

1
2 You describe a harrowing experience, being shocked, and
3 we have all the papers in front of us. What, of all of
4 this, shocked you the most? What was the biggest
5 moment where you were pulled up short and thought 14:40
6 I can't believe this has been allowed to happen?
7 A. Where Daddy's scan was not acted upon over a seven to
8 eight-month period, and the subsequent diagnosis of
9 prostate cancer.
10 DR. SWART: Going back to that, you had a look and you 14:40
11 looked at the RQIA report which is a similar thing.
12 You will be aware this is not an unusual series
13 incident in the UK actually, not just in Northern
14 Ireland. What is your reflection on -- why is it that
15 you think those reports and the recommendations from 14:40
16 them haven't got traction and these things still
17 happen? Do you have any observations for us?
18 A. Yes. I mean, this morning I was reading over the
19 second RQIA report and thinking that one of the
20 recommendations articulates really clearly that scans 14:40
21 or whatever should be followed up and disseminated
22 quickly; that the Trusts should have systems and
23 processes in place for the effective tracking and
24 monitoring of those scans but, more importantly,
25 clinician follow-up. For me, that is a concern for me. 14:41
26 When the NIPACS system came into fruition in Northern
27 Ireland, I think in 2010, you know, one of the aspects
28 that were heralded was that instantaneous ability to
29 click a mouse and you would be able to see a scan to

From: McCaul, Collette

Sent: 30 January 2019 12:33

To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth

Cc: Robinson, Katherine

Subject: Patients awaiting results

Importance: High

Hi all

I just need to clarify this process.

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

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

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

Collette McCaul

Acting Service Administrator (SEC) and EDT Project Officer

Ground Floor

Ramone Building

CAH

Ext 

1 escalation. Separate to this, there is how we as
2 consultants manage our results. I can't remember
3 whether it's in there but there is an element of the
4 monitoring for results which comes to myself and Wendy
5 Clayton as a first-line weekly thing that we do through 14:49
6 the Splunk report.

7 117 Q. I'll move to that in a moment. In terms of this
8 process, if we go over on to the next page and the
9 context is "New Patients". If we scroll down just
10 towards the bottom of this page, I think there's very 14:50
11 much an emphasis on trying to get staff to act
12 electronically or use electronic means because it's
13 safer and provides, I suppose, an audit trail to prove
14 things are being done when it is said they are expected
15 to be done. 14:50

16
17 Moving down the page a little bit further, is it fair
18 to say that a particular onus or particular
19 responsibility is placed on the secretary in this
20 regime? In other words, it's the secretary who must 14:51
21 keep an eye on things and escalate if his or her
22 consultant is not dealing with the result within the
23 expected timeframe?

24 A. As I said, the first step of the monitoring process is
25 undertaken by myself and Wendy Clayton. All of the 14:51
26 consultant -- indeed all of the team, so nurse
27 specialists as well within Urology use electronic
28 sign-off for their results management. That's our
29 primary mechanism for managing results. Myself and

- 1 129 Q. I take it that, to your knowledge, he didn't use DARO
2 at all?
- 3 A. DARO is not utilised by the Consultant; it's our
4 secretarial team use the DARO process. It happens for
5 me and for most -- well, to my knowledge, all my 14:32
6 colleagues, by our secretaries, with investigations
7 that results are identified that we haven't found
8 through our other processes being flagged up to us by
9 our secretaries when they do that check of the DARO
10 list. 14:33
- 11 130 Q. The fact that she, the secretary, in conjunction with
12 Mr. O'Brien, wasn't using that fail-safe, was that
13 known?
- 14 A. It is evident from that correspondence that Mr. O'Brien
15 and his secretary didn't feel that they should apply 14:33
16 the DARO process to the patients under the care of
17 Mr. O'Brien.
- 18 131 Q. What's your understanding of the rationale for that?
- 19 A. I can only repeat the rationale he's put in his e-mail,
20 that is he'd already decided that if the patient needed 14:33
21 a review appointment, they should be waiting for
22 a review appointment, they shouldn't be on another
23 list. He seems to have not accepted that that review
24 appointment might not be for many years, and that
25 patient may sit for many years with an un-actioned 14:34
26 potentially abnormal scan.
- 27 132 Q. This provides further evidence to you, as his Associate
28 Medical Director, of a Clinician not willing to conduct
29 his practice in accordance with the expectations of his

1 A. Of course, yes.

2 248 Q. To make it your business, if you could, to see the
3 reports and action them. One of the safety nets
4 commended to the Inquiry by some of the witnesses we
5 have heard from was the DARO arrangement. If you had 16:07
6 placed Patient 92 on DARO when her investigation report
7 was available from Radiology, it would have rung a bell
8 within your office that there was a report available to
9 be considered, but you didn't use that system, is that
10 right? 16:08

11 A. Yeah. I mean I did use -- you know my reservations
12 about DARO.

13 249 Q. Just let me try to summarise them. You see DARO as
14 being the outworking of an inadequate system whereby
15 patients who you would like to review for good clinical 16:08
16 reasons are, in your eyes, shunted out, at least until
17 the investigation report is available. Is that fair?

18 A. No.

19 250 Q. No. Okay?

20 A. No, it's not. My fundamental reservation about DARO is 16:08
21 that it's not that results wouldn't be returned to the
22 requesting or the responsible clinician and that they
23 would be returned in a robust manner and a reliable
24 manner, and that the clinician would have time to deal
25 with them all, and in addition the patient should be on 16:09
26 a review list. That has been my fundamental issue.
27 And with the added caveat that the review actually in
28 many cases is more important than the viewing of the
29 report, and as you know, you know...



Southern Health
and Social Care Trust

Regional Review of Urology Services

Team South Implementation Plan

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1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week ¹	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1.5
LUTS	3
Haematuria	2
Andrology	2.5
General Urology/Uro Oncology	2.5
	14

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly ²	1 monthly
Flexible Cystoscopy	1.5 weekly ³	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month

2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover

3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	1084
	ICATS/Nurse Led New OP	1233	30		1263
	Total New OP	1843	504	0	2347
	Cons Led Review OP	2391	70	0	2461
	ICATS/Nurse Led Rev OP	1594	0	0	1594
	Total Review	3985	70	0	4055
	Day Case	1502	3	383	1888
	Elective FCE	1199	29	140	1368
	Non Elective FCE	629	0	0	629

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young²	Mr O'Brien	Mr Akhtar³	All Core Activity
2009/10	New OP	242	174	193	609
	Review OP	964	903	327	2194
	Total OP	1206	1077	520	2803
	Day Case	696	452	354	1502
	Elective FCE	380	512	307	1199
	Non Elective FCE	233	210	186	629
	FCEs + DCs	1309	1174	847	3330
	Day Case Rates ¹	65%	47%	54%	56%

¹ INCLUDES flexible cystoscopies (M45) and DCs/FCEs with no primary procedure recorded.

² Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.

³ Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:

1) Source is Business Objects

2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)

3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers

and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	4.04	3.27	3.28	2.09
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	43.8	45.5	48.8	40.0
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	3.7	4.3	3.9	2.7
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	4.5	4.8	4.6	4.7

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADs) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADs targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand. In addition capacity to deal with the current review backlog has not been included. It has been assumed that the Trust's proposal to manage the review backlog (Appendix 2) will be funded separately.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity				SHSCT Activity to be Provided	Team South Capacity Required ⁶
		Core Activity	IHA	IS	Growth in WL		
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	2990
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	4785
	Day Case	1502	3	383	47	1935	2283
	Elective FCE	1199	29	140	28	1396	1647
	Non Elective FCE	629	0	0		629	742

1) Source is Business Objects

2) Activity has been counted on specialty of clinic

3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2

4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).

5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs

6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

Weekly Sessions	
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy ¹	1
Prostate Histology ²	1
LUTS	3
Haematuria	1
Andrology/General Urology/Uro-oncology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	2

1) Prostate Assessment and Biopsy will run side by side

2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.

3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.

4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions has to be agreed with the Western Trust.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Banbridge Poly Clinic, Armagh Community Hospital and Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to the availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11



Urology Services Inquiry

Average	49.2	98.3	5492.8	458	299	-159
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The data for this table is sourced from Business Objects XI (BOXI) query. BOXI is the regional information system.

The table demonstrates that the urology service was unable to achieve the required 62day cancer standard of 95%. This is attributable to the demand for red flag referrals being greater than the capacity within the service to enable patients to have their first definitive treatment by day 62.

S21 5 of 2022 – 20160401 to 20170331 question 12 Urology cancer 31 and 62 day completed waits

S21 5 of 2022 – 20170401 to 20180331 question 12 Urology cancer 31 and 62 day completed waits

S21 5 of 2022 – 20180401 to 20190331 question 12 Urology cancer 31 and 62 day completed waits

S21 5 of 2022 – 20190401 to 20200331 question 12 Urology cancer 31 and 62 day completed waits

S21 5 of 2022 – 20200401 to 20210331 question 12 Urology cancer 31 and 62 day completed waits

S21 5 of 2022 – 20210401 to 20220331 question 12 Urology cancer 31 and 62 day completed waits

61. The Urology performance is discussed at the Urology Cancer MDT Annual General Meeting

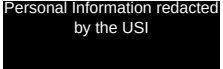
S21 5 of 2022 - 20200101 doc question 12 Urology MDT Business Meeting Jan 2020

62. By 2016 and becoming responsible for Surgical and Elective Care the performance targets as described in the IEAP and applicable to urology were not being achieved by a significant margin: e.g., the IEAP in 2008 described the performance targets of 9 weeks for outpatients and 13 weeks for inpatient / daycase, and 95% for 62 day cancer target and 98% for 31 day cancer target.

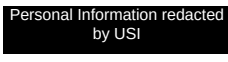
Table 1 - Summary of Urology Access waiting times 2016, 2019 and 2022:

Specialty	Category	IEAP Target	Waiting time as at 1 April 16	Waiting time as at 1 April 19	Waiting time as at 1 April 22
Urology	Outpatients	9 weeks	Red flag = 3.5 wks Urgent = 40 wks Routine = 73 wks	Red flag = 5-7 wks Urgent = 168 wks Routine = 175 wks	Red flag = 11 wks Urgent = 312 wks Routine = 319 wks
Urology	Inpatient / Daycases	13 weeks	Urgent = 119 wks Routine = 124 wks	Urgent = 249 wks Routine = 277 wks	Urgent = 399 wks Routine = 398 wks

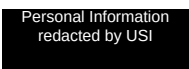
Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: 

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier: 

Service User Details:

D.O.B:  Gender: F Age: 66 yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off: 15 March 2017

Date submitted to HSCB: 16 March 2017

1.0 EXECUTIVE SUMMARY

Patient 10 is a 66 year old lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While **Patient 10** was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomography Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, **Patient 10**'s GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a result of triage omission, **Patient 10** was managed as a 'New Routine' patient as per the Trust's process in place at the time and waited until 6 January 2016 to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2016 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on 31 October 2016.

The Review Panel agree that there are 3 main contributing factors which directly impacted **Patient 10**'s delay in diagnosis. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite **Patient 10**'s referral to Urology.

Secondly, following the CT of chest and abdomen of 29 October 2014 which noted a complex right renal cyst, the letter to **Patient 10** from Dr 3 did not include this information and the result did not trigger a referral to Urology. Again this represents a missed opportunity to expedite **Patient 10**'s care.

