

ANNEX 3B
Patient Minimum Dataset
(also known as Clinical Coding Form)

ALL sections must be completed fully.

For each patient:	For each admitted episode within spell:
Patient ID	Consultant
HPSS number	Consultant function
Date of birth	Consultant specialty
Sex	Start date
Postcode of usual address	End date
GP	Primary diagnosis
Referrer	Secondary diagnosis
	Primary procedure
For each outpatient appointment:	Procedure (others)
	Procedure date (for each procedure)
Consultant	Site of treatment (at start of episode)
Consultant function	
Consultant specialty	For any period of augmented care:
Primary diagnosis	
Secondary diagnosis	Start date
Attended/did not attend	Augmented care period source
First attendance	Intensive care level days
Medical staff type	High dependency care level days
Outcome of attendance	Number of organ systems supported (IC only)
Attendance date	Augmented care planned indicator
Primary procedure	Augmented care outcome indicator
Procedure (other)	Augment care period disposal
Site of treatment	End date
	Specialty function code
For each admitted spell	Augmented care location
Start date	
Admission method	
Discharge destination	
Discharge method	
Discharge date	

Please return completed forms to Clinical Coding Department, Craigavon Area Hospital, 68 Lurgan Road, Portadown.

Acute Elective Services in the Independent Sector:

Interim Operational Protocol and Procedures Guidance:

1.0 Background

There is currently no active Dynamic Purchasing System in place to use in the procurement of acute elective services required in the Independent Sector (DPS). The former Eligible Provider List utilised regionally has expired and is currently being procured by the Social Care Procurement Unit.

In order to facilitate the timely and appropriate commissioning of acute elective activity within the Independent Sector (IS) in the interim period, and in light of learning from 2018/19, the following process has been developed to ensure robustness of the contract award process in keeping with relevant Public Contracting Regulations and best practice guidance.

Acute elective IS services are predominantly utilised in the following circumstances

- Allocation of non-recurrent funding from the Health and Social Care Board (HSCB) for the provision of additional elective capacity where capacity cannot be secured in-house, i.e. within Trust facilities / staffing. Funding is typically allocated on a short term basis
- Operational service need in circumstances where the Trust is unable to provide services, for example in times of consultant/practitioner absence or unplanned equipment breakdown, etc. or is required to purchase additional service to meet urgent need

2.0 Process

2.1 Allocation of non-recurrent funding from HSCB for additional elective activity

The HSCB will allocate non-recurrent funding to be utilised within agreed timescales, further to the submission of bids, for volumes of activity submitted by Operational Teams. Bids developed by teams will have considered the level of additional activity that can be undertaken in-house and the level to be purchased in the IS. Operational teams in their submission bids for activity in the IS will have:

- Obtained prior agreement for the utilisation of the IS from relevant Operational Assistant Directors and Clinical leads;
- Identified that a suitable volume of patients are available to supply the contracted volumes;
- Considered a 'drop out' rate in the suitable volume above, taking account of patients who may opt to refuse an offer of treatment in the IS, have had their procedure already undertaken, or who are deemed not suitable for treatment in the IS, and
- Identified any Treatment/Wash through consequences anticipated and what period these will be delivered in.

Non-recurrent monies allocated by HSCB will detail the level and type of activity to be commissioned

Funding, allocation and volume split between IHA and IS provision – this will be detailed on Allocation and Activity proforma uploaded on Share point by Performance Team.

Any variation to this must be agreed in advance with the Head of Performance/Performance Manager before proceeding to procurement. Any change or proposed veering needs to be agreed throughout the period also.

The Operational teams will detail clinical and operational information pertinent to procurement award including case mix, pathways, clinical skills and experience required for delivery of contract, timescales for completion in year, any wash through consequences in year and beyond via the service specification.

2.2 Process for Procurement:

In the absence of an active dynamic purchasing system the following procurement options will be considered

- Expression of Interest
- Mini-competitive process
- Direct Award

The procurement approach will be based on assessment of risk, value and operational imperative. Expert advice will be sourced from the Social Care Procurement Unit of BSO as required to guide approach. This will be facilitated by the Community Contact Team.

2.2.1 Operational and Financial Approval

In all cases there will be a requirement to seek operational and financial approval to award a contract. The regional Single Tender Action approval form will be used for this purpose. This will be drafted by the Community Contracts Team for review by the Head of Service and approval by the Assistant Director and Director.

The Operational Head of Service will be responsible for obtaining the approvals required and returning the fully completed document to the Community Contracts Team.

Please note the following:

- Where a contract is over the EU threshold value the Director of Finance (Accounting Officer) will also be required to countersign the STA paperwork. This process will be managed via the BSO Compliance Team
- The Trust will be unable to award a contract until full financial and operational approval has been received

2.2.2 Expression of Interest

The Operational Head of Service requiring an IS provision through an Expression of Interest will be required to provide the Community Contracts Manager with the following information along with an updated and approved service specification

Table1.0 –Information for Expression of interest

Service to be Procured	
Source of Funding	
Value of Funding	£
Volumes of Activities	
Unit Cost of Activities (As per financial bid)	£
Any Treatment Consequences & timescales for same	
Treatment Volumes	
Unit Costs for Treatment Consequences	£
Timescales for Delivery (Contract Start and Completion Date Required)	
Service Specification Completed and Attached	
Detail the maximum number of Providers it would be operational viable to award a contract to for the delivery of the service	
Detail the geographical area to be considered for the delivery of the service e.g. - Northern Ireland only - Northern Ireland and Republic of Ireland only - UK only - UK and Republic of Ireland only Detail the rationale for this decision	

*These assumptions will be used as part of a mini competitive tender evaluation process if required

- Based on the information provided above an appropriate list of Providers potentially able to deliver the service will be identified based on the Provider Eligibility List previously in place.
- The Providers on this list will subsequently be issued with an Expression of Interest invite by the Community Contracts Team which will be made up of the following documents:
 - Expression of Interest Invitation document (These will be bespoke depending on the service required, the volume of activity required and the number of Providers in the market)
 - Service Specification
 - Terms and Conditions of Contract
- Completed documentation will be issued to Providers with a closing date for response.

- Community Contracts Team will act as point of contact with the Independent Sector Provider (ISP) in relation to any queries on the EOI.
- If more than one Provider responds to the EOI and multiple Contracts cannot be awarded, a mini competitive process will be required.

2.2.3 Mini Competitive Process

- A mini competitive process will then be completed between the Providers who expressed an interest in delivering the service
 - This mini competitive process will be completed by the Community Contracts Team
 - The tender evaluation will be based on information requested in Table 1.0
 - An Invitation to Tender (ITT) will be issued to Providers with a closing date for response, and will outline the Tender Evaluation Methodology and Marking Scheme
 - The Community Contracts Team will act as a point of contact for Independent Sector Providers in relation to any queries on the ITT
 - The Community Contracts Team will complete the Tender evaluation process and award a contract or contracts as appropriate.
-
- Once the Provider(s) have been selected the Community Contracts Team will advise the Operational HOS and issue the following documents for review and sign off:
 - Contract Award Letter
 - Terms and Conditions of Contract
 - Service Specification
 - Integrated Elective Access Protocol
 - Clinician Approval Summary Sheet / Letter
 - The contract will then be ready for issue and the Community Contracts Team will inform the service when operational processes can commence (pending receipt of signed contract)

2.2.4 Direct Award Process

If the Contracts Team is advised that a Direct Award of Contract is required, the same process will need to be followed as that outlined in section 2.2.2 for the completion of an Expression of Interest process.

In addition to this Appendix 2 attached will also need to be completed by the Head of Service to detail the rationale for the decision to place a Direct Award of Contract.

Appendix 2 to be completed in full and forwarded to the Community Contracts Team prior to the award of a contract.

2.3 Contract Management

All contract management functions are the responsibility of the Contract Owner, who is typically the Operational Head of Service. This includes:

- Maintenance of contract document and appropriate records;
- Contract initiation, monitoring, performance and quality meetings;
- Operational transfers of patient data and follow up, including communication with patients selected, consultant body and referrers;
- Ensuring robust arrangements are in place for the monitoring and delivery of the contract in accordance with the agreed volumes of contract, service specification and terms of contract;
- Measurement of invoices, and first point of contact for all queries on the contract.

Responsibility of the contract owner are set out in CPD guidance on contract management 01/12 (revised July 2017) see link below and summarised in the SHSCT guidance note (appendix 1)

<https://www.finance-ni.gov.uk/publications/procurement-guidance-note-0112-contract-management-principles-and-procedures>

The Community Contracts Team will administer and process any variations to the contract in line with instruction from the contract owner.



SUMMARY OF PROCUREMENT GUIDANCE NOTE 01/12 – CONTRACT MANAGEMENT PROCEDURES AND PRINCIPLES

GUIDANCE FOR CONTRACT OWNERS

1.0 Background

To ensure the Trust is able to effectively manage contracts which deliver both the service procured and best value for money, the Trust established the Contract Management Improvement Group (CMIG). The CMIG seeks to raise awareness of the contract management process and support Directorates with the development and embedding of knowledge and skill to effect improvement and provide assurance.

2.0 Purpose

The purpose of this summary is to ensure that Contract Owners i.e. those designated with responsibility within their service area for ensuring full compliance with the contract, are aware of their responsibilities within contract management arrangements and their need to ensure that these are **proportionate with the value, risk and complexity identified within the contract**. This guidance summarises the Procurement Guidance Note (PGN) 01/02 which defined the procedures and principles for Contract Management and encompassed existing core principles for contract management within the Trust.

<http://www.dfpni.gov.uk/index/procurement-2/cpd/cpd-policy-and-legislation/content - cpd - policy - procurement guidance notes/pgn 01 12.htm>

Formal Training and awareness sessions on contract management will be provided to Contract Owners from Autumn 2012 however this interim guidance is intended to alert contract owners to their responsibilities and will be developed further following feedback from the training sessions.

3.0 Contract Management

The contract Management process includes five key functions:

- The identification of need and contract development
- The procurement process
- Operational service Implementation
- On-going contract management/service delivery
- Contract end/exit strategy

Contract management is defined within the Guidance as ‘the phase of the procurement cycle in which a contractor delivers the required goods, services or works in accordance with a Department’s specification and Terms and Conditions of Contract’ i.e. the phase concerning the activities after the formal award of contract.

Whilst it is recognised that the contract management process is concerned with the activities after the formal award of contract, successful contract management is strongly influenced by the procurement stage, as this is the stage where the specification, terms and conditions of contract and the understanding between the purchaser (within the Trust) and contractor have been formed. Guidance on the principles to secure robust and effective procurement and the application of DHSSPS Procurement Guidance within SHSCT were previously issued in September 2011

4.0 Key Contract management Responsibilities

The Essential Elements of Contract Management are:

1. Good Administration

- Named contract owner who will undertake the contract management responsibilities.
- A contract file maintained in accordance with good records management principles and retained for the relevant time period. The contract file will contain the following
 - o Pre-approval arrangements/business case
 - o Tendering documentation as appropriate
 - o Contract document, including any variation or extension notifications/letters
 - o Formal notes from annual review meetings/performance management meetings/performance reports required from the provider
 - o Formal correspondence with the Provider

2. A Contract Management Initiation Meeting

- An initial meeting with Provider, which may also have representation from PaLS, with the purpose of facilitating the hand- over of the contract from procurement to operational phase, whilst also ensuring a clear understanding by all parties of the contract requirements and key indicators of performance

3. The Performance Management of the Contract

- As a minimum each contract should have an annual review meeting; more frequent monitoring/reviewing of the contract may take place appropriate to the level of risk. Review should consider:
 - o Regular routine monitoring of the contract delivery, Performance Targets, Key Performance Indicators (KPI's)
 - o The need for more regular formal review meetings in order to provide feedback to the Provider on the contract delivery/performance to date

- o Certification – confirming that the goods/works/services have been completed or delivered within the contracted timescales and to the required standard

4. Financial Arrangements

- Contract owners are responsible for ensuring rates and invoices are accurate and reflect the service delivered and are managed on a timely basis. Only contract owners or another authorised signatory who can confirm satisfactory receipt of the service, at the agreed contractual rate, should authorise an invoice for payment

5. Managing Change

- Contract owners must proactively manage change within a contract, initially ensuring that the scope of the original contract is maintained and that if any contract changes that are required eg in terms of extensions to the contract or price increase that they are within the original procurement arrangements and do not lead to the formation of a new contract.
- The contract owner must assume that it is unlikely that any material difference to the service delivery or change in scope/price can be managed within the existing terms. Guidance and advice should be sought from the relevant Centre for Procurement Excellence (CoPE) on any proposed changes.

6. Exit Strategy

- The contract owner must have in place a clear management exit strategy to mitigate the risk associated with provider failure/default or termination of the contract. It should be noted that whilst there may be the facility to terminate the agreement during the contracting period, providing appropriate notice is given, procurement and legal advice must be sought before taking this course of action.
- The contract owner must clearly manage processes to ensure there is timely procurement prior to the end of a contract if the service is required beyond the contract end to ensure there is no breach of procurement regulations. Guidance and advice should be sought from the relevant Centre for Procurement Excellence (CoPE) on any extension or re-procurement process.
- Guidance on awards of contract without competition, commonly known as Single Tender Actions (STA), which may include extensions to existing contracts beyond their lifecycle, can be referenced on the Trust intranet under Finance & Procurement Directorate - policies and procedures.
<http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/GuidanceonApprovalRequestsforSingleTenderAction.pdf>

End
7June2012CMIG

ACUTE CONTRACT REQUIREMENTS**Direct Award of Contract****FOR COMPLETION BY ACUTE SERVICES DIRECTORATE:****1. OUTLINE OF REQUIREMENTS:**

1a Detail service required *(please include details of specific requirements):*

1b Detail the Provider identified for the delivery of the service(s):

1c Detail value of funding available:

1d Detail volumes of service required *(is there potential for funds to be released in subsequent quarters):*

1e Detail price agreed for each activity:

1f Detail required service commencement date:

1g Detail required service completion date:

2. SERVICE SPECIFICATION:

SPECIFICATION APPROVED (Please circle) Yes / No Approved By: _____

SPECIFICATION ATTACHED (Please circle) Yes / No Insert Name: _____

3. BACKGROUND INFORMATION (For Audit Purposes)

3a Detail all Providers on the previously established Eligible Providers List who have been approved for the delivery of this service within the Southern Health and Social Care Trust

3b Outline detail of the contact made with each of the Providers on the Eligible Providers List:

Provide the following information for each Provider:

- Provider Name
- Contact Date
- Provider capability to deliver the service
- Provider capacity to deliver the service

(EXPAND AS REQUIRED TO PROVIDE DETAIL FOR EACH OF THE PROVIDERS)

4. DETAIL THE PROVIDER(S) THE CONTRACT IS TO BE PLACED WITH

Insert detail and the rationale for this decision

5. APPROVALS REQUIRED

SIGNED OFF BY Head of Service (please print): _____

SIGNATURE: _____

APPROVED BY ASSISTANT DIRECTOR (please print): _____

SIGNATURE: _____

DATE: _____

Please forward via email when completed to the Community Contracts Team:

Personal Information redacted by the USI

Terms of Reference for the Internal Urology Oversight Steering Group

Agreed 6th December 2021

The revised terms of reference set out below replace the “modus operandi” of the local urology coordination group by replacing the terms of reference as agreed on 19th November 2020 in order to reflect and adopt the Policy and Guidance for implementing a lookback review process

Note: The purpose of the policy and guidance is to provide a person-centred risk-based approach to the management of a Lookback Review and support to any service users and their families/carers who may have been exposed to harm, and to identify the necessary steps to ameliorate that harm. The scope of the policy and related guidance also includes providing information and support to those not directly exposed to the harm in question i.e. concerned members of the public. Whilst the outcomes of a Lookback Review may inform other processes e.g. Serious Adverse Incident reviews or a Coroner’s Inquest, this is not the primary purpose of a Lookback Review Process.

The Southern Trust Urology Oversight Steering Group will provide oversight in respect of patients identified as previously being under the care of Consultant A. The Group will also be responsible for providing the DOH with assurance regarding the rigour of approach pursued by the Southern Trust and the timeliness of patient review.

Specifically the Urology Coordination Group will be responsible for:

- Overseeing the service review/ risk assessment process to identify the scope of the issue and inform the decision to progress to the service review/audit and recall stages of the Lookback Review Process as required. Risk Assessment will be agenda item at each meeting. Review of lookback information completed and subsequent update of the risk assessment to reflect the situation at that time.
- Establishing the requirement for progression to Stage 3 “Service User Recall”. This will be based on the completion of Stage 2. Terms of Reference specific to the purpose, scope, method and timeframe to be established when decision to progress to Stage 3 is agreed.
- Communicating the need for the service review/audit and recall stages of the Lookback Review Process through the organisation’s governance structures/Assurance Framework to the Board of Directors and external stakeholders (including DoH);
- Using the Process Review Guideline as our framework for the Lookback Review Process. We will incorporate our actions and the allocation to

individuals, set timeframes and RAG rate actions according to priority. We will include actions completed prior to this group commencing to ensure a comprehensive record of the entire process is recorded.

- Overseeing operational management of all aspects of the Lookback Review Process and provide assurance of progression to the external Oversight Team
- The Action and Workplan will reflect the Process Review Guideline. Details of the methodologies to complete will be recorded as agreed at each meeting. A database of patients included in the review cohort will be maintained to allow outcomes for each patient to be recorded including type of review and outcome
- Developing a Lookback Review Action/ Work Plan which outlines the methodologies to be implemented in relation to the Audit and the Recall stages of the Lookback Review Process;
- At each meeting the group will provide details of number of patients that have had desktop/ clinical reviews completed, telephone and face to face appointments and will agree the next cohort of patients to be reviewed/ seen. This will also include patients who have been or need reviewed for SJR consideration and update of any newly identified issues/ themes.
- The group will discuss at each meeting the next cohort of patients that require review either virtually or face to face. The group will agree on those to be seen “in house” and allocation and planning actions to be recorded for creating this capacity, including additionality. If patients agreed for IS review, this will also be agreed and forwarded to IS contract manager for actioning. The Group must also note the discussions and potential impact on other service users when creating capacity to manage “in house”.
- Lookback Review Process, this should include service users not included in the ‘at risk’ cohort who also may be affected by the impact on services as a result of the Lookback Review Process;
- The group will ensure that all service users and staff involved are aware and have access to the dedicated Urology support services.
- Discussing and securing additional resources from Commissioners and ensuring service managers allocate the necessary resources to implement the Lookback Review Process and to meet associated demands;. This will be as the process progresses and when the need is identified that could potentially create a risk to enabling the Lookback Process to continue.
- The group will agree on the information provided to service users included in the Lookback Process. Communication will be patient specific and include details of support, and the outcome timescales.

The Group will be chaired by the Director Acute Services, SHSCT

Membership will include:

- Director of Acute Services (Chair of Regional group)
- Medical Director
- Assistant Director of Surgery and Elective Care
- Deputy Medical Director
- Assistant Director for the Public Inquiry and Trust Liaison
- Associate Medical
- Head of Service - Clinical Assurance
- Chair of any subgroups established by the group as and when regional only
- Clinical Nurse Specialist for Urology
- Representative for Patient and Client Council regional only - by request

Business support – HSCB regional only

Corrigan, Martina

From: McClements, Melanie
Sent: 08 July 2022 18:28
To: Corrigan, Martina
Subject: FW: Level 3 Serious Adverse Incident Review 30.09.2020 (3)
Attachments: Level 3 Serious Adverse Incident Review 30.09.2020 (3).docx

From: Corrigan, Martina [Personal Information redacted by the USI]
Sent: 16 October 2020 15:47
To: Wallace, Stephen [Personal Information redacted by the USI]; Carroll, Ronan
[Personal Information redacted by the USI] McClements, Melanie [Personal Information redacted by the USI];
Corrigan, Martina [Personal Information redacted by the USI]; OKane, Maria
[Personal Information redacted by the USI]
Subject: FW: Level 3 Serious Adverse Incident Review 30.09.2020 (3)

Patricia

From my perspective I have no further comments and happy with these TOR

Thanks

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: Kingsnorth, Patricia
Sent: 16 October 2020 15:01
To: Wallace, Stephen; Carroll, Ronan; McClements, Melanie; Corrigan, Martina; OKane, Maria
Subject: Level 3 Serious Adverse Incident Review 30.09.2020 (3)

Dear all
We have reworded it again and would welcome your comments.

Kind regards
Patricia

PATRICIA KINGSNORTH

ACTING CLINICAL AND SOCIAL CARE GOVERNANCE COORDINATOR

MOB [Personal Information redacted by the USI]

Terms of Reference- Agreed by Group 11 October 2021**Trust's Task and Finish Group into Urology SAI Recommendations*****Terms of Reference of Task and Finish Group***

The Task and Finish group is charged with implementing all the recommendations and providing assurance/evidence to the Urology Oversight Group

Membership of Task and Finish Group

Consultant	Nurse	Manager/Admin
Philip Murphy, Deputy Med Director Shahid Tariq, Deputy Med Director Mark Haynes – Deputy Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, Gen Surgery Kevin McElvanna General Surgery Art OHagan Dermatology Geoff McCracken, Gynae Helen Mathers Breast Rory Convery Lung Christina Bradford, Hematology Anthony Glackin, Urology Marian Korda, ENT	Clair, Quin, Cancer Lead Tracey McGuigan, Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Service Improvement Lead Sharon Glenny, performance manager Jane Scott performance manager Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Sarah Ward, Head of Service Clinical Assurance

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-disciplinary teams to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Life span of Task and Finish Group

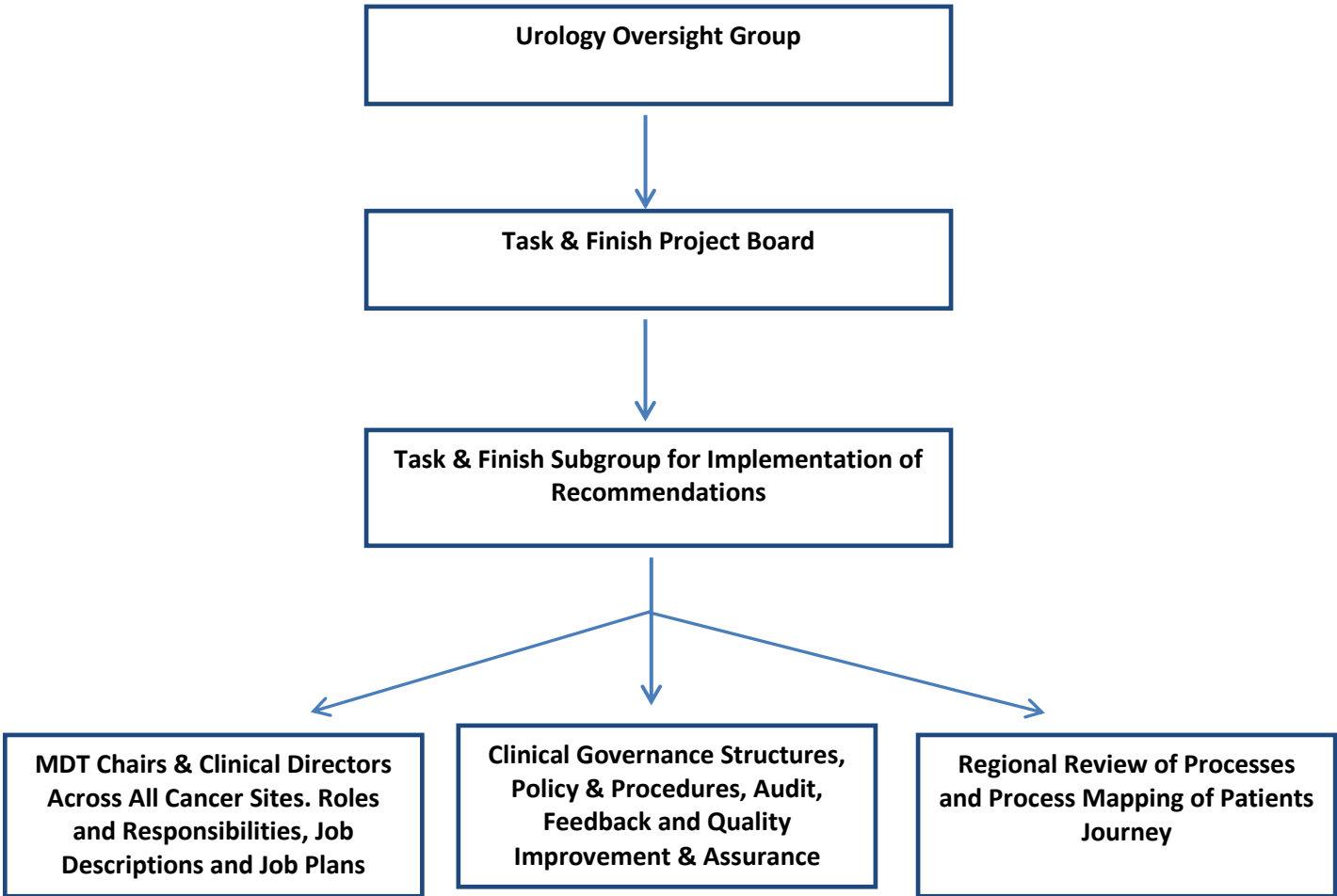
The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.

- 2. Task and Finish Group will report to the Urology Oversight Group Meeting and regular updates will be provided to the HSCB, DoH and families involved in the SAI's.

Governance and Accountability



Frequency of Meetings

Monthly

NCAT Section / Characteristic	Generic issue	Action/s to address	Action Product	Action owner	Action End date	Status update	RAG rating	Evidence when completed	Cross-reference to Urology SAI recommendation/s
Section 1: The Multidisciplinary Team									
1.1.1 / 1.1.3	All relevant specialities are represented in the team, cross cover for some specialities	Audits of attendance at MDM should be more regular (?quarterly) rather than review at annual business meeting - this will also assure on quoracy and allow for issues to be addressed earlier	Audit of MDT Attendance on regular basis	MDT Administrator / Projects Officer & MDT Leads	Will be on-going quarterly	Dr Tariq has written to all MDT Leads to ensure that attendance is being accurately recorded at MDT meetings. Audits of attendance to take place on a monthly basis starting from Feb 2022. Quorarcy to be shared with MDT Leads and Cancer Management Team		Monthly report of all MDT attendances available from Feb 2022 and circulated to the MDT Leads and Cancer Management Team for review and further escalation as required	Recommendation 1
1.2.1	Dedicated time in job plans for preparation & attendance at MDT	Ensure job plans of all MDT members has dedicated time included to prepare and attend the MDT meeting	Review of MDT Job plans	Dr Tariq / C.Quin	Dec-21	Dr Tariq has written to the surgical & medical directors to clarify that MDT time is included in the job plans of all MDT members. Attendance at the MDT meeting has been confirmed for all tumour sites. Preparation time is not included and falls under the time allocated for general patient admin time. C.Quin has checked with all CNS's - they all attend MDTs as required though not all have formal job plans. C.Quin to link with J.Davenport to confirm oncology input to the local MDTs.		Confirmation received per speciality that all core MDT members have dedicated time to prepare and attend MDT. Awaiting confirmation by BT in relation to oncology input to local MDTs.	Recommendation 1; Recommendation 4
1.2.6	Extended members / non-members attend for cases relevant to them	To be agreed by the MDT and detailed in the MDT operational policy	MDT Operational Policy	MDT Leads / SIL / MDT Administrator	30th Jan 2022	Discuss with MDT Leads and include agreed process in each MDT operational policy. MDT Administrator / SIL to ensure this is documented in the Operational policies.		Detailed in MDT Operational Policies. Reference 1.6 Principle Doc re. quality indicator required to audit/monitor.	Recommendation 1
1.3.5	MDT Leader has a broader remit not confined to MDT meetings	Develop role description of the MDT Lead and ensure adequate time is allocated in their job plan	Job description for MDT Lead role	Dr Tariq; Stephen Wallace	Jan-22	Dr Tariq has liaised with Stephen Wallace in relation to MDT Lead role description. A draft has been circulated to all MDT Leads for review / comment.		MDT Lead role description agreed and signed off	Recommendation 7
1.4.1	Each member has clearly defined roles / responsibilities in the team which they have signed up and included in their job plans	Define and detail the roles and responsibilities of all members involved in the MDM meetings	Review of MDT operational policies to ensure all MDT members roles are clearly defined; Review of MDT job plans	MDT Leads; MDT Administrator & Projects Officer; Medical & Surgical Speciality;AMD	Mar-22	MDT Administrator & SIL to review all MDT Operational policies with MDT Lead to ensure roles and responsibilities are included. To date LGI, UGI policies have been reviewed / updated.		Clearly detailed in each MDT Operational policy.	Recommendation 1
1.5.2	Networking opportunities to share learning & experiences with other MDTs locally	Provide opportunity for MDTs to meet locally, at least once per year, to share learning and experiences	Set up an Annual networking meeting for all MDTs	Dr Tariq; CD for Cancer; AD for Cancer services	Mar-22	Dr Tariq to contact MDTs Leads for feedback on the format and content of an annual networking event and to seek a date early 2022		An annual networking event is arranged if agreed by MDT Leads	Recommendation 6
Section 2: Infrastructure for meetings	0								
3.2.5	Locally agreed minimum dataset of information about patients for discussion collated and summarised prior to meeting (pathology, radiology, clinical, co-morbidities, psychosocial & spec palliative care needs	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	MDT proforma for Urology MDT agreed and will be rolled out from 4 Jan 22. Proformas for Lung, UGI and LGI to be considered next.		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.2.6	Members know what info from locally agreed minimum dataset of info they will be expected to present	To be detailed in the MDT Proforma	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT (Jan 22)		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.3.1/3.3.2	It is clear who wants to discuss a patient & why being discussed / a locally agreed dataset of information is presented on each patient including diagnostic information	To develop MDT Proforma per tumour site with locally agreed minimum dataset, clear reason for discussion and sign off from the presenting clinician	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 5
3.3.5	Core data items are collected during meetings and datasets completed in real time	Review and agreement of which data fields should be completed during MDT discussion and by whom, this should be detailed in MDT Principles/Protocol	Audit process agreed to review and monitor	MDT Leads; MDT Administrator / Projects Officer & MDT Co-ordinators; OSL	Mar-22	To start review with Breast & Gynae MDTs as they have more experienced trackers		Completion of core data fields during MDT meeting & process implemented to check compliance (ref 2.1 Principle doc)	Recommendation 5
3.4.1	Processes in place to ensure patients info needs are assessed and met; to ensure actions agreed are implemented;	CNS to use the Cancer Information Recording form to record the information provided by the clinical team to the patient and file in the patient notes. Holistic needs assessment offered to all newly diagnosed patients and a care plan developed to address concerns raised. All patients offered a written record of their management plan with diagnosis and contact details before they leave clinic.	Audits to check completion of Cancer information recording form & permanent record of consultation. Roll out of electronic health needs assessment by CNS's across all tumour sites.	HOS Cancer, Lead Nurse for Cancer and MDT Administrator / Projects Officer	Feb-22	Audits to take place when MDT Administrator is in post		Roll out of audits to check compliance	Recommendation 2
3.4.2	ensure MDT is notified of significant changes made to recommended treatment/care-plan	Any variation from recommended treatment/careplan should be documented at a MDT meeting. Develop an SOP with a clear pathway on whose role it is to capture , record and document and how this will be done per MDT for any patients that have declined further treatment.	Develop SOP; Include in MDT Principle's document (ref 2.6); agree audit process to check compliance	MDT Leads; MDT Administrator & Project Officer	Mar-22	Principles document developed and agreed. SOP to be developed and audit process to be agreed (ref 2.6 Principles Doc)		Roll out of audits to check compliance	Recommendation 5
Section 4: Patient Centred Clinical Decision-making									

