
CAMHS	9-weeks	8-weeks	9-weeks	✓
Learning Disability	9-weeks	5-weeks	9-weeks	✓
Memory/Dementia Services	9-weeks	35-weeks	35-weeks	x
Primary Mental Health Care	9-weeks	27-weeks	13-weeks	x
Psychological Therapies	13-weeks	38-weeks	39-weeks	x

ALLIED HEALTH PROFESSIONALS

AHP	Access Standard/ Backstop	Maximum waiting time @ 04/01/16	End of January 2016 position	Access Target / Backstop will be met at end of January 2016
Physiotherapy	13-weeks	Adult = 26-weeks	24-weeks	x
		Paediatric = 17-weeks	18-weeks	x
Occupational Therapy	13-weeks	Adult = 41-weeks	45-weeks	x
		Paediatric = 40-weeks	37-weeks	x
Dietetics	13-weeks	Adult = 13-weeks	13-weeks	✓
		Paediatric = 35-weeks	33-weeks	x
Speech & Language Therapy	13-weeks	Adult = 17-weeks	13-weeks	✓
		Paediatric = 43-weeks	46-weeks	x
Podiatry	13-weeks	Adult = 34-weeks Paediatric = 32-weeks	33-weeks	x
Orthoptics	13-weeks	Adult = 19-weeks	17-weeks	x
		Paediatric = 17-weeks		x

Aimee Crilly

From: Elliott, Noleen <Personal Information redacted by the USI>
Sent: 10 February 2016 13:47
To: O'Brien, Aidan
Subject: FW: Personal Information redacted by the USI
Attachments: Personal Information redacted by .pdf

From: Coleman, Alana
Sent: 10 February 2016 13:11
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: FW: Personal Information redacted by the USI

Referral attached

From: Coleman, Alana
Sent: 10 February 2016 13:08
To: Elliott, Noleen
Cc: Browne, Leanne
Subject: Personal Information redacted by the USI

Hey Noleen,

Please ask Mr O'Brien to triage this referral – Patient overdue review from 09/2014, does this need to be expedited?

Many Thanks
Alana Coleman
Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH

(moved from AHP office to main office)
Tracking Code: CACRBC
Tel Personal Information redacted by the USI

Aimee Crilly

From: McVeigh, Shauna <[redacted]>
Sent: 26 February 2016 14:43
To: Campbell, Dolores; Connolly, Maureen; Cummings, Ursula; Dabbous, Marie; Davies, Caroline L; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Hazel.Cantley[redacted] Holloway, Janice; Jolyne OHare; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCreesh, Kate; McMahon, Jenny; McVeigh, Gerry; McVeigh, Shauna; Mukhtar, Bashir; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Robinson, NicolaJ; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; Tyson, Matthew; Ward, Ann; White, Deborah; Williams, Marc; Young, Michael
Subject: Urology word MDM minutes 25 02 16
Attachments: Urology word MDM minutes 25 02 16.doc

Hi

Please find attached minutes from Urology MDM 25.02.16.

Thanks

Shauna

MDT UROLOGY CANCER MEETING
THURSDAY 25th February 2016
VENUE: TUTORIAL ROOM 1, MEC

PRESENT
Mr Glackin (Chair), Mr Haynes, Mr O'Donoghue, Mr Mukhtar, Stephanie Reid, Dr Ervine, Kate O'Neill and Shauna McVeigh.

MINUTES

1. **APOLOGIES**
Mr O'Brien, Mr Suresh, Mr Young, Mr Brown, Dr Williams, Dr OHare

2. **MINUTES OF LAST MEETING**
E-mailed to the Urology MDM circulation list on 19th February 2016.

3. **PRESENTATION OF CASES**
Meeting started @ 2:15pm Meeting finished @ 4:00pm
36 cases were listed to be discussed.
Belfast City linked in.

4. **A.O.B**
It was highlighted in the meeting, as a concern, that there have not been full core members in attendance at MDT. We had clinical Consultant Urologists, Consultant Pathologist, clinical nurse specialist, and palliative care nurse specialist. We had no representation from radiology or oncology.

5. **DATE OF TIME OF NEXT MEETING**
The next meeting is to take place at 2.15 pm on **Thursday 25th February 2016,** Tutorial Room 1, MEC, CAH, Ennis Room, Belfast & DHH.

Aimee Crilly

From: Reddick, Fiona <[redacted]>
Sent: 16 December 2016 16:53
To: O'Brien, Aidan
Subject: Urology Peer Review report 2015
Attachments: Final Report for Urology 2015.pdf

Aidan,

Please find attached Urology Peer Review report for 2015 as promised.

Please do not hesitate to contact me should you require anything further

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Macmillan Building
[redacted]

PEER REVIEW VISIT REPORT
(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2015
Peer Review Visit Date	16th June 2015

Compliance

	Self Assessment	Peer Review
UROLOGY LOCAL MDT MEASURES	70.0% (14/20)	35.0% (7/20)

Zonal Statement

Completed By	Clare Langslow
Job Title	Quality Manager
Date Completed	18 June 2015
Agreed By (Clinical Lead/Quality Director)	Richard McMahon
Date Agreed	12 August 2015

Key Themes

Structure and function of the service

The peer review team was pleased to meet with good representation from all of the disciplines that constitute the Southern Health and Social Care Trust (SHSCT) urology multidisciplinary team (MDT) based at the Craigavon Area Hospital site.

The Urology configuration in Northern Ireland was reviewed and reorganised in 2009 to help address long waiting times and to move towards complying with the Improving Outcomes Guidance (IOG). Three urology cancer MDTs were agreed namely Southern, North West and the specialist MDT at Belfast. The County Fermanagh part of the Western Health and Social Care Trust (WHSCT) catchment area population was therefore included in the Southern Urology MDT and so the MDT covers a combined population of 409,832. The transfer of this work has been achieved relatively seamlessly as there was already a single urology team based on a single site at Craigavon. Some outpatient and diagnostic services are provided at South Western Acute Hospital (SWAH) in Enniskillen.

The MDT presented to the review team as being well led and with a vision for developments to

improve the service to patients. Core membership is complete with named cover in place. The MDT has a designated lead clinician and has then opted to rotate the chairing of the MDT meetings between the surgeons and this works well. Dedicated preview time for the MDT chair has been agreed so that there is good preparation for the MDT meeting to ensure smooth running.

The Trust has been successful in recruiting additional urology surgeons over the last 18 months so that they have increased from three to six which has enabled the surgeons to sub specialise. Two of the surgeons undertake only limited cancer procedures such as Transurethral Resection of Bladder Tumours and both attend the MDT when their patients are being discussed. The MDT also has input from a senior general surgeon with a special interest in urology and he undertakes very limited number of procedures and links into the MDT each week.

Histopathology is well represented at the MDT meetings and the core member participates in appropriate specialist External Quality Assurance programmes.

Oncology attendance continues to improve with the appointment of a medical oncologist based at the Trust and there is a good video link into the specialist MDT at Belfast for clinical oncology support.

Radiology attendance is problematic and more so due to long term absence which now leaves a single handed radiologist to provide the clinical services as well as MDT meeting cover. The MDT recognises this is a problem and is in discussions with the senior management team on how to resolve this problem.

There are two Clinical Nurse Specialists (CNSs) in post and their attendance at the MDT meetings is excellent. Specialist nursing services have developed with the CNSs undertaking flexible cystoscopy and Trans Rectal Ultrasound (TRUS) biopsy which is commendable. However, there are clear deficiencies in the completion of holistic needs assessments (HNA) for all patients and the identification of key workers and this needs to be addressed.

The surgeons' and CNSs' individual attendance is good with all achieving the 67% required. There was only one meeting recorded as having no histopathology attendance. In the reported year only six meetings had no radiologist but the review team is concerned that this has deteriorated since January 2015 with only a singlehanded radiologist in place. The medical oncologist only attended 58% of meetings but it was reported that this has improved and the clinical oncologist who links in from Belfast was only recorded as present at 31% of the meetings. Therefore, there were 16 meetings with neither oncologist present including a gap of 5 weeks and this needs to be addressed.

Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment.

The MDT meets on a Thursday afternoon starting at 2.15pm with a planned finish at 5pm. To ensure this, the number of patients to be discussed is capped at 40 to facilitate a full and robust discussion takes place for each patient. 48 meetings took place in the reported year.
The MDT chair has dedicated time to preview and quality assure the clinical summaries provided for each patient prior to the MDT meeting. This ensures that the multiple referral

pathways into the MDT are coordinated and appropriate information is readily available to ease decision making and avoid unnecessary repeat discussions. Patients are discussed alphabetically and this encourages all clinicians to stay for the duration of the meeting to present their patients and participate in all discussions. The plan for each patient is then completed in real time.

Any patients with prostate and bladder cancer that require radical pelvic surgery and radiotherapy are referred during the SMDT discussion. The MDT links into the specialist MDT at Belfast on a regular basis for specialist advice on particular patients.

There is a robust process in place if patients need urgent treatment before the next MDT meeting with discussion between at least two clinicians and patients are then discussed retrospectively.

The MDT coordinator and Cancer Tracker appear to play an important role in the smooth running of the MDT and at the start of each meeting highlight where patients are on the pathway so that cancer waiting times targets can be met.

Coordination of care/patient pathways

There is a NICaN Urology Network Site Specific Group (NSSG) that meets regularly. The MDT lead is the current chair so the MDT is well represented and there is feedback to the MDT.

The three MDTs comply with the European Association of Urologist (EAU) guidelines and the IOG when they have agreed with them and have had the capacity to do so. There have been challenges over those issues where there would not be agreement or where there is not the capacity to comply. The peer review process has supported the NSSG in commissioning draft guidelines, the vast bulk of which will collectively be agreed. However, there remain a range of issues which require discussion prior to proposing these to the commissioners for agreement. This process will start in September 2015 with a view to reaching conclusion with the commissioners in December 2015 so that the guidelines can be formally agreed and adopted.

The MDT runs a single visit, new patient clinic in a dedicated unit which has 24 patient slots. The number of red flag slots within this clinic can be flexed to meet the demand and this has helped even out the waiting times for appointments. The urology surgeons undertake advance triage of all referrals ensuring that essential imaging requests are made prior to patient attendance. Patients are directed to appropriate clinic appointments and patients are contacted to prepare them for additional investigations that may be undertaken. The clinic is supported by two surgeons and a middle grade doctor so that it runs smoothly. Flexible cystoscopy, ultrasound and TRUS biopsies may all be undertaken at the one visit. The CNSs are present at these clinics so that patients are supported at their diagnosis and identified to the MDT tracker. This in turn optimises patient flow at the MDT meetings and along the pathway reducing delays.

It was decided not to include urodynamics at this clinic to ensure smooth running and so patients return to another nurse led clinic if this is required.

There are secured slots in clinics for patients to be seen after the MDT meeting to discuss their treatment options. All patients have to be seen within two weeks and the clinicians will see each other's patients during times of leave to minimise delays.

The surgeons undertake two clinics per month at SWAT and try to ensure that patients are seen closer to home where appropriate.

Surgery including radical and partial (laparoscopic or open) nephrectomy, ureteric surgery, bladder tumour resection and radical inguinal orchidectomy are all performed on the Craigavon Hospital site. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated by national Guidance and this is outlined in the draft NICaN agreed clinical guidelines.

All radical pelvic urological surgery is referred to the Belfast City specialist MDT and patients are transferred for surgical and radiotherapy treatment.

Any patients choosing a Robotic Assisted Laparoscopic Prostatectomy will be referred to a robotic centre in the mainland UK. As yet there are no clear regional guidelines or arrangements on how these patients will be followed up on their return and this needs to be addressed by the NICaN NSSG.

Any patient requiring non-surgical oncological treatment is referred via the MDT to the Cancer Centre at Belfast City Hospital.

The MDT did not include a named stoma nurse in their extended team membership but were able to describe how patient would have access to this nurse if required.

Patient experience

The Trust participated in the regional National Cancer Patient Experience Survey and has also carried out a local survey. The MDT is currently looking at how to implement the recommendations, in particular regarding the lack of privacy for breaking of bad news on the ward.

Holistic needs assessment (HNA) has taken time to be implemented and this is being done in conjunction with introducing the key worker role. CNSs are present at diagnosis and therefore patients know who to contact and this is recorded in the patient records but not on the MDT proforma.

Patients are given written information on disease, support and are directed to national and local services. There is a Macmillan Information Unit on site where patients can access further support. There is no leaflet about the MDT explaining roles and members.

The Trust has developed strong partnerships with local charities and support centres. Generic support groups meet once a month on the Craigavon site and occasionally in Southern Area Hospice in Newry. Cancer Choices in Donaghmore, County Tyrone, and Charis near Cookstown, County Tyrone, both offer support to patients, their families and carers. A range of services are offered such as complementary therapies, counselling, welfare rights advice and short courses. Action Cancer provides complementary therapies for children and young people at its outreach centre in Lurgan, County Armagh.

Patients are not routinely copied into their consultation letters and the MDT needs to decide how to resolve this.

Psychological support for patients is readily available as required by onward referral.

NHS

Clinical outcomes/indicators

The Trust uses the Cancer Patient Pathway System (CaPPS) to record data.

The surgeons all contribute to the appropriate British Association of Urology Surgeon (BAUS) audits and have undertaken local audit on ultrasound for testicular cancer and TRUS biopsy and the results have been discussed.

The MDT has active pathway management with input on cancer waiting times targets focussed at the beginning of the meeting. This is working well and the MDT reported that there have been no breaches of the 62 day target since January 2015.

Patients suitable for oncology trials are identified by the oncologist and research nurse at the MDT meetings. These trials are however based out of Belfast and therefore there are no clear identifiable numbers of patients recruited for this MDT.

No activity data per surgeon was provided.

Communication

GPs are informed of MDT meeting outcomes by post within 24 hours of discussion. The MDT recognises that the timeliness of the postal service is challenging and is awaiting implementation of the Electronic Care Record (ECR) which will mean that the information is sent to the GP promptly.

Five out of the eight appropriate core members have attended the advanced communication skills training.

Good Practice

Good Practice/Significant Achievements

The implementation of the Single Visit Clinic.

Appointment of two additional consultant surgeons.

Well-structured MDT meeting with rotating chair.

Proactive 62 day pathway management and no breaches since January 2015

Secured slots in clinic following MDT meeting for patient discussion.

Protected preview time to allow preparation for the MDT meeting.

Immediate Risks Identified?

Not Identified

Immediate Risks

Immediate Risks Resolved?

Not Applicable

Immediate Risks Resolution

Serious Concerns Identified?

Identified

Serious Concerns

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

Trust response:
The Trust can confirm that the reduction of radiology provision to the urology MDT was entirely unpredictable. The Trust has taken appropriate measures and has advertised a replacement radiologist with urology interest/expertise.

2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment.

Trust response:
The attendance from clinical oncology at MDT has significantly improved over the past year, however, this improvement must continue and to this end HSCB are working with the Regional Oncology Centre to ensure adequate oncology cover at all MDTs.

3. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. Patients who have a diagnosis of urological cancer following routine referral have a significant delay in diagnosis and this could impact on the treatment pathways and significantly affect outcomes for patients.

Trust response:
All referrals to the Trust are triaged by consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients.

Whilst the urology service has increased their capacity to meet the current demand it has not addressed the previous backlog hence the increase in waiting times for routine referrals. The urology service is concentrating its resource on meeting the Red Flags and urgent demand, unfortunately this is at the expense of addressing routine demand. Also of note referrals into the urology service has increased by 20% since the service presented their original plan. The HSCB are aware of this increasing demand and plan to address demand as part of the Regional Review.

4. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the draft NICaN clinical guidelines.

Trust response:
The guidelines remain to be agreed by NICaN and HSCB, and it is intended that they will be by January 2016.

Serious Concerns Resolved?

Not Resolved

Serious Concerns Resolution

Concerns

Lack of implemented keyworker policy.

Lack of HNA and documentation.

No agreed pathway for follow up of patients after referral to mainland services.

No joint or parallel clinic in place to discuss treatment options.

Lack of agreed clinical guidelines.

Lack of data provided on local identification of patients suitable for recruitment to clinical trials.

Lack of a specific information leaflet describing the MDT function and roles.

Timeliness in communicating to GPs as reliant on postal service.

Not all appropriate core members have attended Advanced Communication Skills Training.

Aimee Crilly

Subject: FW: RF 1st Appointment Longest Wait.xlsx
Attachments: RF 1st Appointment Longest Wait.xlsx

Importance: High

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 25 July 2017 21:07
To: ONeill, Kate <Personal Information redacted by the USI>; McMahon, Jenny <Personal Information redacted by the USI>; McCourt, Leanne <Personal Information redacted by the USI>; Young, Jason <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Subject: FW: RF 1st Appointment Longest Wait.xlsx
Importance: High

FYI

Martina

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

Changed My Number

INTERNAL: EXT Personal Information *if dialling from Avaya phone. If dialling from old phone please dial* Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Graham, Vicki
Sent: 25 July 2017 15:27
To: Carroll, Kay; Clayton, Wendy; Corrigan, Martina; Devlin, Louise; Glenny, Sharon; McAreavey, Lisa; McStay, Patricia; McVey, Anne; Nelson, Amie; Reddick, Fiona
Cc: Carroll, Ronan; Muldrew, Angela; Trouton, Heather
Subject: RF 1st Appointment Longest Wait.xlsx
Importance: High

Hi,

Please see attached spreadsheet for current waiting times for RF 1st OPD's.

Extra Gastroenterology clinics are in the process of being set up for August and September so this should help bring waiting times forward.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by the *(Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

RF 1st Appointment Longest Wait

	09/01/2017	16/01/2017	23/01/2017	30/01/2017	06/02/2017	13/02/2017	20/02/2017	27/02/2017	06/03/2017	13/03/2017
Urology (Prostate)	24	26	24	25	36	55	30	31	32	31
Urology (Haematuria)	29	(51 x 1 upgrade) 22	33	25	40	26	29	28	26	24
Urology (Other)	24	N/A	22	12	14	35	46 & 1 x 73 (This is for x 1 referral - OC Late upgrade)	49 (1 x awaiting CT date- this is to be chased up)	21	17

20/03/2017	27/03/2017	03/04/2017	12/04/2017	24/04/2017	12/05/2017	22/05/2017	26/05/2017	05/06/2017	09/06/2017	23/06/2017	05/07/2017
31	30	29	39	31	29	28	27	27	22	30	27
21	25	27	35	31	30	26	23	27	23	30	27
15	18	22	21	37	35	26	27	25	17	36	19

17/07/2017	24/07/2017									
35	34									
30	30									
32	30									

Aimee Crilly

From: McVeigh, Shauna <[redacted]>
Sent: 22 September 2017 12:07
To: O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Jacob, Thomas; Young, Michael; McClean, Gareth; Williams, Marc; ONeill, Kate; Campbell, Dolores; McCourt, Leanne; Reid, Stephanie
Subject: FW: Urology MDT documents for Peer Review Self-assessment
Attachments: Self Assessment Peer Review Report Sept2017.pdf; Urology Self-Assessment matrix 2016.xml; Urology Cancer MDT Operational Policy Final May2017.pdf; Urology MDT Annual Report 2016 .pdf; Southern Urology MDT Workplan 2016-17.pdf

Importance: High

Hi

Please see below email.

Thanks

Shauna

From: Haughey, Mary
Sent: 22 September 2017 08:23
To: McVeigh, Shauna
Cc: Glackin, Anthony
Subject: FW: Urology MDT documents for Peer Review Self-assessment
Importance: High

Good morning Shauna
Tony asked if you could circulate the attached Urology MDT documents, which have been prepared for the peer review self-assessment process, to the Urology MDT members please?
The documents are as follows:

1. Urology self-assessment report
2. Urology self-assessment matrix
3. Urology MDT Operational Policy
4. Urology MDT Annual Report 2016
5. Urology MDT Workplan 2016/17

The documents will be uploaded on Friday 29th September 2017.
Many thanks

Regards

Mary

Mary Haughey
Macmillan Cancer Service Improvement Lead

Southern Health
and Social Care Trust
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
Internal Ext: Personal Information redacted by *(Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

Changed My Number

NICaN MDT Self-Assessment Report Proforma

Network	NICaN
Trust	Southern Health and Social Care Trust
MDT	Urology
MDT Lead Clinician	Anthony Glackin
Date	21st September 2017

Key Themes
Please provide comments including details of strengths, areas for development and overall effectiveness of the team. Any specific issues of concern or good practice should also be noted in the following sections. It is important to demonstrate any measurable change in performance compared to previous assessments.
Structure and function of the service
Comment in relation to leadership, membership, attendance and meeting arrangements, operational policies and workload.

The Urology MDT is held every Thursday from 2.15pm, with the exception of public holidays. There are video-conferencing facilities to Belfast Cancer Centre. Mr Anthony Glackin, Consultant Urologist, is the Lead Clinician of the MDT.
The Urology MDT is a well-structured MDT. Overall weekly attendance is good, however on some occasions this can be difficult due to competing demands.

The greatest challenge for the MDT during the past year has been the inadequacy of the availability of a clinical oncologist and or a radiologist at all MDMs. The inadequacy in both cases has essentially been due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the post where they are required. The inadequacies have been escalated to trust senior management team and are being addressed with the appointment authorities.

With increasing numbers of consultant urologists, the functions of Lead Clinician and of Chair of MDM have been separated to enhance active participation in and responsibility for MDM. The Chair of each MDM will have been decided when scheduling takes place at least one month previously. Scheduling has also ensured that time is allocated to the appointed Chair to preview in detail each Wednesday all of the cases to be discussed at MDM the following day. All of the required clinical summaries, results and reports of investigations will have been provided to the appointed Chair for preview. It also enables all multidisciplinary participants to preview cases and to prepare their contributions to the discussion of cases. This provision has greatly enhanced the quality of scrutiny and preparation for discussion of each case.

The quality of the conduct of MDM has been a singular achievement these past six years. The quality of participation has been enhanced by increasing the number of persons chairing, and by having time allocated for preview.

There had been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past few years, up from 2902 in 2013 to 4761 in 2015/16. The greatest increase was to the Southern Trust, with an increase of 84% from 410

in 2013 to 753 in 2014. The increase has continued and in 2016 there were 1878 red flag referrals.

For 2016, the 31 day performance for the SHSCT was 100% and the 62 day performance was 81% - this reflects the marked increase in GP red flag referrals for the trust.

The diagnostic and operative activity has been reflected in an increase in the numbers of specimens received by the Cellular Pathology Laboratory at Craigavon Area Hospital. Tissue specimens increased from 874 in 2014 to 903 in 2016.

It is notable that there has been an increase in the numbers of Prostate biopsies which reflects the use of MRI to avoid unnecessary TRUS biopsy.

Progress is ongoing in relation to the full implementation of the Key Worker, Holistic Needs Assessments, Communication and ensuring all patients are offered a Permanent Record of Patient Management. With the appointment of two more Nurses to the Thorndale Unit and Clerical Staff, all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner. It is intended that patients newly diagnosed as inpatients will also be included.

Coordination of care/patient pathways
Comment on coordination and patient centred pathways of care, network guidelines and communication.

The MDT adheres to the regional Urology Clinical Reference Group guidelines & patient pathways and these have been agreed at an MDT meeting. There are clear pathways in place for the management of Urology cancers. The network has agreed a pathway for the management of Teenage and Young Adult (TYA) cancer patients. When TYA's are discussed at MDM, the cancer tracker will inform the Trust TYA nurse who will ensure appropriate onward support / referral to the TYA regional service.

Patient experience
Comment on patient experience and gaining feedback on patients' experience, communication with and information for patients and other patient support initiatives.

Patient feedback and experience is very important in planning service development. Patients' views are taken on board through compliments, complaints and feedback through patient surveys. These are considered by the MDT to identify areas for improvement.

A regional cancer patient experience survey (NICPES) was carried out during 2015. 17% of the Southern Trust respondents were from Urology cancer patients. The majority of patients (90%) rated their care as excellent/very good.

A local patient survey was also undertaken in 2016. Response rates were overall complimentary of the service provided. Staff were said to be caring towards patients, giving sensitive but clear explanations of diagnosis and treatment. Verbal information was reinforced by written materials and patients were given adequate time and opportunity to ask questions. Results of the survey have been reviewed and discussed at an operational meeting and an action plan developed to address areas of weakness.

Patients are offered information by appropriate staff in a phased manner relevant to the stage of their journey. An MDT patient information leaflet has been developed and is provided to all patients along with core and site specific information.

For patients with sensory, cognitive or language difficulties bespoke information can be arranged via the Macmillan Health & Wellbeing Manager.
Additionally a regional interpreting service is offered with trained health related interpreters. The Trust also has a contract with the 24 hour telephone interpreting service to ensure that patients have support in the planned or emergency situation. For teenager and young adults, additional support is provided through the Regional Teenager and Young Adult (TYA) service, and appropriate information leaflets are available.

Clinical outcomes/indicators
Where available the data from the clinical indicators should be used. You should comment on the top five clinical priority issues for your team.

The urology MDT holds an annual business meeting to discuss the MDT workload over the previous 12 months. The figures are presented.

At this meeting audit activity is reviewed and suggestions made for future audit activity. There were two audits presented in the past year and data was also submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database:

-Audit on Bladder Cancer Access Standards for non-superficial disease, Mr David Curry, 2016
-Audit of Nurse Provided TRUS Biopsy Service in 2016, Sr Kate O'Neill
-Nephrectomy dashboard - data submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database in 2016

Good Practice/Significant Achievements
Identify any areas of good practice.

Trust Excellence Award to the Thorndale unit

Increased consultant capacity to meet 31 and 62 day targets

Four new clinics per week to provide equitable access to all Red flag referrals.

Appointment of two additional nurses and clerical staff to the unit

Allocation of named key worker to all newly diagnosed patients

Implementation of holistic needs assessment for all newly diagnosed patients

Development of permanent record of patient management

New MDT patient leaflet developed and provided to all patients

Specify Immediate Risks

Refer to the guidance on identifying concerns.

An "Immediate Risk" is an issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes and therefore requires immediate action.

Specify Serious Concerns

A "Serious Concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve.

Update on serious concerns highlighted from peer review assessment 2016:

Single handed radiologist with no cover arrangements in place – **Update**: this is still ongoing - radiology cover is a regional issue.

Only 11% of MDT meetings quorate due to low clinical oncology representation and lack of radiology cover – **Update:** arrangements have been made with Belfast Trust to ensure clinical oncology representation at MDT meetings.

Wait for routine referrals: **Update**: all referrals are triaged by consultants and may be upgraded to red flag or urgent which will reduce risk to patients

Nephron sparing surgery being undertaken locally – **Update:** this is no longer happening as Mr Mark Haynes is providing support to undertake nephron sparing surgery in Belfast City Hospital

Concerns

A concern is an issue that is affecting the delivery or quality of the service that does not require immediate action, but can be addressed through the work programmes of the services.

Highest percentage increase in red flag referrals across the region

Operating theatre capacity and operator time

Summary of the validation process
Describe how the process was undertaken..

A working group was established to examine documentation. The group consisted of Urology Clinical Lead, Urology Clinical Nurse Specialist, Head of Service & Service Improvement Lead. At regular intervals the documentation was circulated to MDT members for review and comments. Feedback was received and documents were adjusted accordingly. The Self-assessment was carried out by the Clinical Lead for the Upper GI MDT, the UGI Nurse Specialist, the Head of Service and a Lay reviewer, who also reviewed the patient information evidence.

Organisational Statement		
	Name & Role	Date
MDT lead agrees this is an honest and accurate assessment	Anthony Glackin MDT Lead Clinician	21st September 2017
Agreed by CEO representative		

Southern Health and Social Care Trust

Quality Care - for you, with you

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

Position	Director of Acute Services
Name	Ms Esther Gishkori
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017

Position	Clinical Director Cancer Services
Name	Dr Rory Convery
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017

Position	MDT Lead Clinician (on behalf of MDT members)
Name	Mr Anthony Glackin
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017

The MDT members agreed this Operational Policy on:

Date Agreed	**1st September 2017**
Operational Policy Review Date	**1st September 2018**

Southern Health and Social Care Trust

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Table of Contents

Introduction

This document outlines the Operational Policy for the Urology MDT and will be reviewed on an annual basis at the Annual General Meeting. It has been developed to ensure all relevant members of staff are aware of the purpose and organisation of the MDT meeting.

Background

The Southern Health and Social Care Trust (SHSCT) was formed on 1 April 2007. The Southern Trust (ST) is an integrated Trust, providing acute and community hospital services together with a range of community health and social services to a population of approximately 324,000 people.

Southern Trust Urological Cancer Services

The Southern Trust has provided a Urology service for patients living in the southern part of Northern Ireland since 1992. Outpatient services are located at a dedicated unit, the Thorndale Unit, based in Craigavon Area Hospital. The Unit is staffed by Consultant Urologists, Clinical Nurse Specialists, Staff Nurses and Health Care workers, in addition to visiting Radiographers and Radiologists.

Following a review of urological service provision in Northern Ireland in 2008/09, the trust took on responsibility for the provision of services to the population of County Fermanagh, with effect from 1st January 2013. County Fermanagh has a population of 61,175. More recently, the trust has agreed on a temporary basis to provide urological services to the population of and surrounding Cookstown, County Tyrone, bringing the entire catchment population to 427,000.

Within the SHSCT, urological cancer services include surgery to treat kidney, urothelial, penile and testicular cancers. The service does not provide radical pelvic surgery for prostate and bladder cancer.

In addition to all of the urological services provided at Craigavon Area Hospital, other services provided include endoscopic and day case surgery at South Tyrone Hospital in Dungannon, outpatient clinics at Banbridge Polyclinic, Armagh Community Hospital and South West Acute Hospital in Enniskillen, County Fermanagh.

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SECTION 1: STRUCTURE AND FUNCTION OF THE MDT

1.0 Purpose of the MDT

MDTs bring together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care for patients with cancer. MDT working has been advocated in each of the NICE Improving Outcomes Guidance and is strongly supported by clinicians.

The primary aim of the SHSCT Urology Cancer MDT is to ensure equal access to diagnosis and treatment for all patients in the agreed catchment area with Urological cancer. In order to achieve this aim we provide a high standard of care for all patients including: efficient and accurate diagnosis, treatment and ensuring continuity of care.

The MDT ensures a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of patients with Urological cancer with the aim of improving outcomes and to:

- Provide an opportunity for multidisciplinary discussion of all new cases of Urological cancer presenting to the team
- To assess newly diagnosed cancers and determine, in the light of all available information and evidence, the most appropriate treatment and care plan for each individual patient
- Ensure care is delivered according to recognised guidelines
- Ensure that the MDT work effectively together as a team regarding all aspects of diagnosis, treatment and care
- Facilitate communication with other professional groups within the hospital and between the MDT and other agencies e.g. primary care, palliative care
- Facilitate collection and analysis of high quality data to inform clinical decision making and to support clinical governance/audit
- Promote multidisciplinary decision making regarding the team's operational policies
- Support implementation of service improvement initiatives
- Ensure incorporation of new research and best practice into patient care
- Ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients fully informed consent
- Provide education to senior and junior medical, nursing and allied health staff.

1.1 Membership Arrangements

Core and extended membership of the Urology cancer MDT is detailed below:

Core Membership **(14-2G-101)**

Position	Name	Cover
Consultant Urological Surgeon*/**	Anthony Glackin	Aidan O'Brien Mark Haynes

Consultant Urological Surgeon	Aidan O'Brien	Anthony Glackin Mark Haynes
Consultant Urological Surgeon	Mark Haynes	Anthony Glackin John O'Donoghue
Consultant Urological Surgeon	John O'Donoghue	Mark Haynes Aidan O'Brien
MDT Co-coordinator	Shauna McVeigh	Member of Cancer Tracker Team
Consultant Clinical Oncologist**	Ciara Lyons (locum)	vacant
Consultant Radiologist	Dr Marc Williams	vacant
Consultant Histopathologist (EQA certified)	Dr Gareth McClean	Dr R.Shah Dr K.Dedic
Clinical Nurse Specialist***	Kate O'Neill	Dolores Campbell
Palliative Care Nurse	Stephanie Reid	Member of Palliative Care Nursing Team

** Lead Clinician*
*** Lead for clinical trial recruitment*
****Lead for patient involvement, information & service improvement*

Extended Membership **(14-2G-105)**

Position	Name	Cover
Consultant Urological Surgeon	Michael Young	Anthony Glackin Aidan O'Brien Mark Haynes
Consultant Psychologist	Dr Mary Daly	Mrs M.Duggan
Consultant in Palliative Care Medicine	Dr Tracy Anderson	Clinical Nurse Specialist
Stoma / Coloproctology Nurse Specialist	Claire Young	Clinical Nurse Specialist

1.2 Leadership Arrangements and Responsibilities **(14-2G-101)**

The Lead Clinician for the Urology Cancer MDT is Mr Anthony Glackin. The Trust and the Clinical Director for Cancer Services, Mr Rory Convery, have agreed the position and the responsibilities (See Appendix 1).

Key Responsibilities of the Lead Clinician:

- Chair the alternate week MDT meeting or delegate to a named deputy
- Ensure that patient management is planned and with input and consensus from the full panel of core members (or their nominated cover)
- Provide leadership for staff within the MDT and facilitate regular business meetings

- Lead the clinical activity of the MDT, working to agreed guidelines, ensuring a high quality integrated service which meets, local, regional and national standards.
- Provision of clear communication to all staff within the MDT and facilitation of effective team working
- Actively participate in the NICaN Urology network meeting and contribute to its work
- Ensure that regional clinical management guidelines are produced and revised regularly
- To be responsible for MDT performance monitoring against activity for National, Network and Trust targets
- To ensure that there are mechanisms in place to assess all patients with cancer for eligibility into clinical trials or research projects
- To ensure the collection of the appropriate cancer minimum dataset, working with the teams and MDT Coordinator
- To establish an audit programme and review of outcomes (this will include audits carried out across the Network)
- To ensure that local policies and guidelines are written, agreed and followed by the MDT and that these complement the Network guidelines
- Working in partnership with key stakeholders to lead on and promote a programme of service improvement and development for the MDT
- Ensuring the integration of patients/users and carers in assessment of service and service improvement

The Clinical Lead may wish to delegate some of these duties but will remain responsible for their completion.

1.4 MDT Quorum and Attendance (14-2G-102) (14-2G-104)

It is intended that all core members of the MDT attend at least two thirds of all meetings. However, in the event that a core member cannot attend they will agree an individual who will be expected to cover the MDT meeting in their absence. In addition the core members needed for a quorum or their cover should aim to attend all meetings so the MDT will be quorate for at least 95% of meetings.

The quorum for the urology cancer MDT is made up of the following core members or their cover: urology surgeon, clinical oncologist (with responsibility for chemotherapy), imaging specialist, histopathologist, clinical nurse specialist and MDT Co-coordinator.

It is the responsibility of the individual to sign in on arrival. A record of attendance of meetings will be kept by the MDT coordinator. Attendance records of the MDT will be calculated on a quarterly basis and fed back to the individual core member.

1.5 Chairing of meetings

The chairing of MDMs has been shared by Mr Glackin, Mr O'Brien and Mr Haynes on a rotational basis. Mr O'Donoghue joined in chairing on a rotational basis during 2016. The person appointed to chair each MDM is decided at least one month previously, when a period of time equivalent to one session is allocated to the appointed Chair to preview all cases one day prior to the MDM. Adequate preparation time is included in Job Plans and in a pro rata, annualised, quantitative manner.

1.6 MDT Review (14-2G-103)

The MDM takes place every Thursday, unless otherwise notified, and begins promptly at 14:15 in the tutorial room, Medical Education Centre in Craigavon Area Hospital. The meeting takes place in a room with video conferencing facilities, enabling communication by video to Daisy Hill Hospital, Newry, and with the Specialist MDM in Belfast.

Video conferencing with the Specialist MDT is scheduled to take place at 3.30 pm, or as soon as is mutually convenient thereafter.
It is the policy of the Southern MDT that all MDMs should finish by 5 pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 40 in order to enable the MDM to finish by 5 pm.

All new cases of Urological cancer and those following Urological biopsy will be discussed. Patients with disease progression or treatment related complications will also be discussed and a treatment plan agreed. Patient's holistic needs will be taken into account as part of the multidisciplinary discussion. The Clinician who has dealt with the patient will represent the patient and family concerns and ensure the discussion is patient-centred.

All meetings are supported and organised by the MDT Coordinator. The MDT Coordinator is responsible for collating the information on all patients being discussed and ensuring that all the necessary information is available to enable clinical decisions to be made.

Responsibilities of the MDT Coordinator:

- Ensuring all cancer patients are discussed at the MDT meeting
- Inserting notes onto the pro forma and ensuring it has been signed-off as being a correct record of the meeting's discussion (this forms the main body of the MDT letter to GP)
- Insertion of clinical summaries and updates onto CaPPs
- Filing the pro forma into the relevant notes and forwarding a copy to the oncology department of those patients who need to be referred to the oncologists
- Posting a summary sheet or the pro forma to the referring General Practitioner within 24 hours of the MDT discussion taking place
- Recording the MDT attendance for every meeting
- Adding any patient on the MDT list not discussed (notes, films or results missing, lack of time), to the following week's list

- Prospectively track all patients with cancer or suspected cancer in achieving the regional cancer access targets
- Ensuring that all patients with cancer or suspected cancer have pre booked appointments and treatment in line with cancer access targets and to raise delays with the MDT
- Ensuring that direct referrals or inter trust transfers are implemented
- Liaising with the Specialist MDT Co-ordinator prior to any MDM when it is intended to discuss patients with that MDM
- Maintaining timely and accurate data collection, within the databases

Referrals to the MDT meeting

All referrals to the MDT meeting should be through any core member of the team to the MDT Coordinator who will then add the patient to the MDT list for discussion.

Clinicians will place cases for presentation onto the meeting agenda by informing the MDT Coordinator of the relevant case details by the day before the MDM at 12.00 hrs. In all instances it is the responsibility of the presenting clinician to ensure all appropriate clinical results are available for the meeting.

MDM Documentation

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

It is the responsibility of both the MDM Chair and the MDT Co-ordinator to ensure the accuracy of the completed textual record of Clinical Summaries, Updates and MDM Plans of all patients discussed at the MDM, and so that the documentation, in correspondence format, may be sent without delay to Family Doctors and to other clinicians to whom it had been agreed patients would be referred (see Appendix 2).

1.7 Protocol for taking action between meetings (14-2I-203)

When clinical circumstance dictates it may be necessary to give patients results and decide treatment plans prior to the next MDT meeting. The clinician responsible for the patient's care may contact the relevant member by telephone to arrange the management. These decisions will be recorded in the patient notes. Additionally this decision will be subsequently discussed and endorsed at the next MDT meeting. The MDT Coordinator will ensure that results from any investigations (including those initiated as part of the agreed emergency plan) are available.

1.8 Virtual MDM

As the numbers of patients discussed at each MDM has increased, it has been necessary to limit the number discussed at each meeting to 40 in order to ensure and maintain the quality of discussion of each patient. On occasion, when it has not been possible to have a MDM this has resulted in a backlog that may take a number of weeks to clear, resulting in delays in progressing the investigation, diagnosis and management of patients in a timely manner. In 2015, the MDT decided to experiment with the concept of a Virtual MDM where an appointed Chair would preview all cases who would have been discussed on the date on which it was not

possible to hold a MDM, arriving at considered MDM Outcomes, which are circulated by email, as soon as is possible thereafter, to all core members, seeking their comments and proposed amendments, before being recorded on CaPPS, the Northern Ireland Electronic Care Record and sent to Family Doctors. It was also the experience of the MDT that the availability of histopathological reports enabled the further assessment and management of many patients to be advanced without controversy or further delay. Dr McClean has ensured that histopathological reports have been agreed and issued to the Chair of Virtual MDM. The MDT has found this practice to be successful and it has been adopted as its routine practice on such occasions.

SECTION 2: CO-ORDINATION OF CARE/PATIENT PATHWAYS

2.1 Clinical Guidelines and Pathways (14-2G-106) (14-2G-110)

The MDT has participated through the Northern Ireland Cancer Network in the development of Clinical Guidelines and Pathways for Urology cancer. This includes referral to the regional Teenager & Young Adult service as appropriate for patients aged between 14-25 years.

2.2 Regular Prostate Clinic & Regular Haematuria Clinic(14-2G-107) (14-2G-108)

There are four New Clinics held each week in the Thorndale Unit. The maximum configuration of a New Clinic is that it will be staffed by two Consultant Urologists and by one Specialist Registrar, and at which a maximum of 24 patients will attend, 9 for each Consultant and 6 for the Registrar. The numbers of patients appointed are reduced pro rata depending upon attending doctors. Red Flag referrals are given priority of appointment. Each Consultant Urologist has one New Clinic each week.

The New Clinics are also staffed by Clinical Nurse Specialists and Practitioners, Health Care Assistants and Radiographers, in order to facilitate patients having further assessment during their visit to the New Clinic. Further investigations include ultrasound scanning of the urinary tract, mictiometry, flexible cystoscopy and transrectal, ultrasound guided, prostatic biopsies. It is also usual to have scrotal ultrasound scanning performed if there is a suspicion of testicular tumour. The purpose of advanced triage and of attendance at the New Clinic is that the New Clinic appointment has an enhanced prospect of having the patient reassured and discharged, requiring more complex assessment, listed for MDM discussion or placed on a waiting list for surgery.

2.3 Agreed Policy for Patient Access to MDT to Discuss Treatment Options (14-2G-109)

Patients with early (organ-confined) prostate cancer, high risk superficial bladder cancer and muscle invasive bladder cancer are referred to the Specialist Urology MDT in Belfast Trust whereby patients will be offered a meeting to discuss treatment options prior to deciding which modality of treatment to use. Patients with early (stage 1) penile cancer are discussed at the local MDT and will be offered a meeting with relevant specialities to discuss treatment options

Patient Review following MDM discussion

If it has been agreed at MDM that the patient is to be reviewed to be advised of the further assessment or management as recommended by the MDT and stipulated in the MDM Plan, a Review Appointment will be made at the Oncology Review Clinic of the responsible Consultant Urologist. Each is provided with six oncology review slots per week. It is the policy of the MDT that all patients are reviewed by the end of the first week following their MDM discussion. If that is not possible, the Chair of MDM

may exercise the right to allocate the review of any patient to that of another consultant, if possible, and if it is considered pertinent to do so.

When it has been concluded by the MDT that a patient's further management may have options, as may be the case in organ confined, prostatic carcinoma, then the patient will be advised of all of those options at review, and will be provided with written information regarding each option. Importantly, it is the policy of MDT that such patients are offered the opportunity of referral to consultant specialists relating to each management modality, such as oncologists, for their further advice, so that the patient may arrive at an optimally informed choice.

2.4 Treatment Planning **(14-2G-111)**

All applicable patient information should be available for the case discussion to proceed.

Case discussion incorporates the patient's age, clinical condition and any psychosocial aspects impacting on clinical management. All patients are discussed at diagnosis or prior to this where confirmation of malignancy is complex.

The MDT should agree and record the multidisciplinary treatment planning decision (i.e. to which modality of treatment - surgery, oncology, best supportive care).
The CaPPS system is used for collecting data on patients and documenting MDT decisions.
The MDT outcome report (Appendix 2) acts as the patient's individual treatment plan and includes:

- The patient's identity
- The diagnosis at the time of making the referral decision: benign, malignant (with histological confirmation), malignant (without histological confirmation)
- The multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment – surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration)
- Confirmation that the holistic needs of the patient have been taken into account

Investigation plans and treatment recommendations are formulated during the meeting and recorded in narrative format by the MDT Co-coordinator.
The chairperson should articulate a summary of the recommendations arising from the discussion before proceeding to the next case.

2.5 Attendance at the Network **(14-2G-110)**

A representative from the team will attend the Network Meetings as follows:

- The MDT will provide representation from either the Lead Clinician or a deputy to all the meetings with minimum attendance of two thirds of meetings.
- The MDT will engage with the Network to develop and implement network-wide clinical, referral, imaging and pathology guidelines.

Mr Aidan O'Brien was Clinical Lead of the network's Urology Clinical Reference Group from January 2013 – January 2016. Mr Mark Haynes has taken up the Clinical Lead post from September 2016.

2.6 Supportive Care and Rehabilitation Services

A comprehensive range of supportive care and rehabilitation services are available for Urology cancer patients. Referral to these services can be made by members of MDT, directly or by way of MDM, by Key Workers, while some can be accessed by patients directly.

2.6.1 Physiotherapy Services

A wide range of physiotherapy is available at Craigavon Area Hospital and to varying degrees at all the other hospitals within the catchment area of the Urology Service.

2.6.2 Stoma Care Services

A readily accessible, stoma care service is available at Craigavon Area Hospital.

2.6.3 Clinical Psychology & Counselling Services

Dr. Mary Daly, Consultant Clinical Psychologist, is an extended member of the Urology MDT, and is based in the Bluestone Unit at Craigavon Area Hospital.
Two nurse counsellors, Mrs Mavis Dougan and Ms Terri Deehan, have been funded by Cancer Focus NI, are based at Craigavon Area Hospital.

2.6.4 Community Continence Services

There is a Community Continence Service serving the entire catchment area and its population. Referrals are made by email and by any member of the MDT, Key Workers and other nursing staff, at any time. The response to referrals is impressively prompt. The service is highly regarded by MDT.

2.6.5 Pre-chemotherapy Education Sessions & Helpline

All patients requiring chemotherapy are invited to attend a pre-chemotherapy education session in the Mandeville Unit at Craigavon Area Hospital. A 24 hour Helpline service is available for advice and support for patients who are receiving chemotherapy.

2.6.6 Complimentary Therapies

A reflexologist provides complimentary therapies on Mondays and Tuesdays in the Mandeville unit at Craigavon Area Hospital. Cancer Focus NI also provides Art therapy at Craigavon Area Hospital.

2.6.7 Welfare Services

Citizens Advice Bureau (CAB) representative Siobhan Edgar offers financial and benefits advice. Nursing staff record details of patients requiring CAB consultation and Siobhan then phones the patient to arrange a suitable appointment.

2.6.8 Macmillan Cancer Support

Macmillan Cancer has an information centre located in the reception foyer of Craigavon Area Hospital. In association with the Southern Trust, Macmillan also conduct a six-week course called **H.O.P.E** (Helping to Overcome Problems Effectively) aimed at helping patients with cancer manage the day-to-day impact of living with the disease.

2.6.9 Other Support Services

The Southern Trust has developed strong partnerships with local charities and support centres which offer a range of services such as complementary therapies, counselling, family support, welfare rights advice and short courses etc.
Information about these groups and services are available in the Macmillan Information Centre.

SECTION 3: PATIENT EXPERIENCE

3.1 Key Worker (14-2G-113)

The identification of the Key Worker(s) will be the responsibility of the designated MDT Core Nurse member.

It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each Urology cancer patient has an identified Key Worker and that this is documented in the agreed Record of Patient Management. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6). It is the intent that all Key Workers will have attended the Advanced Communications Skills Course.

Patients and families should be informed of the role of the Key Worker. Contact details are given with written information, and in the Record of Patient Management.

As patients progress along the care pathway, the Key Worker may change. Where possible, these changes should be kept to a minimum. It is the responsibility of the Key Worker to identify the most appropriate healthcare professional to be the patient's next Key Worker. Any changes should be negotiated with the patient and carer prior to implementation, and a clear handover provided to the next Key Worker.

Urology Clinical Nurse Specialists and Practitioners should be present or available at all patient consultations where the patient is informed of a diagnosis of cancer, and should be available for the patient to have a further period of discussion and support following consultation with the clinician, if required or requested. They may also be present, and should be available, when patients attend for further consultations along their pathway.

Key responsibilities of the Key Worker:

- Act as the main contact person for the patient and carer at a specific point in the pathway
- Should be present when the cancer diagnosis is discussed and any other key points in the patients journey
- Offer support, advice and provide information for the patient and their carers, referring to Macmillan Information and Support Service as appropriate to enable access to services
- Ensure continuity of care along the patients pathway and that all relevant plans are communicated to all members of the MDT involved in the patients care
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patients care

- Support the patient in identifying their needs, review these as required and co-ordinate care accordingly
- Liaise and facilitate communication between the patient, carer and appropriate health professionals and vice versa
- Offer verbal and written information with regard to diagnosis, investigations, treatment options and support groups
- Assist to empower patients as appropriate

3.2 Patient Information **(14-2G-114)**

The key worker will offer the patient and their carers a core information pack and a variety of information at various stages of their pathway, pertaining to their condition as well as any diagnostic procedures or treatments.

This information includes information specific to the MDT's cancer site and its treatment options (including names and functions / roles of the team treating them), information specific to that MDT about local provision of services, information about patient involvement groups / self-help groups, information about services offering psychological, social/cultural, financial information and effects of living with cancer and dealing with its emotional effects.

For patients with sensory, cognitive or language difficulties bespoke information can be arranged via the Macmillan Health & Wellbeing Manager.
Additionally a regional interpreting service is offered with trained health related interpreters. The Trust also has a contract with the 24 hour telephone interpreting service to ensure that patients have support in the planned or emergency situation.

Patients are offered information by appropriate staff in a phased manner relevant to the stage of their journey. For teenager and young adults, additional support is provided through the Regional Teenager and Young Adult (TYA) service, and appropriate information leaflets are available (see TYA regional pathway Appendix 5).

3.3 Permanent Record of Consultation **(14-2G-115)**

At a results clinic an identified member of the multidisciplinary team will effectively convey the patient diagnosis and recommendations of the meeting to the patient, to assist them in participating in decision making about ongoing treatment and care. This should be undertaken in line with the Trust Breaking Bad News policy. The patient should be given the opportunity to have a family member or friend with them.

During 2016, the MDT discussed the developmental priority of ensuring that all newly diagnosed patients had a key worker, had core and tumour specific information provided, had a holistic needs assessment conducted and any needs addressed. The MDT also discussed the format of a Record which would include details of the patients' diagnoses and management, and would include a check list of key worker, information, holistic needs assessment and actual needs or concerns (Appendix 3). The MDT agreed to initially pilot the implementation of the patient record for three

months (from 1st October – 31st December 2016) and to seek feedback from all clinicians before fully implementing.

3.4 Patient Feedback (14-2G-116)

Feedback from service users is obtained on a regular basis both formally and informally. Feedback on patient's experience will be sought using a range of mechanisms including patient surveys, focus groups, complaints, compliments, and participation in the patient and public involvement processes within the Trust.

The Trust has participated in a regional Cancer Patient Experience Survey exploring the patient experience throughout their cancer journey, and completed a local patient feedback survey. Findings have been presented and discussed at an operational meeting and an action plan agreed.

Complaints and compliments will be monitored by the Head of Service and lessons learned will be discussed in the Operational Meetings.
There is the opportunity via the Cancer Services User Forum to present new service developments or information leaflets to capture patients' views.

SECTION 4: CLINICAL OUTCOMES/INDICATORS

4.1 Clinical Indicators Review/Audit (14-2G-217)

The MDT will annually review its data and discuss progress of audits or discuss the completed results, as relevant, of audits. These should be presented at one of the regular network group meetings.
Data on compliance with the Cancer Access Standards in relation to the 31 and 62 day targets will also be reviewed.

4.2 Clinical Trials (14-2G-218)

Clinical trials in Urological Cancers are conducted in Northern Ireland, either as participants in UK and International studies, or designed by the Cancer Centre in Belfast. Recruitment of Urological Cancer patients to clinical trials now accounts for over 20% of all cancer patients recruited to cancer clinical trials in Northern Ireland.

The MDT will promote recruitment to clinical trials both locally and regionally with support from the Clinical Trials Research Nurse. The MDT should produce a report at least annually on clinical trials, for discussion with the network group.

4.3 Attendance at Advanced Communication Skills Training (14-2G-219)

All core members of the team who have direct clinical contact with patients will have attended the national advanced communications skills training.

4.4 Communication with Primary Care (14-2G-220)

The importance of timely communication with primary care is essential.
Where a patient is given a diagnosis of Urology cancer it will be the responsibility of the relevant MDT member to ensure that the patients GP is informed in writing by the end of the next working day of the diagnosis being given (Appendix 4).
An audit of timeliness of GP notification will take place annually.

APPENDIX 1: Clinical Lead appointment letter

Southern Health
and Social Care Trust

.....
Consultant Urology Surgeon,
Craigavon Hospital.

October 2016

Dear Mr Glackin

Re: Clinical Lead for the Urology Cancer Team

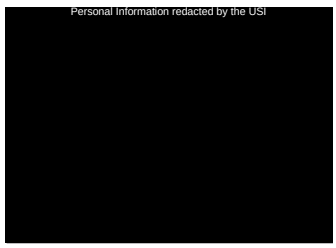
Further to our recent discussion, I understand that the Urology cancer team members have nominated you as the clinical lead for the service.