The third contributory factor is that **Patient 10**'s GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that review of radiology at triage is likely to have resulted in an upgrade of the referral to Red Flag in October 2014. As a result of no triage and the Trust's reliance on the routine category assigned by the GP to the referral, **Patient 10** waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to **Patient 10** in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016
- To carry out this review into the care provided to **Patient 10** using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to **Patient 10**'s delay in treatment.
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of **Patient 10** and the staff associated with **Patient 10**'s management

4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to **Patient 10** within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.
- To carry out this review into the care provided to **Patient 10** using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to the timing of **Patient 10**'s clinical management.
- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to **Patient 10** and the staff associated with **Patient 10**'s care

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

On 18 November 2010, Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On 24 June 2014, Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On 23 September 2014, Patient 10 seen by Dr 3 who ordered CT of Chest and Abdomen (CT CA).

On 26 September 2014, Patient 10 had a MRI of renal tract completed at the request of, or requested on behalf of, Dr 1. Dr 2's report on 29 September 2014 compared the previous CT 25/06/14 and USS 24/07/14. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On 29 October 2014, Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on 20/06/14 and on 1 November 2014 reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re: large renal cyst and mentioning a history of bowel cancer and breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on 29 October 2014, and that there would be further Surgical Outpatient review. The CT reported a complex right renal cyst. This finding was not included in the letter Patient 10 and was not escalated to either Urology or Radiology for further opinion.

On 6 January 2016, Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 regarding the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for 13th January 2016.

On 12th January 2016, Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted

5.0 DESCRIPTION OF INCIDENT/CASE

on CT. A malignant node in the left axilla with invasive lobular carcinoma was confirmed.

15 February 2016 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10's renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on 31 October 2016.

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10's radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the 29 September 2014 MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10's MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. This error was the primary contributing factor to the delayed recognition of a potential renal cancer and its subsequent management.

The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5. The CT chest and abdomen of 29 October 2014 reported a complex right renal cyst. This important finding was not included in the letter by Dr 3 to Patient 10 on 7 November 2014 and was not referred on for urological opinion. This represents a missed opportunity to expedite investigation of a reported abnormality.

The Review Panel reviewed the GP Referral Letter management for Patient 10 in October 2014. In summary; Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters for that week. Patient 10 was one of eight letters for Triage.

The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6's personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event that the triage was not returned. A default management process was formally circulated on 6 November 2015. The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next available new patient appointment. The length of time until

6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until 16 January 2016.

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on 30 October 2016. This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on 14 February 2016. It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10, the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10's delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.

9.0 RECOMMENDATIONS AND ACTION PLANNING

This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP

In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.

10.0 DISTRIBUTION LIST

Patient
10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

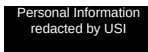
AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

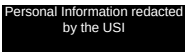
AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services
and Functional Support Services

Chair of Surgical Morbidity and Mortality

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: 

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier: 

Service User Details: *(complete where relevant)*

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020

1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient **Patient 15**, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 a 68-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, **Patient 15** was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 14 a 63-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 11 a 68-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, **Patient 11** was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 13 – a 51-year-old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and **Patient 13** was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. **Patient 13** was reviewed at OPD on 31 January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. **Patient 13** has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Patient 12 a 73-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, **Patient 12** had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 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.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 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, Trust and GPs

Recommendation 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.

TRUST

Recommendation 5

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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting 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.

CONSULTANT 1

Recommendation 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.

Recommendation 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.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients **Patient 15**, **"Patient 13"**, **Patient 12**, **Patient 14** and **Patient 11**, in the period after referral to the SHSCT Urology service using

3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

1 cover unfilled shifts.

2 A. Yeah.

3 482 Q. But would you --

4 A. So I'm not aware of what governance or what management
5 response there was from the Director of Nursing side of 15:10
6 things. Neither am I aware of what response there was
7 from the assistant director or the head of service
8 responsible for urology, you know. So I'm not sure
9 what their response to Catherine Hunter was at this
10 point in time. These were not new issues. Catherine 15:11
11 was not the first person to raise these issues. And
12 some of these issues persist.

13 483 Q. Going back to, I suppose, the point in relation to
14 benign patients. If we go to AOB-01811. And this is a
15 note penned by Mr. Haynes to Mrs. Gishkori. Again, you 15:11
16 and your fellow consultants copied in. And it's May
17 2018. And what he is saying, to summarise this note,
18 is that:

19

20 "There are serious patient safety concerns within the 15:11
21 Urology Department regarding the current status of our
22 inpatient theatre waiting list and the significant risk
23 that this poses to patients."

24

25 If we just scroll down a little bit. The impact, as he 15:12
26 sees it, is on the, primarily the clinically urgent
27 cases, and he makes the point that only limited numbers
28 of non-cancer cases are being seen. They belong within
29 the urgent classification. And no routine patients, or

1 very few, classified as routine are being seen.

2
3 Just in the last paragraph. "Tragically", he refers,
4 without naming Patient 91, you'll see on your list, or
5 at least I take that to be Patient 91, who was a 15:13
6 patient who came in with some comorbidities, but for a
7 stent replacement or removal, I can't quite --

8 A. So I'm very familiar with that patient. Yeah.

9 484 Q. Yeah. And we'll come to it in some detail. But I
10 think we can -- I suppose the thrust of the point is 15:13
11 delays with the management of, for example, stent
12 patients, risks, infection, sepsis, and in this case
13 there may have been other contributory factors, but
14 "This is what we're up against, this is the risk we
15 face." 15:13

16 A. Yeah, he was laying it out in very clear terms to
17 Mrs. Gishkori. And, you know, this was about the
18 inpatient operating capacity and the clear disconnect
19 that we had between the volume of patients that we had
20 to deal with versus the capacity that we had to deliver 15:14
21 care for them. And, you know, we didn't have anywhere
22 else to send these people. Our colleagues in other
23 units were under similar pressures. It's not that we
24 could pick up the phone and ask the Ulster or the City
25 or somebody else to take these people. On occasions 15:14
26 that kind of thing did happen. But, you know, we just
27 had no capacity to sort these people out, which is
28 shocking.

29 485 Q. If we scroll just down three pages to AOB-01814, a

couple of weeks later, it seems, following a meeting, as we can pick up from the first line of this e-mail, Mr. Haynes writing to Mrs. Gishkori again, says that:

"The meeting was to resolve the issues of the impact of the loss of the extended day operating." 15:15

A. (Witness Nods).

486 Q. And we'll come to some of these initiatives in a short moment. "But the meeting did not result", it says: 15:15

"...in urology having its full number of weekly theatres, nor was it intended to address any increase in urology operating to address the waiting list backlog." 15:15

So --

A. So, my point there would be that, first of all, 11 half day slots for a team that's supposed to be six or seven consultants is not enough. But that's what we had. 15:15

487 Q. Yeah.

A. We weren't able to get back to that position. So, we were never going to be able to play catchup.

Secondly, there's a disparity in the waiting times across the specialties, and that was something that was discussed. You can see that some of the larger specialties like orthopedics and general surgery have huge waiting lists as well. We have terrible waiting 15:15

1 lists. But there are other specialties that didn't
 2 have such bad waiting lists. So there was a discussion
 3 as to whether or not the Trust should be applying some
 4 form of quantitative metric as to who gets what
 5 proportion of the available theatre time.

15:16

6
 7 It's also - I think this was written in May, is that
 8 correct?

9 488 Q. It's into June with this one.

10 A. Okay. Yeah. June. So this is the summer. You know,
 11 this is just an example of how there are year-round
 12 pressures. You know, we can't even operate at full
 13 capacity in the summer months. That's -- and that has
 14 been my experience now for I would say probably six to
 15 seven years. Now, you know, I have a recent example.

15:16

16 I went on to the ward on a Friday morning to be greeted
 17 by the ward manager, whom I have known for 20 years,
 18 and she said "We've got outliers in our elective beds.
 19 They promised me they wouldn't put outliers in the
 20 elective beds. We're going to have to cancel some
 21 surgery." This was August.

15:16

22 489 Q. I suppose I can detect perhaps an end of tether moment
 23 on the part of Mr. O'Brien a year later, when perhaps
 24 his tether is longer than that. But in 2019 he wrote
 25 to you and colleagues. If you just bring up on the
 26 screen, please, WIT-55757?

15:17

27 A. It feels like I'm telling you tales of woe.

28 490 Q. Well, I think it's important to put this context in
 29 place before we get on to some of the other substance

1 we have to explore.

2 A. Yeah.

3 491 Q. So, Mr. Haynes is again pointing up the risks of
4 urosepsis, and he's saying: Going forward can we
5 document this? Can we, I suppose, better put it on the 15:18
6 in-tray of those who need to know by filing incident
7 reports where there has been unreasonable waits? I see
8 you smiling. I don't know how you responded to that?
9 Was that --

10 A. I... 15:18

11 492 Q. Is it correct, I suppose, to describe it as a "where do
12 we go?", end of tether moment?

13 A. I think Mr. Haynes here is very clearly outlining how
14 we have to flag to the Trust that there's a significant
15 problem. However, I would say that the Trust should 15:19
16 very well know that there's a significant problem by
17 the volume of the waiting lists. All the procedures
18 that go on the waiting list are coded. All you have to
19 do is run a coding and you can understand very clearly
20 what's waiting on the waiting list. 15:19

21 493 Q. I don't need to bring you to it, but we'll perhaps come
22 to it later.

23 A. Yeah.

24 494 Q. In terms of the dissemination of these key messages, we
25 know, for example, in Patient 91's case, and in other 15:19
26 cases, his SEA report or review pointed up the need for
27 the Trust to deal with capacity issues. It was one of
28 the...

29 A. Yeah.

1 that was Covid-related, was that --

2 A. Subject to Covid- and family-related meant we couldn't

3 come back, so I stayed on and then I came back in --

4 I restarted in October 2021.

5 134 Q. But your original intention was not to stay quite that 12:36

6 long, was it?

7 A. No.

8 135 Q. Okay. Thank you. That's enough on stones. We have

9 heard quite a lot about waiting-list management and how

10 it's done differently, perhaps, in Southern Trust. I 12:37

11 mean, what was your view of the -- being sent Excel

12 spreadsheets of all the patients under your name every

13 week or every period to try and sort out -- I mean, did

14 you think that you needed more help in that respect, or

15 what was your personal view on that? 12:37

16 A. My personal view is that there now is a urology

17 booker --

18 136 Q. Yes.

19 A. -- and you need administrative help to fulfil that role

20 because the waiting lists are so large that they can be 12:37

21 a little bit overwhelming; you are thinking, right, who

22 do you pick and how do you operate? The obvious thing

23 everyone says is, right, well, it's the person who is

24 last on the list. The reality of that is, it isn't the

25 case, and the reality is you need a three-pronged 12:37

26 approach and then it is very time consuming. So I give

27 an example of PCNLs, is, I can't just take the exact

28 last person, but I'm very aware of them and I plan to

29 then do them, but I have to update their imaging, I

1 have to see them in clinic, because time has changed
2 that person, their comorbidities in the situation. So
3 you have to be very mindful of taking the next person
4 who is due on the list, and, at the same point, you
5 have to say, right, who on this list is going to come 12:38
6 to harm? who is hiding in that list that needs to
7 actually be next on that list? And then the third
8 thing is, you have to be aware of, well, what happens
9 if you have cancellations? You need to maximise the
10 resources you have. So I have been very clear on 12:38
11 having a shortlist of people I can bring in very last
12 minute who I know are really well and aren't going to
13 cause the anaesthetic department -- and I know their
14 urines will be negative when they get tested, so the
15 list is used. So you have to do it in three different 12:38
16 approaches to try and maximise, one, your resource and
17 also try and tackle the problem.