4.1.1	Local mechanisms to identify all patients where discussion at MDT is needed	Define and detail what failsafe mechanisms are in place to ensure that there is a safety net to identify all patients who require MDT discussion	Failsafe mechanism agreed with Pathology	Pathology Clinical Lead; MDT Administrator & Project Officer	Mar-22	A report has been developed by Cellular Pathology & Lab service in Belfast and is currently being reviewed and tested.		Process in place to run a report to enable a cross-check across all the MDTs	Recommendation 5
4.1.3	Local agreement about if/when patients with advanced/recurrent disease should be discussed	MDT site specific agreement if/when patients with advanced or recurrent disease are listed for discussion and this is detailed in operational policy. Audit process to monitor this to be detailed in MDT Principles doc and rolled out.	To be guided by what is agreed and funded regionally. MDT Principles Doc details audit process to be carried out.	MDT Leads; OSL; HOS Cancer; MDT Administrator & Projects Officer	Mar-22	Regional discussion required to agree enhanced tracking definitions and funding secured to implement . Reference 2.6 MDT Principles Doc in relation to audit mechanism		To be guided by what is agreed and funded regionally. Audit process agreed and rolled out.	Recommendation 4
4.2.3	Named individual at MDT has responsibility for identifying a key worker for the patient	To be detailed in MDT Principles doc and audit process required; additional field to be added to CAPPs to identify key worker	MDT Principles document; CAPPs	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles doc agreed, audit process to be set up once the additional field is added to CAPPs		Audit process agreed and implemented across all MDTs	Recommendation 5 & Recommendation 2
4.2.4	Named individual at MDT ensures patients information needs are assessed and addressed	To be detailed in MDT Principles doc and key worker identified on CAPPs	MDT Principles document - audit of compliance to be agreed	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles document agreed. Meetings ongoing with CNS's to ensure that patient info needs are assessed and documented appropriately.		Audit proces in place to monitor compliance (ref. 2.8 Principles Doc)	Recommendation 2
4.3.1	A locally agreed minimum dataset of info is provided at the MDT meeting	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Leads; MDT Administrator & Project Officer	Mar-22	Proforma for Urology MDT developed and agreed, this will be used from 4 Jan 2022. Next tumour sites for consideration are Lung, LGI and UGI.		Audit process agreed and implemented across all MDTs	Recommendation 1; Recommendation 5; Recommendation 8
4.3.3	MDTs have access to all current clinical trials, consider patients suitability, relevant research nurses attends MDT where feasible	Ensure that all MDTs have access to clinical trials and recruitment is considered as appropriate	MDT Principles document (ref 2.11)	MDT Leads; Clinical research nurses; Peter Sharpe; Irene Knox;	Ongoing	When Principles doc is agreed by MDT Leads, process will be agreed to ensure that MDTs are aware of clinical trials and consider patients suitability		Audit process agreed and implemented across all MDTs	Recommendation 1;
4.3.12	MDTs collect social demographic data (age, ethnicity & gender) & consider data periodically to reflect on equality of access to active treatments	To review systems to identify how this information can be collected and agree a clear process on how this info is captured, whose role it is to do this and when this will be considered by the MDTs	Data collection	OSL/ MDT Administrator & Project Officer / SIL	Feb-22	MDT Administrator to raise at next regional CAPPs meeting. Meeting held with NICR and info request to be submitted in Spring 2022.		Data is collected and reviewed by MDT Leads	Recommendation 6
Section 5: Team Governance									
5.1.1	Organisational support demonstrated via adequate funding/resources in terms of people, time, equipment for MDT meetings to operate effectively	Review of MDT Leads job plans, clear process in place to escalate any issues that may impact negatively on the effectiveness of the MDT meeting, new MDT room suitable equipped for meetings	MDT job plans; MDT room for meetings; process in place to escalate issues of concern, monthly Cancer checkpoint meetings, attendance at MDT AGMs	Cancer Services Management Team	Jan-22	MDT Leads job plans all reviewed; room allocated for MDT meetings; MDT Administrator post; regular meetings set up to escalate issues / concerns		MDT job plans reviewed and adequate time allocated; new MDT room operational for MDMs; clear process in place to escalate concerns; monthly checkpoint meetings; Cancer management attendance at MDT AGMs	Recommendation 9
5.1.2	Trusts consider their MDTs annual assessments and act on issues of concern	Cancer Services team attend MDT annual meetings and process in place to enable escalation of MDT areas of concern	Clear process in place and communicated to all MDT Leads to escalate issues of concern; Representation from Cancer Management Team at MDT annual business meetings	Cancer Services Management Team	Feb-22	Escalation Process agreed and circulated to all MDT Leads; Schedule of MDT business meetings to be agreed at start of each year and communicated to management team to ensure		MDT annual meetings to be agreed for 2022 and Cancer services management representation agreed for all meetings; escalation of other issues of concern as per agreed	Recommendation 3
5.2.1	Data collection resource is available to the MDT	Identify what data support is required by MDTs and explore funding sources with Trust SMT and commissioners	Data resource allocated	AD / HOS Cancer / OSL /	Feb-21	The MDT Administrator took up post on 04/01 and additional data support will be considered		Adequate data support is available to all the MDTs	Recommendation 6
5.2.2	Key info that directly affects treatment decisions is collected by MDT (staging, performance status, co-morbidity)	To ensure this info is captured in the MDT Proforma	Sytems review / MDT Proforma	MDT Administrator / Projects Officer; OSL; MDT Leads	Feb-22	This has started with the Urology MDT and will be rolled out across all of the MDTs in a phased approach		Key info is collected and considered by the MDT in relation to treatment options	Recommendation 5
5.2.3	Mandated national datasets are populated prior to or during MDT meetings or shortly afterwards	Detailed in MDT Principles doc and clear process detailed on what info is collected and by whom	MDT Principles document	MDT Co-ordinator / OSL / MDT Administrator	30th Nov	Draft presented to MDT Leads at Cancer checkpoint meeting and to the Urology Task & Finish Group meeting. Document is now finalised. Audit process to be implemented.	 	Monitoring process is undertaken as defined in the MDT Principles Doc (ref 2.1) and results shared with MDTs	Recommendation 6
5.2.4	Data collected during MDT meetings (including social demographic data) is analysed and fed back to MDT to support learning	Agree what data is collected, who will collect & analyse it and when this will be shared with the MDTs for consideration	Data collection process agreed per MDT	MDT Leads; MDT Co-ordinator; OSL; SIL	Mar-22	Liaise with HSCB to get a regional steer on social demographic collected. Meeting held with NICR and info request to be submitted in Spring 2022.		Data collected is analysed and fed back to the MDT for review and learning	Recommendation 6
5.2.5	MDT takes part in internal and external audits of processes & outcomes, reviews audit data and takes action to change practice where necessary	MDTs to identify and agree their audits at the annual business meeting including whi will lead and what support is required	Completion and and log of audits per MDT	MDT Leads / Dr Tariq / AD / Clinical audit team	Mar-22	Dr Tariq to write to MDT Leads to seek input on completion and review of future audits and the process for this to be discussed and agreed. Additional audit resource to be secured from the Clinical Audit Team		MDTs to take part in audits, both internal and external, and takes action as appropriate. All audits are logged.	Recommendation 6
5.2.7	Patient experience surveys include questions relevant to MDT working and action is taken to implement improvements in response to pt feedback	Local patient experience surveys per MDT should be rolled out at least once every two years.	Patient experience surveys	CNS's / SIL / MDT Leads	Mar-22	Scope what patient experience surveys have been undertaken and identify any gaps across MDT teams		All MDTs undertake patient experience surveys and action plans developed in response to findings	Recommendation 6
5.3.1	Data collection resource is available to the MDT	Identify what data is required for the MDTs and by whom and how often	Data resource calculated	OSL / MDT Administrator / HOS Cancer / MDT Leads	Feb-21	This will be considered further once the MDT Administrator has had to time to settle into the post		Data support is available to all MDTs	Recommendation 6

5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice	Re-establish the Cancer Service User Group and agree the process for involvement in MDT policy and practice	Establishment of Cancer Service User Group	HOS Cancer; SIL ; Macmillan HWB Manager	Feb-22	Terms of reference developed; recruitment process underway; Group is re-established. Further discussion required to agree process for MDT involvement.		Trust cancer service user group is involved in the development of MDT policy and practice	Recommendation 6
5.3.5	Mechanisms in place to record MDT recommendation v actual treatment given and alert MDT if these are not adopted and reason for this; ensure MDT is alerted to serious treatment complications and adverse/unexpected events/death in treatment	To be detailed in MDT Principles document including quality indicator to audit; additional resource to support this needs to be identified and secured.	MDT Principles Document; Additional resource secured	AD; DMD; OSL; MDT Administrator & Projects Officer	Mar-22	Principles document is agreed. BT audit process to be reviewed and implemented initially for the Urology MDT to test and ascertain resource required.		Mechanisms and audit process are in place	Recommendation 8
5.3.6	Strategies in place to monitor; proportion of pts discussed without sufficient information to make recommendations & proportion of patients offered and/or receiving information recommended by MDT	Agree how this data is collected & analysed for MDTs, by whom and when this will be shared with the MDTs for consideration	Data collection & analysis - AUDITS	MDT Leads; MDT Administrator & Project Officer;	Jan-22	To be agreed with MDT Leads once MDT Administrator & Projects Officer is settled into post		Agreed mechanism and audit process in place	Recommendation 1; Recommendation 2
5.3.7	MDT shares good practice & discusses local problem areas with MDTs in own trust/network	Provide opportunity for MDTs to meet locally to share learning and experiences (see 1.5.2)	MDT networking event	Cancer Services Management Team	Feb-22	Dr Tariq has contacted MDT Leads to seek feedback on whether an event is required or to agree other mechanisms to share learning		Agreed mechanism in place between MDTs to share learning	Recommendation 3
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and subject to audit	This is currently done on a one-to-one basis, a process needs to be developed and implemented	To develop an MDT Communications Protocol	MDT Administrator / MDT Leads /	Mar-22	Dr Tariq to liaise with MDT Leads to discuss process. M.Haughey and A.Muldrew to review BT communications protocol in relation to communication back to local MDTs and advise accordingly.		Agreed process and audit in place	Recommendation 6
5.3.10	MDTs reflect annually on equality issues	Data to be agreed and collected for MDT annual reports for review & reflection by the MDT members	Data collection	MDT Leads / MDT Administrator & Projects Officer	Mar-22	Data and process for collection to be agreed when MDT Administrator & Projects Officer is settled into post. M.Haughey to check with NICR.		Process agreed to collect data which are reviewed by MDTs	Recommendation 1; Recommendation 6
Additional areas	Overall governance of MDT and decisions arising from MDTs	Review of JDs for ADs, CDs and AMDs – both for cancer and specialties.	Process set up to review JDs	AMD / Medical Directorate / Specialities	Mar-22	This is ongoing via the Medical Directorate		Clear governance structure and process in place	Recommendation 6; Recommendation 7

RAG Rated Scale for Actions	
	Action not progressed
	Process in progress
	Process complete and action implemented

PROPOSAL FOR STRUCTURED CLINICAL RECORD REVIEW

DRAFT V1 - 17th February 2021

Background

1. On the 23rd November 2021 the Minister for Health gave direction for the initiation of a Public Inquiry regarding the Clinical Practice of Mr Aidan O'Brien, Consultant Urologist.
2. Although yet to be developed, the terms of reference for Public Inquiry will consider Mr O'Brien's practice across all of his clinical activity. This will likely include reviews involving individual patient cases where a potential adverse outcome was identified.
3. While ensuring that the work of the Public Inquiry is not disrupted or delayed, in the interests of maintaining patient safety it remains incumbent on the Trust to ensure that where potential patient safety incidents are identified, a proportionate patient safety review should take place to inform learning and develop safer systems in a timely manner.
4. Remaining cognisant of regional parameters and requirements for the identification, review and learning from Adverse and Serious Adverse Incidents (SAI) as set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* the Trust has sought to provide an alternative, proportionate and robust review structure that can be utilised to review SAI's in a timely manner.
5. Any patient safety review process will function and report within the existing clinical governance arrangements for the Trust and as such be subject to quality assurance processes and an appropriate level of scrutiny.

Title of Review Structure

6. The Trust is mindful that any proposed alternative review structure should be demarcated clearly as different to the SAI process. It is therefore important that for clarity for service users, staff and the public that the title should articulate this clearly.

Proposal 1 – The name of the review mechanism will be titled STRUCTURED CLINICAL RECORD REVIEW (SCRR)

Underpinning Review Methodology

7. To ensure confidence in the SCRR process an adoption of a robust and validated method will be required. To this end, the Trust has spoken to the Royal College of Physicians with a view to adapting the underpinning principles and methodology found in the Structured Judgement Review (SJR) Process.
8. The Royal College of Physicians SJR combines clinical-judgement based review methods with a standard format. The format requires reviewers to make safety and

quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

9. As an outcome of the SJR the result is a short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
10. The objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.
11. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.
12. The Trust proposes developing an adapted form from the base Royal College of Physicians SJR template and seeking Royal College of Surgeons agreement. The Trust envisages that the tool will be developed in two sections to consider both inpatient and outpatient care provided.

Proposal 2 – The underpinning methodology will be based on the Royal College of Physicians Structured Judgement Review tool

Identification of Cases for Structured Clinical Record Reviews

13. The inclusion criteria and thresholds for cases in the SCRR process will remain in keeping with those set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* with particular reference to section 4.2 of the document which outlines the following specific criteria:
 - Serious injury to, or the unexpected/unexplained death of a service user
 - Unexpected serious risk to a service user and/or staff member and/or member of the public
 - Unexpected or significant threat to provide service and/or maintain business continuity
14. Where appropriate the Trust will continue to screen adverse incidents, complaints and returns from patient record reviews for consideration of inclusion in the SCRR process.

Proposal 3 – The Trust will maintain the same screening criteria, thresholds and processes for SCRR as is currently in place for SAIs

Conducting Structured Clinical Record Reviews

15. The Trust recognises the requirement to conduct SCRR in a timely manner to identify and action learning and system changes as appropriate. In this regard the Trust

proposes engaging the services of an independent Consultant Urologist via the Royal College of Surgeons to conduct the SCRR process who has training, knowledge and experience in applying Structured Judgement Review methodology.

16. To support the process for conducting the SCRR the Trust clinical governance teams will source and share records electronically and support the development of 'timelines' that will support the reviewer in their task completing the SCRR.

Proposal 4 – The Trust will seek to engage an Independent Consultant Urologist Subject Matter Expert to conduct SCRR's and ensure that appropriate clinical governance support is available to facilitate each review

Engaging Patients and Families in Structured Clinical Record Reviews

17. The Trust places paramount importance on the need to fully involve patients and families are engagement in the SCRR process. The Trust recognises that the communication of the SCRR process to patients and families is crucial in terms of setting expectations of outcomes and how this will relate to the work of the Public Inquiry.
18. To support this work the Trust has appointed a dedicated Urology Service User Liaison Officer to communicate and support patients and families who are part of the SCRR process.
19. The outline proposed family engagement strategy is as follows:
 - a. Once the requirement for an SCRR is identified, the patient or family is notified via phone-call and then follow up letter informing of the decision to conduct a SCRR. Communication will include details of what the review process is, what the expected outcomes will be and how this process links to the Public Inquiry. The communication will also contain the contact details of the Service User Liaison Officer who can offer individual patient and family support.
 - b. The review will be conducted by the independent Consultant Urologist and the judgement and outcomes recorded.
 - c. The Service User Liaison Officer will share the report's findings with the patient and family for their review and comment.
 - d. The Service User Liaison Officer will return feedback to the Consultant Urologist from the family if received.
 - e. A final copy of the SCRR will be shared with the family and arrange any required further follow-up or discussions required with the Trust Urology service.

Proposal 5 – The Trust will utilise the Service User Liaison Model to engage patients and families with set milestones as outlined

Timescales for Completion of Structured Clinical Record Reviews

20. Although to be formally agreed it is expected that each SCRR should be completed within 8 weeks in line with the regional timescales for Level 1 Significant Event Audits..

Proposal 6 – The timescale for completion of each SCRR should be a maximum of 8 weeks

Initiating Learning and Change from the SRCC

21. The Trust will incorporate the learning and findings from SCRR's into existing clinical governance streams. This includes ensuring that:
- a. Where actionable outcomes are identified, these are taken forward to improve services
 - b. learning for regional bodies is shared via HSCB
 - c. assurance on action closure is provided to the UAG
 - d. Where a SRCC identifies the requirement for a more in-depth review, this is flagged for consideration at the Trust and HSCB weekly meeting.

Proposal 7 – The process of learning and change from SRCC will be embedded in Trust clinical governance structures and appropriate escalations for learning and if required further review is considered

UNAFI

Care Review Tool for Urology Patients

Section 1

This section should be completed as soon as is possible.

If it is deemed appropriate to complete Section 2, it should be completed within 8 Weeks (56 days) of selected patients' deaths.

Patient identification number:		Gender:	
Date of birth (dd/mm/yyyy)		Age:	
Date of Incident		Date Incident Reported:	
Date of death (if relevant)			
Location of death (if relevant)			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code (if known)			
Co-morbidities			
Healthcare teams involved in the patient's care at the time of incident			
Patient summary (can be completed by the clinical team)			
Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)			

Time taken to complete Section 1 of this form (minutes):

Date of completion:

Name of person completing Section 1:

Job title of person completing Section 1

Care Review Tool for Urology

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Triage (where relevant)

- Was triage conducted in a timely manner?
- Was the triage outcome assigned an appropriate level of priority given the information available at the time?

Please record your explicit judgements about the triage process and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.2. Phase of care: Initial assessment or review (where relevant)

- Were the investigations, prescribing, diagnosis and clinical management approach and communications with patient, primary care and MDT teams appropriate?
- Were diagnostic tests or investigations requested in a timely manner and with sufficient clinical information to allow appropriate onward prioritisation?

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.3. Phase of care: Review of Diagnostics (where relevant)

- Were diagnostic tests or investigations reviewed in a timely manner with appropriate further actions taken?
- Were any required actions adequately communicated to patient / primary care / MDT teams?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.4. Phase of care: Ongoing Outpatient Care (where relevant)

- Were ongoing reviews scheduled at appropriate intervals?
- Were referrals made to other teams / professionals appropriately and in a timely manner?
- Where any further required tests / investigations requested and performed in line with good current practice?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.5. Phase of care: Admission and Initial Management (approximately the first 24 hours) (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

Care Review Tool for Urology

2.6. Phase of care: Ongoing Inpatient Care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

Care Review Tool for Urology

2.7. Phase of care: Care during a procedure (excluding IV cannulation) (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.8. Phase of care: Perioperative care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐

4 Good care ☐

3 Adequate care ☐

2 Poor care ☐

1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.9. Phase of care: Discharge plan of care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.10. Other area of care (please specify)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.11. Overall care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.12. If care was below an acceptable standard, did it lead to harm?

If yes, please provide details and state an action plan

Care Review Tool for Urology

2.13. If the patient died considered more likely than not to have resulted from problems in care delivery or service provision?
If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.14. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.15. Were the patient records adequate for the purpose of the review?

Yes ☐

No ☐

Please outline any difficulties in accessing appropriate information:

Time taken to complete Section 2 of this form (minutes):

Date of completion:

Name of person completing Section 2:

Job title of person completing Section 2:

Assessment of problems in healthcare for Urology patients

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm. Please circle correct response.

Problem types

1. Problem in assessment, investigation or diagnosis	Yes No
Did the problem lead to harm?	No Uncertain Yes
In which phase(s) did the problem occur?	Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
2. Problem with medication / IV fluids / electrolytes / oxygen	Yes No
Did the problem lead to harm?	No Uncertain Yes
In which phase(s) did the problem occur?	Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care

Care Review Tool for Urology

3. Problem related to treatment and management plan Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
4. Problem related to operation / invasive procedure <i>(other than infection control)</i> Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
5. Problem with infection management Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation)

Care Review Tool for Urology

	Perioperative care Discharge plan of care Other area of care
6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes) Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)) Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
8. Problem of any other type not fitting the categories above (including communication with patients and carers and organisational issues) Did the problem lead to harm? In which phase(s) did the problem occur?	Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care

Care Review Tool for Urology

	Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care
--	--

From the Permanent Secretary
and HSC Chief Executive



Shane Devlin
Chief Executive
Southern HSC Trust

Personal Information redacted by the USI
Personal Information redacted by the USI

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

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

Email: Personal Information redacted by the USI

Our ref: RP5593

Date: 22 October 2020

Dear Shane

CONFIDENTIAL EARLY ALERT 182/2020 – SOUTHERN TRUST CONSULTANT UROLOGIST

I refer to the above Early Alert which was notified to the Department on 31 July 2020, and the subsequent report submitted to the Department via the HSCB on 15 October 2020, summarising the Trust's ongoing scoping and management of the issues arising from it.

Whilst I fully appreciate the complexity of this task and the intensive efforts by Trust colleagues to date to quantify these issues and to ensure that no patients come to harm as a consequence, the Department's view is that this process will benefit at this stage from a commensurate level of external oversight and assurance. Further to our discussion today I have therefore attached at **Annex A** draft terms of reference for a Department-led assurance group which I will chair in order to review progress and guide the way forward in terms of the Trust's management plan. It is my intention that the Urology Assurance Group will begin to meet from next week in order to agree the terms of reference and discuss the immediate next steps. Michael O'Neill, Acting Director of General Healthcare Policy, will lead on this in the Department and provide secretariat for the group.

Yours sincerely

Personal Information redacted by the USI

RICHARD PENGELLY
ACCOUNTING OFFICER

cc.

CMO

CNO

Lourda Geoghegan

Naresh Chada

Jackie Johnston

David Gordon

Michael O'Neill

Ryan Wilson

Maria O'Kane, SHSCT

Sharon Gallagher, HSCB

Paul Cavanagh, HSCB

Olive MacLeod, PHA

Brid Farrell, PHA

Tony Stevens, RQIA

Emer Hopkins, RQIA

**UROLOGY ASSURANCE GROUP
DRAFT TERMS OF REFERENCE****Background**

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAls to date, and advising of additional patient safety concerns identified in the course of this exercise.

Objectives

In light of the concerns identified a Department-led Urology Assurance Group will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

Membership

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Interim Chief Executive, HSCB/PHA
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Dr Tony Stevens, Interim Chief Executive, RQIA
- Emer Hopkins, Interim Director of Improvement, RQIA
- Shane Devlin, Chief Executive, Southern Trust
- Maria O'Kane, Medical Director, Southern Trust

- Lourda Geoghegan, Deputy Chief Medical Officer, DoH
- David Gordon, Director of Communications, DoH
- Ryan Wilson, Acting Director of Secondary Care, DoH
- Michael O'Neill, Acting Director of General Healthcare Policy, DoH,
- Anne Marie Bovill, General Healthcare Policy

Support

Secretariat will be provided by General Healthcare Policy Directorate and meetings will initially be held fortnightly, but will be subject to review.

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director, Acute Services IMWH and CCS

Staff Number: Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? Post Outlines can be accessed via Trust Intranet (KSF link) YES ☒ NO ☐ Have Post Outline levels been achieved: YES ☒ NO ☐ If no, record below what action to be taken:	Staff members comments on his/her performance over past year: Personal Information redacted by the USI Line Manager's Feedback on staff members performance over past year: Personal Information redacted by the USI

Objectives for Next Year (draft for discussion at 1:1)

- Agree and implement a sustainable staffing model for the Microbiology specialty in the Laboratory during 2021/22
- Review the staffing models in other laboratory specialties including Clinical Chemistry and Haematology / Blood Bank during 2021/22
- Support the implementation of the recommendations from the Urology SAI Review. This will include implementation of enhanced support to MDTs and enhanced tracking for some tumour sites, starting with Urology. A new role of MDM Administrator (Band 6) should be considered as a priority, supporting improved data sharing with chairs of MDTs and enhanced support for audit
- Work with MDT Chairs, ADs and HOS to develop and implement Cancer Rebuild Plan to address the backlog of Cancer cases which have developed during the COVID19 Pandemic. This will include supporting tumour sites to meet 31 and 62 day pathways.
- Develop a proposal for a new 'safety net' process to reduce the instances whereby radiology reports are not acted upon by the referring clinician. This 'safety net' process will focus on reports for urgent / unexpected findings. This new service will address trends from SAIs. This new service will require additional funding to be implemented.

- Continue to work with the Director of Acute Service and Capital Allocations Group to replace key radiology equipment during 2021/22 as part of the 10 year equipment replacement program
- Work with the Radiology Team to secure the Quality Standards for Imaging (QSI) accreditation during 2021/21
- Implement 7 day working for rehabilitation for Acute Physiotherapy and Occupational Therapy before Autumn 2021
- Continue to work with the Head of Midwifery to improve Midwifery staffing levels
- Continue to work with CDs in IMWH and Head of Midwifery to address themes highlighted through the whistleblowing correspondence received in June 2019.
- Work with the IMWH Team to implement learning emerging from DHH PPH cases and DHH 'never event'

Reviewee Staff Name (Print)

Barry Conway

Signature

Personal Information redacted by the USI

te

6/5/21

Reviewer Manager/Supervisor (Print) **Melanie McClements**

Signature

Personal Information redacted by the USI

Date 5/5/21

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Completed	
	Departmental Induction/Orientation	Completed	
	Fire Safety	4 May'21	
	Record Keeping/Data Protection	Due	
	Moving and Handling	Dec'19	Due December 22
	Infection Prevention Control	4 May'21	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	4 May'21	
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
	Professional Registration	N/A	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)	Development programme for Assistant Directors – discuss support for application to 'Proteus' programme - 9 days – 4 of which are residential	Due to start Autumn'21	

Reviewee Staff Name (Print)

Barry Conway

Signature Personal Information redacted by the USI

Date

6/5/21

Reviewer Manager/Supervisor (Print)

Melanie McClements

Signature

Melanie McClements

Date 5/5/21

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO:

Personal Information redacted by the USI

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director, Acute Services IMWH and CCS

Staff Number: Personal information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? Post Outlines can be accessed via Trust Intranet (KSF link) YES ☒ NO ☐ Have Post Outline levels been achieved: YES ☐ NO ☐ If no, record below what action to be taken:	Staff members comments on his/her performance over past year: Personal information redacted by the USI
	Line Manager's Feedback on staff members performance over past year: Personal information redacted by the USI

Objectives for Next Year:

- Finalise the 10 year equipment replacement programme for Radiology across the Trust by January 2020
- Complete a demand and capacity exercise for Radiology by modality by March 2020
- Establish improved governance arrangements across IMWH with an increased focus on cross site working
- Work with the clinical teams in IMWH to review c-Section rate on an ongoing basis to help reduce the c-Section rate in DHH
- Review the on-call arrangement and overnight cover in DHH laboratory with a view to establishing a more sustainable staffing model by June 2020
- Work with the laboratory team to support the implementation of the regional pathology transformation programme
- Embed the new Cancer Strategic Forum in the Trust and establish its role in setting the future direction for delivery of Cancer Services
- Work with the HOS for Cancer and the wider teams to help support improved performance against the 62 day pathway for Cancer
- Implementation of 7 day working for Physiotherapy and Occupational Therapy by March 2020
- Work with HOS re Recruitment and retention and progress plans for targeted investment including SALT and Paed Physio

Reviewee Staff Name (Print)

Barry Conway

Signature _____ Date

Reviewer Manager/Supervisor (Print) **Melanie McClements**

Signature _____ Melanie McClements _____ Date 4/12/19

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number:

Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Completed	
	Departmental Induction/Orientation	Completed	
	Fire Safety	Applied for place	
	Record Keeping/Data Protection	Completed	
	Moving and Handling	Completed	
	Infection Prevention Control	Completed	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	Completed	
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
	Professional Registration	N/A	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Personal Information redacted by the USI

Reviewee Staff Name (Print)

Barry Conway

Signature

Date 4/12/19

Reviewer Manager/Supervisor (Print)

Melanie McClements

Signature Melanie McClements

Date 4/12/19

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO:

Personal Information redacted by the USI



**Southern Health
and Social Care Trust**

INDIVIDUAL PERFORMANCE REVIEW

Name: **Melanie McClements**

Year: **2020/21**



Southern Health
and Social Care Trust

Individual Performance Review

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes and by March 2021 Measures of Success
Covid-19 - To ensure maximum patient safety and best outcomes for care delivery for patients during pandemic.	- Refresh Acute Pandemic Plan with operational/MDT's and implement and continuously apply learning; - Agree Infection, prevention control measures in line with PHA/HSCB/DOH guidance and local microbiology /IPC/Estates teams; - Oversee cohorting of covid, non covid and query covid/clinical covid patients; - Staff health & wellbeing focus to sustain staff and safe workforce levels; - CCaNNi surge plan development and implementation with regional units.	Daily operational cross directorate meetings attended for collaborative approaches and evaluation of approaches to influence next steps. Pandemic plans amended and implemented in response to pandemic surges, learning from transmission and patient deaths. SAI review commenced to ensure learning and its application following Covid related deaths. Positive feedback from patients /families and staff.	Learning from 20/21 year carried into 21/22. Refresh & Rebuild plans in place. Planning for next potential surge (summer /autumn 21 as per modelling) underway to ensure optimal patient and staff safety. Address outstanding staff concerns.

To maintain, through prudent financial control and resource investment, sustainable financial viability to enable the Trust to achieve its purpose and goals and achieve its statutory and financial duties whilst delivering safe, effective care. - Related workforce actions	4 main workstreams implemented: - Medical Payroll; - Nursing and Other Payroll; - Non-Payroll; - Speciality Costs & Document Review. - Acute Revenue paper to be developed to detail all “at risk” and uncommissioned services, including all changes to bed numbers, workforce pressures, nurse to bed ratio and the change in acuity. - To analyse nursing and medical expenditure and embed alternative incentives and options to agency.	All co-produced working groups, analysed and interpreted each area and agreed areas for action under “Return To Balance” Conversion of Medical Agency posts to substantive positions; Completed. - for HSCB/ Commissioner Medical expenditure is more than £7.6m over budget, the main pressure being in the area of Medical training grades. There continues to be a requirement to use high cost flexible staffing. Flexible usage has increased by almost £0.5m in comparison to the prior year with total Medical Agency cumulative expenditure in excess of £13m. The areas most reliant on agency are General Medicine and ED. Nursing is £10m cumulatively overspent. Expenditure has risen by £9m when compared to the first 11 months of last year. Recruitment/ retention issues persist so high cost flexible usage continues to be the main factor in safely staffing wards. Agency accounts for almost £17m of the nursing spend to date (growth of over £1m from the prior year). General Medicine and ED are the areas with the largest Agency cost YTD.	£800k of savings delivered in 2020/21 To pursue the potential for converting all other agency to substantive posts, where appropriate and where recurrent need is demonstrated. This could achieve a spending reduction of at least a further £4m. Rapid Response payment for Covid and Critical Shift payments introduced with impact in reducing agency expenditure To work with the Directorate of Nursing, Midwifery and Allied Health Professionals to prepare an investment paper for HSCB and address normative nursing gaps.
---	--	--	--

To address unscheduled care pressures and support new models of working	- Continue meetings with DHH Consultant body, operational Management and MD to address a sustainable workforce. - To focus on medical gaps in CAH - Daily regional huddles to share and apply regional approaches. - Hospital Early Warning Score (HEWS) and action plan embedded in daily whole hospital approach. - Performance targets in ED daily monitoring and actioned. - Implement No More Silos work streams for ED, Urgent Care and Ambulatory pathways. - Improve interface working with primary care.	DHH staffing of middle tier and Consultants has been substantively rebuilt. CAH medical workforce paper developed with MDO office for investment support in 21/22. Networked model and good working relationships cross Trust. Learning applied in response to pandemic surges and patient demands. 4 hr and 12 target breaches in ED due to lack of capacity and flow. Discharge & Flow work stream established across Directorates. DHH relocated in Mar 20 to CAH (non-resp) and returned October 2020. Pathfinder active involvement. CAH (Resp Ed) now returned to full ED with segregations in line with IPC. Urgent Care development supported with primary care colleagues.	For Commissioner /Nimda consideration Performance plan ongoing. NMS Director oversight and LIG cross-directorate and with Primary Care / GP's. Influencing resource for best service model.
---	---	--	---

To address the urology concerns first noted in June 2020 with a focus on patient safety and quality care. - Consider Governance Personal Development	- Increase ambulatory care and prevention of admission options - Escalation and early alert. - Range of reviews of various patient groups under Consultant A to be carried out; - Work plan to meet evolving requirements of patients/staff; - Governance arrangements addressed and ongoing work plan. - Linked to broader Acute Clinical Governance agenda to apply learning as it evolves. - Focus this year will be developing good relationships with MDT colleagues and collective leadership.	New ambulatory services open in acute medicine and cardiology. Community pathways and coworking with OPPC. Completed. Weekly/fortnightly internal Trust, HSCB and DOH accountability meetings. 2455 reviews completed to date. Implemented. Partially implemented – evolving. Learning shared with ACG. Extremely effective co-working, respect and impactful performance.	Evolving in line with need and impact – evaluation ongoing. Investment plan developed. This is ongoing and related to patients and numbers of episodes Jan 19- June 20. Acute Strategic Action Plan for next 5 years in 21/22.
--	--	---	--

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date	Date(s) agreed for Interim Review	10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature
<i>MELANIE MCCLEMENTS</i>	MELANIE MCCLEMENTS	23/03 /20					



**Southern Health
and Social Care Trust**

INDIVIDUAL PERFORMANCE REVIEW

Name: Melanie McClements

Year: 2021/22



Southern Health
and Social Care Trust

Individual Performance Review

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes and by March 2021 Measures of Success
To develop an Acute Strategic 5 year Plan – Collective Leadership approach	- To coproduce a vision and strategic action plan with staff and planning colleagues through a series of Team/department and speciality meetings and fortnightly Café conversations for acute services. - To involve other stakeholders including Pathfinder, TUS and elected reps - To cost the additional elements of the service model and initiate commissioner discussions. - To align strategically with Elective Care framework, Cancer Strategy etc. - To ensure evolving Directorate structures are aligned to support the implementation of the 5 year plan.	- Involvement and planning process commenced in April 2021 with regular visioning meetings with teams every week and café conversations fortnightly until September 2021 - Discussed @ Pathfinder and JOF - Preliminary costings underway - Commissioner discussions - Structures alignment discussions	

Develop and implement General Surgery Model	- Trust membership on Regional General Surgery group to align plan - Local Trust support from Dr Simon Paterson Brown (Scotland) for development/planning meetings - Full model worked up and redeployment plan across sites. - Consultation consideration and EQIA	- Pathfinder advised and a Surgeon/Pathfinder meeting with detail planned - Interface meetings with specialities rolled out - NIMDTA discussions - - CAH ambulatory service part of capital development
Covid-19 - To ensure maximum patient safety and best outcomes for care delivery for patients during any further surge of pandemic.	- Refresh Acute Pandemic Plan with operational teams and continuously apply learning; - AD Huddles x 2-3 per week to oversee management of pandemic; - Implement Infection, prevention control measures in line with PHA/HSCB/DOH guidance and local microbiology /IPC/Estates teams; - Staff health & wellbeing focus to sustain staff and safe workforce levels; - CCaNNi surge plan implementation in line with regional network of units; - Covid SAI review – participate in Management Group and embed learning once report received.	- Plans updated with learning on ongoing basis - Plans developed including Respiratory, non-respiratory , covid and non-covid cohort management plan in line with IPC - Range of staff wellbeing and appreciation funded by E/G and psychology support in place - Daily CCaNNi calls and influencing regional and local plans for best pt. outcomes - SAI Report received and both family liaison and implement of recommendations underway.
To maintain sustainable financial viability to enable the Trust to achieve its purpose and	- Acute Revenue Pressures paper to be updated detailing all “at risk” and uncommissioned services, including all changes to bed numbers,	- Updated and costed and discussed with Directors/CEO and Commissioner.

goals and achieve its statutory and financial duties whilst delivering safe, effective care.	workforce pressures, nurse to bed ratio and the change in acuity. - To pursue the potential for converting medical and nursing agency to substantive posts, where appropriate and where recurrent need is demonstrated and to embed alternative incentives to agency. - CAH and DHH medical workforce papers to be developed with Consultant body & MDO office for investment support for Commissioner / NIMDTA consideration.	- Winter plans detailed under-commissioned beds, staffing etc. - Delivering Care resource received for nursing in Theatres, ED & ICU - Substantives Consultants appointed as cost-avoidance of locum replacement scheme. - Medical workforce review refreshed
To address unscheduled care pressures and support new models of working	- NMS Director oversight and LIG cross-directorate with Primary Care / GP's. - Chair & Implement No More Silos work streams for ED, Urgent & Primary Care. - Increase ambulatory care and prevention of admission options. - Discharge & Flow work stream to be further developed.	- NMS planning with co-Directors and interface across Directorates and Primary Care to shape model. - Chaired workstream 1 for UCC /ED and Ambulatory plan and implementation oversight. - Application for extension of NMS funding for ambulatory and for NR resource to cover in year expenditure. - Implement 3 regional targets, home by lunch, discharge to assess and nurse facilitated discharge

To support the urology Public enquiry and clinical services to ensure patient safety and quality care.	- Range of reviews of various patient groups under Consultant A to be carried out; - Work plan to meet evolving requirements of patients/staff; - Governance arrangements to be embedded and monitored through Task & finish group including Cancer & Clinical Services. - Link to broader Acute Clinical Governance agenda to review though SAI & SJR's and apply learning as it evolves. - New learning opportunities to: 1. maintain personal resilience 2. support for staff teams 3. focus on patients/families with the series of ongoing challenges in 21/22	- Look back exercise implemented and monitored with patient safety focus - Weekly oversight with teams and liaison with HSCB and accountability meetings with DOH. - Task & Finish live with focus on compliance with all recommendations - SAI x 10 + series of training and SJR processes underway - Ongoing personal coaching and mentoring with peers evaluated - Uptake of and implementation of learning opportunities to prepare self and support others for e.g. Urology and Covid-19 - Positive impact of Acute SMT impact of psychological support.	
--	--	---	--

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date	Date(s) agreed for Interim Review	10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature
<i>MELANIE MCCLEMENTS</i>	MELANIE MCCLEMENTS	25/03/21					

Initial call made to CMO Office (DoH) on 31.07.2020 DATE

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name Dr Maria O'Kane Organisation Southern Health and Social Care Trust

Position Medical Director Telephone Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. Urgent regional action
2. **Contacting patients/clients about possible harm**
3. Press release about harm
4. **Regional media interest**
5. Police involvement in investigation
6. Events involving children
7. Suspension of staff or breach of statutory duty

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) Personal Information redacted by the USI ; Personal Information redacted by the USI

Mobile (work or home) Personal Information redacted by the USI Telephone (work or home) Personal Information redacted by the USI

Forward pro-forma to the Department at: Personal Information redacted by the USI and the HSC Board at Personal Information redacted by the USI