I would like to confirm your position as Clinical Lead for the Urology Cancer Service from the XXXXX. This term of office will be for an initial 3 years, after which time it will be reviewed.

The role and responsibilities for the lead are detailed in the operational policy for the service.

I would like to welcome you to the wider Cancer team and thank you for your agreement to act as the Clinical Lead.

Yours sincerely



Rory Convery (Dr)
Clinical Director
Cancer Services

APPENDIX 2: MDT Outcomes Proforma

MDM Report from Urology MDM @ The Southern Trust

RE: xxxxxxxxxxxxxx
Address:xxxxxxxxxxxxxx
DOB, Hospital Number: xxxxxxx , HCN: xxxxxxx
Contact Tel: xxxxxxxxxxx

MDM Report from the Urology MDM @ The Southern Trust on 13/10/2016
Diagnosis Renal clear cell carcinoma
Histology Clear cell adenocarcinoma, NOS,
Laterality: left

MDM Update
CONSULTANT MR GLACKIN: This Personal Information redacted by the HSI old man was found to have a solid, left renal lesion on ultrasound scanning in April 2016. His previous medical history included recurrent bouts of vertigo.

Renal CT scanning on 11 May 2016 confirmed the presence of an enhancing mass lesion in the upper pole of the left kidney, highly suspicious for renal cell carcinoma.

Discussed @ Urology MDM 26.05.16. This gentleman has been found to have a lesion of the upper pole of his left kidney, characteristic of a renal cell carcinoma, and considered suitable for partial nephrectomy. For review by Mr Glackin to arrange a CT chest, a DMSA renogram and to arrange surgery.

There was no evidence of thoracic metastatic disease on CT scanning of his chest in July 2016. Renography in August 2016 indicated that his left renal differential function was 45%. Mr XXXXXXXXX was admitted on the 30th September 2016 for a Left Open Partial Nephrectomy.

Histology showed a clear cell adenocarcinoma. Fuhrman nuclear grade III. Tumour necrosis - no. Local invasion - pT1a. Lymphovascular invasion - no. Lymph nodes - none submitted. Margins – on macroscopic examination, tumour was present at the base margin. This was confirmed microscopically. pT1a.

MDM Action
Discussed at Urology MDM 13.10.16. This gentleman has had a renal cell carcinoma of his left kidney resected by partial nephrectomy. The patient has been advised of the pathological findings.

For review by Mr Glackin in 6 weeks to request a renal CT scan in January 2017. To be rediscussed at MDM with CT report.

Radiology
CT Findings
Latest Findings from CT performed on 25/07/2016

CT chest without contrast.
Findings
No lung mass seen. There is no hilar or mediastinal lymphadenopathy.
No bony lesion visualised.

Conclusion
No thoracic metastasis seen.

Comorbidity Summary
Vertigo

APPENDIX 3: MDT Letter to GP

Urology/Head & Neck MDM @ the Southern Trust

<GP Name>
<GP Address>
<GP Address>
<GP Address>
<GP postcode>

RE: <Patient Name>
<Patient Address>
<DOB>, <Hospital Number>, <HCN>

Dear <GP Name>

This patient was discussed at the Urology MDM @ The Southern Trust
On 13/10/2016.

Diagnosis: Renal clear cell carcinoma

MDM Update:
CONSULTANT MR GLACKIN: This Personal Information redacted by the USI old man was found to have a solid, left renal lesion on ultrasound scanning in April 2016. His previous medical history included recurrent bouts of vertigo. Renal CT scanning on 11 May 2016 confirmed the presence of an enhancing mass lesion in the upper pole of the left kidney, highly suspicious for renal cell carcinoma.

Discussed @ Urology MDM 26.05.16. This gentleman has been found to have a lesion of the upper pole of his left kidney, characteristic of a renal cell carcinoma, and considered suitable for partial nephrectomy. For review by Mr Glackin to arrange a CT chest, a DMSA renogram and to arrange surgery.

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MDM Plan:
Discussed at Urology MDM 13.10.16. This gentleman has had a renal cell carcinoma of his left kidney resected by partial nephrectomy. The patient has been advised of the pathological findings. For review by Mr Glackin in 6 weeks to request a renal CT scan in January 2017. To be rediscussed at MDM with CT report.

Appendix 4

Department of Urology

Patient Record Of Management

Addressograph label or patient details
Patient Name
DOB
H&C Number

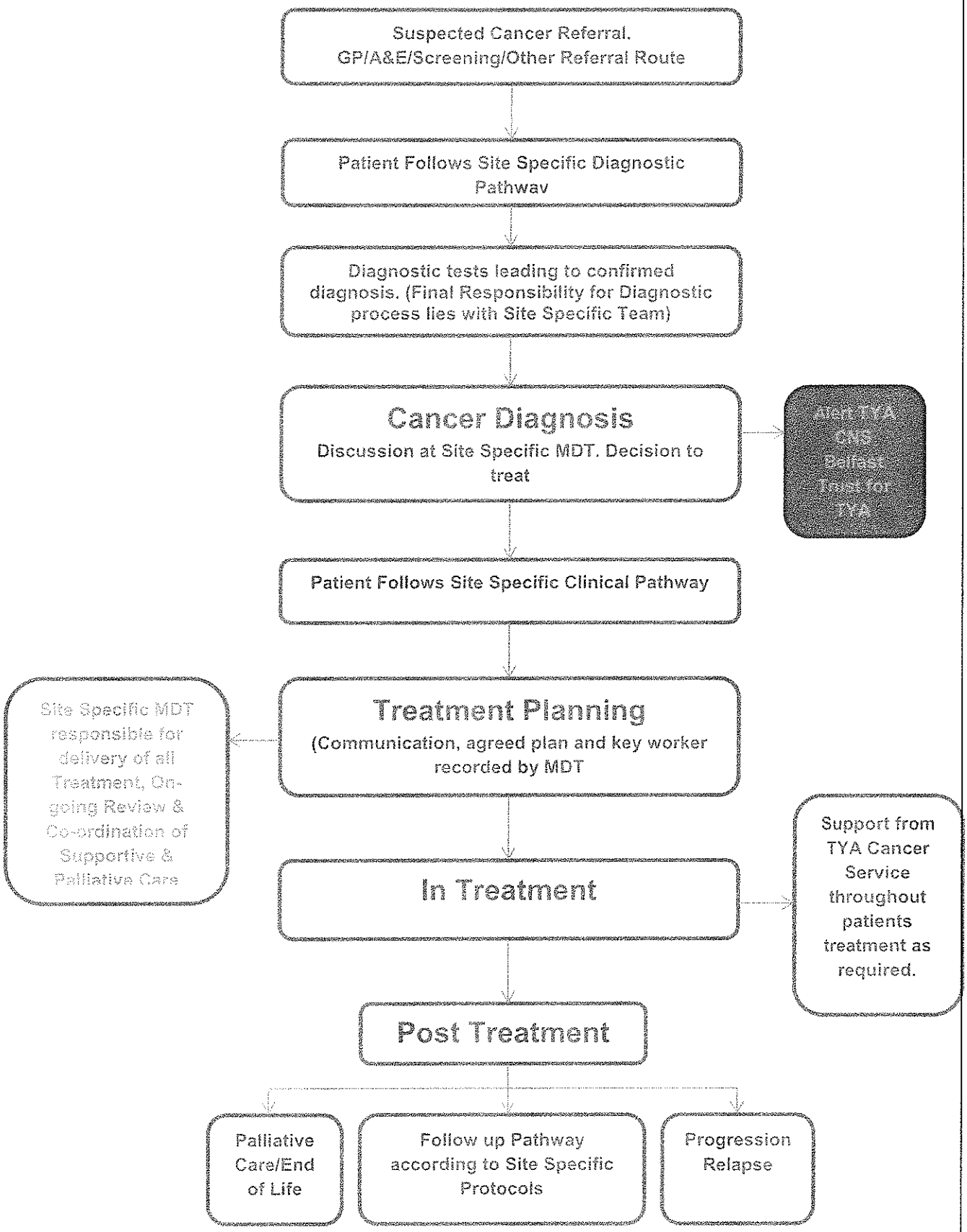
Consultant Name:	
Diagnosis:	
Management Plan:	
Key worker contact details given?	**Yes ☐ No ☐**
Key worker name: _____	
Cancer Specific Information given: **Comments:**	**Yes ☐ No ☐**
Core/general Information Pack given: **Comments:**	**Yes ☐ No ☐**
Plan for Holistic needs assessment: **Comments:**	**Yes ☐ No ☐**

Areas of concern identified:	Actions:

Signed by: **Date:**

To contact your specialist or clinical team during working hours please phone Craigavon Area Hospital Urology Nurse Specialist on (028) 38366979

Appendix 5: Regional referral pathway for Teenagers & Young Adults



Belfast Health and Social Care Trust

Teenager and Young Adult (TYA) Service

Referral information

Referral criteria

- Age14-25th birthday
- Availing of Oncology/Haematology service

How to refer

-email: Personal Information redacted by the USI

-Contact:

- Simon Darby-(CLIC Sargent SW Oncology) Personal Information redacted by the USI
- Laurena Kane-(CLIC Sargent SW Haematology) Personal Information redacted by the USI
- Renée Reid-(TYA CNS FCC) Personal Information redacted by the USI

Please include;

- Patients name
- Patients age and hospital number
- Diagnosis

Friends cancer centre

CLIC Sargent children with cancer

Southern Health and Social Care Trust

Quality Care - for you, with you

Urology MDT

Annual Report for January – December 2016

Presented to the MDT on: 1st September 2017

Agreed by the Urology MDT and signed on their behalf by Mr Anthony Glackin, MDT Lead Clinician on 1st September 2017

CONTENTS

1.0 INTRODUCTION

This annual report relates to the operational period 01/01/2016 – 31/12/2016 for the Southern Trust Urology Multi-disciplinary Team (MDT) and the clinical data presented relates to patients diagnosed in this period.

2.0 KEY ACHIEVEMENTS

Whilst 2016 had begun with 6 Consultant Urologists in post, one consultant, Mr Suresh, subsequently left in October 2016. This post was filled by Locums.

Perhaps our achievements during this past year or more have been crowned by the award of the Trust Excellence Award to the Thorndale Unit in June 2016.

3.0 KEY CHALLENGES

Oncology and Radiology

The greatest challenge for the MDT during the past year has been the inadequacy of the availability of a clinical oncologist and or a radiologist at all MDMs. The inadequacy in both cases has essentially been due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the post where they are required. The inadequacy has been addressed with the appointment authorities.

Red Flag Referrals

There had been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past few years, up from 2902 in 2013 to 4761 in 2015/16. The greatest increase was to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014. The increase has continued throughout 2015/16 – there were 1878 red flag referrals in 2016.

Performance

Even though there has been an increase in Red Flag referrals over the past few years, the increased compliment of Consultant Urologists has enabled the MDT to absorb the increased demand and complete the assessment of patients and enact their definite management within the agreed time period of 62 days.

This has been reflected in the Cancer Performance data. The monthly average waits for an appointment between September-December 2016 were as follows:

Prostate: 22 day wait
Haematuria: 23 day wait
Others: 15 day wait

The diagnostic and operative activity has been reflected in an increase in the numbers of specimens received by the Cellular Pathology Laboratory at Craigavon Area Hospital, Tissue specimens increased from 874 in 2014 to 903 in 2016.

Even though not all tissue specimens were known, suspected or found to be cancerous, the analysis of the tissue type below demonstrates the varied spread of organ biopsies and resections. Biopsies and resections of prostate and bladder comprise the bulk of urological pathological diagnostic activity.

SPECIMENS	2012	2013	2014	2015	2016
Prostate Biopsies	345	225	248	340	318
TURP	158	141	163	176	147
Bladder Biopsies	182	253	224	205	180
TURBT	78	70	115	120	123
Testis Biopsies	-	-	4	8	5
Testis	28	37	36	38	32
Renal Biopsies	-	-	24	14	12
Kidney	28	33	46	76	77
Penile Biopsies	6	9	13	13	7
Penis	4	3	1	3	2

It is notable that there has been an increase in the numbers of Prostate biopsies which reflects the use of MRI to avoid unnecessary TRUS biopsy. The increase in kidney biopsies is in part due to cases being referred from outside the Southern Trust.

New Clinics

The introduction of the New Patient Clinics in October 2014 has contributed significantly to the ability of MDT to absorb the increased Red Flag referrals and meet the target times in all cases by early 2015. For 2016, the 31 day performance for the SHSCT was 100% and the 62 day performance was 81% - this reflects the marked increase in GP red flag referrals for the trust.

Operative Capacity

The main limiting factor in providing a complete cancer service is operating theatre capacity and operator time. Though the MDT has provided for the increased demand on Red Flag pathways, it has been at the expense of patients having, or suspected of having, recurrent bladder tumours, and those awaiting prostatic resection to facilitate their progress to radical radiotherapy for prostatic carcinoma having to wait increasingly longer periods of time for surgery, in addition to all those with non-cancerous pathology. This is a common and concerning experience across Northern Ireland, and will remain an increasing challenge until operative capacity is increased.

Conduct of MDM

The quality of the conduct of MDM has been a singular achievement these past six years. The quality of participation has been enhanced by increasing the number of persons chairing, and by having time allocated for preview.

Development Priorities

In addressing the concerns raised at Peer Review and the findings of Patient Satisfaction Surveys, it has been agreed that we could and should endeavour to make substantial progress in the implementation of Key Worker, Holistic Needs Assessment, Communication and having a Permanent Record of Patient Management. With the appointment of two more Nurses to the Thorndale Unit and Clerical Staff, all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner. It is intended that patients newly diagnosed as inpatients will be included.

Conclusion

While a firm MDM foundation has now been established, and while much success has been achieved during the past year, there remain inadequacies and challenges which are to be addressed in the coming year.

4.0 MDT ATTENDANCE 2016

The Urology MDM takes place every Thursday from 2.15 pm to 5 pm (at the latest) in Tutorial Room 1, Craigavon Area Hospital, with videoconferencing available to Daisy Hill Hospital. The attendance is monitored by the MDT Coordinator. There were 47 meetings held in 2017. The dates of the MDT meetings can be seen in **Appendix 1** along with an attendance spread-sheet for core members and extended members.

Table: Urology MDT Attendance record January 2016 – December 2016

Name	Role	Attended	DNA	% Attended	% Attendance by core /cover
	Surgeon				**100%**
Mr A Glackin*	Surgeon	41	6	87	
Mr M Haynes	Surgeon	33	14	70	
Mr A O'Brien	Surgeon	32	15	68	
Mr R Suresh (left Trust in Oct 2016)	Surgeon	28	19	60	
Mr J O'Donoghue	Surgeon	36	11	77	
	Radiologist				**51%**
Dr M Williams	Radiologist	24	23	51	
Vacant	Radiologist				
	Pathologist				**91%**
Dr G McClean	Pathologist	37	10	79	
Dr R Shah	Pathologist	3	46	6	
A Pathologist	Pathologist	3	7	6	
	Clinical Oncologist				**28%**
Dr Ciara Lyons	Clinical Oncologist	1	46	2	
Dr Jolyne O'Hare	Clinical Oncologist	7	40	15	
Dr Keith Rooney	Clinical Oncologist	3	44	6	
	Urology Specialist Nurse				**98%**
Kate O'Neill**	Urology Specialist Nurse	39	8	83	

Dolores Campbell	Urology Clinical Sister	6	41	13	
	Palliative Nurse Specialist				**100%**
Stephanie Reid	Palliative Nurse Specialist	36	11	77	
A Palliative Nurse Specialist	Palliative Nurse Specialist	10	37	21	
	MDT Co-ordinator				**100%**
Shauna McVeigh	MDT Co-ordinator	38		81	
A MDT Co-Ordinator	MDT Co-ordinator	9		19	

- *Responsible for clinical trials & research
- **Responsible for users issues and patient information

The MDT quorum for 2016 was 11% with Radiology and Clinical Oncology presence being the key issues.

4.1 Attendance at Network Clinical Reference Group Meetings 2016

There was only one meeting of the Urology Clinical Reference Group (CRG) held on 29th January 2016. Details of the attendees are listed below.

Mr O'Brien has since stepped down as Clinical Lead of the Urology CRG. Following an expression of interest process in autumn of 2016, Mr Mark Haynes has been appointed as the new Clinical Lead.

29th January 2016
Aidan O'Brien
Gareth McClean
Kate O'Neill
Gerry Millar

5.0 MDT Workload January to December 2016

Workload	Number
Meetings	47
Number of discussions	1565
Number of patients	910
Number of new patients	746

5.1 Number of New Diagnoses 2016

Final MDM Diagnosis	Number
Prostate	277
Bladder	68
Kidney	64
Testicular	14
Penile	1
Total	**424**

5.2 Cancers by referral source 2016

Referral type	No. of referrals
GP Red Flag	**1878**
Consultant Upgrade	**424**
Other consultant referrals	**868**
Total	**3170**

5.3 Breakdown of first definitive treatments in 2016

The table below provides a breakdown of first definitive treatments of Urology patients on 31 and 62 day pathways during 2016.

Breakdown of first definitive treatments between 1st Jan 201-31 Dec 2016

Pathway	Surgery	Pall	Chemo	Radio	Brachy	Other treatment	No treatment	Active monitoring	Watchful waiting	Total
31 day	67	1	48	3	2	18	1	33	12	185
62 day	84	0	60	2	8	33	0	29	10	227
										412

5.4 Breakdown of cancer waiting times performance

The table below summarizes the performance of Urology patients on 31 and 62 day pathways. Cancer Access Standards mandate that 98% of patients have their definitive treatment within 31 days of decision to treat (when the treating consultant agrees the

treatment with the patient) and 95% of patients on a 62 day pathway are given their first definitive treatment within 62 days of suspect GP referral or consultant upgrade. The 31 day performance for the SHSCT was 100% in 2016 and the 62 day performance was 81%. Pathway breaches are considered at Trust Performance meetings and reasons detailed and escalated as appropriate. The majority of breach reasons are due to the complexity of the pathway, with multiple investigations and discussions often required to obtain a diagnosis and agree a treatment plan.

	31 Day Performance				62 Day Performance			
	Over Target	Within Target	Total	% Within Target	Over Target	Within Target	Total	% Within Target
Jan 16	0	26	26	100%	1	14	14	93%
Feb 16	0	36	36	100%	2	14	14	88%
Mar 16	0	26	26	100%	4	15	15	79%
Apr 16	0	34	34	100%	1	21.5	21.5	96%
May 16	0	29	29	100%	1.5	11.5	11.5	88%
Jun 16	0	31	31	100%	4	15	15	79%
Jul 16	0	33	33	100%	5.5	15	15	73%
Aug 16	0	22	22	100%	2	11.5	11.5	85%
Sep 16	0	28	28	100%	1.5	14.5	14.5	91%
Oct 16	0	33	33	100%	4	16	16	80%
Nov 16	0	24	24	100%	3.5	11	11	76%
Dec 16	0	24	24	100%	3	10.5	10.5	78%
Totals	0	346	346	100%	33	169.5	169.5	81%

Trends for breaches

- Delay in 1st out-patient appointment
- Delay in reporting of MRI scans / delay in discussion at MDT due to no radiologist being present
- Accessing TRUSB appointments due to capacity issues
- Complex cases requiring multiple MDT discussion

6.0 Advanced communication skills training

This has been identified as an area for development. The following members of the MDT have participated in Advanced Communication Skills training and the remaining core members will be offered a position when courses are available in 2017/18:

NAME	ROLE
Aidan O'Brien	Consultant Urologist
Kate O'Neill	Clinical Nurse Specialist
Stephanie Reid	Palliative Nurse Specialist
Joanne Frazer	Palliative Nurse Specialist
Tony Glackin	Consultant Urologist
John O'Donoghue	Consultant Urologist
Mark Haynes	Consultant Urologist
Leanne McCourt	Clinical Sister

7.0 Patient Experience

The Public Health Agency with support from Macmillan Cancer Support commissioned a regional Cancer Patient Experience Survey (CPES) in 2015. This was the first time the survey was undertaken in Northern Ireland and was based on similar surveys used in England and Wales. The survey was issued to over five thousand patients in active treatment for cancer during December 2013 – May 2014, including Urology patients and there was a 62% response rate i.e. 3,217 respondents across the 5 trusts. The results from the survey can be benchmarked against England and Wales and reports are available at a regional and trust level.

It showed overall 91% of patients in Southern Trust rated their care as excellent or very good which was similar to the NI score (92%) and higher than the NHS England score (89%).
Access to a clinical nurse specialist came out as a key issue although those who were given the CNS contact details found it much easier to contact the CNS compared to England.

Areas where SHSCT scored high or higher than the NI score included:

- Possible side effects explained in an understandable way: NI-78%; SHSCT-82% (highest**)
- Patient given written information about side effects: NI – 78%; SHSCT – 80% (highest**)
- Got understandable answers to important questions: NI – 93%; SHSCT – 95% (highest**)
- Hospital staff explained what would be done during operation: NI – 89%; SHSCT – 91% (2/5)
- Given clear written information about what to do / not do post discharge: NI – 85%; SHSCT – 89% (2/5)

- GP given enough info about patient's condition & treatment: NI – 96%; SHSCT – 95%

Access to a clinical nurse specialist came out as a key issue and this is reflective of the disparity of clinical nurse specialists across some of the tumour sites. Cancer research was an area for improvement which reflects the paucity of trials open for some of the tumour sites. Other areas where scores were lower included:

- Patient told about side effects that could affect them in future: NI – 58%; SHSCT – 59%
- Hospital staff gave information on getting financial help: NI – 66%; SHSCT – 67%
- Patient's family had opportunity to talk to doctor: NI – 69%; SHSCT: 63% (**lowest trust)
- Patient offered written assessment and care plan: NI – 21%; SHSCT – 27%

451 patients responded to the survey from the SHSCT and 17% of these were patients with urological cancer.

Further details regarding feedback from the SHSCT CPES report is available in **Appendix 2.**
A local survey was also carried out with Urology patients in August 2016, a report is available in **Appendix 3.** Following these surveys, a service development action plan has been developed, see **Appendix 4.**

8.0 Communication of diagnosis to GPs

When a patient is given a diagnosis of Urological Cancer, the aim of the MDT is that the patient's GP is informed by the end of the next working day of the consultation via a typed letter from the responsible consultant. An audit of GP timeliness of communication was carried out. Please refer to **Appendix 5** for results of the audit.

9.0 Audit

The MDT reviews its data and discusses the progress of its audits annually as part of the MDT annual report at one of the MDT business meetings.

Please refer to **Appendix 7** for results of the following audits:

- Audit on Bladder Cancer Access Standards for non-superficial disease, Mr David Curry, 2016
- Audit of Nurse Provided TRUS Biopsy Service in 2016, Sr Kate O'Neill
- Nephrectomy dashboard - data submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database in 2016

10.0 Clinical Trials

The Urological clinical research activity in Craigavon during 2016 is detailed below:

Urology open studies:

HaBio: Haematuria Biomarker Study

12 patients

UKGPCS: The UK Genetic Prostate Cancer Study
4 patients

See **Appendix 6** for further details of open trials from the NI Cancer Trials Network

Appendix 1: MDT Attendance spreadsheet 2016

MDM Date	MDM Location	Suspect Tumour Site - Description	Mr Anthony Glackin	Mr Mark Haynes	Mr Aidan O'Brien	Mr Ram Suresh	Mr Michael Young	John O'Donoghue	Consultant Urologist x 2	Dr Marc Williams	Cons. Radiologist x1	Dr Gareth McClean	Dr Rajeev Shah	A Pathologist	Pathologist x1	Dr Clare Lyons	Dr Jolyne O'Hara	Dr Keith Rooney	Clinical Nurse Specialist x1	Kate O'Neill	Dolores Campbell	Urology Nurse Specialist	Stephanie Reid	palliative nurse cover	Palliative Nurse x 1	Shauna McVeigh	A MDT Co-Ordinator	MDT Co-ordinator x1	Quorate
07/01/2016	CAH	Urological Cancer	1	1	1	1	0	0	2	1	1	1			1			0	0	1		1	1		1	1	0	1	NO
14/01/2016	CAH	Urological Cancer	1	0	1	1	0	1	2	0	0	1			1			1	1	1		1	1		1	1	0	1	NO
21/01/2016	CAH	Urological Cancer	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM
28/01/2016	CAH	Urological Cancer	1	1	1	1	1	1	2	0	0	1			1			1	1	1		1	1		1	1	0	1	NO
04/02/2016	CAH	Urological Cancer	1	1	1	1	0	1	2	0	0	1			1			0	0	0		0	0	1	1	1	0	1	NO
11/02/2016	CAH	Urological Cancer	1	0	1	1	0	1	2	0	0	1			1			1	1	1		1	1		1	1	0	1	NO
18/02/2016	CAH	Urological Cancer	1	0	1	1	0	1	2	1	1	1			1			0	0	1		1	0	1	1	1	0	1	NO
25/02/2016	CAH	Urological Cancer	1	1	0		0	1	2	0	0	0		1	1			0	0	1		1	1		1	1	0	1	NO
03/03/2016	CAH	Urological Cancer	1	1	0	1	0	1	2	1	1	1			1			0	0	1		1	1		1	1	0	1	NO
10/03/2016	CAH	Urological Cancer	1	1	1	1	1	1	2	1	1	1			1		1	0	0	1		1	1		1	1	0	1	NO
17/03/2016	CAH	Urological Cancer	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	YES
24/03/2016	CAH	Urological Cancer	0	1	1	1	0	1	2	1	1	1			1			0	0	1	0	1	1		1	1	0	1	NO
31/03/2016	CAH	Urological Cancer	1	0	1	1	0	1	2	1	1	0	1		1		1	0	1	1	0	1	1		1	1	0	1	NO
07/04/2016	CAH	Urological Cancer	0	1	1	1	0	1	2	0	0	1			1		1	0	1	1	0	1	1		1	1	0	1	YES
14/04/2016	CAH	Urological Cancer	1	1	1	1	0	0	2	1	1	1			1		1	0	1	1	0	1	1		1	1	0	1	NO
21/04/2016	CAH	Urological Cancer	1	1	1	1	1	1	2	0	0	1			1			0	0	1	0	1	1		1	1	0	1	NO
28/04/2016	CAH	Urological Cancer	1	1	0	1	0	0	2	1	1	0	1		1		1	0	1	1	0	1	1		1	1	0	1	NO
05/05/2016	CAH	Urological Cancer	1	0	0	1	0	1	2	1	1	0	1		1			0	0	1	0	1	0	1	1	1	0	1	NO
12/05/2016	CAH	Urological Cancer	1	0	0	1	0	1	2	0	0	1	0		1			0	0	1	0	1	1		1	1	0	1	NO
19/05/2016	CAH	Urological Cancer	1	0	1	1	0	0	2	0	0	1	0		1			0	0	1	0	1	1		1	1	0	1	NO
26/05/2017	CAH	Urological Cancer	1	0	1	1	0	0	2	1	1	1	0		1			0	0	1	0	1	1		1	0	1	1	NO
02/06/2016	CAH	Urological Cancer	1	0	1	1	0	1	2	1	1	1	0		1			0	0	1	1	1	1		1	1	0	1	NO
09/06/2016	CAH	Urological Cancer	0	1	1	0	0	1	2	0	0	1	0		1			0	0	1	0	1	1		1	1	0	1	NO
16/06/2016	CAH	Urological Cancer	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO
23/06/2016	CAH	Urological Cancer	1	0	0	0	0	1	2	1	1	1	0		1		1	0	1	1	0	1	1		1	1	0	1	NO MDM
30/06/2016	CAH	Urological Cancer	0	1	1	0	0	0	2	1	1	1	0		1		1	0	1	1	0	1	1		1	1	0	1	YES
07/07/2016	CAH	Urological Cancer	0	0	1	1	1	0	2	1	1	1	0		1		1	0	1	1	0	1	0	1	1	1	0	1	YES
14/07/2016	CAH	Urological Cancer	1	0	0	0	1	0	2	0	0	0	0	1	1		0	0	0	1	0	1	1		1	0	1	1	NO
21/07/2016	CAH	Urological Cancer	1	0	1	1	1	1	2	0	0	0	0	0	0		0	0	0	1	0	1	0	1	1	1	0	1	NO
28/07/2016	CAH	Urological Cancer	1	1	1	0	1	0	2	1	1	0	0	1	1		0	0	0	1	0	1	1		1	1	0	1	NO
04/08/2016	CAH	Urological Cancer	1	0	1	0	0	1	2	1	1	1	0	0	1		0	0	0	1	0	1	1		1	1	0	1	NO
11/08/2016	CAH	Urological Cancer	1	1	0	1	0	1	2	0	0	1	0	0	1		0	0	0	1	0	1	0	1	1	1	0	1	NO
18/08/2016	CAH	Urological Cancer	1	1	1	1	0	1	2	0	0	1	0	0	1		0	0	0	1	0	1	0	1	1	1	0	1	NO
25/08/2016	CAH	Urological Cancer	0	1	1	1	0	0	2	0	0	1	0	0	1		0	0	0	0	1	1	0	1	1	1	0	1	NO
01/09/2016	CAH	Urological Cancer	1	1	1	1	0	1	2	1	1	1	0	0	1		0	0	0	1	0	1	0	1	1	1	0	1	NO
08/09/2016	CAH	Urological Cancer	1	1	1	1	1	1	2	1	1	1	0	0	1		0	0	0	1	0	1	1		1	1	0	1	NO
15/09/2016	CAH	Urological Cancer	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO
22/09/2016	CAH	Urological Cancer	1	1	1	1	0	1	2	0	0	1	0		1		0	0	0	1	0	1	1		1	1	0	1	NO
29/09/2016	CAH	Urological Cancer	1	1	1	1	0	1	2	0	0	1	0		1		0	0	0	1	0	1	1		1	1	0	1	NO
06/10/2016	CAH	Urological Cancer	1	1	1	0	0	1	2	1	1	1	0		1		0	0	0	1	0	1	1		1	1	0	1	NO
13/10/2016	CAH	Urological Cancer	1	1	1	0	1	1	2	1	1	0		0	0		0	0	0	1	0	1	1		1	1	0	1	NO
20/10/2016	CAH	Urological Cancer	1	1	1	0	0	1	2	0	0	1	0		1	1	0	0	1	1	0	1	1		1	0	1	1	NO
27/10/2016	CAH	Urological Cancer	1	1	0	0	0	1	2	1	1	1	0	0	1	0	0	0	1	0	0	1	0	1	1	1	1	1	YES
03/11/2016	CAH	Urological Cancer	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM	NO MDM
10/11/2016	CAH	Urological Cancer	1	1	0	0	0	1	2	1	1	1	0		1	0	0	0	0	1	0	1	1		1	1	0	1	NO
17/11/2016	CAH	Urological Cancer	1	1	0		0	1	2	1	1	0	0	0	0	0	0	0	0	1	0	1	1		1	1	0	1	NO
24/11/2016	CAH	Urological Cancer	1	1	0		0	1	2	0	0	1	0	0	1	0	0	0	0	1	0	1	1		1	0	1	1	NO
01/12/2016	CAH	Urological Cancer	1	1	0		0	1	2	1	1	1	0	0	1	0	0	0	0	0	1	1	0	1	1	0	1	1	NO
08/12/2016	CAH	Urological Cancer	1	1	0		0	1	2	0	0	1	0	0	1	0	0	0	0	1	0	1	1		1	0	1	1	NO
15/12/2016	CAH	Urological Cancer	1	1	0		0	1	2	0	0	1	0	0	1	0	0	0	0	1	0	1	1		1	0	1	1	NO
22/12/2016	CAH	Urological Cancer	1	1	1		0	0	2	0	0	1	0	0	1	0	0	0	0	1	0	1	0	1	1	1	0	1	NO
29/12/2016	CAH	Urological Cancer	1	1	1		0	1	2	0	0	0	0	0	0	0	0	0	0	1	0	1	1		1	0	1	0	NO
Weeks Attended			41	33	32	28	9	36	47	24	24	37	3	3	43	1	7	3	13	39	6	46	36	10	47	38	9	47	5
47 Week Year			87%	70%	68%	60%	19%	77%	100%	51%	51%	79%	6%	6%	91%	2%	15%	6%	28%	83%	13%	98%	77%	21%	100%	81%	19%	100%	11%

Appendix 2: Feedback from the NI Cancer Patient Experience Survey 2015

Southern Health and Social Care Trust

Quality Care - for you, with you

NI Cancer Patient Experience Survey – SHSCT results from Urology patients (17% of ST respondents i.e.77)

Questions highlighted in yellow - % difference is +5% less than NI average (-)
Questions highlighted in red - % difference is +5% more than NI average (+)

Question number	Detail	Southern %	NI Average %	Difference %
Q1	Saw GP once/twice	82	74	+8
Q2	Pt thought seen as soon as necessary	87	86	+1
Q4	Pt's health got better or remained about same while waiting	82	84	-2
Q6	Staff gave complete explanation of purpose of test	86	84	+2
Q7	Staff explained what would be done during test	89	88	+1
Q8	Given easy to understand written info about test	83	88	-5
Q9	Given complete explanation of test results in understandable way	80	80	-
Q11	Pt told could bring friend when first told they had cancer	71	76	-5
Q12	Pt felt they were told sensitively that they had cancer	83	86	-3
Q13	Pt completely understood explanation of what was wrong	76	77	-1
Q14	Pt given written info about type of cancer they had	54	48	+6
Q15	Pt given a choice of different type of treatment	67	81	-14
Q16	Pt's views taken into account when discussing treatment	63	69	-6
Q17	Side effects explained in an understandable way	77	75	+2
Q18	Pt given written information about side effects	61	64	-3
Q19	Pt told about side effects that could affect them in future	53	51	+2
Q20	Pt definitely involved in decisions about care and	71	75	-4

	treatment			
Q21	Pt given the name of the CNS in charge of their care	48	53	-5
Q22	Pt finds it easy to contact their CNS	88	82	+6
Q23	CNS listened carefully last time spoken to	90	95	-5
Q24	Get understandable answers to important questions all/most of the time (CNS)	90	89	+1
Q25	Hospital staff gave info about support groups	47	67	-20
Q26	Hospital staff gave info about impact cancer could have on work/education	55	60	-5
Q27	Hospital staff gave info on getting financial help	33	41	-7
Q28	Pt saw cancer research info in hospital	84	79	+5
Q29*	Taking part in cancer research discussed with patient	1	9	-8
Q36	Got understandable answers to important questions all/most of time(doctors)	72	74	-2
Q37	Pt had confidence and trust in all doctors treating them	90	86	+4
Q38	Doctors did not talk in front of pt as if they were not there	86	80	+6
Q39	Pt's family had opportunity to talk to doctor	56	58	-2
Q40	Got understandable answers to important questions all/most of time from (ward nurses)	71	75	-4
Q41	Patient had confidence and trust in all ward nurses	81	79	+2
Q42	Nurses did not talk in form of pt as if they were not there	84	86	-2
Q43	Always/nearly always enough nurses on duty	47	60	-13
Q44	Pt did not think hospital staff deliberately misinformed them	81	86	-5
Q45	Pt never thought they were given conflicting info	83	84	-1
Q46	All staff asked pt what name they preferred to be called by	71	67	+4
Q47	Always given enough privacy when discussing condition or treatment	79	81	-2
Q48	Always given enough privacy when being examined or treated	93	94	-1
Q49	Pt was able to discuss worries or fears with staff during visit	67	69	-2
Q50	Hosp staff did everything to help control pain all of the time	83	84	-1

Q51	Always treated with respect and dignity by staff	86	88	-2
Q52	Given clear written info about what should/should not do post discharge	84	78	+6
Q53	Staff told pt who to contact if worried post discharge	78	81	-3
Q54	Family definitely given all info needed to help care at home	68	59	-9
Q55	Pt definitely given enough care from health or social services	59	51	+8
Q57	Staff definitely did everything to control side effects of chemo	82	82	-
Q58	Staff definitely did everything they could to help control pain	78	80	-2
Q59	Hospital staff definitely gave patient enough emotional support	71	75	-4
Q61	Doctor had the right notes and other documentation with them	98	97	+1
Q62	GP given enough info about pt's condition and treatment	91	94	-3
Q63	Practice staff definitely did everything they could to support patient	81	79	+2
Q64	Hospital and community staff always worked well together	78	73	+5
Q66	Given the right amount of info about condition and treatment	83	85	-2
Q67	Pt offered written assessment and care plan	9	11	-2
Q68	Pt did not feel that they were treated as 'a set of cancer symptoms'	78	84	-6
Q69	Pt's rating of care excellent/very good	90	90	-

Appendix 3: Feedback from local patient experience survey August 2016

Urology Cancer Patient Experience Survey

August 2016

The Urology cancer team, as part of their service improvement plan to seek feedback from patients on the service, issued a patient feedback survey to 20 patients who were diagnosed with a urological cancer in 2015.

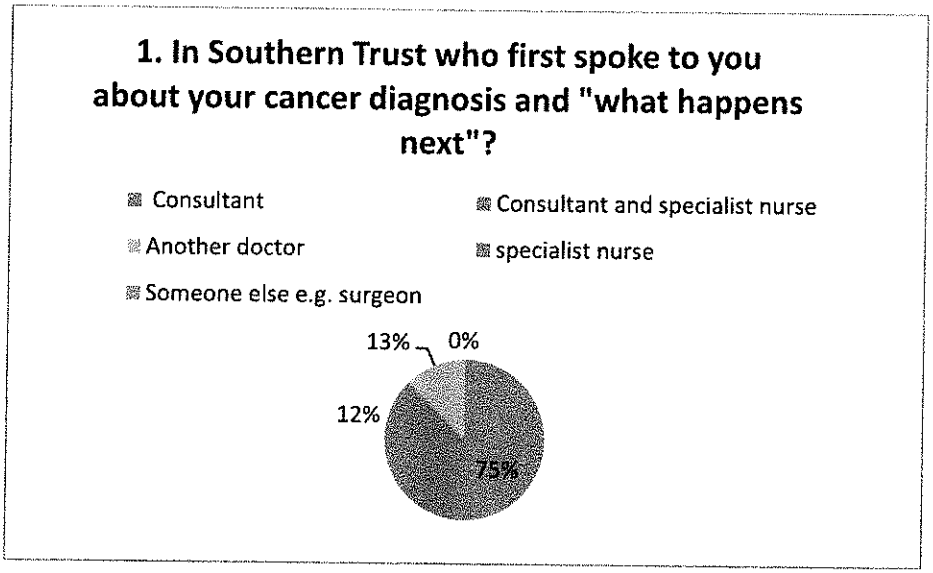
The survey asked questions in relation to their hospital visit and the results from the survey along with the feedback from the NI Cancer Patient Experience Survey will help the team to look at the service currently provided and to plan for the future to make sure they are meeting the on-going needs of patients and families.

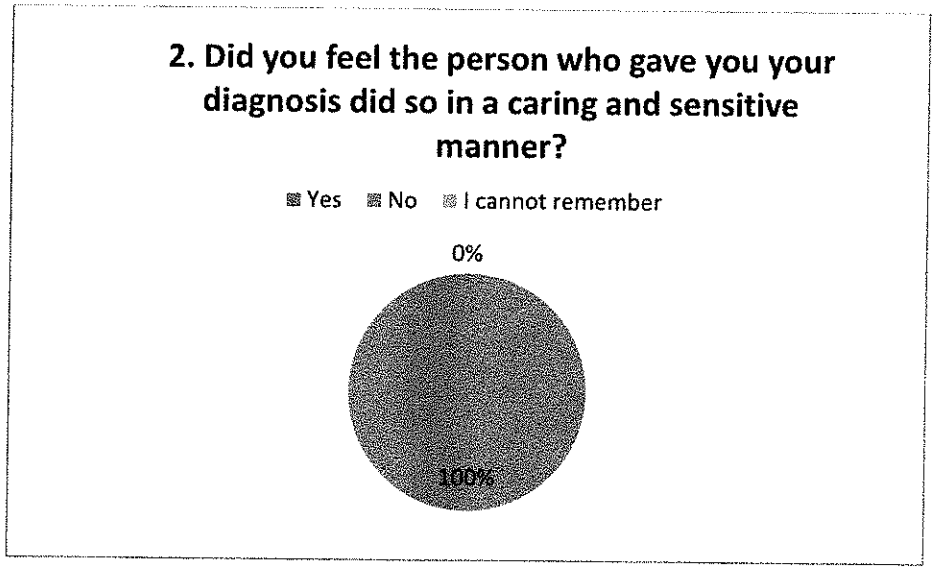
Summary of responses:

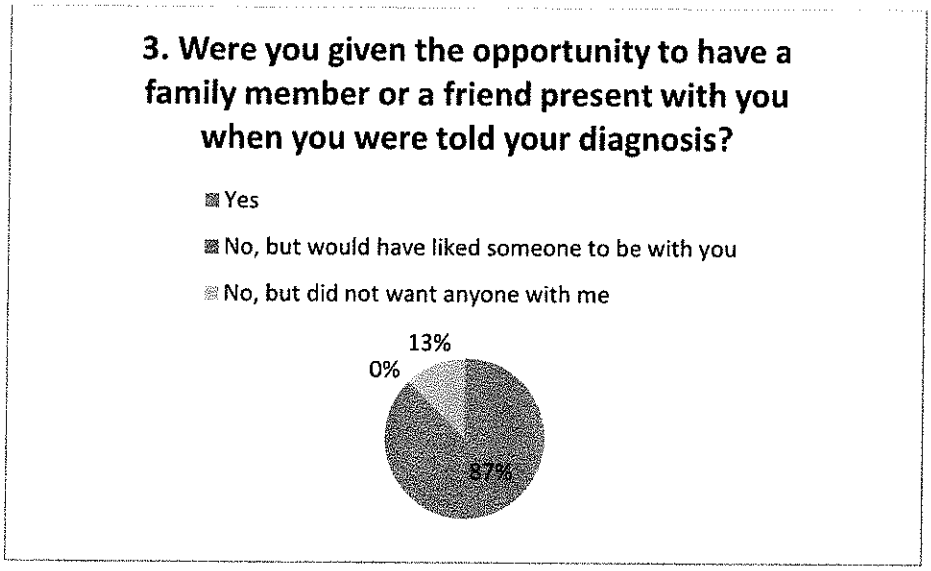
- 8 people completed and returned the questionnaires n = 8 (40%). The age range of the respondents was from 55-75 years & 75% were male. Three respondents were diagnosed with prostate cancer, 2 with bladder cancer and 2 with kidney cancer. All were treated in Craigavon Hospital.
- All patients (100%) were told their diagnosis in person, in a private environment, and felt that the person who gave the diagnosis did so in a caring and sensitive manner.
- All respondents (100%) that they had the opportunity to ask questions.
- 50% of respondents got answers to questions that they could completely understand and 50 % got answers that they understood to some extent
- 87% had the opportunity to have a family member or a friend present
- 75% had the opportunity to meet or speak to a clinical nurse specialist and 12% required further information and support from the CNS in addition to their clinic appointment
- 50% were provided with contact details of a clinical nurse specialist / key worker
- 75% were given a written record of their consultation
- 62% were offered information about their cancer, 12% were offered but did not want it
- 12% were offered printed information about the team looking after them, 37% were not and 38% can't remember
- Other sources of printed information provided to patients were: Local support centre (17%), other hospital services (16%), Local/regional support groups (50%), Psychological/emotional support (17%).
- 43% felt their holistic needs were addresses, 29% felt they were addressed to some extent

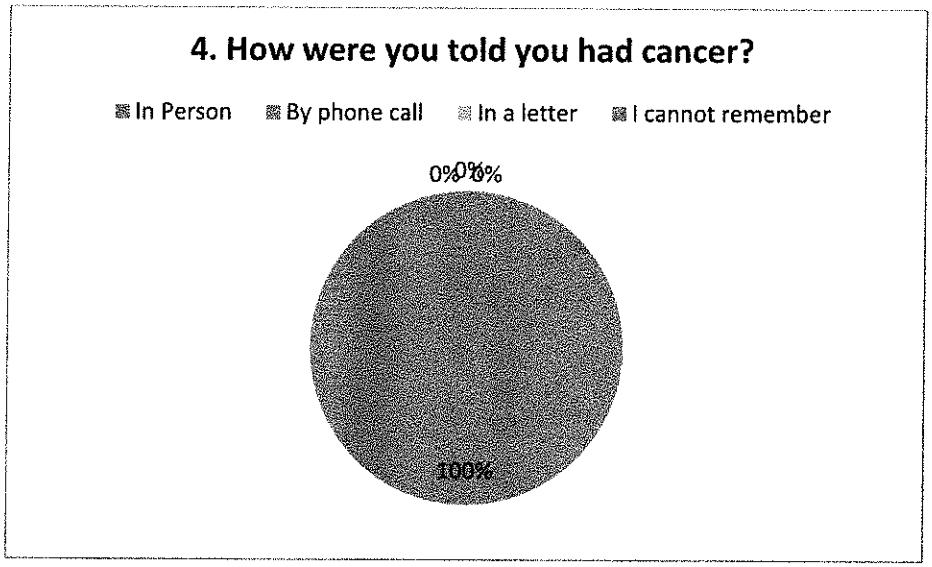
- The respondents rated the quality of information as excellent (37%), or very good / good (37%) and 62% thought the quantity was about right

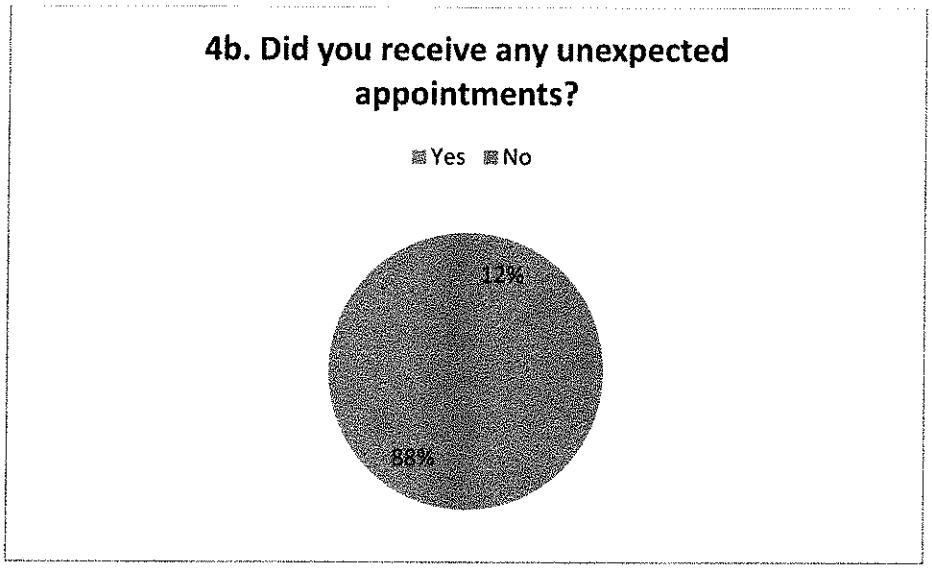
8/20 responses (40%)