18 137 Q. So when did that schedule come in?
19 A. So the schedule had started in the past few weeks.

20 138 Q. Right. So, up until then, it was purely down to the 12:39
21 Urologist to sort it out?
22 A. Yeah.

23 139 Q. Yes, okay. Thank you. We are aware of one particular
24 sort of poor outcome when the theatre checklist, the
25 pre-ureteroscopy urine culture hadn't been done or 12:39
26 there was a problem with pre-assessment and it went
27 ahead and there was perhaps a poor outcome there. I
28 mean, do you have rules that you abide by in terms
29 of --

1 taken place and you not know about it, or would you
2 have expected to have been involved?

3 A. I think there were a lot of conversations between,
4 particularlly, Martina Corrigan, who worked extremely
5 hard on waiting lists, and the urologists, yes. 12:20

6 193 Q. But you don't have any personal knowledge of that; you
7 just believe that to be the case?

8 A. Other than when they interacted with me.

9 194 Q. And how did the interactions with you come about and
10 what did that involve? 12:20

11 A. It involved sending me the waiting list on a regular
12 basis and then I selected off the waiting list those
13 things that I could do, and then those patients were
14 transferred to me, either direct to list or to a clinic
15 for a meet-and-greet before coming to a list. 12:21

16 195 Q. So you received data in relation to waiting lists?

17 A. Yes, I did.

18 196 Q. And was it numerical data simply in the length of time
19 people have been waiting?

20 A. Because I do names, just a long list of names. 12:21

21 197 Q. Just names. Was there ever any exercise undertaken or
22 proposed to look beyond the names, to the clinical
23 presentation of patients, to try and gauge just if
24 there was -- well, I think it probably can be taken as
25 read that waiting lists do, potentially, create harm, 12:21
26 patient harm, people waiting longer than they need to?

27 A. Oh, yes.

28 198 Q. And if we take that as being the real potential, was
29 there ever any suggestion that you should look below

1 the figures and below the names and see what the
 2 priority was for people and were people coming to harm
 3 waiting?

4 A. No, the waiting lists were stratified according to
 5 urgency and time waiting. So there would have been 12:22
 6 routine, urgent, semi-urgent, and, among that, then you
 7 would also have known the length of time that people
 8 were waiting. So I was generally taking from the
 9 routine list and the red-flag list, I was taking mostly
 10 from those two lists, and I would have known how long 12:22
 11 they were waiting.

12 199 Q. When you talk about those designations of red flag and
 13 routine, were they designations that were initially
 14 applied to patients at the outset of their
 15 introduction? 12:22

16 A. Yes, yes.

17 200 Q. And was there any review ever undertaken of upgrading
 18 or downgrading patients, depending -- given the length
 19 of time? Did anyone think, well, we need to go back
 20 and look at these patients because what might be a red 12:22
 21 flag -- or what might be a routine, may now be a red
 22 flag?

23 A. There would have been validations of waiting lists
 24 generally across the Trust where people would have
 25 looked at waiting lists to see if anybody's status has 12:22
 26 changed or whether they had, in fact, passed on.

27 201 Q. And that was during your time as Clinical Director?

28 A. It was a regular thing; that it wouldn't be something
 29 that I would have done, it would happen at non-clinical

1 level.

2 202 Q. So when you say "non-clinical level", was it an
3 administrative process undertaken?

4 A. Yes, it was, yes.

5 203 Q. So the person doing that wouldn't have had the clinical 12:23
6 experience to perhaps assess the patient?

7 A. They would have in case with a clinician. So if there
8 was a validation waiting list that I was engaged in,
9 they would have asked me to look at them as well.

10 204 Q. So did that involve going back asking -- phoning the 12:23
11 patient and saying, "are you as you were when you first
12 came into the system?" or checking if the patient had
13 been back to their GP or presented in ED or -- how
14 would you know if the patient had got worse, I suppose
15 that's the key question I'm trying to find out? 12:23

16 A. I am not sure I can give you a straight answer to that.
17 I can't really remember how validations were done.
18 It's a long time ago.

19 205 Q. Do you have any sense that there was a lack of
20 appreciation on the part of the Trust management as to 12:24
21 the harm and the risk of harm patients could suffer due
22 to the length of time they were waiting for treatment?

23 A. No, I don't think that was ever the case. I think it
24 was always fully appreciated that patients languishing
25 on lists are going to suffer from morbidity. 12:24

26 206 Q. I know that you have listened to the Inquiry and you're
27 aware of the issues and I think you listened to the
28 evidence of Mr. Mackle.

29 A. I did.

1 regret not recognising that a deeper look into
2 Mr. O'Brien's practice was required at the time of the
3 MHPS investigation being instigated. What was looked
4 into were the issues that had been identified, but we
5 didn't proactively look for other things.

15:26

6 81 Q. In terms of the difficulties posed for your patients by
7 the absence of adequate resources, you, both in your
8 AMD role and in your Chairmanship of NICaN, wrote
9 regularly to management, and indeed Commissioner, to
10 express concerns about the kinds of choices Clinicians
11 were going to have to make, or were increasingly having
12 to make, between two patients with both challenging and
13 traumatic conditions, but one having to be preferred
14 over the other. Is that something that caused you
15 a particular difficulty, those kind of choices?

15:26

15:27

16 A. It concerned me that we were in a position that we were
17 having to make those choices. As I have outlined in
18 correspondence, it places us in a vulnerable position,
19 we are having to make prioritisation decisions which we
20 do on the basis of the information available and we do
21 to the best of our ability, but inevitably there is
22 a risk of a patient, an individual patient coming to
23 harm as a result of that prioritisation decision.

15:27

24 82 Q. At one point on 11th October 2019 you wrote to
25 colleagues. The reference is WIT-55757. You wrote to
26 colleagues to say, in essence, if you believe that the
27 treatment of your patient is unreasonably delayed, you
28 should raise a Datix, perhaps to keep themselves right
29 within the system and as some kind of communication or

15:28

1 signal, perhaps to the Commissioners that all was not
2 well?

3 A. Yeah, I think the incident reporting system is, if you
4 like, the intelligence-gatherer for the system.

5 I think I've said in my statement that it had almost 15:28
6 become normalised for patients to wait a long time for
7 treatment. If, if you like, the wider system is
8 normalised such that we kind of know it, we could
9 almost -- I felt we were in a vulnerable position to
10 not be flagging that patients are coming to harm 15:29
11 because they are waiting longer than they should, and
12 so I encouraged to flag that patients are coming to
13 harm because of the waiting times.

14 83 Q. Within this context, Mr. O'Brien in his statement, if
15 we could pull up WIT-82957. I have a rogue reference, 15:29
16 I think. I will read it out, I have a note of it. In
17 essence, Mr. O'Brien says in his statement that the
18 issues which arose in his practice were inextricably
19 linked to the inadequate system within which he was
20 working. We will no doubt ask him about that in the 15:30
21 fullness of time, but one supposes that he is
22 reflecting the fact that, given the pressures and
23 impossible choices placed upon clinicians working
24 within the system, with all its inadequacies that you
25 have described, the issues that arose in his practice, 15:30
26 such as Triaging, dictation, actioning
27 investigations -- to quote some examples -- the ability
28 to do that work as the system might expect or as the
29 employer might expect, was difficult, and perhaps he

1 as was and SPPG in terms of getting more commissioning
2 in and around that to try to build it up. And they
3 did, they have managed to build up the number of CNS's
4 and urologists, but not at the pace we needed.

5 Essentially, right from the get-go, I think what -- he 16:08
6 was certainly raising it. I think it was being raised
7 in different places, but I don't know whether we were
8 forcible enough about that or whether we didn't go the
9 right way around it. But it certainly took quite
10 a period of time, really, for that to gain any purchase 16:08
11 and to get some investment, as far as I can see.

12 385 Q. MR. HANBURY: In the same sort of line, obviously as
13 surgeons we are very worried about patients being on
14 the waiting list for a long time and, obviously, they
15 had come to harm and they are not necessarily seen back 16:09
16 in clinic to make sure they are all right. And there
17 are initiatives for potential harm reviews after, say,
18 a certain length of time, say a year or something. Is
19 that something that you brought in or you would like to
20 see happen? 16:09

21 A. I'm not sure whether they have -- I know that I hear
22 mention -- and I haven't thought about this
23 specifically -- I know that I hear mention of patients
24 that they are concerned about as being long waiters
25 that they have checked up on. So that definitely does 16:09
26 get discussed. I haven't asked specifically is that
27 done through the CNSS or is that done through other
28 aspects of urology. But I can certainly check that out
29 and see. But I know, certainly, those long waiters are

1 on everybody's mind, particularly -- I mean, the vast
2 majority of what they do at the minute, almost entirely
3 with the exception of stents, I think, is red flag.
4 So a lot of those patients with long-term urology
5 problems are waiting to be seen. And I know that, 16:10
6 certainly in recent times, we have gone back -- and I
7 will check whether or not it is specifically urology,
8 but I know for some aspects in surgery we have
9 certainly gone back to patients in writing to check
10 with them that they are still on our waiting lists and 16:10
11 that, actually, if there's anything that we need to do
12 to engage with them. Again, that came out of the back
13 of recommendations marked RQIA and others in relation
14 to that.

15 386 Q. MR. HANBURY: Just one final question about waiting 16:10
16 list management. We've heard potentially the problems
17 that clinicians can run into if they are running it
18 with themselves and their secretary. What's your view
19 of maybe having a waiting list office where this is
20 controlled, there's more of an independent look and 16:10
21 people don't so get forgotten about and scheduled
22 stent-change type patients don't forgotten about as we
23 sort of mark the SAIs. There does seem to be a lot of
24 the section, the consultants themselves, seem to have
25 a lot of responsibility there with that particular 16:11
26 administrative task. Do you think that could
27 usefully go into more generalised administration system
28 such as a waiting list office?

29 A. I know that the current interim director for surgery is

1 Commissioners, perhaps even the Department, that people
2 are coming to harm because of waiting lists backlog?

3 A. I think it was -- first of all, yes, the Trust would
4 have told Commissioners in those Commissioner meetings,
5 and I think the Commissioners fully understood that
6 everyone waiting on a waiting list had the potential to
7 come to harm. Not just Urology. Everyone waiting on
8 a waiting list has the potential to come to harm. The
9 Commissioner also has an X pot of money that the
10 Commissioner choose to commission services, so I think
11 everyone with their eyes open is very clearly aware
12 that when resources do not meet the demands that are in
13 the system, people will come to harm.

14 18 Q. We'll come on later to look at the whole area of early
15 alerts. Is this the kind of problem where you put an
16 early alert out, or an alert or some other form of
17 flashing red light, to the Commissioners and say, you
18 know, 300 weeks for treatment for some categories of
19 patients is just beyond acceptable? Or, how is that
20 message communicated so that the public is aware that
21 action is needed?