FOR COMPLETION BY DoH:

Early Alert Communication received by: Office:

Forwarded for consideration and appropriate action to: Date:

Detail of follow-up action (if applicable)

Corrigan, Martina

From: McClements, Melanie
Sent: 08 July 2022 18:40
To: Corrigan, Martina
Subject: FW: marias aob notes

From: McClements, Melanie [Personal Information redacted by the USI]
Sent: 30 October 2019 16:48
To: Corrigan, Martina [Personal Information redacted by the USI]; Carroll, Ronan
[Personal Information redacted by the USI]
Subject: marias aob notes

Discussion- draft notes :

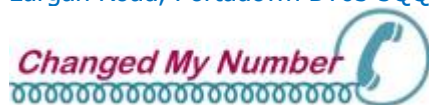
1. Concerns re escalation
2. Concerns re process
3. Concerns re pp and making arrangements for investigation through the NHS -?Interface with pp policy – letters no longer on NIECR – now the patients are on list without letter- consider how tracking
4. Plan point :1: How can each be monitored and how is this escalated if concerns? Monitor through the information office
 2. concerns re notes at home – weekly spot check? Meant to sign notes out – he has a condition on his action point that he is not to take notes home – make assumption that if notes not in his office or clinic or theatre they are in his home? No transport to take notes between cah and swah. Monitoring difficult
 3. Martina can only monitor what she is given – his secretary has not engaged. Martina has had to go onto ECR to check if notes uploaded.
5. IR1 went in from MDT on Wednesday last re 1st delayed cancer patient – AOB letter on patient sent Friday
6. 2nd patient did not come to harm following escalation to MDT by trackers which builds contingency checks in to system for all clinicians in urology

Plan :

1. Will ask Mr McNaboe to discuss concerns with AOB to make aware that this has been raised with the MHPS case manager – on leave until Monday
2. Will consider escalation plan including option to exclude
3. Will consider the full system review September 2018 and progress

Melanie McClements

Interim Director of Acute Services
Craigavon Area Hospital
Lurgan Road, Portadown BT63 5QQ



Tel: [Personal Information redacted by the USI]
Email: [Personal Information redacted by the USI]
PA: [Personal Information redacted by the USI]

You can follow us on [Facebook](#) and [Twitter](#)

Incident Oversight Group

Tuesday 2th February 2021, 1:00pm

Via Zoom

AGENDA

1	Apologies	
2	Minutes	 MINUTES - Incident Group 08.12.2020.doc
3	Team Working - Maxine Williamson	
4	Private Practice - Private Practice Audit - Private Practice Patients transferred to HSC	
5	Update on Radiology and MDM Review	
6	IPT for Review Process	 Urology Inquiry IPT - draft 8 15.12.2020.c
7	Additional Subject Matter Expertise - British Association of Urological Surgeons - British Association of Urological Nurses	 RE Subject Matter Expertise.msg
8	Royal College of Surgeons Engagement - Terms of Reference - Team Membership - Selection of Records - Costing	 Draft Terms of Reference CLINICAL  RCS Review Team.txt  RE CONFIDENTIAL - Urology Assurance Gi
9	Bicalutamide Patient Review	 Clinical And Social Care Audit Registrati
10	Engagement of ISP to undertake waiting list work	
11	Telephone Support Service / Patient Triage Update	
12	MDM Processes	
Professional Governance		
13	GMC Discussions	
14	Litigation / DLS Update	
15	Grievance Process	
16	Administration Review Update	
Serious Adverse Incident (SAI) Reviews		
17	Update on Current SAI Progress	
18	Initial SAI Recommendations	 Action plan Person.docx
19	Structured Judgement Review Process	
20	Family Liaison Role	
Communications		
21	Media / Assembly Questions	

22	Personal Information redacted by the USI Complaint	 Personal Information redacted by the USI
23	Coronial Processes	
24	Letter to Staff re AOB Patient Reviews	  07.12.2020 - Memo - Identification of Varia UROLOGY PATIENT REVIEW FORM v1.do
25	Declaration re CURE	
26	Securing Records for Public Inquiry	 Letter to Chief Executives - Pubic Inc
27	Urology Timeline for the HSCB	 SHSCT Urology Timeline 2 Feb 21 MC
Date of Next Meeting		
28	Via Zoom – 10 th February 2021	

Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

	Item	Actions
1	In Attendance Stephen Wallace Melanie McClements Martina Corrigan Dr Maria O’Kane Dr Damian Gormley Jane McKimm Siobhan Hynds Mr Mark Haynes Patricia Kingsnorth	
2	Apologies Vivienne Toal Ronan Carroll	
3	Weekly DoH Update Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn’t likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required.	
Management of Patient Reviews		
4	Private Practice Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought.	DLS to update on AOB work
5	Update on Radiology and MDM Review No update this meeting, to follow next week	Update next meeting
6	IPT for Review Process Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process.	To be discussed at HSCB meeting
7	Additional Subject Matter Expertise Group reviewed the role description and agreed content.	
8	Royal College of Surgeons Engagement Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate.	
9	Bicalutamide Patient Review No further update	
10	Engagement of ISP to undertake waiting list work Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December.	Martina / Mark to discuss with

		Message
11	Information Telephone Line Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT. Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holding letters should be issued.	Holding letter to patients to be issued
Professional Governance		
12	GMC Discussions Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15 th December 2020.	
13	Litigation / DLS Update Next meeting – update covered in item 4	
14	Grievance Process Next meeting	
15	Professional Alert Letter Next meeting	
16	Administration Review Update Next meeting	
Serious Adverse Incident Reviews		
17	Update on Current SAIs Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines.	Patricia to write to AOB on SAI Chair behalf
18	Initial SAI Recommendations Recommendations are in progress, update to be provided at a future meeting	SJR model to be discussed with the HSCB
19	Structured Judgement Review Process Next meeting	
20	Family Liaison Role Liaison role closes on Friday this week.	
Communications		
21	Media / Assembly Questions No update this week	
Any Other Business		
22	Coronial Processes Next meeting	
23	Letter to Staff re AOB Patient Reviews Letter agreed	
24	Declaration re CURE	
25	Securing Records for Public Inquiry	
Date of Next Meeting		
26	Via Zoom – 15th December 2020	



Quality Care - for you, with you

Strictly Confidential

Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
 - Offering additional clinical activity
 - Provide complaints resolution
 - Media queries, Assembly Questions responses
 - Managing the volume of patients who require to be reviewed
 - Patient Support (Psychology / Telephone Support / Liaison)
 - Staff Support
 - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. [\(Patients returned with management plan are included in Table 3.2/Table 3.4\)](#)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 --Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	Band	WTE
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective [and the acquired learning process and may include:-](#)

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents

- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests [\(DLS 20%\)](#)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAls. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

Risk Identified	Mitigation Measure
Recruitment of experienced staff –	- Complete recruitment documentation as soon as possible - Liaise with Human Resources
Staff Backfill	Complete recruitment

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.



TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust
under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of a Trust Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases who were under the care of the Consultant between the period January 2015 – December 2015 put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices;
- Communication with the patient, their family and patient consent;
- Communication with General Practitioners;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc)).
- Actions taken as a result of Multidisciplinary Meeting recommendations
- Administration in connection to the patients episode

Conclusions and recommendations

The review team will, where appropriate:

- Raise any immediate patient safety issues that are identified during the course of the engagement with the Medical Director of Southern Health and Social Care Trust
- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.
- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Dear Dr O’Kane,

I hope you are well.

I am writing with further information about the invited review that you have commissioned from the Royal College of Surgeons of England.

The invited review team

The team appointed to undertake this review is as follows:

- Clinical Reviewer: Mr David Jones FRCS
- Clinical Reviewer: Mr Jonathan Glass FRCS
- Clinical Reviewer: Mr Mark Speakman FRCS
- Clinical Reviewer: Mr Brian Birch FRCS

With best wishes,
Jessica

Jessica Govier-Spiers
Invited Review Coordinator

Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE

T: Personal Information redacted by the USI
E: Personal Information redacted by the USI
W: www.rcseng.ac.uk

Disclaimer

The information contained in this communication from the sender is confidential. It is intended solely for use by the recipient and others authorized to receive it. If you are not the recipient, you are hereby notified that any disclosure, copying, distribution or taking action in relation of the contents of this information is strictly prohibited and may be unlawful.

Dear Dr O’Kane,

I hope you are well.

I am writing with further information about the invited review that you have commissioned from the Royal College of Surgeons of England.

The invited review team

The team appointed to undertake this review is as follows:

- Clinical Reviewer: Mr David Jones FRCS
- Clinical Reviewer: Mr Jonathan Glass FRCS
- Clinical Reviewer: Mr Mark Speakman FRCS
- Clinical Reviewer: Mr Brian Birch FRCS

With best wishes,
Jessica

Jessica Govier-Spiers
Invited Review Coordinator

Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE

T: Personal Information redacted by the
USI

E: Personal Information redacted by the USI

W: www.rcseng.ac.uk

Disclaimer

The information contained in this communication from the sender is confidential. It is intended solely for use by the recipient and others authorized to receive it. If you are not the recipient, you are hereby notified that any disclosure, copying, distribution or taking action in relation of the contents of this information is strictly prohibited and may be unlawful.

Kelly, Elaine

From: Wallace, Stephen
Sent: 28 January 2021 11:58
To: 'O'Neill, Michael (DoH)'
Subject: RE: CONFIDENTIAL - Urology Assurance Group Meeting - Friday 8th January 2021

Area	Number of Charts
All Penile, testicular and renal	6 Cases in total
Prostate	15
Invasive Bladder	10
Raised PSA (Out Patients)	15
Haematuria (Out Patients)	15
Female Lower UTI	10
Male Lower UTI	10
Ureteric Colic	10
Andrology	10

Audit Title: Audit of Prescribing of anti-androgen medicine 'Bicalutamide'			
Directorate: Acute Services ☒ Children & Young People ☐ Older Persons & Primary Care ☐ Mental Health & Disability ☐ Corporate request ☐			
Division:			
Auditor's name: Mr Mark Haynes		Audit Supervisor's Name : Not Applicable	
Contact details: (email) Personal Information redacted by the USI			
Is this a: National audit ☐ Regional audit ☐ Trust audit ☒ International audit ☐			
Proposed audit commencement date 27 th October 2020		Proposed audit completion date .../.../....	
Audit Aims			
To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management			
Audit Objectives			
- To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage - To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages - To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care - To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale			
Audit Standards			
The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management Published date: 09 May 2019.			
Audit Criteria	Target	Exceptions	Source of Evidence
Bicalutamide prescribed as per indicated conditions in NICE NG131	100%	Clinical rationale for deviation from guidance	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg).	100%	Discussions with patient / Clinical rationale	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Audit Methodology			
The following audit methodology will be followed: - HSCB to provide information on primary care prescriptions of the medication Bicalutamide - Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management			
Rationale for the audit (please tick all that apply)			
Topic is included in the Directorate's clinical audit work-plan		☐ Compliance with standards & guidelines ☒	

National Healthcare Quality Improvement Partnership (HQIP) audit	☐	Regional RQIA/GAIN audit	☐
Other national / international audit	☐	Trust based audit topic important to team/division	☒
Clinical risk	☒	Recommendation from national / regional report	☐
Serious Adverse Incident or Adverse Incident review	☒	Clinician / personal interest	☐
Incident reporting	☐	Educational audit	☐
Other – please specify			
Level 1 ☐ Level 2 ☒ Level 3 ☐ Level 4 ☐			
Has this audit been approved based on the priority level? Yes ☒ No ☐			
Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 3 – Approval required by Supervising Consultant Level 4 – Approval required by Supervising Consultant Please be advised that the audit cannot proceed without approval as above.			
Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above. The clinical audit team will also advise contact with Information Governance for any advice required.			
The clinical audit team can be contacted via: Email: Personal Information redacted by the USI Tel: Raymond Haffey Terri Harte Sandra McLoughlin Personal Information redacted by the USI Mary Markey Roisin Feely Philip Sullivan Personal Information redacted by the USI			
<i>In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with: the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team</i>			
Please submit your audit registration form to: Personal Information redacted by the USI			

Priority levels for clinical audit

Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	- National audits not contained within the HQIP list, or other clinical audits arising from: - Clinical risk - Serious untoward incident / internal reviews - National Institute of Clinical Excellence Standards & Guidelines - Complaints - Re-audit - Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	Local topics important to the division	3
Level 4 audits	- Clinician / personal interest - Educational audits	4

Action Plan Urology

Personal
Information
redacted by

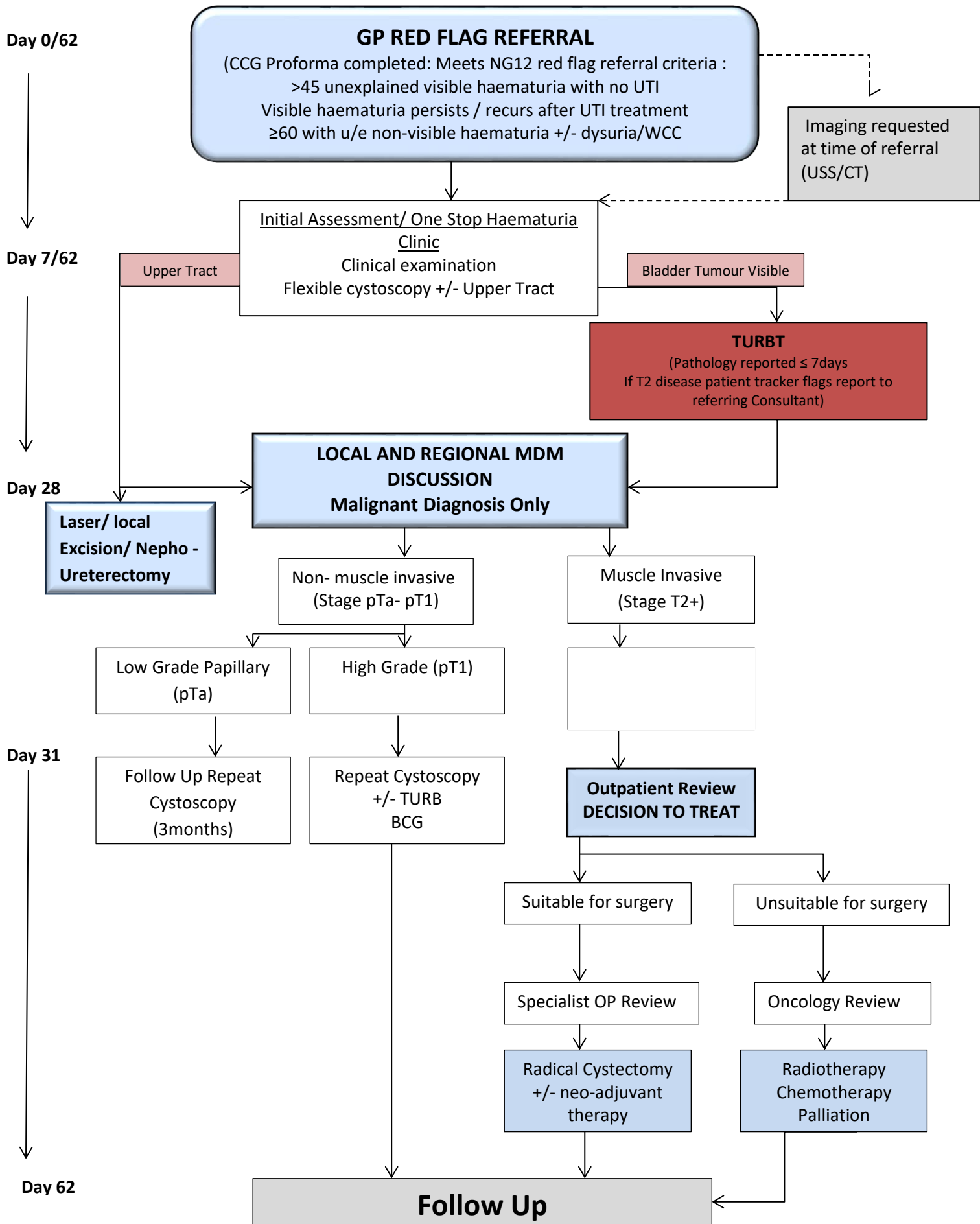
Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB	See recommendation 5		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB			
3	HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.	HSCB			
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB			

5	TRUST Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		NiCan pathway.  Bladder Cancer Pathway March 2020  Revised Prostate Diagnostic Pathway C  Female Lower Urinary Tract Sympto  Female Urinary Tract Infection.docx  Male Lower Urinary Tract Symptoms.docx  male urinary tract infections.docx
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	Jan 2021	

7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	 Integrated Elective Access Protocol - Apr  Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. Imca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	
10	The Trust must set in place a robust system within its medical management hierarchy for highlighting	MD			

	and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.				
11	Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD			
12	Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.	MD			

NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



Incident Management

ID	Element	Actions Required	Responsible	Date for Completion	Attachments	Complete
1	GMC Request for Information 27th July 2020	GMC Response issued, further update information required regarding patient notes for original 5 SAls	M Corrigan / S Wallace	27th August	Response attached  4CA5AFA5.msg	In progress
2	MHPS Investigation (New)	Response from AOB solicitor awaited regarding participation in the MHPS process. AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020. DLS advice to be sought on continuing MHPS process	M O'Kane / S Hynds / S Wallace	8th September		In progress
3	Administration Review	Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. Report due to be presented to the Director of Acute Services	R McCullagh / M Donnelly	30th September		In progress
4	Screening of potential SAls - Service User A - Service User B - Service User C - Service User D - Service User E - Service User F - Service User G	Three SAls screened, (Service Users A, B and C). Further 4 cases to be screened	M Haynes / M Corrigan / P Kingsnorth	1st September	SAI Screening complete - 3 confirmed SAls - clinical summaries  \\svrfile11\users6\$\stephen.wallace\Desktop\New  \\svrfile11\users6\$\stephen.wallace\Desktop\New  \\svrfile11\users6\$\stephen.wallace\Desktop\New	In progress
5	Communication with Service Users / Families	S Wallace / P Kingsnorth to discuss potential content of family communications with Jane McKimm. Further discussion with PHA / HSCB re approach also required	M Haynes / P Kingsnorth / S Wallace / J McKimm	8th September		In progress
6	Conducting SAls	Leadership centre had been approached to identify a SAI chairperson to conduct the SAI's. This process was required to go to mini-competition and will be concluded next week. BAUS have been contacted via the RCS to identify both a subject matter expert with regard to the SAI's and to assist with identifying an appropriate IRS sample.	S Wallace / P Kingsnorth	10th September		In progress

7	Engagement of ISP to undertake waiting list work	Draft contract engagement document under development pathways for service access to be mapped	M Haynes / M Corrigan	3rd September	Pathways under development	In progress
8	Lookback Scope	Contact with IRS re lookback scope who have suggested a sample taken over last five years. IRS potentially can carry out casenote review lookback during October- Nov. Realistically this will be a maximum of 80 patient charts Regional lookback policy reviewed, contact made with DoH (Jackie Johnston) who has advised that potential lookback scope should be discussed with PHA / HSCB in the first instance Data activity for 5 years for AOB collated. To consider all elements of practice 5 year activity being mapped for AOB -Inpatient Elective -Inpatient Emergency -Outpatients -Review Appointment - Cancer -Review Appointment - Non-Cancer	M McClements / M Haynes / S Wallace / M O'Kane / M Corrigan / R Carroll	1st September		In progress
9	Clinician Early Alert	M O'Kane / S Wallace to discuss Clinician Early Alert with DoH	Dr Maria O'Kane / S Wallace	27th August		
10	AOB work at other Trusts	To identify if AOB conducted sessions at other Trusts outside of SHSCT employment	S Wallace / M Corrigan	1st September	Preliniary enquiries have not identified any additional sessional work directly with other regional Trusts	No
11	Copies of Patient Records (Service users A and B) to be provided to AOB)	Copies of notes to be sourced, copied and redacted	M Corrigan	7th August	Redaction of notes being completed 7th August, viability of electronic sharing of notes to be considered	Complete
12	Early Alert to DoH	Early Alert issued to DoH and HSCB	Dr Maria O'Kane / S Wallace	31st July	Early Alert issued to DoH and HSCB. Phone contact made from Dr O'Kane to Deputy CMO 6th August 2020	Complete
13	Information on Appraisal, Job Planning and Complaints	Information on appraisal, job planning and complaints collated	S Wallace	7th August	Information Collated - saved in shared folder	Complete
14	Incident Governance Oversight	Terms of reference developed - for agreement by oversight group / SMT CX	Dr Maria O'Kane / S Wallace	10th August	ToR Agreed	Complete

Quality Care - for you, with you

17th August 2020

Ref: MOK/ec

Via email

Personal Information redacted by the USI

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

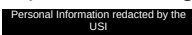
Dear Mr Brammall,

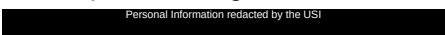
RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.

A copy of Mr O'Brien's job plan	Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30 th July 2020.
Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that	The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28 th July 2020 which explored the options for and extent of any potential lookback should this be required. A follow up call was conducted on 4 th August with the

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Tel: 

Email: 

may have arisen out of any review	Royal College of Surgeons Head of Invited Review manager where potential scale and scope of a lookback was discussed. The Trust will be discussing the potential for progressing with any lookback with the Department of Health over the next week.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust has commenced preliminary enquiries in respect of the additional concerns which have now arisen under the MHPS Framework. Mr O'Brien's former clinical manager Mr Haynes, as Associate Medical Director, is the clinical manager co-ordinating preliminary enquiries under para 15 of Section I of MHPS. Mr O'Brien has been notified of this and a request has been made for his input to the preliminary enquiries process. A formal investigation has not been commenced at this point. Mr O'Brien is seeking advices in respect of his engagement in the MHPS preliminary enquires process and the Trust awaits his decision in this regard, via his solicitor.
Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?): • Patient 14 • Patient 11 • Patient 13 • Patient 12	The Serious Adverse Incident Reviews for the listed patients have been completed. Copies of the review which was provided in a consolidated single report can be found attached in Appendix 2.

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

Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	Both Service User A and B have been screened and meets the requirement for a Serious Adverse Incident review and are being progressed as per regional and Trust processes. Since our last update a third case, Service User C has also been identified as meeting the requirement for a Serious Adverse Incident review.
Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mis-triaged	The Trust does not have formal data on the triage comparison between Mr O'Brien and his peers. All incidents have been identified by exception; no other triaging related incidents have been identified with any other Urology Consultant.
The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)	The review of administrative procedures is underway and will be shared following completion in September 2020 at which point a copy will be shared with the GMC.
Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien	The Trust do not use the three tier system for triaging but follow the Northern Ireland Cancer Network (NICA) referral guidance, which is based on NICE guidelines. Appendix 3 show the prostate and bladder guidance for triage (which is usually updated every year) and which is shared and used by all urology consultants in Northern Ireland.

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

The relevant medical records for service user A and service user B as identified in the more recent concerns.	Copies of Service Users A and B redacted notes are attached as Appendix 4.
The relevant medical records for the following patients as identified in the concerns originally sent to the GMC. • Patient 10 • Patient 14 • Patient 11 • Patient 13 • Patient 12	Copies of the patient will not be available until 24th August 2020 and will be forwarded following this.
Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management	The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress. The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

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

Northern Ireland Cancer Network (NlCaN) referral guidance

The Northern Ireland Cancer Network (NlCaN) referral guidance issued in 2012 was informed by the NICE Referral Guidelines for Suspected Cancer 2005. NICE issued revised guidance, Suspected cancer: recognition and referral (NG12) in 2015 which sets out suspect cancer referral guidance for all cancers. The CRG recently undertook a review of the referral guidance for patients with suspect prostate cancer and proposed alternative guidance. Based on a review of other pathways across NHS England, HSE Ireland and considering evidence from the Prostate Cancer Risk Management Programme, Stockholm STHLM3 JNCI J National Cancer Institute 2016.

The revised guideline, whilst cognisant of the NICE recommendations, provides additional detail to help guide primary health care professionals in their decision making in relation to when to undertake PSA testing and when to refer patients as suspect cancer. The CRG completed a review of the Pre PSA Testing Advice leaflet given to patients by their GP and with the help of the NlCaN Readers Panel updated this to ensure the information would offer the best advice to those who were considering having a PSA test. Pre-PSA Testing Advice Leaflet

The revised guidance has been approved by the NlCaN Board, the HSCB and is supported by NIGPC: GP Suspect Prostate Cancer Referral Guidance Pathway. Alongside the development of revised referral guidance for suspect prostate cancer the CRG is undertaking a review of the diagnostic pathway which is in the final stages of approval. This pathway will help navigate patients through the diagnostic pathway ensuring timely and appropriate investigations are completed to determine each patient's treatment care plan.

NICA SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

Initial Assessment

- DRE
- Flow Rate (with moderate symptoms, IPSS >8)
- Residual volume
- Consider Assessment of Prostate volume / PSA Density
- ECOG status
- Charlson Co-morbidity index:
<https://www.mdcalc.com/charlson-comorbidity-index-cci>

ECOG <2 or CCI <5

PSA <20 and
ECOG ≥2 or
CCI ≥5

Abnormal DRE
PSA >20
• Biopsy
• CT/ Bone Scan
• +/- MRI

Benign DRE and
PSA >20: **MRI**
OR
Benign DRE and
PSA >40: **Biopsy**

DRE normal
And
PSAD (US/ DRE) <0.1

Abnormal DRE
Or
DRE Normal and
PSAD (US/DRE) >0.1
Or
PSADT (on PSA
Monitoring) <4yrs

MRI prostate

MRI PSAD <0.15
And
MRI No
Abnormality

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring

(Education of patients regarding PSA monitoring,
alert symptoms and access to services)

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality

(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

PIRADS 3 and PSAD <0.15
discuss options of PSA
monitoring and biopsy,
context of imaging and
PSA history with patient
and proceed according to

MRI PSAD ≥0.15
Or
PIRADS 3/4/5
abnormality

**Watchful Waiting /
Symptomatic management**

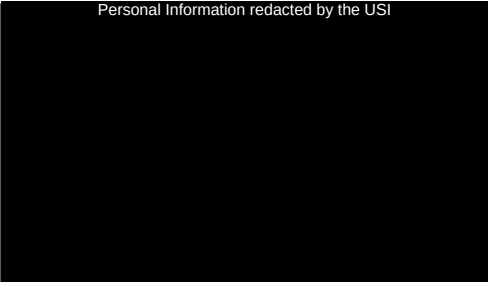
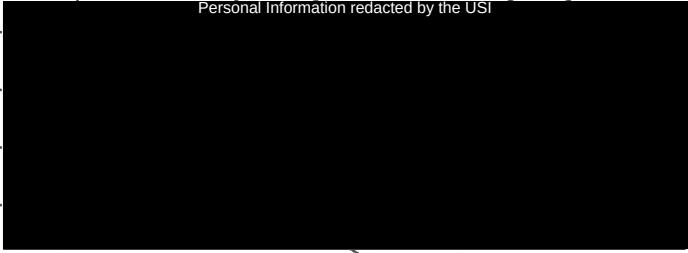
(Refer to NICA Watch and Wait Pathway)

Guidance Notes

To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.

Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.

Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

		Date	Clinical Notes
→		18.01.15	mc O'Brien
Age			Urology
URINE Protein			PRON
Sugar			
Acetone			
WEIGHT			
	kg.		• MRV ? • DMSA
→			• CPEX • ECHO
Age			• MIDM
URINE Protein			
Sugar			
Acetone			
WEIGHT			
	kg.		
→		19.2.19	PRON
Age			• RIGHT RADICAL NEPHRECTOMY
URINE Protein			06 MARCH 19
Sugar			
Acetone			
WEIGHT			
	kg.		
→			
Age			
URINE Protein			
Sugar			
Acetone			
WEIGHT			
	kg.		

Personal Information redacted by the USI

Personal Information redacted by the USI

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept
Address
Consultant

Patient 5

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	7/3/19	T-Town CONS Lubing
Age		
URINE Protein Sugar Acetone		
WEIGHT		- DAY 1 Right Nephrectomy
kg.		
→		- ITH - Norchenline
		- mobile
Age		- 14g 9x →
URINE Protein Sugar Acetone		- 1500 Sup. 2000
WEIGHT		
kg.		
→		- Blood
		- E+D
Age		- Chest Exercise/physio
URINE Protein Sugar Acetone		
WEIGHT		
kg.		

Personal Information redacted by the USI

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 5

Personal Information redacted by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	09/03/19	WR Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		Day 1 Right nephrectomy.
WEIGHT kg.		
→		Plan: - Pain team review ✓ ? stop Spidars - Keep drain until Monday. - ↑ oral fluids - Chest physio - Daily bloods.
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.	09/03/19	C.O' CONNOR PI Personal Information redacted by the USI
→		Hb 86(80) ↑ WCC 10 (12) pH 7.3 (7.35) ↑ CRP 40 (54) Na 136 (141) K+ 4.8 (4.7) eGFR 45 (>60)
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		N.B. AKI.
→		Plan: fluids, encourage oral intake, medication review.
		Personal Information redacted by the USI

LPC 03/08/021

WPH000134

	Date	Clinical Notes
→	10/3/19	Fr - cons
Age		
URINE Protein Sugar Acetone		- feels well E + D ✓
WEIGHT		- 700 to 800
kg.		- Epidural
		- Pain controlled
→		P. D. Anest. - epidural removed
Age		
URINE Protein Sugar Acetone		
WEIGHT	10/3/1	Personal Information redacted by the USI
kg.	18:00	
		Pain.
→		Pb from to myself. Open Nephrectomy on 6th March
Age		
URINE Protein Sugar Acetone		
WEIGHT		Epidural in situ (D4)
kg.		- Pain free @ rest.
		- Regular paracetamol.
→		→ Deep Breathing ✓
		→ Sitting Out ✓
→		→ E + D ✓
Age		→ Alebile ✓
URINE Protein Sugar Acetone		→ Bowels x
WEIGHT		Plan
kg.		* Remove epidural tomorrow - enoxaparin held
		tonight + tomorrow morning.
		* Laxative.
		→ Contact if concerned.
		→ Pass M. Mulla

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only		Date	Clinical Notes
	→		
Age		11/3/19	WP [Redacted] Personal Information redacted by the USI
URINE Protein Sugar Acetone			Dx nephrectomy
WEIGHT kg.		NFUD0 appx	eGFR 43
			Hb 90
			wcc 8.4n
			drai 130ml cr
			- SOB well
	→		
Age			
URINE Protein Sugar Acetone			pla - blood
WEIGHT kg.			- ? drai our tomorrow
			- TPOC
			Patient 5
			[Redacted]
			Hb 95
			wcc 8.3
			vte RFLSOCED)
			CRP 68(AS) ^{RFL}
	→		
Age			
URINE Protein Sugar Acetone			
WEIGHT kg.			

	Date	Clinical Notes
→	12/03/19	WR Personal Information redacted by the USI
Age	09:15	
URINE Protein Sugar Acetone		
WEIGHT		Pt. feels well - sitting out ~40ml serous fluid in drain. Has been walking around ward
→		Plan → Remove drain today. → Re-commence warfarin - 4mg daily as per pt. → continue clexane until INR in range → (H) once INR in range → clexane
Age		
URINE Protein Sugar Acetone		
WEIGHT		
→		Personal Information redacted by the USI 1)
Age	12/3/19	Patient 5 Hb 95 CRP 52 Plt 291 WCC 8.96 INR 1.0
URINE Protein Sugar Acetone		
WEIGHT		U+E Na 137 K 4.6 Cl 97 urea 4.7 Scr 120 eGFR 50.
→		
Age	13/03/19	WR Personal Information redacted by the USI
URINE Protein Sugar Acetone		
WEIGHT		Pt Feels well at present No new issues Plan 1) INR, liaise with community to see if can be removed 2) (H)
→		Personal Information redacted by the USI

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 5

Personal Information redacted by the USI

NOTES

When used for In-patient follow-up ignore left-hand column.

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein Sugar Acetone		Patient 5
WEIGHT		FBP
kg		Hb: 97
		WCC: 16.7 (8.96)
		Ht: 361
		CRP: 57.78
→		
Age		UTE
URINE Protein Sugar Acetone		Na 134
WEIGHT		K ⁺ : 4.8
kg		creat 123
		eGFR 48
		Personal Information redacted by the USI
→	13/03/19	Personal Information redacted by the USI
Age		Retropective note
URINE Protein Sugar Acetone		- Temp spike @ 12.00
WEIGHT		- Pt otherwise well
kg		- Denies infective symptoms
		Plan
		1) CXR, MSSU
		2) C/O Tazodin 4.5g 105

LPC 03/08/021

Personal Information redacted by the USI

PH000134

	Date	Clinical Notes
→		
Age		Patient 5
URINE Protein Sugar Acetone		Personal Information redacted by the USI
WEIGHT		
kg.	14/3/14	CR
	69.4g	
→		post nephrectomy - temp spike last night none since - pt. not at bedside
Age	NRWSO	
URINE Protein Sugar Acetone	apynexic	
WEIGHT	since 12 gals	plan - CT abdomen + pelvis - D/W m/cn - normal to MPT
kg.		
→		Personal Information redacted by the USI
Age	14/03/19.	Personal Information redacted by the USI
URINE Protein Sugar Acetone	16:50.	Patient 5
WEIGHT		CRP 179. INR 1.2. Na 134 Hb 87 (97) K ⁺ 4.5. P/E 34/6 Cl 99 WCC 12.8 urea 6.1 scr 138 eGFR 42.
kg.		
→		Phone call received from microbiology who advised 3 different bacteria have grown from blood cultures - significance will be known tomorrow. They advised: → continue Taracin. → if deteriorates add ceftazidime. → Re-contact tomorrow.
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		
		Personal Information redacted by the USI

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 5

Personal Information redacted by the USI

Personal
Information
redacted
by the
USI

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only		Date	Clinical Notes
→	29/03/19	CAOBUD - MR O'BRIEN	
Age			
URINE Protein Sugar Acetone		VERY WELL	
WEIGHT		RON	
kg.			
→		• CT-CAP IN JUNE '19	
Age		• REVIEW JULY 2019	
URINE Protein Sugar Acetone			
WEIGHT			
kg.			
→			
Age			
URINE Protein Sugar Acetone			
WEIGHT			
kg.			