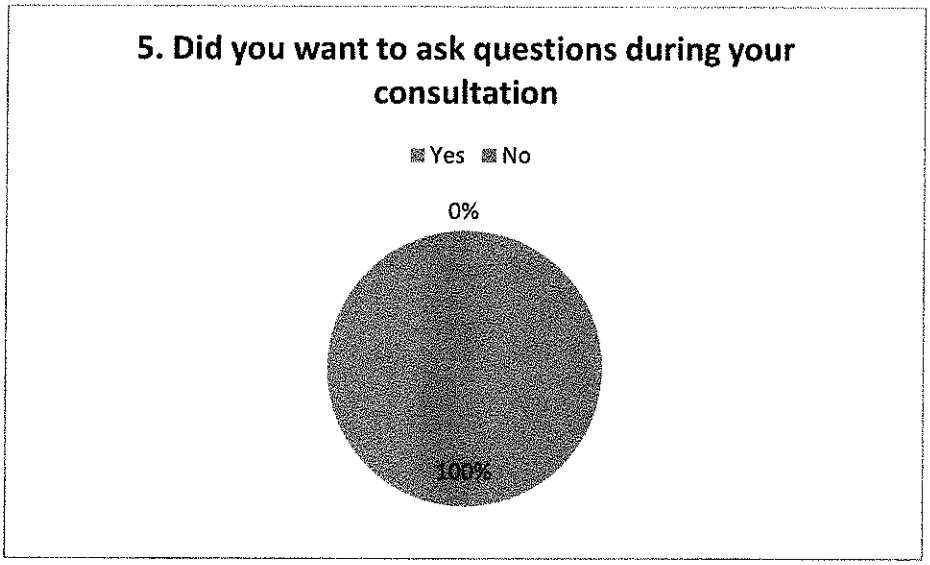


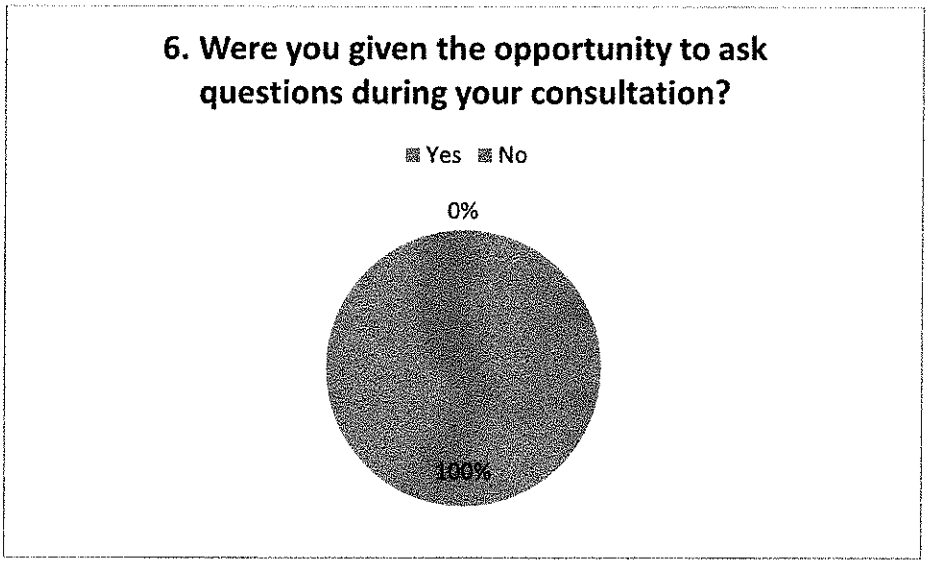


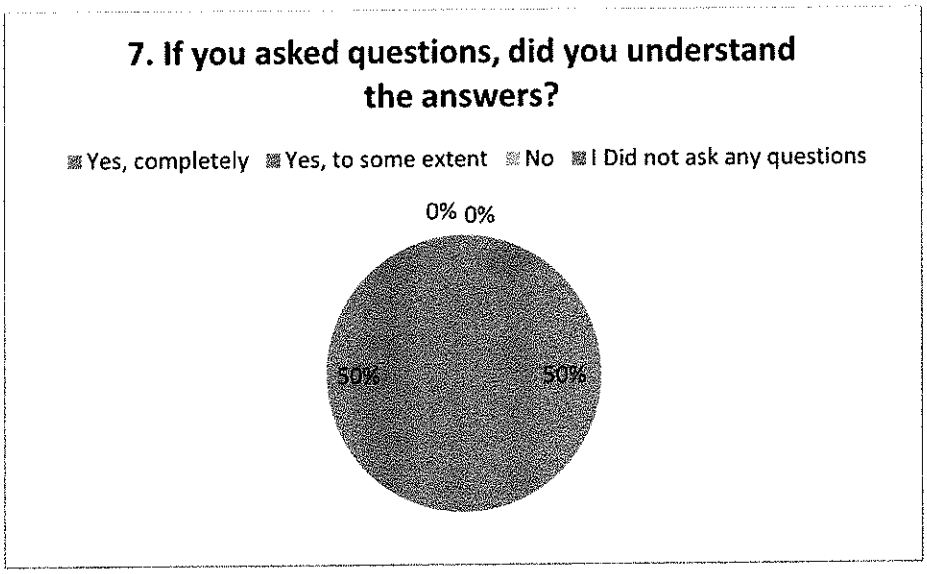


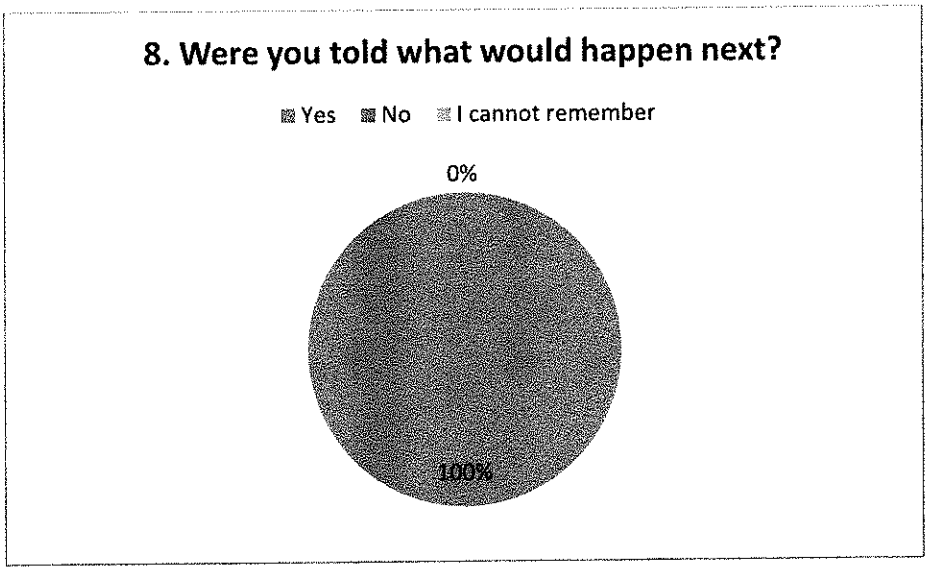


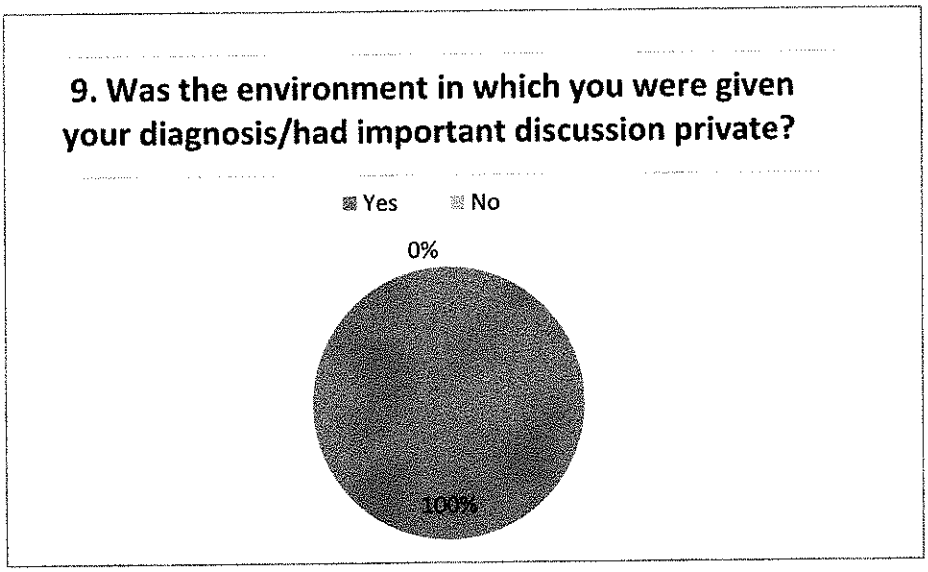


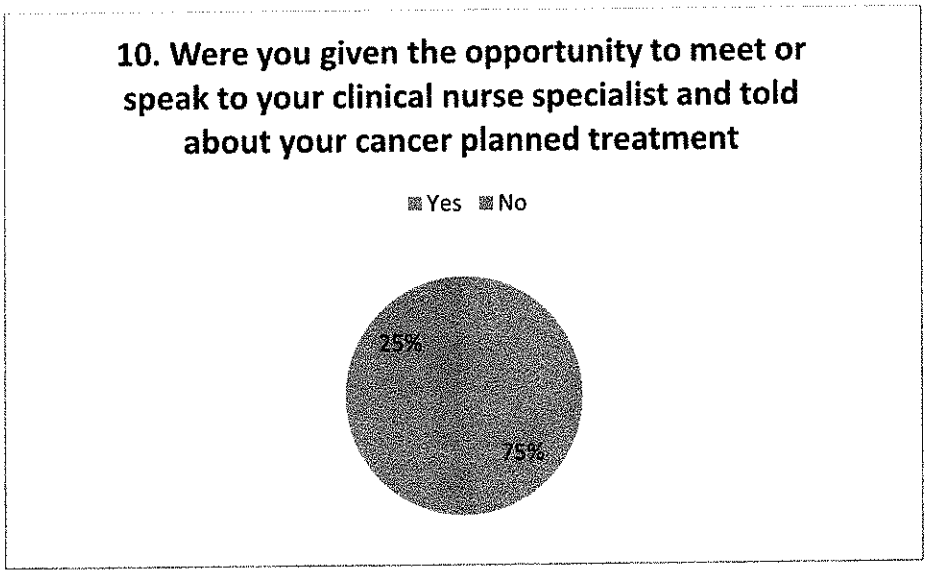


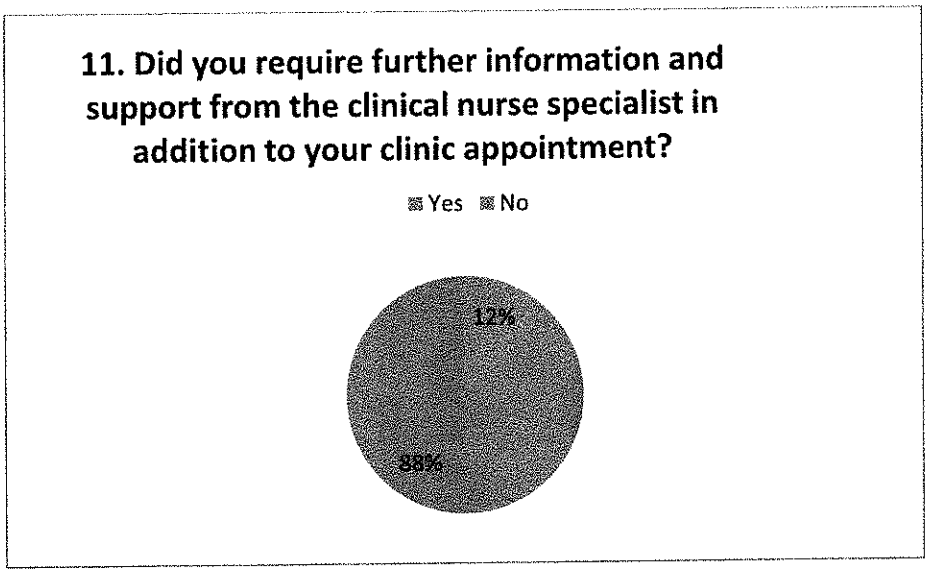


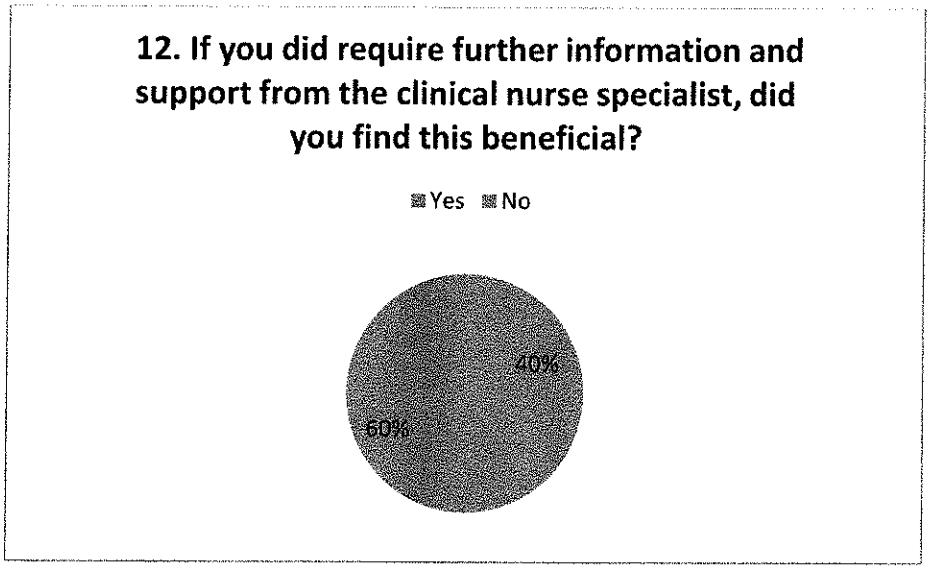


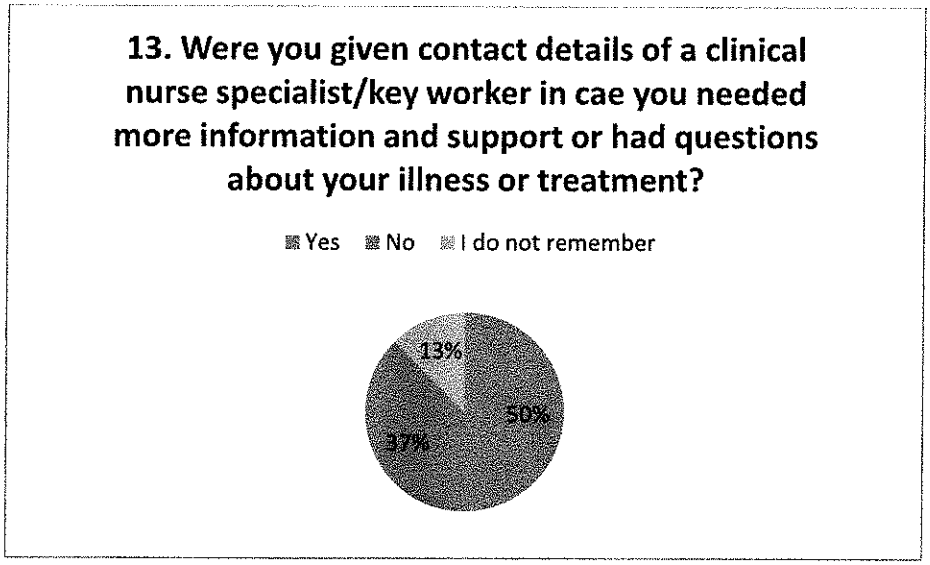




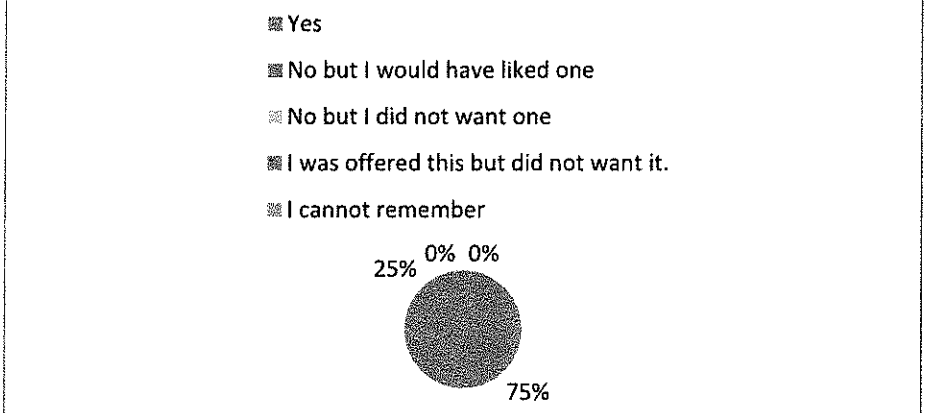




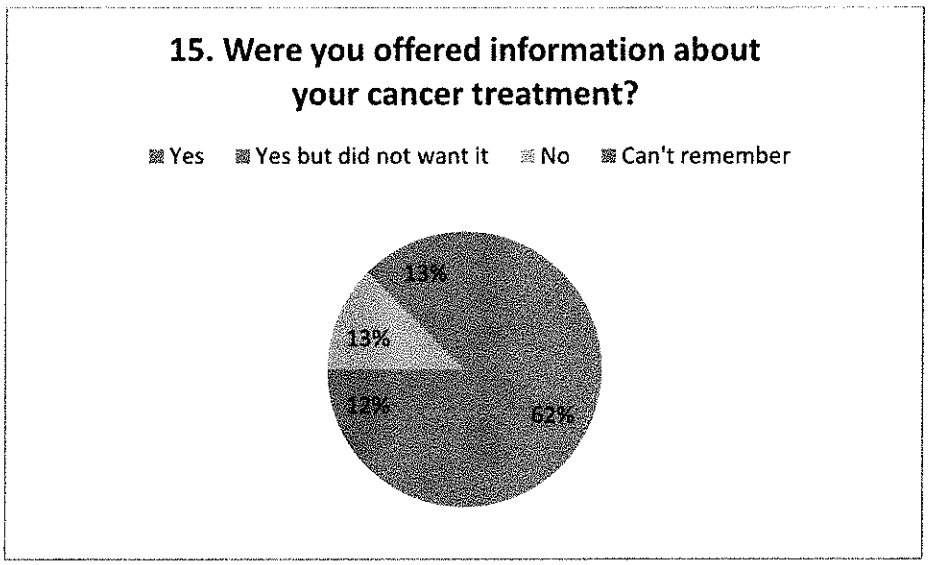


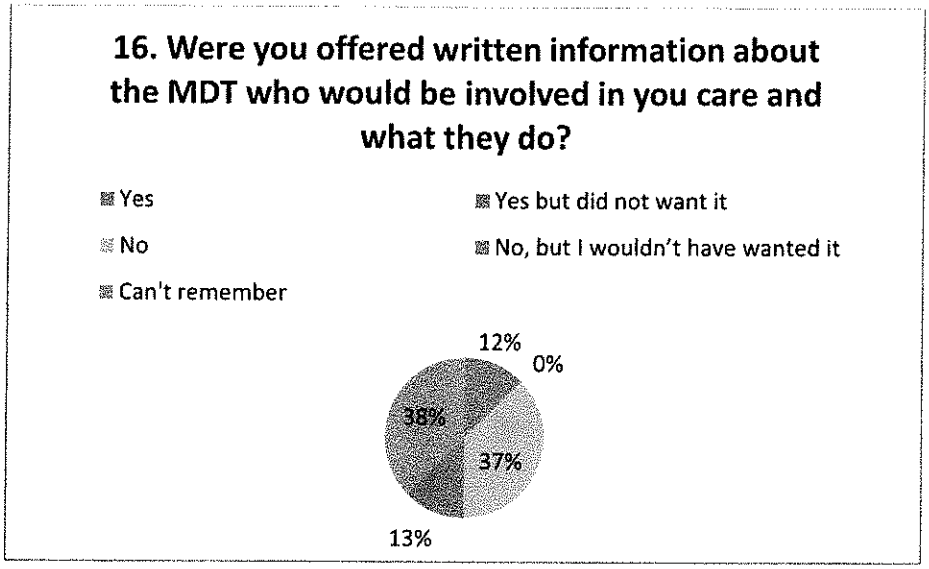


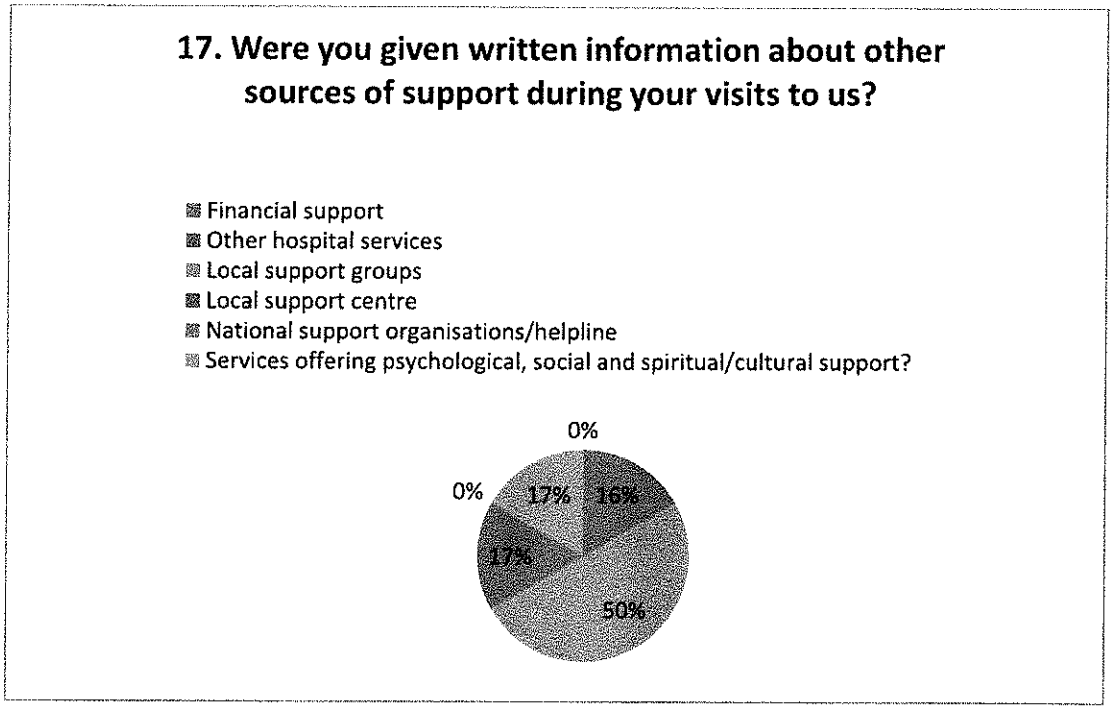
14. Were you given a written record of your consultaion?



15. Were you offered information about your cancer treatment?

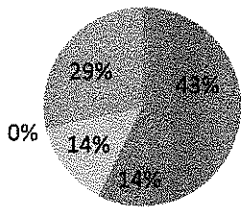






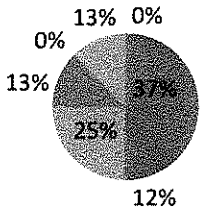
18. Do you feel your Holistic needs were addressed during your cancer journey?

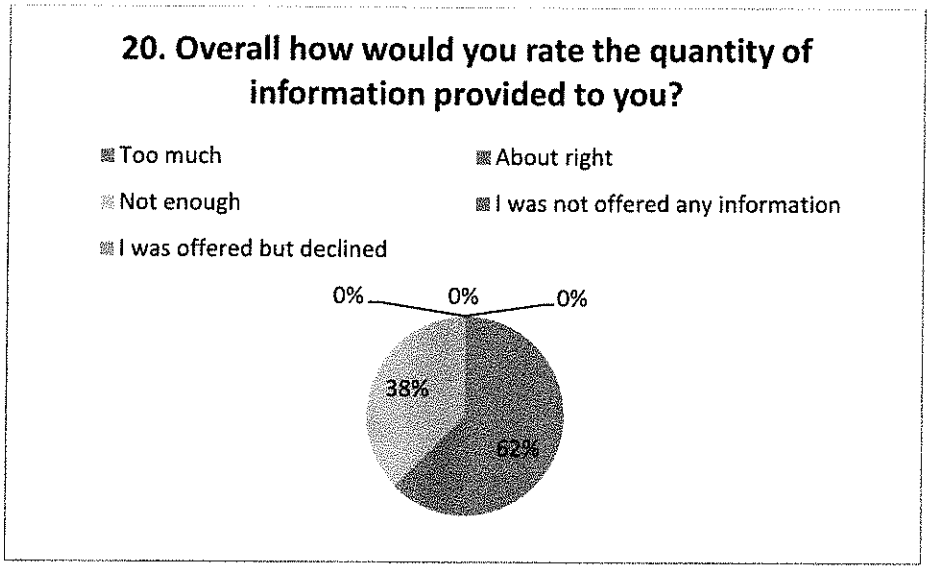
Yes
No
No, but I would have wanted it to some extent
I cannot remember

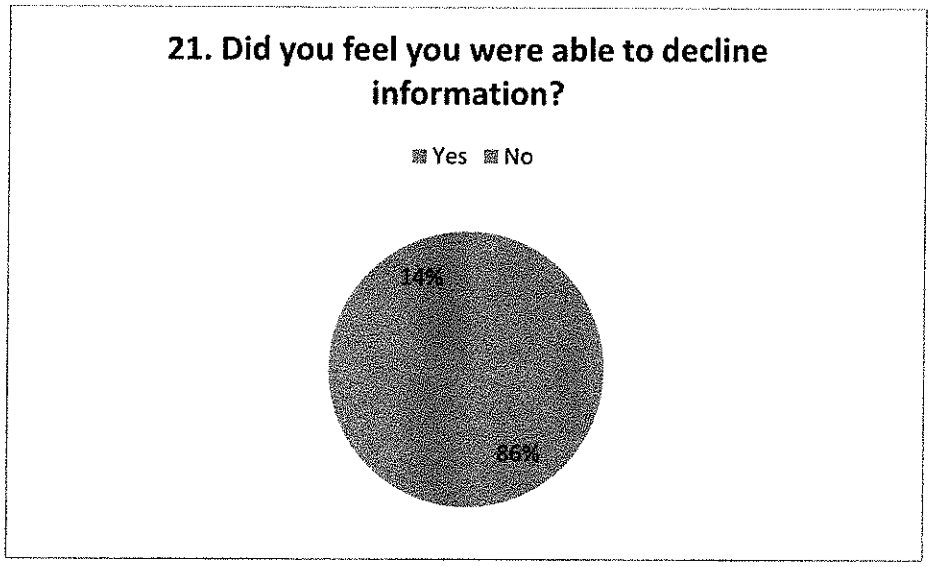


19. Overall how would you rate the quality of the information provided to you?

Excellent
Very good
Good
Fair
Poor
I was not offered any information
I was offerd but refused







Qualitative Feedback

Was there anything particularly good about the care you received?

- Mr Glackin and his team were excellent throughout the journey, thank you and well done.
- I feel I received good care and when I was diagnosed by the consultant I was treated very quickly and the staffs were very helpful.
- The staff was brilliant in looking after me.
- The treatment from I was red flagged in A&E was quick efficient and positive. Consultants and staff excellent and outcome positive
- Getting all care needed at moment.

Was there anything that could be improved?

- When the machine he was assigned to broke down, sometimes they forgot to put up on board you were left sitting wondering why you weren't called.
- It would have been nice to talk to someone about financial help.
- A&E experience horrendous. 7 hour wait following ambulance admission after collapsing at home with major haematuria; was told again at 4 hours I was next. That took another 3 hours even though my wife explained I was deteriorating. I was left in the minors with a repetitive message on the TV for 7 hours and no seat only a wheelchair if we managed to get.

Any other comments?

- Once seen by a doctor in A&E after 7 hours, care was excellent. Referral and follow up second to none. Only problem was following theatre procedure to diagnosis cancer. I was handed a leaflet in word to read about chemo I just received in theatre; and I didn't even know I had cancer until they give me the leaflet and walked away. I was traumatised as on my own.
- Staff and consultants at Craigavon are very caring and professional.

Appendix 4: Service Improvement Action plan based on patient feedback 2016/17

Area	Lead responsibility	Date	Update
Appointment of two extra nurses to the Thorndale Unit	Martina Corrigan /Kate O'Neill	Dec 2016	Two new clinical sisters have been appointed and will take up post early 2017
Allocation of Clerical staff to the Thorndale Unit	Martina Corrigan	Dec 2016	New clerical staff member appointed to the unit
Allocation of named Key Worker to all newly diagnosed patients	Urology consultants / CNS's	Dec 2016	All newly diagnosed patients are allocated a key worker and contact details provided to the patient along with the core information pack and site specific information
Ensure a Holistic Needs Assessment is completed for all newly diagnosed patients	Kate O'Neill / CNS's	Ongoing	Due to appointment of new staff, work is ongoing to ensure that an assessment is being completed for all newly diagnosed patients
Pilot a Permanent Record of Management for all newly diagnosed patients.	Urology consultants / nurses	Oct-December 2016	Permanent record of management form developed and implemented for 3 months. Patient evaluation to be completed and results shared with Urology team for further consideration.
Pilot a community prostate review clinic	Martina Corrigan / urology team / Mary Haughey	June 2017	Steering group established to take forward community based review clinics for stable prostate cancer patients

Appendix 5: Audit of Communication of Diagnosis to GPs

Standard

One of the local peer review measures outlined by NICaN relates to communication with the patient's GP following the diagnosis of a cancer; the standard states:

"The MDT should have an agreed policy whereby after a patient is given a diagnosis of cancer the patient's general practitioner (GP) is informed of the diagnosis by the end of the follow working day"

Methodology

To test if the MDT is meeting this standard and if GPs are receiving timely information on all patients diagnosed with cancer an audit was carried out. 10 patients from the Southern Trust who were discussed at the MDT held between January and December 2016 were selected at random. The audit was carried out by using the Northern Ireland Electronic Care Record (NIECR) to establish when the patient was given their diagnosis, when the letter was typed and then by phoning the GP practices to establish when the letter was received.

Results

Four GP practices out of 10 received notification of the patient's diagnosis within 1 day. The letters of four of the patients were received by GP Practices within 4-7 days, the letter of one patient was received within 13 days and one patient letter was received within 16 days. Six of the letters were typed on the same day as the patient was given their diagnosis and therefore these would have been available on the NIECR for the GP to view. Two letters were typed within 1 day and two were typed within 4 days.

Time between patient being informed of diagnosis and GP receiving Clinic letter:

	Southern Trust
Shortest time	1 days
Longest time	16 days
Median	6 days

Time between diagnosis given to patient and letter typed:

	Southern Trust
Shortest time	0 days
Longest time	5 days
Median	1 day

Appendix 6: Clinical Trial Activity 2016

UROLOGY CANCER TRIAL ACTIVITY 2016

During the past year urological cancer clinical trial activity in NI has contributed significantly to the overall NICTN portfolio with 20 trials being open to recruitment during this time. In total 1266 participants were recruited into urology cancer studies, with 79 participants being recruited into interventional trials. No Teenage and Young Adult patients were recruited to urology trials in 2016.

Prostate cancer trials continue to dominate urology clinical trial activity with 17 trials recruiting 1160 participants (1055 non-interventional, 75 interventional). Activity in testicular cancer was limited to one open trial; **UKGTC**, a genetic epidemiology study in testicular cancer open at all Cancer Units. This study closed in June 2016, recruiting no patients in the current reporting period. Only one randomised controlled trial was available for patients with renal cell cancer (**STAR**). A further 4 patients were recruited in 2016. One Belfast Trust sponsored study in bladder haematuria (**HaBio**) continued to recruit steadily in Belfast but was extended to recruit patients within the South Eastern and Southern Health and Social Care Trusts due to the exceedingly challenging recruitment target and timeframe set for this study. The study has now closed to recruitment.

Appendix 1 gives recruitment details on a per trial per site basis.

Urological cancer clinical trial activity is still predominantly conducted within the Belfast Cancer Centre, although activity at the Cancer Units is increasing, not only in their role as Patient Identification Centres, but also in supporting full trial activity for studies such as **UKGPC**, **HaBio** and **Life After Prostate Cancer Diagnosis**. At the Cancer Centre, Professor Joe O'Sullivan and Dr Suneil Jain have driven the establishment of an extensive portfolio of prostate cancer clinical trials and following the success of being awarded Movember Centre of Excellence in 2014, activity in this area is set to grow. The portfolio already includes randomised controlled trials of investigational medicinal products, radionuclide and radiotherapy studies, translational biomarker studies and delivers a good balance of commercial, non-commercial and investigator-led studies; however there is now a very real increase in investigator led activity and a number of 'Born in Belfast, Led by Belfast' studies have been developed. These include **ADRRAD**, a trial looking at neo-adjuvant androgen deprivation therapy, pelvic radiotherapy and radium-223 in prostate cancer patients. This study developed by Professor O'Sullivan opened to recruitment in January 2016, and has recruited 21 patients to date (14 in 2016). Recruitment to Dr Jain's **SPORT** feasibility study evaluating stereotactic body radiotherapy in men with high-risk prostate cancer commenced in August 2016 and has recruited 7 patients to date, 5 within this reporting period. A further Belfast led study, **CASPIR** opened in November 2015. This prospective feasibility study assesses calcifications as an alternative to surgically implanted fiducial markers for Prostate Image Guided Radiotherapy and has currently recruited 55 patients. To facilitate the fiducial insertion associated with CASPIR, PACE and SPORT, a dedicated research clinic (the **FAST Clinic)** has been developed using a multidisciplinary approach. Trial patients are now routinely seen at this bimonthly clinic.

The Phase II PARP inhibitor trial **TOPARP** recruited a further two patients in 2016 and remains open to recruitment. The screen failure rate is high with 15 patients screened and found to be ineligible in 2016. The **PROSPER** trial remains open in Belfast and recruited a further 4 patients in 2016, a total of 9 to date. The **PACE** study also continued to recruit patients in the current reporting year, 11 patients entered the trial, bringing the total recruitment to 15. Seven patients were recruited in total to the **BAYER 15396** study before enrolment closed in August 2016. The **Janssen Prostate Study** opened to recruitment in March 2016 and recruited 4 patients before closing in February 2017. The **Life After Prostate Cancer Diagnosis** study, a UK wide questionnaire study opened in April 2016 and recruited 1028 patients regionally. The radiographer led study **TRUFU** opened to recruitment in August and completed enrolment of its target of 30 patients in November.

Several further prostate studies have been presented to the Northern Ireland Cancer Trials Coordinating Committee in 2016 and are currently in set up or are now open. These include:

RE-AKT: A randomised phase II study of Enzalutamide (MDV3100) in combination with AZD5363 in patients with metastatic castration – resistant prostate cancer (PI: Dr S Jain). This study was presented in January 2016 and was initiated in August 2016. The study did not open to recruitment within the reporting period (opened in March 2017) and has not yet recruited to date.

Core: **A randomised trial of conventional care versus radioablation (stereotactic body radiotherapy) for extracranial metastases** (PI: Dr S Jain). This study will recruit patients with breast, prostate and NSCLC primaries. The study was presented in January 2016. Set up has been delayed due to requirements for pulmonary function tests and finalising IRMER requirements, as well as delays in receiving all relevant documents from the coordinating centre.

Add-Aspirin:

A phase III, double blind, placebo controlled, randomised trial assessing the effects of aspirin on disease recurrence and survival after primary therapy in common non-metastatic solid tumours (PI: Professor R Wilson). The Add Aspirin trial was adopted to the portfolio is January 2016 and will recruit across the disease sites of colorectal, prostate, breast and gastro-

oesophageal cancers. R&D approval was granted in September 2016 and study should open to recruitment in June 2017.

TRUFU: **Therapeutic radiographer undertaking follow-up for prostate cancer patients** (PI: Ms Stacey Hetherington). This study was presented in February 2016 and opened to recruitment in August 2016. The target recruitment was met in November and the study closed to recruitment.

GAP 4: **Intense exercise for survival among men with metastatic castrate-resistant prostate cancer (INTERVAL – MCRPC): A multicentre, randomized, controlled phase III study** (PI: Dr S Jain). The study was adopted into the portfolio in April 2016. Submission to R&D has been delayed as the lead site has not yet obtained ethics approval.

Enzalutamide Extension Study:

A phase 2 open-label extension study for subjects with prostate cancer who previously participated in an Enzalutamide clinical study (PI: Professor J O'Sullivan). This study is the extension of two Enzalutamide studies (TERRAIN and AFFIRM) which have now closed. Opening this study will allow patients continue Enzalutamide treatment. The study was presented in November 2016. R&D approval is awaited.

CTC Stop: **Utilising Circulating Tumour Cell (CTC) Counts to optimize systemic therapy of metastatic prostate cancer** (PI: Dr S Jain). This study was presented by Dr Jain in November. The study has been submitted to Research Governance and approval is awaited.

ARASENS Bayer 17777:

A randomized, double-blind, placebo-controlled Phase III study of ODM-201 versus placebo in addition to standard androgen deprivation therapy and docetaxel in patients with metastatic hormone-sensitive prostate cancer (PI:

Professor Joe O'Sullivan). This study was presented in November 2016 and is currently with Research Governance for approval.

MADCAP: **A phase I/randomised phase II trial of abiraterone acetate with or without RO5503781 in patients with metastatic castrate resistant prostate cancer (mCRPC) who have not previously received docetaxel** (PI: Dr V Coyle). Although presented in 2013 significant delays encountered with the sponsor has resulted in the local decision to only open the phase II component of this study in late 2016, however phase II of this study is no longer proceeding.

Appendix 1: PROSTATE STUDIES OPEN TO RECRUITMENT 2016

Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/05/17)	% of Target	Recruit. 2016	Project status
RADIATION BIOMARKER STUDY	**A Study Examining Serum Biomarkers Of DNA And Tissue Damage In Patients Undergoing Radical Radiotherapy For Prostate Cancer**								
	O'Sullivan, Prof Joe	BHSCT	01/11/2011	01/11/2016	50	39	78%	1	Suspended
RADICALS (MRC PR10)	**Radiotherapy and Androgen Deprivation In Combination After Local Surgery - A RCT in prostate Cancer**								
	O'Sullivan, Prof Joe	BHSCT	26/11/2009	30/06/2016	5 per year	27	84%	0	Open
RAPPER	**Radiogenomics: assessment of polymorphisms for predicting the effects of radiotherapy**								
	O'Sullivan, Prof Joe	BHSCT	03/06/2011	31/08/2018	15-20 per annum	141	101%	3	Open
	Mitchell, Dr Darren	WHSCT - patient identification and consent only				13	N/A	0	Open
STAMPEDE	**Systemic Therapy in Advancing or Metastatic Prostate Cancer: Evaluation of Drug Efficacy**								
	O'Sullivan, Prof Joe	BHSCT	16/12/2005	01/01/2017	Original Target 50 (now 200)	191	95%	5	Open
UKGPC	**UK Genetic Prostate Cancer Study (formerly Familial Prostate Cancer Study)**								
	O'Sullivan, Prof Joe	BHSCT	27/10/2006	31/12/2017	240	211	88%	5	Open
	Harney, Dr Jackie	SEHSCT	02/03/2009		NK	17	NK	9	Open
	Carser, Dr Judith	SHSCT	21/01/2009		NK	50	NK	4	Open
	McAleese, Dr Jonathan	NHSCT	25/11/2013		NK	25	NK	1	Open
	Mitchell, Dr Darren	WHSCT	22/03/2008		NK	50	NK	4	Open
PROMPTS	**Prospective randomised phase III study of observation versus screening MRI and pre-emptive treatment in castrate resistant prostate cancer patients with spinal metastasis**								
	Jain, Dr Suneil	BHSCT	30/05/2014	02/05/2017	21	7	33%	1	Closed
	Mitchell, Dr Darren	WHSCT - patient identification and consent only				0	0	0	

Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/05/17)	% of Target	Recruit. 2016	Project status
TOPARP	**Phase II Trial of Olaparib in Patients with Advanced Castration Resistant Prostate Cancer**								
	Jain, Dr Suneil	BHSCT	09/04/14	28/2/2017	15	4	20%	2	Open
PROSPER	**A multinational, phase 3, randomized, double-blind, placebo-controlled, efficacy and safety study of Enzalutamide in patients with non-metastatic castration-resistant prostate cancer**								
	Jain, Dr Suneil	BHSCT	27/08/2014	31/12/2018	10	9	90%	4	Open
BUSTIN	**A randomised trial comparing 2 bladder filling instruction sheets in achieving bladder volume consistency using an ultrasonic bladder scan device and biomarker analysis during intensity modulated prostate radiotherapy**								
	Hynds, Mrs Sharon	BHSCT	05/11/2012	24/12/2018	100	45	45%	0	Open
BAYER 15396	**A phase III randomized, double-blind, placebo-controlled trial of radium-223 dichloride in combination with abiraterone acetate and prednisone/prednisolone in the treatment of asymptomatic or mildly symptomatic chemotherapy-naïve subjects with bone predominant metastatic castration-resistant prostate cancer (CRPC)**								
	O'Sullivan, Prof Joe	BHSCT	14/07/2015	22/08/2016	10	7	10%	3	Closed - in FU
PACE	**PACE - International Randomized Study of Laparoscopic Prostatectomy vs Robotic Radiosurgery and Conventionally Fractionated Radiotherapy vs Radiosurgery for Early Stage Organ-Confined Prostate Cancer**								
	Jain, Dr Suneil	BHSCT	22/10/2015	01/09/2016	20	15	75%	11	Open
CASPIR	**Calcifications as an alternative to surgically implanted fiducial markers for Prostate Image guided Radiotherapy: A prospective feasibility study**								
	O'Sullivan, Prof Joe	BHSCT	20/11/2015	30/10/17	90	55	61%	26	Open
ADRRAD	**Neo-adjuvant Androgen Deprivation Therapy, Pelvic Radiation and RADium-23 for new presentation of T1-4 N0/1 M1B adenocarcinoma of prostate (ADRRAD Trial)**								
	O'Sullivan, Prof Joe	BHSCT	21/01/2016	31/07/2017	30	21	70%	14	Open
SPORT	**A Randomised Feasibility Study Evaluating Stereotactic PrOstate RadioTherapy in High-Risk Localised Prostate Cancer with or without Elective Nodal Irradiation (SPORT High-Risk Trial)**								
	Jain, Dr Suneil	BHSCT	18/01/2016	18/01/2018	30	7	23%	5	Open

Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/5/17)	% of Target	Recruit. 2016	Project status
Janssen Prostate Study	A Phase 3 Randomized, Placebo-controlled Double-blind Study of JNJ-56021927 in Combination with Abiraterone Acetate and Prednisone Versus Abiraterone Acetate and Prednisone in Subjects with Chemotherapy-naive Metastatic Castration-resistant Prostate Cancer (mCRPC)								
	Jain, Dr Suneil	BHSCT	08/03/2016	11/02/2017	10	4	40%	4	Closed – in FU
LAPCD	Life After Prostate Cancer Diagnosis								
	Mitchell, Dr Darren	BHSCT	22/04/2016	31/12/2018	4000	1028	171%	1028	Closed
	McAleese, Dr Jonathan	NHSCT							
	Harney, Dr Jacqui	SEHSCT							
	Glackin, Dr Anthony	SHSCT							
TRUFU	Therapeutic Radiographer undertaking Follow-Up for Prostate Cancer Patients								
	Hetherington, Stacey	BHSCT	22/06/2016	03/11/2016	30	30	100%	30	Closed

TESTICULAR

Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/5/17)	% of Target	Recruit. 2016	Project status
UKGTC	Identification of testicular germ cell tumour susceptibility genes								
	Dr Olabode Oladipo	BHSCT	19/01/2010	01/06/2016	500	334	67%	0	Closed

RENAL

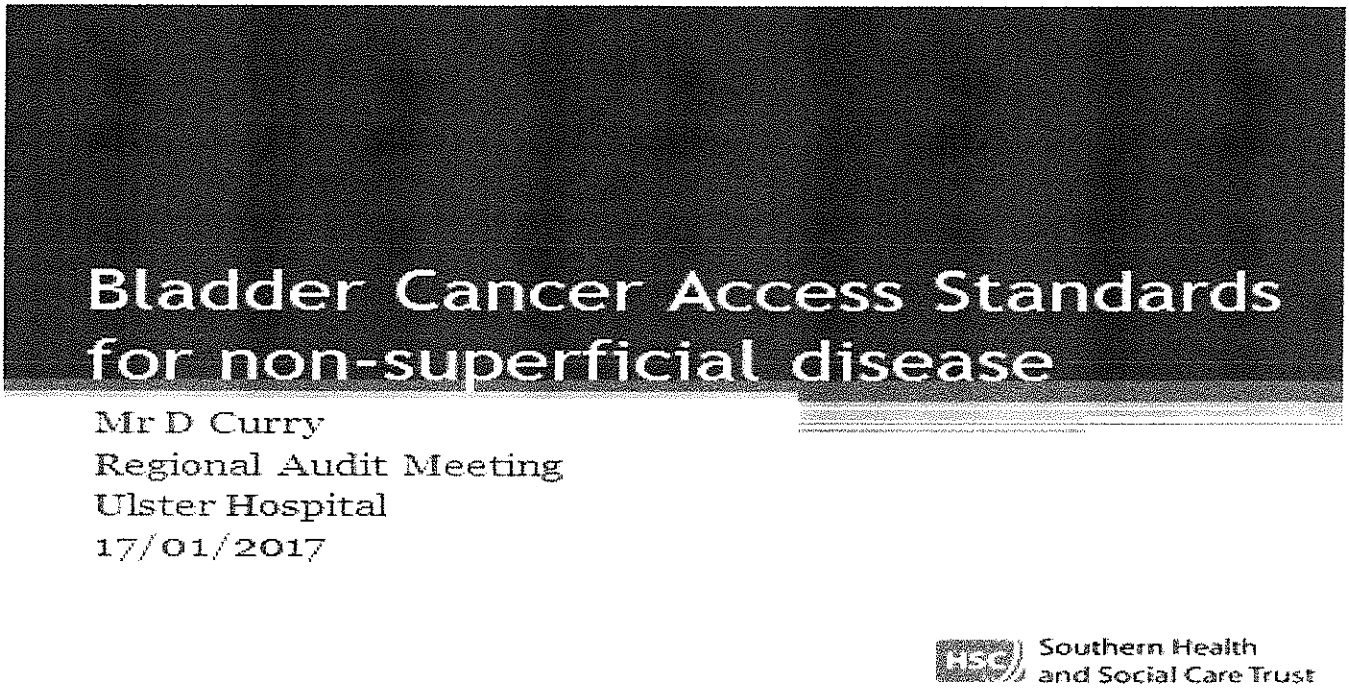
Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/5/17)	% of Target	Recruit. 2016	Project status
STAR	**A randomised multi-stage phase II/III trial of Sunitinib comparing temporary cessation with allowing continuation, at the time of maximal radiological response, in the first-line treatment of locally advanced and/or metastatic renal cancer**								
	Clayton, Dr Alison	BHSCT	30/08/2013	03/04/2018	72	13	18%	4	Open

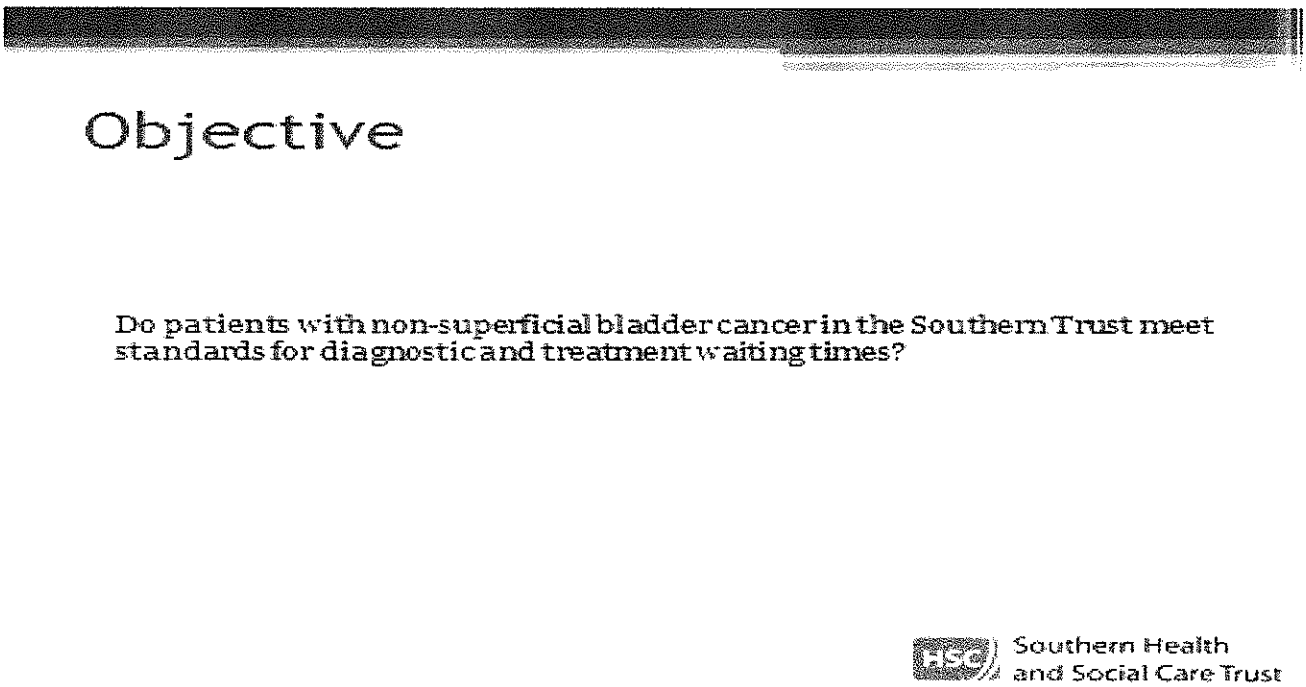
BLADDER

Trial	Principal Investigator	Site	Open to recruit.	Close to recruit.	Target	Total recruited (31/5/17)	% of Target	Recruit. 2016	Project status
HaBio	**Haematuria Biomarker Study**								
	O'Kane, Dr Huge	BHSCT	10/10/2012	30/06/2016	333 pts 666 cont.	585	66%	78	Closed – in FU
	Duggan, Dr Brian	SEHSCT	02/06/2014			75		12	
	Glackin, Mr Anthony	SHSCT	NK			17		12	

Appendix 7 AUDITS

7.1 Audit on Bladder Cancer Access Standards for non-superficial disease





Standards - NICE

Bladder cancer

1.6.4 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are:

- aged 45 and over and have:
  - unexplained visible haematuria without urinary tract infection or
  - visible haematuria that persists or recurs after successful treatment of urinary tract infection, or
- aged 60 and over and have unexplained non-visible haematuria and either dysuria or a raised white cell count on a blood test. [new 2015]

1.6.5 Consider non-urgent referral for bladder cancer in people aged 60 and over with unexplained or persistent unexplained urinary tract infection. [new 2015]

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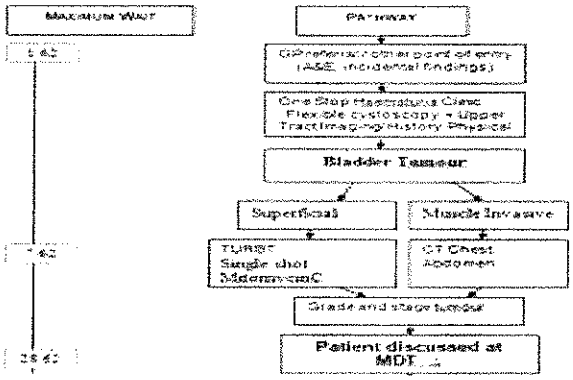
Standards -NICaN - CAH



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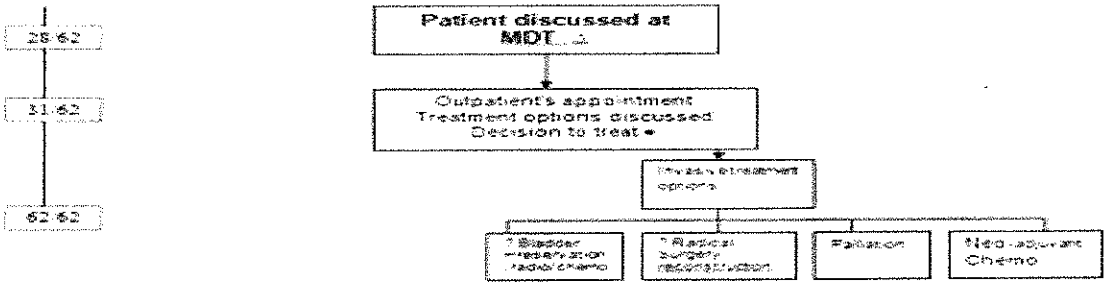
Standards - NICaN - CAH/BCH



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Standard 1-Red Flag Referral n=18

1.6.4 Refer people using a suspected cancer pathway referral for an appointment within 2 week(s) for bladder cancer if they are:

- 18/25 Patients triaged red flag
- Median Time from ref to 1st review – 16 days (IQR 14-17)
- 7/18 (38.9%) seen within 14 days
- 14/18 (77.8%) seen within 21 days
- Longest 42 days – however appointment at 25 days cancelled by patient

- NHS England target is 93%

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Materials and Methods

- Review of all bladder cancer patients through MDT Aug 2015 –Aug 2016
- Retrospective review of electronic records.
- 82 bladder cancer patients through MDT
- 25 (30.5%) had MIBC or required tertiary referral

- Mean age 76 (Range 56-90)
- 10 Female/ 15 Male

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Results - Demographics

- 25 (30.5%) had MIBC or required tertiary referral
  - Small cell carcinoma - 2 (8%)
  - Lymphoma - 1 (4%)
  - Squamous Cell Carcinoma - 3 (12%)
  - Transitional Cell Carcinoma – 19 (76%)
    - 2 BCG Refractory/ 17MIBC
- Referral Pathways
  - Emergency - 4 (16%)
  - Red Flag – 18 (72%)
  - Routine – 1 (4%)
  - Upstaged – 2 (85)

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Standard 1-Red Flag Referral n=18

1.6.4 Ensure people using a suspected cancer pathway referral service are given an appointment within 2 weeks for bladder cancer if they are:

- 18/25 Patients triaged red flag
- Median Time from ref to 1st review – 16 days (IQR 14-17)
- 7/18 (38.9%) seen within 14 days
- 14/18 (77.8%) seen within 21 days
- Longest 42 days – however appointment at 25 days cancelled by patient
- NHS England target is 93%

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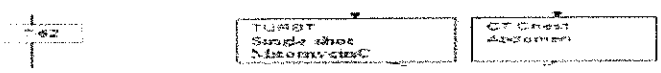
Standard 2 n=18



- Cystoscopy to TURBT
  - Median Time 23 days (IQR 13-32)
  - 2/18 (11%) within 7days
  - 10/18 (55.6%) >21 days

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Standard 3 n=22

- **Referral to MDT**
  - Median time 37days (IQR 31-56)
  - 5/22 (22.7%) within 28 days
  - 6/22 (27.3%) >56 days
- **TURBT to MDT**
  - Median Time -10 days (IQR 8-13)

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Standard 4 -

- **MDT to Results (n=21)**
  - Median Time 12 days (IQR 5-25)
  - 6/21 (28.6%) seen within 3 (working) days
  - 9/21 (42.9%) seen with 7 days
- **Referral to Results (n=22)**
  - Median Time 54 days (IQR 37-63days)
  - 5/22 (22.7%) within 31 days

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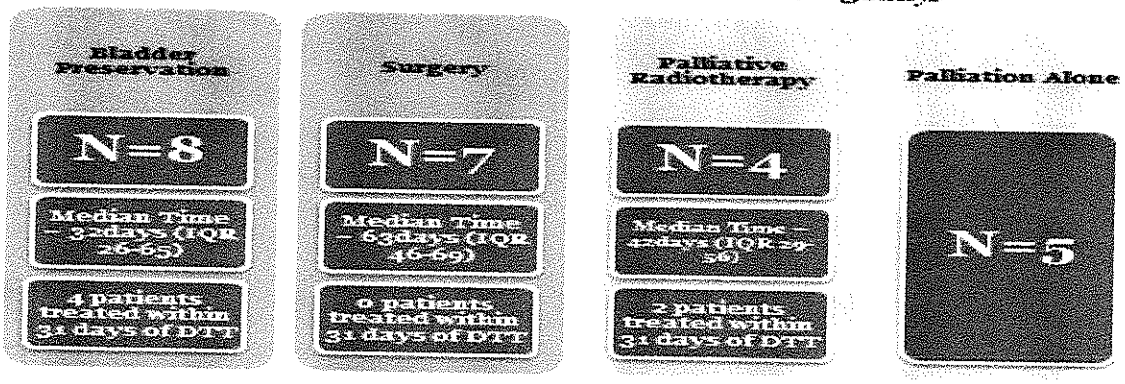
Standard 5 -

Decision to Treat (DTT) to Intervention – 31days



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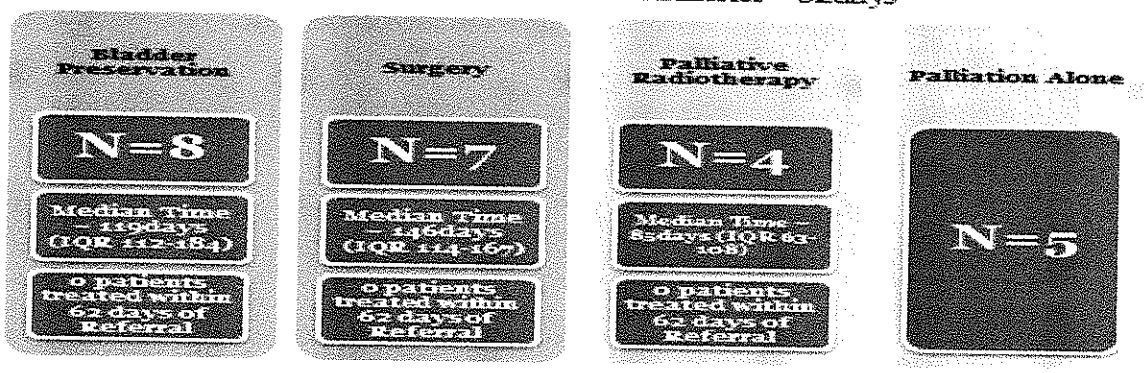
Standard 6 -

Referral to Definitive Treatment – 62days



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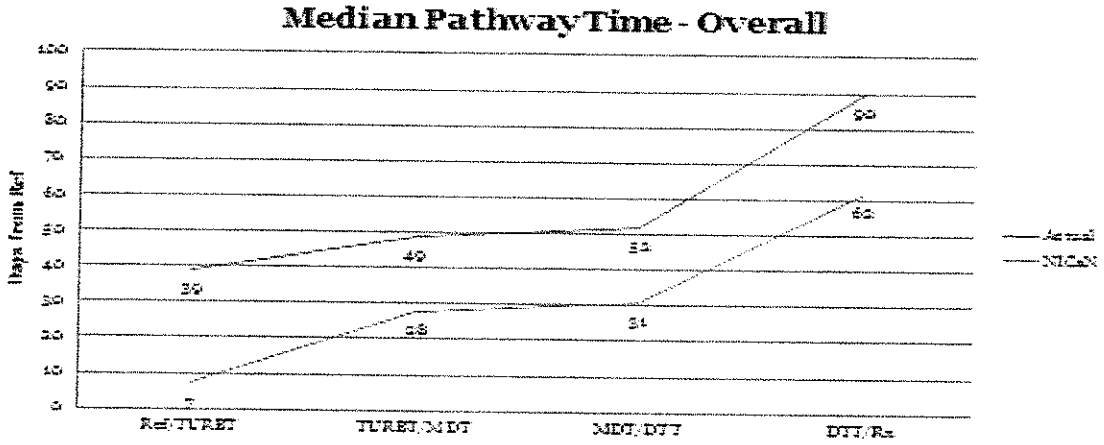
Overall Pathway



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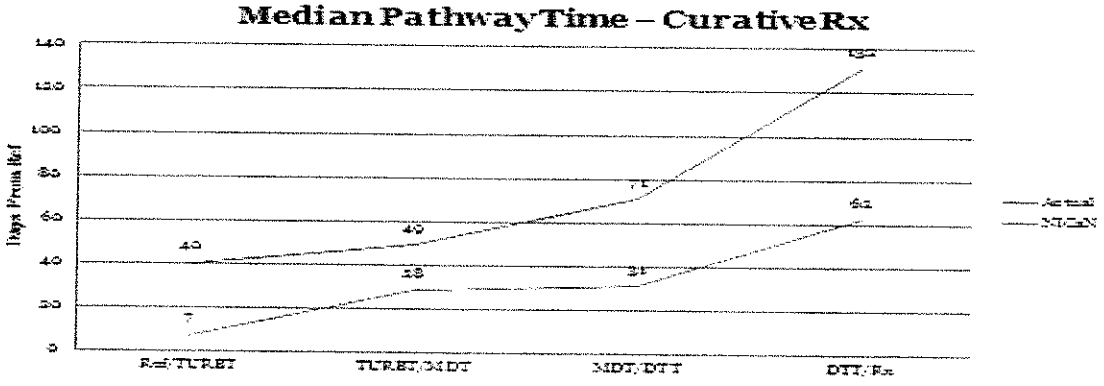
Pathway for Curative Rx



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TURBT to Radical Therapy

An interval longer than 12 weeks between the diagnosis of muscle invasion and cystectomy is associated with worse outcome in bladder carcinoma.