22 A. Again, through those performance meetings. The
23 Directorate of Performance and his or her team would be
24 meeting with the Commissioner. If it were just
25 a single service with a flashing red light, then
26 I could totally understand that there would be a real
27 focus on that particular service. The situation within
28 Northern Ireland now, and actually over that period of
29 time, is that many, many, many specialities did not

1 piece of work done out of a report that had come out of
 2 the Patient Client Council around the waiting lists in
 3 Northern Ireland and the people on them. I recall a
 4 time at which the Trust Board had asked about that,
 5 about the experience of people on the waiting list. 11:56

6 So, there had been a patient experience piece done as
 7 well. I remember it because we had said, well, is
 8 there -- I remember actually Mark Haynes had done a
 9 piece about do you contact people who have been
 10 essentially languishing on the waiting list for a long 11:57
 11 time, but it was quite morally distressing even for
 12 clinicians to do so when you had no solution for how
 13 you were going to be able to see them and when.

14
 15 There was a lot of work done around that sort of 11:57
 16 things; that people were recognising the difficulties
 17 and the potential harm essentially to people on long
 18 waiting lists.

19 220 Q. Is it ever the case that the Commissioner or the HSCB,
 20 with an awareness of the issues that are causing 11:57
 21 problems, offer help or seek to provide, for example,
 22 funding for Peer Review or speciality review or an
 23 external audit? Is it ever the case that they would
 24 unilaterally approach the Trust, or is it a
 25 wait-and-see for them? 11:57

26 A. I'm not aware of them having approached us to suggest
 27 that. I suppose what I would say, to be fair to both
 28 Commissioner and the services, is that if you
 29 approached them to seek that sort of funding for



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63. Recognising that the waiting times as described in the IEAP were being exceeded, several actions were taken:

- a) There was a continuous monitoring of the waiting times against targets for Urology Services within the Surgical Division.
- b) As the waiting times were far in excess of those targets described in the IEAP the performance target positions were placed on the Directorate Risk Register. The reason for placing it on the risk register was that the solutions required to address the waiting times were greater than that which existed within the Urology Service.
- c) At Director level a monthly performance meeting was held with senior members of Trust's Performance team in attendance. At these meetings the waiting times were reviewed and actions taken when possible to address the waiting times. These actions included undertaking 'in-house' additionality. The Urology Service would have been able to undertake in house additionality when it received non recurrent waiting list monies from the HSCB. In-house additionality would have been undertaken by our consultant urologist for outpatient activity, inpatients and or day case activity.
- d) The waiting times targets were also addressed by the Trust engaging with the Independent Sector (IS) to undertake agreed volumes of clinical activity. Similar to In-House additionality contracts with the IS could only happen when the Trust received additional non recurrent waiting list monies from the HSCB.

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- e) Meetings where also held between the Trust and the HSCB at which the waiting times targets were discussed.

Summary of Actions taken:

64. Internal

- a) Monthly Performance Heads of Service meeting, attended by the Performance Head of Service for the Southern Trust, examples are located in:
 - a. *Relevant to Acute, Document Number 13, 13b, 2016.04.26 Minutes - HOS performance meeting, 2017.03.14 - Minutes - HOS Performance Meeting and 2018.04.26 Minutes - HOS Performance Meeting*
 - b. Monthly Performance Acute SMT, attended by the Assistant Director for Performance & Reform
- b) Monthly Cancer Performance Meetings
- c) Risk register – performance escalated for outpatients, elective and planned waiting times

65. External



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II. How was it implemented, reviewed and its effectiveness assessed?

68. I assume that Dr Gillian Rankin (Acute Director), Mrs Heather Trouton (AD) and Mr Eamon Mackle (AMD) would have had responsibility for the implementation, review and effectiveness assessment of the plan. I had no role in the Trust's review or effectiveness assessment of the Regional review for Team South in 2010/2011. My only role in the Trust's implementation of the Plan was to provide 3 session days for theatre, which was done.

III. What was your role in that process?

69. Please see response to Question 13(II).

IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

70. In 2010 when I had responsibility for theatres, I knew that 3 session days for theatres was in operation to accommodate Urology. In April 2016 when assuming role as AD for ATICs /SEC I would not have been aware of the aims of the Regional Review of Urology Services, or Team South Implementation Plan as published in 2010 or whether the targets were being met at that time. Neither the Regional Review of Urology Services nor the Team South Implementation Plan as published in 2010 documentation was shared with me upon my appointment as AD in April 2016. I received both documents for first time on April 29, 2022.

71. However, now having had sight of the Team South Implementation Plan I can confirm that the following elements were in place in April 2016 when I became AD. These included:

- a) The main acute elective and non-elective inpatient unit for Team South was in operation at Craigavon Area Hospital
- b) Day surgery for Urology was being undertaken at Craigavon and South Tyrone.
- c) Outpatient clinics were being held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital (Daisy Hill had ceased upon retirement of Mr Robin Brown).
- d) All outpatient referrals were directed to Craigavon Area Hospital.
- e) Suspected cancer referrals were being appropriately marked and recorded.
- f) Consultant led sessions were being provided over 42 weeks.
- g) Six Consultant Urologists were in place (The Team South Implementation Plan proposed 5)
- h) Two CNS were in post (had been in post since 2005).

1 in terms of making substantive appointments based on
 2 nonrecurrent monies. It was a risky move. Some Trusts
 3 did it but our Trust, we didn't do it.

4 312 Q. Thank you.

5
 6 Just one thing on the PP analysis. A slightly unusual
 7 situation that, from my reading, almost all the
 8 patients start as NHS patients and were put on a
 9 waiting list and then saw Mr. O'Brien in his private
 10 rooms. Were they already on a surgical waiting list?
 11 That wasn't well demonstrated in the analysis. This
 12 has caused confusion, I think.

13 A. I am not sure. I don't know the answer, Mr. Hanbury,
 14 in terms of patients were initially seen as an NHS
 15 patient and subsequently went on to see Mr. O'Brien
 16 privately, or they only saw Mr. O'Brien privately and
 17 then were transferred into the Health Service. I don't
 18 know the answer to that.

19 313 Q. But that would make a difference if they were?

20 A. Yes.

21 314 Q. Thank you.

22
 23 Just lastly referring to Patient 16, sort of waiting
 24 list issues, especially for scheduled patients, stent
 25 change is delayed and that.

26 A. Yes.

27 315 Q. What mechanism did you have to oversee the waiting list
 28 of a patient who has to wait a certain length of time,
 29 but not shorter or longer, which is an unusual thing in

1 the case of a lot of urology patients?

2 A. So, Patient 16 required to have a stent removed in
3 order to have his chemotherapy. I suppose, as
4 Mr. Wolfe said, there was lots of miscommunication or
5 noncommunication between the Regional Oncology Centre 16:46
6 and the Trust. It was simply capacity to allow Patient
7 16 to allow to have the stents removed. He was caught
8 up in our inability to provide timely stent removal.

9 316 Q. Is that rather than having waiting list, clerical
10 office support-type factors in your thoughts? 16:46

11 A. I'm not too sure. Sorry?

12 317 Q. I was getting at the fact that Mr. O'Brien used to run
13 a lot of his waiting lists himself rather than relying
14 on clerical colleagues who may have assisted. Do you
15 think that was a problem? 16:47

16 A. Well, I know consultants obviously do -- if they don't
17 have the capacity and they're concerned about a
18 patient, they would speak to their colleague and say
19 would you operate on this patient for the following
20 reasons, and I'm sure nine times out of ten that 16:47
21 happens. I'm not aware that Mr. O'Brien made that
22 request of one of his colleagues for Patient 16.

23 318 Q. Thank you.

24 CHAIR: Just a couple of questions.

25
26 In one of your answers to Mr. Wolfe, you said that you
27 felt it was better that operational managers could
28 investigate the issues of concern regarding
29 Mr. O'Brien's practice if he were excluded rather than 16:47

1 him being there. why was that?

2 A. I suppose -- and Mrs. Corrigan referred to that.
3 Mr. O'Brien is a big presence. It was not uncommon
4 that Mr. O'Brien would be in the hospital for many,
5 many, many hours, you know, well into the evening. 16:48
6 I met him when I was on-call sometimes walking the
7 corridors at maybe nine o'clock at night. So it was
8 generally felt his presence would just make things
9 easier.

10 319 Q. His absence, not his presence? 16:48

11 A. Sorry. His absence, yes.

12 320 Q. I suppose the corollary of that is why do you think
13 nobody sat down and talked to Mr. O'Brien about all of
14 this that was going on in the background, the MHPS
15 investigation? 16:48

16 A. I don't think anybody took ownership of it. I suppose
17 the management of Mr. O'Brien was through the MHPS
18 vehicle. That's a medically driven vehicle with
19 support of HR. I suppose from my perspective, I was
20 looking for senior clinicians to take the lead on it. 16:49
21 As I said, my knowledge of it was limited, very
22 limited. It's been my experience, working in the
23 Health Service many years, that senior clinicians
24 always interact better and communicate better with
25 their peers. whilst I'm a senior manager and a nurse, 16:49
26 it's much more powerful and meaningful if an AMD or CD
27 or the Medical Director, but that didn't happen. I
28 suppose to answer your question why did that not
29 happen, I don't know.

1 that my colleagues who undertake private practice, when
2 they transfer the patients in for NHS care, are
3 completing that form. That form is collated through
4 a central -- I think it is linked to the Medical
5 Director's office. There are audits that are 10:13
6 undertaken to check that they have gone through the
7 right steps. In terms of the expediting or bringing
8 people ahead of patients who have been waiting longer
9 for the same procedure, if we look within Urology, we,
10 as a team, function from a pooled waiting list. While 10:13
11 someone may be added to the list under my name, that
12 doesn't mean that they are getting their operation
13 under me. They will get their operation when they come
14 to the top of the waiting list by an appropriately
15 trained clinician on the next available list. We have 10:13
16 a scheduler who plans and schedules our list rather
17 than us having a direct point. So the ability for
18 a consultant to transfer a patient from their private
19 practice into NHS care and then on to their next
20 operating list is much more limited. 10:14

21 9 Q. Okay, that's helpful. That's a response centrally to
22 the private patients points. But a little more
23 broadly, as was the focus of my question, the mischief
24 here I'm identifying is -- and, as I say, it is not
25 just private patients, the evidence seems to suggest 10:14
26 that it's divergence or compliance issues across
27 a number of practice areas; management, whether
28 operational or professional, knew about them but the
29 private patients example, in your own words, is an

- 1 149 Q. There was a change in approach then?
- 2 A. There was a change in approach.
- 3 150 Q. The scheduling would be not so much centralised but --
- 4 A. All the other consultants scheduled their theatre list
- 5 with somebody else, who then took it away to actually 12:13
- 6 implement it. Mr. O'Brien was the only surgeon who did
- 7 the scheduling of the Patient Targeting List himself
- 8 and so, therefore, we had no visibility at the point in
- 9 time of who he was scheduling. And that's where this
- 10 comment relates to. So, I put a process around him to 12:13
- 11 support him in the process of scheduling but to make
- 12 sure that the longest waiters within the urgency
- 13 category were those that were being taken first.
- 14 151 Q. Just while we are on that, the scheduling of patients,
- 15 you say Mr. O'Brien did that on his own. Was he 12:13
- 16 supported in that role by a scheduler?
- 17 A. He should have been but he was refusing that support,
- 18 as I understand it at that time.
- 19 152 Q. The new arrangements to standardise the procedure
- 20 around the scheduling of patients, was that something 12:14
- 21 that was adopted by other consultants in Urology?
- 22 A. I don't think there had been a problem in terms of the
- 23 other consultants.
- 24 153 Q. Was it your understanding that it was only Mr. O'Brien
- 25 who allegedly didn't schedule the admission of patients 12:14
- 26 in chronological order?
- 27 A. That is my understanding, yes.
- 28 154 Q. It was your understanding then that once this system of
- 29 chronological scheduling was asked to be adopted by the



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regional Radiology system it was eventually possible to see on the system which reports had been read by the consultant who had ordered the test. This ensured that reporting could be in place, once the requisite report software was written and the system updated. As the radiology system was implemented as a regional system this reporting function only became available after the Root Cause Analysis report was completed and the problem would have been difficult to identify earlier through formal systems. I do not recall whether a report on the monitoring of the consultant sign off of test results in the radiology system was made available during my tenure.