Personal Information redacted by the USI

LPC 03/08/021

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

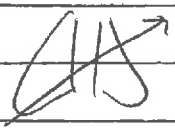
Patient 5

Personal Information redacted by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	30/10/19	Personal Information redacted by the USI
Age	700	
URINE Protein Sugar Acetone		Telephone call from McCreave Pharmist? reason to change from apixaban to edoxaban.
WEIGHT kg.		
→		- Notes reviewed - changed in A&U on admission - Notes reviewed from clinic letter
Age		from Dr. [Personal Information redacted by the USI] - no mention of edoxaban
URINE Protein Sugar Acetone		- renal function now @baseline.
WEIGHT kg.		- Diuretic given, advised switch back to apixaban.
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

	Date	Clinical Notes
→	21/10/19	WR Personal Information redacted by the USI
Age	09:55	- Hx noted. Admitted from clinic with
URINE Protein Sugar Acetone		AKI / ↓Hb.
WEIGHT		- Renal function back to baseline; eGFR = 41 (35)
kg.		furosemide / rebateson → Wheld.
→		- Note ECHO results. Denies SOB. Minimal
		peripheral leg oedema.
		- Hb = 94 ↔ Vit B12 / Folate (N).
		Iron (N).
Age		
URINE Protein Sugar Acetone		 HS 1 + 11 + 0.
WEIGHT		Personal Information redacted by the USI
kg.		
→		Plan / - Stop furosemide; aware to see GP
		& ↑ SOB / leg swelling.
Age		- Restart rebateson @ 150mg
URINE Protein Sugar Acetone		OD + GP to monitor BP.
WEIGHT		- Continue apixabens as per
kg.		pre-admission
→		- No need for USS kidneys as
		renal function recovered
		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by the USI]

E mail: [Personal Information redacted by the USI]

Secretary: Mrs N. Elliott

[Personal Information redacted by the USI]

Dear DR [Personal Information redacted by the USI]

Re: Patient Name:
D.O.B.:
Address:
Hospital No:

Patient 5

[Personal Information redacted by the USI]

I last wrote to you regarding this 89 year old man who had an open right radical nephrectomy performed earlier that month for renal cell carcinoma infiltrative of his right renal vein. I arranged for him to have a further CT scan of his chest, abdomen and pelvis performed on the 17th of June 2019 when there was no definitive evidence of any disease recurrence or progression.

I am aware that you more recently referred Patient 5 to the Department of Cardiology at Craigavon Area Hospital as he had become increasingly dyspnoeic and fatigued. He was found to be quite anaemic with a haemoglobin of 80g/L and his global renal function had also deteriorated somewhat, his glomerular filtration rate having decreased to 35mls/min. I am aware that he was admitted to the Department of Cardiology following consultation with Dr [Personal Information redacted by the USI] Consultant Cardiologist. Nephrotoxic medication was withheld. He was hydrated intravenously. Irbesartan was reintroduced at 75mgs daily upon his discharge on the 31st of October 2019, but I gather that the daily dose of Irbesartan has since been increased to 150mgs daily due to worsening hypertension.

I have had the opportunity of speaking with his daughter by telephone, she advising that her father was keeping somewhat better than he had been in recent months. I am aware that he has been prescribed Ferrous Fumarate. However, in addition, I do believe that he would benefit from being prescribed Folic Acid 5mgs to be taken once daily for a period of 3 months, particularly as he was found to be folic deficient in October 2019, and presumably still remains anaemic. Therefore, I would be grateful if you would issue a prescription for Folic Acid 5mgs to be taken once daily for a period of 3 months, and I have asked Patient 5 to collect a prescription from your practice.

I have requested the Department of Radiology at South Tyrone Hospital to arrange a further appointment for Patient 5 to have CT scanning of his chest, [Personal Information redacted by the USI]



Southern Health
and Social Care Trust

28/10/19

CHART

LJB



Personal Information
redacted by the USI

Patient 5

Dear colleague.

I saw this man today. He
had (R) nephrectomy for renal
cell carcinoma earlier this year.
Hb ~~not~~ has fallen to 80 and
renal function has deteriorated -
eGFR falling. I have advised
stopping apixiban and renal tonic
agents - IRBESARTAN, FOSFEMIDE.
Impaired 1) dehydration, ~~now~~
2) deterioration in renal function
3) Blood loss →

Hegarty

Personal Information redacted by the USI

Neerutikul
CARDIOLOGY



CARDIOLOGY DEPARTMENT
Craigavon Area Hospital
Lurgan Road
Portadown, Co Armagh,
BT63 5QQ
Secretary: Personal Information redacted by the USI
Telephone
Consultant

30/10/19

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name:
D.O.B.:
Address:
Hospital No:

Patient 5

Personal Information redacted by the USI

Personal Information redacted by the USI

H&C No:

I reviewed Patient 5 who attended today with his daughter. He has had an eventful year with right nephrectomy carried out under Mr Aidan O'Brien for renal cell carcinoma in March 2019.

In terms of previous cardiology history I note that in 2014 he was noted to have atrial fibrillation. He was anticoagulated and had DC Conversions. An echocardiogram showed normal LV function. Left atrium was dilated. He reverted to atrial fibrillation. He has changed to NOAC (Apixaban 2.5mg bd) more recently.

Since the urological surgery he has reported low energy. His Hb prior to surgery was 132. It has fallen to variable levels but most recently it was around 80 which likely accounts for his fatigue. His iron indices were low with ferritin at 12 on 7th of October. Indices tending towards macrocytic. Also of concern he has a deterioration in renal function which was previously normal. Most recent renal function shows a EGFR of 35 22nd of October.

On examination he appears pale and clinically dehydrated. Pulse 90 irregular. BP 110/70. Two heart sounds and no murmurs. Chest was clear.

ECG showed atrial fibrillation with control of ventricular response.

I reviewed his medications which include Apixaban, Irbesartan and Furosemide.

I note that a BNP is elevated on recent measurements. His previous echo showed normal LV function.

There are multiple medical issues on-going including dehydration, anaemia, deteriorating renal function and possible new onset heart failure. In the circumstances I felt the safest thing to do was to admit for work up. He may require transfusion and IV fluids. I have indicated that he should discontinue Apixaban and nephrotoxic ie: Furosemide and Irbesartan for the interim.

If his renal function does not recover he may need to change to Warfarin in view of his age.

Yours sincerely,

Dictated but not signed by

Personal Information redacted by the USI

Consultant Cardiologist

Personal Information redacted by the USI

Date Dictated: 28/10/19

Date Typed: 30/10/19

ED



Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [REDACTED]

E mail: [REDACTED]

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR [REDACTED]

Re: Patient Name: [REDACTED]

D.O.B.: [REDACTED]

Address: [REDACTED]

Hospital No: [REDACTED]

Patient 5

Personal Information redacted by the USI

Personal Information redacted by the USI

HCN: [REDACTED]

Personal Information redacted by the USI

Date/Time of Clinic: 29/03/19

Follow Up: Review July 2019

I last wrote to you in February 2019 when I arranged for Patient 5 to be admitted to our department on Wednesday the 6th of March 2019 when he underwent open right radical nephrectomy that day. His inpatient stay was prolonged by the development of a bacteraemia due to Enterobacter on the 13th of March 2019. After initial intravenous antibiotic therapy using Gentamycin and Tazocin, he was indeed fit for discharge on the 17th of March 2019 to remain on Ciprofloxacin for a further period of 1 week.

I reviewed Patient 5 on the 29th of March 2019 when I was absolutely delighted to find him keeping so well. He has had a remarkable postoperative recovery for a man of his age. I was able to advise him that histopathological examination of the resected right kidney confirmed the presence of a large, clear cell, renal cell carcinoma measuring 11cms in diameter, invasive of the renal vein, but without any evidence of resection margin involvement. Such a large renal cell carcinoma with venous and lymphovascular infiltration much be accompanied by a significant risk of occult microscopic disease. To this end, I have requested a further CT scan of his chest, abdomen and pelvis to be performed during June 2019, and I hope to review him with the report in July 2019.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

mu

Date Dictated: 12/04/19

Date Typed: 17/04/19-NE

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname Patient 5
 Forename [Redacted]
 Hosp. No. [Redacted]
 DOB/Sex [Redacted] Male
 Address [Redacted]
 Source CRAIGAVON AREA HOSPITAL
 Consultant MR A O'BRIEN
 Ward/GP WARD 1 WEST (ELECTIVE)
 CRAIGAVON AREA HOSPITAL
 68 LURGAN ROAD
 PORTADOWN BT63 5QQ

15 MAR 2019

Specimen KIDNEY RESECTION

CLINICAL DETAILS

Radical nephrectomy for renal tumour.

SPECIMEN – Right kidney.

PATHOLOGIST'S REPORT

GROSS DESCRIPTION

NATURE OF SPECIMEN:	Right radical nephrectomy.
ADRENAL GLAND:	Absent.
LYMPH NODES:	Absent.
IVC THROMBUS:	No
TUMOUR FOCALITY:	Large and unifocal.
TUMOUR DIMENSION:	110 mm.
TUMOUR EXTENT:	Grossly into major veins (present in proximal renal vein) – see comments
TUMOUR TYPE:	Clear cell renal cell carcinoma.
WHO/ISUP TUMOUR GRADE:	Predominantly Grade II with some Grade III.
SARCOMATOID MORPHOLOGY:	Not identified.

Reported by: [Redacted]
 Date of Specimen : 06 Mar 2019
 Date of report print : 13 Mar 2019

Sample Number: 19K03651

CRAIGAVON CELLULAR PATHOLOGY

Surname	Patient 5	Source	CRAIGAVON AREA HOSPITAL
Forename		Consultant	MR A O'BRIEN
Hosp. No	Personal Information redacted by the USI	Ward/GP	WARD 1 WEST (ELECTIVE)
DOB/Sex			CRAIGAVON AREA HOSPITAL
Address	Male		68 LURGAN ROAD
			PORTADOWN BT63 5QQ

Specimen **KIDNEY RESECTION**

RHABDOID MORPHOLOGY:	Not identified.
TUMOUR NECROSIS:	Not identified.
PERINEPHRIC FAT INVASION:	No.
INVASION BEYOND GEROTAS FASCIA:	No.
RIGHT RENAL SINUS INVASION:	Not identified.
TUMOUR PRESENT IN MAJOR VEINS:	Microscopically confirmed - see comments
LYMPHOVASCULAR INVASION:	Yes – intratumoural.
TUMOUR INVOLVES PELVICALYCEAL SYSTEM:	No.
RESECTION MARGIN STATUS:	Not involved.
CO-EXISTING PATHOLOGY IN NON-NEOPLASTIC KIDNEY:	None identified.
pTNM STAGE (UICC8):	pT3a – tumour extends into the renal vein.

Comments:

Gross examination showed a large tumour deposit bulging into the proximal renal vein corresponding to the appearances identified on MRI. Microscopic examination of this area confirms the tumour nodule though it is harder to appreciate this is renal vein

Reported by: Personal Information redacted by the USI

Date of Specimen : 06 Mar 2019

Date of report print : 13 Mar 2019

Sample Number: 19K03651

CRAIGAVON CELLULAR PATHOLOGYSurname **Patient 5**Source **CRAIGAVON AREA
HOSPITAL**

Forename

Consultant **MR A O'BRIEN**

Hosp. No.

Personal Information redacted by the
USI

DOB/Sex

Male

Ward/GP

WARD 1 WEST (ELECTIVE)

Address

Personal Information
redacted by the USI**CRAIGAVON AREA HOSPITAL****68 LURGAN ROAD****PORTADOWN****BT63 5QQ**Specimen **KIDNEY RESECTION**

involvement (Block B) but on balance it is felt to be proximal vein involvement in keeping with a pT3a tumour.

DIAGNOSIS**RIGHT KIDNEY****NEPHRECTOMY****CLEAR CELL RENAL CELL CARCINOMA****Electronically authorised by**

Personal Information redacted by the USI

Date:- 13/03/19

Personal Information redacted by the USI

Reported by: Personal Information redacted by the USI

Date of Specimen : 06 Mar 2019

Date of report print : 13 Mar 2019

Sample Number: 19K03651



Southern Health
and Social Care Trust

**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT**Telephone:**

Personal Information redacted by the USI

E mail:

Personal Information redacted by the USI

Secretary:**Mrs N. Elliott**

25/02/19

CONFIDENTIAL

Patient 5

Personal Information redacted by the USI

HCN: Personal Information redacted by the USI**Dear** Patient 5

I was pleased to have the opportunity of reviewing you once again on 19th February 2019. I write to confirm that I have arranged for you to be admitted to our department, on Wednesday 6th March 2019 for right radical nephrectomy that day. You will receive formal notification of your admission before then. You will be expected to arrive at the Elective Admissions Ward, Ward 1 West, at 8am that day. I would be grateful if you would ensure that you arrive anytime after 7.30am and no later than 8am, just in case any further blood tests need to be performed prior to surgery. It is critically important that you do not have anything to eat or drink after midnight the night before.

I also write to confirm that I have advised that you continue to take Warfarin as usual up until and including Thursday 28th February 2019. You should not take any Warfarin thereafter. I have written to your family doctor, Dr [redacted], requesting that the Practice Nurse administer Enoxaparin subcutaneously, 60mg on Monday 4th March 2019 and 40mg on Tuesday 5th March 2019. I have also requested that the Practice Nurse repeat your INR on Tuesday 5th March 2019.

Patient 5

Personal Information redacted by the USI

When you receive this letter, I would be grateful if you would contact
Personal Information redacted by the USI to arrange those appointments with the Practice Nurse on
Monday 4th March and Tuesday 5th March. I look forward to meeting you
again following your forthcoming admission.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon



**Southern Health
and Social Care Trust**

**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT

Telephone:

Personal Information redacted by the USI

E mail:

Personal Information redacted by the USI

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

**CONSULTANT ANAETHETIST
CRAIGAVON AREA HOSPITAL**

Dear

Personal Information redacted by the USI

Re: Patient Name:

Patient 5

D.O.B.:

Personal Information redacted by the USI

Address:

Personal Information redacted by the USI

Hospital No:

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

I enclose a copy of a further letter addressed to the family doctor of this 88 year old man who's perioperative risk you recently assessed. Upon further review on 19th February 2019, it was evident that Patient 5 was particularly keen to proceed with surgery, even though he had a reasonable appreciation of the risks which accompany such significant surgical intervention in a man of his age. I have arranged for him to be admitted on Wednesday 6th March 2019 for open right radical nephrectomy.

I would be grateful if it were possible for a bed in Intensive Care or in the High Dependency Unit to be reserved for his immediate post-operative care.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS

Consultant Urological Surgeon

Date Dictated:

Date Typed: 25/02/19

Patient 5

Personal Information redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by the USI]

E mail: [Personal Information redacted by the USI]

Secretary: Mrs N. Elliott

DR [Personal Information redacted by the USI]

[Personal Information redacted by the USI]

Dear DR [Personal Information redacted by the USI]

Re: Patient Name: [Patient 5]

D.O.B.: [Personal Information redacted by the USI]

Address: [Personal Information redacted by the USI]

Hospital No: [Personal Information redacted by the USI]

HCN: [Personal Information redacted by the USI]

Date/Time of Clinic: 19/02/19

Follow Up: Admission 6th March 2019

I wrote to you in January 2019 when I arranged for [Patient 5] to have radioisotope renography performed on 5th February 2019, and when his right renal differential function was reported to be 37%. He then had MRI scanning of his inferior vena cava performed on 7th February 2019. Though it demonstrated that tumour had probably infiltrated along the right renal vein, it was reassuring to find that it had not reached the inferior vena cava.

[Patient 5] also had further echocardiography performed on 7th February 2019. The dominant finding was that his left atrium is severely dilated, and with a capacity of 92ml. It is disconcerting that there has been evidence of progressive left atrial dilatation, even though there has been evidence of only mild mitral regurgitation, normal left ventricular systolic function and no evidence of any aortic valvular stenosis. Apart from left atrial dilatation, there was no evidence of any other significant valvular or ventricular dysfunction.

[Patient 5] then attended for cardiopulmonary exercise testing on 8th February 2019, when it was not possible to proceed with testing due to arthritis in his right knee rather than because of the [Personal Information redacted by the USI]. In any case, [Patient 5] was advised that right radical nephrectomy would be accompanied by significant risk of mortality of the order of 10 to 18%, and of morbidity of the order of 70 to 80%.

I reviewed [Patient 5] again accompanied by his daughters, on 19th February 2019, when they had concluded that he was not going to be offered any prospect of surgical intervention. They had interpreted the calculated risk of mortality and morbidity as absolutely contraindicating surgical intervention. I advised that it was possible to proceed with right radical nephrectomy, though I also did

[Patient 5]

[Personal Information redacted by the USI]

Page 1 of 2

emphasize the risks that accompanied surgery. Patient 5 was particularly keen to proceed with surgery. It was evident that this was his overriding preference. His dominant concern was that surgery could be complicated by some severely disabling complications such as cerebral infarction. His daughters were also relieved to learn that surgical intervention remained a prospect.

I have therefore arranged for Patient 5 to be admitted to our department on Wednesday 6th March 2019 for open right radical nephrectomy. I have advised Patient 5 not to take any Warfarin after Thursday 28th February 2019. I would be grateful if your practice nurse would administer Enoxaparin 60mg subcutaneously on Monday 4th March 2019 and Enoxaparin 40mg subcutaneously on Tuesday 5th March 2019. I would also be grateful if she could repeat his INR on Tuesday 5th March 2019. I would be grateful and am appreciative of your assistance in this regard.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

CC. DR RAYMOND MCKEE
CONSULTANT ANAETHETIST
CRAIGAVON AREA HOSPITAL

Date Dictated: 24/02/19

Date Typed: 25/02/19 - SM



Southern Health and Social Care Trust

Preoperative Assessment Clinic
Craigavon Area Hospital
Department of Anaesthetics
68 Lurgan Road
Portadown
BT63 5QQ



*Anaesthetics, Theatres
Intensive Care Services*

Tel: [Personal Information redacted by the USI]

8th February 2019

Mr A O'Brien
 Consultant Urologist
 Craigavon Area Hospital

Predicted Perioperative Risk:

P-POSSUM 30-Day Mortality: 10-18%

30 Day Morbidity: 70-80%

Dear Aidan

Re: Name: Patient 5
DOB: [Personal Information redacted by the USI]
Address: [Personal Information redacted by the USI]
Hospital No: [Personal Information redacted by the USI] **HCN:** [Personal Information redacted by the USI]

I saw Patient 5 this morning, accompanied by [Personal Information redacted by the USI] his [Personal Information redacted by the USI] daughters. He is currently being considered for a nephrectomy for a large right sided renal tumour.

He is 88, with his main health issues to date being cardiac. He has known hypertension (on irbesartan), and atrial fibrillation (maintained on bisoprolol and warfarinised). There is a history of a failed DC cardioversion. Most recent echocardiogram (7th February 2019) shows mild-moderate tricuspid regurgitation, biatrial dilation (with his left atrium severely dilated), preserved systolic function but evidence of diastolic cardiac dysfunction (which would be in keeping with his hypertension).

Patient 5 has no respiratory problems, and remains active. He lives independently, and continues to garden, including grass cutting. He would become dyspnoeic on climbing stairs. There is no clear suggestion in his history to suggest overt cardiac defeat. He has had a previous [Personal Information redacted by the USI] and also suffers from arthritis in his right knee.

I had hoped to perform CPX testing on him today, however the limited flexion available in his arthritic knee meant we were unable to proceed, and the attempted test was essentially non-diagnostic. He did become fairly dyspnoeic early into cycling, however it is difficult to read too much into that, as there was ongoing discomfort from his arthritic knee.

Despite his remaining active and independent, such a procedure does have significant associated risk. I have discussed this with him in detail, specifically discussing the mortality and morbidity figures quoted above. Major concerns outlined were CVA, MI, development of heart failure requiring ongoing treatment, pneumonia, DVT, PE, and other infective problems. The possibility of his not being as well able to manage independently following surgery has also been raised.

I have explained that given the risk profile here, he would need level 2 / HDU care post-operatively. His daughters seemed to grasp the significance of this, however, certainly on discussion today, Patient 5 seemed to be keen to actively consider surgery. I have explained that you would plan to review him following all his investigations and discuss this all in the round, including any other options which may be available.

I hope this is of some benefit in helping plan his future course. If there is anything else you want to know here, please let me know.

Yours sincerely

[Personal Information redacted by the USI]

Consultant in Anaesthesia and Intensive Care Medicine

Please remember these scores are a *prediction* of morbidity and mortality and the scores tend to slightly overpredict in the low-risk group and at the extremes of age.

MDM Report from Urology MDM @ The Southern Trust

RE:

Patient 5

Personal Information redacted by the USI

②

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Contact Tel:

Personal Information redacted by the USI

O'Brien office
Noleen Elliott await Res

Asp took notes after clinic
18/01/19

MDM Report from the Urology MDM @ The Southern Trust on 17/01/2019.

MDM Update

CONSULTANT MR O'BRIEN: This 88 year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, mild mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardiological review in 2015.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

MDM Action

Discussed at Urology MDM 17.01.19. Patient 5 has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

Radiology

Findings

MDM Report from Urology MDM @ The Southern Trust

RE: Patient 5
Personal Information redacted by the USI
DOB: Personal Information redacted by the USI
Hospital Number: Personal Information redacted by the USI
Contact Tel: Personal Information redacted by the USI
HCN: Personal Information redacted by the USI

Latest Findings from CT performed on 04/01/2019
04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

MDM Report from Urology MDM @ The Southern Trust

RE:

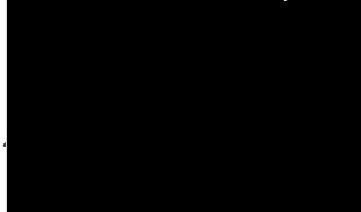
Patient 5

Personal Information redacted by the USI

Contact Tel:

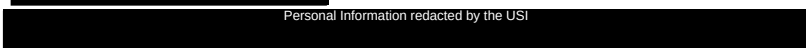
0

Urology MDM @ The Southern Trust

Personal Information redacted by the USI


RE:

Patient 5

Personal Information redacted by the USI


DOB:

Personal Information redacted by the USI

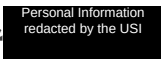
Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Dear Dr

Personal Information redacted by the USI


This patient was discussed at the Urology MDM @ The Southern Trust
On 17/01/2019.

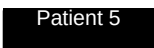
MDM Update:

CONSULTANT MR O'BRIEN: This 88 year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, mild mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardiological review in 2015.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

MDM Plan:

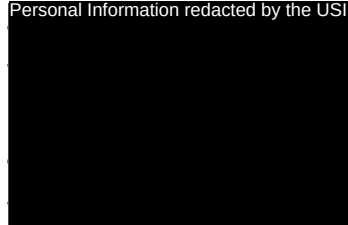
Discussed at Urology MDM 17.01.19.  Patient 5 has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

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

Yours sincerely,

Urology MDM @ The Southern Trust

Personal Information redacted by the USI



Patient 5

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Dear Dr

Personal Information redacted by the USI

This patient was discussed at the Urology MDM @ The Southern Trust
On 14/02/2019.

MDM Update:

Urology MDM @ The Southern Trust

Personal Information redacted by the USI

RE: Mr. Patient 5

Personal Information redacted by the USI

DOB: Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

CONSULTANT MR O'BRIEN: This 88 year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion did not succeed in permanent restoration of sinus rhythm. He has remained in controlled atrial fibrillation on Bisoprolol 7.5 mg daily since. On ECHO in 2016, he was reported to have a LVEF of 55 %, mild mitral regurgitation, severe biatrial dilatation and mild tricuspid regurgitation. When repeated in February 2018, the biatrial dilatation was reported to be moderate in severity. The remaining parameters remained unchanged. He was discharged from cardiac review in 2018.

He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15 cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour.

An outpatient consultation on 18 January 2019 has been arranged.

Discussed at Urology MDM 17.01.19. Patient 5 has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.

Patient 5 was advised of the reported CT findings at review on 18 January 2019. It was then additionally appreciated that he had suffered Personal Information redacted by the USI many years previously, resulting in a Personal Information redacted by the USI. His daughters advised that their father was very active, and had been cutting hedges one day previously. MRI scanning of his inferior vena cava was requested. A renogram was requested to quantify left renal differential function.

A comparative analysis of ECHO performed in 2016 and 2018 indicated that the biatrial dilatation of 2016 may have been better reported as mild in severity, but that there had been increased dilatation by 2018, considered to be moderate in severity. A further ECHO was requested. CPEX assessment was requested and agreed.

MDM Plan:

Urology MDM @ The Southern Trust

Personal Information redacted by the USI

RE:

Patient 5

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Discussed at Urology MDM 14.02.19. Patient 5's imaging indicates a large right renal lesion with right renal vein involvement but no involvement of the IVC. Pre op assessment indicates high risk for mortality and morbidity in the post-operative period. For review with Mr O'Brien to discuss with patient and family if surgery is in his best interest.

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

Yours sincerely,

Chairman of Urology MDM

Personal Information redacted by the USI

Consultant Urologist

MDM Report from Urology MDM @ The Southern Trust

Nolen Elliott - Awaiting Results

RE:

Patient 5

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN

Personal Information redacted by the USI

Contact Tel:

Personal Information redacted by the USI

MDM Report from the Urology MDM @ The Southern Trust on 14/03/2019.

Diagnosis

Renal clear cell carcinoma

Histology

Clear cell adenocarcinoma, NOS,

Laterality:

right

MDM Update

MDM Report from Urology MDM @ The Southern Trust

RE:

Patient 5

Personal Information redacted by the USI

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

Contact Tel:

Personal Information redacted by the USI

Latest Findings from CT performed on 04/01/2019

04/01/2019 12:36 CT Urogram, Author:

Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author:

Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to be a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Urology MDM @ The Southern Trust

DR

Personal Information redacted by the USI

Personal Information redacted by the USI

RE:

Patient 5

Personal Information redacted by the USI

Personal Information redacted by the USI

DOB:

redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Dear Dr

Personal Information redacted by the USI

This patient was discussed at the Urology MDM @ The Southern Trust
On 14/03/2019.

Diagnosis: Renal clear cell carcinoma

MDM Update:

Urology MDM @ The Southern Trust

Personal Information redacted by the USI

RE:

Patient 5

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

MDM Plan:

Discussed at Urology MDM 14.03.19. Patient 5 has a high risk Clear Cell Renal Cell Carcinoma. For review with Mr O'Brien to arrange CT in 3 months.

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

Yours sincerely,

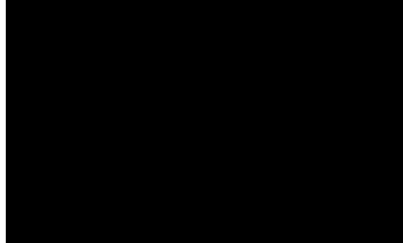
Chairman of Urology MDM

WIT-35238Southern Health
and Social Care Trust**Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ**
Tel: 028 3861 3674/2952

Ward Tel:

Notes Copy

Personal Information redacted by the USI



Date: 17/03/2019 17:08

Discharge Id: Personal Information redacted

Version: 17

505

Dear Personal Information redacted by the USI

DISCHARGE NOTIFICATION

The patient was admitted under the care of **MR A O'BRIEN** (specialty: **UROLOGY(C)**) into **3 SOUTH ELECTIVE WARD** Ward at **CRAIGAVON AREA HOSPITAL** on **06/03/2019 08:00:00** and discharged on **17/03/2019**.

Forenames:

Patient 5

Address:

Personal Information redacted by the USI

*Surname:**D.O.B:*

Personal Information redacted by the USI

*Hospital No:**NHS No:**Gender:*

Male

Ward:

3 SOUTH ELECTIVE WARD

Personal Information redacted by the USI

Admission Reason

Right radical nephrectomy for RCC

Principle Discharge Diagnosis

Right radical nephrectomy

Operations/Procedures/Radiology

TUMOUR TYPE: Clear cell renal cell carcinoma.

WHO/ISUP TUMOUR GRADE: Predominantly Grade II with some Grade III.

pTNM STAGE (UICC8): pT3a - tumour extends into the renal vein.

<http://10.142.37.153/ecm/content/msummary2.asp>

17/03/2019

Comments:

Gross examination showed a large tumour deposit bulging into the proximal renal vein corresponding to the appearances identified on MRI. Microscopic examination of this area confirms the tumour nodule though it is harder to appreciate this is renal vein involvement (Block B) but on balance it is felt to be proximal vein involvement in keeping with a pT3a tumour.

Additional Information for GP**Changes to Medications - Start/Stop**

See discharge prescription below for medication changes

Clinical Information/Comments

This 88 year old man was admitted electively for a radical nephrectomy for suspected renal cell carcinoma. He was t/f to ICU post op for inotropic support. He was later transferred to the ward.

He developed *Enterobacter aerogenes* +ve BC. On micro advice he was continued on tazocin + ciprofloxacin. He is to be discharged on a 7 day course of ciprofloxacin.

Histology confirmed renal cell carcinoma

He is to be followed up by Mr O'Brien.

INR subtherapeutic, on pharmacy discussion to be discharged on prophylactic clexane.

Many thanks

Did the patient receive a blood transfusion?

No

Allergies Patient has no known allergies

Discharge Date 17/03/2019 **Discharge Time**

Arrangements For Follow-Up

****Please CC Mr O'Brien, for OP follow up following MDM results****

Further Detailed Discharge Letter To Follow: No

Awaiting Further Results: Yes

Awaited Results

WIT-35240

MDM results

Patient Aware Of
Diagnosis: Yes

Other Management Information For GP**Anticoagulation Therapy**

Anticoagulant Therapy was commenced prior to this Admission.
Contact details of Clinical Team normally responsible for monitoring INR:

GP

Reasons For Anticoagulation Therapy:

Atrial fibrillation

INR Target:

2.50 (range: 2.00 - 3.00)

Duration of oral anticoagulant therapy required:

Long Term

INR Test Results:

INR Test Date	INR Test Value	Warfarin Dose
12/03/2019	1.2	5mg
13/03/2019	1	6mg
14/03/2019	1.2	Held (Procedure)
15/03/2019	0	5mg
16/03/2019	1.2	5mg

Dose until next INR test	5mg
Next INR test appointment	19/03/2019

Other information:**Yellow Book Completed?:**

Yes

Patient educated / For existing patients education confirmed?:

Yes

Patient has anticoagulant therapy pack?:

Yes

Discharge Prescription:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP
------	------	-----------	------	-------	----

WIT-35241

					Continue?
Admission drugs (unamended)					
WARFARIN Tablets	As per INR	When Required	-	Oral	Yes
BISOPROLOL Tablets	5mg	Twice Daily	-	Oral	Yes
IRBESARTAN Tablets	150mg	Each Morning	-	Oral	Yes
Drugs prescribed since admission					
CIPROFLOXACIN Tablets	750mg	Twice Daily	5	Oral	No
ENOXAPARIN Pre-filled Syringe	40mg	Each Night	until INR greater than 2	Subcutaneous	Review
<i>(Additional Info: Amber List Medicine) 2 days supplied on d/c. Warfarin clinic to supply further doses if needed please)</i>					
Admission drugs (amended)					

Stopped Medication:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				

Authorised Forms

Form	Authorised By	Date/Time
Adult Clinical Details (Elective-CMPM)	GEORGE MOMTAZI	17/03/2019 11:5
Anticoagulant Therapy	GEORGE MOMTAZI	17/03/2019 11:5

Prescribing Clinician:

Personal Information redacted by the USI

Bleep No:

Personal Information redacted by the USI

WIT-35242

Patient 5

Personal
Information
redacted
by the
USI

Personal Information redacted by the USI

HOSPITAL: CRAIGAVON ARCA

Operations Performed

RIGHT RADICAL NEPHRECTOMY

Date

06 MARCH 2019

Surgeon

AIDAN O'BRIEN

Anaesthetist

Personal Information redacted by the USI

Assistant

KEN HIEW

Sister

AIDAN CULLEN

Incision

Blood

Findings

Drains

Packs

PROCEDURE

RIGHT FLANK INCISION, RESECTING TIP OF TENTH RIB
 LARGE RIGHT RENAL TUMOUR MASS EXTENDING TO
 RIGHT HEMIPELVIS

SINGLE RIGHT RENAL ARTERY & VEIN
 RIGHT RADICAL NEPHRECTOMY PERFORMED
 20 F ROBINSON'S DRAIN

CLOSURE: LAYERED MUSCULAR USING
 OF 1 LOOP DIS x 2
 3/0 SUBCUTICULAR MONOCRYL

LISTED FOR MDM DISCUSSION

Signature of

Personal Information redacted by the USI

Patient ID	Personal Information redacted by the USI	Patient Name	Patient 5
Sex	Male	Date Of Birth	11-Feb-2019 14:32
Time Performed	07-Feb-2019 14:30	Time Reported	Urology Outpatients
Requested by	Aidan O'Brien	Requested from	Craigavon
Order Number	Personal Information redacted by the USI	Status	Final

Report

07/02/2019 15:03 MRV Inferior vena cava, Author: Personal Information redacted by the USI

Image quality suboptimal, due to patient movement.

Large, 14 cm mass in the right kidney.

There is likely tumour in the right renal vein.

Over a distance of 1.7 cm, the vein is clear of thrombus before it joins the IVC.

Clinical Info From Order

This 88 year old man has a large right renal tumour which may be distending the right renal vein and may be extending to IVC.

Discussed with Dr. Personal Information redacted by the USI

Patients wears

Patient may be

Personal Information

Personal Information redacted by the USI

Priority: Red Flag

Pacemaker / implanted cardiac device leads?: No

Intra-cranial clips or shunts?: No

Surgery involving implants to eyes or ears?: No

Ever had metal fragments in eyes or skin?: No

Surgery involving implants to the heart?: No

Surgery involving implants to the head?: No

Surgery involving implants to the abdomen?: No

Any other implants eg endoscopic clips, stents, neurostimulators etc?: No

Is the patient pregnant?: No

Method of transport: Walking

Does the patient have a known infection status?: No

Does the patient have a disability?: Physical

Is the patient diabetic?: No

Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes

Renal function information: eGFR

eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min

eGFR date: 12 December 2018

Referral status: NHS

Referrer grade: Consultant

Referrer name: Aidan O'Brien

Referrer contact / bleep detail: Personal Information redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

**UROLOGY DEPARTMENT
OUTPATIENT LETTER**

Telephone: Personal Information redacted by the USI

E mail: Personal Information redacted by the USI

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear,

Personal Information redacted by the USI

Re: Patient Name:

Patient 5

D.O.B.:

Personal Information redacted by the USI

Address:

Personal Information redacted by the USI

Hospital No:

HCN:

Personal Information redacted by the USI

Date/Time of Clinic: 18/01/19

Follow Up: Awaiting results –
echocardiogram/PFT's/MRI/renography

I write to you regarding this 88 year old man who presented to the Emergency Department at Craigavon Area Hospital on 12th December 2018 following the onset of visible haematuria earlier that day. He reported some associated low back pain. Otherwise, he appeared well. There was no indication of any urinary infection, and he was then referred to our department for further assessment.

I arranged for Patient 5 to have a CT scan of his chest, and a CT urogram performed on 4th January 2019. The dominant finding was that of a large, enhancing, right renal tumour, measuring some 15cm in diameter. The tumour certainly arose from the lower pole of the right kidney, and appeared to have a necrotic centre. More importantly, the cranial pole of the tumour appeared to directly extend into the right renal vein, causing distension of the vein. It was not possible to determine whether tumour additionally extended to the lumen of the inferior vena cava. However, the presence of punctate calcification within the caval lumen would raise the index of suspicion that there may be extension of tumour into the lumen of the inferior vena cava.

Otherwise, he was reported to have a mildly enlarged, lower, pre-tracheal, lymph node measuring 1.2cm in short axis. Apart from the additional presence of a small, intrapulmonary lymph node related to the horizontal fissure, there was no definite evidence of any pulmonary or mediastinal metastatic disease. There were a couple of lesions of low density within his liver, and which were too small to accurately characterise but which were probably simple hepatic cysts.

Personal Information redacted by the USI

I met **Patient 5**, accompanied by his two daughters, on Friday 18th January 2019. It was then that I appreciated that **Patient 5** had **Personal Information redacted by the USI** through his left knee joint, as a consequence of **Personal Information redacted by the USI** whilst **Personal Information redacted by the USI** many years ago. He has **Personal Information redacted by the USI**. Nevertheless, his two daughters advised that he has remained very active indeed, and had been out cutting hedges in recent days.