Delaying radical cystectomy for muscle invasive bladder cancer results in worse pathological stage.

- **Radiotherapy (n=6)**
  - Median 107 days (IQR 87-131)
  - 67% >90days
- **Surgery (n=7)**
  - Median 89 days (IQR 79-110)
  - 42.8% >90days

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Summary

- **Failure to meet NICE/NICaN access standards**
  - Red flag Cystoscopy
  - Initial TURBT
  - MDT to DTT
  - DTT to Treatment
- **Improvements?**
  - Fast cystoscopy access
  - Dedicated pooled red flag GA lists/slots
  - Results - clinic timing and ref pathway
  - Regional discussion

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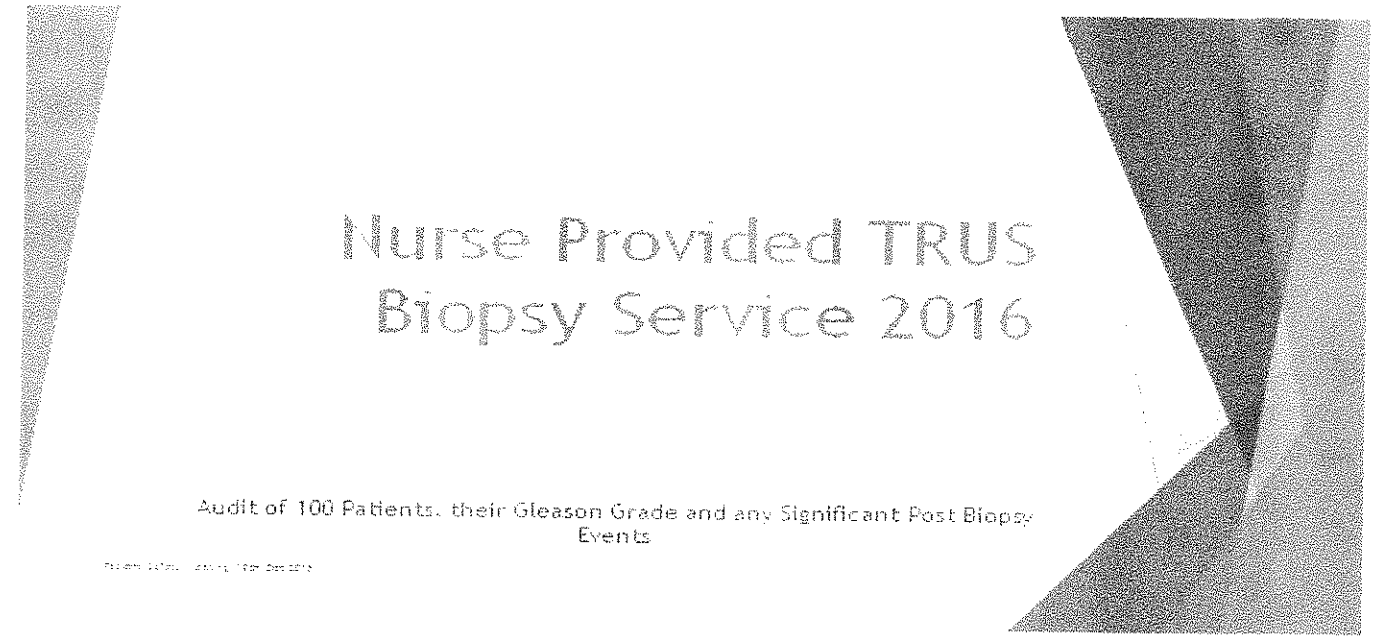
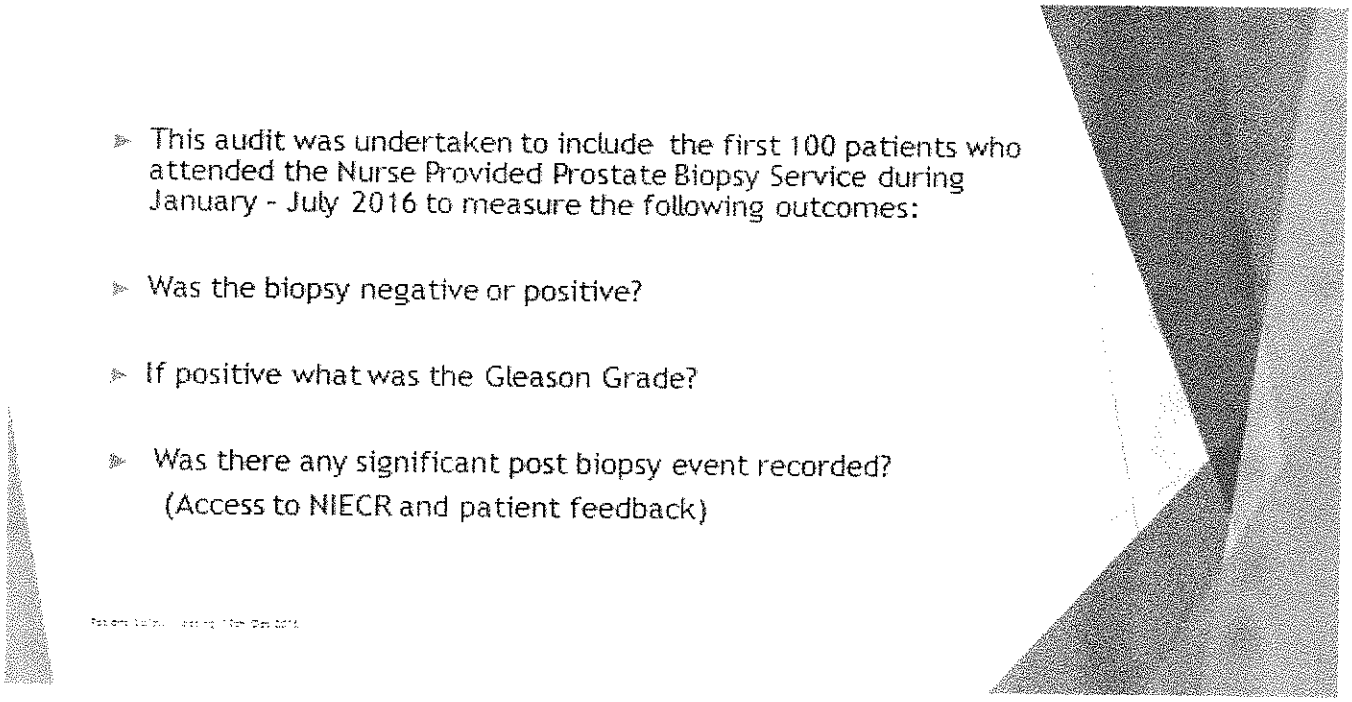
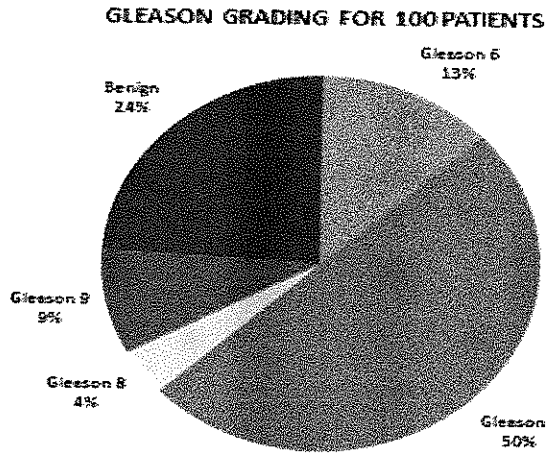
7.2 Audit of Nurse Provided TRUS Biopsy Service 2016







Significant Post Biopsy Events

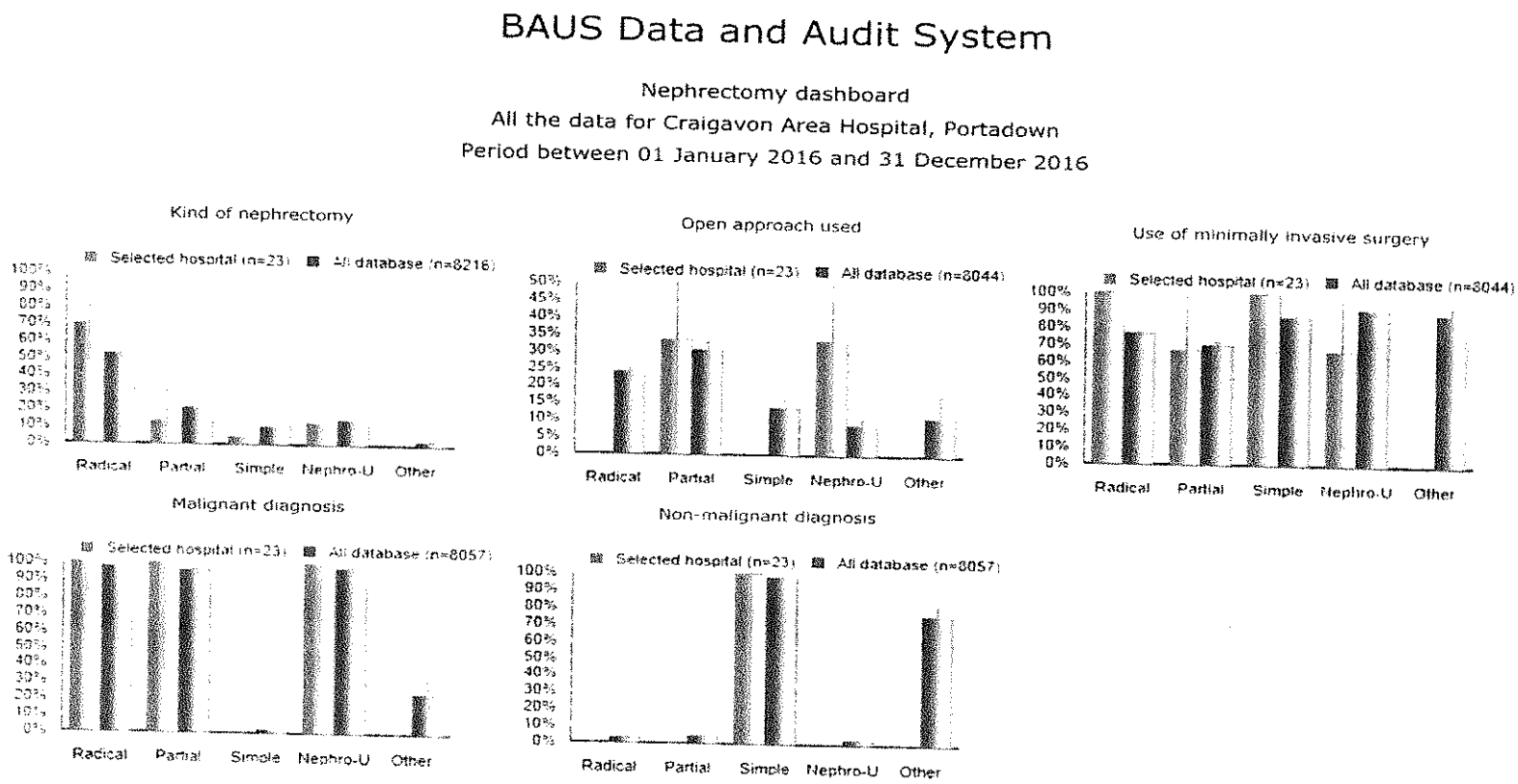
- Attendance at Out Of Hours services
  - 1 x Day 1 attendance with Retention of Urine (successful TROC followed)
  - 1 x Day 6 attendance with Dysuria (antibiotic prescribed)
- Attendance at Emergency Department
  - 1 x Day 8 attendance with UTI (antibiotic prescribed)
- Admission to Hospital
  - 1 x admission on the day with Bradycardia (Pacemaker inserted that PM)
  - 1 x admission Day 1 post biopsy with Pyrexia (Treated with IV antibiotics for 4 days. Negative Blood Cultures, no evidence of MSSU collected)

Biopsies Performed By Colleagues

During same period Jan - July 2014

Name	TRUS	GA- Biopsy	Total
Mr Glackin	10	7	17
Mr Haynes	11	2	13
Mr O' Donoghue	11	2	13
Mr Suresh	18	2	20
Radiology	31	0	31
Overall Total			94

7.3 BAUS Data and Audit System



Southern Health and Social Care Trust

Work Programme

Urology Cancer Service

2016/17

Agreed by the Urology MDT and signed on behalf of the team by Mr Anthony Glackin, Clinical Lead

UROLOGY MDT WORKPLAN FOR 2016/17

	Key Areas	Actions	Lead	Target Date	Update
Service Improvement and Development	Core membership of MDT	To ensure that all consultant urologists are core members of the MDT	MDT Lead / F.Reddick	Sept 2016	Completed. Mr Young is an extended member
		To encourage specialist registrar attend MDM		Dec 2016	Ongoing
		To address radiology and oncology representation at the MDT		Sept 2016	Ongoing – attendance issues have been escalated to SMT
	Communication Skills of MDT members	To ensure all MDT core members attend advanced communication skills course • Identify core members without training • Identify suitable training dates	MDT Lead/ Team	March 2017	To date all core members have completed ACST

	Key Areas	Actions	Lead	Target Date	Update
	Key worker role	To ensure that every new urology cancer patient has a key worker identified To support full implementation of the key worker role by ensuring dedicated time for telephone and face-to-face reviews and provision of clerical support	MDT Team / Martina Corrigan	Nov 2016	Work ongoing to address
	Patient Information	To ensure that all patients receive the required information to support their journey To develop a MDT Leaflet	Urology CNS's	Oct 2016	A MDT leaflet has been developed and is now provided to all new patients
	Improve data collection to support information on clinical outcomes	Continue to collect high quality data via CaPPS	MDT Team	Ongoing	This is ongoing

	Key Areas	Actions	Lead	Target Date	Update
	Participation in regional tumour specific group	Attendance at NICaN Regional Urology Group Meetings	MDT Lead	Ongoing	Mr Aidan O'Brien has stepped down as Clinical Lead. Mr Mark Haynes has been elected as the new Clinical Lead
	Record of patient management	To develop and implement permanent record of patient management	MDT Team	September 16	Record was trialled between Oct-Dec 2016 for newly diagnosed patients. Feedback being sought from patients and the team.
	New models of review	To pilot a community based prostate follow-up clinic for stable prostate patients	Urology Team	Summer 2017	Pilot clinics are planned for June 2017
Patient and carer feedback	Integrate patient feedback into service improvement	To disseminate feedback from National Cancer Patient Experience Survey	MDT Lead /UCNS's	August 16	Feedback has been disseminated to the MDT and local

	Key Areas	Actions	Lead	Target Date	Update
					survey completed. An action plan has been developed to address areas of concern
		To carry out a local patient experience survey and develop an action plan based on findings	Urology CNS's / MDT Team	September 16	Completed. Local action plan developed and being implemented as a result.
Clinical Governance Issues	Patient Safety	To regularly review and learn from critical incidents, near misses and complaints within the service at the Patient Safety meetings	T.Glackin / MDT	On-going quarterly	These are presented at the Trust Patient Safety meeting
Audit	Ongoing audit projects at local regional & national level	Participation in NICaN audit portfolio	MDT Lead	Ongoing	This is to be agreed regionally
		Participate in annual / national audits	Audit Lead/MDT Lead	Ongoing	

	Key Areas	Actions	Lead	Target Date	Update
Clinical trials	Continued contribution to clinical research	Continue to recruit and increase patient numbers recruited to clinical trials	MDT Lead / Clinical trials lead	Ongoing	
Action from previous peer review	Preparation for peer review on a continuous basis	Arrange regular business meetings to contribute to future peer review assessments	Core MDT	Ongoing	Regular team meetings are arranged

Aimee Crilly

From: Hynds, Siobhan <[redacted]>
Sent: 04 March 2018 14:03
To: O'Brien, Aidan
Cc: Chada, Neta
Subject: Statement 2 - Mr A O'Brien 061117 (names redacted)
Attachments: Statement 2 - Mr A O'Brien 061117 (names redacted).docx

Importance: High

Mr O'Brien

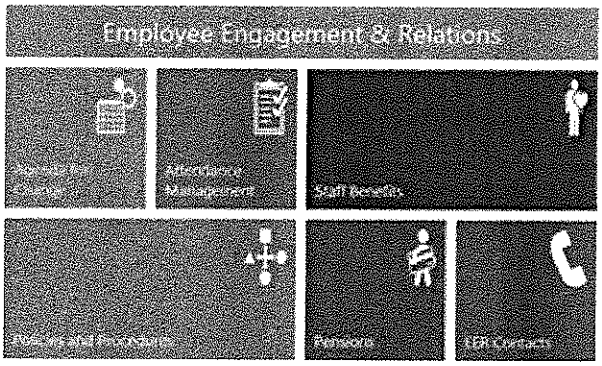
Please find attached notes from the November meeting for your agreement.

I would be grateful for an update from you regarding your comments on the previous meeting notes (statement1) and the witness statements.

Many thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: [redacted] Mobile: [redacted] Fax: [redacted]



Click on the above image for SharePoint: Employee Engagement & Relations information

'You can follow us on Facebook and Twitter'

Respondent Statement

NAME OF WITNESS	Mr Aidan O'Brien
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Monday 6 November 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. The meeting commenced with welcome and introductions. The format of the meeting was outlined to me and it was explained that the meeting would be based on the previously shared Terms of Reference for the investigation.

2. The purpose of the meeting is to address Term of Reference 4 which had not been previously responded to.

3. Dr Chada explained that this was the final meeting after which she could conclude the process. I explained to Dr Chada that I have a number of priorities in November / December including my Appraisal which I wish to get completed. I advised that I would be concentrating on this in the coming weeks. I outlined that this process is having a significant impact on myself and my wife – it is a difficult time. Dr Chada outlined that once we have agreed statements, a case report can be provided to the Case Manager.

4. I advised that I have a number of issues with and comments to make on the previously shared notes from my first meeting with Dr Chada and also with the witness statements shared with me. I noted I intend to make commentary on both.

5. I advised that of the 9 patients, highlighted to me for response in respect of time being added to the waiting list and when they came in for a procedure, only 2 were TURP patients. The initial information shared with me in respect of these concerns related only to TURP patients. I asked for clarification on this and if there had been a full review of my private patients undertaken – not just TURP patients.

6. I provided Dr Chada with a written synopsis relating to each patient queried, including an explanation as to why they had been seen and timescale. I outlined that the date recorded for these patients as to when they were placed on waiting list is incomprehensible. I provided the date of the private consultations and noted that the procedure dates were correct in the main.

7. *For the purpose of this note, I have appended a copy of the written response submitted to Dr Chada on 6 November 2017. This note provides only comments made at the meeting that are not contained in the written submission:*

a. **PATIENT** Personal Informa

I reviewed this man privately on 20 February 2016. He was an anxious man, his mother was ill at time. I was not able to convince him that a scrotal swelling he had was benign. He had his procedure 31 days after I saw on 22 March 2016. He returned to me on 25 June 2017 and had a CT scan which showed no evidence of pathology. He was referred to mental health services for treatment of depression.

When I reviewed him in Armagh Community Hospital in June, he was still an anxious man – he had an anxiety about cancer. Some people are anxious with the fear or prospect of cancer – so I expedited his admission. I would have done same thing if he had attended as a NHS patient.

b. **PATIENT** Personal Informatio n

My comment here is on the word reasonable as confirmed by my colleague. This was an Personal Information redacted by the old with haematuria seen after 46 days. This person was seen after 46 days and not 9 days as suggested. She was seen within the 62 day cancer guidelines.

c. **PATIENT** Persona l Informati

This man attended my clinic privately on 2 May 2015 with persistent incontinence. His wife had died in Personal Information redacted by the USI I expedited his cystoscopy, which was on 15 April 2016 as an additional patient in my SPA time. This was 349 days after seeing this patient.

d. **PATIENT** Personal Informatio

This lady was seen on 24 March 2016 with loin pain, she had a large left renal stone and was admitted on 27 April 2016 (after 25 days). This patient would have been an emergency had she been referred from the Emergency Department.

e. **PATIENT** Perso nal Inform

This patient had been referred twice by his GP. He was seen for procedures on 8 July 2016, he would probably have been routine (a 94 weeks wait for routine). He had significant difficulties with bed wetting. I expedited this patient and they were seen as an outpatient after 45 days and further referred to the Day Surgical Unit after a further 32 days.

f. **PATIENT** Personal Information redacted

I saw this patient privately on 20 July 2015. At that time the wait for routine appointment was 170 weeks. It would have been indefensible not to put this gentleman on an urgent NHS list. His admission was on 21 July 2016 after 428 days.

In July 2015 he would have been on a waiting list, he wasn't but should have been. No one knew he needed to be on a waiting list. The Trust should have known he was on a waitling list but didn't. I put this patient on medication in July 2015 to try to improve symptoms.

g. **PATIENT** Personal Informa

This patient was seen by me on 21 November 2015. A CT scan was performed on 30 November 2015 and he was admitted on 24 February 2016 and had bladder cleared. He was then entirely symptom free. This gentleman died in Personal Information

h. **PATIENT** Personal Information

This patient was seen by me on 23 July 2016 and was admitted on 16 August 2016 and catheterised. It is hard to understand how a senior clinician could say this was not reasonable.

i. **PATIENT** Personal Information redacted by

I saw this Personal Information redacted by the old man on 8 October 2016 because of discomfort due to on-going catheterisation. I expedited his admission on 2 November 2017. It is not appropriate for a Personal Information redacted year old man to cope with a recurrence of infection.

j. **PATIENT** Personal Information redacted

I first assessed Mr Personal Information redacted by on 1 October 2016 because of severe urinary symptoms. Because of the severity of his symptoms I arranged for him to attend hospital on 4 November 2016, 34 days later.

k. **PATIENT** Personal Information redacted

This is the Personal Information redacted by the USI who has been a personal friend for many years and Personal Information redacted by the USI. I reviewed Personal Information redacted by on 30 January 2016 at her fathers

request as she was experiencing severe symptoms and was rising up to 4 – 5 times per night to pass urine. Personal Information redacted by was seen on 16 February 2016 after 17 days. No patient was displaced. I operated during an additional operating session on 24 February 2016 (after a further 8 days). I was operating an additional 3 hours on that particular day. Mr M Young and I started doing longer days to try to get operating done. There was resistance to this from some nursing staff and anaesthetists. I do additional operating sessions when Theatre is vacant rather than admin or SPA time. I do not have operating prior to 12 noon in job plan. My clinical admin time is separate to this.

8. I had intended to bring along my Waiting List but have not got it with me. Foolishness in the Department of Health have left us with only 2 categories for referrals. Categories 1 and 3 were removed and now we have only have 2 and 4. There is no official category for red flag.

9. I always put patients with Catheter on urgent. I review waiting list every month to look at red flags. There is a 3rd Category – those with catheter, if symptomatic they need to be seen, we need to grade those on the waiting list all the time. Urgent are those with Indwelling catheter, stent, red flags.

10. Dr Chada asked if I looked at the NHS waiting list would this look the same and I replied yes. I receive complaints constantly regarding waiting lists.

11. The last day when we met on 3 August 2017, I got the list of patients to comment on. I found this day very difficult. My wife who does my private admin has no access to unit numbers etc. but I did know the first patient was Personal Information redacted by the USI and she said Personal Information redacted by the USI is not a TURP patient. I was advised at a meeting on 24 January 207 that the concern was regarding TURP patients. This was further re-affirmed by Dr Wright on 30 March 2017 that a review was conducted of TURP patients and Ronan Carroll's witness statement stated there had been 3 TURP patients identified. I was shocked by that.

12. I looked at TURP patients on the back of the meetings and I reviewed all patients. Waiting times for private TURP patients were looked at. There was a marginal difference between NHS and TURP patients. I was left wondering were the concerns all anecdotal – a generalisation arrived at. I expect this to be forensically looked at – what was the issue/added issue in January. I expected to have those lists long before August 2017.

This statement was drafted on my behalf by Mrs Siobhan Hynds, Head of Employee Relations and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a conduct or clinical performance hearing. I understand that I may be required to attend any hearing as a witness.

SIGNATURE	
DATE	

From: Corrigan, Martina
To: Henry, Gillian; Haughey, Mary; Carroll, Ronan; Sharpe, Dorothy; Matthews, Josephine; (Aidanpobrien [redacted]); ([redacted]); Glackin, Anthony; Haynes, Mark; Mark (mark.d.haynes [redacted]); Young, Michael; O"Brien, Aidan; ODonoghue, JohnP; odonoghuejp [redacted]; Tony Glackin ([redacted]); McCourt, Leanne; McMahon, Jenny; ONeill, Kate; Young, Jason; Caddell, Caroline; Lockhart, Sharon; Magee, Naomi; Magill, Gayle; McElvanna, Ciara; Uprichard, Susanna
Cc: Witczak, Maria; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: HOLD THE DATE
Date: 22 June 2018 04:04:32

Dear all

We are planning to hold a Urology Service Development Day and therefore we would be grateful if you could hold Monday 24 September for this workshop. I am hoping to book somewhere like the Seagoe Parish Hall, but I will confirm the venue nearer the time.

In the meantime it would be great if you could hold the date and I will come back with more details.

Regards

Martina

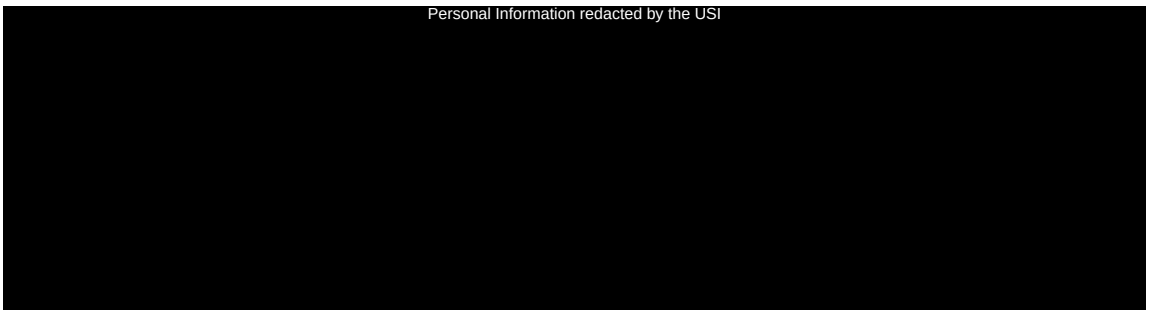
Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Corrigan, Martina
To: Aidan O'Brien's email address; Michael Young's email address; Glackin, Anthony; Haynes, Mark; Mark Haynes's email address; Young, Michael; O"Brien, Aidan; ODonoghue, JohnP; John P O'Donoghue's email address; Tony Glackin Personal Information redacted by the USI
Subject: Away day - monday 24 September
Date: 06 September 2018 12:49:04
Importance: High

Dear all

Just checking if you are happy for this to still go ahead? As means of an update regarding myself……



If this is still going ahead then I can get Stephen to bring me down and collect me until I am confident regarding the driving but I am conscious I would have liked to be prepared for this beforehand.

I will be guided by yourselves.

Thanks

Martina

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

INTERNAL: EXT Personal Information
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Corrigan, Martina
To: Michael Young's email address ; Anthony Glackin's email address
Cc: Aidan O'Brien's email address ; Glackin, Anthony; Haynes, Mark; Mark Haynes's email address ; Young, Michael; O"Brien, Aidan; ODonoghue, JohnP; odonoghuejp@gmail.com
Subject: RE: Away day - monday 24 September
Date: 08 September 2018 11:58:15

Thanks

I suppose the point I was trying to make was that we need to make sure that the Away Day, is well structured with a tight agenda and clear objectives of what we want to achieve. I feel that we really need to ensure that it is a worthwhile day particularly as clinical activity has been cancelled and also as there are so many others due to attend (Consultants/Thorndale staff/Ward staff/Lead nurses and Ronan Carroll) are all scheduled to be at this event.

Whilst I will ensure that I will be there if this was to go ahead, I am just concerned that we have not prepared anything and I would have really liked to be involved in the preparation for this day with regards to objectives, papers/stats etc……. so as we all will get the full benefit of this away day.

Personal information redacted by USI .

Regards

Martina

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

INTERNAL: EXT Personal Information
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Michael Young's email address
Sent: 07 September 2018 16:40
To: Anthony Glackin's email address
Cc: Corrigan, Martina
Subject: Re: Away day - monday 24 September

No = I think we should still have
was going to send you a few points
you may wish to consider a start and finish time that is not all day ? 9-30 to 2 or 10-30 to 1 with consultants and 1-3 with the nurses just an idea.
It would be best that Martina is there though but if not possible it can still be an opportunity

MY

Sent from Windows Mail

From: Anthony Glackin's email address
Sent: Friday, 7 September 2018 16:01
To: Aidan O'Brien's email address, Michael Young's email address, Glackin, Anthony, Haynes, Mark, Mark Haynes's email address, michael.young Personal Information redacted by the USI, O'Brien, Aidan, ODonoghue, JohnP, John P O'Donoghue's email address, Corrigan, Martina

Dear Martina,
I think we might be best postponing the away day until your return. October is already scheduled. So November is looking like the earliest suitable time.

Tony

Get Outlook for Android

On Thu, Sep 6, 2018 at 12:49 PM +0100, "Corrigan, Martina"
<Personal Information redacted by the USI> wrote:

Dear all

Just checking if you are happy for this to still go ahead? As means of an update regarding myself……

Personal Information redacted by the USI

If this is still going ahead then I can get Stephen to bring me down and collect me until I am confident regarding the driving but I am conscious I would have liked to be prepared for this beforehand.

I will be guided by yourselves.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients

Craigavon Area Hospital

INTERNAL: EXT Personal Information
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Aimee Crilly

Subject: FW: NICR Factsheets 2017
Attachments: Prostate Stats 2017.pdf; Bladder Stats 2017 NICR.PDF; Kidney Stats 2017 NICR.PDF

Importance: High

From: Sarah Donaldson <Personal Information redacted by the USI>
Sent: 02 April 2019 10:48
To: Aidan O'Brien <Personal Information redacted by the USI>; Alison Clayton <Personal Information redacted by the USI>; a.gavin <Personal Information redacted by the USI>; Arthuy Grey <Personal Information redacted by the USI>; Brian Duggan <Personal Information redacted by the USI>; Bridget Tourish <Personal Information redacted by the USI>; Caroline Lynas (SEHSCT) <Personal Information redacted by the USI>; Chris Hagan <Personal Information redacted by the USI>; Chris.thomas <Personal Information redacted by the USI>; Ciara Toal <Personal Information redacted by the USI>; Clodagh O'Brien <Personal Information redacted by the USI>; colin.mulholland <Personal Information redacted by the USI>; Corrigan, Martina <Personal Information redacted by the USI>; Darren Mitchell (niecr) <Personal Information redacted by the USI>; 'Davinia Lee <Personal Information redacted by the USI>' <Personal Information redacted by the USI>; Debbie Wightman (BHSCT) <Personal Information redacted by the USI>; declan.orourke <Personal Information redacted by the USI>; Dermot Hughes <Personal Information redacted by the USI>; dianne.kirkpatrick northerntrust <Personal Information redacted by the USI>; Dr Jackie Jamison <Personal Information redacted by the USI>; Eatock, Martin <Personal Information redacted by the USI>; Edel Aughey <Personal Information redacted by the USI>; elizabeth.burgess <Personal Information redacted by the USI>; Fiona Reddick <Personal Information redacted by the USI>; fionnuala.houghton <Personal Information redacted by the USI>; Gareth McClean <Personal Information redacted by the USI>; Gerry McCarthy <Personal Information redacted by the USI>; Gillian Traub <Personal Information redacted by the USI>; gillian.cairns <Personal Information redacted by the USI>; Graeme Crawford (Personal Information) <Personal Information redacted by the USI>; Lisa Houlihan (BHSCT) <Personal Information redacted by the USI>; Hugh kane (niecr) <Personal Information redacted by the USI>; Hutchinson, Chris <Personal Information redacted by the USI>; Igho Diegbe <Personal Information redacted by the USI>; jacqui.harney <Personal Information redacted by the USI>; "jim.mcguigan <Personal Information redacted by the USI>; Joe O'Sullivan <Personal Information redacted by the USI>; John Keane (niecr) <Personal Information redacted by the USI>; John McKinght (niecr) <Personal Information redacted by the USI>; John Smyth (niecr) <Personal Information redacted by the USI>; Johnny Brown <Personal Information redacted by the USI>; Jonathan McAleese (niecr) <Personal Information redacted by the USI>; juliea.alexander <Personal Information redacted by the USI>; Kate O'Neill <Personal Information redacted by the USI>; Kerry Chambers <Personal Information redacted by the USI>; Caoimhe Lavery (NIECR Contact) <Personal Information redacted by the USI>; Lin Shum (niecr) <Personal Information redacted by the USI>; Loretta Gribben <Personal Information redacted by the USI>; Lynn McLean <Personal Information redacted by the USI>; MacKenzie Niall <Personal Information redacted by the USI>; Mark Haynes <Personal Information redacted by the USI>; Mary.haughey <Personal Information redacted by the USI>; Mary Jo Thompson <Personal Information redacted by the USI>; Robert McCormac (SEHSCT) <Personal Information redacted by the USI>; McCourt, Leanne <Personal Information redacted by the USI>; McDonnell, Margaret <Personal Information redacted by the USI>; McLaughlin Maeve <Personal Information redacted by the USI>; John Keane (niecr) <Personal Information redacted by the USI>; Mr Michael Reilly <Personal Information redacted by the USI>; Naomi McCay <Personal Information redacted by the USI>; Pat Shiels <Personal Information redacted by the USI>; Patricia Thompson <Personal Information redacted by the USI>; Patrick Keane <Personal Information redacted by the USI>; Paul Downey <Personal Information redacted by the USI>; Peter.Ball setrust <Personal Information redacted by the USI>; Ruth Moore <Personal Information redacted by the USI>; Sam Gray <Personal Information redacted by the USI>; Samantha Thompson <Personal Information redacted by the USI>; Sarah Donaldson <Personal Information redacted by the USI>; Simon Gibson <Personal Information redacted by the USI>; Sinead Lardner <Personal Information redacted by the USI>; Suneil Jain <Personal Information redacted by the USI>; Suneil Jain (2) <Personal Information redacted by the USI>; Thamra Ayton <Personal Information redacted by the USI>; Tim Vits <Personal Information redacted by the USI>; Mr Ajay Pahuja <Personal Information redacted by the USI>; Mr Alex Mac Leod

Personal Information redacted by the USI
>; Mr Anthony Glackin <Personal Information redacted by the USI>; Mr Daniel Safar <Personal Information redacted by the USI>; Mr David Connolly <Personal Information redacted by the USI>; Mr Fawzay Subin <Personal Information redacted by the USI>; Mr Filip Subin <Personal Information redacted by the USI>; Mr Frank Schattka <Personal Information redacted by the USI>; Mr Funsho Abogunrin <Personal Information redacted by the USI>; Mr Hugh O'Kane <Personal Information redacted by the USI>; Mr John O'Donoghue <Personal Information redacted by the USI>; Mr Michael Young <Personal Information redacted by the USI>; Mr Paul Downey <Personal Information redacted by the USI>; Mr Saif Elamin <Personal Information redacted by the USI>; Mr Trevor Thompson <Personal Information redacted by the USI>; Ms Carole O'Neill <Personal Information redacted by the USI>; Woolsey Siobhan (niecr) <Personal Information redacted by the USI>

Subject: NICR Factsheets 2017
Importance: High

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

Dear All,

The NICR has produced an up to date factsheet for Prostate, Bladder and Kidney which I have attached for ease of reference. Work is ongoing and further sheets will be uploaded over the coming weeks. Further information is available on their website which you can access here.

2018 Statistics on cancer incidence and survival will be published on **Thursday 2nd April 2020**.

Regards

Sarah

Sarah Donaldson
Macmillan Network Co-ordinator-NICaN
12-22 Linenhall Street
Belfast
BT2 8BS
Tel: Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Northern Ireland Cancer Network 70 NHS 70

PROSTATE CANCER

NUMBER OF CASES PER YEAR (2013-2017)[1]	NUMBER OF DEATHS PER YEAR (2013-2017)[1]
Male	Male
1,133	274
FIVE-YEAR SURVIVAL (2007-2011)	**25-YEAR PREVALENCE (2017)**
Male	Male
88.3%	10,337

[1] Mean yearly incidence data for period 2013-2017 has been rounded to nearest integer, and thus some numbers in tables will not add to give the exact total.

INCIDENCE

In 2013-2017 there were 1,133 men diagnosed with prostate cancer each year. The risk for men of developing a prostate cancer up to the age of 75 was 1 in 12.

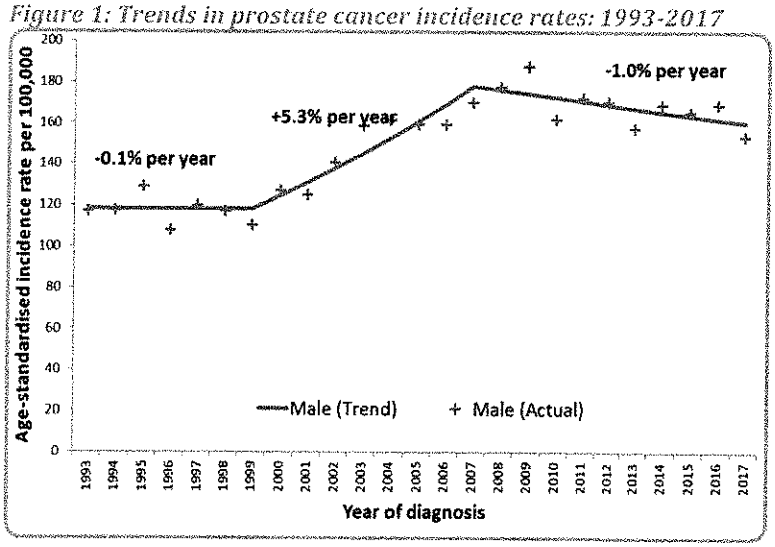
Incidence trends

Table 1: Incidence of lung cancer by sex and year of diagnosis: 2008-2017

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Male	1,029	1,123	970	1,077	1,098	1,040	1,151	1,147	1,189	1,137

Over a ten year period from 2008 to 2017 the number of prostate cancers cases in men has increased from 1,029 to 1,137. Prostate cancer incidence rates in men have increased during 1999-2007 by an average of 5.3% per year, and then have decreased by 1.0% from 2007-2017.

Figure 1: Trends in prostate cancer incidence rates: 1993-2017



Incidence and age

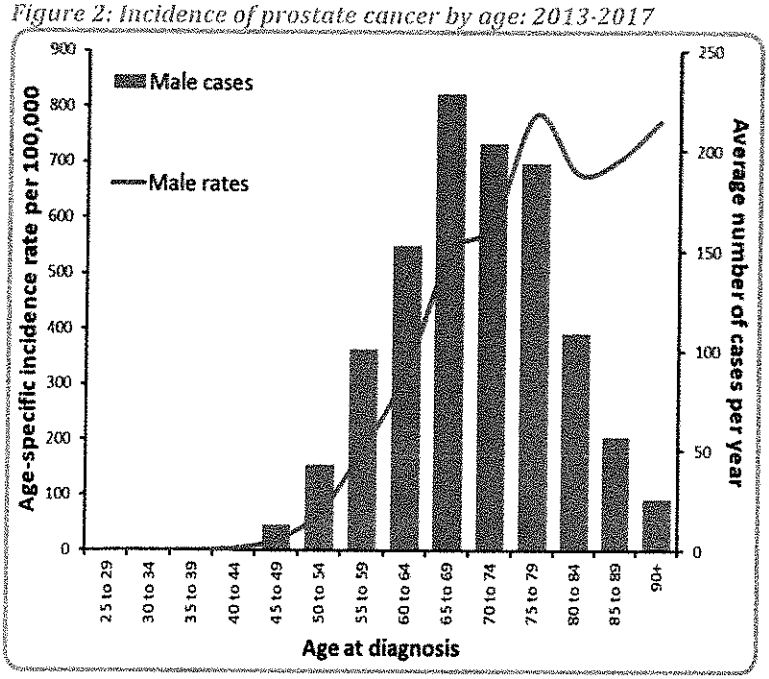
Prostate cancer risk is strongly related to age with approximately 72% of patients diagnosed over the age of 65 years and incidence rates greatest among those aged over 70.

Table 2: Average number of prostate cancers diagnosed per year by age: 2013-2017

Age	Male
0 to 49	15
50 to 64	297
65 to 74	433
75 and over	386
All ages	1,133

Due to rounding of yearly averages, 'All ages' may not equal the sum of age categories in tables.

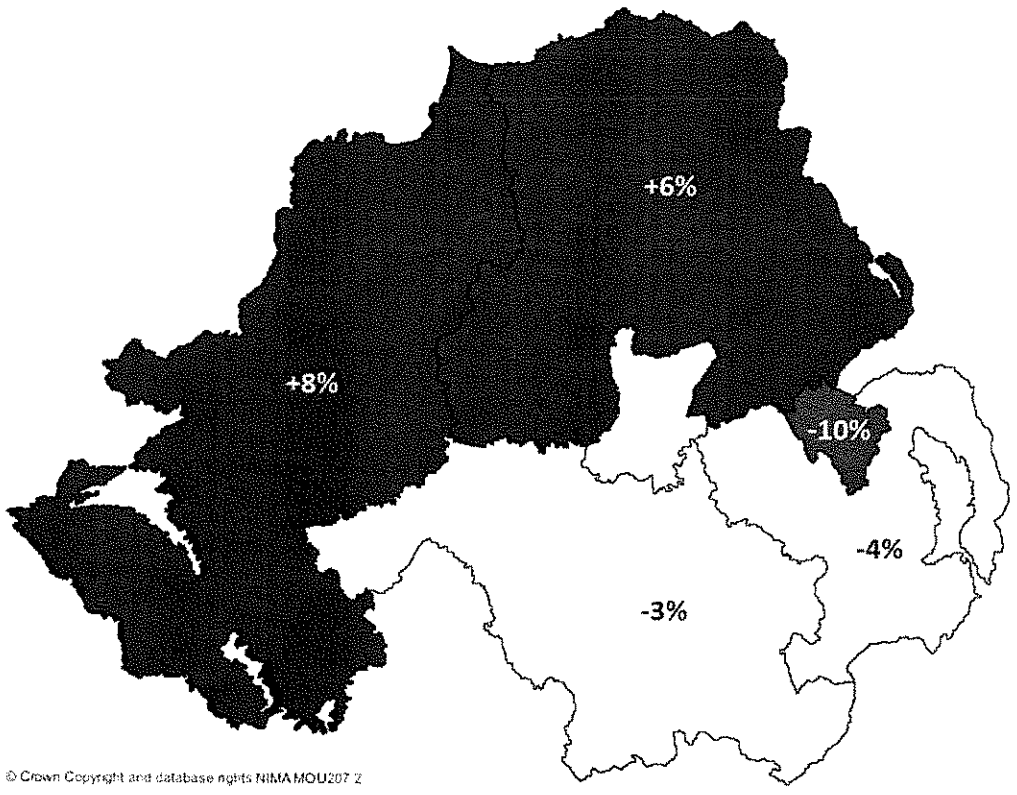
Figure 2: Incidence of prostate cancer by age: 2013-2017



Incidence by Trust area

Prostate cancer incidence rates in 2013-2017 were 6% and 8% higher among people living in the Northern and Western Trust areas respectively than in Northern Ireland as a whole while those living in Belfast Trust area had a 10% lower incidence rate of prostate cancer than the Northern Ireland Average.

Figure 3: Prostate cancer incidence rates compared to the NI average by sex and HSC Trust of residence: 2013-2017



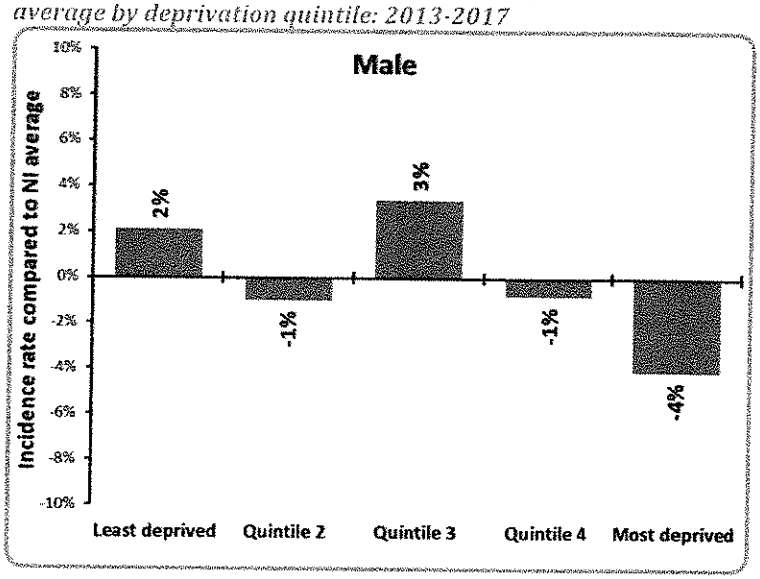
Significantly higher than average

Significantly lower than average

Incidence by deprivation

While incidence of many cancers vary by socio-economic deprivation, there is no evidence of this association for prostate cancer incidence rates in Northern Ireland since 2013.

Figure 4: Prostate cancer incidence rates compared to the NI average by deprivation quintile: 2013-2017



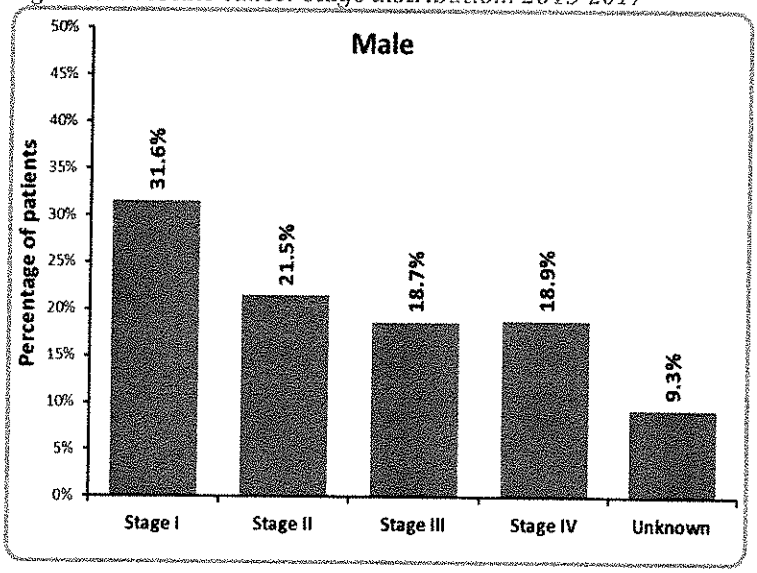
Incidence by stage

Cancer stage is a way of describing the size of a cancer and how far it has grown and spread. This information is important in helping decide what treatments are needed and stage of disease at diagnosis is strongly associated with cancer survival.

From 2013 to 2017 91% of prostate cancer patients in Northern Ireland were assigned a stage at diagnosis.

The majority of prostate cancer patients were diagnosed at early stage (31.6% at stage I and 21.5% at Stage II) and 18.9% diagnosed at late stage (stage IV).

Figure 5: Prostate cancer stage distribution: 2013-2017



SURVIVAL

The net survival was 96.5% at one year, and 88.3% at five years for prostate cancer patients diagnosed in 2007 to 2011.

Table 3: Prostate cancer survival by survival time: patients diagnosed 2007-2011

Time since diagnosis	Diagnosed 2007-2011
	Male
6 months	97.6%
1 year	96.5%
5 years	88.3%

Survival Trends

Five-year survival for prostate cancer in men has improved from 57.8% in the 1993-1996 diagnosis period to 88.3% in the 2007-2011 diagnosis period.

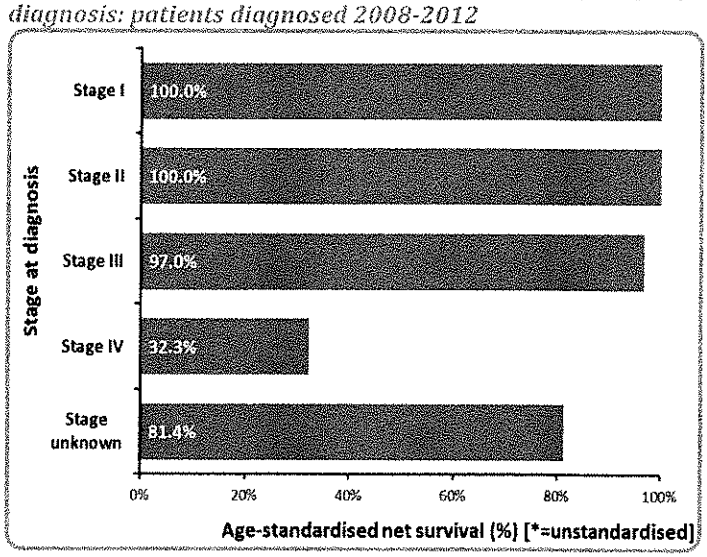
Table 4: Five-year prostate cancer survival by period of diagnosis

Period of diagnosis	Male
1993-1996	57.8%
1997-2001	70.6%
2002-2006	84.8%
2007-2011	88.3%

Survival and stage

Stage at diagnosis is one of the most important factors in prostate cancer survival with five-year survival decreasing as stage increases. Stage at diagnosis data is available for cancer patients diagnosed since 2008. Five-year survival was almost 100% for all patients except those diagnosed with late stage IV disease (32.3%).