- i The laboratory IT system was developed to ensure that there was sign off of each blood test by the doctor who had ordered the specific blood tests. Any discrepancies were monitored and followed up. This process of developing reporting was undertaken within the Trust by the Laboratory Head of Services in the Acute Services Directorate and was not linked to a regional system.
- ii The scheduling of patients in order of urgency and chronology was addressed through a stronger process of scheduling involving the Head of Service and the Operational Support Lead scheduling patients with Mr O'Brien, a process not required with other consultants. This ensured that Mr O'Brien no longer had sole control of booking patients for surgery.
- iii Patients requiring the operation of cystectomy for either malignant or benign conditions were transferred to the Belfast Trust as part of the implementation of the regional review of urology.
- iv The use of IV therapy for patients with recurrent UTIs was addressed through the development of a multidisciplinary process of discussion involving the consultant urologist, the CD for surgery and a consultant microbiologist prior to the treatment commencing for each patient. This ensured that the use of oral antibiotics was fully discussed and IV

21. With NICER the issue re patient notes has become less and so people have found ways around missing notes. There are still 13 sets of notes missing and he has been asked about them. I have no recollection of anyone using IR1's to document missing notes.
22. The Consultants working through the notes and undictated clinics have some concern that other appointments to other specialities have been missed as the letters were not dictated. There are no significant patient complaints regarding Mr O'Brien. The waiting lists are now so long so we have complaints generally about waiting times. Mr O'Brien does not use digital dictation and therefore it is not possible to monitor when clinics haven't been dictated. All of the other Consultants use digital dictation which allows for every clinic to be linked on PAS. If a clinic is not dictated this would highlight it. Consultants are using digital dictation 3 to 4 years now. While there is nothing specifically documented, my expectation would be that Mr O'Brien's secretary should have been flagging if outcomes were not dictated. I am now aware there are hundreds of letters from clinics not dictated by Mr O'Brien.
23. Mr O'Brien knows his patients really well but has kept a lot of the information relating to his patients retained in his head. It is not safe clinical practice.
24. An issue which concerned me this week is that when I checked regarding bed pressures, Mr O'Brien has no clinical priority noted on the theatre list. He said they are all urgent and 'they will all be done'. We need to be able to prioritise patients when there are bed pressures so we know who can be cancelled if absolutely necessary. The only person who knows the priority is Mr O'Brien.
25. In respect of TOR 4 – I was notified via e-mail from Mr Haynes about concerns relating to Mr O'Brien's private patients. Currently checks are ongoing on all patients in 2015 and 2016. The current waiting time for a routine procedure in Urology is 170 weeks. There does appear to be patients taken out of chronological order and operated on sooner. This is being looked into further to see if there were specific reasons for clinical priority in these cases.
26. Mr O'Brien says he has 4 categories of prioritisation; semi urgent, urgent, soon and routine, or something like that. This Trust has 2 categories urgent or routine. The rest of the urologists follow that.

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

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

stated in her report that these cases were reviewed by Mr Michael Young and that it is Mr Young's assessment that was being relied upon.

Mr Young provided a witness statement, signed on 5th October 2017 (Tab 41). In response, to the issue of private patients, Mr Young stated:

"33. In respect of TOR 4, I am aware that Mr O'Brien does private consultations at home, he doesn't see private patients in the hospital at all to my knowledge. I know this through conversations with Mr O'Brien. As far as I am aware Mr O'Brien does not perform surgery privately, patients convert to the NHS for their treatment.

34. I can't comment on the placement of private patients in the NHS queue. I don't track Mr O'Brien's patients. Any concerns I heard about private patients were just hearsay. I had no idea when patients were seen by Mr O'Brien at his home. I would have thought patients go on to the NHS list as per clinical priority. I have subsequently heard that some private patients might have been given dates sooner on the list but I was not aware if this was down to clinical priority. While I have recently heard this, I personally had no evidence of it."

Mr Young's statement clearly contradicts any assertion that he was providing a clinical assessment of the priority given to patients or the appropriateness of their placement on the waiting list.

Dr Chada attached Mr Young's assessment to her report. The assessment is simply a post it note put on each of 11 letters that I had dictated to GP's for private patients. These are attached at Tab 42.

Dr Chada never conducted a comparative analysis of NHS patients. Without such an analysis, it is not possible to state that the private patients were given favourable treatment to NHS patients. I have been able to demonstrate that there was no favourable treatment given to TURP patients and I intend to review all of my elective patients to provide a similar comparison given the Trust's failure to do so. The sum total of the Trust's investigation was 11 post-it notes placed on 11 letters by a colleague who did not appear to know that he was providing an assessment of whether the waiting times were justified.

The investigation of patients seen privately by me has been handled in a vexatious manner. It is my belief that the approach taken has been to cause me the maximum distress and reputational damage. The Trust has not conducted a reasonable investigation into this matter. The Case Investigator was not the individual conducting the investigation. The investigation has not been transparent in providing the basis for which the patients were chosen from all of the procedures conducted in 2016 or the details of the individual/individual(s) who chose them. It is not clear who compiled the list at Tab 39.

As part of my grievance, I am relying on Appendix 2 of the Trust Guidelines where it is stated that the Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence. Accordingly, I am requesting the opportunity to see the following all correspondence that gave rise to the concern about private patients becoming part of this investigation and relating to the handling of the investigation. I believe that it is essential that the Trust be transparent about how these cases came to be assessed.

concerns regarding my triage activity taking too long, nor do I have any recollection of any escalation to me as CD or AMD of concerns regarding any monitoring of clinicians triage performance, or other clinicians (including urologists) not undertaking triage within the timescales noted in the IEAP, outside of the concerns identified regarding Mr O'Brien and detailed later in this statement.

12.3 As an individual consultant, the time limits outlined in the IEAP per se did not impact on how I delivered care on a day to day basis, aside from the impact on the proportion of Red Flag new patients I saw in outpatient clinics. Consultant urologists have a limited ability to impact on the scale of the capacity:demand mismatch and so our primary role is in prioritisation of those awaiting surgical treatment based on clinical priority. The IEAP details a number of principles for management of waiting lists. These principles align with what should be standard for any doctor with patients managed in chronological order, according to their clinical priority. Where the capacity:demand mismatch is such as in NI urology it has meant that effectively patients on routine waiting lists do not get treatment, and urgent non cancer cases may often wait many years.

12.4 Unfortunately, this approach (chronological management of waiting lists based on clinical priority) was not always followed in the department and I identified that Mr O'Brien, in particular, was bringing patients in whom he had seen privately ahead of those who had been on the waiting list for longer, even though, as far as I could see, they had the same indication and urgency as patients who waited years. Examples of emails escalating this concern are attached. *Please see:*

17. 20151126-email queue jumpers

18. 20150527-email urology longest waiters

19. 20150527-email urology longest waiters attachment 1

20. 20150527-email urology longest waiters attachment 2

12.5 As AMD the IEAP and time limits within it did not have any impact on my role in the management, governance and oversight of urology services. However,

McAllister was AMD and they continued to be so when I was AMD. This was escalated to the Medical Director by me. *Please see:*

89. 20180614-email litigation, 90. 20180614-email litigation att, 91. 20180614-email litigation att1, 92. 20180614-email litigation att3, 93. 20180614-email litigation att4, 94. 20180614-email litigation att5, 95. 20180614-email litigation att6 and 95a. – 95p. email litigation att7-att22

61.5 During my Urologist of the Week activity, where the on-call consultant conducts the ward round of all inpatients, it became evident to me that Mr O'Brien was transferring patients from his private practice for NHS care for surgery but their treatment times were expedited compared with patients on the standard NHS waiting list. I raised this in emails (*please see 17. 20151126-email queue jumpers, 18. 20150527-email urology longest waiters' 19. 20150527-email urology longest waiters attachment 1, 20. 20150527-email urology longest waiters attachment 2*). However, I am not aware of the action taken at this time.

61.6 In August 2016, I raised a concern via email (Mr Patient 93) regarding a routine referral which would have been upgraded to red flag (suspected cancer) but had not been returned from triage. *Please see 98. 20160831-email Patient 93 and 99. 20160831-email Patient 93 attachment 1.*

61.7 I also became aware, through a new patient referral, that there appeared to be an issue with Mr O'Brien receiving and actioning investigations he had requested or that had been requested on his behalf (concerning a patient with a likely kidney cancer on CT scan). I raised this as an IR1 (Patient 92, July 2018) and a subsequent SEA was conducted.

61.8 I had also raised an IR1 (Patient 10, January 2016) regarding a further patient with kidney cancer which led to the identification of a significant number of un-triaged referrals in Mr O'Brien's office. *Please see 44. 20180717 Datix Irrelevant redacted by the USI 45. 20201113 Final Report Irrelevant redacted by the USI 46. 20210719 Approved Action Plan to HSCB and 47. 20210719 Approved Action Plan to HSCB A1.*

Corrigan, Martina

From: Haynes, Mark <[Personal Information redacted by USI]>
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private patients being brought onto NHS lists having significantly jumped the Waiting List. As I have been through our inpatients in preparation for taking over the on-call today I have once again come across examples of this behaviour continuing. Specific patient details are;

[Personal Information redacted by USI] AOB
Referred Sept 2015, Seen OP ([Personal Information redacted by USI]) Sat 10/10/15, Urodynamics @thorndale unit 6/11/15, Cystodistension 25/11/15.

[Personal Information redacted by USI] AOB
Referred 28/10/15, Seen OP ([Personal Information redacted by USI]) Sat 7/11/15, GA cystoscopy 25/11/15 (?recurrent stricture)

I have expressed my view on many occasions. This is Immoral and unacceptable. Aside from the immorality of patients who have the means to seek private consultations having their operations on the NHS list to the detriment of patients without the means, who sit on the waiting list for significant lengths of time, the behaviour is apparent to outsiders looking in. The HSC board can see it when they look at our service and any of our good work is undone by this.

Can you advise me what action has been taken since I raised this?