I noted that **Patient 5** had been found to have fast atrial fibrillation accompanied by left bundle branch block, in 2012, since when he has remained anti-coagulated on Warfarin. DC conversion failed to permanently maintain sinus rhythm in 2014. I gather that he has remained in controlled atrial fibrillation on Bisoprolol 7.5mg daily since.

I reviewed the reports of echocardiography performed in 2016 and again in February 2018. He does not have any evidence of stenotic valvular disease. He was indeed reported to have mild regurgitation of his aortic, mitral and tricuspid valves. Left ventricular function was maintained with an ejection fraction of 55%. He was reported to have severe dilatation of both atria in 2016, and modest dilatation of both atria in February 2018. Since then, I have had the opportunity of reviewing these two cardiograms with an echocardiographer who indicated that the degree of atrial dilatation in 2016 may probably have been better described as mild in severity. Nevertheless, there has been an increase in the degree of atrial dilatation, it more appropriately being described indeed as moderate in February 2018. In any case, a further echo will be arranged in the near future.

I have also requested cardiopulmonary exercise testing which may be compromised in view of **Patient 5's** **Personal Information redacted by the USI**, though I have been advised that having had an **Personal Information redacted by the USI** does not necessarily contraindicate cardiopulmonary exercise testing.

Patient 5 has had mild recent impairment of global renal function, with a glomerular filtration rate of 57ml per minute in December 2018. It would appear that his left kidney is probably contributing the greater part of his global renal function. I have requested radioisotope renography in order to quantify left renal differential function.

I had the impression on meeting **Patient 5** that he may not be keen on surgical intervention. However, I persuaded him not to rush to any conclusions in that regard until we have had the opportunity of completing staging and operability of the tumour, and until a qualitative and quantitative assessment has been made of operative risks. In any case, in the interim, his further management will be discussed once again when the reports of MRI scanning of his inferior vena cava and renography are available.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 18/01/19

Date Typed: 28/01/19 – SM

Personal Information redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone:

Personal Information redacted by the USI

E mail:

Personal Information redacted by the USI

Secretary:

Mrs N. Elliott

28/01/19

CONFIDENTIAL

Patient 5

Personal Information redacted by the USI

HCN: Personal Information redacted by the USI

Dear Patient 5

I was pleased to have the opportunity of meeting you, accompanied by your daughters, on Friday 18th January 2019. Since then, I have had the opportunity of discussing the usefulness of further scans with my colleagues. It has been agreed that it would certainly be most useful for you to have an MRI scan performed in order to determine whether there is any extensive involvement of major vessels in your abdomen by the tumour arising from your right kidney. You will receive an appointment to attend the MRI department at Craigavon Area Hospital in the near future.

I have also requested a radioisotope renogram in order to quantify the function of your left kidney, in order to be able to advise you of the likely remaining kidney function, if you were to have your right kidney removed. You will also receive a letter of appointment to attend the Department of Radiology at Craigavon Area Hospital to have that renogram performed.

I have also had the opportunity of reviewing echocardiograms that you have had done of your heart in 2016, and again more recently in February 2018. The Department of Cardiology will arrange a further appointment for you to attend to have a further echo performed in the near future.

Personal Information redacted by the USI

Lastly, I have also shared your history with my colleagues in anaesthesia, and who have kindly agreed to arrange a consultation for you, in order to further assess the risks posed by significant surgery. You will receive that appointment as well.

When all of that has been conducted, I will arrange a further review appointment for you when I will discuss with you the views of my colleagues, and when hopefully you will be enabled to arrive at an informed decision regarding your further management.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Patient 5

DOB:

Personal Information
redacted by the USI

H+C:

Personal Information
redacted by the USI

Radiology Report

South Tyrone Hospital
South Tyrone Hospital

Tel.:
Fax: 02887713498

Carland Road
BT71 4AU

9 JAN 2019

Personal Information redacted
by the USI

Patient 5

Personal Information redacted by the USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth

Personal Information
redacted by the USI

Request no.

Personal Information redacted by the USI

Ref. clinician O'Brien, Aidan

Request date 23/12/2018 17:41:00

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Requested examination(s) CT Urogram

Clinical details

This man has had visible haematuria.

He is anticoagulated with Warfarin because of atrial fibrillation.

Personal Information redacted by the USI

Please advise his daughter, of the date and time of his appointment, as she will bring him to the appointment.

Personal Information redacted by the USI

Priority: Red Flag

Is the patient female and of child bearing age (11-55)? No

Irradiated area between diaphragm / upper femora? Yes

Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs? Yes

Renal function information: eGFR

eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min

eGFR date: 12 December 2018

Does the patient have a known infection status? No

Does the patient have a disability? Physical

Is the patient diabetic? No

Method of transport: Chair

Referral status: NHS

Referrer name: Aidan O'Brien

Referrer grade: Consultant

Referrer contact / bleep detail:

Personal Information redacted by the
USI

Radiology Report

South Tyrone Hospital
South Tyrone Hospital

Tel.:
Fax: 02887713498

Carland Road

BT71 4AU

Report recipient
Craigavaon Area Hospital
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted
by the USI

Patient 5

Personal Information redacted by the USI

Date of birth

Personal Information
redacted by the USI

Request no.

Personal Information redacted by the USI

Reason for referral
To assess anatomy of urinary tract

Author: Personal Information redacted by the USI
Authorized by: Personal Information redacted by the USI
Prel. Sign:

Document date: 07/01/2019
Secretary: Personal Information redacted by the USI
Sign. datum:

04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There ap-

Radiology Report

**South Tyrone Hospital
South Tyrone Hospital**

**Tel.:
Fax: 02887713498**

Carland Road

BT71 4AU

**Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON**

BT63 5QQ

Personal Information redacted
by the USI

Patient 5

Personal Information redacted by the USI

Date of birth

Personal Information
redacted by the USI

Request no.

Personal Information redacted by the USI

pears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Patient ID	Personal Information redacted by the USI	Patient Name	Patient 5
Sex	Male	Date Of Birth	Personal Information redacted by the USI
Time Performed	04-Jan-2019 11:35	Time Reported	07-Jan-2019 20:39
Requested by	Aidan O'Brien	Requested from	Urology Outpatients Craigavon
Order Number	Personal Information redacted by the USI	Status	Final

Report

Final

04/01/2019 12:36 CT Urogram, Author: Personal Information redacted by the USI

04/01/2019 12:36 CT Chest with contrast, Author: Personal Information redacted by the USI

Indication: Frank haematuria. Anticoagulated.

Technique: A dual phase CT urogram was performed. A delayed phase volume scan of the chest was subsequently performed following the abdominal findings.

Findings: There is very large heterogeneously enhancing right renal tumour. This arises from the lower pole and extends over 14.6 cm in maximal diameter. This has a low density necrotic appearing centre, and contains several small areas of calcification.

Incidental note made of a small simple cyst at the upper pole of right kidney. The left renal cortex enhances normally.

The presence or absence of tumour extension into the right renal vein is difficult to exclude on these phases of examination. A small fleck of calcification within the inferior vena cava immediately adjacent to the left renal vein however should be viewed with suspicion, and a dedicated multi phase CT scan of the kidneys would be worth considering after MDT discussion. There appears to a solitary right renal artery.

The ureters and left pelvocaliceal systems enhance normally with no soft tissue filling defects, back pressure change or calculi.

The heart is enlarged. A lower pretracheal lymph node is mildly enlarged measuring up to 12 mm in short axis. There is no size significant lymphadenopathy elsewhere within the scan range. Incidental note is made of a small intrapulmonary lymph node related to the horizontal fissure. Overall, no definite evidence of lung metastasis.

A couple of sub centimetre low density lesions in the liver are too small to accurately characterise, but are most suggestive of cysts. The adrenal glands and spleen and pancreas are unremarkable.

The aorta has normal calibre, there is no destructive osseous lesion.

Conclusion: 14.6 cm right renal tumour. No definite evidence of metastatic disease, but there is an isolated mildly enlarged mediastinal lymph node, and subtle evidence of right renal vein invasion.

Report marked for urgent communication.

Clinical Info From Order

Final

This man has had visible haematuria.

He is anticoagulated with Warfarin because of atrial fibrillation.

Personal Information redacted by the USI

Patient ID	Personal Information redacted by the USI	Patient Name	Patient 5
Sex	Male	Date Of Birth	Personal Information redacted by the USI
Time Performed	04-Jan-2019 11:35	Time Reported	07-Jan-2019 20:39
Requested by	Aidan O'Brien	Requested from	Urology Outpatients
Order Number	Personal Information redacted by the USI	Status	Craigavon Final

Please advise his daughter, Personal Information redacted by the USI of the date and time of his appointment, as she will bring him to the appointment.

Personal Information redacted by the USI may be contacted at Personal Information redacted by the USI

Priority: Red Flag

Is the patient female and of child bearing age (11-55)?: No

Irradiated area between diaphragm / upper femora?: Yes

Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes

Renal function information: eGFR

eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: 57 ml/min

eGFR date: 12 December 2018

Does the patient have a known infection status?: No

Does the patient have a disability?: Physical

Is the patient diabetic?: No

Method of transport: Chair

Referral status: NHS

Referrer name: Aidan O'Brien

Referrer grade: Consultant

Referrer contact / bleep detail: Personal Information redacted by the USI

UROLOGY RED FLAG TRIAGE SHEET

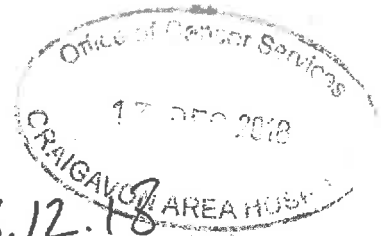
PATIENT NAME:

Patient 5

HOSPITAL NO:

Personal Information redacted by the USI

HCN:



RED FLAG ✓	TRUS
UPGRADE RED FLAG	FLEX. C/U ✓
URGENT	FLOW RATE
ROUTINE	ULTRASOUND ✓
OTHER	
VIRTUAL	

--none req'd - ~~see~~
Tracked emailed

CAOBUIO

18/01

rf.appointment

From: AEreception
Sent: 13 December 2018 05:44
To: rf.appointment
Subject: Red Flag referral
Attachments: SKM_284e18121306480.pdf

Please find Red Flag Haematuria referral for Patient 5 Personal Information redacted by the USI

Many thanks,

Christine P.

From: noreply@southerntrust.hscni.net [mailto:noreply@southerntrust.hscni.net]
Sent: 13 December 2018 06:49
To: AEreception
Subject: Message from KM_284e

HCN [Personal Information redacted by the USI] Surname Patient 5 Forename Patient 5 DoB [Personal Information redacted by the USI]

AE Number [Personal Information redacted by the USI]

GP [Personal Information redacted by the USI]

GP TEL [Personal Information redacted by the USI]

Diagnosis

1. haematuria ? m

2.

3.

ED Discharge Plan

ABx. Source haematuria clinic

Referred to Specialty

Time

Admission Agreed By:

DTA Time

Grade of Doctor

Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine Dose Route Frequency Duration Signature Supply Checked Given Quantity

TRIMETHOPRIM 200 mg po BD 7 days [Personal Information redacted by the USI] [Personal Information redacted by the USI] 10

Admit to ward

CDU

TNF to OH

Home

Fracture Clinic

CBYL

Psych. Assess

CTMA

ED Physio

Absconded

Discharge OBS

BP RESP

TEMP

SPO2

GCS

CR

BM

Ref if NIAS

UNOCINI complete

Patient property returned

GP letter given

Breach Time 02:41

Time left department

02:35

Signature Nurse

Page 4

FBP ☒ Coag. ☒ Amylase ☒ AL ☒ U&E ☒ D-dimer ☒ Other: ☒ CRP ☒ Troponin ☒ Time: 23:10 JQQ LFT's ☒ VBG ☒ Sign: INR EL tscnl.net

Er

AE Number [Personal Information redacted by the USI] HCN [Personal Information redacted by the USI] Priority Code 3

Surname Patient 5 [Personal Information redacted by the USI]

Forename [Personal Information redacted by the USI]

DoB [Personal Information redacted by the USI] Age 88

Sex M MS W

Occ. RETIRED

Caseworker [Personal Information redacted by the USI] Mobile/Other [Personal Information redacted by the USI]

Arrival Date/Time 12/12/2018 22:41 Prev Episodes 02 / 01 Adult Safeguarding Concerns Yes/No

Arrival Mode PR Incident Type NT Triage Date/Time 12/12/2018 22:53 Social Work Involvement? Current/Past/None/Not Applicable

Source of Referral Out Of Hours Breach Time 02:41 Special Needs No Special Needs

Accompanied By Nurse [Personal Information redacted by the USI]

NOK [Personal Information redacted by the USI] Tetanus Status: NOT REQUIRED

Home [Personal Information redacted by the USI] Work [Personal Information redacted by the USI] Booster Given Yes/No

Patient at risk of leaving Yes/No

Presenting Complaint ?UTI (ON WARFARIN) REQUESTING INR TEST

Presentation URINARY PROBLEMS

Discriminator FRANK HAEMATURIA

Triage Text NOTICED URINE RED THIS AM WITH SOME POSSIBLE CLOTS ALSO LOWER BACK PAIN

Medication

Anti-Coagulant WARFARIN On Anti-Coagulant

Allergies NKDA

Pulse 76 B/P 170/88 RR 18 PFR Temp 37 SaO2 96 GCS 15 CRT BM PERL AVPU A

Visual Flight Left Urine Pregnancy Test Weight

Acuity Eye Eye

ECG required yes/no History MRSA Patient Location: GREEN AREA Pain Score 8 Category 3 Infection

(< 10 minutes cardiac) CDIIF Time 22:53

Commenced on NEWS/CNS/PEWS chart Yes No Signature

Nursing Assessment

MENTAL STATE Yes No WASHING AND DRESSING Yes No SOCIAL HISTORY Yes No

Alert and Orientated Independent Lives Alone

Confused Help Required Lives With

Agitated Full Assistance Required Relatives Present

Aggressive Pressure Areas Checked Aware

Drowsy Commode required Contacted by

Trolley Sides in Situ Pad Changed Relative Contact Number

MOBILITY FEEDING AND DIET

Independent Dietary Requirements Patient updated at regular intervals

Walk with Help Dentures top

Walk with Aids bottom Yes No

Page 1

HCN [redacted] Surname [redacted] Patient 5 Forename [redacted] Patient 5 Dob [redacted] Personal Information [redacted]
 AE Number [redacted] Personal Information [redacted] by the USI
 Assessed by [redacted] Seen By [redacted] Personal Information [redacted] by the USI Time 0140

History and Examination

8:00 PM - Vaginal
 EG AP on vagina
 Since mid AM → from home
 Dark red.
 Small flecks but no clots
 Some dysuria
 Flank (R) pain earlier when was running
 I had some wetting but of which
 was settled
 No confirmed temp
 E. v. little moving up. ~ 3-4 yrs ~ 20s
 joined - exposed to various cuts of silica
 with o.k. results.
 No one bleeding episodes

US 1+4+0
 cerv. clear
 Asado soft
 PR - smooth prostate
 ?(R) (L) (L)
 No blood.
 Ure - from nodule
 No clots
 sent for msa - urine
 to msa to
 blood.

Imp. from nodule
 so cuts / infection.
 ? infection, however quite faint +
 odd + RF

Plan: send a Gerson - few days nodule clinic
 msa sent
 case: 2 ABX. (safety net advice
 - it rate than logg bleeding med
 few days. 1 pen to up, no
 reaction for 1 week
 "Case discussed with ED consultant" yes

HCN [redacted] Surname [redacted] Patient 5 Forename [redacted] Patient 5 Dob [redacted] Personal Information [redacted]
 AE Number [redacted] Personal Information [redacted] by the USI

Prescription (Medicines in Department)				Administration		
Medicine	Dose	Route	Time to be given	Signature	Given by	Time

Nursing/care delivered in ED

SPB ED M.O
 - PR done
 - for discharge - certificate
 - News TX
 went home

Personal Information [redacted] by the USI

Personal Information [redacted] by the USI

Signature of Nurse

Admission checklist (please tick if completed)

Time Bed manager informed	Ward Ready at
Copy ED Films ☐	MEWS/CNS ☐ IV Cannula Form ☐
Fluid Balance ☐	Relevant performa ☐ C diff completed ☐
Copy of NIAS notes stroke PTs ☐	Own Drugs ☐ Relatives aware admission ☐
Patient handover given to admitting nurse	(please record their name) Time
Patient has previous history of C Diff	yes ☐ no ☐
Patient has vomiting and/or diarrhoea	yes ☐ no ☐
Patient had contact with anyone with vomiting and/or diarrhoea in last 5 days	yes ☐ no ☐
If yes to any of above refer to agreed guidance.	

Patient: Patient 1

H&C: Personal Information redacted by the USI

Diagnosed with locally advanced prostate cancer August 2019. MDM 31st October 2019 recommended ADT and refer for EBRT. Not referred for EBRT and hormone treatment not as per guidance. March 2020 rising PSA and local progression (urinary retention). Re-staged June 2020 and developed metastatic disease

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

Patient: [Redacted]
 H&C: [Redacted]
 Personal Information redacted by the [Redacted]

11/11/19	Seen at clinic in SWAH - able to tolerate lower dose. Bloods taken PSA. Seen at clinic. Letter states It would be ideal to have optimal biochemical response to androgen blockade or androgen deprivation prior to consideration for radical radiotherapy. If his PSA has not decreased further it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of Bicalutamide to 50mgs twice a day and hopefully subsequently to taking the higher dose of 150mgs once again. As I suspect that the addition of a LHRH agonist may be more intolerable. Dictated 2/1/19 typed 10/01/2020	
2/1/2020	Phone call from AOB to [Redacted] – PSA dropped to 3.84 Needs repeat bloods in preparation for clinic appointment in January.	
27/1/2020	Seen at OPD appointment Serum PSA down 2.23 by 7th January 2020. Noted to be doing well. Only problem nocturia (twice at night). Plan to increase Bicalutamide 100mgs daily.	
5/3/2020	Serum PSA increased 5.37ng/ml	
11/3/2020	Letter to GP asking to increase dose to Bicalutamide 150mgs daily indefinitely. Plan repeat PSA mid-April. Plan review in SWAH 27th April 2020.	
27/04/2020	Appointment cancelled in view of covid outbreak. PSA check on 14 April – 12.08ng	
1/06/2020	Consultant spoke with [Redacted] advised to commence Leuporelin 3.75mgs to be administered subcutaneously. To commence 1st week in June and repeat bloods at the same time. Plan for TURP in DHH. Needs to have adenocarcinoma restaged by having radioisotope bone scan.	
17/06/2020	Admitted to DHH for TURP Complicated by urinary sepsis requiring iv antibiotics. Failed trial removal of catheter for repeat TROC in SWAH in two weeks.	
22/06/2020	Discharged from DHH	
	Pathology report Adenocarcinoma – perineural and lymphovascular invasion seen.	
22/6/2020	Letter to GP Noted further elevation of PSA from 27.22ng/ml on 3 June 2020 to 29.5ng/ml on 12 June 2020.	

Patient:

Patient 9

H&C:

Personal Information redacted by the US

Initial assessment May 2019. Clinically felt to have a malignant prostate. Commenced on Bicalutamide 50mg OD, TURP arranged (Benign pathology). Reviewed in outpatients in July 2019. Planned for repeat PSA and further review. Emergency Department attendance May 2020 resulting in catheterization. Rectal mas investigated and diagnosed as locally advanced prostate cancer. Commenced on Hormone treatment July 2020 and staging investigations arranged.

Date/ Time	Summary Of Events	Staff
1 May 2019	Attendance at Emergency Department Urinary Problems, severe pain, referred to Urology	
24/5/2019	Outpatient appointment with AOB Recent Urinary Retention on 1 May 2019. Preceding LUTS, Had TROC which failed, URE Normal, PSA 9.45, DRE: T3? TA CP. <u>Plan:</u> Rx Bicalitamide 50 MG's TURP on 12 June 2019	AOB
12/06/19	Admitted for TURP	AOB
13/06/19	Day 1 post TURP NEWS 0 Bloods awaited Needs clexane prescribed - TROC 6am - PRN antimedication	FY1
14/06/19	Day 2 Post TURP TROC today	Urology Registrar
15/06/19	Discharged Review with Mr O'Brien July 2019	FY1
02/07/19	Review OPD with AOB LUTS Hesitancy Unsatisfactory voiding Noturia x 4-5 Dysuria <u>Plan</u> PSA MSSU Rx ciprofloxacin 250 mgs BD x 2 weeks U/S Urinary tract Review September 2019	AOB
08/05/2020	Attended Emergency Department: <i>Symptoms: running to toilet a lot but unable to pu - in a lot of pain, not passed any urine today, bowel blockage also</i>	
12/05/2020	Virtual appointment: by Mr O'Brien, wrote to patient and to GP to advise GP to prescribe Bicalutamide 50mgs, in addition to Tamsulosin 400mgs, and that he would be reviewed in Surgical	AOB

Patient: [Redacted]
 H&C: [Redacted]
 Personal Information redacted by the US

	Assessment Unit on 18 May 2020 for removal of indwelling urethral catheter	
18/05/20	CAOBHOT – Ambulatory Care Unit CAH Extract from letter: <i>He had his catheter removed this morning and he attended to the clinic for post voids. Unfortunately at this point he was unable to void and was uncomfortable. He had 500mls in his bladder and therefore we catheterised him again. This is despite him having restarted his Bicalutamide and his Tamsulosin. His PSA recently was 9.5ng/ml and I know from my colleague Mr Elbaroni last week this his DRE felt malignant. I have booked him for a MRI of his prostate. I have discussed with [Redacted] his symptoms further as well as he describes tenesmus, PR bleeding for the last 2 weeks, increase in his bowel habit. Given this, I have also written a letter to our colleagues in General Surgery to see if they could follow this up as a Red Flag. I will be in contact with the results.</i>	Urology registrar
02/07/20	Discussed at Urology MDM 02.07.20. [Redacted] has locally advanced prostate cancer at the very least. He needs seen at clinic and commenced on ADT, a bone scan arranged, further MDM discussion and possible referral to Oncology.	
06/07/20	Outpatient clinic with Mr O'Donoghue Extract from letter: <i>PSA 9.40ng/ml 8th May 2020, MRI prostate 27/05/2020 showed large locally advanced prostate cancer, CT chest, abdomen and pelvis 12/06/2020 showed large rectal mass with small volume groin nodes and no distant metastasis, rectal biopsies 26th June 2020 showed prostatic adenocarcinoma which is high grade.</i> Plan from appointment was: <i>We are going to start him on an LHRH analogue and we will discuss him further at the MDT once the scan results come to hand. It is most likely that if he doesn't have metastatic disease he will be referred to oncology</i>	JOD
27/07/20	Attendance to Emergency Department with urinary retention, ongoing problem with catheter, changed earlier in the day, [Redacted] not passing urine since Taken to theatre from ED for open insertion of a suprapubic catheter and admitted to 4S	ED and M Haynes
	Discharged from 4S: Extract from discharge letter: <i>It was decided this man would need a defunctioning stoma and ? ileal conduit. Stoma nurse reviewed [Redacted] re future stoma.</i> <i>Surgical team are happy to operate on this man when he feels fit enough, he currently wants to return home to recuperate before undergoing any more operations. Discussed with Mr Epanomeritakis and SpR Mr Convie and he is able to go home</i>	M Haynes/Mr Epanomeritakis

Patient:

Patient 9

H&C:

Personal Information redacted by the US

	<i>for now. I will cc this letter to Mr Haynes Consultant urologist also so that the teams can liase re. whether urology want to also operate at the same time if required and to ensure appropriate follow-up</i>	
--	--	--

Patient: Patient 5

H&C: Personal Information redacted by the USI

This 89 year old man underwent right radical nephrectomy in March 2019 for a large right renal cell carcinoma infiltrative of the renal vein. There was no definite evidence of disease recurrence or progression on CT scanning in June 2019. He was found to have an iron and folate deficient anaemia in October 2019 and a further CT scan was requested for December 2019. This scan was reported on 11 January 2020 and was not followed up until 28 July 2020.

Date/ Time	Summary Of Events	Staff
17/01/2019	Urology MDM This 88 year old man has remained on Warfarin since 2012 when he was found to have fast atrial fibrillation and left bundle branch block. DC conversion in 2014 did not succeed in permanent restoration of sinus rhythm. Taking Bisoprolol 7.5 mg daily has maintained controlled atrial fibrillation since. Echocardiography in 2015 confirmed a LVEF of 55%, mild mitral valvular regurgitation, moderate left atrial dilatation and mild right ventricular dilatation. He was discharged from cardiology review in 2015. He presented to the Emergency Department on 12 December 2018 following the onset of visible haematuria. His GFR was 57 ml/min. A CT Chest and CT Urogram were performed on 04 January 2019. The heart was reported to be enlarged. One pretracheal lymph node had a diameter of 12 mm and there was one small intrapulmonary lymph node related to the horizontal fissure. He was found to have a large, right renal tumour mass with a craniocaudal diameter of 15cm. The right renal vein appeared to be distended, and in continuity with the cranial pole of the tumour. MDM Plan: Discussed at Urology MDM 17.01.19. Patient 5 has a large right renal tumour with no definite evidence of metastatic disease. For review by Mr O'Brien on 18 January 2019.	
18/01/2019	Urology Outpatient Clinic Letter to patient - It has been agreed that it would certainly be most useful for you to have an MRI scan performed in order to determine whether there is any extensive involvement of major vessels in your abdomen by the tumour arising from your right kidney. You will receive an appointment to attend the MRI department at Craigavon Area Hospital in the near future. I have also requested a radioisotope renogram in order to quantify the function of your left kidney, in order to be able to advise you of the likely remaining kidney function, if you were to have your right kidney removed. You will also receive a letter of appointment to attend the Department of Radiology at Craigavon Area Hospital to have that renogram performed. I have also had the opportunity of reviewing echocardiograms that you have had done of your heart in 2016, and again more	Mr A O'Brien Consultant Urologist

Patient: Patient 5

H&C: Personal Information redacted by the USI

	recently in February 2018. The Department of Cardiology will arrange a further appointment for you to attend to have a further echo performed in the near future. Lastly, I have also shared your history with my colleagues in anaesthesia, and who have kindly agreed to arrange a consultation for you, in order to further assess the risks posed by significant surgery. You will receive that appointment as well. When all of that has been conducted, I will arrange a further review appointment for you when I will discuss with you the views of my colleagues, and when hopefully you will be enabled to arrive at an informed decision regarding your further management.	
05/02/19	NM Renal DMSA. There is photopenia at the lower pole of the right kidney corresponding to the known tumour. The left kidney appears unremarkable. Differential function estimated as follows: Left kidney 63%; right kidney 37%.	Dr S Vallely
07/02/19	MRV Inferior vena cava. Image quality suboptimal, due to patient movement. Large, 14 cm mass in the right kidney. There is likely tumour in the right renal vein. Over a distance of 1.7 cm, the vein is clear of thrombus before it joins the IVC.	Dr R McConville Consultant Radiologist
08/02/19	Anaesthetic Review Letter to referrer – Patient 5 is 88, with his main health issues to date being cardiac. He has known hypertension (on irbesartan), and atrial fibrillation (maintained on bisoprolol and warfarinised). There is a history of a failed DC cardioversion. Most recent echocardiogram (7th February 2019) shows mild-moderate tricuspid regurgitation, biatrial dilation (with his left atrium severely dilated), preserved systolic function but evidence of diastolic cardiac dysfunction (which would be in keeping with his hypertension). Patient 5 has no respiratory problems, and remains active. He lives independently, and continues to garden, including grass cutting. He would become dyspnoeic on climbing stairs. There is no clear suggestion in his history to suggest overt cardiac defeat. He has had a previous Personal Information redacted by the USI, and also suffers from arthritis in his right knee. I had hoped to perform CPX testing on him today, however the limited flexion available in his arthritic knee meant we were unable to proceed, and the attempted test was essentially non-diagnostic. He did become fairly dyspnoeic early into cycling,	Dr R McKee Consultant Anaesthetist

Patient: Patient 5
 H&C: PERSONAL INFORMATION REDACTED BY THE USI

	however it is difficult to read too much into that, as there was ongoing discomfort from his arthritic knee. Despite his remaining active and independent, such a procedure does have significant associated risk. I have discussed this with him in detail. Major concerns outlined were CVA, MI, development of heart failure requiring ongoing treatment, pneumonia, DVT, PE, and other infective problems. The possibility of his not being as well able to manage independently following surgery has also been raised. I have explained that given the risk profile here, he would need level 2 / HDU care post-operatively. His daughters seemed to grasp the significance of this, however, certainly on discussion today, Patient 5 seemed to be keen to actively consider surgery. I have explained that you would plan to review him following all his investigations and discuss this all in the round, including any other options which may be available.	
14/02/19	Urology MDM Patient 5's imaging indicates a large right renal lesion with right renal vein involvement but no involvement of the IVC. Pre op assessment indicates high risk for mortality and morbidity in the post-operative period. For review with Mr O'Brien to discuss with patient and family if surgery is in his best interest.	
19/02/19	Urology Outpatient Clinic Letter to patient - I write to confirm that I have arranged for you to be admitted to our department, on Wednesday 6th March 2019 for right radical nephrectomy that day. You will receive formal notification of your admission before then. You will be expected to arrive at the Elective Admissions Ward, Ward 1 West, at 8am that day. I would be grateful if you would ensure that you arrive any time after 7.30am and no later than 8am, just in case any further blood tests need to be performed prior to surgery. It is critically important that you do not have anything to eat or drink after midnight the night before. I also write to confirm that I have advised that you continue to take Warfarin as usual up until and including Thursday 28th February 2019. You should not take any Warfarin thereafter. I have written to your family doctor, PERSONAL INFORMATION REDACTED BY THE USI, requesting that the Practice Nurse administer Enoxaparin subcutaneously, 60mg on Monday 4th March 2019 and 40mg on Tuesday 5th March 2019. I have also requested that the Practice Nurse repeat your INR on Tuesday 5th March 2019. When you receive this letter, I would be grateful if you would contact PERSONAL INFORMATION REDACTED BY THE USI to arrange those appointments with the Practice Nurse on Monday 4th March and Tuesday 5th March. I look forward to meeting you again following your forthcoming admission.	Mr A O'Brien Consultant Urologist
06/03/19	Inpatient Admission	

Patient: Patient 5

H&C: Personal Information redacted by the USI

	Admitted electively for a radical nephrectomy for suspected renal cell carcinoma. He was transferred to ICU post op for inotropic support. He was later transferred to the ward. He developed Enterobacter aerogenes +ve BC. On micro advice he was continued on tazocin + ciprofloxacin. He is to be discharged on a 7 day course of ciprofloxacin. Histology confirmed renal cell carcinoma. He is to be followed up by Mr O'Brien. Discharged 17/03/19.	
14/03/19	Urology MDM Discussed at Urology MDM 14.03.19. Patient 5 has a high risk Clear Cell Renal Cell Carcinoma. For review with Mr O'Brien to arrange CT in 3 months.	
29/03/19	Urology Telephone Consultation Letter to patient - I am aware that you had not been feeling well during recent months, and I do suspect that your anaemia may have been contributing to that lack of wellbeing. I am aware that you are currently taking iron tablets. I write to advise you that I have also written to Personal Information redacted by the USI, requesting that he issue you a prescription for Folic Acid tablets, 5mgs to be taken once daily, for a period of 3 months. When you receive this letter, I would be grateful if you would collect a prescription from Personal Information redacted by the USI. I also write to advise you that I have requested the Department of Radiology at South Tyrone Hospital to arrange an appointment for you to have a further CT scan of your chest, abdomen and pelvis performed during December 2019, and I hope to review you with the report in January 2020.	Mr A O'Brien Consultant Urologist
11/06/19	CT Chest, abdomen and pelvis with contrast. Comparison with 4 January 2019 and the 4 March 2019. Unchanged 1 cm pretracheal node and multiple other smaller mediastinal nodes. Small (1.7 cm) low density lesion posterior to the left atrium, unchanged and of doubtful clinical significance. Multiple small and unchanged pulmonary nodules. No definite pulmonary metastasis. Multiple small low density lesions within the liver some of which too small to categorise. No convincing change.	Dr M Williams Consultant Radiologist

Patient: Patient 5

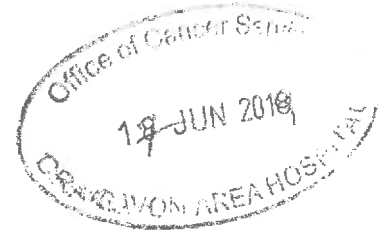
H&C: Personal Information redacted by the USI

	Right nephrectomy. No enlarged abdominal or pelvic nodes are seen. There is a little ill-defined soft tissue posterior to the cava and adjacent to surgical clips which is probably postsurgical. Advanced degenerative change at both shoulders. No skeletal metastasis seen. CONCLUSION: No evidence of disease recurrence.	
17/12/19 15:36	CT Chest, abdomen and pelvis with contrast Indication: Restaging of recurrent renal cell carcinoma. Right radical nephrectomy March 2019. Technique: Portal venous phase volume scan of the chest, abdomen and pelvis with oral contrast. Comparison is made to the previous CT scan from 11 June 2019. Findings: The lung parenchymal appearances are stable, with no convincing evidence of metastatic disease. A borderline enlarged 10 mm short axis lower pretracheal lymph node is stable. There is no suggestion of active lymphadenopathy elsewhere within the scan range. Sub centimetre low density lesions in the liver remained stable, presumably relating to a simple cysts. The right renal bed is unremarkable, as is the left kidney, adrenal glands, spleen and pancreas. Within the left side of the L1 vertebral body, there is new area of ill-defined sclerosis slightly extending into the pedicle. This was not evident on the previous CT scan, and sclerotic metastasis is within the differential; a dedicated isotope bone scan would be worth considering for further evaluation. Conclusion: Possible sclerotic metastasis in L1 vertebral body.	Dr A Milligan Consultant Radiologist
28/07/20	Urology Virtual Clinic Letter to patient - Apologies in the delay in coming back to you with the result of this scan. As you are aware this was performed as follow up following your previous surgery for kidney cancer. Within the abdomen and chest your CT scan is satisfactory and does not show any problems related to your previous kidney cancer. There is however an indeterminate area of possible abnormality within one of the bones of your spine which requires further assessment with a follow up CT scan and a further scan called a bone scan. I have requested these from the X-ray Department and you will receive appointments in the near future. In addition to the follow up	Mr M Haynes Consultant Urologist

Patient: Patient 5**H&C:** Personal information redacted by the US

	scans I would be grateful if you could arrange a blood test with your GP using the enclosed blood test request form for an up to date kidney function blood test and also a prostate blood test.	
06/08/20	CT Bone Scan appointment booked.	