Figure 6: Five year survival from prostate cancer by stage of diagnosis: patients diagnosed 2008-2012



Mortality

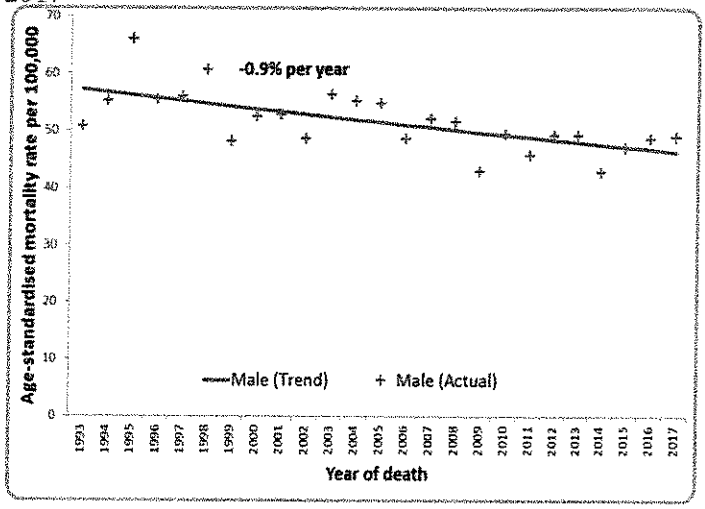
Mortality statistics are provided by the Northern Ireland General Registrar's Office. In 2013-2017 there were 274 deaths from prostate cancer each year.

Mortality trends

Over the last ten years the number of prostate cancer deaths has increased from 232 among men in 2008 to 295 among men in 2017, a 27% increase over time.

When adjusted for age and population change, prostate cancer mortality rates decreased by -0.9% per year during 1993-2017.

Figure 7: Trends in prostate cancer mortality rates: 1993-2017



Prevalence

At the end of 2017 there were 10,337 men living in NI who had been diagnosed with prostate cancer from 1993-2017 (Table 5). Of these, 68.5% were aged 70 and over and 10.7% had been diagnosed in the previous year.

Table 5: Number of men living with prostate cancer at the end of 2017 who were diagnosed from 1993-2017 by time since diagnosis

Sex	Age	Time since diagnosis				25-year Prevalence
		0-1 year	1-5 years	5-10 years	10-25 years	
Male	0-69	528	1,475	960	292	3,255
	70+	573	2,222	2,293	1,994	7,082
	All ages	1,101	3,697	3,253	2,286	10,337

Further Information

Further data is available from the Northern Ireland Cancer Registry web site: **www.qub.ac.uk/nicr**

NI Cancer Registry
Phone: +44 (0)28 9097 6028
e-mail: nicr@qub.ac.uk

Acknowledgements

NICR is funded by the Public Health Agency and is hosted by Queen's University, Belfast. This work uses data provided by patients and collected by the NHS as part of their care and support.

Aimee Crilly

From: McVeigh, Shauna <Personal Information redacted by the USI>
Sent: 12 April 2019 13:45
To: Campbell, Dolores; Connolly, Maureen; Dabbous, Marie; Dignam, Paulette; Elliott, Noleen; Glackin, Anthony; Graham, Vicki; Gribben, Trudy; Hanvey, Leanne; Hasnain, Sabahat; Haynes, Mark; Hiew, Kenneth; Holloway, Janice; Hughes, Paul 2; Jacqui Harney; joe o'sullivan; Johnston, Charlene; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; Margaret Fleming ; McCartney, Rachel; McClean, Gareth; McCourt, Leanne; McCreesh, Kate; McCrum, Gillian; McMahon, Jenny; McVeigh, Shauna; Moore, SarahM; Mulligan, Sharon; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; McConville, Richard; Robinson, NicolaJ; Shannon, Hilda; Shum, Lin; Troughton, Elizabeth; Turkington, Ann E; Tyson, Matthew; Ward, Ann; White, Deborah; Williams, Marc; Young, Michael
Subject: Urology MDM outcomes and minutes from 11.04.19
Attachments: Urology MDM minutes 11.04.19.doc

Update Report from Urology MDM @ The Southern Trust on 11/04/2019

Surgeon	Oncologist	Clinician	Palliative Medicine
O'DONOGHUE J P MR (C8245)	None	None	None

Personal Information redacted by the USI Mr Personal Informatio DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date 12/02/2019

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the old gentleman had a PSA of 2.61ng/ml in July 2016, October 2017 it was 5.13ng/ml, November 2018 5.96ng/ml and December 2018 it was 6.87ng/ml. His urinary tract symptoms he tells me in the last 6 months are worse. He is complaining of urinary frequency up to 18 times a day and nocturia up to 3 times. The flow was good and he denies urgency or urgency incontinence. He has no hesitancy. I note his EGFR is 42mls. On digital rectal examination he had a large benign feeling prostate. His IPSS is 10 + 3. MRI, 19.02.19 - No radiological evidence of a significant prostate tumour. PSA density of 0.34. TRUS biopsy, 12.03.19 - Prostatic adenocarcinoma of Gleason score 3+4=7 is present in 7 out of 12 cores with a maximum tumour length of 3mm. Tumour occupies approximately 9% of the total tissue volume. Discussed at Urology MDM 21.03.19. This man has been found to have intermediate risk, probably organ confined, prostatic carcinoma. In view of PSA density of 0.34 and a PSA doubling time of 2.46 years, he may be advised to consider management with curative intent. He could be considered eligible for all three modalities of management with curative intent. He may need further assessment and management of his storage urinary symptoms prior to curative management. Mr. O'Donoghue to review and advise. Mr Personal Information redacted by the USI has been referred to Oncology and urology for consideration of treatment.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by the USI has intermediate risk prostate cancer for consideration of all active treatment options. Surgery or radiotherapy may be preferable to Brachytherapy given LUTS.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'DONOGHUE J P MR (C8245)	None	None	None

Personal Information redacted by the USI Mr Personal Informati DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date 31/03/2019

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the old gentleman has no significant urinary tract symptoms. His PSA was 18.16 in July 2018, 20.80 in September 2018 and 22.56 in February 2019. On rectal examination he had a moderate sized prostate and a query whether he had a small nodule on the left lobe of the prostate. MRI, 07.10.18 - Probable tumour within the left posterolateral peripheral zone as described. Extension to but not definitively beyond prostatic capsule. rT2a N0 M0. TRUS biopsy, 19.02.19 - Prostatic adenocarcinoma of Gleason score 4 + 3 = 7, is present in 5 of 13 cores with a maximum tumour length of 4.9 mm. The tumour occupies proximally 10% of the total tissue volume. Of note the core biopsies from the left base and left mid show Gleason 4 + 4 = 8 tumour. Discussed at Urology MDM 28.02.19. Mr Personal Information redacted by the USI has a high risk prostate cancer which appears organ confined on MRI. Mr O'Donoghue to review in outpatients, arrange a Bone scan and subsequent review regarding radical treatment options if bone scan confirms no metastases. Bone scan, 15.03.19 - No evidence of bony metastatic disease. Mr Personal Information redacted by the USI has already been referred to Oncology for consideration of radiotherapy.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by the USI has intermediate risk prostate localised cancer (High tier). For consideration of active treatment options. Has been referred to Dr Jain.

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI Mr	YOUNG M MR (C6861)	None	None	None
	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Bladder tumour

Staging:

MDMUpdate

CONSULTANT MR YOUNG: This Personal Information redacted by the old gentleman has been diagnosed with a new bladder tumour following attendance with frank haematuria. Past history of type II diabetes and smoker of 15 a day. Functional status. CTU, 03.02.17 - Right-sided small renal cortical cysts. No evidence of underlying malignancy. For discussion at MDT with imaging and pathology when available. TURBT, 04.04.17 - Part 1, Urothelial carcinoma, Papillary. High-grade (G3). Local invasion - Into lamina propria, pT1. Lymphovascular invasion - no. Adjacent mucosa - flat carcinoma in situ - no. Granulomas - no. Muscularis propria - a few fragments present, clear of tumour. Part 2, Histological examination shows five fragments of bladder tissue with striking cautery artefacts making the interpretation difficult. The mucosa is oedematous, markedly inflamed with lymphoid follicles within the stroma and in places has also morphology of granulation tissue. One fragment shows short segments of surface urothelium that is partly denuded, however shows no features of dysplasia or carcinoma in-situ. Discussed at Urology MDM 20.04.17. Mr Personal Information redacted by should be seen in clinic for results and arrangements made for an induction course of intravesical BCG. Bladder biopsies, 10.07.18 - inflammation, granulomatous inflammation. Discussed at Urology MDM 19.07.18. Mr Personal Information redacted by 's recent bladder biopsies are benign. Mr Young to write to Mr Personal Information redacted by and recommend ongoing maintenance BCG and flexible cystoscopy surveillance. Bladder biopsy, 02.04.19 - Histology shows urinary bladder mucosa with an oedematous lamina propria and a havy mixed inflammatory cell infiltrate. There is necrosis, scattered lymphoid follicles and some vague granulomas. The histological features are in keeping with inflammation and previous BCG treatment.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by s recent bladder biopsy is benign. For review by Mr Young to offer BCG and endoscopic surveillance.

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI Mr	GLACKIN A.J MR (C8102)	None	None	None
	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis:

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This [redacted] old man with previous history of CIS and pTa G2 TCC bladder. DRE found a small very firm prostate, PSA last July 2015 was 0.5. For review of histology. PSA to be repeated and for consideration of prostate MRI vs TRUS biopsy. Cystoscopy and bladder biopsies taken from posterior wall of bladder, 01.04.16 - Histological examination shows four fragments of bladder mucosa in which there is focal atrophy and denudation of the surface epithelium, however there is no carcinoma in-situ or transitional cell carcinoma identified. There is very focal cystitis cystica and mild chronic inflammation within the subepithelium. Discussed at Urology MDM 07.04.16. Mr [redacted] recent bladder biopsies show no evidence of malignancy. Mr Glackin to review and discuss ongoing endoscopic surveillance at STH vs maintenance BCG and to assess LUTS. Bladder biopsy, 28.04.17 - Histological examination shows two fragments of bladder tissue comprising a small amount of muscularis propria. The lamina propria is oedematous and congested, with mild chronic inflammatory infiltrate. The surface epithelium shows some reactive changes but no dysplasia or CIS. Discussed at Urology MDM 01.06.17. Mr [redacted] recent bladder biopsies show no evidence of malignancy. Mr Glackin to recommend ongoing maintenance BCG and cystoscopic surveillance. This gentleman with a history of non-muscle invasive TCC bladder first noted in 2009 followed by carcinoma in-situ in October 2013 with 2 subsequent courses of induction BCG and maintenance BCG completed 15th January 2018. Mr [redacted] was complaining of dysuria and discomfort in his bladder. He had rigid cystoscopy and biopsies of the bladder mucosa completed on 4th April. The histology has confirmed carcinoma in-situ. For review of histology and for discussion of further treatment at MDT please.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Glackin to review in outpatients and arrange re-induction BCG followed by further bladder mucosal biopsies.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
[redacted] Mr [redacted]	DOB: [redacted]	Age: [redacted]		Target Date

Diagnosis: Bladder tumour
Staging: Ta

MDMUpdate

CONSULTANT MR O'DONOGHUE: [redacted] old gentleman admitted from ED with an AKI, urinary sepsis and haematuria. CT urogram revealed a likely left ureteric TCC. He proceeded to theatre for ureteric biopsies, however on entering his bladder he had a 3.5cm TCC of the trigone, both ureteric orifices were not involved. We proceeded to a retrograde on the left which showed no contrast past the very distal ureter, no wire was able to pass this area either. Advancing the ureteroscope to the bottom of this area there was just a stricture but no TC was evident, however I suspect that just above this strictured area TCC is the most likely diagnosis. Ureteric washings were taken, pathology confirms atypia suspicious of malignancy. We then proceeded to resect his bladder tumour to muscle with haemostasis. Most significantly Mr [redacted] has severe COPD with home oxygen, CCF and OSA. His baseline fitness is not very good. He is also overweight, weighing 109kgs. Left ureteric washings, 01.04.19 - atypia suspicious of malignancy. TURBT, 01.04.19 - AWAIT PATHOLOGY.

MDMAction

Discussed at Urology MDM 11.04.19. Mr [redacted] probably has a left ureteric carcinoma. He is unfit for a nephroureterectomy. He has been found to have a non muscle invasive low grade TCC of his bladder. For review by Mr O'Brien and for further flexible cystoscopy in July 2019.

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

Diagnosis: Renal cell carcinoma
Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This very fit, Personal Information redacted by the old man was found to have a right renal mass when he had an ultrasound scan on 07 May 2014 in the assessment of right flank discomfort. On CT scanning, he was reported to have a right renal lesion, measuring 14 cms in maximum diameter, and with an enhancing, peripheral, soft tissue component surrounding a central cystic component. He was reported to have a small hepatic lesion which is probably a cyst. He was reported to have bilateral, upper lobe fibrosis, in addition to pleural based densities of doubtful significance. Patient reported at review on 16 May 2014 that he had previously been advised by Oncologists, following his diagnosis of Hodgkin's lymphoma in 1997, that he had pulmonary nodules of no oncological significance. His only other morbidity is Personal Information redacted by the USI He takes no medication. A renal MRI scan has been requested to further characterise the renal lesion. A bone scan and DMSA renogram have been requested. He has been provisionally listed for right radical nephrectomy, pending outcome of MDM discussion. MRI Abdomen, 20.05.14 - 12.9 cm right renal mass lesion appears largely cystic with a proteinaceous content but there are multiple irregular soft tissue nodule arising from the cyst wall. No convincing enhancement. Findings are consistent with a Bosniak type 3 cyst and the differential diagnosis includes a cystic neoplasm. Bone scan, 29.05.14 - Abnormal uptake in the right seventh rib suggestive of query bony metastasis. DMSA, 05.06.14 - Differential renal uptake is calculated at left side 76.7%, right side 23.3%. Discussed @ Urology MDM, 12.06.14. This gentleman has been found to have a large right renal mass which is predominantly cystic but also contains solid tissue, which may well be malignant. For admission on 17.06.14 for right radical nephrectomy on 18.06.14. Laparoscopic right radical nephrectomy performed on 18 June 2014. Pathology reports papillary renal cell carcinoma, type I, well-differentiated, Fuhrman Grade II, tumour infiltrates beyond the capsule of the lesion focally to infiltrate perinephric adipose tissue. No infiltration of hilar adipose tissue. Ureteric margins - clear. Perinephric margin - tumour comes to within 0.1 mm of the perinephric margin but no definite margin involvement is seen. Stage pT3a (TNM7) - perinephric fat involvement. Review with Mr O'Brien arranged for Saturday 05.07.14. Discussed @ Urology MDM, 03.07.14. This gentleman has been found to have papillary type 1 renal cell carcinoma, stage pT3a, with close surgical margins. For review by Mr O'Brien, to request follow-up CT of chest, abdomen and pelvis in three months time. Mr. Personal Information redacted by the has remained well since right nephrectomy in June 2014. There was no evidence of disease recurrence or progression on Ct scanning in December 2017 when there was no change in previously present, small, bilateral pulmonary nodules. On further Ct scanning on 21 January 2019, the nodules in the right lower lobe and in the left upper lobe were reported to have increased in size. In addition, he was reported to have a 1.5 cm, hypodense, solid lesion in the right hepatic lobe. This lesion had not been present previously, and it was advised that it be considered suspicious of a metastasis until proven otherwise. Discussed at Urology MDM 24.01.19. There has been a progressive increase in lung nodules and there has been a new liver lesion found on recent CT scanning. For review by Mr O'Brien prior to regional MDM discussion. Personal information was advised on 08 March 2019 of the recommendation of having a biopsy of the hepatic lesion performed. He was also advised of the recommendation of having MRI scanning prior to biopsy. On MRI scanning on 25 March 2019, he was reported to have two lesions within the right hepatic lobe, considered characteristic of metastases. He was additionally reported to have a similar lesion, measuring 11 mm in diameter, located beneath the right latissimus dorsi, adjacent to his right eleventh rib. He was admitted on Thursday 04 April 2019 for ultrasound guided biopsy of the larger, right hepatic lesion, and possibly of the thoracic wall lesion. Histological examination with the aid of immunohistochemistry shows a core and fragments entirely consistent with metastatic papillary renal carcinoma. No normal hepatic parenchyma is seen.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by biopsy of liver lesion has confirmed metastatic renal cell carcinoma. For review by Mr O'Brien and refer to Oncology. For regional MDM discussion on 25.04.19.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date 02/05/2019
Mr	Persona l			
Diagnosis:				
Staging:				

MDMUpdate

CONSULTANT MR O'DONOGHUE: Personal Information redacted by the old gentleman admitted via ED. At cystoscopy this gentleman had a normal urethra and a very abnormal looking bladder. There was a previous TURP but he still had a considerable amount of lateral lobes of prostate left behind. The bladder mucosa was bleeding and looked heaped up which was very suspicious for malignancy. As there was also some overhanging abnormal looking prostate I also resected this and this was sent for histology. CTU, 12.02.19 - Within the limitations of this examination, no obvious malignancy in the upper tracts. Small lesion anteriorly in the renal pelvis cannot be excluded. TURBT, 02.04.19 - AWAIT PATHOLOGY

MDMAction

Discussed at Urology MDM 11.04.19. Defer for pathology.

Surgeon	Oncologist	Clinician	Palliative Medicine
YOUNG M MR (C6861)	None	None	None

Personal Information redacted by the USI Mr Personal Information redacted by DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis: TCC Bladder pTa Grade 2

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old gentleman gives a recent history of intermittent frank haematuria which is painless. He denies any significant other lower urinary tract symptoms and is otherwise fit and well. Flexible cystoscopy unfortunately revealed multifocal likely TCC of the bladder near the dome with the largest lesion being approximately 3cm in diameter. CT Urogram, 18.12.17 - No ureteric filling defect or renal / ureteric calculus demonstrated. TURBT, 23.01.18 - Histology shows features of a WHO Grade II (low) papillary transitional cell carcinoma with no invasion into the subepithelium (pTa). Fragments of muscle are represented and these are not involved by tumour. Discussed at Urology MDM 01.02.18. Mr Personal Information redacted by the has an intermediate risk non muscle invasive urothelial cancer of the bladder. Mr Young to review in outpatients, recommend a course of MMC and for subsequent endoscopic surveillance. Mr Personal Information redacted by the USI has history of Ta GII (non-muscle invasive low risk) TCC of the bladder diagnosed January 2018. He attended for his surveillance flexible cystoscopy although the bladder mucosa itself was clear of any tumour recurrence, there were multifocal small areas of recurrence noted at 7 O'clock near the veru montanum within the prostate. TURBT & TURP, 02.04.19 - Histology shows no evidence of malignancy on bladder biopsy and prostate biopsy.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by the 's recent pathology is benign. For review by Mr Young to recommend endoscopic surveillance.

Surgeon	Oncologist	Clinician	Palliative Medicine
YOUNG M MR (C6861)	None	None	None

Personal Information redacted by the USI Mr Perso nal Inform DOB: Personal Information redacted by the USI Age: Personal Information redacted by the USI Target Date

Diagnosis: Benign

Staging:

MDMUpdate

CONSULTANT MR YOUNG: Personal Information redacted by the old gentleman referred with multiple episodes of painless visible haematuria. Patient has had urine cultures sent which were normal. Flexible cystoscopy showed no evidence of urethral strictures. However, it did identify a polypoid lesion in the prostatic urethra overlying the veru montanum. The rest of the prostate looked unremarkable. There were further areas of inflammation and red patches noted along the entire right posterolateral wall. He was previously investigated for same in 2008 by Mr O'Brien. Patient underwent a urethral dilatation, hydrostatic distension of the bladder and GA cystoscopy and bladder biopsies. Hydrostatic distension of the bladder was carried out due to patient having a low capacity bladder. Bladder biopsies confirmed chronic inflammation with some deposits of amyloid within the bladder. A left ureteroscopy was done at the time of

surgery to ensure that there were no left ureteric filling defects. A stent was left in situ for a brief period of time. TURBT, 02.04.19 - Part 1, Histological examination shows bladder mucosa with a little underlying muscularis propria. There is abundant amyloid deposition within the lamina propria and on the surface there is cystitis cystica/glandularis last. A focus of somewhat atypical appearing apocrine cells is present but there is no carcinoma in situ and no invasive malignancy. Part 2, Histological examination shows similar features to those in part one. There is amyloid deposition and cystitis cystica/glandularis. There is no PIN or invasive malignancy.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Young to review in outpatients and continue to monitor his renal function and consider ongoing flexible cystoscopy surveillance.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'BRIEN A MR (C6514)	None	None	None
Personal Information redacted by the USI Mr Personal Information	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Bladder tumour
Staging: Ta
MDMUpdate

CONSULTANT MR O'BRIEN: Personal Information redacted by the -old gentleman who had 2 or 3 episodes of painless frank haematuria. No other symptoms. Non-smoker. History of HTN. Otherwise well. CT urogram – No upper tract lesion Flexible cystoscopy showed – Small TCC right lateral recess. Discussed at Urology MDM 21.02.19. Mr Personal Information redacted has been found to have a small bladder tumour. For review by Mr O'Brien to arrange bladder tumour resection. Patient was found to have an entirely exophytic, papillary, transitional cell carcinoma located lateral to the right ureteric orifice at cystoscopy on 03 April 2019. The tumour was completely resected from a rather thin bladder wall. Pathology shows Histological examination shows fragments of urothelial carcinoma-grade 2 (low-grade). No invasion into the lamina propria is seen and while there are fragments of muscularis propria these are not involved (pTa).

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by has low grade non muscle invasive bladder cancer. For review by Mr O'Brien to arrange a flexible cystoscopy in July 2019.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
Personal Information redacted by the USI Mr Personal Information	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Probable renal tumour
Staging: cT1
MDMUpdate

CONSULTANT MR HAYNES: Personal Information -old presented with storage urinary symptoms. An ultrasound with subsequent CT have demonstrated a 2 cm enhancing mass within the right kidney suggestive of early renal cancer. Right laparoscopic partial nephrectomy, 29.03.19 - Papillary renal cell carcinoma Type I. G2 SARCOMATOID MORPHOLOGY: Not identified RHABDOID MORPHOLOGY: Not identified TUMOUR NECROSIS: Not identified LYMPHOVASCULAR INVASION: Not identified.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Haynes to review in outpatients and arrange a CT in 6 months.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	YOUNG M MR (C6861)	None	None	None
Personal Information redacted by the USI Mrs Personal Information	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR YOUNG: This [redacted] old lady was referred by the liver physicians in the Royal. During their scans they picked up a 3cm right renal Bosniak II F cyst; this was back in September 2018. Follow up scans were organised which have now been performed. There appears to be further change and the conclusion the radiologist feels that there is a suspicious low-growth rate right renal cell carcinoma but this appears to be different to the Bosniak II assessment lesion found earlier. It is appreciated that the radiologist has recommended further scan in six months but I think this would be best passed through the committee first.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Young to review in outpatients and advise biopsy of the renal lesion.

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

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR O'BRIEN: This is a [redacted] old gentleman that was initially admitted on the medical take with a 6 week history of back pain, he underwent an MRI which showed a large sacral mass, subsequent CT CAP, did not show a primary, he underwent a core biopsy and was discharged while awaiting results. The biopsy has showed metastatic poorly differentiated adenocarcinoma, favoring prostate or lung. He has had a subsequent PSA 7.8. He does report reduced urinary flow. I've discussed this patient with Dr Saba, who advised that he will need seen urgently in clinic and discussed at MDM. I will arrange for his PSA to be repeated on 23/07/2018. This gentleman has no other significant past medical history. He does have significant back pain secondary to the sacral mass and he is currently longtec and pregabalin. He has been seen by the spinal team who were happy there wasn't any evidence of cauda equina. I would be grateful if you would be able to arrange review and MDM discussion of this patient. Mr [redacted] is aware of his biopsy result. Discussed at Urology MDM 26.07.18. This [redacted] old man has been found to have a soft tissue mass infiltrative of the left sacrum and a similar lesion affecting the right ninth rib. Histopathological examination of biopsies of the sacral lesion has found it to be a metastatic adenocarcinoma. In the absence of a detectable pulmonary lesion on CT scanning, it has been reported that the most probable primary is prostatic. The patient has had palliative radiotherapy to the sacral lesion. Mr. Young to liaise with the patient and with radiologist to arrange Prostatic MRI scanning and Prostatic Biopsies as soon as is possible. Mr. [redacted] was reviewed on 31 July 2018 when he was considered to have a locally advanced, prostatic carcinoma on examination. He was prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mgs daily. Prostatic MRI scanning on 01 August 2018 was arranged. A Bone Scan on 08 August 2018 was arranged. An appointment for prostatic biopsies was requested. Discussed at Urology MDM 02.08.18. Mr [redacted] needs a prostate biopsy to obtain a histological diagnosis and an urgent sigmoidoscopy. MRI Pelvis, 01.08.18 - Prostate volume of 54 cc. Poor quality examination as a result of patient movement. Likely very large prostate tumour with extracapsular extension and extension to the pelvic sidewall. Pelvic lymphadenopathy. Sacral metastases. rT3b N1 M1b. TRUSB, 07.08.18 - Histology with the help of immunohistochemistry shows features of a small focus of prostatic adenocarcinoma with significant crush artefact within part 6. The Gleason score within this specimen is 3+4=7 but it may not be representative of the actual Gleason score given the crush artefact and the scanty amount of tumour present. 1 of the 7 cores is involved by tumour and the maximum tumour length is <1 mm. The tumour occupies <1 mm of the total tissue submitted. Bone scan, 08.08.18 - There is evidence of bony metastatic disease in the sacrum and iliac bones bilaterally, particularly in relation to the left sacroiliac joint, as well as within the posterior aspect of the right ninth and left sixth ribs. There is further metastatic disease in the body of the sternum. Discussed at Urology MDM 16.08.18. For review by Mr O'Brien to advise resection of prostate. Mr. [redacted] remained well at review on 20 August 2018 apart from incomplete relief of pain and nausea. Increasing the dose of Oxycodone and prescribing Ondansetron resulted in complete relief of

both. On endoscopic assessment on 22 August 2018, he was found to have severe bladder outlet obstruction, more due to anterior displacement of the bladder neck than to prostatic occlusion. The prostate was resected and transperineal prostatic biopsies were performed. He was able to pass urine satisfactorily following catheter removal on 24 August 2018 when he was discharged. TURP, 22.08.18 - Part 1, Histology shows prostatic parenchyma infiltrated by prostatic adenocarcinoma. The overall Gleason sum score is Gleason 5+5=10 (grade group 5). Foci of perineural invasion are identified. Approximately 15% of the total tissue volume is infiltrated by adenocarcinoma. Prostate biopsies, Part 2 - Histology shows four of the six cores of tissue to be infiltrated by prostatic adenocarcinoma of Gleason score 5+5=10 (grade group 5). Foci of necrosis are identified. The maximum tumour length is 3.6 mm and the tumour involves 10% of the total tissue volume. There is no evidence of seminal vesicle, extracapsular or lymphovascular invasion. Perineural invasion was identified within the TURP specimen (Part 1) but not within the cores. Discussed at Urology MDM 30.08.18. Mr Personal Information has high grade, metastatic prostate cancer, confirmed on his recent biopsies. Mr O'Brien to review in outpatients, switch to an LHRH analogue and refer for oncology review and consideration of additional systemic treatment and for subsequent central MDM discussion. Discussed at Urology MDM 13.09.18. Has been commenced on hormones. Has been referred for assessment of upfront DOCETAXOL +- STAMPEDE. To be seen at CAH Oncology 18.09.2018. Personal Information s serum PSA had decreased to 1.49 ng/ml in September 2019 following TURP and as a consequence of androgen deprivation. Even though he proceeded to have Docetaxel, his serum PSA levels subsequently progressively increased to 35.11 ng/ml in March 2019. Prednisolone was prescribed in December 2018 but discontinued because of troublesome oesophageal reflux. Enzalutamide was commenced in January 2019. He was acutely admitted in February 2019 following the onset of severe drowsiness due to opioid toxicity. On admission, he was also found to be in urinary retention. He had 1.8 L of urine drained on urethral catheterisation. He was electively readmitted on 13 March 2019 for a further prostatic resection. Almost all of the resected tissue was infiltrated by Gleason 5+5 adenocarcinoma. He was unable to pass urine following catheter removal. He was discharged on 15 March 2019 with an indwelling urethral catheter. He was acutely readmitted on 27 March 2019 following the onset of urinary infection which was successfully managed with intravenous antibiotic therapy. He was discharged on 04 April 2019. He was found to have evidence of metastatic disease progression on CT scanning on 03 April 2019 with new mediastinal lymphadenopathy, increased para-aortic and pelvic lymphadenopathy and increased skeletal metastatic disease, with a left sacral metastasis resulting in mild left upper tract dilatation. For oncology review on 10 April 2019 and urology review on 15 April 2019.

MDMAction

Discussed at Urology MDM 11.04.19. For regional MDM discussion 25 April 2019.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
Personal Information redacted by the USI Personal Information redacted by the USI Mr Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR HAYNES: Mr Personal Information redacted by the USI presents with a raised PSA of 12ng/ml. An MRI shows a 67cc gland with PIRADS 3 abnormalities in the left gland apex and right mid gland transition zone. He was unable to have TRUS biopsies due to a slight anal stenosis and could not tolerate the TRUS probe. Trans-perineal biopsies were performed under a general anaesthetic. TRUS biopsies, 25.03.19 - Prostatic adenocarcinoma of Gleason score 3+4=7 is present in 10 of 40 cores with a maximum tumour length of 2 mm. The tumour occupies <10% of the total tissue submitted. The Grade Group is 2. For Pathology review of Radiology and pathology and subsequent outpatient follow up with Mr Haynes.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by the USI has intermediate risk organ confined prostate cancer. For review by Mr Haynes to consider sigmoidoscopy to exclude any imflammatory bowel disease prior to consideration of referral for radical radiotherapy.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date
Mr				

Diagnosis: Prostate cancer
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: Personal Information redacted by the old gentleman with a PSA of 15ng/ml in February 2019, despite Finasteride. MRI, 28.02.19 - Prostate volume is estimated at 45 cc. PSA density is estimated at 0.34 ng/ml/cc. Limited study as the right hip replacement gives off significant artefact. DWI was not possible. Allowing for this I am suspicious of an ill-defined 16 mm region of T2 hypo-intensity at the left base, possible early T3aNo disease. TRUS biopsy, 04.03.19 - Acinar adenocarcinoma. Gleason score- 4+5=9 (tertiary Grade 3 present). WHO grade group- Group 5. Number of cores involved- Right base - 0 out of 2. Right mid - 0 out of 2. Right apex - 1 out of 2 (core involvement- <1%). Left base - 3 out of 4 (core involvement- 15%, 35% and 40%). Left mid - 4 out of 4 (core involvement- 30%, 30%, 30% and 40%). Left apex - 0 out of 2. Total % of tumour - 13.8%. Maximum tumour length - 5 mm. Perineural invasion- no. Lymphovascular invasion- no. Invasion of adipose tissue- no. Discussed at Urology MDM 14.03.19. Mr Personal Information redacted by the USI has high risk locally advanced prostate cancer. Mr Glackin to see Mr Personal Information redacted by the USI in clinic and arrange a bone scan and then further review after MDM discussion. Bone scan, 05.04.19 - The scan findings demonstrate increased uptake at the wrists, shoulders, right sternoclavicular joint and around the left hip joint. Further uptake overlying the dorsum of both feet and at both great toes is also noted. This distribution of uptake is highly likely to represent degenerative change.

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by the USI has high risk prostate cancer. Mr Glackin to review in outpatients commence ADT and recommend referral for radiotherapy.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'BRIEN A MR (C6514)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date
Personal Information redacted by the USI Mr	Personal Information redacted by			

Diagnosis: Bladder tumour
Staging:
MDMUpdate

CONSULTANT MR O'BRIEN: Personal Information old man who had been found to have intermediate risk, Gleason 3+4 adenocarcinoma found in 8 of 12 cores taken from his prostate gland when he had prostatic biopsies performed in February 2016 when his serum total PSA level was 11.38ng/ml. Flexible cystoscopy showed an enlarged, obstructive, lateral prostatic lobes. However, in addition, the prostatic urethral anatomy was irregular and distorted. The appearance may have been entirely due to his known prostatic carcinoma. However, it could equally well have been due to urothelial malignancy. In addition, the base of his urinary bladder appeared to be quite inflamed, in addition to multiple foci of abnormal bladder mucosa, and which may very well be due to the presence of transitional cell carcinoma. Patient continued to have his prostatic carcinoma managed by watchful waiting. Serum PSA levels increased to 16.08 ng/ml in August 2018, before decreasing spontaneously to 12.85 ng/ml by January 2019. His predominantly storage urinary symptoms progressively increased in severity. The patient was referred again in January 2019 following the onset of visible haematuria which persisted until he was prescribed Tranexamic Acid. On flexible cystoscopy on 08 March 2019, he was considered to have obstructive, lateral prostatic lobes, to probably have transitional cell carcinoma of the prostatic urethra, and to have similar transitional cell carcinoma of the trigone of his bladder. On cystoscopy under spinal anaesthesia on 03 April 2019, he was found to have a solid lesion of the trigone. It was unclear whether this lesion was a median lobe of prostate, or solid bladder tumour, or a combination of both. The lesion was resected. The lumen of the right ureter was exposed by resection. It was considered that he had prostatic urethral mucosal pathology. His prostate was endoscopically resected. The bladder and prostatic resection specimens were separately submitted for histopathological examination. TURBT, 03.04.19 - Histological

examination shows the presence of a high grade urothelial carcinoma with extensive invasion into the underlying subepithelial connective tissue. There are some fragments of muscularis propria/detrusor muscle present but no definite invasion into this muscle is seen. In one or two fragments is seen to be around some slender smooth muscle bundles which may be muscularis mucosae and therefore the stage is regarded as at least T1 (see comments in part 2). TURP, 03.04.19 - Acinar adenocarcinoma. Gleason 3+4 = 7. Approximately 12 out of 60 cores. Approximately 10%. Perineural invasion - Not identified. Local invasion - Not identified. Examination shows the presence of prostatic acinar adenocarcinoma. The predominant Gleason pattern is 3 although a focal area of pattern 4 is identified.

MDMAction

Discussed at Urology MDM 11.04.19. Mr [redacted] has high grade non muscle invasive TCC of his bladder and continues to have intermediate risk prostate cancer. For review by Mr O'Brien to arrange a CT Chest, bone scan and subsequent MDM discussion.

Surgeon	Oncologist	Clinician	Palliative Medicine
None	None	None	None

[redacted] DOB: [redacted] Age: [redacted] Target Date 17/03/2019

Mr [redacted]

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR TYSON: This [redacted] old gentleman was referred for non-visible haematuria noted on a medical. PSA of 8.23ng/ml in February 2019, previous 7.57ng/ml in January 2019. Renal function normal. No bothersome LUTS. On examination mild BXO to foreskin, unable to retract, no palpable glandular lesion. DRE 40g benign feeling gland no masses. Ultrasound scan normal kidneys. Flexible cystoscopy glans penis appeared normal, normal urethra, mildly occlusive and mildly intravesical prostate, normal bladder mucosa, x2 UOs. MRI Pelvis, 22.03.19 - Equivocal signal change within the right transition zone (PIRADS 3) may represent stromal hyperplasia. If prostatic biopsies are being considered, it would be prudent to include the right transition zone. PSA density of 0.15. TRUSB, 02.04.19 - Prostatic adenocarcinoma of Gleason score 3+4=7 is present in 4 of 16 cores with a maximum tumour length of 5 mm. The tumour occupies approximately 10% of the total tissue submitted.

MDMAction

Discussed at Urology MDM 11.04.19. Mr [redacted] has intermediate risk organ confined prostate cancer. For review by Mr Tyson to advise either curative management or a period of careful active surveillance.

Surgeon	Oncologist	Clinician	Palliative Medicine
O'BRIEN A MR (C6514)	None	None	None

[redacted] DOB: [redacted] Age: [redacted] Target Date

Mr [redacted]

Diagnosis: Renal clear cell carcinoma

Staging:

MDMUpdate

CONSULTANT MR O'BRIEN: This [redacted] old man was referred to the Emergency Department of Antrim Area Hospital on 29 November 2017 for investigation of visible haematuria which he had for the previous five days, during which time he [redacted]. On CT Urography on 30 November 2017, he was reported to have a large, right renal tumour, measuring 15 cms in maximum diameter. The tumour was reported to infiltrate the renal pelvis, to compress the right renal vein and to be in contact with the right hepatic lobe and the duodenum. He was reported to have 'shotty' mediastinal lymphadenopathy on CT Chest on 03 December 2017. There was otherwise no evidence of skeletal or soft tissue metastases on either CT scan. It was appreciated at review on 29 December 2017 that [redacted] has a long history [redacted] which has probably contributed significantly to his [redacted] He assured that he had [redacted] since admission to hospital on 29 November 2017. He had a history of having sustained a left shoulder injury in 1999 and of having cervical dystonia in 2011. Patient was referred for Preoperative Assessment. Pending MDM discussion on 04 January 2018, for right radical nephrectomy 10 January 2018. Discussed at Urology MDM 04.01.18. Mr [redacted] is to proceed to surgery as planned. Laparoscopic Right Radical

nephrectomy, 10.01.18 - Renal clear cell carcinoma. Nested and trabecular. WHO/ISUP NUCLEAR GRADE: 3 Tumour necrosis - no. Local invasion - pT2b- Confined to kidney (>100 mm). Lymphovascular invasion - no. Lymoh nodes - N/A. Margins - Clear, 1 mm to perirenal fat. pT2b LEIBOVICH SCORE: 5 Discussed at Urology MDM 25.01.18. Mr O'Brien to review in outpatients and arrange a CT C/A/P in 6 months and for ongoing review. Personal Information redacted by remained well at review in February 2018 apart from having left sciatica. He was prescribed Ferrous Fumarate for iron deficiency. He was reported to have lumbosacral, epidural lipomatosis causing central canal stenosis, and lower lumbar disc herniation causing left neural foraminal stenosis on MRI scanning in May 2018. Though the sciatica had improved by review in October 2018, he was referred to a spinal surgeon for advice regarding his further management. Personal Information was reported to have a number of small nodules in the upper lobes of both lungs on CT scanning in July 2018. He was reported to have a greater number of small nodules in both lungs on further CT scanning of his chest in January 2019. He remained very well at review on 01 March 2019. A Bone scan and a CT Chest, Abdomen and Pelvis were requested to complete restaging. CT Chest, 20.03.19 - Increase in size of the small pulmonary nodules. Primary differential diagnosis of pulmonary metastases. Bone scan 05.04.19 - The bone scan appearances are considered to be unremarkable. No convincing evidence to suggest osteoblastic metastasis. Renal cell tumours are often associated with osteolytic lesions. No photopenic bone lesion identified on this study.

MDMAction

Discussed at Urology MDM 11.04.19. Further CT scanning would indicate that Mr Personal Information has progressive pulmonary metastatic disease. For further review by Mr O'Brien, for referral to Oncology and regional MDM discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR (C8244)	None	None	None
Personal Information redacted by the USI Mr Personal Informati	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Renal clear cell carcinoma
Staging: T1a NX

MDMUpdate

CONSULTANT MR HAYNES: Personal Information redacted by the old gentleman presented with a 3/52 history of RUQ pain, nausea and night sweats. His eGFR is >60. CT, 19.02.19 - showed upper pole left renal lesion measures 4.3 x 3.8 cm in transaxial diameter. Imaging characteristics are in keeping with a primary renal malignancy. CT Chest, 21.02.19 - No definite metastases. Tiny left basal nodule is likely inflammatory. This can be followed up along with surveillance imaging post renal cancer treatment. Discussed at Urology MDM 28.02.19. Mr Personal Information has a left renal mass consistent with renal cancer. Mr Haynes to review in outpatients and recommend a laparoscopic nephrectomy. Left laparoscopic nephrectomy, 01.04.19 - Histological type: Renal clear cell carcinoma. Growth pattern: Solid. WHO/ISUP grade: Grade 2. Tumour necrosis: No. Local invasion: pT1a - tumour <4 cm and limited to the kidney. Lymphovascular invasion: No. Lymph nodes: Not submitted and none identified within the nephrectomy specimen. Margins: Clear pTNM stage (TNM8): pT1aNx. Leibovich score: 0 (low risk).

MDMAction

Discussed at Urology MDM 11.04.19. Mr Personal Information redacted by has low risk renal cell carcinoma. For review by Mr Haynes to arrange a CT in 6 months.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	None	None
Personal Information redacted by the USI Mrs Persona l Informat	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis:
Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This Personal Information old lady was recently admitted to the Medical Ward with unintentional weight loss and anaemia and following that she was booked to have a Red Flag OGD and colonoscopy under Mr Epanomeritakis. She has had a CT chest, abdomen and pelvis carried out, which revealed a left sided renal tumour with significant metastases. In view of this we have cancelled her GI endoscopy. This lady has not been seen by Mr Glackin yet. Discussed at Urology MDM 28.02.19. Mrs Personal Information has a Left renal mass consistent with renal cancer. There is also radiological evidence of a liver metastasis along with concern regarding some peritoneal nodules, mediastinal nodes and an indeterminate lung nodule. Mr Glackin to review in outpatients, assess fitness / performance status, arrange a bone scan and MRI liver and for subsequent central MDM discussion. Bone scan, 15.03.19 - There is further patchy tracer activity elsewhere in the lumbar spine but there is no evidence of osteoblastic bony metastatic disease in the visualised skeleton. MRI Liver, 20.03.19 - The lesion straddling segments II and III and the lesion in subcapsular segment VIII are highly suspicious of liver metastases. Large left renal tumour as previously described. Discussed at Urology MDM 28.03.19. For consideration of systemic therapy with Dr Clayton. For biopsy prior to referral. US Liver biopsy, 05.04.19 - AWAIT PATHOLOGY

MDMAction

Discussed at Urology MDM 11.04.19. Mr Glackin to review in outpatients and refer this lady to Oncology.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR (C8102)	None	GLACKIN A.J MR (C8102)	None
Personal Information redacted by the USI Ms Personal Information	DOB: Personal Information redacted by the USI	Age: Personal Information redacted by the USI		Target Date

Diagnosis: Probable renal tumour

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: Personal Information old lady with a history of kidney transplant secondary to adult polycystic kidney disease. She was found to have an incidental solid lesion in her left native kidney and referred for consideration of nephrectomy v active surveillance. Patient was happy to have MRI follow up. MRI (BCH 14.11.16) No evidence of increasing size in the lesion noted anteriorly in left kidney. For review of imaging and treatment plan. Latest imaging reviewed and shows stable disease. Patient keen to undergo active surveillance. Has been referred back to Mr Glackin. Please have latest MRI renal reviewed at MDT. This lady has polycystic kidneys and a renal transplant. The lesion of concern in the left kidney is slightly larger than before. MRI, 24.03.18 - Slight increase in transverse diameter of left renal lesion. No other significant interval change. Discussed at Urology MDM 12.04.18. Ms Personal Information surveillance MRI shows a minimal increase in size of the left native renal lesion. Mr Glackin to review in outpatients and recommend further surveillance with an MRI in 1 year. US, 11.09.18 - Elevated resistive indices in the transplant kidney. Differential diagnosis would include acute or chronic transplant rejection, drug toxicity or renal artery stenosis. Multiple complex cysts in the transplant kidney. Please list this lady's recent US for review and comparison with MRI of March 2018 in light of possible complex cyst in transplant kidney. Discussed at Urology MDM 11.10.18. Ms Personal Information recent US shows complex cysts in her transplanted kidney. Cysts were also present on her previous MRI imaging in 2016 and March 2018. Mr Glackin has planned a FU MRI in 2019. For inclusion of the transplanted kidney in this MRI for surveillance of the complex cysts. MRI, 13.03.19 - The left renal lesion demonstrates a further slight increase in size. I wish to know whether a biopsy is feasible. Please advise when the next imaging should be undertaken if surveillance is recommended.

MDMAction

Discussed at Urology MDM 11.04.19. The locality of the complex left renal lesion makes a biopsy hazardous. Ms Personal Information renal function is slowly declining. For repeat MRI in March 2020 and ongoing nephrology follow up.

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator

MDT UROLOGY CANCER MEETING
THURSDAY 11 April 2019
VENUE: TUTORIAL ROOM 1, MEC

PRESENT
Mr O'Donoghue (Chair), Mr Glackin, Mr O'Brien, Mr Haynes, Dr Shah, Dr Williams, Stephanie Reid, Kate O'Neill & Shauna McVeigh.

MINUTES

1. APOLOGIES
   N/A

2. MINUTES OF LAST MEETING
   E-mailed to the Urology MDM circulation list on 05 April 2019.

3. PRESENTATION OF CASES
   Meeting started @ 2:15pm meeting finished @ 3:25pm
   21 cases were listed to be discussed.

4. A.O.B
   It's a virtual meeting only on 18 April 2019.

5. DATE OF TIME OF NEXT MEETING
   The next meeting is to take place at 2.00pm on **Thursday 25 April 2019**, Tutorial Room 1, MEC, CAH, Ennis Room, Belfast.

Aimee Crilly

Subject: FW: Theatres in May

From: Young, Michael <Personal Information redacted by the USI>
Sent: 17 April 2019 11:31
To: O'Brien, Aidan <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Tyson, Matthew <Personal Information redacted by the USI>
Cc: Dignam, Paulette <Personal Information redacted by the USI>
Subject: Theatres in May

Dear All
Have just been informed that the theatre allocation for May has been changed with implications for us.
Shame not defined before now but am told it related the quantum of theatre staff.

Until I get back, can you put on hold booking patients for May please.

PD – can you tell the other secretaries.

MY

Aimee Crilly

Subject: FW: [redacted]

From: Elliott, Noleen <[redacted]>
Sent: 17 April 2019 15:16
To: O'Brien, Aidan <[redacted]>
Subject: [redacted]

Aidan,

The above patient's daughter was ringing regarding a date for her father's surgery. He is on your waiting list for TURP since 10/3/15. She advised that her father has had 3 proven UTI's in the past 3 weeks. He would appreciate a date for his surgery as soon as is possible.

Many thanks.

Noleen

Noleen Elliott
Mr A. O'Brien's Secretary
Level 2 (Beside Bed Lifts)
CRAIGAVON AREA HOSPITAL

Changed My Number

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]

From: Williams, Marc
To: O"Brien, Aidan; Newell, Denise E; Green, Lynn
Subject: FW: Patient 112
Date: 24 June 2019 09:06:06

Denise/Lynn

Please see below.
Can these images be imported or do we need the discs? If so, can these discs be requested from RVH so that the images are imported for MDT this week?
Thanks
Marc

From: O'Brien, Aidan
Sent: 23 June 2019 16:52
To: Williams, Marc
Subject: FW: Patient 112

Marc,

I have just triaged a referral regarding this Personal Information redacted by old man whom I would hope to have discussed at our MDM on Thursday 27 June 2019.
All of his recent, relevant imaging has been performed at RVH.
I do hope that it is not inappropriate for me to ask you if you could arrange to have the images imported for MDM discussion.
The relevant scans are

- CT Thorax, Abdomen and Pelvis 0n 20 March 2019
- CT Kidney on 17 April 2019
- PET CT 15 June 2019

I will be in SWAH all day tomorrow, otherwise I would ask the PACS staff in Radiology.
I do not have an email address for them,

Thank you,

Aidan.

From: O'Brien, Aidan
Sent: 23 June 2019 16:31
To: McVeigh, Shauna
Cc: cancer.tracker
Subject: Patient 112

Shauna,

I would be grateful if you would list this man for MDM discussion on Thursday 27 June 2019, but only if the images of recent scans have been successfully imported from RVH have been

imported to facilitate discussion.
I have asked Dr. Marc Williams to have the images imported.
Please enter the following clinical summary on CaPPS:

'This Personal Information redacted by old man was found to have a mild Haemophilia A in 2011, since when he has only required prophylactic Factor VIII therapy in relation to surgical procedures. He had a papillary carcinoma of the right thyroid lobe managed by right thyroid lobectomy in 2014, followed by complete thyroidectomy in 2015, followed by radio-iodine therapy in 2015. There has been no evidence of recurrence since. In 2017, he had a diagnosis of an inherited, non-ischaemic, dilated cardiomyopathy, with a left ventricular ejection fraction of 35%.

He has been known to have cervical lymphadenopathy since 2016. There was no evidence of malignancy on fine needle aspiration cytology in 2017. The cervical lymphadenopathy had become more pronounced on clinical review and was considered pathological on ultrasound scanning in March 2019. On CT scanning, he was reported to have extensive lymphadenopathy extending from his neck to both groins, in addition to having small, bilateral pulmonary nodules. He was found to have suspicious atypia on further fine needle aspiration cytology in March 2019. Excision lymph node biopsy in April 2019 confirmed a diagnosis of low grade, follicular lymphoma. A bone marrow biopsy was performed on 12 June 2019 to determine whether there was evidence of bone marrow infiltration, resulting in a pancytopaenia, as such involvement would be considered an indication for treatment.

On CT scanning in March 2019, he was also reported to have a mixed density lesion of the lower pole of the right kidney, measuring 4.9 cm in axial diameter. On triphasic CT scanning in April 2019, the lesion was reported to have a maximum diameter of 6.5 cm. The lesion was reported to have a maximum SUV of 2.9 on PET CT scanning on 15 June 2019. As the lymphadenopathy had a maximum SUV of 9.0, these findings suggested a synchronous different right renal pathology. Renal involvement by lymphoma would be considered a separate indication for treatment.'

Thank you,

Aidan.

From: Drake, Mary <Personal Information redacted by the USI>
Sent: 15 August 2019 17:46
To: O'Brien, Aidan <Personal Information redacted by the USI>
Subject: RE: Patient 112

HI Aidan,
As you correctly state, Mr Patient 112 has commenced chemotherapy for follicular NHL. I would be happy to accept your guidance wrt biopsy of the renal lesion – if it appears to be a renal cell ca, maybe the best approach would be for him to complete chemo, and then be considered for partial nephrectomy. I hope that chemo will be finished in around 12 weeks or so.
Happy to discuss Personal Information redacted by the USI,
All the best,
Mary

From: O'Brien, Aidan [mailto: Personal Information redacted by the USI]
Sent: 15 August 2019 17:06
To: Drake, Mary
Subject: Patient 112

Dear Dr. Drake,

This is Aidan O'Brien, Consultant Urologist at Craigavon Area Hospital.

You had referred this man to the Department of Urology at Belfast City Hospital in June 2019 for consideration of biopsy of a right renal lesion found on CT scanning performed in the assessment of extensive lymphadenopathy, since found to be a follicular lymphoma.
If renal lesional biopsy confirmed renal involvement by lymphoma, that would have been considered an indication for treatment.
Presumably because the patient lives in Personal Informatio in our catchment area, your referral was redirected to us.
When discussed at our MDM on 27 June 2019, we agreed to arrange a biopsy with Factor VIII prophylaxis.
I firstly regret the delay in doing so.

In speaking with Kathryn Boyd, Consultant Haematologist here, she advised that it is her understanding that Factor VIII is administered prophylactically for surgical procedures only in Belfast.
Haemophiliacs are no longer managed in Craigavon.
If that is so, then he would need to have the biopsy performed in Belfast.

However, I do note that you have since commenced chemotherapy, though currently suspended due to an arrhythmia.
On viewing the images, I suspect that this lesion is a cystic, renal cell carcinoma.
If it was his only pathology, I don't think that biopsy would be strongly indicated.
Instead, one would consider partial ? radical nephrectomy.

I have arranged to meet Patient 112 as an outpatient tomorrow.
My question in the interim is 'Is renal lesional biopsy still required?'

I would be grateful for your advice,

Thank you,

Aidan.