Mark

Corrigan, Martina

From: Haynes, Mark <[REDACTED] Personal Information redacted by USI >
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Attachments: UROLOGY LONGEST URGENT WAITERS WITHOUT DATE FOR SURGERY - FOR SCHEDULING - 27.05.xlsx; UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15.xls

Importance: High

Dear Michael / Martina

I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. On the attached total urgent waiting list there are 89 patient listed for an Urgent TURP, the majority of whom will have catheters insitu. They have been waiting up to 92 weeks.

However, on the ward this week is a man ([REDACTED] Personal Information redacted by USI) who went into retention on 16th March 2015, Failed a TROC on 31st March 2015. He was seen in a private clinic on Saturday 18th April and admission arranged for 25th May with a view to Surgery 27th May. The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. I would not disagree with any argument that this patient got the treatment we should be able to offer to all but it is indefensible that this patient waited 5 weeks while another patient waits 92 weeks. Both with catheters insitu for retention. An argument that this man was very distressed with his catheter does not hold with me. All of our secretaries can vouch for many patients in this situation being in regular contact because of catheter related problems.

This behaviour needs to be challenged a stop put to it. I am unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times / chronological listing for all of us and an honest discussion as a team, perhaps led by Debbie. The alternative is to remove waiting list management from all of us consultants and have an administrative team which manages the waiting list / pre-op / filling of waiting lists in a chronological order.

Happy to discuss and plan a strategy for taking this forward.

Mark

From: Glenny, Sharon
Sent: 27 May 2015 14:32
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Hi Everyone

Following the departmental meeting last week and discussion re urgent waiting times and volumes with consultants for elective surgery – I have attached a total urgent waiting list for your review.

- (b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.
- (c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.
- (d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.
2. (a) It was found that in January 2017 Mr O'B█ returned 307 sets of patient notes which had been stored at his home. Mr O'B█ accepts that there were in excess of 260 patient notes returned from his home in January 2017.
- (b) The notes dated as far back as November 2014. It was found that Mr O'B█ returned patient notes as requested and he asserts therefore there was no impact on patient care.
- (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'B█.
3. (a) It was found that there were 66 undictated clinics by Mr O'B█ during the period 2015 and 2016. Mr O'B█ accepts this.
- (b) It was accepted by Mr O'B█ that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC are that all notes / dictation are contemporaneous.
- (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.
6. It has been found that Mr O'B█ scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.



Urology Services Inquiry

5. At paragraph 64.15 (WIT-51820), I wish to correct an omission.

a. I have stated as follows:

'64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, to my knowledge, at the meeting in January 2017 as part of the lookback exercise and I am unaware of further meetings on same.'

b. I wish to amend this to the following:

'64.15 The issue in reference to private patients potentially having surgery at an earlier point than expected was first raised, I believe, with me in an email from Mr Haynes on 27 May 2015 (WIT-54107) and subsequently in his further email of 26 November 2015 (WIT-54106). I believe that I spoke briefly to Mr Haynes at some point after the first email (I have a recollection it was after a ward round at the nurses' station) and asked him if he was aware of any clinical reason for the patient being seen in the timescales in question. I cannot recall if he responded then or later nor can I recall if I made any attempt to follow up the issue (although, for the avoidance of doubt, I accept that I should have done). I recall that I also spoke to Mr O'Brien at some stage, most likely at a point after receiving the first email, which would be consistent with what I have said in my response to Mr Haynes' second email (at TRU-270116 – 'I had spoken before to the person in question re this issue in general ...'). I cannot recall the detail of my conversation with Mr O'Brien but believe that I must have received some reassurance from him that he was not prioritising patients whom he had seen privately. I do not know if I spoke to Mr O'Brien again after the second email from Mr Haynes. On reflection, I believe that it might have been better for me simply to have escalated the second email to more senior managers. It is possible that at the time



Urology Services Inquiry

I may have assumed Martina Corrigan would do this because the emails were sent to her as well as to me. It may well be that, as with the issue of follow up with Mr Haynes in respect of the first email, this issue simply got side-lined because of other more pressing day-to-day work. The next time any private patient issue was raised to my knowledge was at the meeting in January 2017 as part of the lookback exercise.'

6. At paragraph 65.8 (WIT-51823), I have stated, 'I have had no other conversations on this point that I can recall.' This should state, 'I have had little in the way of other conversations on this point that I can recall other than at interview for the MHPS and as described at paragraph 64.15 above.'

Additional Material

7. I wish to provide the following additional information, not already included in the 'Mr O'Brien' (Q61 to Q74) section of the Section 21 Notice:
 - a. When triaging on 30th July 2018, I observed in correspondence from the A&E department that the patient had seen Mr O'Brien and had recently been commenced on Desmopressin 200 micrograms. She had a subsequent admission with hyponatraemia in June 2018. Her hyponatraemia did resolve and correspondence from Mr O'Brien did acknowledge the relationship between the Desmopressin dosage and her hyponatraemia. On seeing this correspondence, I emailed Mr O'Brien to note that the correct dose of the medication for an elderly lady was 25 micrograms (see 2. 20180730 -Email MY to AOB Desmopressin). I thought he would appreciate this correspondence. On reviewing the situation, I note that the correct dose was recorded on a discharge comment of October 2018. My memory of this episode was only triggered in very recent times (when seeing another elderly patient potentially in need of Desmopressin). Having reflected on it, I acknowledge that an option open to me in 2018 would have been to complete an IR1 form. I

Hynds, Siobhan

From: Young, Michael Personal Information redacted by the USI
Sent: 26 November 2015 12:03
To: Haynes, Mark; Corrigan, Martina
Subject: RE: Queue jumpers

I had spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.
Will have to speak again then

MY

From: Haynes, Mark
Sent: 26 November 2015 06:42
To: Young, Michael; Corrigan, Martina
Subject: Queue jumpers

Morning Michael

I emailed you on 2nd June 2015 about the ongoing issue of patients on waiting lists not being managed chronologically and in particular private pa

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Southern Health & Social Care Trust

Management of Waiting Lists - Pre-Operative Assessments & Patient Consent 2019/20



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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	None held (due to corona virus)
Working Draft Issued On:	10 April 2020
Management Actions Received:	6 October 2020
Final Report Issued On:	7 October 2020

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Helen O'Neill	Director of Finance, Procurement and Estates
Melanie McClements	Interim Director of Acute Services
Dr Maria O'Kane	Medical Director
Ronan Carroll	Assistant Director of Acute Services
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Introduction

In accordance with the 2019/20 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Management of Waiting Lists focusing on Pre-operative Assessments and Patient Consent during September 2019 to March 2020. These 2 areas have not previously been subject to review by Internal Audit.

It is important to note that this audit was conducted before the impact of Covid 19.

A recent SAI case and previous work by Internal Audit in relation to Theatre Utilisation had indicated issues with timeliness of pre-operative assessments particularly in the current scenario of lengthy waiting lists. This led to concerns regarding patient safety where the Trust was potentially reliant upon pre-operative self-assessments which were out of date and also instances where these had to be rushed just ahead of surgery to ensure maximum utilisation of theatre slots, because previous assessments had time lapsed due to Waiting List length. Also in such scenarios, there is a query as to whether time was taken to properly discuss risks with the patient.

The **pre-operative assessment** is an opportunity to identify co-morbidities that may lead to patient complications during the anaesthetic, surgical, or post-operative period. Patients scheduled for elective procedures generally attend a pre-operative assessment 2-4 weeks before their date of surgery. The objectives of a pre-operative assessment are:

- to perform a structured preoperative anaesthetic assessment of a patient prior to surgery and recognise when further assessment/optimisation is required;
- to explain options and risks of routine anaesthesia to patients, in a way they understand, and obtain their consent for anaesthesia;
- to formulate a plan for the management of common co-existing diseases;
- to ensure all elective patients who must undergo a surgical intervention under general anaesthetic (GA) or local anaesthetic (in some cases) are passed fit to do so.

Within the SHSCT, the specialties for which pre-operative assessments are performed are:

- Orthopaedics
- Gynaecology
- ENT
- General Surgery inc. breast surgery
- Urology; and
- Maxi-facial surgery.

This will be for all referrals triaged as Routine, Urgent or Red Flag. In cases involving a local anaesthetic where a patient is on a blood thinning drug, they don't do a full assessment as the patient must cease all such drugs in advance of the operation. Also where a patient is due to undergo endoscopy and they are on a blood thinning drug they must have a pre-operative assessment performed. Pre-operative assessments are not performed for patients admitted as inpatient or daycases via Emergency Departments (EDs).

In practice pre-operative assessments are carried out using a range of methods based on a risk assessment of the patients' medical history –

- Pre-op health questionnaire (virtual – online review of NIECR etc);
- Pre-op health questionnaire (conducted over telephone by band 5 or 6 nurse);
- Pre-op health questionnaire (conducted face to face with band 5 or 6 nurse);
- Anaesthetist review of health questionnaire (for certain conditions);
- Pre-op assessment (conducted face to face with consultant anaesthetist) or where there is a need to perform additional tests for certain conditions;

The completed questionnaire is filed on the patients' file and type and date of pre-operative assessment performed is recorded on Patient Administration System (PAS).

The Pre-operative Assessment (POA) Team is part of Anaesthetics, Theatres & Intensive Care (ATICS) within the Surgery, Elective Care & ATICS Division of the Acute Services Directorate. It provides services from Craigavon Area (CAH), Daisy Hill (DHH) and South Tyrone (STH) Hospitals, primarily in close proximity to Outpatient Departments. The POA team comprises 18 qualified nurses (14.68 wte). There are also 6.0 wte administrative staff. A consultant anaesthetist provides one morning session per day (5

days a week) conducting virtual clinics at CAH. They will also see / advise on booked face to face appointments (those patients where risks are greater) and conduct tests on booked appointments where necessary. During the 6 month period from 1st October 2018 to 31st March 2019 there were approximately 14,000 pre-operative assessments (POA) performed of which approximately 900 were performed by Anaesthetists (*based on PAS figures*).

In order to function efficiently and effectively the POA team must co-ordinate its work with a number of other services such as consultants and their secretaries and specialty theatre scheduling teams re timely notification of patients on upcoming consultant theatre sessions; specialty outpatient teams to perform timely pre-operative assessments for patients designated as red flag or urgent; and medical records. Failure to notify the pre-operative assessment team of patients who require a pre-operative assessment on a timely basis could result in patients not having their pre-operative assessment completed timely prior to surgery. If patients are admitted without being deemed as pre-op fit, this increases patient safety risk and potential for cancellation of surgery on the day. If patients require any blood tests or other tests, results may not be available prior to surgery where there are delays in notifications. Best practice guidance indicates pre-operative assessments are valid for a period of 13 weeks (3 months), and must then be re-performed, when the patient referred has not yet had surgery.

It is a general legal and ethical principle that valid **consent** must be obtained from a patient or their guardian before commencing an examination, starting treatment or physical investigation. For consent to be valid it must comply with the following principles:

- It must be given **voluntarily**, and freely without pressure or undue influence being exerted on the individual. Coercion from whatever source will invalidate consent.
- Given by an appropriately **informed** person (the individual or, where relevant, someone with parental responsibility for a young person under the age of 16). The patient/client needs to understand the nature and purpose of the procedure and the risks, benefits, alternatives and implications of no treatment or care. Any misrepresentation of these elements will invalidate consent. Information about anaesthesia should be given as well as information about the procedure itself. The Trust requires as evidence of good practice that patient/client records include a summary of the information given prior to gaining consent.
- The person must have **capacity** to consent and be able to comprehend and retain information relevant to the decision, understand the consequences, weigh up the information and arrive at a choice, and be able to communicate their choice.