WIT-35268

UROLOGY RED FLAG TRIAGE SHEET

PATIENT NAME: Patient 1

HOSPITAL NO: Personal Information redacted by the USI

HCN: Personal Information redacted by the USI

RED FLAG ✓	TRUS
UPGRADE RED FLAG	FLEX. C/U
URGENT	FLOW RATE
ROUTINE	ULTRASOUND
OTHER	
VIRTUAL	

22/7/19
11-10
EUPROD00

- MRI Prostate HAS BEEN REQUESTED
- PLEASE ARRANGE APPOINTMENT AT MY CLINIC AT SWATH ON 22 JULY 2019 OR AT A NEW CLINIC AT CATH AFTER DATE OF SCAN

Patient 1

d69b86d1-c6fc-4838-b6b9-0ee5a6fe1f98

Personal Information redacted by the USI

BORN
OHCPPersonal Information redacted
by the USI

GENDER Male



eReferral Triage

Last updated by Personal Information redacted by the USI 8:55 (v. 2)

Triage Outcome

GP Priority Red Flag
Triage Priority Red Flag
Triage Decision Redirect

Redirect Referral

Redirect To Craigavon Area Hospital - UROLOGY
Redirection Reason Enniskillen pt

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	
Virtual	

For Trust use only: HCN: [Personal Information redacted by the USI]	Referral Date: 13-Jun-2019
Date Sent: 13-Jun-2019	Surname: [Patient 1]

LAKESIDE MEDICAL PRACTICE

Practice address

Personal Information redacted by the USI

Practice code: [Personal Information redacted by the USI]

Contact number(s)

Telephone: [Personal Information redacted by the USI]

Fax: [Personal Information redacted by the USI]

Practice Email: [Personal Information redacted by the USI]

Referral to: Omagh Hospital & PCC Referral Type: Out Patient
 Specialty: UROLOGY Nature of Request: Investigate
 Urgency: RED FLAG
 Cancer Site: URC
 Electronic Attachment Present?: No
 HCP Name:
 Designation:

Practice Code: [Personal Information redacted by the USI] Registered GP: [Personal Information redacted by the USI] Registered GP Cypher: [Personal Information redacted by the USI]
 Referring GP: [Personal Information redacted by the USI] Referring GP Cypher: [Personal Information redacted by the USI] Referred by: Referring GP

HCN Number	[Personal Information redacted by the USI]	Title:	[Personal Information redacted by the USI]
Surname:	Patient 1	Forenames:	Patient 1
Previous Surname:		Known as:	-
DOB:	[Personal Information redacted by the USI]	Gender:	Male
Registered Contact Details:	[Personal Information redacted by the USI]		
Tel No:		Mobile:	[Personal Information redacted by the USI]
Patient Email:			
Preferred Contact Details if different from above:		Marital Status:	(Not Known)

Special Needs or Requirements

Reason for Referral/ History of Presenting Complaint

Description: raised psa

Comment: Date Consultation Text

13-Jun-2019 GP Surgery

Personal Information redacted by the USI

History psa repeated 19.16-19.81, nocturia x2, walks 6km daily and did so prior to tests

Examination pr with consent, cod, smooth rubbery prostate lobes, no masses noted

Comment refer urology

RELEVANT PAST MEDICAL HISTORY**Pre-existing conditions (High & medium priority - all)**

<u>Description</u>	<u>Comment</u>	<u>Date of onset</u>	<u>Date recorded</u>
Type 2 diabetes mellitus	-	06-Feb-2017	06-Feb-2017
Acute non-ST segment elevation myocardial infarction	-	24-May-2016	24-May-2016
Acute coronary syndrome	-	24-May-2016	24-May-2016
Inguinal hernia	right sided reducible indirect incomplete inguinal hernia with a positive cough impulse	16-Aug-2012	16-Aug-2012
Trochanteric bursitis	-	15-Feb-2008	15-Feb-2008
[D]Impaired glucose tolerance	review 6/12	28-Feb-2006	28-Feb-2006
Duodenitis	-	20-Dec-2004	20-Dec-2004
Duodenitis	-	08-Nov-2004	08-Nov-2004
Osteoarthritis	-	19-Aug-2004	19-Aug-2004
Ischaemic heart disease	-	20-Jul-2004	20-Jul-2004
Angina pectoris NOS	-	16-May-2004	16-May-2004
Mixed hyperlipidaemia	-	16-Mar-2004	16-Mar-2004
Essential hypertension	-	16-Apr-2003	16-Apr-2003

Past procedures (High and medium priority - all)

<u>Description</u>	<u>Comment</u>	<u>Date recorded</u>
Patient reviewed	-	14-Jan-2019
Magnetic resonance imaging	did not reveal any evidence of trochanteric bursitis but clinically very tender over the right greater trochanter area	26-Oct-2018
Had a discussion with patient	-	10-Aug-2018
Magnetic resonance imaging	Conclusion: No significant abnormality identified. No cause for the patient's symptoms established.	25-Jun-2018
Percutaneous coronary intervention	-	22-Jun-2016
Angiogram	Elective	27-May-2016
Angiogram	Elective - three vessel disease	27-May-2016
Primary repair of inguinal hernia	right	07-Sep-2012

Varicose vein ligate + right leg 11-Oct-2006
strip
Cardiac catheterisation - 15-Sep-2004

Family conditions (All priorities)

Description	Extension	Modifier to Patient	Relation	Date Recorded
FH: Ischaemic heart dis. >60	-	-	Mother	21-Jun-2011
FH: Ischaemic heart dis. <60	-	-	Mother	30-Dec-2002
No family history diabetes	-	-		30-Dec-2002
FH: CVA/stroke	-	-	Aunt	30-Dec-2002

MEDICATION**Current medication** (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration
Pregabalin 25mg capsules	415164004	-	One To Be Taken Twice A Day	-	17-Sep-2018	-
Co-codamol 30mg/500mg tablets	322341003	-	2 tabs 4-6hrly as required	-	07-Feb-2018	-
Bilxona 30mg modified-release tablets (Actavis UK Ltd)	30982411000001107	-	ONE TO BE TAKEN DAILY	-	19-Dec-2017	-
Omnitest 3 testing strips (B.Braun Medical Ltd)	18242411000001102	-	AS DIRECTED	-	17-May-2017	-
Omnican Lance Soft lancets 0.3mm/30gauge (B.Braun Medical Ltd)	22236511000001105	-	AS DIRECTED	-	17-May-2017	-
Lyrinel XL 10mg tablets (Janssen-Cilag Ltd)	4529411000001103	-	ONE TO BE TAKEN DAILY	-	25-Jul-2016	-
Isosorbide mononitrate 50mg modified-release capsules	319117009	-	ONE TO BE TAKEN DAILY	-	01-Jul-2016	-
Diltiazem 180mg modified-release capsules	319184008	-	ONE TO BE TAKEN DAILY	-	17-Jun-2016	-
Glyceryl trinitrate 400micrograms/dose pump sublingual spray	18358011000001101	-	ONE-TWO SPRAYS AS REQUIRED	-	17-Jun-2016	-
Losartan 100mg tablets	407784004	-	ONE TO BE TAKEN DAILY	-	06-Jun-2014	-
	579211000001108	-		-	17-Feb-2010	-

Proscar 5mg tablets (Merck Sharp & Dohme Ltd)			ONE TO BE TAKEN DAILY			
Rosuvastatin 10mg tablets	408036003	-	ONE TO BE TAKEN DAILY	-	22-Mar-2006	-
Pantoprazole 20mg gastro-resistant tablets	317322009	-	OD	-	23-Mar-2005	-
Aspirin 75mg tablets	319775004	-	ONE TO BE TAKEN DAILY	-	20-May-2004	-
Bendroflumethiazide 2.5mg tablets	317919004	-	ONE TO BE TAKEN IN THE MORNING	-	20-Aug-2003	-

Recent medication (Any medication issued within last 168 days not shown above)

<u>Drug name</u>	<u>Code</u>	<u>Formulation</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Date started</u>	<u>Duration</u>
Phenoxymethylpenicillin 250mg tablets	323416001	-	One To Be Taken Four Times A Day	-	26-Feb-2019	29 Days
Diffiam 0.15% spray (Meda Pharmaceuticals Ltd)	531611000001106	-	As Directed	-	19-Feb-2019	43 Days
Doxycycline 100mg capsules	324059006	-	One To Be Taken Twice A Day	-	14-Jan-2019	29 Days
Amoxicillin 250mg/5ml oral suspension sugar free	323740008	-	Two 5ml Spoonfuls To Be Taken Three Times A Day	-	07-Jan-2019	29 Days
Chloramphenicol 0.5% eye drops	330286001	-	One Drop To Be Used In The Affected Eye(s) Four Times A Day	-	07-Jan-2019	29 Days
Nystatin 100,000units/ml oral suspension	324689003	-	1ml To Be Dropped Into The Mouth Four Times A Day.	-	07-Jan-2019	29 Days
Phenoxymethylpenicillin 250mg tablets	323416001	-	Two To Be Taken Four Times A Day	-	02-Jan-2019	29 Days

ALLERGIES & RISKS**Lifestyle risks**

AllergiesDescription

Adverse reaction to Ticagrelor

Adverse reaction to Bisoprolol Fumarate

Adverse reaction to Xatral

Adverse reaction to Lipitor

SMOKING STATUS

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Ex smoker		17-Oct-2017

ALCOHOL INTAKE

<u>Description</u>	<u>Comment</u>	<u>Date Recorded</u>
Alcohol consumption 6 units/week		17-Oct-2017

BMI

<u>BMI</u>	<u>Height</u>	<u>Weight</u>	<u>Date Recorded</u>
25.4			2018-11-06
25.7			2018-04-24
24.4			2017-05-10
25.1			2016-12-13
25.9			2016-09-19
25.1			2016-08-03
24.9			2016-07-05
24.8			2015-08-06
25.3			2014-08-08
25.5			2013-07-16
25.8			2012-07-04
25.1			2012-01-10
26.4			2011-06-21
25.1			2010-01-26
25.8			2009-02-25
26.1			2008-01-18
26.8			2007-01-19
26.4			2006-05-19
27.1			2005-11-30
25.5			2004-11-19
26.4			2004-05-28
26			2002-12-30
21.7			1900-01-01

Blood Pressure

<u>Diastolic</u>	<u>Systolic</u>	<u>Date Recorded</u>
------------------	-----------------	----------------------

SOCIAL HISTORY**OTHER PATIENT DATA**

Signature of referring doctor
(or other professional)

Date

Personal Information redacted by the USI

From: Personal Information redacted by the USI
Sent: 14 June 2019 10:54
To: referrals.rbc
Subject: FW:
Attachments: [Untitled].pdf

This e-mail is covered by the disclaimer found at the end of the message.

Morning

There are 2 referrals in the above attachment for your attention

Kind Regards

Personal Information redacted by the USI

Urology Appointments

Personal Information redacted by the USI

-----Original Message-----

From: ICATS Personal Information redacted by the USI
Sent: 14 June 2019 10:52
To: Personal Information redacted by the USI
Subject:

Please open the attached document. This document was digitally sent to you using an HP Digital Sending device.

This email is confidential and intended solely for the use of the individual to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent the views of the Trust or organisation it was sent from.

If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited.

If you have received this email in error please contact the sender.

The content of this e-mail and any attachments or replies may be subject to public disclosure under the Freedom of Information Act 2000, unless legally exempt.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Personal
Information
redacted
by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	MR O'BRIEN UROLOGY CLINIC SWAH	Clinical Notes
→	22/7/19		
Age			
URINE Protein Sugar Acetone			LUNGS
WEIGHT			· UNSATISFACTORY VOIDING
kg.			· NOCTURIA X 1-2
→			ON FINASTERIDE SINCE 2010
Age			AND
URINE Protein Sugar Acetone			OXIBUTYNIN MR 2016
WEIGHT			DRG : INCREASED PROSTATIC
kg.			MRI : rT3A
→			PROX
Age			· U/S URINARY TRACT
URINE Protein Sugar Acetone			· TRUS13
WEIGHT			
kg.			

Personal Information redacted by the USI

		Date	Clinical Notes
→		20/8/19	NZ PROSTATE Biopsy
Age			Written Consent
URINE Protein Sugar Acetone			local Anaesthetic
WEIGHT			20 x core biopsy of prostate
kg.			3/4 oral antibiotics
			Plan ① MOM discussion
			② RW Mr O'Brien
→			Personal Information redacted by the USI
Age			Thomdale Clinic
URINE Protein Sugar Acetone			
WEIGHT			
kg.			
→		23/9/19	MR O'BRIEN UROLOGY CLINIC SWAH.
Age			
URINE Protein Sugar Acetone			PLAN
WEIGHT			• PSA = 21.8
kg.			• SERUM TESTOSTERONE = 19.3
→			• BS
Age			• CT - COP
URINE Protein Sugar Acetone			• R BICICLIDAMIDE 150 MGS
WEIGHT			AND
kg.			TAMOXIFEN 10 MGS

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Personal
Information
redacted
by the
USI

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		• MDM
URINE Protein Sugar Acetone		Personal Information redacted by the USI
WEIGHT kg.		
→	11/11/19	MR. A. OGDEN Urology / OPD CAU
Age		
URINE Protein Sugar Acetone		LUTS UNCHANGED
WEIGHT kg.		PSA
→		• PSA = ↓ 3.84
Age		• ? CBRT / REVIEW
URINE Protein Sugar Acetone		Personal Information redacted by the USI
WEIGHT kg.		

30723

Date	Clinical Notes
→ 23/1/20	PSA ↓ 2.23 ON 07 JAN 20
Age	LUTS
URINE Protein Sugar Acetone	• NOCTURIA X 2
WEIGHT kg.	PAN
→	• INCREASE BICKLITAMIDOC TO 100 MGS ONLY
Age	• WRITE TO [REDACTED]
URINE Protein Sugar Acetone	? BRACHYTHERAPY
WEIGHT kg.	? CBRT
→	? COMBINATION
Age	[REDACTED]
URINE Protein Sugar Acetone	[REDACTED]
WEIGHT kg.	[REDACTED]
→	[REDACTED]
Age	
URINE Protein Sugar Acetone	
WEIGHT kg.	

Sheet Number NM/24

SURNAME (Block letters)

CHRISTIAN NAMES

Personal Information redacted
by the USI

Patient 1

17/06/20

Personal Information redacted by the USI

20:15

18:50

RR 18
 SpO₂ 97% (RA)
 Temp 38°C
 BP $\frac{130}{56}$

ATSP regarding HR 37 bpm and temp 38°C

Patient Feels comfortable at rest.

Mr O'Brien seen patient and started

IVF and IV tazocin

HR 37 bpm

Pt post TURP

NEWS = 4

1. Telemetry started.
 2. IVF
 3. IV tazocin
 4. Bloods taken
 5. Blood cultures taken after stat dose of IV tazocin.
 6. Moved to side room as temp spike
- } as per Mr O'Brien (urology)

Personal Information redacted by the USI

NEWS (a) 20:30 = 1

Temp 37.6°C

HR 42

Personal Information redacted by the USI

18/06/20

0500

Personal Information redacted by the USI

temp 38.6°C

feels well

blood cultures taken - (R) Aef

ANIT

routine bloods also sent

(P) a/w bloods / cultures

Personal Information redacted by the USI

Personal Information redacted by the USI

18/6/20

H well (none of scale)
 D. post long tail
 Post-op sepsis / IV tazocin

One rose on the inguinal
 H/c Culture skin inguinal

(2) Culture W abs
 (3) Bloods

Personal Information redacted by the USI

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Personal
Information
redacted
by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	19/6/20	will / signs of / absolute 24^h fast / tub Post-op sepsis Her one on uninfected
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		Chine ultra ② ? WASH which man
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→	19/6/20	Pharmacist @ 5:25 Please review dose of Torsemide according to eGFR. BNF states eGFR 20-40 ml/min dose = 4.5g 8^o and with eGFR < 20 max dose = 4.5g 12^o. There be please review dose as deemed clinically appropriate
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

30723

	Date	Clinical Notes
→		
Age	20 JUNE 20	
URINE Protein Sugar Acetone		Well
WEIGHT kg.		Plan
→		REMOVE CATHETER
Age		HOME (TOMORROW) IF WELL
URINE Protein Sugar Acetone		MTM DISCUSSION
WEIGHT kg.		
→		
Age	20/06/20	Personal Information redacted by the USI
URINE Protein Sugar Acetone	22:30	STERILE EO 2019-07 2024-06 Foley Catheter: For urethral or suprapubic use CE 0124 1 unit EC REP Teleflex Medical Sdn. Bhd. Lot PT 2577, Jalan Perusahaan 4, 34500 Kemuning, Perak, Malaysia Made in Malaysia Teleflex Medical IDA Business & Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland Indication <u>Urinary Retention</u> Residual Volume (ml) <u>300 ml</u> Colour of Urine <u>Haematuria</u> Easy Insertion? ☒ N If No, why? Name <u>D. BLADES</u> Signed <u>[Signature]</u> Date _____
WEIGHT kg.		
→		
Age		BRILLANT AquaFlete REF A310114 All-Silicone ☒ LOT 19GE27 Long-Term (up to 12 weeks use) 2024-06 Standard, 2-way Foley SIZE Ch. 14 (4.7mm) / 10ml Teleflex Medical, IDA Business & Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland
URINE Protein Sugar Acetone		ATSP re catheterization TROC today put up TURP 17/6/20 easy insertion haematuria. p/blo. pt comfortable
WEIGHT kg.		
		(P) ? TROC tomorrow vs leave catheter + TROC in local hospital

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label
or Enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Personal
Information
redacted
by the
USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	21/6/20	PT hit head off table ♀ fall ♀ LOC ♀ vomiting Bent down to pick up mobile phone GCS 15/15 since Obs stable. No new issues or concern. (P) Bloods none check Hb. & U+E.
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→	22/6/20	Failed TROC → Switch to 3/12 h Decapeptide (Pull note to GP.) TROC SWAH 2/502 (I will refer to gynae). Please have i lumboscopy - D on levetiracetam present is any additional cardiac work / FU required Unilaterally OK to Prostate
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

LPC 03/08/021

30 AUG 2019

CRAIGAVON CELLULAR PATHOLOGY

Surname Patient 1
Forename
Hosp. No. Personal Information redacted by the USI
DOB/Sex Male
Address Personal Information redacted by the USI

Source CRAIGAVON AREA HOSPITAL
Consultant MR A O'BRIEN

Ward/GP THORNDALE UNIT
CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
CRAIGAVON BT63 5QQ

Specimen PROSTATIC BIOPSY/PROSTATIC BIOPSY/PROSTATIC
BIOPSY/PROSTATIC BIOPSY/PROSTATIC BIOPSY/PROSTATIC
BIOPSY

CLINICAL DETAILS

Recent MRI. PIRADS 3 + PIRADS 5 areas. PSA 19.81. Medication - proscar.

PATHOLOGIST'S REPORT

GROSS DESCRIPTION

NATURE OF SPECIMEN: needle core biopsy
SITE: 1. Right base -- three cores, 15, 12 and 12 mm
SITE: 2. Right mid -- three cores, 16, 15 and 14 mm
SITE: 3. Right apex -- three cores, 19, 18 and 9 mm
SITE: 4. Left base -- three cores, 19, 15 and 14 mm
SITE: 5. Left mid -- three cores, 17, 15 and 7 mm
SITE: 6. Left apex -- five cores, 18, 14, 14, 14 and 5 mm

HISTOLOGY

HISTOLOGICAL TYPE: adenocarcinoma
DIFFERENTIATION/GLEASON SUM SCORE: overall 4 + 3 = 7
GRADE GROUP: 3
NUMBER OF CORES/CHIPS INVOLVED: 7
Right base - no tumour identified
Right mid -no tumour identified
Right apex -no tumour identified
Left base -2 of 3 cores involved, Gleason 3 + 4, 10% of tissue
Left mid - 2 of 3 cores involved, Gleason 3 + 4, 5% of tissue
Left apex -3 of 5 cores involved, Gleason 4 + 3, 25% of tissue, 6 mm max length

INVASION INTO FAT: no

Reported by: Personal Information redacted by the USI

Date of Specimen : 20 Aug 2019

Date of report print : 28 Aug 2019

Sample Number: 19K12534

CRAIGAVON CELLULAR PATHOLOGY

Surname	Patient 1	Source	CRAIGAVON AREA HOSPITAL
Forename		Consultant	MR A O'BRIEN
Hosp. No.	Personal Information redacted by the USI	Ward/GP	THORNDAL UNIT
DOB/Sex			CRAIGAVON AREA HOSPITAL
Address	Personal Information redacted by the USI		68 LURGAN ROAD
			CRAIGAVON BT63 5QQ

Specimen **PROSTATIC BIOPSY/PROSTATIC BIOPSY/PROSTATIC BIOPSY/PROSTATIC BIOPSY/PROSTATIC BIOPSY**

PERINEURAL INVASION: no

LYMPHOVASCULAR INVASION: no

FURTHER COMMENTS:

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

**PROSTATE
NEEDLE CORE BIOPSY
ADENOCARCINOMA**

Personal Information redacted by the USI

Date:- 28/08/2019

Reported by: Personal Information redacted by the USI
Date of Specimen : 20 Aug 2019
Date of report print : 28 Aug 2019

Sample Number: 19K12534

Radiology Report

South West Acute Hospital

Tel.: 028 6638 2602

Fax: 028 6638 2656

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Personal information redacted
by the USI

Patient 1

Personal information redacted by the USI

Report recipient:
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

Date of birth

Personal information redacted by the USI

Request no.

Personal information redacted by the USI

BT63 5QQ

Ref. clinician O'Brien, Aidan

Request date 13/08/2019 16:50:00

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

27 AUG 2019

Requested examination(s) US Urinary tract

Clinical details

This 74 year old man was referred in June 2019 with significantly elevated serum PSA levels of 19.16 ng/ml in May 2019 and 19.81 ng/ml in June 2019.

He has been reported to have features of organ confined, prostatic carcinoma on MRI scanning on 10 July 2019 when he was calculated to have a prostatic volume of 40 ml.

He is awaiting prostatic biopsies.

He has a sensation of unsatisfactory voiding following micturition, in addition to nocturia x 1 - 2.

He may be contacted at [Personal information redacted by the USI]

Priority: Red Flag

Method of transport: Walking

Is the patient diabetic?: No

Does the patient have a known infection status?: No

Referral status: NHS

Referrer name: Aidan O'Brien

Referrer grade: Consultant

Referrer contact / bleep detail: [Personal information redacted by the USI]

Reason for referral

To assess anatomy of urinary tract, including prostatic and residual urine volumes.

Author: [Personal information redacted by the USI]

Authorized by: [Personal information redacted by the USI]

Prel. Sign:

Document date: 21/08/2019

Secretary: [Personal information redacted by the USI]

Sign.datum:

Radiology Report

South West Acute Hospital

Tel.: 028 6638 2602

Fax: 028 6638 2656

Personal Information redacted by the USI

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Patient 1

Personal Information redacted by the USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth,

Personal Information redacted by the USI

Request no.

Personal Information redacted by the USI

21/08/2019 14:02 US Urinary tract, Author:

Personal Information redacted by the USI

The kidneys are normal in size with normal parenchyma and collecting systems.
The bladder is normal in appearance

Volume of prostate = 40.3 mls approx.

Pre- mict bladder volume = 385.4 mls

Post- mict bladder volume = 204 mls.

PROSTATE BIOPSY CLINIC

Personal Information redacted by the USI
Patient 1
Personal Information redacted by the USI

Personal Information redacted by the USI

Date: 20/8/19

Tel:

Consultant: AOB

Doctor/Nurse performing procedure:

Personal Information redacted by the USI

Current Medication including any herbal remedies/over the counter drugs:

co-codamol 30/500PRN
Ciliclaside
Lyrinel XL
Rosuvastatin
Aspirin 75mg
150 Sorbide monohydrate
Losartan
Finasteride
Pantoprazole
Bendroflumethiazide

Have you taken your medication today: Yes / No

Anticoagulants: Yes / No

Methotrexate: Yes / No

Allergies: Yes / No
(check latex allergy)

Any Sedation taken today: Yes / No

History of eg MRSA: Yes / No

Relevant Medical History:

Type 2 diabetes. PCI - 12 yrs ago
MI - 2010. Osteoarthritis. IHD. HTN.

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes? Yes / No

If Yes, refer to infection control for advice and refer to guidance available, Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection: Annex J (Revised 12013). If No, no further action required.

pacemaker/ Cardiac Stenting/ Prosthetic Metallic Heart Valve : Yes / No

Epilepsy: Yes / No

Diabetic: Yes / No - Type 2

Tendonitis or Ruptured Tendons: Yes / No

Previous Prostate Biopsy: Yes / No

Any joint replacement within the last 6 months: Yes / No

Prostate Biopsy Documentation - Updated January 2017

WIT-35291

S.emen:
ClinitePATIENT
HERE

Serial Number

Y CHECKLIST

BP:

TEMP:

RESP:

PULSE: 58

SATS: 97% / 10

(record weight if IV antibiotic required)

Patient ID:

Multistix® 8 SG

Lot Number 901011

Expiration date 2020-07

Test date 20-08-2019

Time 10:02

Test number 0755

GLU Negative

KET Negative

BLD Negative

pH 7.0

PRO Negative

NIT Negative

LEU Negative

it attached
/ Changed into gown
then explained?

Yes / No

Yes / No

Yes / No Signature: _____

PROPHYLAXIS:

50mgs BD x 3 days

t home at:

AM / PM

apply provided on arrival
red at:

10:25 AM / PM

SIGNATURE/S:

Personal Information
redacted by the USIShould IV antibiotics be required for any reason, discuss with
practitioner performing procedure and administer as prescribed on
medicine Kardex

Consent obtained

YES ✓

Procedure commenced at:

10:30

Lidocaine 1% 10mgs/ml: 10mls
20 MLS

20 mls

Instillagel 11mls PR

Yes (No)

DRE / Prostate Volume

cc

PSA:

Probe No:

1

Biopsy specimens

Right

Left

Base x 3 Base x 3

Mid x 3 Mid x 3

Apex x 3 Apex x 5

TOTAL CORES:

20

Samples checked against addressograph
label and sent to histology lab

Yes ✓

Prostate Biopsy Documentation – Updated January 2017

trophon

20/08/2019 10:22

SN:88014-033

Disinfection: PASS

Cycle #: 689

Indicator: PASS/FAIL

Operator:

Probe:

Notes:

POST BIOPSY CHECKLIST

	Insert ✓ or give details where appropriate	Signature
Assist into outdoor clothing		
Fluids/light snack tolerated		
Passed urine without difficulty	✓	
Record amount / colour	120mls clear urine	

BP: 148/82

PULSE: 69

TEMP: 36.0

SATS: 95%

RESP: 22

IV Cannulae removed

Complete IPSS

N/A

Discharge advice leaflet given

✓

Informed review appointment would be arranged by phone / posted

✓

Accompanied home by

✓

Time left department

wife + brother-in-law
11:30

Comments post biopsy:

Comfortable on o/c
Advice re-enforced

Prostate Biopsy Documentation – Updated January 2017

Lab Tube

Personal Information
redacted by the USI

Patient 1

Personal Information
redacted by the USI

TRUS biopsy of prostate

Department of Urology

Craigavon Area Hospital

Date 20/08/2019

Consultant MR O'BRIEN

Patient

Patient 1

HCN

Personal Information
redacted by the USI

PSA ng/ml

19.81 (on Finasteride)

DRE

Click here to enter text.

Family History of Prostate Cancer:

Father No

Brother

No

Allergy

nil

Operator

Personal Information
redacted by the USI

LA

20ml 1% Lidocaine



Antibiotics

Ciprofloxacin 750mg po stat

Other ☐

Prostate Volume

32 cc

Cores

Left 11

Right 9

Follow up

Tissue to histology

MDT

Written information provided post biopsy

Ciprofloxacin 750mg BD po 3 days

Other ☐

Signed

Personal Information redacted by the USI

Patient 1

Personal Information
redacted by the USI**AL PROSTATE SYMPTOM SCORE (I-PSS)**

	Not At All	Less Than 1 Time In 5	Less Than Half The Time	About Half The Time	More Than Half The Time	Almost Always	YOUR SCORE
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	2
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?	0	1	2	3	4	5	1
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	2
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	2
5. Weak Stream Over the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5	2
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	1
	None	Once	Twice	3 times	4 times	5 or more	YOUR SCORE
7. Nocturia Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	1
Total I-PSS Score							11

Quality of Life due to Urinary Symptoms

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly unhappy	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: 0 - 7 = mildly symptomatic; 8 - 19 = moderately symptomatic; 20 - 35 = severely symptomatic.

The International Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.

HSS TRUST _____

Hospital Unit _____

GP PRACTICE or other _____

Primary Care Provider _____

FORM 3 – CONSENT FOR EXAMINATION, TREATMENT OR CARE
(Procedures where consciousness not impaired)**Personal details (or pre-printed label)**

Surname/family name.....

First names.....

Date of Birth.....

☐ Male ☐ Female H+C No. (or other identifier) ..

Special requirements (language or other)

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Personal
Information
redacted
by the
USI**Statement of healthcare professional**Responsible healthcare professional Mr O'Brien Job Title Consultant

Name of proposed procedure or course of treatment (include side of body or site and brief explanation if medical term not clear)

True copy of prostate
I have explained the procedure. In particular, I have explainedThe intended benefits diagnosisSerious or frequently occurring risks bleeding, infection, sepsis
retention of urine, false negative

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of those involved.

☐ The following leaflet/tape has been provided

Personal Information redacted by the USI

Signed Date 20/8/19Name (PRINT) Job Title Urology Nurse Specialist**Statement of Interpreter (where appropriate)**

I have interpreted the information above to the best of my ability and in a way which I believe s/he/they can understand.

Signed..... Date.....

Name (PRINT).....

Statement of person giving consent or with parental responsibility for child

I agree to the procedure or course of treatment described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature Personal Information redacted by the USI Date 20/8/19

Name (PRINT)..... Relationship to child.....

Copy accepted Yes/ No (please circle)



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Redacted]

E mail: [Redacted]

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear [Redacted]

Re: Patient Name: [Redacted]

D.O.B.: [Redacted]

Address: [Redacted]

Hospital No: [Redacted]

Patient 1

Personal Information redacted by the USI

Personal Information redacted by the USI

HCN: [Redacted]

Personal Information redacted by the USI

Date/Time of Clinic: 22/07/19

Follow Up: Awaiting results - USS and TRUS biopsies - then MDM

I write to you regarding this 74 year old man whom you referred in June 2019 for further investigation of significantly elevated serum PSA levels of 19.16ng/ml in May 2019 and of 19.81ng/ml in June 2019. When I met [Redacted] at my clinic at South West Acute Hospital in Enniskillen on the 22nd of July 2019, he reported relatively mild urinary symptoms, consisting of a sensation of unsatisfactory voiding following micturition and of nocturia, having to rise once or twice each night to pass urine. He reported having the symptoms even though he had been taking Oxybutynin since 2016. The elevated serum PSA levels were all the more significant in view of the fact that he had also been taking Finasteride since 2010. I found him to have a moderately enlarged and indurated prostate gland on clinical examination.

I had already arranged for [Redacted] to have MRI scanning of his prostate gland performed on the 10th of July 2019 when he was reported to have a prostatic volume of 40mls. He was reported to have modest features of benign hypertrophy of the transition zone, though he was additionally reported to have a focus of hyper intensity within the transition zone in the anterior midline. However, he was additionally reported to have significant features characteristic of adenocarcinoma affecting the peripheral zone of both lateral lobes, but more particularly of the left lateral lobe.

I advised [Redacted] of these findings at review on the 22nd of July 2019. I have requested the Department of Radiology at South West Acute Hospital to arrange an appointment for him to attend there to have ultrasound scanning of his urinary tract performed, and particularly with a view to assessing the quality of bladder voiding on micturition. I have also requested that an appointment be arranged for him to attend our department at the Thorndale Unit, Craigavon Area [Redacted]

Patient 1

Personal Information redacted by the USI

Hospital as an outpatient for transrectal, ultrasound guided prostatic biopsies. I have also arranged for his further assessment and management to be discussed at the Urology Multidisciplinary Meeting when the reports of both the ultrasound scan and of the prostatic biopsies are available. An appointment will subsequently be arranged following MDM discussion.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 13/08/19

Date Typed: 03/09/19-NE

Personal Information redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT**Telephone:**Personal Information redacted by the USI**E mail:****Secretary:** Mrs N. Elliott**Patient 1**Personal Information redacted by the USI**Hospital No:**Personal Information redacted by the USI**HCN:****Dear** **Patient 1**

I was pleased to have the opportunity of meeting you at my clinic at South West Acute Hospital on the 22nd of July 2019, though it is regrettable that I did have to advise you of the probability that you would be found to have some malignancy of your prostate gland on further investigation.

I take this opportunity to advise you that I have requested the Department of Radiology at South West Acute Hospital to arrange an appointment for you to attend there to have ultrasound scanning of your urinary tract performed, and particularly with a view to determining whether you are able to achieve satisfactory bladder emptying on passing urine. You will receive a letter of appointment in the near future.

I have also requested that an appointment be arranged for you to attend our department at the Thorndale Unit at Craigavon Area Hospital as an outpatient for transrectal, ultrasound guided prostatic biopsies. I do hope that you will have received an appointment by the time that you receive this letter.

I have also arranged for your further assessment and management to be discussed at our specialist, Multidisciplinary Meeting when the reports of both the ultrasound scan and of the prostatic biopsies are available. I will arrange a subsequent review appointment for you.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 13/08/19**Date Typed:** 03/09/19-NE

Radiology Report

South West Acute Hospital

Tel.: 028 6638 2602

Fax: 028 6638 2656

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Personal Information redacted by the USI

Patient 1

Personal Information redacted by the USI

Report recipient
Craigmavon Area Hospital
Urology Department
68 Lurgan Road
CRAIGAVON

11 6 JUL 2019

Date of birth

Personal Information redacted by the USI

Request no.

Personal Information redacted by the USI

BT63 5QQ

Personal Information redacted by the USI

Ref. clinician O'Brien, Aidan

Request date 21/06/2019 15:31:00

Referral source
Craigmavon Area Hospital
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Requested examination(s) MRI Pelvis prostate

Clinical details

This 74 year old man has been referred with serum PSA levels increasing to 19.81 ng/ml by 12 June 2019. His prostate gland was considered. When he had a MRI Pelvis performed in July 2018, he was reported to have benign prostatic enlargement. He may be contacted at Personal Information redacted by the USI

Priority: Red Flag

Pacemaker / implanted cardiac device leads?: No

Intra-cranial clips or shunts?: No

Surgery involving implants to eyes or ears?: No

Ever had metal fragments in eyes or skin?: No

Surgery involving implants to the heart?: No

Surgery involving implants to the head?: No

Surgery involving implants to the abdomen?: No

Any other implants eg endoscopic clips, stents, neurostimulators etc?: No

Is the patient pregnant?: No

Method of transport: Walking

Does the patient have a known infection status?: No

Is the patient diabetic?: No

Does patient have any of the following contrast risk factors; Over 70 years of age, renal impairment, diabetes, CHF, myeloma, chemotherapy or nephrotoxic drugs?: Yes

Renal function information: eGFR

eGFR value? Failure to provide required information when applicable may cause a delay due to requests being returned: > 60 ml/min

eGFR date: 14 June 2019

Referral status: NHS

Referrer grade: Consultant

Radiology Report

South West Acute Hospital

Tel.: 028 6638 2602

Fax: 028 6638 2656

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Personal Information redacted
by the USI

Patient 1

Personal Information redacted by the USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

Date of birth

Personal Information redacted
by the USI

Request no.