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Aimee Crilly

Subject: FW: available theatres and cover for oncall

Importance: High

From: Corrigan, Martina <[redacted]>
Sent: 06 September 2019 14:57
To: (Aidanpobrien[redacted] <[redacted]; ([redacted]) <[redacted]>; Glackin, Anthony <[redacted]>; Haynes, Mark <[redacted]>; Mark ([redacted]) <[redacted]>; Young, Michael <[redacted]>; O'Brien, Aidan <[redacted]>; ODonoghue, JohnP <[redacted]>; [redacted]; Solt, Gyorgy <[redacted]>; Tony Glackin ([redacted]) <[redacted]>
Subject: available theatres and cover for oncall
Importance: High

Good afternoon

It is not looking promising that we are going to get anyone to replace Gyorgy. So I need to let theatres know if we can use the theatres below
Mark has picked up a few in October (see below) and there are some listed below which are still available so can you let me know by Monday at the latest so that I can either put your name against it or give it over to one of the other specialties.

September Theatres
Friday 20th AM Main theatre session
Tuesday 24th AM DSU - CAH
Friday 27th AM Main theatre session

October Theatres
Tuesday 1 October - AM – DSU – CAH (Mark) - I am happy to cover Laura or one of the SPRs to do a list here and will find suitable cases
Friday 4 October - AM & PM main theatres CAH (Mark) can do the PM list - [redacted]
Friday 11 October - AM main theatres – CAH
Tuesday 15 October - PM main theatres – CAH (Mark) - I can do (while am UoW)

Also for the ONCALL week in October see below from Mark – any thoughts/swaps please?
[redacted] I will do 14/15/16 but will not give up my theatres (so keep them running). At present I can't do the weekend but if someone can swap I think I can do some of the weekend before or after

Regards

Martina

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

Telephone:
EXT Personal Information redacted by the USI (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 04 October 2019 12:37
To: O'Brien, Aidan <Personal Information redacted by the USI>
Cc: Elliott, Noleen <Personal Information redacted by the USI>
Subject: RE: Patient 112

Thanks Aidan

As everything with regards the renal mass will be done in BCH I am happy to take this on from here.

As we were unclear as to what was happening he has been booked to my OP next week and I will discuss with him then. Given that the renal mass is enlarging and the nodes have responding I would favour proceeding to nephrectomy without biopsy, once his thrombocytompaenia has recovered, with factor VIII cover, in BCH, and can start the process of POA etc in BCH after I meet him on Monday.

Mark

From: O'Brien, Aidan
Sent: 04 October 2019 12:18
To: Haynes, Mark
Cc: Elliott, Noleen
Subject: RE: Patient 112

Mark,

I did not appreciate that Patient 112 was listed for MDM discussion yesterday.
By the time that I reviewed Patient 112 on 16 August, he had already begun treatment for lymphoma, based upon the high SUV levels on PET CT scanning and upon the bone marrow findings.
The chemotherapy consists of six cycles of O-CHOP three weeks apart.
He has had a CT scan performed in Belfast following three cycles, demonstrating a significant response of the lymphadenopathy to treatment.
However, it has been reported that there has been an increased in the size of the right renal lesion which now has a maximum diameter of 8 cms.
I have been in contact with Dr. Mary Drake who had been managing the patient, finding her to be on [redacted] leave [redacted] Personal Information redacted by the USI.
She advised that his further management has been taken over by Professor Morris, Consultant Haematologist, while she is off.
I have not been able to speak to Professor Morris.
In any case, I have spoken with the patient who remains extremely well.
He has had his fourth cycle last Thursday, 26 September 2019.
He is scheduled to have his fifth on 17 October, and the last on 07 November 2019.
Dr. Drake has advised me that after a period of recovery, and on the assumption that he still did have a maintained response, he would embark upon a single agent, maintenance regimen for a period of two years.
In view of the fact that the current treatment has been accompanied by a thrombocytopaenia, Dr. Drake and I had considered that either biopsy or nephrectomy or both would be best performed following resolution of the cyclical thrombocytopaenia, and with Factor VIII cover, in Belfast.

So, I had planned to have his further management discussed at our MDM next week when I would be present to advise of the above, and when we may be able to review the recent CT images from Belfast.
I had also arranged for his further management to be discussed at the Haematology MDM in Belfast, by Dr. Oonagh Shields, Chair of their MDM, so that we may be have their advice regarding the optimal timing for biopsy / surgery etc.

I will provide an update for our MDM for next week,

Aidan.

From: Haynes, Mark
Sent: 04 October 2019 08:06
To: O'Brien, Aidan; Elliott, Noleen
Subject: RE: [redacted]

Hi Aidan

This man was brought back to MDM yesterday by Shauna for clarity regarding where things are with his investigation. He has not yet had a biopsy and there is no OP letter on ECR from when you saw him on 16th August.

Is the biopsy in hand? Can I help by organising while I am in BCH?

Mark

From: Haynes, Mark
Sent: 24 July 2019 11:09
To: O'Brien, Aidan; Elliott, Noleen
Subject: [redacted]

Morning Aidan

RE [redacted] (Male /[redacted])

This man was discussed at MDM on 27th June regarding a renal lesion and the outcome was that your were going to organise a renal biopsy (with Factor VIII). A further referral has come in about his renal lesion which I am triaging as nil extra needed. Have you the biopsy in hand?

Mark

Gibson, Simon

From: Joanne Donnelly [Personal Information redacted by the USI] [Personal Information redacted by the USI]
Sent: 12 November 2019 12:53
To: OKane, Maria
Cc: Support TeamELS; Gibson, Simon; Parks, Zoe
Subject: SHSCT - Dr O'Brien GMC - 1394911

Importance: High

Dear Maria,

We need some further information from you (further to the information you provided at our ELA/RO meeting on 7.10.19 that Dr O'Brien has recently, Sept. 19, deviated from his agreed action plan) which will be relevant to our decision as to whether to whether a GMC investigation is necessary:

1. *Can you advise whether there is have any evidence to demonstrate that Dr O'Brien was complying with his agreed local action plan (up to September 19 when the recent deviation occurred)?*

2. *Has Dr O'Brien made any comments to the Trust in response to the recent deviation from his agreed action plan in September 19?*

3. *Regarding the recent incident in September 19, can you provide an update on what actians the Trust plon to take against Dr O'Brien? Specifically, are any measures being put in place to support Dr O'Brien and help him to address his current deficiencies?*

We would be grateful if you would provide this information just as soon as you can – and by Tues 19 Nov 19 at the latest - if that timescale is unworkable for you, or if you need to discuss any aspect of this, please do not hesitate to give me a call.

Kind regards
Joanne

STeamELS@gmc-uk.org – ftp -other – SHSCT - Dr O'Brien GMC – 1394911- GMC request for further information (12.11.19)

Joanne Donnelly
GMC ELA for Northern Ireland
[Personal Information redacted by the USI]

Southern Health and Social Care Trust

Medical Directorate

Our Ref:

Date:

Joanne Donnelly
ELC Liaison Officer
GMC

Dear Joanne

RE: SHSCT - Dr O'Brien GMC - 1394911

I am writing in response to your e-mail dated 12th November regarding the above, within which you asked three questions. My response to these questions is as below:

Can you advise whether there is have any evidence to demonstrate that Dr O'Brien was complying with his agreed local action plan (up to September 19 when the recent deviation occurred)?

The February 2017 action plan was put in place following Mr O'Brien's return to work following an immediate exclusion process in January 2017. The action plan was shared with Mr O'Brien at a meeting on 9 February 2017 and was to be monitored on-going with any deviation from the action plan to be immediately escalated to the MHPS Case Manager. See attached action plan for information.

A summary e-mail was sent weekly by the service manager to the Case Manager (an example is attached). There were occasions when the backlog reports identified small deviations but given the complex nature of the monitoring process, we could not be confident that these were true deviations but actually resulted from delays in transcription of clinic letters by administrative staff and so continued to assess compliance. These small deviations were not showing consistently from one month to the next. In or around November 2018, the Case Manager sought only to be advised on significant deviations from the action plan as he determined that Dr O'Brien was reasonably compliant.

In terms of evidence of compliance with the action plan the following monitoring arrangements were, and remain, in place. The details of the monitoring arrangements are as follows:

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Tel: Personal Information redacted by the USI

Action Plan Monitoring Element	Details
Triage of Referrals	Compliance regarding triage of referrals is monitored via two mechanisms; • The service manager reviews electronic referrals received via NIECR to ensure appropriate triage management • The Trust Referral and Booking Centre Team monitor hardcopy referrals received, and if not returned within the agreed timescale, escalate this to the service manager. In respect of Red flag triage, the action plan initially set out that triage should be completed by 4pm on the Friday following being Mr O'Brien Urologist of the Week. It was amended slightly through monitoring to an understanding that Mr O'Brien would complete all Red Flag triage referrals from his week on call by the end of the working day on the Thursday and the rest by the following Monday morning after he finished the week (handover is Thursday morning). Mr O'Brien had been meeting this expectation however in August and September the completion dates have extended to Tuesday or Wednesday of the following week that he has finished his triage. As the waiting times to first appointments for urology are significant (recently was 67 days), this has not impacted on patient pathways, and so this minor deviation was not considered material.
Clinical Dictation	Completed dictations from each clinic are monitored by the service manager by random checks on NIECR of outpatient sessions and checking if letters have been done. In addition the secretarial staff report backlog data to the admin team and a report is generated monthly. This details any outstanding dictation from outpatient clinics. Escalation occurred at the end August 19 when it appeared that dictations were not done and awaiting transcription. Following further investigation this matter was resolved and no action was

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

Southern Health and Social Care Trust

	necessary.
Keeping Patient Notes at Home	The process whereby Mr O'Brien is expected to transport patient notes on behalf of the Trust to outpatients clinics in South West Acute Hospital (SWAH) remains the same as previous. No patient notes have been tracked out to Mr O'Brien's home and no reports of notes being unavailable at the location they have been tracked to (e.g. Mr O'Brien's secretaries office), or instances of notes being unavailable as not found following a consultation with Mr O'Brien have been noted. Notes are present at Mr O'Brien's home overnight on any Monday that he conducts an outpatient clinic in SWAH. This is for logistical reasons as Mr O'Brien lives in [redacted] and would not return to Craigavon Area Hospital until Tuesday morning.
Private Practice	Mr O'Brien complies with the trust private practice policy regarding transfer from private care to NHS care and there have been no identified occasions where patients transferring from private care had their treatment expedited more patients of the same urgency from NHS clinics.

Has Dr O'Brien made any comments to the Trust in response to the recent deviation from his agreed action plan in September 19?

Mr O'Brien has made comments to the Trust (letter attached)

Regarding the recent incident in September 19, can you provide an update on what actions the Trust plan to take against Dr O'Brien? Specifically, are any measures being put in place to support Dr O'Brien and help him to address his current deficiencies?

The Trust has offered a meeting with Mr O'Brien on 12th December for further discussions on his job plan, which will include measures to support him in his working practices. As this meeting has not yet taken place, we have not yet had the opportunity to discuss the issues raised in his letter to clarify expectations, agree an action plan and consequence of continued non-compliance. Once an action plan has been agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes.

I hope the above is useful.

Yours sincerely,

Personal Information redacted by the USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

Aimee Crilly

Subject: FW: NICaN Urology CRG Meeting
Attachments: **Urology MDM Re-scheduled date** Now 03-12-19 (194 KB); Draft Mins 240919.docx; 031219Draft Agenda.docx

From: Sarah Donaldson <Personal Information redacted by the USI>
Sent: 03 December 2019 10:00
To: Sarah.Donaldson Personal Information redacted by the USI O'Brien, Aidan <Personal Information redacted by the USI>; alison.clayton Personal Information redacted by the USI a.gavin Personal Information redacted by the USI arthur.grey Personal Information redacted by the USI; brian.duggan Personal Information redacted by the USI; Bridget.tourish Personal Information redacted by the USI; caroline.lynas Personal Information redacted by the USI; chris.hagan Personal Information redacted by the USI; Chris.thomas Personal Information redacted by the USI Ciara.toal Personal Information redacted by the USI; colin.mulhollandsec Personal Information redacted by the USI colin.mulholland Personal Information redacted by the USI; Corrigan, Martina <Personal Information redacted by the USI>; darren.mitchell Personal Information redacted by the USI; declan.orourke Personal Information redacted by the USI; Dermot.hughes Personal Information redacted by the USI; dianne.kirkpatrick Personal Information redacted by the USI; Jackie.jamison Personal Information redacted by the USI; Martin.Eatock Personal Information redacted by the USI; Edel.aughey Personal Information redacted by the USI elizabeth.burgess Personal Information redacted by the USI; Reddick, Fiona <Personal Information redacted by the USI>; fionnuala.houghton Personal Information redacted by the USI; McClean, Gareth <Personal Information redacted by the USI>; gerry.mccarthy Personal Information redacted by the USI; gillian.traub Personal Information redacted by the USI; gillian.cairns Personal Information redacted by the USI; Graeme.Crawford Personal Information redacted by the USI; lisa.houlihan Personal Information redacted by the USI; hugh.o'kane Personal Information redacted by the USI; Chris.Hutchinson Personal Information redacted by the USI; Igho.Diegbe Personal Information redacted by the USI; jacqui.harney Personal Information redacted by the USI; jim.mcguigan Personal Information redacted by the USI; joe.o'sullivan Personal Information redacted by the USI joe.osullivan Personal Information redacted by the USI John.Keane Personal Information redacted by the USI; john.mcknight Personal Information redacted by the USI; john.smyth Personal Information redacted by the USI johnnybr Personal Information redacted by the USI; jonathan.mcaleese Personal Information redacted by the USI; juliea.alexander Personal Information redacted by the USI; ONeill, Kate <kate.oneill Personal Information redacted by the USI>; KerryM.chambers Personal Information redacted by the USI; Caoimhe.Lavery Personal Information redacted by the USI; lin.shum Personal Information redacted by the USI Loretta.Gribben Personal Information redacted by the USI; lynn.mclear Personal Information redacted by the USI; Niall.MacKenzie Personal Information redacted by the USI Haynes, Mark <Personal Information redacted by the USI>; maryjo.thompson Personal Information redacted by the USI; robert.mccormac Personal Information redacted by the USI; McCourt, Leanne <Personal Information redacted by the USI>; Margaret.McDonnell Personal Information redacted by the USI; michael.reilly Personal Information redacted by the USI; Naomi.McCay Personal Information redacted by the USI Pat.shiels Personal Information redacted by the USI; patricia.thompson Personal Information redacted by the USI; Peter.Ball Personal Information redacted by the USI; ruth.moore Personal Information redacted by the USI; sam.gray Personal Information redacted by the USI; samanthae.thompson Personal Information redacted by the USI; Gibson, Simon <Personal Information redacted by the USI>; S.lardner Personal Information redacted by the USI; suneil.jain Personal Information redacted by the USI; s.jain Personal Information redacted by the USI; thamra.ayton Personal Information redacted by the USI; timvits Personal Information redacted by the USI; Debbie.wightman Personal Information redacted by the USI; Tracey.Waring Personal Information redacted by the USI
Subject: NICaN Urology CRG Meeting

Subject:	NICaN Urology CRG Meeting
Location:	Tutorial Room 2 Craigavon Area Hospital : rescheduled meeting
Importance:	Normal
Start:	2019-12-03 10:00:00Z
End:	2019-12-03 11:30:00Z
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Urology Clinical Reference Group Meeting
Tuesday 24 September 2019
9.30am-11.30am, Post Grad Centre, Belfast City Hospital

Record of Discussion & Agreed Actions

In Attendance	Mr Mark Haynes (Chair), Dr Graeme Crawford, Mr Hugh O'Kane, Mr Darren Mitchell, Mr Chris Thomas, Ms Ciara Toal, Ms Samantha Thompson, Ms Sinead Lardner (NICR), Ms Sarah Donaldson (NICaN) **Via Videoconference** **SEHSCT:** Mr Sam Gray, Ms Patricia Thompson, Mr Robert McCormac **SHSCT:** Dr Gareth McLean, Ms Kate O'Neill, Ms Leanne McCourt **WHSCT:** Mr Colin Mulholland, Mr Alex McLeod
Apologies	Dr Chris Hutchinson, Ms Mary Jo Thompson, Dr Jackie Jamison, Ms Margaret McDonnell,

Item	Actions
	Welcome, Introductions & Apologies Mr Haynes welcomed everyone to the meeting of the Urology Clinical Reference Group. Mr Haynes opened the meeting to all members for introductions and apologies were noted as above.
1.	**Minutes of Previous Meeting** <u>MDM Proforma</u> Ms Donaldson advised colleagues that BSO have confirmed that the request for the upload of the MDM referral proforma dataset (c/w autofill fields) would now be subject to approval by the ECR Project Team. Collation of a minimum dataset and the use of the MDM referral proforma was the preferred option however as this is no longer an option and progressing this is proving problematic the group have agreed to move to regionally agreed wording when referring patients for MDM discussion. Where possible capturing the minimum dataset should be continued by MDM co-ordinators. Mr Haynes confirmed that the CRG will be given the opportunity to propose a minimum dataset for inclusion on Encompass. Action 1: Ms Donaldson has flagged response from BSO to NICaN Medical Director and Cancer Commissioning AD and will feedback on any progress made. <u>Draft Prostate Diagnostic Pathway-</u> A revised pathway was presented at the meeting and minor amendments were completed as the pathway was reviewed. Action 2: Final amendments will be completed and pathway circulated to the group for implementation. Copy will be uploaded to NICaN Website and SharePoint. <u>PSMA PET- stakeholder response to the implementation of Fluciclovine-</u> Dr Darren Mitchell advised the group of the recent response submitted on behalf of the Urology CRG to NHS England in relation to the proposal for PET with fluciclovine tracer for the diagnosis and staging of prostate cancer. This is specifically for patients with a biochemical recurrence and radical treatment through routine commissioning. The position of the CRG is that the resource, time and capital investment to implement fluciclovine could detract from or delay the consideration of more effective PSMA based screening.

	Dr Mitchell advised colleagues of the ongoing discussions with HSCB Commissioning colleagues for the provision of PSMA PET. NICE NG131- Impact Assessment- Response to Consultation – A full service impact assessment was completed with CRG and wider Urology colleagues following the publication of the revised NICE NG131. This guidance covers the diagnosis and management of prostate cancer in secondary care, including information on the best way to diagnose and identify different stages of the disease, and how to manage adverse effects of treatment. It also includes recommendations on follow-up in primary care for people diagnosed with prostate cancer. Action 3: Comments submitted through the consultation process were reviewed and amended at the meeting and a copy of the final response to be submitted to the HSCB on behalf of the CRG is attached in Appendix 1. NICE NG12 Revised Guidance and Draft Correspondence to Primary Care- Correspondence is to be issued from the HSCB which will be co-signed by Mr Haynes and Dr Crawford on behalf of the CRG. This correspondence will be issued to GPs, Dentists and all Trusts to advise that the NICaN Referral Guidance for Suspected Cancer – Red Flag Criteria (NICaN 2014) has been revised for prostate cancer which will be effective from 1 October 2019. This information will be launched on the primary care clinical communication gateway (CCG) and will be available on both the NICaN and Primary Care Website. The Pre-PSA Testing Advice Leaflet reviewed and amended by the NICaN readers panel will also be issued alongside the letter. Mr Haynes welcomed the launch of the guidance 12months after this was ratified through the CRG, NICaN Board and NIGPC however advised that NICE are currently preparing to review the 2015 NICE NG12 referral guidance.
2.	**Update from Bladder Cancer Pathway Subgroup** Mr Haynes advised colleagues that the Bladder Cancer Pathway Subgroup held their inaugural meeting on Thursday 12 September 2019. A work plan has been agreed which includes the; • collation a dataset to help provide an insight to the delays along the pathway, • exploring regional implementation of administration of mitomycin in theatre (WT colleagues have SOP and guidance which will be shared with the group) • completion of audit on G3TI patients which will include specific info on time to commence BCG induction • Literary research on the management of BCG induction in other centres • Inclusion of MIBC subset information into monthly performance data The consensus of group is to adopt NG12 referral guidance and work will commence to explore potential to engage with primary care colleagues to deliver GP education sessions on suspect bladder cancer referrals. The proposed bladder cancer guidance was also review at the meeting and reissued to all to ensure that patients are presented to correct MDM for discussion and tracked correctly through their cancer pathway.

3. **Update from PIG Meeting 11/09/19**

Mr Haynes and colleagues had attended the PIG meeting on Wednesday 11 September 2019. Mr Mulholland provided an update on the development of the Penile Cancer service at the NWCC and colleagues from the PHA had considered this in the development of the ED and Penile Prosthesis paper to be presented to SMT for approval.

This paper sets out the proposed local delivery of penile prosthesis as part of the development of a surgical andrology service to complement the existing medical andrology service already being delivered by two GUM consultants. These consultants are psychosexually and andrologically qualified and provide a regional service currently from bases in BHSCT, NHSCT and SHSCT.

It is recognised that there is also a need to ensure the pathway leading to surgical management of ESED is consistent for all patients. Work on this is ongoing involving lead clinicians from relevant specialties and will ensure consistency of care and equity of access for patients from primary care onwards. It will also help to appropriately triage patients with different conditions leading to erectile dysfunction to the specialist team with the correct skill set at the right time, optimising use of limited resources and improving patient experience.

Feedback on approval and associated funding will be provided at the next PIG meeting.

4. **Urology Overview**

Mr Haynes opened the meeting to enable colleagues to flag any concerns across their individual Trust Urology service; the following was highlighted:

Trust	Update Provided
BHSCT	Mr Thomas confirmed that the next flexi list is 22/10/19, next PSA clinic is scheduled for 16/10/19 with the results expected mid/end of October. MRI capacity is under pressure with loss of staffing and impact of pre biopsy MRI. Waiting times are 10- 12 weeks for MRI and 8-10 weeks for pre-biopsy MRI. Bladder- theatre capacity remains problematic; patients are managed in chronological order with clinical prioritisation applied for surgical lists however concerns have been flagged by the Urology Team. Theatre access remains problematic impacted by lack of physical capacity, lack of access to funded sessions and the lack of theatre nurses Oncology: CNS staffing and pension reform is impacting on service. It is hoped that impact to service could be divided across all Trust areas rather than in just one Trust.
SET	Imaging plan in place, CT reduced from 4 weeks to 14 days. Increased capacity in MRI due to outsourcing reduced from 8-9 weeks to 4-5 weeks. Diagnostics: Outsourcing scopes. TPBX: lead in time required, more colleagues being encouraged to move to TPBX and complete training
SHSCT	MRI waits currently 4-5 weeks for red flag and sitting around 7 months for routine Reduced capacity as team are 1 member down- impact on inpatient work, with waits at every point. Theatre capacity also an issue. Initial Red Flag Appointment – waits approximately 8—9 weeks. Outpatient nurse vacancy impacting on CNS and CNS activity
NWEST	Links have been established with Christie for penile service. Dr Brady will provide oncology input from NWCC and Dr Lynn Campbell had confirmed her input however with Dr Campbell being off alternative oncology input from Belfast will be explored. There is currently no TPBX waiting list with 2 lists being undertaken each week. Pre Bx MRI continues and waits are steady. Flexis, TURBT, nephrectomy and clinic are all running on time Bladder remains problematic. Keeping pace with kidney service however only red flag being done as no capacity for routine. MRI and CT are carried out within a few days in WT however work is ongoing to improve the waits within the Northern Trust. It was noted that nothing outside of cancer is being done.

Concerns with current management of waiting lists were discussed at length and the following was noted;

- **Chronological management will be applied in BT however when required patients will be risk**

stratified to determine surgical priority
- **Bladder Cancer Surgery will be prioritised over others**
- **Risk stratification can impact on individual patient as they can potentially progress to high risk whilst waiting to undergo surgery**
- **Sub-stratification is sometimes unavoidable however is not the preferred management process**

Surgeons expressed concerns with the expectation that individual clinicians are left to risk assess patients against others. Whilst this is recognised as a clinical responsibility there was some unease noted by clinicians. It was acknowledged that some degree of sub stratification is required.
There was regional consensus that this should be flagged from the CRG to the HSCB so as the HSCB can accept that this risk is present and unavoidable at this time to maintain management of the increasing waiting list.

Action 4: A letter will be drafted from the CRG to the HSCB which sets out the issues discussed at the meeting.

5. **Emerging Issues**

Robotic Prostatectomy Patient Information Video
Mr Haynes confirmed that Ms Donaldson has secured funding from PCUK for the production of a patient information video for patients considering robotic prostatectomy as their treatment plan. The video will feature advice and information from Mr Hugh O'Kane and Ms Samantha Thompson about the procedure and will include a "virtual tour" of both the unit and the robot Further discussions are required with the Belfast team to decide final content and format of the video and a meeting will be scheduled with PCUK as they are keen to be involved in this process.

Dr Crawford queried the "steering of patients" towards one treatment option over another however on further discussion with both surgeon and oncology colleagues it was noted that all patients are fully counselled on the range of treatment options available and overall patients are happy with this approach.

Dr Mitchell confirmed that the Friends of the Cancer Centre have produced an oncology video and Ms Donaldson will liaise with them to source a copy of this and ensure this is also available for patients.

Impact Study: Evidence for Prostate-specific Antigen Screening in BRCA2 Mutation Carrier
Dr Mitchell advised colleagues of the Interim Results from the IMPACT Study which have demonstrated that after 3 years of screening, compared with noncarriers, BRCA2 mutation carriers were associated with a higher incidence of PrCa, younger age of diagnosis, and clinically significant tumours. Therefore, systematic PSA screening is indicated for men with a BRCA2 mutation and oncology and genetic colleagues are keen to link with both colleagues in PHA and Commissioning to ensure a multiprofessional approach is agreed to progress this.
Ms Donaldson provided the relevant contact details for screening and PHA leads to Dr Mitchell.

Peer Review SET
The newly established standalone SET MDT and meeting will be subject to Peer Review on 15 October 2019. The Peer Review is as detailed below:

Peer Review Team	Consultant	Nurse Specialist	Manager	Lay Reviewer
Ms Millie Forde Mr Tim Jackson	Mr Anthony Glackin	Ms Beverley Rogers	Ms Edel Aughey	Ms Helena McCambridge

7. **Date of Next Meeting**
The next meeting is scheduled for Tuesday 10 December 2019, 10am and will be hosted from Tutorial Room 1, MEC Craigavon Area Hospital

The purpose of the document review record is to establish a clear pathway of consultation and to ensure that all comments are collected and considered. The document itself is straightforward and self explanatory. Comments regarding each section should be entered into the relevant section.

Document Review Record

Document title	NICE NG131 Prostate Cancer : Diagnosis and Management	Version	May 2019

Recommendation (s)	Potential Impact	Any Other Comment
1.1.1-1.1.13 • For advice on communication and patient-centred care throughout the patient journey, follow the recommendations in the NICE service guidelines on improving outcomes in urological cancers and improving supportive and palliative care for adults with cancer. [2008] • Offer people with prostate cancer information tailored to their own needs. This information should be given by a healthcare professional (for example, a consultant or specialist nurse) and may be supported by written and visual media. [2008] • Offer people with prostate cancer advice on how to get information and support from websites, local and national cancer information services, and from cancer support groups. [2008]	Oncology - Partially compliant – the majority of these tasks are shared between the clinical team including CNS/keyworkers. The current provision of CNS funding does not allow all patients to meet and discuss their newly diagnosed prostate cancer with a CNS. Increased funding for CNS's required	Increased funding for CNS's required. NI CNS staffing remains behind all other areas in the UK.
1.2.1-1.2.2 • Do not routinely offer multiparametric MRI to people with prostate cancer who are not going to be able to have radical treatment. [2019] • Offer multiparametric MRI as the first-line investigation for people with suspected clinically localised prostate cancer. Report the results using a 5-point Likert scale. [2019]	Partially compliant. Pre-biopsy MRI in appropriate cases has been under development and is increasingly being utilised. The Impact on MRI provision and waiting times has been documented previously. Impact – prolonged waiting time for pre-biopsy MRI and routine MRI services. This needs to be flagged to MRCN.	LIKERT is based on radiologist having all information. Commonly using PIRADS: Clinical information is taken into account in combination for decision making. Prostate diagnostic pathway demonstrates a review of clinical information in
1.2.3-1.2.4 • Offer multiparametric MRI-influenced prostate biopsy to people whose Likert score is 3 or more. [2019] • Consider omitting a prostate biopsy for people whose multiparametric MRI Likert score is 1 or 2, but only after discussing the risks and benefits	Partially compliant. Most radiologists currently use PIRADS but are moving to LIKERT. It was noted that the scale used is irrelevant as it is anticipated that there will be a move to bi-parametric. If urologist is doing the biopsy the consensus is that PIRADs is a	

Recommendation (s)	Potential Impact	Any Other Comment
with the person and reaching a shared decision. If a person opts to have a biopsy, offer systematic prostate biopsy. [2019]	better unbiased system.	decision making so in effect this approach applies LIKERT risk prior to biopsy.
1.2.5 Do not offer mapping transperineal template biopsy as part of an initial Assessment, unless as part of a clinical trial. [2019]	Compliant. Mapping TP biopsies are not performed but Local anaeasthetic TP biopsies (not mapping) are increasingly being used as targeted procedure post MRI and in previously negative TRUS biopsy cases	Need for regional adoption of TP biopsies and cessation of TRUS biopsies as part of strategy to reduce potential harm of diagnostic procedure, in particular reducing risk of gram negative sepsis.
1.2.6-1.2.7 • Help people decide whether to have an MRI or prostate biopsy by discussing: their prostate-specific antigen (PSA) level their digital rectal examination (DRE) findings (including an estimate of prostate size) any comorbidities, together with their risk factors (including increasing age and black African-Caribbean family origin) any history of a previous negative prostate biopsy. Do not automatically offer a prostate biopsy on the basis of serum PSA level alone. [2008] • Give people and their partners or carers information, support and adequate time to decide whether or not they wish to have an MRI or prostate biopsy. Explain the risks (including the increased chance of having to live with the diagnosis of clinically insignificant prostate cancer) and benefits. [2008]	Compliant	
1.2.8 If the clinical suspicion of prostate cancer is high, because of a high PSA value and evidence of bone metastases (identified by a positive isotope bone scan or sclerotic metastases on plain radiographs), do not offer	Compliant – as per current regional guidance	

Recommendation (s)	Potential Impact	Any Other Comment
prostate biopsy for histological confirmation unless this is needed as part of a clinical trial. [2008]		
1.2.9-1.2.12 Have a core member of the urological cancer MDT review the risk factors of all people who have had a negative first prostate biopsy. Discuss with the person that: • there is still a risk that prostate cancer is present and • the risk is slightly higher if any of the following risk factors are present: • the biopsy showed high-grade prostatic intra-epithelial neoplasia (HGPIN) • the biopsy showed atypical small acinar proliferation (ASAP) • abnormal digital rectal examination. [2014] **If the MRI or biopsy is negative** **1.2.10** For people with a negative biopsy who have an MRI Likert score of 3 or more, discuss the possibility of significant disease in an MDT meeting with a view to repeating the prostate biopsy. [2019] **1.2.11** For people who have a raised PSA and MRI Likert score of 1 or 2, and who have not had a prostate biopsy, repeat PSA test at 3 to 6 months and: offer prostate biopsy if there is a strong suspicion of prostate cancer (for example, PSA density greater than 0.15 ng/ml/ml or PSA velocity greater than 0.75 ng/year, or strong family history), taking into account their life expectancy and comorbidities discharge the person to primary care if the level of suspicion is low; advise PSA follow-up at 6 months and then every year, and set a PSA level for primary care at which to re-refer based on PSA density (0.15 ng/ml/ml) or velocity (0.75 ng/year). [2019] **1.2.12** For people who have a raised PSA, an MRI Likert score of 1 or 2 (or a contraindication to MRI), and negative biopsy, repeat PSA at 3 to 6 months and: offer prostate biopsy if there is a strong suspicion of prostate cancer (for example, PSA density greater than 0.15 ng/ml/ml or PSA velocity	Compliant – this is being adopted by the urology team. LIKERT scoring will become SOC	

Recommendation (s)	Potential Impact	Any Other Comment
greater than 0.75 ng/year, or strong family history), taking into account their life expectancy and comorbidities discharge the person to primary care if the level of suspicion is low; advise PSA follow-up every 2 years, and set a PSA level for primary care at which to re-refer, based on PSA density (0.15 ng/ml/ml) or velocity (0.75 ng/year). [2019]		
1.2.13 The PROGENSA PCA3 assay and the Prostate Health Index is not recommended in people having investigations for suspected prostate cancer who have had a negative or inconclusive prostate biopsy. [2019]	Compliant – PCA3 is not used	
1.2.14-1.2.17 STAGING ISOTOPE/ CT/ MRI	Compliant	
1.3.1-1.3.6 • Before radical treatment, explain to people and, if they wish, their partner, that radical treatment for prostate cancer will result in an alteration of sexual experience, and may result in loss of sexual function. [2008, amended 2014] • Explain to people and, if they wish, their partner, about the potential loss of ejaculation and fertility associated with radical treatment for prostate cancer. Offer sperm storage. [2008, amended 2014] • Warn people undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. [2008, amended 2014] • Offer a urological assessment to people who have troublesome urinary symptoms before treatment. [2008] • People with prostate cancer who are candidates for radical treatment should have the opportunity to discuss the range of treatment modalities and their serious side effects in relation to their treatment options with a specialist surgical oncologist and a specialist clinical oncologist. [2008] • 1.3.6 Explain to people that there is a small increase in the risk of colorectal cancer after radical external beam radiotherapy for prostate cancer. [2014]	Compliant	
1.3.16 Commissioners should base robotic systems for the surgical treatment of	Less than 150 per year regionally	Covered I suspect in the business case

Recommendation (s)	Potential Impact	Any Other Comment
localised prostate cancer in centres that are expected to perform at least 150 robot-assisted laparoscopic radical prostatectomies per year to ensure they are cost effective. [2014]		for RRP – Can we confirm
1.3.17-1.3.28 **RADICAL EXTERNAL BEAM RADIOTHERAPY / ANDROGEN DEPRIVATION THERAPY/ BRACHYTHERAPY AND DOCETAXEL AND WATCHFUL WAITING.**	Compliant	
1.3.29 -1.3.30 • Do not offer immediate post-operative radiotherapy after radical prostatectomy, even to people with margin-positive disease, other than in the context of a clinical trial. [2008] • Do not offer adjuvant hormonal therapy in addition to radical prostatectomy,even to people with margin-positive disease, other than in the context of a Clinical trial. [2008]	Partially Compliant – pending results of the RADICALS study there are men with such a high risk of local recurrence that a discussion on the advantages and disadvantages of early vs delayed radiotherapy is offered and the evidence for the use of hormone therapy in such cases is also discussed. The move to salvage XRT only would have minimal impact on the number of cases treated.	
1.3.31-1.3.32 LOCALLY ADVANCED	Compliant	
1.3.33-1.3.35 Offer people who have had radical treatment for prostate cancer access to specialist erectile dysfunction services. [2008, amended 2014] 1.3.34 Offer people with prostate cancer who experience loss of erectile function phosphodiesterase type 5 (PDE5) inhibitors to improve their chance of spontaneous erections. PDE5 inhibitors do not restore erectile function or are contraindicated, offer people vacuum devices, intraurethral inserts or penile injections, or penile prostheses as an alternative. [2008	Partially Compliant – there is limited access to specialist ED services as a consequence of CNS numbers. Andrology service OBC is in process which supports the local delivery of penile prosthesis as part of the development of a surgical andrology service to complement the existing medical andrology service already being delivered by two GUM consultants, who are psychosexually and andrologically qualified and provide a regional service. Development of a regional ED pathway has been proposed and work is ongoing with HSCB and PHA to secure funding and support to deliver this.	Improved CNS support Andrology service OBC in process
1.3.36 SPECIALIST CONTINENCE SERVICES	Compliant- thanks to charitably funded physiotherapy service. Should charitable funding	Note risk to service by virtue of non-

Recommendation (s)	Potential Impact	Any Other Comment
	stop then we would be non-compliant.	recurrent charitable funding.
1.3.37-1.3.38 URINARY INCONTINENCE	Compliant	
1.3.37-1.3.41 • Offer people with signs or symptoms of radiation-induced enteropathy carefrom a team of professionals with expertise in radiation-induced enteropathy(who may include oncologists, gastroenterologists, bowel surgeons, dietitians and specialist nurses). [2014] • Include the nature and treatment of radiation-induced enteropathy in training programmes for oncologists and gastroenterologists. [2014] • Carry out full investigations, including flexible sigmoidoscopy, in people who have symptoms of radiation-induced enteropathy to exclude inflammatory bowel disease or malignancy of the large bowel and to ascertain the nature of the radiation injury. Use caution when performing anterior wall rectal biopsy after brachytherapy because of the risk of fistulation. [2014]	partially Compliant – patients are referred to specialist teams but I do not think there is a formally funded radiation enteropathy service. Funding required for a radiation enteropathy service	
1.3.42-1.3.45 FOLLOW-UP FOR PEOPLE WITH LOCALISED OR LOCALLY ADVANCED PROSTATE CANCER HAVING RADICAL TREATMENT OR ON WATCHFUL WAITING	Compliant	
1.3.47 Follow up people with prostate cancer who have chosen a watchful waiting regimen with no curative intent in primary care only if protocols for this have been agreed between the local urological cancer MDT and the relevant primary care organisation(s). Measure their PSA at least once a year.	Non-Compliant – efforts to have remote or GP led/pt self directed care have been largely rejected by general practice. There are very few uro-CNS's so patients are almost all maintained on a formal clinical followup schedule as per 1.3.44 to 5 years. This has a significant impact on clinic waiting times and new patient appointments. Significnat investment required in uro-CNS and GP led/self-directed care	
1.3.9 Table 4 Protocol for active surveillance TIMING	Primary Care doesn't have a recall system available and would depend on patients remembering. There	

Recommendation (s)	Potential Impact	Any Other Comment
Year 1 of active surveillance **TESTS** • Every 3 to 4 months: measure prostate specific antigen (PSA)b • Throughout active surveillance: monitor PSA kinetics • At 12 months: digital rectal examination (DRE) • At 12 to 18 months: multiparametric MRI	may be hostility from GPs. Could it be done as patients sent the form and sample bottle by a tracker?	
1.4.1-1.4.2 INTERMITTENT THERAPY	Compliant	
1.4.3-1.4.5 • Offer medroxyprogesterone (20 mg per day), initially for 10 weeks, to manage troublesome hot flushes caused by long-term androgen suppression. Evaluate the effect at the end of the treatment period. [2014] • Consider cyproterone acetate (50 mg twice a day for 4 weeks) to treat troublesome hot flushes if medroxyprogesterone is not effective or not tolerated. [2014] • Tell people that there is no good-quality evidence for the use of complementary therapies to treat troublesome hot flushes. [2014]	Compliant but rarely used or effective	
1.4.6-1.4.11: **SEXUAL DYSFUNCTION**	Compliant	
1.4.12-1.4.15 • Do not routinely offer bisphosphonates to prevent osteoporosis in people withprostate cancer having androgen deprivation therapy. [2008] • Consider assessing fracture risk in people with prostate cancer who are having androgen deprivation therapy, in line with the NICE guideline on osteoporosis: assessing the risk of fragility fracture. [2014] • Offer bisphosphonates to people who are having androgen deprivation therapy and have osteoporosis. [2014] • Consider denosumab for people who are having androgen deprivation therapy and have osteoporosis if bisphosphonates are contraindicated or not tolerated. [2014]	non-Compliant – again pilot bone health study by a CNS provided useful data but not currently enough CNS support to use routinely. Improving access to DEXA scanning. Regional guidelines in development and may require increased use of bisphosphonates and DEXA scanning, Increased CNS input and increased access to Osteoporosis service	Increased CNS input and increased access to Osteoporosis service
1.4.16-1.4.17 Gynaecomastia	Non-Compliant – Not on protocol due to concern over radiation induced second malignancies.	

Recommendation (s)	Potential Impact	Any Other Comment
• For people starting long-term bicalutamide monotherapy (longer than 6 months), offer prophylactic radiotherapy to both breast buds within the first month of treatment. Use a single fraction of 8 Gy using orthovoltage, or electron beam radiotherapy. [2008] • If radiotherapy does not prevent gynaecomastia, consider weekly tamoxifen [2008]	Tamoxifen is used first line in the majority of cases with excellent effect.	
1.4.18-1.4.19 **FATIGUE**	Compliant	
1.5.1-1.5.23 **METASTATIC PROSTATE CANCER**	Compliant	

Urology Clinical Reference Group Meeting
Tuesday 03 December 2019
Tutorial Room 2, Craigavon Area Hospital
10.00am -11.30am

Video-Conference Available on 3111190

Agenda

Welcome, Introductions & Apologies

1. **Minutes and actions from previous meeting 24 September 2019**
   - Draft Diagnostic Pathway
   - NG131 Service Impact Assessment

2. **Update from Bladder Cancer Pathway Subgroup-**

3. **Feedback from Urology PIG/ Cancer AD/ MRCN-**

4. **Individual Trust Feedback on Overall Service**

5. **Emerging Issues-**
   - Hormone Pathways

6. **Date and Venue for Next Meeting:** Tuesday 3 March 2020

Aimee Crilly

From: ClientLiaison, AcutePatient <[redacted]>
Sent: 10 December 2019 15:17
To: O'Brien, Aidan; Corrigan, Martina
Cc: Carroll, Ronan; Livingston, Laura; Stinson, Emma M; Wright, Elaine; Haynes, Mark
Subject: AB complaint 10420
Attachments: Final response 10420.pdf

Dear all

I refer to the [redacted] complaint and have attached a copy of the Trust's response for your records.

Kind regards
Pamela

Pamela Truesdale
Governance Office, Acute Services
The Maples
Craigavon Area Hospital
68 Lurgan Road
Craigavon
BT63 5QQ

Tel: [redacted]

Southern Health and Social Care Trust

09 December 2019 **Our Ref:** AS60.19/20

Private & Confidential

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

I refer to your complaint in respect of the provision of care to your partner Ms Personal Information redacted by the USI Personal Information redacted by the Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

I would like to begin by apologising for the delay in responding to you, I believe we had hoped to meet with you and Ms Personal Information redacted by the but you have declined this invitation. To respond to the issues you raised in your complaint I had asked Mr O'Brien, Consultant Urological Surgeon to investigate the issues that you have raised.

Mr O'Brien felt that it was important to provide me with some background. At the outset Mr O'Brien apologises for the following narrative as it is very clinical but he feels it is necessary to outline this all to you both. Mr O'Brien would still very much like to meet with your both to go through all of this background. We would ask you to reconsider and so our invitation remains open to you both.

"Mr O'Brien advised that when Personal Information redacted by the USI *was* Personal Information redacted by the USI *old in 1999 she was found to have a poorly functioning and chronically infected duplex left kidney complicated with Left lower urinary tract reflux.* Personal Information redacted by the USI *'s left renal differential function was 36% (normal 100%). It was concluded that reflux into her left kidney had resulted in its poor function and chronic infection and that both of these were the cause of* Personal Information redacted by the USI *'s chronic pain.*

In 2000, Mr O'Brien performed an open, left, lower moiety, heminephroureterectomy, with reimplantation of the ureter draining the left upper moiety. Surgery resulted in complete relief of pain for a period of less than one year only. On further investigation of her recurrent pain, it was determined that she had reflux of urine up the reimplanted ureter draining the remaining left upper renal moiety. Mr O'Brien performed a Cohen anti-reflux reimplantation of that left ureter in 2004.

Even though there had been no evidence of left ureteric reflux since then, her left loin and flank pain persisted and to the extent that consideration was given during the course of 2011 to resecting her left upper urinary tract completely and particularly as it was found to contribute only 27% of global renal function, which was normal. On reassessment of her urinary tract prior to concluding to do so, she was found to have a solid lesion arising from the cortex of the upper pole of her right kidney. She had been reported to have a simple cyst within the cortex of the upper pole of her right kidney on ultrasound scanning in 2004. It

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The Maples, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by the USI

had increased in size on further scanning in 2007. There was no reported solid lesion of the right kidney on ultrasound scanning in 2009.

Percutaneous biopsy of the solid lesion in January 2012 confirmed a diagnosis of renal cell carcinoma. There was no evidence of metastatic disease found on CT and radioisotope bone scanning. Personal Information redacted by the USI was then electively admitted under the care of Mr. Akhtar, Consultant Urological Surgeon and had a right partial nephrectomy performed by him in March 2012. Histopathological examination of the resected specimen found it to be an intermediate grade, clear cell, renal cell carcinoma which did reach the deep resection margin.

Personal Information redacted by the USI was referred by her family doctor to the Orthopaedic Service in November 2012 because of increasingly severe pain referred to her left knee during the previous year, and during which time it had given way on a number of occasions. She had X Rays of her left knee requested by her family doctor and performed in May 2013, when it was reported that there was slight loss of the medial joint space and minor spiking of tibial spines, in keeping with early degenerative disease. She had a MRI scan of her left knee performed in December 2013, when it was reported that she had a tear of the medial meniscus with an associated para meniscal cyst. She was also found to have left patellar mal tracking with patellar chondromalacia. She was referred by the Southern Trust Orthopaedic ICATS Service to the Orthopaedic Department at Musgrave Park Hospital in Belfast in December 2013.

There was no evidence of recurrence or progression of renal carcinoma when Personal Information redacted by the USI had CT scanning of her chest, abdomen and pelvis performed in September 2012. Though she failed to attend for urological review on two occasions in 2013, she remained well at review in May 2014, but for intermittent, left loin pain as before, and troublesome lower urinary tract symptoms. There was no evidence of recurrence or progression of carcinoma on CT scanning in June 2014. As she did have significant urinary symptoms of a mixed nature, including diurnal urge incontinence and nocturnal enuresis, she was placed on the waiting list for urodynamic studies at further review in June 2014. Having failed to attend on two occasions in March 2015, when Personal Information redacted by the USI attended for urodynamic studies in May 2015, she was found to have involuntary detrusor over activity and bladder outlet obstruction. There was no endoscopic evidence of urethral stenosis (narrowing) when she had an intramural injection of Botulinum Toxin performed under general anaesthesia in November 2015.

There was no evidence of recurrence or progression of renal cell carcinoma on further CT scanning of Personal Information redacted by the USI s abdomen and pelvis in February 2016, it was reported that multiple vertebrae showed sclerosis which had not changed from previously, and that there were multilevel degenerative changes seen in the spine. At review by Mr. Jacob, Locum Consultant Urologist, in January 2017, Personal Information redacted by the USI was troubled by severe nocturia, having to rise up to seven times each night to pass urine. She was referred to the Community Continence Service to be taught self-catheterisation as she was considered to have inadequate bladder voiding on micturition. She was placed on a list for further review three months later.

Personal Information redacted by the USI had further X-Rays of her left knee requested in June 2016, but she failed to attend. She did do so in June 2017 when she was reported to have moderately severe osteoarthritis of her knee joint. She was referred by her family Doctor to the Orthopaedic

Service in October 2017 for assessment of increasing pain referred to her neck, arms and thighs. Following clinical assessment in November 2017, whole spine MRI scanning was requested and performed in January 2018, when she was reported to have multilevel, spondylotic, degenerative change throughout her spine, with disc prolapse indenting the thecal sac, particularly in the mid cervical and lower lumbar spine. There was no evidence of spinal metastatic disease.

On review at the Orthopaedic Service in March 2018, Personal Information redacted by the USI was referred to the Department of Spinal Surgery at Musgrave Park Hospital, Belfast, as she was experiencing increasing pain referred to both arms, increasing upper limb weakness, altered sensation in both hands, as well as reduced power and coordination of both lower limbs, as a result of which she had had a number of falls. Her family Doctor was also concerned that her falls may have been related to her painful left knee. He additionally wrote to the Department of Orthopaedic Surgery at Musgrave Park Hospital, Belfast, in April 2019, and again on 25 May 2019, requesting that her elective admission to Musgrave Park Hospital for arthroscopy be expedited.

Personal Information redacted by the USI was acutely admitted to Craigavon Area Hospital three days later, on 28 May 2019, her left leg having given way on her while standing in her kitchen at home. X Rays revealed a large lytic lesion, measuring 5.5 cm in diameter, in the lower left femur, resulting in an angulated and impacted, pathological fracture. MRI scanning confirmed that the lytic lesion was a solid lesion, either a primary tumour or a metastatic lesion. CT guided biopsy confirmed that the femoral lesion was a metastasis from renal cell carcinoma. There was no evidence of metastatic disease elsewhere on CT scanning of her chest, abdomen and pelvis, or on radioisotope bone scanning.

Personal Information redacted by the USI had the lower part of her left femur resected and a rotating hinged, total left knee replacement performed on 07 June 2018. She required significant, postoperative analgesia and was discharged on 20 June 2018 on a combination of Gabapentin and Oxycodone. She was understandably depressed and worried by the confirmed recurrence of her cancer, and had been referred to the Cancer Focus NI Counselling Service prior to her discharge.

On learning of the above diagnosis and management, Mr O'Brien contacted Personal Information redacted by the USI by telephone on 29 June 2018, when she advised that she was recovering satisfactorily following surgery. Mr O'Brien reassured her that there was no evidence of metastatic disease elsewhere at that time. I also explained that the removed lower left femur required decalcification over a period of several weeks to permit complete histopathological examination.

There was no evidence of malignancy present at the surgical resection margins on histopathological examination completed in early July 2018. When her further management was discussed at the Regional Urology MDM on 19 July 2018, it was agreed that it would be optimal to offer palliative radiotherapy to her remaining left femur, followed by referral to Dr. Clayton, Consultant in Medical Oncology at the Cancer Centre at Belfast City Hospital, concerning her future management. Mr O'Brien advised Personal Information redacted by the USI of the above recommendations at further review on 02 August 2018, and when he agreed to continue to review her for further assessment and management of her persistent, lower urinary tract symptoms.

Personal Information redacted by the USI completed a course of palliative radiotherapy to her left thigh in August 2018, following which she had a consultation with Dr Clayton when she expressed her anxiety regarding the prospect of having similar metastases develop elsewhere. On radioisotope bone scanning combined with CT scanning, she was reported to have increased uptake of radioisotope at the right lateral aspect of the twelfth thoracic vertebra, corresponding to a lytic lesion in the right transverse process of that vertebra, and considered suspicious of a new metastatic lesion which had not been present on review of the images of bone and CT scanning performed in May and June 2018.

Further whole spinal MRI scanning in November 2018 was supportive of a diagnosis of a metastatic lesion located in the right transverse process of the twelfth thoracic vertebra. Though there were features of degenerative disease affecting the lower cervical spine, there was no evidence of spinal metastatic disease elsewhere. There was no evidence of metastatic disease elsewhere when CT scanning of her chest, abdomen and pelvis was repeated in November 2018. When Personal Information redacted by the USI was reviewed at the Cancer Centre in December 2018, it was evident that she had required increasingly high doses of opioids and non-steroidal anti-inflammatories to achieve adequate relief of increasingly severe pain related to the presumed, metastatic lesion in her lower thoracic spine. She proceeded to have stereotactic radiotherapy to the lesion in January 2019.

At review at the Cancer Centre following completion of radiotherapy, it was considered that the addition of radiotherapy had resulted in improved relief of spinal pain. It was also reported that Personal Information redacted by the USI continued to struggle psychologically with the recurrence of her cancer, resulting in depression and anxiety. Her family had become increasingly concerned with her deteriorating mental state. She was then encouraged to attend a clinical psychologist with whom an appointment had been arranged. She was also provided with Kidney Cancer UK's support telephone contact details. She was referred to the Community Palliative Care Service with a view to regulating her analgesia, and to a Social Worker.

Personal Information redacted by the USI presented to the Emergency Departments of Craigavon Area and Daisy Hill Hospitals during February 2019, reporting increasing left leg pain and swelling. She was found to have thrombus within her left distal femoral vein on Doppler ultrasound scanning, and has since been prescribed Enoxaparin for a period of six months.

The appearance of the twelfth thoracic right transverse process has remained unchanged on spinal MRI scanning in February 2019, on CT scanning in March 2019 and most recently on further CT scanning of her chest, abdomen and pelvis in June 2019. There has been no suspicion or evidence of metastatic disease elsewhere on these further scans. The appearance of her left knee replacement was satisfactory on imaging in April 2019, by which time it was reported that Personal Information redacted by the USI was free of pain referred to her left leg.