Consent must be sought before commencing examination, treatment or care of a patient/client. If consent is sought after a patient/client is given routine pre-operative medication, it may be deemed to be invalid. For major activities, such as surgery under anaesthetic, it is good practice to fully inform the individual about the implications, potential risks and benefits well in advance of the proposed activity. This will allow the individual time to reflect on the information about the activity or event and for the professional to respond appropriately to questions. The health or social care professional should again check, before the activity starts, that the consent is still valid and that the patient/client has not had a change of mind about proceeding. If consent is not gained until just before the activity care event is due to start, at a time when the patient/client may be feeling particularly vulnerable, there may be doubt as to the validity of the consent gained.

The Southern Trust requires as evidence of good practice that information is provided to the patient to help inform consent and any decision by the patient to withdraw or refuse consent, is recorded in the patient record. It is important that a recording format is agreed and applied consistently and records should also include the information given to the patient or client to aid his/her decision and where refusal of consent by a patient/client prevents care being given.

Scope of Assignment

This audit covered Pre-operative Assessments and Patient Consent processes during the audit test period outlined below. Discussions took place with a number of consultants across the following specialties – ENT, Gynaecology, Urology, General Surgery and Anaesthetics. Discussions also took place with Pre-operative Assessment, Scheduling, and Booking Centre Teams, as well as consultants' secretaries. Reports were obtained from PAS through the Informatics Department showing:

- i. All recorded pre-operative assessments for the 6 month period 1st October 2018 to 31st March 2019.

- ii. All elective inpatients and day cases recorded for the 3 month period 1st January 2019 to 31st March 2019.

Based on analysis of these reports, 105 patients' files were pulled and reviewed.

A copy of the Pre-operative Assessment Team database from CAH was obtained and used to supplement / verify reported data. Queries arising from testing were discussed with appropriate clinical staff.

The audit was based on the risks that due to increasing length of elective waiting lists, and pressure to maximise usage of limited elective theatre slots:

1. there is potential for increased patient safety issues during surgery due to issues with timeliness / elapsed pre-operative assessments performed on elective patients; and
2. failure to obtain timely informed patient consent resulting in patients' not fully understanding all surgical risks.

The objectives of this audit were:

- To ensure that pre-operative assessments are performed in a timely manner ahead of proposed surgery and are properly assessed by an appropriate individual well in advance of planned surgery.
- To ensure that valid patient consent is obtained and there is evidence of timely informed discussion of risks with the patient.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Pre-Operative Assessments

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Patient Consent

Satisfactory

Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide limited assurance in relation to Management of Pre-operative assessments. Limited assurance has been provided on Pre-Operative Assessments on the basis that 25% of patient files examined where a pre-operative assessment was required did not have a completed assessment form on the file - 63.6% were Urology cases; in 8.4% of sampled surgical cases the pre-operative assessment had expired.

Satisfactory assurance has been provided in relation to Management of Patient Consent on the basis that consent forms signed by the patient were available on all patient files examined, although we noted that extent and quality of completion of consent forms varied significantly.

There are 2 significant findings in this audit, impacting on the assurance provided:

1. Specialties such as Urology, General Surgery and Orthopaedics routinely do not provide theatre lists to the Pre-operative Assessment Team 6 weeks in advance. Testing of 105 patient files found 7 cases where the pre-op was performed either on the same day or within 3 days of actual operation.

As a consequence of high levels of red flags and urgent patients, some routine patients who are moved down the waiting list subsequently present through the ED pathway as their conditions deteriorate – testing found that of 17 patient files tested in Urology, 14 (88%) had presented through this pathway for stent insertions / replacements. Subsequently these patients must then have the stent removed typically 4-8 weeks later.

There are a number of other occasions when patients will only become known to PreOp Assessment team once a late theatre list is received, impacting on the ability to perform an appropriate PreOp assessment.

From 44 files tested which should have had a POA, there were 11 (25%) with none on file for the selected procedure - 7 (63.6%) were Urology procedures, and one each from Gynaecology, Orthopaedics, General Surgery and ENT.

2. An analysis of date of surgery against date of latest POA on PAS for the test period found that out of the 2,161 patient records matched i.e there was a POA completed, there were 182 records (8.4%) where the time between (date of surgery – date of latest pre-op) was greater than 91 days or 13 weeks. General Surgery, Gastro, ENT and Urology were the specialties with largest numbers of exceptions.

Other key findings of the audit are:

3. While all 100 sampled consent forms had been signed by the patients, the following exceptions were observed in completion of consent forms:
 - 9 consent forms were not signed by the consultant, evidencing the patient had consented to the procedure to be performed;
 - In 80 cases, the copy consent form had not been given to the patient;
 - 5 consent forms did not outline benefits / risks etc discussed with the patient;
 - 88 consent forms did not record evidence that relevant information leaflets on the surgery / procedures had been provided to the patient.
4. There are no documented procedures available for pre-operative assessment. A number of issues with the database system within the PreOp assessment team were observed.

There were no other findings in this report.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Notification of Elective Patients to Pre-operative Assessment	-	5	1
2.	Expiration of Pre-operative Assessments	-	1	-
3.	Patient Consent	-	2	-
4.	Documented Policies / Procedures for Pre-operative Assessment and Database	-	3	-

Detailed Findings and Recommendations

1 Notification of Elective Patients for Pre operative Assessment (POA)

Findings

All elective patients who require a General Anaesthetic (GA) whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. In practice the optimum time is to ensure patients' POAs takes place between 13 weeks and approximately 3 weeks ahead of planned surgery date. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team by the scheduling team or consultants' personal secretaries, 6 weeks in advance of the theatre date. In reality this does not happen in certain specialties such as Urology, General Surgery and Orthopaedics, as the lists are often prone to late changes. Testing identified one case where pre-op was performed on the same day as surgery, 2 cases one day in advance, 2 cases where 2 days in advance and 2 cases where pre-op was performed 3 days in advance of operating date.

The underlying reasons for late lists can be increasing numbers of red flag patients presenting, which when coupled with reduced availability of theatre sessions, often mean routine or less clinically urgent patients must be cancelled from lists at short notice. This has a knock on effect for those latter patients as not only does their waiting list time increase but quite often conditions deteriorate and they subsequently present through ED pathway and are admitted as an inpatient. (*See Urology stent cases below*).

There are a number of other occasions when patients will only become known to POA team once a late theatre list is received, such as:

- Private patients – they will not have been seen at the Trust Outpatient Department, and when they are subsequently referred as NHS inpatients will not have been assessed following a clinic attendance, as per urgent / red flag NHS patients;
- Patients admitted to wards (primarily through ED), who are subsequently discharged having had their immediate emergency resolved, but the consultant then adds them to the waiting list because they require further urgent surgery e.g. emergency Urology stent insertions, where the patient must return in typically 4-8 weeks for it to be removed (typically as a day case). Before the patient leaves hospital the discharging doctor should get them to complete a POA questionnaire, or to attend the POA Department in urgent / red flag cases;
- Patients who have had investigations either at the day procedure units or scope clinics, and are then referred following biopsy or other tests. In these instances as the test results are not known and consequently the consultant does not ask them to complete a POA questionnaire available at clinics;
- Outpatient attendees, whom the consultant refers for surgery but doesn't notify to POA at the time of their Outpatient visit – ideally all red flag / urgent cases should be sent immediately to POA team.

Using data analysis of PAS reports, Internal Audit reviewed a sample of 105 elective patient files for patients seen in the period 1st January to 31st March 2018 to ascertain whether the patient had required a pre-operative assessment prior to having their inpatient or day case procedure. Only 44/105 (42%) files examined required the patient to have a pre-operative assessment. Of the 44 files which should have had a POA, there were 11 (25%) with none on file for the selected procedure. These 11 cases can be analysed as follows:

- 7 (63.6%) were Urology procedures
- 1 was Orthopaedics
- 1 was Gynaecology
- 1 was ENT
- 1 was General Surgery

From the 61 cases where there was no pre-operative assessment, 17 urology stent removals / replacements were further examined to ascertain whether a Pre-Operative Assessment was carried out for the original stent insertions. 3/17 (12%) patient files did have a Pre-Operative Assessment booklet. The remaining 14 cases were all admitted through ED and consequently did not have a POA. Discussion with consultants indicated more patients, primarily because of the waiting time were presenting through ED route, and emergency temporary stent insertion was required to relieve immediate discomfort / pain. The

stent is subsequently removed 4-8 weeks later. In some cases the stent may be routinely replaced every 3-6 months.

Implication(s)

Planning issues for POA Team when theatre schedules are presented late and new or updated POA is required at very short notice.

Patient safety risks where theatre schedules are not notified timely to the POA team and assessments are either not completed in advance of surgery or may be rushed in order to meet theatre scheduling e.g. all results of POA tests may not be known / completed etc.

Increased risk of cancellation of surgery on the day of operation because POA not completed, potentially resulting in loss of theatre time.

Recommendation 1.1	As previously reported in the 2018/19 Theatre Utilisation report, the surgical rotas should be prepared and made available on a timely basis, (4 weeks) to allow for efficient scheduling and booking of patients onto theatre lists and appropriate time for pre-operative assessments to be completed. Responsible Officer: Not stated Original Implementation Date: Not stated
Priority	2
Management Action	ACCEPTED Medical annual leave to be confirmed with 6 weeks' notice. This will then enable the Heads of Service to develop the emergency and elective rotas for their specialities. Their rotas are forwarded to Theatres who then develop the overall theatre/anaesthetic rota. The Trust will aim for the final theatre/anaesthetic rota to be developed at 4 weeks minimum.
Responsible Manager	Head of Service for ATICs and Surgical specialities
Implementation Date	April 2021

Recommendation 1.2	As previously reported in the 2018/19 Theatre Utilisation report, as per procedure, to allow timely completion of pre-operative assessments, patients listed in theatre sessions should be notified to Pre-Operative Assessment Team 4 weeks in advance of surgery date. Responsible Officer: Not stated Original Implementation Date: Not stated
Priority	2
Management Action	ACCEPTED Medical annual leave to be confirmed with 6 weeks' notice. This will then enable the Heads of Service to develop the emergency and elective rotas for their specialities. Their rotas are forwarded to Theatres who then develop the overall theatre/anaesthetic rota. The Trust will aim for the final theatre/anaesthetic rota to be developed at 4 weeks minimum.
Responsible Manager	Head of Service for ATICs and Surgical specialities

Implementation Date	April 2021
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Recommendation 1.3	Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Booking Centre Manager
Implementation Date	April 2021

Recommendation 1.4	Management should review and strengthen processes where ward admissions via ED, are subsequently re-booked for urgent surgery e.g. Urology Stent removals within 4-8 weeks, so they are promptly notified to the Pre-operative Assessment Team on discharge.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Booking Centre Manager
Implementation Date	April 2021

Recommendation 1.5	Management should review and remind Surgical specialities in relation to limited use of pre-operative assessments given the high volume of exceptions found.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Head of Service for ATICs and Surgical specialities
Implementation Date	April 2021