Personal Information redacted by the USI

BT63 5QQ

Referrer name: Aidan O'Brien

Referrer contact / bleep detail:

Personal Information redacted by the
USI

Reason for referral

To assess anatomy of prostate gland

Author: Personal Information redacted by the USI

Authorized by: Personal Information redacted by the USI

Prel. Sign:

Document date: 10/07/2019

Secretary: Personal Information redacted by the USI

Sign. datum:

10/07/2019 10:17 MRI Pelvis prostate, Author: Personal Information redacted by the USI

INDICATION:

Serum PSA levels increasing to 19.81 ng/ml. MRI Pelvis performed in July 2018, he was reported to have benign prostatic enlargement.

TECHNIQUE:

Standard prostate protocol (sagittal, coronal oblique and axial oblique T2-w, axial oblique T1-w and axial T2-w turbo-spin-echo sequences, diffusion--w EPI-spin-echo (b50, 400 and 800 values, and b1400 calculated from lower b values) and ADC map, and axial T2-w and truFISP at the pelvis).

COMPARISON:

None.

FINDINGS:

Dimensions of the prostate: transverse 4 cm, anteroposterior 3.5 cm and craniocaudal 4.4 cm; ellipsoid volume: 32 cc; bullet volume: 40 cc.

Hypertrophy of the transition zone with no suspicious areas on T2-w assessment (mostly encapsulated nodules and heterogeneous signal areas with obscured margins) and a small focus of marked hyperintensity on diffusion-w images and hypointensity on ADC at the left anterior mid portion abutting the fibromuscular stroma but no corresponding suspicious lesion noted on T2-w images (PI-RADS assessment 3).

Radiology Report

South West Acute Hospital

Tel.: 028 6638 2602

Fax: 028 6638 2656

**Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN**

Personal Information redacted
by the USI

Patient 1

Personal Information redacted by the USI

Report recipient

**Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON**

BT63 5QQ

Date of birth

Personal Information
redacted by the USI

Request no.

Personal Information redacted by the USI

The peripheral zone shows an area of circumscribed homogeneous moderate hypointensity on T2-w of about 2.5 cm abutting the capsule in the bilateral posteromedial and left posterolateral and anterior apex with corresponding marked hyperintensity on diffusion-w and hypointensity on ADC map (PI-RADS assessment 5). There is no definite extraprostatic extension but the lesion largely abuts the capsule with no bulging or irregular contour. The lesion abuts the external urethral sphincter as well but there is no evidence of invasion of this structure.

The periprostatic compartment and seminal vesicles show normal.

No regional lymphadenopathy demonstrated.

No significant bony signal alteration visualized in the pelvis.

The urinary bladder, external urethral sphincter and perineal tissues, penis root and visible scrotum, anorectum, mesorectum and presacral space, pelvic sidewall, etc. appear within normal limits.

IMPRESSION:

PI-RADS assessment 5 for the peripheral zone (left apical lesion), MRI staging T3 N0 M0.
PI-RADS assessment 3 for the transition zone.

Southern Health
and Social Care TrustCRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Direct Line:

E mail:

Secretary:

MRS N. Elliott

Patient 1

Personal Information redacted by the USI

Dear Patient 1

Re: Patient Name:
D.O.B.:
Address:
Hospital No:

Patient 1

Personal Information redacted by the USI

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

I last wrote to you on the 1st of June 2020, advising that I had arranged to have Patient 1 admitted during June 2020 for prostatic resection. I had also requested that he have his serum PSA level repeated prior to admission. It is of further concern to find that his serum PSA levels had increased markedly to 27.22ng/ml by the 3rd of June 2020, and further to 29.5ng/ml by the 12th of June 2020.

As indicated by the Discharge Notification of the 22nd June 2020, Patient 1 was admitted on the 17th of June 2020 when I found him to have a large, obstructive, prostate gland which I resected. When I reviewed him on Saturday the 20th of June 2020, all haematuria had resolved, and his catheter was removed that day. However, as indicated by Patient 1 in his letter of the 22nd of June 2020, Patient 1 required to be re-catheterised that evening as he was entirely unable to pass urine following catheter removal. When re-catheterised, he had recurrence of haematuria, and still did have haematuria when discharged on the 22nd of June 2020 with an indwelling urethral catheter. Patient 1 has been referred to Urology Nurse Specialist Patient 1, requesting that she arrange an appointment for Patient 1 to have a further trial removal of the indwelling urethral catheter. He has also requested CT scanning and bone scanning in order to update his staging, in addition to referring Patient 1 to Consultant in Clinical Oncology at Altnagelvin Area Hospital, requesting an appointment for Patient 1 to attend there with a view to consideration of radical radiotherapy if there is no evidence of metastatic disease progression.

I have had the opportunity of speaking with Patient 1 by telephone since his discharge, and was pleased to hear that the haematuria has again completely resolved. He is currently not particularly bothered by the indwelling urethral catheter, but would indeed look forward to having it removed when arranged. He does have an appointment for CT scanning on Monday the 29th of June 2020. An appointment for radioisotope bone scanning has not yet been arranged.

Personal Information redacted by the USI

When I spoke with him by telephone, I found him to be somewhat vague. I do believe that he does have some, probably significant degree of memory loss. He did not appreciate that he had been referred to the Cancer Centre at Altnagelvin Area Hospital, and did not fully appreciate that any radiotherapy would be for the malignancy of his prostate gland. I do believe that there is some global deterioration in cognitive function since I first met him in July 2019. Whether it was denial or lack of insight, he did not particularly wish to have any treatment for his prostatic carcinoma in late 2019, preferring to go on holiday in December 2019, deferring initiation of any treatment until after he returned. While he was able to convince me that he had been taking the Bicalutamide daily recently, he could not remember having that first injection of Leuporelin during the 1st week of June 2020.

A provisional report of the histopathological examination of recently resected prostatic tissue has found that he now does have Gleason 5+5 adenocarcinoma involving approximately 60% of resected prostatic tissue. I have advised Patient 1 that his prostatic carcinoma is now appearing to be more aggressive than it had been in August 2019.

In order to ensure that he is administered the Decapeptyl 11.25mgs injection intramuscularly, I took the liberty of contacting your Practice, requesting that the prescription be issued and transferred to Personal Information redacted by the USI Pharmacy. Your receptionist ensured that she would then arrange for Patient 1 to have the injection administered, and his serum PSA level repeated, by the Practice Nurse during the week commencing Monday the 29th of June 2020.

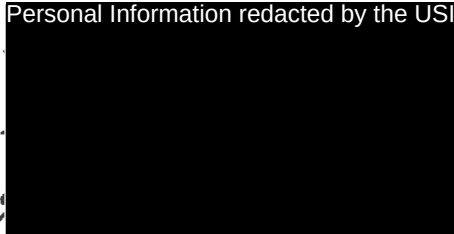
I do hope that there will be no evidence of any metastatic disease on scanning, and that Patient 1 may proceed to have radical radiotherapy. I believe that it would be preferable for him to be free of indwelling urethral catheterisation prior to any radical radiotherapy. If Patient 1 is unable to pass urine following catheter removal, or is unable to achieve satisfactory bladder voiding, it would be preferable for him to be taught self-catheterisation prior to radical radiotherapy. I have written to Personal Information redacted by the USI Urology Nurse Specialist asking her to consider introducing Patient 1 to self-catheterisation in the event of satisfactory bladder voiding not being achieved.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

c.c. Personal Information redacted by the USI



Date Dictated: 26/06/20

Date Typed: 02/07/20-NE

Personal Information redacted by the USI



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT**Direct Line:****E mail:****Secretary:****MRS N. ELLIOTT**

Personal Information redacted by the USI

Dear

Personal Information redacted by the USI

Re: Patient Name:**Patient 1****D.O.B.:**

Personal Information redacted by the USI

Address:

Personal Information redacted by the USI

Hospital No:

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

Further to the letter of the 22nd of June 2020 from **Patient 1** I enclose a further letter addressed to this 75 year old man's family doctor. I would indeed be grateful if you could arrange for **Patient 1** to have a further trial removal of the indwelling urethral catheter, and importantly, to introduce him to the technique of clean intermittent self-catheterisation if he is unable to pass urine, or is able to do so but unable to achieve satisfactory bladder voiding. I do believe that it would be preferable for him to be practicing self-catheterisation prior to having radical radiotherapy rather than having an indwelling urethral catheter.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 26/06/20**Date Typed:** 02/07/20-NE

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname Patient 1
Forename
Hosp. No. Personal Information redacted by the USI
DOB/Sex Male
Address Personal Information redacted by the USI

Source DAISY HILL HOSPITAL
Consultant MR A O'BRIEN
Ward/GP MS DHH

- 2 JUL 2020

Specimen **PROSTATIC CHIPPINGS**

Personal Information redacted by the USI

CLINICAL DETAILS

Prostatic carcinoma refractory to androgen blockade. TURP to relieve outlet obstruction.

SPECIMEN – Prostatic tissue.

PATHOLOGIST'S REPORT

Received multiple chippings which together weigh 20 grams.

Histological examination shows prostatic chippings approximately 60% of which are infiltrated by tumour. The tumour cells are largely sheeted in nature and consist of cells with prominent nucleoli in keeping with prostatic adenocarcinoma. Many of the tumour areas are hyperchromatic in nature but there is no evidence of neuroendocrine differentiation. The features are those of Gleason 5+5 adenocarcinoma but grading following androgen therapy is unreliable. Perineural and lymphovascular invasion are seen.

DIAGNOSIS:
PROSTATE
TURP
ADENOCARCINOMA

Personal Information redacted by the USI

Secretary: Personal Information redacted by the USI
Date: 29/06/2020

Reported by: Personal Information redacted by the USI
Date of Specimen : 17 Jun 2020
Date of report print : 29 Jun 2020

Sample Number: **20K05485**

WIT-35306Southern Health
and Social Care TrustDaisy Hill Hospital, 5 Hospital Road, Newry, County Down, BT35 8DR
Tel: 028 3083 5000

Ward Tel:

Notes Copy

Personal Information redacted by the USI

Date: 22/06/2020 18:16

Discharge Id: Personal Information redacted by the USI

Version: 43

564

Dear Dr Personal Information redacted by the USI

DISCHARGE NOTIFICATION

The patient was admitted under the care of **MR A O'BRIEN** (specialty: **UROLOGY(C)**) into **MALE SURGICAL** Ward at **DAISY HILL HOSPITAL** on **17/06/2020 07:30:00** and discharged on **22/06/2020**.

Forenames:

Patient 1

Address:

Personal Information redacted by the USI

Surname:**D.O.B:**

Personal Information redacted by the USI

Hospital No:**NHS No:****Gender:**

Male

Ward:

MALE SURGICAL

Admission Reason

Elective admission for TURP

Principle Discharge Diagnosis

TURP

Operations/Procedures/Radiology

TURP

Additional Information for GP**Past Medical/Surgical History**

NSTEMI

Bilateral inguinal hernia repair

T2DM

WIT-35307

Varicose veins

Changes to Medications - Start/Stop

See discharge prescription below for medication changes

Clinical Information/Comments

Patient 1

was electively admitted for TURP. Large prostate resected.

Admission complicated by post operative urinary sepsis. Treated with IV Tazocin.

Period of telemetry due to being bradycardic. Asymptomatic. No arrhythmias; Sinus bradycardia. Diltiazem stopped.

Failed TROC. For repeat TROC in SWAH in two weeks.

Early morning hypoglycaemia. DSN advised stopping gliclazide and HbA1C to be rechecked in two months.

Patient 1

is now for discharge. Many thanks.

Did the patient receive a blood transfusion?

No

Allergies Patient has allergies**Details of Allergies**

Xatral

Atorvastatin

Bisoprolol

Ticagrelor

Tamoxifen

Lipitor

Known Reactions to Allergies**Discharge Date** 22/06/2020 **Discharge Time****Arrangements For Follow-Up**

TROC in SWAH in two weeks

MDM discussion

HbA1C to be repeated in 2 months

Further Detailed**Discharge Letter To Follow:** No**Awaiting Further Results:** No

**Patient Aware Of
Diagnosis:**

Yes

WIT-35308

Other Management Information For GP

Patient states not taking mirtazapine. Please r/v

Discharge Prescription:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?
Admission drugs (unamended)					
ASPIRIN Dispersible Tablets	75mg	Each Morning	-	Oral	Yes
LEUPRORELIN ACETATE Injection (Change Reason: .)	3.75mg	Once monthly	-	Subcutaneous	Yes
OXYBUTYNIN HYDROCHLORIDE Modified release Tablets	10MG	Each Morning	-	Oral	Yes
ISOSORBIDE MONONITRATE Modified release Tablet / Cap	50MG	Each Morning	-	Oral	Yes
Losartan Tablets	100MG	Each Morning	-	Oral	Yes
FINASTERIDE 5 mg Tablets	5MG	Each Morning	-	Oral	Yes
ROSUVASTATIN Tablets	10MG	Each Night	-	Oral	Yes
PANTOPRAZOLE Enteric coated Tablets	20MG	Each Morning	-	Oral	Yes
BENDROFLUMETHIAZIDE Tablets	2.5MG	Each Morning	-	Oral	Yes
BICALUTAMIDE Tablets (Additional Info: Amber List Medicine)	150MG	Each Morning	-	Oral	Yes
Pregabalin 25mg Capsules	25MG	Twice Daily	-	Oral	Yes
GLYCERYL TRINITRATE 400 micrograms Aerosol T Spray		When Required	-	Sublingual	Yes
DIAZEPAM Tablets	5MG	Once Daily When Req.	-	Oral	Yes
ZOPICLONE Tablets	7.5MG	At Night When Req.	-	Oral	Yes
CO-CODAMOL 30mg/500mg Caps/Tabs	TT	4-6 Hourly When Req.	-	Oral	Yes

WIT-35309*(Change Reason: .)*

MIRTAZAPINE Tablets	15MG	At Night When Req.	-	Oral	Review
---------------------	------	-----------------------	---	------	--------

*(Additional Info: **Patient states not using. Please review.**)**(Change Reason: .)***Drugs prescribed since admission****Admission drugs (amended)****Stopped Medication:**

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				
GLICLAZIDE 30 mg Modified release Tablets	30mg	Each Morning	-	Oral
<i>(Indications: HSCB Cost Effective Choices List recommends Bilxona MR® brand where appropriate for individual patient)</i> <i>(Change Reason: As per DSN.)</i>				
DILTIAZEM (ZEMTARD XL) Modified Release Capsules	180MG	Each Morning	-	Oral
<i>(Change Reason: BRADYCARDIC ON TELEMTRY.)</i>				

Authorised Forms

Form	Authorised By	Date/Time
Adult Clinical Details (Elective-CMPM)	Personal Information redacted by the USI	22/06/2020 14:55:21

Prescribing Clinician:**Discharged by:**

Personal Information redacted by the USI

Bleep No:**Bleep No:**

Personal Information redacted by the USI

Elliott, Noleen

From: O'Brien, Aidan
Sent: 01 June 2020 14:47
To: Elliott, Noleen
Subject: Patient 1

Personal Information redacted by the USI

Noleen,

Please place this man on CURWL for

- TURP
- Urgency 2 (Red Flag)
- Date of entry: 01 June 2020

I have dictated correspondence,

Thank you,

Aidan.

**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT

CONSULTANT: Mr A O'Brien, Consultant Urologist
SECRETARY: Mrs Noleen Elliott
TELEPHONE: Personal Information redacted by the USI

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name:
D.O.B.:
Address:
Hospital No:

Patient 1

Personal Information redacted by the USI

HCN: Personal Information redacted by the USI

I last wrote to you on the 07th March 2020, requesting that Patient 1 be prescribed the increased dose of 150mgs of Bicalutamide daily, in view of the increase in his serum PSA level to 5.37 ng/ml on the 05th March 2020. I also requested that he would have his serum PSA level repeated prior to his intended further review on the 27th April 2020. It was most concerning to find that his serum PSA level had increased further to 12.08 ng/ml when repeated on the 14th April 2020. Regrettably, it was not possible to review Patient 1 on the 27th April 2020 as intended due to the corona viral pandemic.

I have since learned that Patient 1 began to experience increasing difficulty in passing urine, requiring him to attend the Emergency Department at South West Acute Hospital on the 23rd March 2020. When he attended again on the 07th April 2020, he required urethral catheterisation for urinary retention, his bladder containing 600mls of urine. In retrospect, this is probably not particularly surprising in view of the finding of inadequate bladder voiding on ultrasound scanning performed in August 2019 when he had a residual urine volume of 204mls following micturition. He has found indwelling urethral catheterisation to be bothersome since then.

I have had the opportunity of speaking with Patient 1 by telephone on Monday 01st June 2020. I have also had the opportunity of speaking with your colleague, requesting that he be prescribed Leuprorelin 3.75mgs to be administered subcutaneously once monthly, during the first week of each new calendar month. I do hope that it will be possible for Patient 1 to have the first injection administered during this first week of June 2020. I have also requested that he have his serum PSA level repeated by the practice nurse when administering that first injection of Leuprorelin.

Personal Information redacted by the USI

I have also advised ^{Patient 1} that I would arrange for him to be admitted to our department at Daisy Hill Hospital in Newry for prostatic resection. I have advised him that he should continue in self-isolation until his admission, and I have advised him that he will have COVID-19 testing arranged prior to his admission. His admission will only be proceeded with if he is found to be COVID-19 negative.

Thereafter, ^{Patient 1} will require to have his prostatic carcinoma restaged by having radioisotope bone scanning and CT scanning repeated, there having been no evidence of metastatic disease when both of these scans were previously performed in October 2019.

Yours sincerely,

Dictated but not signed by:

AIDAN O'BRIEN FRCS
CONSULTANT UROLOGIST

Date Dictated: 01/06/2020

Date Typed: 01/06/2020

**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT

CONSULTANT:
SECRETARY:
TELEPHONE:

Mr A O'Brien, Consultant Urologist

Mrs Noleen Elliott

Personal Information redacted by the USI

01/06/20

CONFIDENTIAL

Patient 1

Personal Information redacted by the USI

HCN: Personal Information redacted by the USI

HOSPITAL NO: Personal Information redacted by the USI

Dear Patient 1

I was pleased to have the opportunity of speaking with you and with your wife by telephone on Monday, 01st June 2020. I write to confirm that I was able to speak with your family doctor, arranging for you to have the first monthly injection of Leuprorelin administered by the practice nurse, as well as having your serum PSA level repeated. I do hope that both of these will have been done by the time that you have received this letter.

I also write to confirm that I will arrange for you to be admitted to our department at Daisy Hill Hospital in Newry for endoscopic resection of your prostate gland. You will be advised of a date for your admission in due course. I would request that you continue to remain in self-isolation until then, apart from attending the health centre. Personal Information redacted by the USI to have the Leuprorelin injection administered. Arrangements will be made for you to be tested for COVID-19 at Personal Information redacted by the USI two days prior to the planned date of your admission to Daisy Hill Hospital.

Personal Information redacted by the USI

I do hope that you remain safe and reasonably well until the date of your admission, and I look forward to meeting you then once again.

Yours sincerely,

DICTATED BUT NOT SIGNED BY:

AIDAN O'BRIEN FRCS
CONSULTANT UROLOGIST

PSA

Patient: Patient 1

Date Of Birth: Personal Information redacted by the USI

HCN: Personal Information redacted by the USI

Recipient GP: Personal Information redacted by the USI

Status: Filed

Viewed: Personal Information redacted by the USI

Specimen: UNSPECIFIED

Taken: 05/03/2020 11:34

PSA

(CD) - fao mr o'brien, cah urology

Se prostate specific Ag level 5.37 ng/mL (0 - 6.5)

EMIS Report ID: 2644099 Lab Report ID: 2003056222

Issued: 05/03/2020 00:00

Received: 07/03/2020 06:00

23 MAR 2020



Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Redacted]

E mail: [Redacted]

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear [Redacted]

Re: Patient Name: [Redacted]

D.O.B.: [Redacted]

Address: [Redacted]

Hospital No: [Redacted]

Date/Time of Clinic: 27/01/20

Follow Up: Review 27/4/20

I last wrote to you on the 2nd of January 2019, requesting that [Redacted] have a serum PSA level repeated prior to his further review on the 27th of January 2020. I was delighted to find that his serum PSA level had decreased to 2.23ng/ml by the 7th of January 2020. I found [Redacted] to remain very well at review on the 27th of January 2020, his only urinary symptom being that of nocturia, having to rise twice each night to pass urine. As I concluded that his serum PSA level would continue to decrease to an optimal level prior to his referral for definitive management with curative intent, and as he had tolerated the 50mgs of Bicalutamide daily without adverse toxicity, I advised [Redacted] to increase the dose of Bicalutamide to 100mgs daily. However, I have been disappointed to find that his serum PSA level had increased to 5.37ng/ml on the 5th of March 2020.

I have been in contact with [Redacted] by telephone, advising him of this increase in his serum PSA levels. As he has been able to tolerate the increased dose of 100mgs of Bicalutamide without difficulty, I would be grateful if you would issue once again a prescription for Bicalutamide 150mgs daily, indefinitely. I have asked [Redacted] to collect a prescription from your Practice, and I have also asked him to arrange an appointment with your Practice Nurse to have his serum PSA level repeated in mid-April 2020, and so that the result will be available when he returns for further review at my clinic [Redacted] on the 27th of April 2020.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 07/03/20

Date Typed: 11/03/20-NE

Personal Information redacted by the USI

**Southern Health
and Social Care Trust****CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ****UROLOGY DEPARTMENT****Telephone:****E mail:****Secretary: Mrs N. Elliott****Patient 1**

Personal Information redacted by the USI

Hospital No:**HCN:**

Personal Information redacted by the USI

Dear **Patient 1**

I was pleased to have the opportunity of speaking with you by telephone on Saturday the 7th of March 2020, though it was regrettable that I had to advise you that your serum PSA level had increased to 5.37ng/ml by the 5th of March 2020.

I have written to your Family Doctor, **Personal Information redacted by the USI** requesting that a further prescription be issued for Bicalutamide 150mgs to be taken once daily. When you receive this letter, I would be grateful if you would collect a prescription from the **Personal Information redacted by the USI** at the **Personal Information redacted by the USI** and continue to take 1 daily until I have the opportunity of reviewing you at my clinic at **Personal Information redacted by the USI** once again on Monday the 27th of April 2020.

I would also be grateful if you would arrange an appointment with the Practice Nurse at the Health Centre to have your serum PSA level repeated 1 week prior to my reviewing you on the 27th of April 2020.

Yours sincerely

*Dictated but not signed by***Mr A O'Brien FRCS
Consultant Urological Surgeon****Date Dictated: 07/03/20****Date Typed: 11/03/20-NE**

**CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ**

UROLOGY DEPARTMENT

Telephone: [REDACTED]

E mail: [REDACTED]

Secretary: [REDACTED]

Personal Information redacted by the USI

Dear, [REDACTED]

Re: Patient Name: [REDACTED]
D.O.B.: [REDACTED]
Address: [REDACTED]
Hospital No: [REDACTED]

Patient 1

Personal Information redacted by the USI

HCN:

Personal Information redacted by the USI

Date/Time of Clinic: 11/11/19**Follow Up:** Review 27/1/20

I last wrote to you in October 2019 when I requested that you prescribe for Patient 1 the lower daily dose of 50mgs of Bicalutamide as he had been intolerant of the higher dose of 150mgs due to a sensation of lightheadedness. When I reviewed Patient 1 on the 11th of November 2019, I was pleased to find him keeping somewhat better, and able to tolerate the lower dose of Bicalutamide. He undertook to continue to take that lower dose until his further review, and whilst on holiday abroad during December 2019.

I have been able to speak with Patient 1 by telephone on the 2nd of January 2020, and was pleased to advise him that I had found his serum PSA level to have decreased further to 3.84ng/ml on the 11th of November 2019. I have asked Patient 1 to arrange an appointment with your Practice Nurse to have his serum PSA level repeated and so that the result will be available when he returns for further review on Monday the 27th of January 2020.

It would be ideal for Patient 1 to have an optimal biochemical response to androgen blockade or androgen deprivation prior to consideration of radical radiotherapy. If his serum PSA level has not decreased further, it may be necessary to take an incremental approach to increased androgen blockade by increasing the dose of Bicalutamide to 50mg twice daily, and hopefully subsequently to taking the higher dose of 150mgs once again, as I suspect that the addition of a LHRH agonist may be more intolerable.

In any case, I look forward to reviewing him with the recent result of a further serum PSA level, and I will advise you in due course of plans for his further management.

Yours sincerely

Dictated but not signed by

**Mr A O'Brien FRCS
Consultant Urological Surgeon**

Date Dictated: 02/01/19**Date Typed:** 10/01/20-NE



Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Redacted]

E mail: [Redacted]

Secretary: Mrs M. Elliott

Patient 1

Personal Information redacted by the USI

Hospital No: [Redacted]

HCN: [Redacted]

Dear Patient 1

I was pleased to have the opportunity of speaking with you by telephone on Monday the 14th of October 2019. I have to confess that I have not previously experienced anyone having the sensation of lightheadedness or of having a fuzzy head as a consequence of taking either Bicalutamide or Tamoxifen. In any case, I do believe that it is entirely safe and preferable that you do not take any more of either medication from now until the 1st of November 2019.

I write to confirm that I have written to your Family Doctor, [Redacted] requesting that he issue a prescription for the lower dose of Bicalutamide 50mgs to be taken once daily. When you receive this letter, I would be grateful if you would collect a prescription from [Redacted] and begin taking this lower dose of Bicalutamide alone on Friday the 1st of November 2019, and so that you may be able to advise me of your tolerance of this lower dose when you return for review at my clinic at [Redacted] on Monday the 11th of November 2019.

I would also be grateful if you would arrange an appointment with the Practice Nurse to have your serum PSA level repeated during the 1st week of November 2019, and so that the result will also be available when you return for further review on Monday the 11th of November 2019. I also write to confirm that I have requested the Department of Radiology at South West Acute Hospital in Enniskillen to arrange an appointment for you to attend there to have a CT scan of your chest, abdomen and pelvis performed.

Equally, I also write to confirm that I have requested the Department of Radiology at Craigavon Area Hospital to arrange an appointment for you to attend there to have a bone scan performed.

I look forward to reviewing you at my clinic at [Redacted] on Monday the 11th of November 2019, and I do hope that I will find you to be keeping better by then.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 14/10/19

Date Typed: 15/10/19-NE



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Telephone: [Personal Information redacted by the USI]

E mail: [Redacted]

Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR [Redacted]

Re: Patient Name: [Redacted]

D.O.B.: [Redacted]

Address: [Redacted]

Hospital No: [Redacted]

Patient 1

Personal Information redacted by the USI

Personal Information redacted by the USI

HCN: [Redacted]

Date/Time of Clinic: 23/09/19

Follow Up: Review 11th November 2019

I last wrote to you in August 2019 when I arranged for Patient 1 to have prostatic biopsies performed on the 20th of August 2019. There was no evidence of any prostatic adenocarcinoma in any of the 9 cores taken from the right lateral lobe of his prostate gland. He was however found to have Gleason 4+3 adenocarcinoma found in 7 of the 11 cores taken from the right lateral lobe of his prostate gland. The maximum tumour length was 6mm, and tumour was considered to occupy approximately 8% of total core tissue volume. There was no evidence of perineural infiltration, lymphovascular infiltration or extracapsular invasion.

I advised Patient 1 of the histopathological diagnosis at review at my clinic at [Redacted] on the 23rd of September 2019. I advised him that the nature of the adenocarcinoma that had been found was considered to be of high risk category, particularly in view of he having elevated serum total PSA levels of almost 20ng/ml, and even though he had been taking Finasteride since 2010. For this reason, I initiated androgen blockade by prescribing Bicalutamide 150mgs daily, in addition to Tamoxifen 10mgs daily in order to minimise the risk of gynaecomastia arising as a consequence of androgen blockage. However, Patient 1 subsequently contacted my secretary to advise that the combination of Bicalutamide and Tamoxifen had resulted in adverse toxicity which he found difficult to tolerate. When I spoke with him by telephone on Monday the 14th of October 2019, he reported that he was quite fuzzy headed, and to the extent that he was concerned that it was safe for him to drive. I therefore advised him to discontinue taking both for a period of time.

I had found that his serum PSA level had increased to 21.8ng/ml at review on the 23rd of September 2019. I found him to have very normal serum testosterone level of 19.3nmols/L, and which would hopefully indicate that the prostatic carcinoma would be androgen dependent, and that androgen blockade or [Redacted]

Personal Information redacted by the USI

deprivation would result in an optimal biochemical response. I have requested a radioisotope bone scan and a CT scan of his chest, abdomen and pelvis as advised when his further assessment and management was discussed at the Urology Multidisciplinary Meeting of the 29th of August 2019. I have arranged to review him at my clinic at [Personal Information redacted by the USI] on Monday the 11th of November 2019 when the reports of both scans should be available and when his further management will have been discussed again at the Urology Multidisciplinary Meeting.

In the interim, I would be grateful if you would issue a further prescription for Bicalutamide 50mgs daily. I have asked [Patient 1] not to take any more of the higher dose of Bicalutamide, or of the Tamoxifen, until the end of October 2019. I have asked [Patient 1] to collect the prescription for the lower dose of Bicalutamide, 50mgs daily, from your practice, and to begin taking that alone, once daily, on the 1st of November 2019, and so that I may be able to review his tolerance of it when he returns for review on the 11th of November 2019. I have also asked [Patient 1] to arrange an appointment with your Practice Nurse to have his serum PSA level repeated during the 1st week of November 2019 and so that the result may also be available when he returns for further review.

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 14/10/19

Date Typed: 15/10/19-NE



Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT**Telephone:****E mail:****Secretary:** Mrs N. Elliott

Personal Information redacted by the
USI

Dear Personal Information redacted by the USI

Re: Patient Name:Patient 1**D.O.B.:**Personal Information redacted by the USI**Address:****Hospital No:**Personal Information
redacted by the USI**HCN:**Personal Information
redacted by the USI

Date/Time of Clinic: 20/08/19	Follow Up: Review by Mr O'Brien
Procedure (if applicable) TRUS biopsies	

Patient 1 attended the Thorndale Unit today. Written consent was obtained, local anaesthetic inserted and following guidance from his recent MRI scan, a total of 20 core biopsies of prostate were collected.

He was provided with a 3 day course of prophylactic antibiotics and was discharged home in the company of a family member. His histology results will be discussed at the Urology Multidisciplinary Meeting and he will be reviewed by Mr O'Brien thereafter.

Yours sincerely

Dictated but not signed by

Personal Information redacted by the USI

Clinical Nurse Specialist in Urology to:
Mr A O'Brien FRCS
Consultant Urological Surgeon

Date Dictated: 20/08/19	Date Typed: 30/08/19-NE
--------------------------------	--------------------------------

Personal Information redacted by the USI

WIT-35323

MDM Report from Urology MDM @ The Southern Trust

Noted Elliot CHT Clinic 20-08-19

RE:

Patient 1

Personal Information redacted by the USI

DOB:

Personal Information
redacted by the USI

Hospital Number:

Personal Information
redacted by the USI

, HCN:

Personal Information
redacted by the USI

Contact Tel:

Personal Information
redacted by the USI

Library 2

MDM Report from the Urology MDM @ The Southern Trust on 29/08/2019.

MDM Update

CONSULTANT MR O'BRIEN: This 74 year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

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

TRUS biopsy, 20.08.19 -

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

MDM Action

Discussed at Urology MDM 29.08.19.

Patient 1 has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

radiology

MRI Findings

MDM Report from Urology MDM @ The Southern Trust**RE:**

Patient 1

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Contact Tel:

Personal Information redacted by the USI

Latest Findings from MRI performed on 10/07/2019**10/07/2019 10:17 MRI Pelvis prostate, Author:** Personal Information redacted by the USI**INDICATION:**

Serum PSA levels increasing to 19.81 ng/ml. MRI Pelvis performed in July 2018, he was reported to have benign prostatic enlargement.

TECHNIQUE:

Standard prostate protocol (sagittal, coronal oblique and axial oblique T2-w, axial oblique T1-w and axial T2-w turbo-spin-echo sequences, diffusion-w EPI-spin-echo (b50, 400 and 800 values, and b1400 calculated from lower b values) and ADC map, and axial T2-w and truFISP at the pelvis).

COMPARISON:

None.

FINDINGS:

Dimensions of the prostate: transverse 4 cm, anteroposterior 3.5 cm and craniocaudal 4.4 cm; ellipsoid volume: 32 cc; bullet volume: 40 cc.

Hypertrophy of the transition zone with no suspicious areas on T2-w assessment (mostly encapsulated nodules and heterogeneous signal areas with obscured margins) and a small focus of marked hyperintensity on diffusion-w images and hypointensity on ADC at the left anterior mid portion abutting the fibromuscular stroma but no corresponding suspicious lesion noted on T2-w images (PI-RADS assessment 3).

The peripheral zone shows an area of circumscribed homogeneous moderate hypointensity on T2-w of about 2.5 cm abutting the capsule in the bilateral posteromedial and left posterolateral and anterior apex with corresponding marked hyperintensity on diffusion-w and hypointensity on ADC map (PI-RADS assessment 5). There is no definite extraprostatic extension but the lesion largely abuts the capsule with no bulging or irregular contour. The lesion abuts the external urethral sphincter as well but there is no evidence of invasion of this structure.

The periprostatic compartment and seminal vesicles show normal.

No regional lymphadenopathy demonstrated.

No significant bony signal alteration visualized in the pelvis.

The urinary bladder, external urethral sphincter and perineal tissues, penis root and visible scrotum, anorectum, mesorectum and presacral space, pelvic sidewall, etc. appear within normal limits.

IMPRESSION:

PI-RADS assessment 5 for the peripheral zone (left apical lesion), MRI staging T3 N0 M0. PI-RADS assessment 3 for the transition zone.

MDM Report from Urology MDM @ The Southern Trust

RE:

Patient 1

Personal Information redacted by the USI

DOB:

Personal Information
redacted by the USI

Hospital Number:

Personal Information
redacted by the USI

, **HCN:**

Personal Information
redacted by the USI

Contact Tel:

Personal Information
redacted by the USI

Urology MDM @ The Southern Trust

Personal Information redacted by the USI

RE:

Patient 1

Personal Information redacted by the USI

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

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust
On 29/08/2019.

MDM Update:

CONSULTANT MR O'BRIEN: This 74 year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an enlarged prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

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

TRUS biopsy, 20.08.19 -

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

MDM Plan:

Discussed at Urology MDM 29.08.19.

Patient 1 has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

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

Yours sincerely,

Urology MDM @ The Southern Trust

RE: Patient 1
Personal Information redacted by the USI
DOB: Personal Information redacted by the USI Hospital Number: Personal Information redacted by the USI , HCN: Personal Information redacted by the USI

Chairman of Urology MDM

Personal Information redacted by the USI

Consultant Urologist

Urology MDM @ The Southern Trust

RE:

Patient 1

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust
On 29/08/2019.

MDM Update:

CONSULTANT MR O'BRIEN: This 74 year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

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

TRUS biopsy, 20.08.19 -

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

MDM Plan:

Discussed at Urology MDM 29.08.19.