At review in April 2019, Mr O'Brien focussed on Personal Information redacted by the USI continued urinary symptoms, which included both diurnal and nocturnal urinary incontinence. I found her to have mildly inadequate bladder voiding on micturition with a residual urine volume of 150 ml. Personal Information redacted by the USI advised that she had been unable to self-catheterise since her left knee replacement. Mr O'Brien referred her to the Community Continence Service to provide encouragement and support to her in her attempted resumption of self-catheterisation. He also expressed his concern regarding her continued dependence on high daily doses of opioid analgesia, and which he considered may have been contributing to her urinary retention and incontinence. Mr O'Brien advised her family Doctor to begin incrementally decreasing the dosage of

opioids. Personal Information redacted by the USI *agreed to return to the Urology Department in due course for flexible endoscopic assessment of her lower urinary tract and to have urodynamic studies repeated".*

With respect to the issues raised in your correspondence Mr O'Brien has provided me with the following response.

Mr O'Brien feels that you appear to be of the view that the finding of renal cell carcinoma at a surgical resection of Personal Information redacted by the USI kidney in March 2012 has been the reason for the development of, or the source of the metastatic disease in 2018. And that you may feel that there was some cancer left behind in the right kidney at the time of surgery, Mr O'Brien believes that this is not the case as there still has been no evidence of carcinoma present in the right kidney as recently as June 2019, seven years later.

Mr O'Brien advises me that although you may feel that the cancer was the cause of the pain in Personal Information redacted by the USI s left knee, that this is not the case as just to reassure you that having cancer within the bone will not have caused this pain and that there was no evidence of any bone disease on X Rays of her left knee in May 2013, on MRI scanning in December 2013, and on further X Rays in June 2017. Mr O'Brien advises me that all of these scans show that Personal Information redacted by the USI had a torn medial meniscus and a para meniscal cyst, and which had been considered to be the cause of her left knee pain, swelling, locking and giving way and not the cancer.

Mr O'Brien feels that you may think that Personal Information redacted by the USI was knowingly discharged in March 2012, with spread of cancer to her left femur, causing her all of the symptoms that she had at that time, without referral to Marie Curie, District Nurses, Occupational Therapists or Physiotherapists to support her in *'her rehabilitation with walking'*. Mr O'Brien has asked that I reassure you that if there had been any evidence of metastatic disease causing left femoral pain, consideration would certainly have been given to radiotherapy as a minimum therapy, possibly prophylactic fixation to avoid pathological fracture, and referral for consideration of systemic therapy. Personal Information redacted by the USI would additionally have been referred to all appropriate support services. None of that occurred as the pain in her left knee was unrelated to presence of microscopic metastasis in her distal left femur, at that time.

However Mr O'Brien has asked that I apologise that as per your letter that if she was discharged in March 2012, without referral to appropriate support services following surgery for renal cancer, even if the surgery was expected to probably be curative, or without referral to appropriate support services for a painful left knee, even though there was no causal relationship between the renal cancer and the painful left knee, then that was a regrettable deficiency in care.

To reassure you Mr O'Brien has advised me that it is evident from Personal Information redacted by the USI s clinical history, that she did have ongoing review of her renal cancer by CT scanning and it is evident by later CT scanning of her chest, abdomen and pelvis in 2018, that there was no evidence of metastatic disease. Moreover to advise you that it would not have detected the left femoral metastasis, as the femora are not included on CT scanning of the chest, abdomen and pelvis.

From looking through [redacted]'s notes Mr O'Brien advises me that it would appear that there had been a significant, progressive increase in the severity of [redacted]'s pain referred to her left knee or distal left femur, during the months preceding the diagnosis of pathological fracture due to femoral metastasis. When assessed by the Southern Trust Orthopaedic ICATS Service in November 2017, the focus related to an assessment of possible spinal pathology that may have been the cause of her symptoms with which she had been referred, though it was reported that she had recently had one fall due to knee pain or leg weakness. On further review by the ICATS Service in March 2018, it was reported that she had had a number of recent falls which may have been secondary to her knee problem for which she was awaiting surgery. Thereafter, there would appear to have been a significant increase in the severity of her pain, resulting in her family Doctor writing twice to the Department of Orthopaedic Surgery at Musgrave Park Hospital, requesting that her admission for arthroscopy be expedited. Mr O'Brien would like to apologise for the wait and the stress that this pain caused [redacted].

Mr O'Brien advises me that [redacted] had not been reviewed by the Urology department since January 2017, even though she was on the list awaiting review since April 2017, for this we would like to apologise as there has not been an adequate capacity to review all patients after the interval intended. Mr O'Brien believes that it would be speculative whether imaging of her left knee or femur would have been requested and performed prior to the pathological fracture, if [redacted] had been reviewed by our Department in early 2018. On the other hand, if the severity of pain had been considered disproportionate or uncharacteristic of that due to a torn meniscus, then appropriate imaging should have been requested, if reviewed, in view of the history of renal cell carcinoma.

I know that from your correspondence you feel that [redacted] *was 'never once called in for follow up'*. However as you will see that it is evident from the clinical history, that was not the case. Nevertheless, Mr O'Brien acknowledges that it is understandable that there will have been a distinct difference in the intensity and scope of review following a partial nephrectomy which was correctly considered to probably curative, and that of review following a diagnosis of metastatic renal cell carcinoma and Mr O'Brien hopes that in his response that he has been able to explain this.

Mr O'Brien has advised that in preparation of this report, he has been unable to clarify whether [redacted] had been advised of, or offered, counselling or support services following surgery in March 2012. In your letter you have advised that she had been provided with information leaflets of booklets, presumably concerning renal cell carcinoma. Whether the surgery was considered to probably be curative, a proportion of patients will welcome and benefit from support services. It is regrettable that such support may not have been offered, or provided. Mr O'Brien would like to apologise to [redacted] and you on behalf of Mr. Akhtar, and both medical and nursing staff of that time. It would be optimal to ensure that counselling and support services are offered to all patients following cancer surgery and to assure you that we now have Clinical Nurse specialists in place who are trained in a key worker role and are the point of contact for all patients that have had a cancer diagnosis.

Mr O'Brien advises me that review of patients following an initial diagnosis of renal cell carcinoma usually includes regular CT scanning. Radioisotope bone scanning or CT scanning of head, neck and limbs are not usually included in follow up imaging, unless there is a clinical indication. He advises me that he suspects that any form of imaging of the

left femur during 2017 may have been normal, in the same manner in which CT and MRI scanning in May and June 2018 did not detect any spinal metastatic disease detected three months later.

Mr O'Brien as stated previously advises that Personal Information redacted by the USI had been due a review appointment with the Urology Department in April 2017 and he has apologised that she still awaited that review by May 2018. If she had been reviewed in early 2018 he advises me that he would not have requested further imaging of her left knee as he may have felt that the pain in her knee may have been mistakenly put down to being due to the torn medial meniscus and cyst that she had been known to have on the previous imaging.

I realise all of the above is very clinical and we still would like to offer you and Personal Information redacted by the USI a meeting with Mr O'Brien to help reassure you both, and should you wish to avail of this please contact a member of our complaints team and we will organise this for you and anyone you may wish to bring with you.

I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on Personal Information redacted by the USI *or email:* Personal Information redacted by the USI *within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.*

Yours sincerely

Personal Information redacted by the USI

Melanie McClements (Mrs)
Interim Director of Acute Services

for Mr Shane Devlin, Chief Executive

Aimee Crilly

From: Glackin, Anthony <[redacted] Personal Information redacted by the USI >
Sent: 20 February 2020 11:07
To: Haffey, Raymond; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Tyson, Matthew; Young, Michael; Elbaroni, Wesam; Hasnain, Sabahat; McAuley, Laura; Sharma, AbhishekDutt; Steen, Benjamin; Caddell, Caroline; McCourt, Leanne; McMahon, Jenny; ONeill, Kate
Subject: Urology PSM Feb 2020 minutes
Attachments: Urology Department Patient Safety Meeting 14022020 Minutes.docx; ECR report Urology MM Feb 2020.pdf

Dear All,
Please find attached the minutes and M&M report for Feb 2020.

Kind regards

Tony

Urology Department Patient Safety Meeting 14 February 2020

In attendance:
Mr Glackin (Chair), Mr O'Brien, Mr Young, Mr O'Donoghue, Mr Elbaroni, Mr Sharma, Mr Steen, Sr McCourt, Mrs Corrigan

Apologies: None

1. Minutes of last meeting and matters arising NIL
2. Morbidity & Mortality

   See NIECR report
3. Complaints & Compliments NIL
4. Learning from SAI's, DATIX etc.
   a. Datix Incident Report Number W105607.msg
5. Audits.
   a. Antimicrobial Stewardship Summary SHSCT Surgery and Elective Consultants (October 2019).pdf
6. Any other business
   a. Acute Standards & Guidelines Monthly Summary Report December 2019.xlsx
   b. Memo - Death Certification HCAI (2) - 18.11.19.pdf
   c. Final Report to HSCB 3.2.2020.pdf
   d. REF156_NPCA-Short-Report-Prostate-Biopsy_FINAL_131219.pdf
   e. Acute Standards & Guidelines Monthly Summary Report December 2019.xlsx
7. Next meeting
   a. Urology M&M Rolling calendar January to December 2020.doc

Meeting Details	
Date/time	14-Feb-2020 09:30
Primary Team	CAH - Urology
Joint Team(s)	
Attendees	Aidan O'Brien / Anthony Glackin / Corrigan, Martina / Elbaroni, Wesam / John P O'Donoghue / Mark Haynes / McCourt, Leanne / Michael Young / Sharma, Abhishek / Steen, Benjamin

HCN	Full Name	Date of Death	Discussion Details	Lesson Category	Lesson Discussion Details	Action(s)	Outcome
[redacted]	Personal Information redacted by the USI		Patient considered fit for cystectomy by objective anaesthetic assessment, was then considered unfit by subjective assessment.	N/A	N/A		4. contained aspects that have already been, or SHOULD² be, referred to Trust Incident Reporting System.
				N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
				N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
				N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
			This lady had bilateral nephrostomy tubes placed in Dec 2018 at BCH whilst under the care of haematology. She had not attended Urology at SHSCT. It would appear that Haematology at BCH did not make plans for change of nephrostomy tubes at discharge in Feb 2019.	Good practice	It is the responsibility of the admitting team to arrange ongoing management of nephrostomy tubes	Action:Admitting team to arrange appropriate follow up, Responsible Team:By another team, Date to be completed:, To be action by:N/A	3. contained aspects that SHOULD² be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported.
				N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
				N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.

Aimee Crilly

Subject: FW: Wait Times for First Appointment
Attachments: RF 1st Appointment Longest Wait 2020.xlsx

Importance: High

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 24 February 2020 12:30
To: Nixon, Gemma <Personal Information redacted by the USI>; Craughwell, Martin <Personal Information redacted by the USI>; Wright, Brendan <Personal Information redacted by the USI>; Farnan, Turlough <Personal Information redacted by the USI>; Gurunathan, Ramesh <Personal Information redacted by the USI>; Korda, Marian <Personal Information redacted by the USI>; Lesay, Michal <Personal Information redacted by the USI>; McCaul, David <Personal Information redacted by the USI>; McNaboe, Ted <Personal Information redacted by the USI>; Reddy, Ekambar <Personal Information redacted by the USI>; Cheah, Marisa <Personal Information redacted by the USI>; McGreevy, Angela <Personal Information redacted by the USI>; McKenna Dominic <Personal Information redacted by the USI>; McKenna, Conor <Personal Information redacted by the USI>; Taggart, Andrew <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; O'Brien, Aidan <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>; Elbaroni, Wesam <Personal Information redacted by the USI>; Hasnain, Sabahat <Personal Information redacted by the USI>; McAuley, Laura <Personal Information redacted by the USI>; Sharma, AbhishekDutt <Personal Information redacted by the USI>; Steen, Benjamin <Personal Information redacted by the USI>; McCourt, Leanne <Personal Information redacted by the USI>; McMahon, Jenny <Personal Information redacted by the USI>; ONeill, Kate <Personal Information redacted by the USI>
Subject: FW: Wait Times for First Appointment
Importance: High

Dear all

FYI

Regards

Martina

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

Telephone:
EXT Personal Information (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

From: Muldrew, Angela
Sent: 20 February 2020 17:36
To: Carroll, Kay; Carroll, Ronan; Clarke, Wendy; Corrigan, Martina; Devlin, Louise; McAreavey, Lisa; McVey, Anne;

Nelson, Amie; Scott, Jane M; Lappin, Lynn; Leeman, Lesley
Cc: Conway, Barry; Reddick, Fiona
Subject: Wait Times for First Appointment
Importance: High

Dear All

Find attached RF waiting time as at 20/02/2020

Thanks

Angela Muldrew
Acting Operational Support Lead
CCS & IMWH
Tel. No. Personal Information redacted by the USI

RF Longest Wait (Number of days waiting)

Tumour Sites	14/01/2020	21/01/2020	20/02/2020			
Breast	6	11	14			
Gynae	6	6	21			
ENT	6	10	10 (62*)			
Surgical (GPC)	40	41	40			
Gastro	0	46	33			
Urology (Prostate)	101	100	116			
Urology (Haematuria)	51	51	53			
Urology (Other)	51	51	52			
Lung	20	12	19			
Skin	14	10	10			
Haematology	45	45	59			
Oral Surgery	34	35	37			

*ENT - there is a late OC referral only received by cancer services on 17/02/2020 but was referred on 17/12/2019 - this is just 1 referral and their cancer pathway is

not started. The next longest waiter will be 10 days

WIT-83407

Health and Social Care

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HCN	Full Name	Sex	Date of Birth	Hospital	Specialty	Referral Date	Priority	Triage Consultant
Personal Information redacted by the USI				Daisy Hill Hospital	UROLOGY	13-May-2020	Red Flag	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	29-May-2020	Red Flag	
				Craigavon Area Hospital	UROLOGY	20-Apr-2020	Urgent	Mr M Haynes
				Daisy Hill Hospital	UROLOGY	01-May-2020	Urgent	Mr M Young
				Craigavon Area Hospital	UROLOGY	11-May-2020	Urgent	Mr M Young
				Craigavon Area Hospital	UROLOGY	19-May-2020	Urgent	Mr M Young
				Craigavon Area Hospital	UROLOGY	20-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY - MALE LUTS	22-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	22-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	22-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY - MALE LUTS	26-May-2020	Urgent	Mr A OBrien
				Craigavon Area Hospital	UROLOGY	27-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	27-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	28-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	28-May-2020	Urgent	

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WIT-83408

HCN	Full Name	Sex	Date of Birth	Hospital	Specialty	Referral Date	Priority	Triage Consultant
[redacted]	Personal Information redacted by the USI			Daisy Hill Hospital	UROLOGY	13-May-2020	Red Flag	Mr M Haynes
				Daisy Hill Hospital	UROLOGY	04-Jun-2020	Red Flag	
				Craigavon Area Hospital	UROLOGY	20-Apr-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	20-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY - MALE LUTS	22-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	22-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	22-May-2020	Urgent	Mr J ODonoghue
				Craigavon Area Hospital	UROLOGY	27-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	27-May-2020	Urgent	Mr M Haynes
				Craigavon Area Hospital	UROLOGY	28-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	28-May-2020	Urgent	
				Daisy Hill Hospital	UROLOGY	28-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	28-May-2020	Urgent	
				Craigavon Area Hospital	UROLOGY	29-May-2020	Urgent	
				South Tyrone Hospital	UROLOGY	29-May-2020	Urgent	

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Via email [redacted] Personal Information redacted by the USI

Mr Andrew Anthony
Tughans
Marlborough House
30 Victoria Street
Belfast

Dear Mr Anthony,

RE: UROLOGY STRUCTURED CLINICAL RECORD REVIEW PROCESS

I wish to update you on progress regarding our lookback on patients under the care of your client between January 2019 and June 2020 while he were employed as Consultant Urologist within the Southern Health and Social Care Trust.

As a result of this lookback we have identified to date a further 53 patients whose care we have found to have met the threshold for a Serious Adverse Incident Review. Further to discussions with the Department of Health and Health and Social Care Board the review of these cases will not be undertaken as Serious Adverse Incident reviews but instead will be conducted using a Structured Clinical Record Review that is underpinned by Structured Judgement Review Methodology. The use of this methodology will support the Trust identification of learning and allow the Trust to take any further actions required to maintain patient safety. Each review will be undertaken at this stage by Consultant Urologists not under the employment of the Southern Health and Social Care Trust.

Upon completion of this exercise it is anticipated that a summary themed report detailing the outcomes of this work will be produced. A copy of this will be shared with your client when it becomes available.

I trust you will pass this update on to your client.

Yours sincerely

Tughans

tughans.com

Avril Frizell
Directorate of Legal Services
Business Services Organisation
2 Franklin Street
Belfast
BT2 8DQ

Our Ref: AFA/NW-McC/00003911.100

Your Ref:

Date: 13 June 2022

By Email
Personal Information redacted by the USI

Dear Ms Frizell

MR AIDAN O'BRIEN

On 20 May I was forwarded a letter by DLS. I assume there was an administrative error as it was not on headed paper nor signed off. I assume however, as you were copied into the covering email, that you are the correct Solicitor I should respond to. If not, please direct me elsewhere.

The correspondence in question advised me that you were updating me on the lookback on patients under the care of Mr O'Brien from January 2019 to June 2022 in his capacity as an NHS consultant. I should make it clear that, other than being made aware that there was such a process ongoing, Mr O'Brien has neither been provided with substantive information in relation to it nor invited to contribute in any way to it. We have no way of telling how the Trust went about identifying the 53 patients your letter refers to, nor of the underlying issues raised.

We have not been provided with any information by you in relation to the discussions between your client and the DOH whereby it was concluded Serious Adverse Incident Review's ("SAI") should not be undertaken, but rather Structured Clinical Records Reviews ("SCR") were the preferred method of investigation. Please provide the relevant documentation to me. You will be aware of the serious concerns my client has in relation to how the SHSCT went about the SAI's undertaken in late 2020/early 2021.

I would welcome the following clarification from the letter of 20 May:

1. Who identified the 53 patients whose clinical records have been or are to be reviewed?
2. The methodology used to identify the 53 patients.
3. Copies of all communications with the 53 patients and all information given to them concerning the SCRR.
4. Is the review under the auspices of a Royal College? If so which one?
5. Can you please let us have the Royal College's procedures for carrying out such a review?

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Belfast BT1 3GG

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Tughans

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6. If not under a Royal College's procedures, please identify the procedures your client is following?

7. Has the Royal College, other institution, or the independent urologists referred to in the letter been made aware of the ongoing public inquiry and GMC investigation. On perusal of guidelines from certain Royal Colleges we note a SCR or similar process would not normally be undertaken when there are already investigations of such a kind ongoing.

8. Is Mr O'Brien to be provided with the records for the patients, and the documentation that substantiates, presumably on the Trust's analysis, the finding they have met the threshold for a SAI?

9. Is Mr O'Brien to be invited to contribute to the SCR? If not, why not?

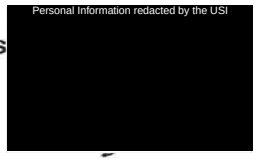
10. Please identify the Consultant Urologists that either have been appointed or are to be appointed so that we can ensure there is no conflict of interest arising from our perspective.

11. Whether Mr O'Brien is to be afforded the opportunity to contribute to the review or not, is he to be afforded the opportunity of commenting on any draft summary themed report prior to its conclusion? If not why not?

I look forward to hearing from you.

Kind regards.

Yours



ANDREW ANTHONY

Personal Information redacted by the USI

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11 July 2022

Dear Aidan

I have been thinking of you for quite sometime and this letter has been written many times in my mind but never gone to print. So today I am taking this opportunity to assure you of my thoughts and prayers. Having gotten to know you over the years of my time as Personal Information redacted by the in Craigavon Hospital and also as my consultant I always had a great regard and respect for you.

Due to your expertise and early diagnosis of my brother Personal Information redacted by the illness he is ever indebted to you as you saved his life; and this is also true of my late brother in law Personal Information redacted by the USI where at the time (over 25 years ago) you reassured his family and brother Personal Information redacted by who was in Personal Information redacted by that Personal Information redacted by the would not die of prostate cancer, which was the case. For what it is worth I felt it important that you should be aware of me and my family's deep appreciation for the professional service that you provided us. You did so with such humility, care and compassion. This is also what I experienced when I worked alongside with you in Craigavon Hospital.

This of course is a difficult time for you and your family and I can only but imagine the stress it has caused. I will keep you in my prayers and will offer up Mass for you and your family.

Personal Information redacted by the USI

Fifty years ago, I met Aidan, when we started as medical students. I have been listening to his praises ever since then, from patients and colleagues. There is absolutely No doubt that Aidan O'Brien is the epitome of the perfect doctor, for whom Care, Competence and Compassion are the hallmarks. These qualities are present in abundance. As one of the contributors here has said, "He is one, in ten million".

There is also NO doubt that he is the victim of a witch hunt. This is disgraceful behaviour by the Health Board, who are trying to destroy his good name, and clinical reputation.

I look forward to the huge apology that will be necessary after these inquiries, private and

Sent from my iPhone

Personal Information redacted by the USI

Mr O'Brien cared for me for over 20 years! His care went beyond operations and hospital treatments. He cared for both me and my family. When discharged from hospital regular phone calls where made to make sure everything was as it should me. Mr O'Brien is the best in his profession. So caring and thoughtful towards his patients. I could in no way fault him. He saved my life many many times. I will be forever grateful.

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14 Reply

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Personal Information redacted by the USI

I met Mr O'Brien as a patient of his over 10 years ago and he was very professional and put me right at ease.

I now work in the medical field myself in Personal Information redacted by the USI and it is very easy to see that he is being targeted by the trust.

I believe that if a massive audit of any doctor or healthcare professional occurred, comments and criticisms could always be found, as different doctors have different styles of doing things etc. It all comes down to whether the doctor is a good person and truly puts their patients best interests first. There is no doubt that Mr O'Brien put his patients first and the support from his colleagues is also evidence of that too.

 13   Reply

293 COMMENTS

Newest

Personal Information redacted by the USI

Aiden I had the pleasure of working with you as a Personal Information redacted by the USI in CAH for 22yrs. You were a true gentleman, treating your theatre nurses as equals in the care you delivered to patients. You were always respectful and appreciative of our role and patients were always the centre of the care we delivered. No one was a number on your list or a procedure name, you knew and cared for them all. God bless you on this unenviable journey to disclose the real reason for this nightmare

293

13 Reply


giffgaff
17:31
19%
Personal Information redacted by the USI
Personal Information redacted by the USI
I worked in for over 12 years and during that time I became acquainted with Mr O'Brien. I was always impressed and admired how dedicated and respectful he was to all those who he served. I also experienced this at first hand when I myself became one of his patients. I had the utmost trust and confidence in his professionalism and the manner in which he treated me. My family and I are also indebted to him for the early diagnosis of my brothers illness as he saved his life. It was during this time that Mr O'Brien went beyond the call of duty and made a number of telephone calls to assure our family of his recovery. We deeply appreciate the professional service that he provided us. He did so with humility, care and compassion. Mr O'Brien is in our thoughts


and prayers at this difficult time.
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Reply
supportaidanobrien.com

Clinical History of Service User A

Introduction

The following clinical history of Service User / Patient A has been compiled from photocopies of documentation contained within the patient's hospital chart and from information retrieved from the Northern Ireland Electronic Care Record (NIECR.

Clinical History

Service User A (SUA) was Personal Information redacted by the USI old at the time of his referral in June 2019. He was born on Personal Information redacted by the USI. Personal Information redacted by the USI He was found to have essential hypertension in 2003 and to have mixed hyperlipidaemia when he presented with angina in May 2004, leading to a diagnosis of ischaemic heart disease in July 2004. He underwent cardiac catheterisation in September 2004. He suffered acute myocardial infarction in May 2016 and underwent percutaneous coronary arterial intervention for triple vessel disease in June 2016. At the time of his referral in June 2019, he had remained on Bendroflumethiazide 2.5mg daily since 2003, Aspirin 75mg daily since 2004, Rosuvastatin 10mg daily since 2006, Diltiazem 180mg daily since 2016, Isosorbide Mononitrate 50mg daily since 2016 and Glyceryl Trinitrate 400mcg to be taken when required since 2016

SUA had also had a diagnosis of osteoarthritis in 2004 and a clinical diagnosis of right greater trochanteric bursitis in 2008. He suffered duodenitis in 2004, remaining on Pantoprazole since 2005. He had varicose veins stripped from his right leg in 2006 and a right inguinal herniorrhaphy performed in 2012. He was found to have type II diabetes in 2017 and remained on Glicazide 30mg daily since then. He additionally had been taking Pregabalin 25mg twice daily for chronic pain since 2018.

SUA had been prescribed Finasteride 5mg daily in February 2010 for urinary symptoms indicative of bladder outlet obstruction. He had additionally been prescribed Oxybutynin MR 10mg daily in 2016 for storage urinary symptoms. He remained on both when referred by his GP on Thursday 13 June 2019 due to the finding of serum PSA levels of 19.16ng/ml in May 2019 and of 19.81ng/ml when repeated in June 2019. He was referred to Omagh Hospital and Primary Care Centre. The referral was triaged by a consultant urologist at Altnagelvin Area Hospital. The referral was redirected on 13 June 2019 to the Department of Urology at Craigavon Area Hospital (CAH) as the patient lived in Enniskillen, County Fermanagh, for which region the Southern Health & Social Care Trust provided the urological service.

The redirected referral was received by the Southern Trust Booking Centre on Friday 14 June 2019. As I was Urologist of the Week from Thursday 13 June 2019, I triaged the referral. There were concerns within the Trust in February 2019 regarding the increasingly long periods of time newly referred patients suspected of, or at increased risk of, having prostate cancer, were awaiting a first outpatient consultation, and who were then waiting 67 days for a first appointment. By June 2019, some such patients were waiting up to 15 weeks for a first outpatient appointment. In view of such long waiting times and in order to expedite his assessment, I contacted SUA by telephone to confirm receipt of his referral and to ascertain whether there were any contraindications to him

having MRI scanning. I then requested an appointment for SUA to have a MRI scan of his prostate gland at South West Acute Hospital (SWAH) in Enniskillen.

It was my usual practice to request that an appointment be arranged for such a patient from County Fermanagh at my clinic at SWAH, for the patient's convenience, but also in view of the clinical urgency and in the context of long waiting times for appointments. However, in addition, my colleagues and I had learned in 2019 that newly referred patients were not necessarily being placed on waiting lists for first outpatient appointments if investigations, such as scans, were requested at triage. Instead, there was an expectation that results or reports of these investigations would be returned to consultants who would then determine whether outpatient appointments were required.

I therefore requested that an appointment be arranged for him to attend my clinic at SWAH in Enniskillen on Monday 22 July 2019, or alternatively at a New Patient Clinic at CAH if an appointment could be arranged for him earlier than 22 July 2019, following MRI scanning, though that would have been most unlikely due to the long waiting times. The triaged referral was returned to the Office of Cancer Services at CAH on Monday 17 June 2019. The Office then arranged an appointment for SUA at my clinic at SWAH on Monday 22 July 2019 at 11.10 am.

SUA had MRI scanning performed on 10 July 2019. His ellipsoidal prostatic volume was calculated to be 32ml. He was reported to have an equivocal, PI-RADS 3 lesion within the left anterior mid-portion of the transition zone which otherwise had the appearances characteristic of benign nodular hyperplasia. However, there were appearances characteristic of carcinoma affecting the peripheral zone bilaterally, more so on the left side than on the right side. The suspect carcinoma was reported to abut the prostatic capsule and the external sphincter, but there was no radiological evidence of extracapsular infiltration, lymphadenopathy or of skeletal metastatic disease.

I met SUA at my clinic at SWAH on Monday 22 July 2019 as arranged. He reported urinary symptoms of mild severity, consisting only of a sensation of unsatisfactory voiding following micturition and of nocturia, having to rise once or twice each night to pass urine. I found him to have a moderately enlarged, indurated prostate gland on examination. I informed SUA of the significance of his elevated serum PSA levels, of the findings on MRI scanning and of the probability that he would be found to have malignancy of his prostate gland on further investigation. I requested an appointment for him to attend SWAH to have ultrasound scanning of his urinary tract, including an assessment of bladder voiding. I requested an appointment for him to attend CAH for transrectal, ultrasound guided, prostatic biopsies. I submitted by email a clinical summary to the cancer tracker, requesting that SUA's further management be discussed by the Urology Multidisciplinary Team (MDT) at a Multidisciplinary Meeting (MDM) when the reports of ultrasound scanning and prostatic biopsies were both available.

Prostatic biopsies were performed by Ms O'Neill, Clinical Nurse Specialist, with antibiotic prophylaxis at CAH on 20 August 2019. There was no evidence of adenocarcinoma on histopathological examination of nine cores taken from the right lateral lobe of his prostate gland. However, he was found to have Gleason 4+3=7 adenocarcinoma in seven of eleven cores taken from the left lateral lobe. The maximum core tumour length was 6mm and tumour was reported

to involve approximately 8% of total core tissue volume. There was no evidence of perineural, lymphovascular or extraprostatic infiltration.

Ultrasound scanning of his urinary tract was performed on 21 August 2019. Both upper urinary tracts were reported to be normal. He was reported to have a prostatic volume of approximately 40ml and to have a postmicturitional, residual urine volume of 204ml.

The findings were discussed at the Urology MDM, chaired by Mr O'Donoghue, on 29 August 2019, when Mr Glackin and Mr O'Brien, Consultant Urologists, Dr McConville and Dr Williams, Consultant Radiologists, Dr McClean, Consultant Pathologist and Ms O'Neill, Clinical Nurse Specialist, were also present. There was no consultant oncologist present. It was agreed that SUA had high risk prostatic carcinoma and that he would be reviewed by me to arrange a radioisotope bone scan and a CT scan of his chest, abdomen and pelvis, followed by further MDM discussion when the reports of both were available.

I reviewed SUA at my next available clinic at SWAH on Monday 23 September 2019. I ~~i~~nformed him of the high risk nature of his prostatic carcinoma particularly in view of him having serum PSA levels of almost 20ng/ml, levels which may have been suppressed by Finasteride which he had been taking since 2010. I explained that his serum PSA levels may have been significantly higher if he had not been taking Finasteride, and it was for that reason that it had been recommended at MDM that he should have bone and CT scanning performed to ensure that there was no evidence of metastatic disease. I also explained to him the role of androgens in prostate cancer, the impact of androgen deprivation therapy (ADT) and of the different forms of ADT. Particularly in view of the history of ischaemic heart disease, I advised him to embark upon treatment of his high-risk carcinoma by having Bicalutamide 150 mg daily prescribed before and without waiting for his disease to be staged by having the scans performed. I also requested his GP to prescribe Tamoxifen 10 mg daily to minimise the risk and severity of gynaecomastia developing as a consequence of androgen blockade. I advised SUA that further treatment options would then be discussed with him following completion of staging.

I repeated his serum PSA level on 23 September 2019, finding it to have increased to 21.8ng/ml. I also found that he had a very normal serum testosterone level of 19.3nmol/L. I later requested appointments for him to have CT scanning and bone scanning performed at SWAH and CAH respectively.

SUA subsequently contacted my secretary to advise that he had experienced significant adverse effects since taking the combination of Bicalutamide and Tamoxifen. When I spoke with him by telephone on Monday 14 October 2019, he reported that he had particularly become fuzzy or light headed to the extent that he was concerned as to whether it was safe for him to drive. In view of such a risk to the safety of himself and to others, I advised SUA to discontinue taking both with immediate effect, and not to take either for the remainder of October 2019. I advised SUA that I would write to his GP requesting that he be prescribed the lower dose of 50 mg of Bicalutamide, and which I requested that he begin taking on 1 November 2019. I also requested SUA to arrange an appointment with the GP practice nurse to have his serum PSA level repeated during the first week of November 2019, so that the result would be available at his next review at my clinic at SWAH on Monday 11 November 2019. I submitted by email an update to the previous clinical summary, detailing the adverse effects and the alterations to his immediate therapy, requesting

that the update be included when his further management would be discussed at MDM when the reports of CT and bone scans would be available.

There was no evidence of metastatic disease on CT scanning performed on 28 October 2019 or on radioisotope bone scanning performed on 31 October 2019.

SUA's intolerance of the combination of Bicalutamide 150 mg daily and Tamoxifen 10 mg daily, the discontinuation of both and the planned resumption of the lower dose of Bicalutamide was related in the update to the clinical summary discussed at the Urology MDM on 31 October 2019 when it was noted that there was no radiological evidence of metastatic disease. Those attending this MDM included Mr O'Donoghue, Mr Glackin, Mr Haynes and Mr O'Brien, Consultant Urologists, Dr Williams, Consultant Radiologist, Ms McCourt and Ms O'Neill, both Clinical Nurse Specialists. No oncologist was present. No issue was raised in relation to the appropriateness of prescribing the lower dose of Bicalutamide to a patient who appeared to have been unable to tolerate the higher dose. Even though this MDM was again chaired by Mr O'Donoghue, he either incorrectly dictated that SUA had *'intermediate risk prostatic carcinoma to start ADT and refer for ERBT (sic)',* or the MDM Plan had been incorrectly typed by the cancer tracker in attendance.

When I reviewed SUA at the next available clinic at SWAH on Monday 11 November 2019, I was pleased to find him somewhat better than when I had spoken with him by telephone on 14 October 2019, though not quite as well as he had been prior to having Bicalutamide and Tamoxifen prescribed. I was pleased to inform him that there had been no evidence of metastatic disease on CT and bone scanning. He did not have a serum PSA level repeated and the result available prior to the consultation that day. I discussed with him the prospect of proceeding to definitive treatment with curative intent, in the form of the combination of ADT and radical radiotherapy. However, at that time, he had just begun to tolerate taking Bicalutamide 50 mg daily. I would have preferred to be able to increase the dose of Bicalutamide that day, particularly as I was unaware of the biochemical response to ADT to date, but I was concerned that he would not be able to tolerate an increased dose at that time, as he had yet to regain his former well-being. In any case, his dominant priority was to proceed with his pre-arranged holiday at [redacted], and to do so without fear of being unwell due to recurrence of adverse effects of an increased dose of Bicalutamide. I was particularly concerned that he may have discontinued ADT altogether while on holiday if he felt unwell. He undertook to remain on Bicalutamide 50 mg daily until his further review in January 2020.

I did not consider it appropriate at his review on 11 November 2019 to refer SUA to Oncology with a view to considering radical radiotherapy. He had just embarked upon neo-adjuvant hormonal therapy to which he appeared to have experienced intolerance due to adverse effects which warranted discontinuation for a period of two weeks, prior to resumption of a lower dose of Bicalutamide. Though feeling somewhat better, he still did not feel as well as he did prior to commencement of hormonal therapy. I did not know the biochemical response that he already had to the interrupted androgen blockade as I did not know what his serum PSA level was at review on 11 November 2019. If he had not been looking forward to his arranged holiday, I believe that I would have had little difficulty in persuading him to remain on Bicalutamide, at least until a further review to reassess his well-being, and with the result of a serum PSA level. I did not consider it appropriate to refer him for radical radiotherapy until I had established that he was

tolerant of a comparatively safer form of androgen deprivation therapy that was oncologically effective.

I repeated his serum PSA level on 11 November 2019 and was pleased to find that it had decreased significantly to 3.84ng/ml, reflecting the androgen dependency of his prostatic carcinoma. I contacted SUA by telephone on 2 January 2020, finding that he had continued to take Bicalutamide 50 mg daily since November 2019, without any adverse effects, and that he and his wife had thoroughly enjoyed their holiday. I asked him to arrange an appointment with the practice nurse to have a serum PSA level repeated prior to his further review later that month.

I reviewed SUA on 27 January 2020. I was very pleased to find him ~~k~~keeping very well. He continued to tolerate Bicalutamide 50 mg daily without difficulty. His only persistent urinary symptom was that of nocturia, having to rise twice each night to pass urine. I was also pleased to find that his serum PSA level had decreased further to 2.23ng/ml when repeated on 7 January 2020. As he continued to have a progressive biochemical response to a tolerable, low dose of Bicalutamide, and wary of any further adverse effects jeopardising his further management, I advised him to increase the dose of Bicalutamide to 100 mg daily, and with a view to his referral for consideration of radical radiotherapy, or a combination of brachytherapy and external beam radiotherapy, as the inclusion of brachytherapy may have been all the more attractive in view of the biochemical response to ADT to date. These radiotherapeutic options were discussed with him that day.

I contacted SUA by telephone on 07 March 2020 to enquire of his well-being and particularly of his tolerance of the increased dose of Bicalutamide, and with a view to increasing the dose further to 150 mg daily if he had remained tolerant of 100 mg daily. Entirely expecting that his serum PSA levels would have continued to decrease, it was my intent to refer him that day for consideration of radical radiotherapy or the combination of brachytherapy and radiotherapy, as discussed at review in January 2020. As was my practice, I intended to request him to have a further serum PSA level repeated so that the report would be available when he would attend the Cancer Centre in Belfast for consultation.

However, on doing so, I noted that his serum PSA level had increased to 5.37ng/ml when repeated on 5 March 2020. He advised me that he had remained very well since review in January 2020. He confirmed that he had been taking the increased daily dose of 100 mg of Bicalutamide and reported no adverse effects since doing so. I therefore advised him to increase the daily dose to 150 mg. I considered with him the possible explanations for the unexpected increase in his serum PSA level, advising that it may have been spurious, or that he may have been less compliant in taking the increased dose of Bicalutamide than he believed, though he assured me that he had been, or that it could be indicative of disease progression. In view of his previous adverse effects, we agreed to increase the daily dose of Bicalutamide to 150 mg and to have a serum PSA level repeated in April 2020 prior to his further review at the next available clinic at SWAH on 27 April 2020. I wrote to his GP requesting that he prescribe Bicalutamide 150 mg daily and which was prescribed on 13 March 2020.

SUA began to experience difficulty in passing urine later in March 2020. He attended the Emergency Department at SWAH on 23 March 2020, as his urinary flow was poor. However, I gathered from SUA subsequently that he was considered to be achieving adequate bladder voiding at that time. He again attended on 7 April 2020 due to increased difficulty in passing urine during

the previous week. Though there was no evidence of bladder distention on examination, his bladder contained 600 ml of urine on ultrasound scanning following micturition. He was catheterised. Not only had he developed increased bladder outlet obstruction, his serum PSA level had increased to 12.08ng/ml even though he had been taking the increased dose of 150 mg of Bicalutamide daily since early March 2020.

Regrettably, he could not be reviewed on 27 April 2020 as the clinic was cancelled by the Trust due to the Covid 19 pandemic lockdown.

On subsequently learning of the need for catheterisation, I contacted SUA by telephone on Monday 1 June 2020. He advised that he found the indwelling catheter to be uncomfortable. He was otherwise feeling reasonably well. He did not report any systemic features of increased tumour burden. I discussed with him the significance of the further increase in his serum PSA level in April 2020, advising him that it should be concluded that his prostate cancer had progressed. Particularly as he had experienced no adverse toxicity from the increased dose of Bicalutamide, I advised that he additionally have a LHRH agonist administered. On discussing the option of having his prostate resected to relieve him of the need for continued urethral catheterisation, he was keen to proceed. I contacted the GP practice by telephone to request that he be prescribed and administered Leuprorelin 3.75 mg subcutaneously and to have a serum PSA level repeated. He was administered Leuprorelin 3.75 mg subcutaneously on 3 June 2020 when his serum PSA level had increased markedly to 27.22ng/ml. His serum PSA level increased further to 29.5ng/ml by the 12 June 2020 even though he was by then managed with combined androgen blockade.

I also advised SUA to self-isolate and arranged for him to have Covid testing performed prior to his admission to Daisy Hill Hospital (DHH) in Newry on 17 June 2020 for endoscopic resection of his prostate gland. On endoscopic assessment, I found him to have a large, obstructive prostate gland which was resected. He was found to be febrile and bradycardic at 08.00 pm on 17 June 2020. Blood cultures were taken and telemetry was initiated. He was prescribed intravenous fluids and antibiotics. He remained well though febrile at review on 18 June 2020. Thereafter, he remained afebrile.

When I reviewed him as an inpatient on Saturday 20 June 2020, all postoperative haematuria had resolved. I advised that the indwelling urethral catheter be removed later that day, but he was unable to pass urine following its removal. He was re-catheterised.

SUA was reviewed as an inpatient by Mr. Haynes, Consultant Urologist, on Monday 22 June 2020. Mr. Haynes advised SUA that he could be discharged from DHH that day with an indwelling urethral catheter. A referral was made for a further trial removal of the catheter at SWAH two weeks later. A bone scan and a CT scan of chest, abdomen and pelvis were requested, and SUA was referred to Dr David Stewart, Consultant in Clinical Oncology at Altnagelvin Area Hospital for consideration of radical radiotherapy if no evidence of metastatic disease was found on further scanning. On discharge, Diltiazem was discontinued due to the bradycardia found postoperatively, and Gliclazide was also discontinued due to hypoglycaemia experienced each morning. Mr. Haynes additionally dictated a letter to SUA advising him of the above requests and referrals.

I contacted SUA by telephone on Friday 26 June 2020. He reported that haematuria had recurred following further catheterisation on 20 June 2020 but that it had since resolved. He remained keen

to have a further trial removal of the indwelling urethral catheter. I was able to confirm with him that he did have an appointment for CT scanning on Monday 29 June 2020, but that no appointment had yet been arranged for him to have bone scanning performed. As I had obtained a provisional report of the finding of Gleason 5+5 adenocarcinoma on histopathological examination of resected prostatic tissue, I advised SUA that the prostate cancer was found to be more aggressive than it had been previously.

SUA was unable to recall whether he had been administered Leuprorelin on 3 June 2020. I contacted the GP practice by telephone to ensure that he had been. As Mr. Haynes had requested that he next be prescribed Decapeptyl 11.25 mg every three months, I also requested the GP practice to ensure that he be prescribed and administered this during the week commencing Monday 29 June 2020.

I was particularly concerned that SUA may proceed to have radical radiotherapy with an indwelling urethral catheter still in place, as I had experienced some of the worst adverse outcomes of radical radiotherapy in such circumstance. I therefore wrote to Sr. Travers, Urology/Continence Nurse Specialist at SWAH, requesting an appointment for SUA to have a further trial removal of the indwelling urethral catheter, and requesting that he would be taught how to self-catheterise in the event that he was unable to pass urine satisfactorily following removal of the indwelling urethral catheter. Lastly, I submitted by email to the cancer tracker an update to his previous clinical summary for further MDM discussion with the reports of histopathological examination of resected prostatic tissue, bone and CT scans when available.

The formal report of histopathological examination found that approximately 60% of resected prostatic tissue was infiltrated by Gleason 5+5 adenocarcinoma. There was evidence of perineural and lymphovascular infiltration.

CT scanning of his chest, abdomen and pelvis was performed on 29 June 2020, revealing advanced, metastatic disease progression. He was reported to have one metastatic lymph node located within the mediastinum, to the left of his oesophagus. He was reported to have extensive, retroperitoneal, para-aortic, perirectal, presacral and pelvic lymphadenopathy. There was a large, soft tissue mass infiltrating the left internal and external obdurator muscles. There was thickening of the rectosigmoid with perirectal soft tissue stranding, and he was reported to have thickening of the wall of his bladder with perivesical stranding. An appointment was arranged for him to have a radioisotope bone scan at Craigavon Area Hospital on 19 August 2020, by which date SUA was deceased.

SUA was reviewed by a Consultant Urologist (name redacted) at Craigavon Area Hospital on 14 July 2020. In the letter which he dictated to the GP that day, he advised that SUA had initially been diagnosed with locally advanced prostate cancer in August 2019. He wrote that SUA was *'commenced on a low dose of Bicalutamide initially'*. This was not correct. As related above, SUA was initially prescribed Bicalutamide 150mgs, in addition to Tamoxifen 10 mg daily, following which he experienced adverse effects which he was unable to tolerate. He advised SUA that his disease had progressed and that treatment with curative intent could no longer be offered. He also wrote that he advised *'switching to an LHRH analogue'* and he advised SUA to discontinue Bicalutamide. He was prescribed Dexamethasone 0.5 mg daily and Omeprazole 20 mg daily. He also wrote that SUA's family did ask whether radiotherapy given sooner may have impacted upon

the course of his disease. He advised that he could not be certain of this, but would initiate assessment of his management to date in order to answer this question and also to assess if any lessons could be learned. There is no written evidence in the records and information provided of SUA having been offered any palliative or psychological support at this consultation, or of referral to the Palliative Care Service of the Western Health & Social Care Trust. Similarly, there is no written evidence of engagement with or by a Urological Cancer Clinical Nurse Specialist (CNS). Lastly, there is no documentary evidence in the records provided of a review appointment being intended or arranged.

SUA attended the North West Cancer Centre at Altnagelvin Area Hospital on Wednesday 15 July 2020 when he met with a Registrar in Oncology (name redacted), and with a Consultant in Clinical Oncology (name redacted). It was noted that SUA attended with his daughter, and that both remained upset that SUA's prostate cancer was incurable. The course of his disease was explained to SUA and his daughter, and it was agreed that approval would be sought for the addition Abiraterone. It was intended that SUA would return for further review on 27 July 2020, but he was unable to do so as he remained an inpatient in SWAH following his acute admission on 23 July 2020.

SUA had been having increasingly difficulties at his home since discharge from DHH on 22 June 2020. He attended the Emergency Department at SWAH on 10 July 2020 due to blockage of the indwelling urethral catheter, resulting in pain and bypassing of urine around the catheter. There was no evidence of significant urinary infection. He again presented to the Emergency Department at SWAH at 00:58 am on 20 July 2020 due to having distal penile pain associated with the indwelling urethral catheter. He wished to have the catheter removed. When he again attended the Emergency Department on 22 July 2020, it is recorded that he had had the indwelling urethral catheter replaced on 20 July 2020 when he had also been prescribed oral antibiotics for a presumed urinary infection.

SUA remained in the Emergency Department until his admission to SWAH on 23 July 2020 for further management of decreased oral intake, abdominal pain and diarrhoea. The discharge letter of 28 July 2020 reported that urinary culture at the time of replacement of the indwelling urethral catheter on 20 July 2020 had confirmed the presence of a coliform infection. It was noted that his global renal function had deteriorated on admission. Losartan and Bendroflumethiazide were discontinued due to their nephrotoxicity, and SUA was managed with intravenous hydration and antibiotics. Ultrasound and CT scanning was reported to have demonstrated further pelvic progression of carcinoma resulting in a mild left upper urinary tract obstruction. SUA recovered clinically and was discharged on 28 July 2020.

The discharge letter of 28 July 2020 related that the finding of mild left upper tract obstruction was discussed with Urology, that SUA's further management would be discussed at MDM, and that he would be contacted directly with the outcome of that discussion. A copy of the discharge letter of 28 July 2020 was sent to the Department of Urology. There is no record in the information provided to me of SUA's further management having been discussed subsequently at MDM or of SUA having had any further contact from the Department of Urology at CAH.

SUA and his caring family continued to experience increasing difficulties at home following his discharge from SWAH on 28 July 2020. On 3 August 2020, the Out of Hours service was contacted

to report that his indwelling urethral catheter was leaking and that he was distressed and exhausted. His GP referred him to the Northern Ireland Hospice Specialist Nursing Service on 5 August 2020 as his family was finding things very tough, being up all though the night with SUA who was very unsettled and anxious. He then referred SUA to the Social Work Service on 7 August 2020 as he was concerned that his family were exhausted and unable to manage.

The Out of Hours Service was again contacted on 8 August 2020 as SUA was not sleeping and was restless, though he had settled the night before after taking Diazepam and Zopiclone. His wife and daughter reported that he was not drinking much and appeared to be dehydrated. He was confused and weak. The urethral catheter continued to leak and he was febrile with a temperature of 37.8 degrees, even though he had been prescribed Augmentin the previous day. His wife and daughter were unable to cope, as he required 24 hour care. His wife did not want him to be readmitted to hospital. His daughter reported that she had been advised by an oncologist the previous Monday that her father had about six months to live. It was reported that a package of palliative care was to commence on Monday 10 August 2020.

The Out of Hours Service was again contacted on 9 August 2020 due to concern that SUA had an irregular heart rate. It would appear that the irregularity was considered to be related to urinary infection.

SUA was brought by ambulance to the Emergency Department at SWAH on 13 August 2020. It was reported that he had been having Augmentin administered intravenously at home for urinary infection, and that it had not been possible to gain further peripheral venous access due to his state of dehydration. The major diagnostic finding on 13 August 2020 was that there had been a significant deterioration in his global renal function, his estimated glomerular filtration rate (eGFR) having decreased from 57 ml/min on 10 August 2020 to 10 ml/min. It was noted that his serum PSA level had increased from 33.45ng/ml on 01 July 2020 to 62.27ng/ml on 30 July 2020. He remained Covid 19 negative on PCR testing.

SUA was admitted to SWAH on 13 August 2020 from the Emergency Department. It would appear from the Mortuary Summary of Personal Information redacted by the USI that SUA continued to be managed with intravenous hydration and antibiotic therapy following his admission on 13 August 2020. His global renal function had improved significantly by 15 August 2020 when his eGFR was 48 ml/min. Then oxygen saturation levels deteriorated on 17 August 2020. It was considered that he probably had developed pulmonary oedema due to fluid overload. This was confirmed on a further Chest XRay on 17 August 2020 when he was reported to have a mild left pleural effusion in addition to pulmonary oedema. He had also developed severe heart failure, reflected in a grossly elevated, serum ProBNP concentration in excess of 35,000ng/L. Despite intravenous diuretic therapy, he continued to deteriorate. A decision was made to focus on comfort care. He died on Personal Information redacted by the USI [redacted]

The certified cause of death was metastatic prostatic carcinoma which he was stated to have had for one year.

Aidan O'Brien

Comments concerning the SAI Report of Service User A

Introduction

In his letter of 11 July 2020, Mr Haynes, Associate Medical Director, advised that the case of Service User A was a potential Serious Adverse Incident. The case was reported by completion of Datix Form Personal information redacted by USI on 14 July 2020. The Datix Form was opened for assessment on 22 July 2020. The concern was stated as '*MDM outcome not followed and patient has subsequently developed progression of disease'.* The incident date was 31 October 2019 (the date of the MDM).

1.0 Executive Summary: Factual Inaccuracies

The executive summary states that the patient was discussed at MDM on 31 October 2019 and that a *'recommendation to commence LHRH analogue and refer for an opinion from a clinical oncologist regarding external beam radiation therapy (EBRT) was agreed'.* This statement is incorrect. The MDM Outcome stated that the patient had '*intermediate risk prostate cancer to start ADT and refer for ERBT(sic)'.*

The executive summary then states that '*this was not actioned'.* That is correct, as it was not the recommendation recorded in the MDM Outcome of 31 October 2019.

The executive summary then states that he was '*commenced on Bicalutamide 50 mg daily'.* This is also incorrect as he had already been commenced on Bicalutamide 150 mg daily.

The executive summary states that he was *'commenced on LHRH analogue' on 1 June 2020'.* This too is incorrect; had the injection administered on 03 June 2020.

3.0 SAI Review Terms of Reference

It is worthy of note that the aims and objectives of this review include:

- Carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology

- Reviewing individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes

It is evident that these aims and objectives were not met. If all factors that may have adversely influenced or contributed to the subsequent clinical outcome of SUA were considered, they were not included in the Report.

5.0 Description of Incident/Case: Factual Inaccuracies, Omissions and Comments

In the description of the case, in the first paragraph on page 4 of the Report, it is related that SUA was reviewed by Dr.1 on 23 September 2019 and was told that he had high risk, prostate cancer. It then states that *'no staging investigations were requested'.* It omitted to relate that no staging investigations were requested on 23 September 2019. The staging investigations were requested on 14 October 2019.

In the second paragraph on page 4 of the Report, it is written that '*However, although XX's PSA was noted to be rising (21.8ng/ml), a plan was made to re-check the PSA.'* The implication of this statement is unclear. It may be that it was mistakenly considered that the increased serum PSA level was found on 14 October 2019, following a period of androgen deprivation using Bicalutamide, and that repeating the serum PSA level was inappropriate. It may not have been appreciated that the increased serum PSA level of 21.8ng/ml had been found at his review on 23 September 2019 and prior to the commencement of androgen deprivation.

Again, in the third paragraph on page 4, it is stated that the case was discussed at the MDM of 31 October 2019 when *'a recommendation to commence androgen deprivation therapy (a LHRH analogue) and refer for an opinion from a Clinical Oncologist regarding external beam radiation therapy (EBRT) was agreed'.* As indicated above, this repeated claim is incorrect.

It is worthy of note that it is stated in the seventh paragraph on page 4 that a *'planned review appointment for 27 April 2020 had been made'* but thereafter omitted to inform why it had not taken place. It had been cancelled by the Trust due to the Covid 19 pandemic lockdown.

It later states, in the third paragraph on page 5, that Dr 2, on 22 June 2020, '*dictated a letter (typed on 26 June 2020)…'* This is incorrect as the letter was typed on 25 June 2020.

It then states, in the same paragraph, that a '*referral letter was sent on the same day by Dr 2 to Nurse 1 asking to arrange a further trial of voiding two weeks later'.* This too is incorrect as the letter was addressed to Ms. K. Travers, Urology / Continence Nurse Specialist at South West Acute Hospital (SWAH), and not to Nurse 1 who had performed the prostatic biopsies in August 2019. This incorrect assertion is restated, in the fourth paragraph on page 5, with regard to my letter dictated on 26 June 2020 and typed on 02 July 2020, in which it asserted that I made reference to '*the need for trial removal of catheter by Nurse 1 as indicated by Dr 2 letter'.* The letter which I dictated on 26 June 2020 was addressed to Ms Travers, and not to Nurse 1.

It is worthy of note that there is no reference to the patient having been reviewed by Dr 2 once again on 14 July 2020. Dr 2 dictated a letter addressed to the patient's GP following that review. The letter was typed on 15 July 2020. In the letter, Dr 2 incorrectly advised the GP that the patient had initially been prescribed *'low dose Bicalutamide'.* As related above, this advice was incorrect. In addition, and even though SUA was advised that he had incurable cancer, there is no record of the patient having any consultation with a Urology Cancer Clinical Nurse Specialist. Similarly, there is no record of the patient having a consultation with, or being directed to, Palliative Care Services. There is no record of any planned or intended further urological review, either in person or remotely.

In the fifth paragraph on page 5, it is stated that the patient was reviewed by Dr 3 (Consultant Oncologist) in Altnagelvin Area Hospital on 15 July 2020 and that the patient *'was deemed not fit for any other treatment option'.* This too is incorrect as he was considered fit for treatment with Abiraterone.

In the sixth paragraph on page 5, the patient's first admission to South West Acute Hospital on 23 July 2020 is related. The Report does refer to contact having been made with Urology following the finding of left hydronephrosis on ultrasound scanning, and that Urology had advised CT scanning which indicated that the left upper tract dilatation was due to further progression of prostatic carcinoma in the pelvis. However, the Report omits to relate that prior to the patient's discharge from South West Acute Hospital on 28 July 2020, there had been an undertaking to have his current clinical status discussed again at MDM and for direct contact to be subsequently made with the patient concerning his further management. There is no evidence in the provided information of further MDM discussion having taken place, and there was no further contact with the patient.

It is concerning that the SAI Report has omitted any reference to the challenges faced by SUA, his wife and daughter, following his discharge from South West Acute Hospital on 28 July 2020. Those management challenges may have been obviated or mitigated by engagement with Urology Cancer Nurse and/or Palliative Care Nurse Services following his review on 14 July 2020, and/or by execution of the undertaking by Urology to contact the patient following his discharge from SWAH on 28 July 2020.

It is remarkable that the management of the patient following his readmission to South West Acute Hospital on 13 August 2020, leading to his death on Personal Information redacted by the USI, should be simply related as *'*Personal Information redacted by the USI *XX passed away in SWAH'*. It is concerning that any reference to the cause of his acute readmission and to the fluid overload prior to his death on Personal Information redacted by the USI, has been omitted.

6.0 Findings

The introduction to this section states that the patient was investigated appropriately up to and including the original biopsies. It is remarkable that the Report makes no reference to the fact that patients referred in 2019 with a suspicion of prostatic carcinoma waited up to 15 weeks for a first outpatient consultation. Had SUA's referral not been triaged by me, he may not have had a first outpatient consultation until late September 2019. Moreover, the patient may have awaited that length of time without having had any prostatic imaging requested and performed prior to that first consultation. In that case, the patient would have had to await prostatic MRI scanning prior to having prostatic biopsies performed. He would probably have had both performed during October 2019. He may have had the diagnosis discussed at MDM by the end of October 2019. He then would have had CT and bone scans requested and performed prior to further MDM discussion in late November 2019 or early December 2019.

Patients referred with a suspicion of prostate cancer have had to wait such long periods of time for first outpatient consultations, in breach of Ministerial targets, primarily due to the inadequacy of the urological service provided by the Trust. The impact of that inadequacy has been compounded by having triage of referrals undertaken by consultant urologists while 'urologist of

the week' (UOW). Consultant urologists declined in 2015 to undertake to request imaging in advance of first outpatient consultations as they did not have enough time to do so while being UOW. Moreover, I believe that they were not incentivised to do so as they considered that they may be additionally held responsible for the reports of any such investigations requested. That concern would have been exacerbated on learning that the placing of patients on waiting lists for first outpatient consultations may have been contingent upon the report of such an investigation.

The Report also states that the staging scans *'would normally be expected to have been performed with a degree of urgency'* and that the initial assessment was satisfactory '*although rather prolonged'.* In addition to the above issues affecting triage, progress in assessment and diagnosis was adversely affected by the inadequate capacity for outpatient review appointments. The Report did not include an appreciation that the requirement for urgency had been mitigated by the patient having had ADT initiated while awaiting completion of staging.

It is then stated that the *'initial treatment should have been reversible ADT – most commonly a LHRH analogue – pending the results of the staging scans'.* The initial treatment was a reversible ADT in the form of Bicalutamide 150 mg daily. Fortunately, the choice of Bicalutamide enabled its early discontinuation when it appeared that the patient had suffered intolerable, adverse effects of Bicalutamide or of Tamoxifen, which had also been prescribed. If similar adverse toxicity had been experienced following the administration of a LHRH agonist, reversibility and relief from adverse effects would have been much more prolonged.

It is then stated that '*the prescribed hormone therapy did not conform to the Northern Ireland Cancer Network (NICAN) Urology Cancer Clinical Guidelines (2016), which was signed off by the Southern Health and Social Care Trust (SHSCT) urology multidisciplinary meeting, as their protocols for cancer care for Cancer Peer Review (2017)'.* This statement is incorrect. The only recommendation in the above Guidelines relevant to Service User A appears on page 58 of the Guidelines. It states that *'In patients with locally advanced PCa T3-4 N0 M0, concomitant and adjuvant hormonal therapy for a total duration of 3 years, with external-beam irradiation for patients with WHO 0-2 performance status, is recommended, as it improves overall survival'.* The initial prescription of Bicalutamide 150 mg daily, to minimise the increased risk of a major adverse cardiovascular event associated with LHRH analogues in a man with a previous history of ischaemic heart disease, and with Tamoxifen 10 mg daily, to minimise the risk and severity of gynaecomastia developing as a consequence of taking Bicalutamide, did conform to the Guidelines.

It is then stated that the *'subsequent management with unlicensed anti-androgenic treatment (Bicalutamide) at best delayed definitive treatment'.* This statement is incorrect as Bicalutamide 150 mg daily is licensed for the management of locally advanced prostate cancer at high risk of disease progression, either alone or as adjuvant treatment to prostatectomy or radiotherapy, and in locally advanced, non-metastatic prostate cancer when surgical castration or other medical intervention is inappropriate.

Secondly, the definitive treatment recommended for SUA at the MDM on 31 October 2019 was the combination of ADT and EBRT and did not consist of EBRT alone. Optimal ADT had been initiated in September 2019, but had to be discontinued in October 2019 due to possible, significant adverse toxicity, and prior to resumption at the lower daily dose of 50 mg in November

2019. Progression of his recommended treatment was subsequently delayed due to the need for a further period of time for him to recover from the adverse toxicity, followed by the disease progression while resuming adequate androgen deprivation.

It is then stated that Bicalutamide (50mg) is '*currently only indicated as a preliminary anti-flare agent and is only prescribed before ADT'.* This too is incorrect as Bicalutamide 50 mg daily is licensed in advanced prostate cancer, in combination with gonadorelin analogue or surgical castration. In addition, in March 2020, the Section of Oncology of the British Association of Urological Surgeons (BAUS) recommended Bicalutamide 50 mg daily for patients with low- and intermediate-risk, non-metastatic prostatic carcinoma while awaiting radical prostatectomy or radiotherapy deferred during the Covid 19 pandemic. However, I would contend that its unlicensed use for a period of time in a patient suspected of having had significant intolerance of 150 mg daily was reasonable and appropriate.

It is then stated that treatment '*for prostate cancer is based on achieving biochemical castration (Testosterone < 1.7nmol/L), which is best accomplished with ADT through a LHRH analogue, by a LHRH antagonist and by bilateral subcapsular orchidectomy'.* This statement is also concerning as it would at least imply that the hormonal treatment of any patient with prostate cancer necessitates castration, irrespective of how it is achieved, and irrespective of its reversibility. Castration is certainly indicated in the management of patients with metastatic disease, as treatment with androgen receptor blockade without castration has been found to be inferior. However, castration may not be required in the management of patients with non-metastatic cancer as Bicalutamide 150 mg daily has not been found to be inferior to castration in the management of high risk, locally advanced disease.

As Bicalutamide 150 mg daily has not been found to be oncologically inferior to castration in the management of non-metastatic, locally advanced, prostate cancer, in combination with radical radiotherapy, Bicalutamide should be considered as the primary treatment modality due to its lesser adverse toxicity profile, particularly of a systemic nature.

With reference to SUA, using Bicalutamide in the first instance avoided the increased risk of serious adverse events of a cardiovascular nature in a man with a previous history of ischaemic heart disease.

It is then stated that *'following discussion with the families, the review team have noted that the variance from regional care pathways and the anti-androgen dosage used in this case was not discussed'* with the patient. This statement is incorrect on two counts. Firstly, there was no variance from the regional care pathways. Secondly, the prescription of the lower dose of Bicalutamide was certainly discussed with the patient as it arose due to his presumed intolerance of the higher dose.

It is then stated that '*he could not and did not give informed consent to this alternative care pathway'.* For all of the reasons stated above, the initially prescribed ADT was not an alternative pathway excluded from the recommended pathway. However, it is true to state that I did not discuss with him the alternatives of surgical and medical castration. In view of its oncological non-inferiority to castration, its lesser adverse toxicity profile and particularly in view of his previous history of ischaemic heart disease, I considered that prescribing Bicalutamide 150 mg daily initially

was the most appropriate option for SUA, unless and until evidence of metastatic disease was found on further staging. It would be perverse to insist that one would expect a patient to be asked to give consent to one form of androgen deprivation which at the outset could be as effective as another form of androgen deprivation, but less harmful.

It is then stated that the review team *'identified that the MDMs were not quorate due to the absence of an oncologist at the meetings'.* This statement is correct. Despite approaches over a number of years, the Trust failed to provide an adequate oncological service sufficient to ensure that Urology MDMs have been quorate.

It is then stated that the specific MDM recommendation of 31 October 2019 '*to prescribe a LHRH analogue and to refer to clinical oncology for external beam radiotherapy'* was not actioned. This statement is incorrect. Even if it was wrongly considered by the Review Team that the only form of ADT was pharmacological castration, it is remarkable that it persists in claiming that the MDM of 31 October 2019 recommended a LHRH agonist, when it did not. With regard to referral to clinical oncology, the patient had experienced significant adverse effects since being prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mg daily. Having been advised to discontinue taking both for two weeks, he resumed taking Bicalutamide 50 mg daily upon my advice. Even though he still had not fully recovered from the adverse effects, he was persuaded with reluctance to remain on Bicalutamide 50 mg daily until his review in January 2020 following his return from holiday. Indeed, it would have been his preference not to have resumed any hormonal treatment until after his return from holiday Personal Information redacted by the in December 2019. He was certainly not prepared to consider any further hormonal treatment until then. I believed that it inappropriate to refer him for EBRT in November 2019 for the reasons which I have related in the Clinical History.

It is then stated that *'Dr 1 neither provided a noted rationale for this inaction nor was it discussed with the patient'.* This statement is at best disingenuous as SUA's intended treatment was explained and discussed with him at review in September 2019, in November 2019, in January 2020 and by telephone in October 2019 and in March 2020. My letter of 26 June 2020, addressed to his GP, referred to the patient being reluctant to consider the initiation of any treatment for his prostate cancer in late 2019. Moreover, if the Review Team had not compiled its draft report prior to allowing me a reasonable opportunity to have an input following provision of requested, almost complete, clinical records, it would have been fully appraised of the rationale for any alleged inaction.

It is then stated that the patient *'could not and did not give informed consent for this action'.* This statement is incorrect. Remaining on Bicalutamide 50 mg daily was the only undertaking to which he was agreeable.

It is then stated that the patient *'did not have a Cancer Nurse Specialist (CNS) or Key Worker to support his care'.* This statement is correct. There has been a failure on the part of CNSs to arrange holistic needs assessments, to provide further information required, to provide any support services required and requested, and to provide their contact details for the patient. Even though this patient was reviewed by me at SWAH, where no Cancer CNSs were available, those based at Craigavon Area Hospital could still have contacted the patient by telephone to fulfil these obligations. CNSs were certainly aware of his diagnosis and proposed management, as they attended MDMs when both were discussed. Moreover, the Trust's Urology Cancer MDT's

Operational Policy of 01 September 2017 is explicit in asserting that it is the joint responsibility of the MDT Lead Clinician and of the MDT Core Nurse Member to ensure that all newly diagnosed cancer patients have a Key Worker allocated.

It is then stated that the Review Team had been informed that I, Dr 1, '*excluded all CNSs from the care of his patients at clinic'.* I find this allegation to be egregiously, offensively untrue. I have never excluded any CNS from the care of my patients at clinics. On the contrary, I have requested the involvement of CNSs in the care of my patients on many occasions, and that involvement was always gladly given.

It is then stated that without appropriate CNS support, the patient and his family *'had difficulties in accessing support and care, especially in the community. This resource was provided by the SHSCT but was denied to XX by exclusion of CNS involvement'.* Most importantly, the Report does not clarify whether a CNS had been allocated in the first instance. As stated above, I have never excluded CNSs from involvement in the care of my patients. I am unable to address whether a CNS had been allocated or excluded from the patient's further care at his review by Dr 2 on 14 July 2020. The apparent failure of engagement by or with palliative and cancer CNS services when the patient was reviewed in July 2020 resulted in a lack of proactive provision of support when the patient and his family most needed that support. It may be that the pandemic lockdown continued to have CNSs deployed elsewhere when the patient was reviewed in July 2020. If so, it should still have been possible to have the patient and his family directed towards those services in the community. There is no evidence from the correspondence dictated by Dr 2 of any such consideration or direction.

It is then stated that the patient's case '*was not re-discussed at the MDM despite clear progression of his disease'*. I had noted reference to his further discussion at MDM in the correspondence from Dr 2 of 22 June 2020, but I did not find any evidence of this having happened. I therefore submitted by email an update to the cancer tracker on 26 June 2020, requesting that his further management be discussed at MDM again when the reports of histopathology, CT and bone scanning were available. As the patient did not subsequently have a bone scan performed, that may have been the reason for lack of further MDM discussion. Nonetheless, contact had been made with the urology service prior to the patient's discharge from South West Acute Hospital on 28 July 2020 to advise of the radiological finding of further disease progression resulting in mild, left upper tract dilatation. An undertaking had been given to have his further management discussed at MDM and to make contact with the patient thereafter. However, there was no evidence from the information provided that this took place. It is regrettable that the further management of his progressive disease was apparently not discussed at MDM.

It is then stated that '*the absence of any CNS input to XX's care meant that they were unaware of the disease progression and could not refer back to MDM independently'.* This may be true. It certainly would have been my practice to have involved a Urology Cancer CNS or Palliative Care CNS or both when reviewing a patient who was being advised that his/her cancer had progressed to an advanced, incurable stage. It was my practice to arrange CNS participation in advance of the consultation. Having CNS participation at the patient's review on 14 July 2020 may have provided an additional assurance of MDM discussion.

It is then stated that the patient *'received uniprofessional treatment and care despite multi-professional resources being available'.* This statement is correct. Even though there was no Urology Cancer CNS available at the outpatient clinics at South West Acute Hospital, there was a failure by CNSs at Craigavon Area Hospital to contact the patient to ensure assessment and provision of any additional advice, information and support required and requested on an ongoing basis. This failure was primarily due to a lack of allocation or appointment of a Key Worker / CNS by those responsible for doing so.

It is then stated that his *'care did not follow regional guidance and treatment recommendations from the MDM were ignored'.* As detailed in the clinical history and explained above, this statement is incorrect.

It is then stated that the patient was *'denied the opportunity of multidisciplinary professional referral and care, initially from a clinical oncologist when radical radiotherapy should have been considered'.* Again, as detailed above, this statement is incorrect. Radical radiotherapy was considered at MDM on 31 October 2019, and again at review of the patient on 11 November 2019. However, at that time, the patient was just beginning to tolerate ADT and did not wish to consider any further hormonal treatment until his further review in January 2020.

It is then stated that he was similarly denied multidisciplinary professional referral and care '*from high quality palliative care when it became necessary'.* As I was not involved in his care at that time, I cannot clarify whether he was actively denied referral to palliative care, or that it was unavailable, or that it just was not considered. If engagement by or with palliative care in July 2020 was unavailable, he could have been directed to those services in the community. Either way, the patient and his family certainly did not receive it when he most needed it.

It is then stated that the patient 'developed metastases whilst being inadequately treated for high-risk prostate cancer', and that the 'opportunity to offer him radical treatment with curative intent was lost'. I do not agree with this statement.

Firstly, he was initially prescribed Bicalutamide 150 mg daily at review on 23 September 2019. As related above, Bicalutamide 150 mg daily was prescribed as it has non-inferior oncological efficacy to castration as neo-adjuvant and adjuvant, androgen deprivation therapy combined with radical radiotherapy in the management of high risk, locally advanced, prostatic carcinoma. Bicalutamide was chosen because of its lesser adverse toxicity profile, and particularly in view of the patient's history of ischaemic heart disease and comorbid risk factors for further cardiovascular events. It would have been improper to have initially prescribed a LHRH agonist prior to determining whether there was any evidence of metastatic disease.

Secondly, having experienced significant adverse toxicity, he was advised on 14 October 2019 to discontinue taking Bicalutamide (and Tamoxifen) for a short period of time prior to resumption at the lower dose of 50 mg daily on 01 November 2019. If he had been found to have evidence of metastatic disease by the time of his further review on 11 November 2019, pharmacologically induced castration would have been advised and prescribed. As there was no evidence of metastatic disease on staging, and even though he was still not as well as he had been prior to having hormonal treatment initiated, he was persuaded to continue taking Bicalutamide 50 mg daily until his further review in January 2020 following his return from holiday abroad. He was

certainly not prepared to consider any further hormonal treatment until then. Moreover, he had an impressive, progressive biochemical response to reduced doses of Bicalutamide by January 2020, when the dose of Bicalutamide was increased to 100 mg daily, with the intent that it would be increased further to 150 mg daily if remaining tolerant of it, in addition to referral for consideration of radiotherapeutic options.

The increase in his serum PSA level to 5.37ng/ml on 05 March 2020 was unexpected. I considered and discussed with the patient the possible explanations. As he had remained well since review in January 2020, having had no recurrence of adverse effects, I advised him to increase the dose of Bicalutamide to 150 mg daily, and to have a serum PSA level repeated prior to his further review in April 2020. I believe that it was appropriate to have his serum PSA level repeated to check its validity, rather than acting upon one unexpected value. That review did not take place due to cancellation of clinics as a consequence of the pandemic. If it had taken place as planned, the symptomatic and biochemical evidence of disease progression would have been available. I would certainly have converted his hormonal therapy to combined androgen blockade and restaged his disease by repeating CT and bone scanning. Depending upon his priorities at that time, I would have either had him discussed again at MDM with the reports of both scans, or alternatively had him admitted for prostatic resection following the scans and followed by MDM discussion. Either way, he would have then been referred to oncology for consideration of his further management following a complete reassessment of his disease status.

The consequences of the pandemic lockdown were significant for SUA. By the time that I learned in May 2020 that he had since developed urinary retention requiring catheterisation, I arranged his admission for endoscopic resection of his prostate gland as it was the patient's dominant wish to have the prospect of being free of an indwelling urethral catheter, as he was otherwise feeling well, and even though I did appreciate that the further increase in his serum PSA level to 12.08ng/ml in April 2020 indicated that he had disease progression. As indicated in my letter of 1 June 2020 and addressed to his GP, I then planned to have him subsequently restaged prior to oncological referral for consideration of his further management.

The increase in serum PSA levels from 2.23ng/ml in January 2020 to 5.37ng/ml in March 2020 was significant, in that it increased despite having doubled the daily dose of Bicalutamide which had previously resulted in a marked reduction in serum PSA levels of the order of 90% from September 2019 to January 2020. The increase from January 2020 represented a PSA doubling time of only six weeks. The further increase in serum PSA levels to 12.08ng/ml by 7 April 2020 despite increasing the daily dose of Bicalutamide to 150 mg daily further reflected rapid disease progression, with the PSA doubling time decreasing to four weeks. In view of the extent of metastatic disease found on CT scanning on 29 June 2020, it would be reasonable to expect that SUA would have been found to have evidence of metastatic disease, albeit less advanced, if he had had staging repeated in March or April 2020. If so, a LHRH agonist or antagonist would have been prescribed, but his disease would have progressed relentlessly, as it did subsequently.

The statement that he *'developed metastases while being inadequately treated for high risk prostate cancer'* risks the inference of a definite causal relationship, that he developed metastases because he was inadequately treated. As related, the initial intent was that he would be 'adequately' treated. It was as a consequence of the experience of adverse toxicity that his treatment may have been considered 'inadequate' for a period of time. However, that

'inadequate' treatment resulted in an impressive biochemical, disease response initially. Biochemical evidence of rapid disease progression emerged while his treatment returned to 'adequacy' and persisted after it had done so. The '*opportunity to offer him radical treatment with curative intent was lost'* due to his experience of adverse effects of the adequate hormonal treatment initially prescribed in September 2019, and to his consequent wish not to consider any further hormonal treatment until his review in January 2020. Thereafter, radical treatment with curative intent would not have been curative, even if available despite Covid 19.

It is worthy of note that the cause of the patient's death on Personal Information redacted by the USI was registered as metastatic prostate cancer and that it was recorded that he had had metastatic prostate cancer for one year. While there was no evidence of metastatic disease in October 2019, it is indeed entirely possible, if not probable, that SUA had occult metastatic disease ab initio, particularly in the context of unquantifiable suppression of PSA secretion due to Finasteride. If that had been the case, he was not curable.

It would be reasonable to presume that SUA would have been found to have metastatic disease if staging scans had been repeated in March 2020 or April 2020, as he was found to have extensive, metastatic disease in June 2020. If he had been found to have metastatic disease two or three months earlier, he could have been considered for adjuvant treatment, such as with Enzalutmide, Docetaxel or Abiraterone, as was considered in July 2020. However, his serum PSA kinetics from January 2020 confirmed that his disease was rapidly progressive. It is therefore unlikely that such additional treatment would have had a significant beneficial impact upon his disease, and any impact may have been outweighed by adverse toxicity.

Family Engagement

The review team met with the family of SUA following his death. They were advised that the patient did not have a CNS to support him through his cancer diagnosis. The family described how difficult it had been to access district nursing and palliative care services during the pandemic, which resulted in his admission to hospital and subsequent passing. As related above, a Urology Cancer CNS service was unavailable at South West Acute Hospital in Enniskillen. There was a primary failure of allocation of a Key Worker and of the Urology Cancer CNSs at Craigavon Area Hospital to contact or engage with the patient and with his family. That failure was particularly significant at or following his review by Dr 2 in July 2020 when their support was most required. The failure to engage with or by Palliative Care Services at or following his review in July 2020 was even more regrettable.

It was reported that the family considered that SUA had died sooner than had been expected. It may be the case that the advice given in August 2020 that he had about six months to live was generous. Nevertheless, it would appear that fluid overload following his acute admission to SWAH on 13 August 2020, resulting in pulmonary oedema and heart failure, may have hastened his death on Personal Information redacted by the USI. The Report does not include any reference to, or commentary regarding, his management at South West Acute Hospital.

Questions from the Family

The Report related that the family had enquired about the initial biopsy of 20 August 2019 '*as they had been informed that it may not have been representative and that XX may have had aggressive cancer from this date'.* It related that the Review Team had scrutinised the report and found that the biopsy sample was adequate and comprised appropriate numbers of biopsy cores of both lobes of the prostate gland, that the biopsy report had been signed off by consultant pathologists with specific interest in urological cancer and that the biopsy was deemed representative of the tumour. It concluded that the Review Team would *'dispute the statement of Dr 1 as there is no evidence to support his contention that the biopsy may not have been representative'.*

While it is remarkable that a Review Team would deem it appropriate to dispute a '*statement*' allegedly made by me without enquiring of me concerning the alleged statement, the Team's conclusion is concerning. The weight of prostatic tissue retrieved by a 18G biopsy needle has been reported to range from 5 to 10 mg. Assuming that the volume of the patient's prostate was reliably calculated to be 34 ml on MRI scanning, it would have required a minimum of 34 biopsies to be taken to have sampled 1% of his prostate gland. Thirteen biopsy cores will have sampled less than 0.4% of SUA's prostate gland. Moreover, transrectal, ultrasound guided biopsies are well known to be compromised by difficult or impossible access to all regions of the prostate gland, and particularly to the anterior midline region of the gland.

The Team's conclusion is concerning in the face of the urological literature being replete with reports of upgrading of prostate cancer on template transperineal biopsies, on multiparametric MRI targeted biopsies, on Doppler ultrasound guided biopsies, on super-microvascular ultrasound guided biopsies and on elastography ultrasound guided biopsies compared to transrectal ultrasound guided biopsies. The most definitive diagnostic biopsy is when the entire prostate gland is resected at radical prostatectomy. When the histopathological findings of 17,598 patients who had undergone radical prostatectomy in UK from 2011 to 2016, were compared with the histopathological findings of their diagnostic biopsies, upgrading had occurred in 4,489 patients (25.5%) and upstaging in 5,389 patients (30.6%).

Histopathological examination and reportage of SUA's prostatic biopsies would have been meticulous and of a quality assured standard by an experienced pathologist. However, irrespective of how arguably adequate the quality and number of biopsy cores have been in any individual case, it cannot be asserted that there is no evidence that the biopsy may not have been representative.

7.0 Conclusions

'XX was investigated appropriately up to and including the original biopsies.'

In fact, the investigation of SUA was expedited by virtue of his enhanced triage.

'The staging scans (bone and CT) would normally be expected to have been performed with a degree of urgency.'

Both scans were requested three weeks following review of the patient on 23 September 2019 when neo-adjuvant hormonal therapy had been initiated. There had not been adequate time

available to request the scans at the review appointment of 23 September 2019, and initiation of hormonal treatment had minimised the need for urgency in doing so.

'These would have demonstrated no metastases and this should have led to a referral to a Clinical Oncologist as it would have been reasonable to consider radical treatment with external beam radiotherapy.'

It is evident that the intent was to refer SUA for consideration of radical radiotherapy. However, his referral was deferred due to his apparent intolerance of androgen deprivation, necessitating its modification, and most importantly, his lack of consent to any further hormonal treatment until after his review in January 2020.

'Conventionally this would have been preceded by at least 4 months of neo-adjuvant ADT and this could have been started before the results of the scans were available.'

Neo-adjuvant ADT was commenced in September 2019 prior to the results of staging scans being available.

'XX suffered disease progression whilst being inadequately treated for high-risk prostate cancer.'

The reason for the inadequate treatment of his prostate cancer had been his apparent intolerance of its adequate treatment.

'The opportunity to offer him radical treatment (with curative intent) was recommended by the MDM, but was not actioned by those responsible for his care.'

As related above, the MDM recommendation was not actioned due to the patient's apparent intolerance of neo-adjuvant ADT and due to the time required to enable him to safely tolerate androgen deprivation that would have been expected to be adequately effective prior to radical radiotherapy which would have been contraindicated due to disease progression, and which in any case was unavailable due to Covid 19.

'The local progression of the disease should have been considered in the light of both the symptomatic deterioration and PSA changes.'

It is evident that disease progression was considered and discussed with the patient in March 2020 following the increase in his serum PSA level that month. He was then advised to increase the dose of Bicalutamide to 150 mg daily as a consequence. Radical radiotherapy for prostate cancer had been suspended as a consequence of the Covid 19 pandemic by the time that the patient was found to be in urinary retention in April 2020.

8.0 Lessons Learned

- *'The effective management of urological cancers requires a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through diagnosis, treatment planning and completion, and survivorship.'*

Agreed.

- *'A single member of the team should not choose to, or be expected to, manage all of the clinical, supportive and administrative steps of a patient's care.'*

  Agreed, though it should remain the responsibility of the urologist to completely inform and advise the patient concerning the diagnosis and management options, their merits and risks etc. The involvement of clinical nurse specialists in patient care should not be an excuse to outsource these primary responsibilities of the urologist who is best placed to provide them.

- '*A key worker, usually a cancer nurse specialist, should be independently assigned to every patient learning of a new cancer diagnosis.'*

  Agreed, as has been the Operational Policy since 2017

- *'The multi-disciplinary team meeting is primarily a forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. Any other function is secondary to, and if necessary be sacrificed to, this aim.'*

  Agreed, though I am unaware of the other functions referred to and which may need to be sacrificed to the primary aim of the MDM.

- *'The multi-disciplinary team meeting should be quorate, and all participants must feel able to contribute to discussion.'*

  Agreed

  It is regrettable that the Trust failed to ensure that all MDMs were quorate since their establishment in 2010 even though it has been aware of the lack of quoracy since then.

- *'Any divergence from a MDT recommendation should be justified by further MDT discussion and the informed consent of the patient.'*

  I would have a concern regarding the above lesson learned, as I believe it carries an unintended risk of compromising the rights of the individual patient. It has been my experience that the MDT may be ill informed of the patient's global status when discussed at MDM, and that there may be good reason for the clinician to diverge from a recommendation on further consultation and assessment of the patient. It may also in effect be coercive for the patient, being advised of the recommendation(s) and compromising of his/her right to choose. The choice of the clinician and patient could be recorded and the choice discussed and registered with the MDT at a further MDM.

  This difficulty could largely be obviated by ensuring that the Chair of MDM accurately dictates an agreed recommendation that includes all of the appropriate management

options for each patient. Otherwise, an unintended consequence may be that the policy could add significantly to the numbers of cases to be discussed at MDM with all of the additional, time-consuming administration required of clinicians, without time being provided.

- *'Each MDM requires a Chair responsible for the audit and quality assurance of all aspects of its primary function.'*

  Agreed.

  Having been both Lead Clinician and Chair, I believe that this should be the responsibility of the Lead Clinician of the MDT, or one delegated to act as such, rather than of the Chair of MDM.

- *'The clinical record should include the reason for any deferments or variation in MDM management decisions'*

  Agreed, apart from emphasising that the MDM makes management *recommendations*, not decisions

- *'After any patient interaction, best practice includes the prompt communication with the patient (and their General Practitioner) in plain English of the rationale for any decisions made.*

  I am unaware of any explicit requirement to write to the patient following any interaction, though I do agree that it would be optimal. I would be concerned that the requirement to write to the patient and to the GP following any interaction will consume time which may be subtracted from and compromise the interaction, or indeed become a substitute for the interaction. Adequate time will be required and should be provided to ensure that all can be implemented without compromise of any.

- *'An operational system that allows the future scheduling of any investigations or appointments should be available during all clinical interactions'*

  Agreed

  The Trust has failed to date to provide an adequate service to facilitate the scheduling of investigations and appointments. While investigative procedures have not been so affected, the failure to provide adequate capacity for review appointments has resulted in patients waiting years beyond the intended review time, with resultant potential and actual harm being suffered.

9.0 Recommendations and Action Planning

Implementation of the Recommendations can only be achieved if the Trust provides a service adequately resourced to do so. In this regard, it is worthy of note that the last lesson learned above, *'An operational system that allows the future scheduling of any investigations or appointments should be available during all clinical interactions',* has not translated into a recommendation and action to be planned in this section. Since 1992, the Trust has failed in its duty of care to patients by its failure to provide a service sufficiently adequate to ensure that any and all patients are reviewed after the interval intended by the clinician.

It would therefore be my concern that the cumulative effect of the nine recommendations and actions planned will add to the quantum of work, responsibility and accountability for clinicians, without the Trust being obliged to provide adequate resources, personnel and time to ensure their implementation, and avoidance of further compromise of the safety of the service.

Summary concerning SUA in Overarching SAI Report

The Summary concerning Service User A again reiterates that the patient was started on an anti-androgen as opposed to androgen deprivation therapy, and that this did not adhere to the NICAN Urology Cancer Guidelines (2016). As I have related, this is incorrect. The Guidelines do not stipulate that androgen deprivation must be by castration.

It is ironic that the Summary notes that the *'guidance was issued when Dr 1 was the regional chair of the Urology Tumour Specialty Group and should have had full knowledge of the contents'.* I can assure the Inquiry that I did have full knowledge of its contents, as I read them many times.

Again, the Summary records that there had been no discussion with the patient that the treatment was at '*variance'* with regionally recommended practice, and that there was no evidence of informed consent to this *'alternative'* care pathway. The treatment was not at variance and the pathway was not alternative.

The Summary relates that *'similar practice in prescribing an anti-androgen had been challenged. Any challenges made regarding the appropriateness of treatment options were not minuted nor was the issue escalated'.* I have no memory of any such challenge. I have no doubt that the reason for my not having any memory of such challenge is because there never was any challenge. If there had been such a challenge, I would have been well able to address it, and would have remembered doing so.

It is concerning that the Summary should relate that, following his initial assessment, the patient's subsequent management *'with unlicensed anti-androgenic treatment (Bicalutamide) at best delayed definitive treatment'.* Bicalutamide 150 mg daily is licensed for the neo-adjuvant and adjuvant hormonal management of patients with non-metastatic, locally advanced prostatic carcinoma. It proceeds to assert that *'Bicalutamide monotherapy (150 mg) is not recommended for intermediate risk, localised prostate cancer (reference is EAU guidelines), and further it decreases overall survival'.* Apart from the fact that SUA did not have intermediate risk prostate cancer, it was evidently never intended that he would be managed with Bicalutamide alone. As has been asserted, it is concerning to read that treatment for prostate cancer is *'based on*

achieving biochemical castration', even though Bicalutamide 150 mg daily has been found to be non-inferior to castration in the management of non-metastatic, locally advanced disease, has been licensed as a consequence, and is preferable to castration due to its adverse toxicity profile.

The Summary then relates that *'there were no resources for a Urology Cancer Nurse Specialist to attend outreach clinics'* but that *'their contact numbers should have been provided to the patient'.* The first is a contradiction of the claim that the Trust had invested to ensure that all cancer patients did have access to a CNS. The second carefully avoids explicitly asserting by whom the contact numbers should have been provided. I would have considered that it was the least to be expected of Clinical Nurse Specialists that they contact the patients who have attended outreach clinics to offer any further supports requested, subsequent to their appointment or allocation to those patients by the MDT Core Nurse Member whose responsibility it has been to do so.

It is worthy of note that the Executive Summary begins by stating that the '*purpose of the review is to consider the quality of treatment and the care provided by Doctor 1 to the patients identified and to understand if actual or potential harm occurred'.* As with all patients identified, the purpose of the review was to understand if SUA had suffered actual or potential harm as a consequence of the quality of treatment and care provided by me. It was focussed on the treatment and care provided by one doctor, rather than the treatment and care received by the patient. For example, I found it worthy of note that SUA had remained on Finasteride for nine years without having had a serum PSA level checked prior to May 2019. A few serum PSA levels during those years may have had SUA travel a different course with a different outcome.

Aidan O'Brien

Clinical History of Patient SUF

Patient SUF was Personal Information redacted by the old when referred by his GP on 03 May 2019 for assessment and management of lower urinary tract symptoms associated with serum PSA levels of 11.64ng/ml in March 2019 and 11.15ng/ml in April 2019. The GP also reported that the patient had lost 7lbs during the previous two months. The GP considered that the prostate gland was mildly enlarged and did not palpate any features of prostatic malignancy.

I triaged the referral on 07 May 2019 as I was Urologist of the Week (UOW) from Thursday 02 May 2019. I requested an ultrasound scan of his urinary tract on 07 May 2019. In doing so, I requested that the volume of his prostate gland and the volume of residual urine following micturition be assessed by ultrasound scanning. I also requested that an appointment be arranged for him to attend a New Patient Clinic following ultrasound scanning.

The purpose of requesting ultrasound scanning prior to first consultation was primarily to have an assessment of prostatic volume available at the time of first consultation, in addition to screening for other pathology of the urinary tract. In someone with no previous serum PSA levels available, and in someone whose second serum PSA level was lower than the first, his serum PSA levels may have been a consequence of a large prostate gland which was benign. He had the ultrasound scan performed on 08 May 2019 when both upper urinary tracts were reported to be normal. He was reported to have a prostate volume of 50ml and to have complete bladder voiding on micturition.

This initial assessment enhanced the significance of his serum PSA levels. The relationship of serum PSA levels to prostatic volume is known as PSA Density (PSAD). It is calculated by dividing a serum PSA level by prostatic volume, and is expressed in ng/ml/ml. The international consensus has been that the upper limit of the normal range of PSAD, denoting a benign prostate, has historically been either 0.1ng/ml/ml or 0.15ng/ml/ml. Therefore, if his 50ml prostate gland had been entirely benign, the upper limit of his serum PSA levels would have been 7.5ng/ml, at most. He had a mean serum PSA level of 11.4ng/ml. His PSAD was 0.228, at least. Such a PSAD is not only associated with an increased risk of having prostatic carcinoma, but it is also predictive of the carcinoma being more clinically significant, if the presence of carcinoma is proven.

Patient SUF then attended as an outpatient on 28 May 2019 when he was assessed by Mr Hennessey, Locum Consultant Urologist, who additionally considered that he could palpate a nodule within the left lateral lobe of the prostate gland. He prescribed Tamsulosin to relieve the patient of symptoms presumed to be due to bladder outlet obstruction, and he requested MRI scanning of his prostate gland.

MRI scanning was performed on 13 June 2019. It was reported that there was probable tumour within the peripheral zone of the left lateral lobe of the prostate gland. There was no definite evidence of extracapsular infiltration. However, as I related in my letter of 19 July 2019, addressed to the GP, I was concerned, on reviewing the images, by adjacent irregularity of the capsule of the prostate gland. Irregularity may have been an indication of involvement of the capsule by carcinoma, without any extracapsular infiltration. Equally well, it may have had no pathological significance. There was no suspicion of metastatic disease. As important as the reported features of probable carcinoma was the report that the volume of the prostate gland was only 19ml. As I

related in subsequent correspondence, calculation of prostatic volume by MRI scanning was more reliable than by ultrasound scanning. The calculated PSAD was reported to be 0.58mg/ml/ml. This more reliable PSAD was even more significant in its prediction of the presence of clinically significant carcinoma.

I met Patient SUF for the first time as an outpatient on 19 July 2019. He reported persistent significant symptoms consistent with bladder outlet obstruction, including hesitancy of micturition, a poor urinary flow and post-micturition incontinence in addition to having to rise up to six times during the night to pass urine. I advised him to proceed with prostatic biopsies. Importantly, he expressed concern and anxiety regarding the risk of progression of any prostatic carcinoma while awaiting biopsies. It was for that reason that I prescribed Bicalutamide 50 mg daily. I repeated his serum PSA, as well as a serum testosterone level, arranged for him to return on 30 July 2019 for biopsies, and I submitted a clinical summary to the Cancer Tracker by email, requesting that he be discussed at MDM with the histopathological report of the biopsies.

There are a number of comments worth making at this point. Firstly, it is evident that this patient had two urological issues of significance to be addressed. He had severe, lower urinary tract symptoms (LUTS) which had not improved since Tamsulosin had been prescribed in May 2019, and he probably had clinically significant, prostatic carcinoma awaiting diagnostic confirmation and assessment. The LUTS may or may not have been caused by his prostate, and may or may not have been caused by any malignancy of his prostate gland. Irrespective of the extent of any causal relationship with any prostatic carcinoma that he may be found to have, the management of any prostatic carcinoma could not be divorced from the assessment and management of such significant LUTS.

Secondly, even though I related in my letter of 19 July 2019, addressed to his GP, that I had advised Patient SUF that it would be prudent to proceed with prostatic biopsies in view of the reported findings of MRI scanning, I did not explicitly record in my hand-written notes or in that letter that I had informed him of the findings. However, the primary purpose of the review consultation was to advise the patient of the report of the MRI scan. Not only did I inform him of the findings, it has been my practice to demonstrate the findings on digitalised images at consultation. In any case, one has to provide the patient with a rational justification for proceeding with prostatic biopsies. Moreover, it was explicitly stated in the clinical summary submitted to the Cancer Tracker and contained in the MDM report that I did do so.

Thirdly, on having been advised of the reported findings on MRI scanning, Patient SUF was understandably anxious with regard to the risk of disease progression, while awaiting its confirmation. As his serum PSA levels were greater than 10ng/ml, any confirmed carcinoma would be classified as intermediate risk, at least. Subsequently finding that his serum PSA level that day had increased to 13.44ng/ml did further justify his concern. The increase in his serum PSA level from 11.15ng/ml three months earlier indicated a PSA doubling time of 1.2 years. Such a PSA doubling time would be persuasive of active therapeutic management.

While some such anxious patients can be reassured that the risk of progression during a relatively short period of time is minimal, it is entirely possible to eliminate that anxiety by initiating a degree of androgen deprivation therapy which would probably be sufficient to prevent progression of a malignancy during a relatively short period of time during which its presence

would be confirmed. It was for that reason that I prescribed Bicalutamide 50 mg daily. I additionally chose Bicalutamide 50 mg daily as it would have been associated with minimal risk of adverse toxicity, as that would have been all the more appropriate if carcinoma were not to be confirmed on biopsies. Bicalutamide may also have resulted in some improvement in his urinary symptoms.

Patient SUF had prostatic biopsies performed on 30 July as arranged. He was found to have overall Gleason 3+4, prostatic carcinoma, which was present in 12 of 14 biopsy cores. Such prevalence was indicative of a significant volume of tumour within his prostate gland. That was also reflected in the findings of a maximum continuous tumour length of 6.3mm, and of tumour occupying approximately 21% of total core tissue volume. It is also worthy of note that all three biopsies taken from the apex of the prostate gland contained Gleason 4+3 carcinoma, rather than 3+4 carcinoma. Lastly, there was evidence of perineural infiltration which is associated with an increased risk of extracapsular infiltration.

The patient's diagnosis and management was listed for MDM discussion on 08 August 2019. This MDM was a virtual MDM conducted by Mr. Haynes, Consultant Urologist. Such a *'virtual MDM'* was not one conducted by Zoom. Instead, it was an on-line review conducted by one consultant urologist of the cases listed, if it was evident on prior scheduling that there would be no other urologists available to attend. It had been our experience that deferring the usual discussion of patients to subsequent weeks led to further cumulative delays in MDM discussion of patients, their subsequent review and ongoing management. The reason for non-attendance on that date would have been a combination of annual leave and one being UOW. I was on annual leave. It had been my practice when conducting such a virtual MDM to have circulated my proposed MDM recommendations by email to all other consultants for any comments and proposed amendments. I do not have any evidence that Mr Haynes did do so.

There was no discussion of Patient SUF's diagnosis or of his management options at the Virtual MDM of 08 August 2019. It was the recommendation of one consultant urologist. In preparing to chair a MDM, Mr Haynes could have been aware of the increase in the patient's serum PSA levels prior to Bicalutamide being prescribed. It was all the more incumbent that he should have been fully appraised of all aspects of Patient SUF's confirmed prostatic carcinoma to date, in view of the absence of any MDM discussion. However, it remains unknown whether he had been aware of the further increase in Patient SUF's serum PSA level prior to Bicalutamide having been prescribed and biopsies having been conducted. It is not possible to know whether he would still have included active surveillance as a management option if he had known. Nevertheless, active surveillance was included as a management option. Moreover, Mr Haynes did not comment upon or record any recommendation concerning the Bicalutamide 50 mg daily which had already been prescribed.

The MDM plan was stated as "*Discussed at Urology MDM 08.08.19. [Patient SUF] has an intermediate risk organ confined prostate cancer. Mr O'Brien to review in outpatients and discuss management with curative intent or surveillance".* It is unfortunate that it was recorded that Patient SUF was discussed at MDM on 08 August 2019 when he was not. It is regrettable that the MDM Plan with each and every patient has always stated that the patient was discussed at MDM on a particular date, irrespective of whether the MDT actually met at a MDM to discuss any patients on that date. In this case, it was additionally regrettable that the proposed

recommendations do not appear to have been circulated by the consultant urologist who undertook this virtual MDM, providing an opportunity for scrutiny.

It is opportune at this point to review the current recommendations for Patient SUF's prostate cancer (NICE guideline [NG131] Published: 09 May 2019 Last updated: 15 December 2021). His prostate cancer is categorised as Cambridge Prognostic Group 3 (CPG3), at least. This is because he had Gleason 3+4 = 7 carcinoma, had a diagnostic PSA level between 10ng/ml and 20ng/ml, and had been considered to have localised, organ confined disease, as there had been no convincing evidence of extracapsular infiltration on MRI scanning. Management guideline 1.3.10 recommends for people with CPG3 localised prostate cancer:

- *Offer radical prostatectomy or radical radiotherapy, and*
- *Consider active surveillance (in line with recommendation 1.3.14) for people who choose not to have immediate radical treatment*

It is evident that patients with CPG3 disease are to be offered radical treatment with curative intent as the preferred management option, active surveillance being reserved for those who decline such treatment with curative intent. Even though there was no convincing evidence of capsular involvement, I did believe that capsular irregularity, coupled with perineural infiltration, increased the risk of capsular infiltration which would have placed Patient SUF in CPG4 for whom NICE recommends that active surveillance should not be offered. In any case, NICE guidelines recommended that Patient SUF should be offered management with curative intent.

Moreover, CPG3 encapsulates a spectrum of prostatic carcinoma. It would have captured a localised, Gleason 3+4, prostatic carcinoma involving two core biopsies in a patient whose serum PSA levels were between 10ng/ml and 20ng/ml. The finding of perineural infiltration did not impact upon its categorisation. Active surveillance may have been a more reasonable option if carcinoma had been found to involve only two biopsy cores, involving less than 10% of total core tissue volume, with a maximum tumour length of 2mm, with no perineural or lymphatic infiltration and with a repeat serum PSA level which had not increased as it had done.

I reviewed Patient SUF on 03 September 2019. As related in a subsequent letter addressed to his GP, I informed him of the findings of histopathological examination of the prostatic biopsies. As indicated by that letter, I have no doubt that I would have described the findings in detail, as that was my practice, and which was the primary reason for his review on that date. I would also have summarised all that was known of his prostate cancer to date: the rate of increase in serum PSA levels, the significance of his PSAD, the MRI findings and the extent of carcinoma hopefully confined to his prostate gland. While I did not make a record of it, I would have informed him of the management options recommended by MDM, even though there had been no actual MDM, as it was my practice in all cases. Nevertheless, I would not have recommended active surveillance, and did not recommend it, as I did not consider it optimal, prudent or reasonable, and as reflected in the NICE guidance. Moreover, the patient had been so anxious concerning the risk of disease progression just two months previously. Instead, I recommended androgen deprivation prior to radical radiotherapy as indicated in my letter dated 27 October 2019.

However, his confirmed prostate cancer was not the only issue. He continued to have severe LUTS which had not been relieved by the combination of Tamsulosin and Bicalutamide. These urinary

symptoms could have been due to pathology entirely unrelated to his confirmed prostatic carcinoma, and all the more so in view of the finding that his prostate gland was not enlarged, and may not have been causing bladder outlet obstruction. He could have had detrusor overactivity, particularly as he had been found to have complete bladder voiding on micturition on ultrasound scanning. Indeed, androgen deprivation may result in an increase in bladder outlet resistance in a minority of patients, and reflected in more severe LUTS, rather than less severe.

It is for these reasons that the management of prostate cancer should not be divorced from the management of significant LUTS. NICE recommendation 1.3.4 advises:

- *Offer a urological assessment to people who have troublesome urinary symptoms before treatment.*

The essence of the review consultation of 03 September 2019 was to advise Patient SUF that he did have prostate cancer with the characteristics as described, to advise him that he would be best served by management with curative intent, consisting of the combination of androgen deprivation and radical radiotherapy, to advise of the need to assess, manage and resolve his urinary symptoms prior to radical radiotherapy, and to ensure that continuing to take Bicalutamide 50 mg daily prevented disease progression while doing so. I therefore advised him to remain on both Tamsulosin and Bicalutamide until he attended on 27 September 2019 for flexible cystoscopy and urodynamic studies. I repeated his serum PSA level. I made the following handwritten entry in the clinical records:

LUTS unchanged
Plan:
*PSA = 8.41**
F/C & UDS 27.09.19

**The PSA level of 8.41 was added to this handwritten clinical record by me when the patient was reviewed on 27 September 2019, at which stage the PSA result from the test on 3 September 2019 was available.*

He attended for flexible cystoscopy and urodynamic studies at 09.00 am on 27 September 2019. He understandably and wisely preferred not to undergo any invasive procedure that morning as he was dressed to attend a funeral later that day. There was no significant change in his urinary symptoms. I was pleased to advise him that his serum PSA level had decreased to 8.41ng/ml by 03 September 2019. As it had done so and as he had not experienced any side effects from his medication to date, I additionally prescribed Oxybutynin MR 5 mg daily as his mixed LUTS were predominantly of a storage nature. I repeated a serum PSA and arranged a further appointment for him to attend for review on 08 November 2019, particularly to determine whether taking Oxybutynin had resulted in any improvement in his urinary symptoms.

In writing to his GP on 27 October 2019, I advised him that I had found Patient SUF's serum PSA level to have decreased further to 6.37ng/ml when repeated on 27 September 2019, and I additionally requested the GP to facilitate the patient having his serum PSA level repeated by the practice nurse during the first week of November 2019, and so that the result would be available

when he returned for review on 08 November 2019. I similarly wrote to the patient requesting that he arrange an appointment with the practice nurse to have his serum PSA level repeated.

Patient SUF did have his serum PSA level repeated on 01 November 2019 when it had decreased further to 4.51ng/ml.

Patient SUF attended for review on 08 November 2019 as arranged. My handwritten clinical note dated 8 November 2019 states the following:

LUTS have increased in severity
Esp: Nocturia x 7-8
PSA decreased to 4.51
Tender right breast

Plan
Rx Tamoxifen 10 mgs daily
Rx Omeprazole 20 mgs daily
F/C & UDS 13 Dec 2019

The dominant issue at his review on 08 November 2019 was that there had been a significant increase in the severity of his urinary symptoms, and even though he had been prescribed Oxybutynin by his GP on 27 September 2019 as requested. He was by then rising seven or eight times each night to pass urine. I again advised him of the need for further assessment of his lower urinary tract anatomy and dysfunction so as to enable its management, and certainly prior to radical radiotherapy. He agreed once again to return on 13 December 2019 for flexible cystoscopy and urodynamic studies.

I was pleased to advise Patient SUF on 08 November 2019 that his serum PSA level had decreased to 6.37ng/ml by 27 September 2019, and further to 4.51ng/ml when repeated on 01 November 2019. Even though there had been a progressive decrease in serum PSA levels since July 2019, I considered that increasing the dose of Bicalutamide at that time was contraindicated as the increased severity of his urinary symptoms may have been attributable to Bicalutamide. Moreover, he reported tenderness of his right breast, without enlargement, and for which I prescribed Tamoxifen 10 mg daily. Lastly, he reported recurrence of some indigestive symptoms, for which I additionally requested the GP to prescribe Omeprazole, as I noted he had previously been prescribed Omeprazole, presumably in relation to his hiatus hernia and oesophageal reflux.

Patient SUF attended on 13 December 2019 for flexible cystoscopy and urodynamic studies, but he declined to have either performed, despite my reassurance and persuasion. I was surprised that he declined, particularly as he had both procedures explained to him when he attended previously. He certainly was not going to agree to have any invasive procedure performed that day. In any case, he did report a significant improvement in his urinary symptoms. His only persistent symptom was nocturia which had improved significantly. He reported having to rise three times each night to pass urine. He did not report any obstructive or voiding symptoms. I considered that he probably primarily had detrusor over-activity which was being relieved by Oxybutynin. He agreed to have his serum PSA level repeated and I advised him that I would arrange a further review when I would have the result.