Patient 1

has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

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

Yours sincerely,

DIOMETER ABL800 FLEX

Theatre DRT Syringe - S 195uL 02:37 PM 6/17/2020
Sample # 1415

TS Patient 1
Name
Name
Arterial
37.0 °C
21.0 %
Personal Information redacted by the USI

Values
7.372 [7.350 - 7.450]
4.92 kPa [4.30 - 6.40]
17.3 kPa [11.0 - 14.4]
(P.st)_c 21.7 mmol/L [22.0 - 29.0]
(P)_c 21.0 mmol/L [22.0 - 29.0]
status
ct)_c -3.4 mmol/L [-3.0 - 3.0]
tus
98.1 % [94.0 - 98.0]
3.58 kPa [3.30 - 3.90]
Corrected Values
7.372 [7.350 - 7.450]
17.3 kPa [11.0 - 14.4]
4.92 kPa [4.30 - 6.40]
es
116 g/L [115 - 180]
95.8 % [94.0 - 98.0]
0.9 % [0.0 - 2.0]
1.9 % [1.0 - 5.0]
1.4 % [0.0 - 2.0]
0.357 [0.370 - 0.530]
alues
6.4 mmol/L [3.5 - 5.3]
0.6 mmol/L [0.4 - 0.8]
alues
3.2 mmol/L [3.5 - 4.5]
137 mmol/L [136 - 145]
1.19 mmol/L [1.15 - 1.33]
106 mmol/L [98 - 107]
10.4 mmol/L [12.0 - 18.0]

↑ Value(s) above reference range
↓ Value(s) below reference range
d Default value(s)
c Calculated value(s)

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre PATIENT REPORT Syringe - S 195uL 02:37 PM 6/17/2020
Sample # 14

Identifications
Patient ID Patient 1
Patient Last Name
Patient First Name
Date of birth
Sample type
T
FO₂(I) 37.0 °C
21.0 %
Operator
Personal Information redacted by the USI

Blood Gas Values
pH 7.372 [7.350 - 7.450]
pCO₂ 4.92 kPa [4.30 - 6.40]
↑ pO₂ 17.3 kPa [11.0 - 14.4]
↓ cHCO₃⁻(P.st)_c 21.7 mmol/L [22.0 - 29.0]
↓ cHCO₃⁻(P)_c 21.0 mmol/L [22.0 - 29.0]
Acid Base Status
↓ cBase(Ecf)_c -3.4 mmol/L [-3.0 - 3.0]
Oxygen Status
↑ sO₂ 98.1 % [94.0 - 98.0]
p50(st)_d 3.58 kPa [3.30 - 3.90]
Temperature Corrected Values
pH(T) 7.372 [7.350 - 7.450]
↑ pO₂(T) 17.3 kPa [11.0 - 14.4]
pCO₂(T) 4.92 kPa [4.30 - 6.40]
Oximetry Values
ctHb 116 g/L [115 - 180]
FO₂Hb 95.8 % [94.0 - 98.0]
FCOHb 0.9 % [0.0 - 2.0]
FHHb 1.9 % [1.0 - 5.0]
FMetHb 1.4 % [0.0 - 2.0]
↓ Hct_c 0.357 [0.370 - 0.530]
Metabolite Values
↑ cGlu 6.4 mmol/L [3.5 - 5.3]
cLac 0.6 mmol/L [0.4 - 0.8]
Electrolyte Values
↓ cK⁺ 3.2 mmol/L [3.5 - 4.5]
cNa⁺ 137 mmol/L [136 - 145]
cCa²⁺ 1.19 mmol/L [1.15 - 1.33]
cCl⁻ 106 mmol/L [98 - 107]
↓ Anion Gap_c 10.4 mmol/L [12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
d Default value(s)
c Calculated value(s)

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre PATIENT REPORT Syringe - S 195uL 11:48 AM 6/17/2020
Sample # 1413

Identifications
Patient ID Patient 1
Patient Last Name
Patient First Name
Date of birth
Sample type
T
FO₂(I) 37.0 °C
21.0 %
Operator
Personal Information redacted by the USI

Blood Gas Values
pH 7.332 [7.350 - 7.450]
pCO₂ 5.54 kPa [4.30 - 6.40]
? pO₂ kPa [- -]
↓ cHCO₃⁻(P.st)_c 21.3 mmol/L [22.0 - 29.0]
↓ cHCO₃⁻(P)_c 21.4 mmol/L [22.0 - 29.0]
Acid Base Status
↓ cBase(Ecf)_c -3.5 mmol/L [-3.0 - 3.0]
Oxygen Status
sO₂ 96.5 % [94.0 - 98.0]
Temperature Corrected Values
pH(T) 7.332 [7.350 - 7.450]
pCO₂(T) 5.54 kPa [4.30 - 6.40]
Oximetry Values
ctHb 114 g/L [115 - 180]
FO₂Hb 94.7 % [94.0 - 98.0]
FCOHb 0.5 % [0.0 - 2.0]
FHHb 3.4 % [1.0 - 5.0]
FMetHb 1.4 % [0.0 - 2.0]
↓ Hct_c 0.352 [0.370 - 0.530]
Metabolite Values
↑ cGlu 5.5 mmol/L [3.5 - 5.3]
↑ cLac 1.3 mmol/L [0.4 - 0.8]
Electrolyte Values
↓ cK⁺ 3.2 mmol/L [3.5 - 4.5]
cNa⁺ 138 mmol/L [136 - 145]
cCa²⁺ 1.22 mmol/L [1.15 - 1.33]
cCl⁻ 106 mmol/L [98 - 107]
↓ Anion Gap_c 11.2 mmol/L [12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)
D210: Calibration error(s) present
D476: Measurement unstable

RADIOMETER ABL800 FLEX

ABL835 DHH Theatre PATIENT REPORT Syringe - S 195uL 12:53 PM 6/17/2020
Sample # 1414

Identifications
Patient ID Patient 1
Patient Last Name
Patient First Name
Date of birth
Sample type
T
FO₂(I) 37.0 °C
21.0 %
Operator
Personal Information redacted by the USI

Blood Gas Values
pH 7.382 [7.350 - 7.450]
pCO₂ 4.79 kPa [4.30 - 6.40]
↑ pO₂ 21.9 kPa [11.0 - 14.4]
↓ cHCO₃⁻(P.st)_c 21.8 mmol/L [22.0 - 29.0]
↓ cHCO₃⁻(P)_c 20.9 mmol/L [22.0 - 29.0]
Acid Base Status
↓ cBase(Ecf)_c -3.4 mmol/L [-3.0 - 3.0]
Oxygen Status
↑ sO₂ 98.7 % [94.0 - 98.0]
p50(st)_d 3.58 kPa [3.30 - 3.90]
Temperature Corrected Values
pH(T) 7.382 [7.350 - 7.450]
↑ pO₂(T) 21.9 kPa [11.0 - 14.4]
pCO₂(T) 4.79 kPa [4.30 - 6.40]
Oximetry Values
ctHb 114 g/L [115 - 180]
FO₂Hb 96.5 % [94.0 - 98.0]
FCOHb 0.9 % [0.0 - 2.0]
FHHb 1.3 % [1.0 - 5.0]
FMetHb 1.3 % [0.0 - 2.0]
↓ Hct_c 0.360 [0.370 - 0.530]
Metabolite Values
↑ cGlu 5.4 mmol/L [3.5 - 5.3]
cLac 0.7 mmol/L [0.4 - 0.8]
Electrolyte Values
↓ cK⁺ 3.3 mmol/L [3.5 - 4.5]
cNa⁺ 137 mmol/L [136 - 145]
cCa²⁺ 1.18 mmol/L [1.15 - 1.33]
cCl⁻ 106 mmol/L [98 - 107]
↓ Anion Gap_c 10.6 mmol/L [12.0 - 18.0]

Notes
↑ Value(s) above reference range
↓ Value(s) below reference range
d Default value(s)
c Calculated value(s)

PREOPERATIVE ASSESSMENT		ASA status: 1 2 3 4 5 6	
CHART	FFN	PERSONNEL	PROCEDURE DETAILS
	Anesthetist (Grade): Surgeon:	Diagnosis: Operation: NCEPOD : Scheduled Urgent Emergency	
Ward staff to complete Weight (kg) 75 Height (m) BMI (kg/m ²) Temp (°C) Pulse (/min) BP (mm Hg) RR (/min) O ₂ Sat (%) Fasting time: Ban Solids Liquids Allergy: Multiple NSAID ok? N MEDICATIONS (generic) See AA.		MEDICAL HISTORY Fit & well ☒ N CVS disease ☒ RS disease ☐ Endocrine ☒ CNS Arthritis GORD PHYSICAL EXAMINATION & NOTES Type I PCI 2017 post MI + frail. + Anxious	
LAB RESULTS (/ /) Hb Plts Na K Urea Creat X Match/G & S		ANAESTHETIC HISTORY Previous anaesthesia Y N Problems? Family Hx? Teeth Intact Y N Airway Risk of dental damage explained & accepted ☐ Smoking ☐ C ₂ H ₅ OH ☐ Aspiration Risk ☐	
ECG CXR		PLAN/PATIENT INFORMATION GA (+/- RSI) ☒ Risks ☐ Benefits ☒ Sedation ☐ Risks ☐ Benefits ☐ RA ☐ Risks ☐ Benefits ☐ Invasive monitoring ☐ Risks ☐ Benefits ☐ Postop Care/Analgesia ☒ Risks ☒ Benefits ☒ Written information ☐ Opportunity for questions ☐	
PREOPERATIVE INSTRUCTIONS 1. 2.		- Needs more of life - Refused GA	

[illegible]

HSS TRUST _____
Hospital Unit _____

GP PRACTICE or other _____
Primary Care Provider _____

FORM 1 - CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name
First names
Date of Birth
☐ Male ☐ Female H+C No. (or other identifier)
Special requirements (language or other)
.....

Personal Information
redacted by the USI
Patient 1

Personal Information
redacted by the USI

Personal Information
redacted by the USI

Statement of healthcare professional

Responsible healthcare professional ADP Job Title
Name of proposed procedure or course of treatment (include side of body or site and brief explanation if medical term not clear)
1. UPR prostate

I have explained the procedure. In particular, I have explained:

The intended benefits

Serious or frequently occurring risks BLEEDING, INFECTION, CATHETER PORTAL, PAIN, FAILURE, POST-OP GRADE 5 SPACULATION, URINARY STRONG

Possible additional procedures which may become necessary during the procedure.

☐ Blood transfusion ☐ other procedure (please specify)
This procedure will involve: ☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

☐ The following leaflet has been provided.

Signed Date 7/6/22
Name (Print) Job Title

Contact details (if patient wishes to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed Date
Name (Print)

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

*I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. *You may remove this sentence without affecting your care.

Signature X Date

Name (Print)

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature Date

Name (Print)

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature Date

Name (Print) Job Title

Important notes: (tick if applicable)

☐ See also advance directive/living will (eg Jehovah's Witness form)

☐ Person has withdrawn consent Date

(ask person to sign/date here)

Urology MDM @ The Southern Trust

RE: Patient 1
Personal Information redacted by the USI
DOB: Personal Information redacted by the USI **Hospital Number:** Personal Information redacted by the USI , **HCN:** Personal Information redacted by the USI

Dear Dr

This patient was discussed at the Urology MDM @ The Southern Trust
On 07/11/2019.

Diagnosis: Prostate cancer

Gleason Score 4 + 3

MDM Update:

RE:

Patient 1

Personal Information redacted by the USI

DOB:

Personal Information redacted by the USI

Hospital Number:

Personal Information redacted by the USI

, HCN:

Personal Information redacted by the USI

CONSULTANT MR O'BRIEN: This 74 year old man was referred in June 2019 with serum PSA levels of 19.16 ng/ml in May 2019 and of 19.81 ng/ml in June 2019. He reported mild urinary symptoms at review in July 2019, consisting of a sensation of unsatisfactory voiding following micturition, and of nocturia, having to rise once or twice each night to pass urine. He was noted to have been taking Finasteride since 2010 and Oxybutynin since 2016. He was found to have an indurated prostate gland on examination. He was reported to have a prostatic volume of 40 ml on MRI scanning in July 2019, when it was reported that he had a PIRADS 3 lesion within the anterior transition zone, and PIRADS 5 features with the peripheral zones of both lateral lobes.

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

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

Discussed at Urology MDM 29.08.19. Patient 1 has high risk prostate cancer. For review with Mr O'Brien to organise a Bone Scan, CT Chest, Abdomen and Pelvis. For further discussion at MDM with radiology results.

Patient 1 was advised of the histopathological diagnosis of prostatic carcinoma on 23 September 2019 when his serum PSA had increased to 21.8 ng/ml and his serum testosterone was 19.3 nmol/L. He was prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mg daily while awaiting completion of imaging. The medication was accompanied by intolerable adverse toxicity, mainly in the form of light headedness, and to the extent that he lost the confidence to drive. He was advised to discontinue taking both on 14 October 2019, and to resume taking Bicalutamide 50 mg daily alone on 01 November 2019. A bone scan and CT scan of chest, abdomen and pelvis were requested. A review on 11 November 2019 was arranged.

CT, 28.10.19 - No evidence of metastatic disease.

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

Discussed at Urology MDM 31.10.19. Review with Mr O'Brien as arranged. Patient 1 has intermediate risk prostate cancer to start ADT and refer for ERBT.

Patient 1

has review appointment with Mr O'Brien on 11.11.19.

Urology MDM @ The Southern Trust

RE: Patient 1

Personal Information redacted by the USI

DOB: Personal Information redacted by the USI **Hospital Number:** Personal Information redacted by the USI **, HCN:** Personal Information redacted by the USI**MDM Plan:**Discussed at Urology MDM 07.11.19. This patient is not for discussion. ****NO GP LETTER****

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

Yours sincerely,

Chairman of Urology MDM

Personal Information redacted by the USI

Consultant Urologist

Southern Health and Social Care Trust.

This job plan started 01 April 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Locked down
Appointment	Full Time
Cycle	Rolling cycle - 12 weeks
Start Week	1
Report date	30 Jul 2020
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		24 Apr 2018	Mr Zircadian Support
In 'Discussion' stage - awaiting doctor agreement		24 Sep 2018	Mr Colin Weir
In 'Discussion' stage - request cancelled		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - request cancelled		31 Oct 2018	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		21 Nov 2018	Mr Colin Weir
Locked down		9 Dec 2019	Dr Edward James McNaboe

Hours Breakdown

	Main Employer PAs	Core PAs	APA PAs	Total PAs	Core hours	APA hours	Total hours
Direct Clinical Care (DCC)	10.271	10.271	0.000	10.271	41:03	0:00	41:03
Supporting Professional Activities (SPA)	1.462	1.462	0.000	1.462	5:51	0:00	5:51
Total	11.733	11.733	0.000	11.733	46:54	0:00	46:54

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000
Type	Normal	Premium	Cat.	PA		
			Total:		1.000	
Predictable	n/a	n/a	DCC		0.000	
Unpredictable	n/a	n/a	DCC		1.000	
The total PAs arising from your on-call work is:		1.000				
Your availability supplement is:		5% (based on the highest supplement from all your rotas)				

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	0.000 1.000
Weekend work	
(A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	0.000 0.000
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Clinical Manager	Role: Clinical Director	Role: Board Member
Name: Dr McNaboe, Edward James (Con)	Name: Mr Haynes, Mark Dean (Con)	Name: Mr Carroll, Ronan
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 12:00 Week 6,12 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)		
			Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)			

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 13:30 - 17:00		
		Post-op ward round 18:00 - 19:00				

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00	Surgery MDT 14:00 - 17:00	Core SPA 13:30 - 17:00		
		Post-op ward round 18:00 - 19:00				

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
	New patient Clinic 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00	Surgery MDT 14:00 - 17:00	Surgery MDT 13:15 - 17:15		
		Post-op ward round 18:00 - 19:00				

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 13:30 - 17:00	Day surgery 08:30 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
	New patient Clinic 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00	Surgery MDT 14:00 - 17:00	Core SPA 13:30 - 17:00		
		Post-op ward round 18:00 - 19:00				

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00		
	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00		Sub Specialty clinic 13:30 - 17:00		
		Post-op ward round 18:00 - 19:00				

Week 7

There are no activities this week

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00	Surgery MDT 14:00 - 17:00	Surgery MDT 13:15 - 17:15		
		Post-op ward round 18:00 - 19:00				

Week 9

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 11

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 12

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Activities

- Additional Programmed Activities
- Hot Activity
- Unaffected by hot activity
- Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	Core APA	10.120 0.000	40:27 0:00
	Mon	08:30 - 13:00	wks 3, 8	New patient Clinic 30 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	7	0.188	0:45
U	Mon	08:45		New patient	Southern Health and Social Care Tru..	Erne Hospital	DCC	12	0.625	2:30

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		- 17:30		Clinic 75 minutes travel from Craigavon Area Hospital.						
S	Mon	09:00 - 17:00	wks 4, 9- 11	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	12.19	0.580	2:19
H	Mon	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Mon	13:30 - 17:00	wks 3, 5, 8	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	9.14	0.190	0:46
S	Tue	08:30 - 13:00	wks 4-5, 9-11	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.446	1:47
S	Tue	09:00 - 13:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.397	1:35
H	Tue	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Tue	13:30 - 17:00	wks 4-5, 9-11	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.347	1:23
S	Tue	13:30 - 17:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.347	1:23
	Wed	08:30 - 09:00	wks 2-6, 8-12	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
H	Wed	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Wed	09:00 - 18:00	wks 2-6, 8-12	Planned in- patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	1.786	7:09
	Wed	18:00 - 19:00	wks 2-6, 8-12	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
H	Thu	09:00 - 12:00	wks 6, 12 12 wk cycle	Surgeon of the week Comments: Handover to oncoming Urologist of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.155	0:37
S	Thu	09:00 - 12:00	wks 2-5, 8-11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	24.67	0.440	1:46
H	Thu	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Thu	14:00 - 17:00	wks 2-6, 8-12	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.595	2:23
S	Fri	09:00 -	wks 2-6,	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		13:00	8-12							
H	Fri	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Fri	13:15 - 17:15	wks 4, 8, 12	Surgery MDT Comments: Reconstruction MDM Lagan Valley Hospital 45 minutes travel from Craigavon Area Hospital. 45 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Royal Victoria Hospital, Belfast	DCC	10	0.238	0:57
S	Fri	13:30 - 17:00	wks 2, 6, 10	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	10	0.208	0:50
S	Fri	13:30 - 17:00	wks 3, 5, 9, 11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	13.33	0.278	1:07

No specified day

"()" Refers to an activity that replaces or runs concurrently

Additional Programmed Activities

Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
						Total:	Core APA Replaced	0.613 0.000 (0.000)	6:27 0:00 (0:00)
	3:00	0:00	Surgery MDT Comments: MDT Chair preparation	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.232	0:56
	8:00	0:00	Triaging of new patients referrals	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	8	0.381	1:31

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

Curriculum Vitae

Professor Krishna K Sethia

Consultant Urological Surgeon

**Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7UZ**

1 February 2020

NAMEKrishna Kumar **SETHIA****ADDRESS****HOME**

Personal Information redacted by the USI

WORK

Norfolk & Norwich NHS University Trust
Colney
Norwich NR4 7UZ

TELEPHONE**HOME****MOBILE**

Personal Information redacted by the USI

Email

Personal Information redacted by the USI

NATIONALITY

British

DATE OF BIRTH

Personal Information redacted by the USI

MARITAL STATUS

Personal Information redacted by the USI

GENERAL MEDICAL COUNCIL

Personal Information redacted by the USI

MEDICAL DEFENCE

Medical Protection Society

QUALIFICATIONS

MA (Oxford)	1986
MBBS (London)	1979
FRCS (England)	1984
DM (Oxford)	1988
FRCSEd	2006

EDUCATION

Eton College, Windsor, Berks

Exeter College, Oxford

Guys Hospital Medical School, London SE1

PRESENT APPOINTMENTS

Consultant Urologist
Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7FP

Honorary Professor
University of East Anglia, Norwich

Chairman
British Journal of Urology International

PREVIOUS APPOINTMENTS

Medical Director, Norfolk & Norwich University NHS Trust (2009-2015)

Hon Treasurer, British Association of Urological Surgeons (2003-2006)

Director of Surgical Division, Norfolk & Norwich University NHS Trust (2003-2007)

Manpower Planning Officer, British Association of Urological Surgeons (2000-2006)

Member of and Examiner for the Intercollegiate Board in Urology (2000-2008)

Vice-Chairman of Specialist Advisory Committee in Urology, Royal College of Surgeons (2003-2006)

Clinical Director, Urology & Nephrology, Norfolk & Norwich University NHS Trust (1997-2002)

Member of Council, British Association of Urological Surgeons (1997-2002)

Honorary Lecturer, Institute of Urology (1996-1999)

Norwich District Ethics Committee (1994-1998)

R& D Committee, Norfolk & Norwich NHS Trust (1996-1998)

Lead Doctor in Urology, Waveney Cancer Centre (1998 -2003)

Senior Registrar in Urology, Freeman Hospital, Newcastle (1988-1990)

EXPERIENCE**1. Clinical**

Having completed training posts in Oxford and Newcastle I was appointed to a Consultant Urologist post in Norwich in 1990. As well as providing a general urological service I developed special interests in urological cancers (especially bladder and prostate) and andrology and during the 1990's I developed the Norwich unit into a tertiary referral centre for both these subspecialties. I also established the superregional service for the management of patients with cancer of the penis.

Together with the specialist urological cancer nursing team for which I secured the initial funding I set up a local patient support group for men with prostate cancer and their families.

My clinical commitments inevitably decreased when I became Medical Director but since relinquishing that post in I have increased my clinical practice. I continue to develop the urological cancer services in Norwich. My current main interests are in the management of superficial bladder tumours, penile cancers and the diagnosis of prostate cancer. I continue to run the specialist andrology service for the region.

2. Hospital Management**a. Director of Surgery (2003-2007)**

As Director of Surgery I was responsible for the organisation of surgical services, clinical governance in surgery and ensuring that access targets were met. My specific achievements in my 4 year tenure were;

1. Reorganisation of the theatre schedules and surgeon timetables to create 25% more operating time in the week and increased theatre utilisation to over 90%.
2. Introducing centralised pre-operative assessment for all surgical patients.
3. Building of a unit to ensure that all patients were admitted on the day of surgery rather than the night before.
4. Achieving all access targets.
5. Increasing day-case surgical rates to the best quartile in the country.
6. Achieving cost-savings to plan.

b. Medical Director (2009 to 2015)**1. Clinical Governance**

In my time as Medical Director I was involved in two reorganisations of clinical governance the second of which was designed to take account of all the Francis, Keogh and Berwick reports and CQC requirements. I was chairman of the Clinical Safety and Clinical Effectiveness Sub-Boards and of meetings of all Directorate Governance Leads.

2. Quality Improvement.

Five years ago I instigated a programme of annual safety improvement projects based on IHI methodology. Over 250 clinicians were eventually involved and significant changes to practice have resulted. Projects I have led or been involved in with other Executive Directors by 2015 had achieved significant improvements including

- a. No hospital-acquired MRSA bacteraemias for 3 years
- b. 85% reduction in C difficile infection over 3 years
- c. Significant reduction in medication prescribing errors
- d. Compliance with the WHO checklist
- e. Compliance with thromboprophylaxis assessment. Hospital granted exemplar status.
- f. Improved Early Warning Score completion and response to triggers.
- g. Declining cardiac arrest calls outside critical care
- h. Central line infection rates of under 1/1000 hospital days

c. Operational

As Medical Director

- a. I shared responsibility for day-to-day operational performance.
- b. I led a project to enlarge and redesign the emergency areas of the NNUH. We have established a regular GP presence in the emergency department.
- c. I completed a review of critical care capacity and formulated plans for an increase thereof.
- d. I regularly met and represented the hospital with the local Clinical Commissioning Groups and played an active role in contract negotiations.

d. Revalidation

- a. I was Responsible Officer for over 800 doctors working at the Norfolk & Norwich Hospital.
- b. I was responsible for introducing the policies and processes for enhanced appraisal and, with the help of a Revalidation Lead, ensured that the Trust was prepared for medical revalidation.

e. University

- a. In 2009 together with the Medical School I instigated a strategy to increase research activity in the hospital by appointing a series of clinical academics with focussed areas of interest.
- b. I established a Joint Research Committee which includes doctors, nurses, allied health professionals and university staff.
- c. I helped establish a joint research office with UEA for managing clinical research.
- d. Together with the Dean of Health I have supervised the development of the Norwich Clinical Trials Unit and Clinical Research facilities which now have full NIHR registration.
- e. I promoted joint projects involving the hospital and other Institutes on the Norwich Research Park. I was the hospital representative on the NRP Scientific Board.
- f. I supported the UEA project to obtain a new Medical School Building (BCRE) including a Biorepository.
- g. In 2013, I was author of and together with the CEO led the Norfolk & Norwich Hospital successful bid to host the NIHR Eastern Clinical Research Network
- h. I was involved with the Norwich bid to build a new Institute for Food and Health to include clinical gastroenterology.
- i. I represented the hospital on the UEA/NNUH Joint Board University/NNUH (chaired by the Vice-Chancellor and Trust CEO)

f. Other hospitals

I have actively encouraged clinical collaborations with neighbouring hospitals (Kings Lynn and James Paget). To date this has resulted in an increasing number of consultant joint appointments. I was instigated and was involved with projects to

- a. Standardise clinical guidelines between the Trusts
- b. Establish joint formularies
- c. Establish a single Drugs, Therapeutics and Medicines Management Committee
- d. Integrate clinical teams

3. National Associations / Committees**i. British Association of Urological Surgeons****a. Council Member (1997-2002)****b. Manpower Planning Officer (200-2007)****c. Treasurer (2005-2008)**

For the past 18 years I have contributed to the development of BAUS and British Urology. Particular achievements have been:

1. As a major contributor to the development of different types of Consultant Urologists trained to have skills matching service need.
2. Regular liaison with National Workforce Planning Groups to ensure training numbers correct.
3. Responsibility for the reorganisation of BUAS into a charitable company limited by guarantee.
4. Rewriting of the M&A's and Rules of the Association.
5. Rewriting of all protocols for Governance within the organisation.
6. Establishing the budgeting process for the Association.
7. Creating a Strategic Plan for the Association.

ii. SAC in Urology (2000-2006), Vice-Chairman (2003-2006)

Apart from the normal duties of an SAC member I have made a particular contribution in:

- i. The revision of the curricula in Urology
- ii. Supervision and planning of urological manpower.
- iii. Review of section 14 applications to PMETB

iii Examiner for Intercollegiate Board in Urology (2000 to 2008)**Member of Intercollegiate Board in Urology (2003 -2008)****Examiner for International Urology exam (2018- present)**

As a member of the Intercollegiate Board I was responsible for exam design, standard-setting and ensuring educational validity. I personally rewrote over 25% of the then clinical question bank. In 2018 I was again appointed an examiner for the joint colleges international exam in urology.

4. British Journal of Urology International (BJUI)

Having been a Trustee for 7 years I was appointed Chairman of the BJUI in 2015.

For the past 5 years I have led the development of a comprehensive educational on-line programme which will serve international CPD and CME requirements. This involves collaboration with the Urological Societies of Australia and New Zealand, Hong Kong, Canada, India, Indonesia, Malaysia, Korea and the Republic of Ireland. The education programme was launched in January 2016 and has accreditation from the Edinburgh College of Surgeons (RCSEd). It has been now used by all UK urological trainees and widely in Asia and Australasia. We are working with the GMC and urology SAC to establish it as the standard for knowledge for all trainees.

5. Teaching experience

In the 1990's I was responsible for Higher Surgical Training in Urology in Norwich. I established and ran an annual residential regional teaching course which has remained an important part of our specialist registrar programme and is consistently highly-rated by trainees. I continue to contribute to this.

For the past 60 months I have been working with the RCSEd to develop a surgical training programme for Myanmar. This is being expanded to involve all the surgical specialties in the country.

6. Research experience

Following appointment as a consultant I was PI in several clinical trials within the Urology department.

For most of my career my other research activity has involved facilitating researchers in collaborations with University departments.

I took responsibility for establishing and organising the Norwich contribution to the national 100,000 Genome project.

In the past 12 years I have been involved in supervising 3 PhD and one MD student.

8. Medicolegal

For the past 17 years I have provided medicolegal opinions. I have been instructed by solicitors for acting both for the plaintiff and the defence (current ration 30:70). I currently provide approximately 80 reports per year. I am prepared to travel anywhere in the UK to see patients. I regularly attend case conferences with barristers and I have experience of giving expert evidence in Court.

9. Other

In the past 7 years I have been invited to perform 3 major reviews of urology department's performance and organisation in the UK.

I am experienced in reviewing serious incidents which I have done both for the Royal College of Surgeons and when requested by individual Trusts.

PUBLICATIONS

- Sethia K.K., Darke S.G. Long Saphenous incompetence as a cause of venous ulceration. *Br J Surg* (1984) 71:154-755
- Sethia K.K., Berry A.R., Morrison J.D., Collin J., Murie J.A., Morris P.J. The changing pattern of lower limb amputation in peripheral vascular disease. *Br J Surg* (1986) 73:701-703
- Sethia K.K., Smith J.C. Non-invasive measurement of intravesical pressure. *Br J Urol* 1986) 58:657-658
- Sethia K.K., Skelton J.B., Turner C.M., Berry A.R., Kettlewell M.G., Gough M.H. A prospective randomised controlled trial of suprapubic vs urethral catheterisation in patients undergoing general surgical procedures. *Br J Surg* (1986) 74:624-625
- Speakman M.J., Sethia K.K., Fellow G.J., Smith J.C. A study of pathogenesis, urodynamic assessment and outcome of detrusor instability associated with bladder outflow obstruction. *Br J Urol* (1987) 60:516-518
- Sethia I.K., Smith J.C. The effects of pH on detrusor function. *Proc ICS, Bristol* (1987) 177-178
- Sethia K.K., Bickerstaff K.E., Murie J.A. The changing pattern of scrotal exploration for testicular torsion. *Urology* (1988) 31:408-410
- Sethia K.K., Brading A.F., Smith J.C. The role of micturition reflex in bladder instability in the minipig. *Neurolol. Urodynamic.* (1988) 7:251
- Crawford R.A.F., Sethia K.K., Fawcett D.P. Unusual presentation of urachal remnant. *Br J Urol* (1989) 64:315-316
- Sethia K.K., Brading A.F., Smith J.C. A model of non-obstructed bladder instability. *J Urol* (1990)
- Sethia K.K., Webb R.J., Neal D.E. Urodynamic study of ileocystoplasty in the treatment of idiopathic detrusor instability. *Br J Urol* (1991) 67:286-290
- Pickard R.S., Oates C.P. Sethia K.K., Powell P.H. The role of colour duplex ultrasonography in the diagnosis of vasculogenic impotence. *Br J Urol* (1991) 68:537
- Devitt A.T., Sethia K.K. Grangrenous cystitis: case report and review of the literature. *J Urol* (1993) 149:1554
- Hanbury D.C., Sethia K.K. Erectile function following transurethral prostatectomy. *Br J Urol* (1995) 75:12-14
- Mills R.D., Sethia K.K. Reproducibility of penile arterial ultrasonography. *Br J Urol* (1996) 78:109
- Mills R.D., Sethia K.K. Limited sub-coronal incision for insertion of semirigid penile prostheses. *Br J Urol* (1997) 79:802

Kirby R.S., Chapple C.R., Sethia K.K., Flannigan M., Milroy E.J.G., Abrams P. Mornign vs evening doxazosin in benign prostatic hyperplasia: efficacy and safety. Prost.Cancer (1998) 1:1630171

Mills R.D., Sethia K.K. Maximisation of the erectile response in the investigation of impotence. Int J Impot Res (1999) 11:29-32

Mitchell S.M., Sethia K.K. Hazards of aspirin withdrawal prior to transurethral prostatectomy. Br J Urol (1999) 84:101

Probert JL, Mills R, Persad RA, Sethia KK. Imaging assessment of uncomplicated bladder outflow obstruction. Int J Clin Pract. (2000) Jan-Feb;54:22-4

Szemere J.C., ...Sethia K.K., Ball R.Y., Bardsley A. A surgical technique to the conservative management of urethral melanoma. Br J Plast Surg (2001) 45:361-3

Chitale S.V, Peat D, Lonsdale R, Sethia K.K. Xanthoma of the urinary bladder. Int.Urol.Nephrol (2002) 34: 507-509

Riddick A.C.P.....Sethia K.K., Edwards D.R, Ball R.Y. Banking of fresh-frozen prostate tissue: methods, validation and use. Br J Urol (2003) 91:315

Chitale SV, Burgess NA, Sethia KK et al. Management of urethral metastasis from colorectal carcinoma. ANZ Journal of Surgery (2004) 74:925-7

Riddick ACP,Sethia KK, Edwards DR Identification of degradome components associated with prostate cancer progression by expression analysis of human prostatic tissues. Br J Cancer (2005) 92:2171-2180

Sethia KK. Screening for prostate cancer. Ann.RCS Eng (2005) 87:88

Shukla CJ, Edwards D, Sethia KK Laser capture microdissection in prostate cancer research: establishment and validation of a powerful tool for the assessment of tumour - stroma interactions. BJUI (2008) 101:765-774

Viswanath S, Zelhof B, Ho E, Sethia K, Mills R. Is routine urine cytology useful in the haematuria clinic? Ann R Coll Surg Engl. (2008) Mar; 90(2):153-5.

Sethia KK. Why I do not have a robot. Ann R Coll Surg Engl (2010) 92:5-8

Bayles AC, Sethia KK. The impact of Improving Outcomes Guidance on the management and outcomes of patients with carcinoma of the penis. Ann R Coll Surg Engl (2010) 92:44-45

Chitale S, Morsey M, Swift L, Sethia K. Limited shock wave therapy vs sham treatment in men with Peyronie's disease: results of a prospective randomized controlled double-blind trial. BJU Int. (2010) 106:1352-6

Chitale S, Morsey M, Sethia K. Is penile shortening part of the natural history of Peyronies Disease? Urol Nephrol J (2010)3:16-20

Manson-Bahr D, Ball R, Sethia K.....Cooper C. Mutation Detection in Formalin Fixed Prostate Cancer Biopsies at the Time of Diagnosis Using Next Generation DNA Sequencing. Prostate. J Clin Pathol. 2015 Mar;68(3):212-7. doi: 10.1136/jclinpath-2014-202754

Kumar VK, Sethia KK. A prospective study comparing videoendoscopic radical inguinal lymph node dissection with open radical inguinal lymph node dissection for penile cancer over an 8 year period. BJU International 2016 (accepted for publication).

Luca BA.....Sethia KK..... Cooper C. DESNT: a poor prognosis category of human prostate cancer. European Urology Focus (2017) S2405-4569(17)30025-1

BOOKS

Parkhouse H., Sethia K.K. (eds) Illustrated Case Histories in Urology. Mosby-Wolfe. London (1996)

Eardley I., Sethia K. Erectile Dysfunction. Mosby-Wolfe 1998

Eardley I., Sethia K. Erectile Dysfunction for General Practitioners. Mosby-Wolfe 1999

OTHER

Models and Mechanisms of Detrusor Instability - Bard Silver Medal, British Association of Urological Surgeons, 1988

The Pathophysiology of Detrusor Instability. D.M. Thesis, University of Oxford.

EDITORIAL ACTIVITY

I am a regular reviewer for the British Journal of Urology International, Current Opinions in Urology, the Journal of Clinical Urology and the Journal of Sexual Medicine.