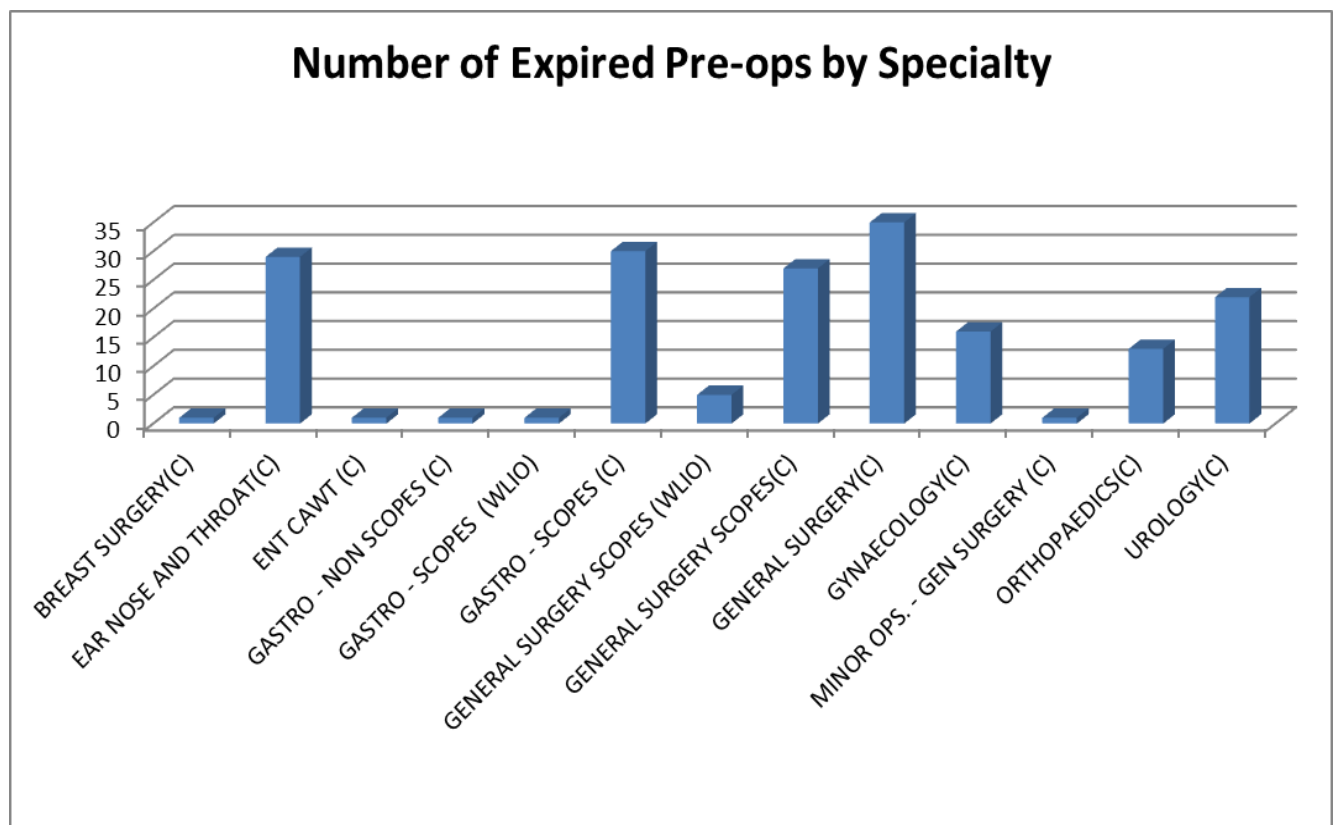
Recommendation 1.6	Management should retrospectively investigate the 11 exceptions noted where there was a pre-operative assessment expected but not performed, and identify learning.
Priority	3
Management Action	ACCEPTED
Responsible Manager	Lead Nurse and Pre-op Band 7 Sister
Implementation Date	April 2021

2 Expiration of Pre operative Assessments

Findings

A paper Pre-op assessment questionnaire should be completed by patients following their attendance at a surgical outpatient clinic when advised that they require surgery. When the questionnaire /NIECR is reviewed by Pre Op Assessment staff, there is an escalation process in place for patients deemed more at risk or with certain conditions. Pre-operative assessments remain valid for a period of 3 months (13 weeks) from completion i.e. when the patient is passed fit for surgery. With the growth in waiting lists for urgent and routine procedures, particularly in specialties such as ENT, General Surgery, Orthopaedics, and Urology, there may have been significant change in the patient's condition over the intervening period since they were initially seen in POA or added to the inpatient waiting list, with in excess of 2 years or longer not unusual. This also means pre-op staff are reviewing patient data which is significantly out of date and consequently this increases the time necessary to review and update patient data.

An analysis of POAs from PAS for the 6 month period 1st October 2018 to 31st March 2019 against all elective inpatients and daycases recorded for the 3 month period 1st January 2019 to 31st March 2019 found there were 2,161 Elective Inpatient / Daycase patients that had a POA. In 182 (8.4%) of these cases, the time between (date of surgery – date of latest pre-op) was greater than 13 weeks. An analysis of exceptions by specialty is shown in the graph:



Implication(s)

Patient safety risks where POAs are out of date (greater than 13 weeks) particularly for routine / urgent patients who have been on waiting lists for considerable periods of time and their condition has changed / deteriorated significantly impacting their fitness for surgery.

Potential for greater risk of cancellation of surgery on the day of planned operation, resulting in loss of theatre time.

Increased time for aged referrals to be fully pre-operatively assessed / update patient clinical data. Also where time is limited ahead of theatre slot this potentially increases risk of rushing through patient's fitness for surgery.

Where POAs must be completed more than once there is potentially a negative patient perception of the service efficiency and duplication of information.

Recommendation 2.1	Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including General Surgery, Gastro, ENT and Urology.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Lead Nurse and Pre-op Band 7 Sister
Implementation Date	April 2021

3 Patient Consent

Findings

It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation. For consent to be valid it must be voluntarily given by an appropriately informed person who has capacity. We observed that the Trust's Policy on Gaining Consent is dated November 2009, and has not been subject to review since then and no regular training for new doctors.

Discussions with 8 consultants found that they were very aware of the issues and risks around consent and when it should be discussed with patients etc.

Of the 105 patient files and corresponding procedures examined, there were 5 cases where there was no consent form completed. In discussion with clinical staff it was deemed appropriate that there was no consent form due to the nature of the procedures. While all remaining 100 consent forms had been signed by the patients, the following exceptions were observed in completion of consent forms:

- 9 consent forms were not signed by the consultant evidencing the patient had consented to the procedure to be performed;
- 80 consent forms the copy had not been given to the patient;
- 5 consent forms did not outline benefits / risks etc discussed with the patient;
- 88 consent forms did not record evidence that relevant information leaflets on the surgery / procedures had been provided to the patient.

Implications

Absence of up to date policy and corresponding training may expose the Trust and clinicians to additional risks.

Non-recording of all aspects of the consent process could call into question the validity of consent where there is a subsequent complaint or legal action by or on behalf of the patient.

Recommendation 3.1	Management should review and update its Policy on Gaining Consent to ensure all the latest legal and ethical standards have been incorporated into the policy.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Associate Medical Director
Implementation Date	April 2021

Recommendation 3.2	All medical staff should be reminded of the importance of fully completing patient consent forms in order to fully comply with Trust procedures and minimise risk of future queries / concerns from patients.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Associate Medical Director
Implementation Date	April 2021

4 Pre operative Assessment Policies / Procedures and Database

Findings

There are no documented procedures available for pre-operative assessment. We did note that within the POA Team a patient pathway flow-chart has been developed for internal use.

The database system within the Pre-operative Assessment Department for managing the referral of patients has been developed using an Excel spreadsheet and is very basic in recording patients referred to the service and recording actions taken. Testing found issues such as inconsistent recording, use of colour coding and variable quality of notes. Additionally Internal Audit was unable to use the database to match patient records to corresponding PAS data to verify completeness of records. There are separate databases for CAH and DHHsites.

Implication(s)

Absence of clear documented policy and procedures resulting in ambiguity in processes for staff particularly new or inexperienced staff
Incomplete or inaccurate POA records e.g. not all attendees recorded or actions taken.

Recommendation 4.1	Management should produce comprehensive policy and procedures for pre-operative assessment processes and its interfaces with specialties and scheduling teams etc.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Clinical Lead for Pre-Op, Head of Services, Lead Nurse for Pre-op & Pre-op Sister
Implementation Date	June 2021

Recommendation 4.2	Management should further document and strengthen its POA database procedures for managing and recording of pre-operative assessments to ensure quality and consistency of records.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Clinical Lead for Pre-op and ATICS Head of Service
Implementation Date	April 2023 Implementation date will be dependent on the introduction of Encompass and any funding required for a database system

Recommendation 4.3	In the longer term Management should assess the need to develop a more comprehensive solution to managing and recording pre-operative assessments, integrated with PAS / NIECR etc.
Priority	2
Management Action	ACCEPTED
Responsible Manager	Clinical Lead for Pre-op and ATICS Head of Service
Implementation Date	April 2023 Implementation date will be dependent on the introduction of Encompass and any funding required for a database system

Appendix A Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in fulfilling their responsibilities.

Internal Audit Service – Ballymena Office
Greenmount House
Woodside Road Industrial Estate
BALLYMENA
BT42 4TP
TEL 028 95362540

Internal Audit Service – Londonderry Office
Lime Cabin
Gransha Park
Clooney Road
LONDONDERRY
BT47 6WJ
TEL 028 95361727

Internal Audit Service – Belfast Office
2 Franklin Street
BELFAST
BT2 8DQ
TEL 028 95363828

Internal Audit Service – Armagh Office
Pinewood Villa
73 Loughgall Road
ARMAGH
BT61 7PR
TEL 028 95361629

Manual for Cancer Services

Urology Measures

Version 1.0

VERSION CONTROL SHEET

Date	Version	Changes	Update by
Jan 2014	1.0	Initial version	Julia Hill
Mar 2014	1.1	p14 for bladder cancer - remove asterix after neo-adjuvant chemotherapy	Julia Hill

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Section 2 – Clinical Indicators / Lines of Enquiry

TBA

National Cancer Peer Review and The Manual for Cancer Services

1 Introduction

The National Cancer Peer Review Programme provides important information about the quality of clinical teams and a national benchmark of cancer services across the country. It aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

The Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Robert Francis Jan 2013) said the creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement. Among the recommendations made is recommendation 49, Enhancement of monitoring and the importance of inspection, which states;

Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.

The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.

1.1 National Cancer Measures

The development of cancer measures is a dynamic process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new developments and initiatives in treatment and patient care;
- reflect the NHS Commissioning Board specialised service specifications.

1.2 Clinical Indicators/ Outcomes

Peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, clinical indicators have been introduced and form part of the review process along with a reduced number of structure and process measures.

2 Interpretation of the National Manual for Cancer Services

2.1 Guidance Compared to Cancer Measures

National guidance is exactly what it says – guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the “perfect” service, using phrases like “the best possible”, “to all patients at all times”, etc. It may involve all-inclusive, far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person’s accountability for each task is often not stated. Without this underlying type of mind-set guidance would not inspire, lead, motivate or guide and would probably be almost unreadable.

The Manual for Cancer Services has to take a different approach. It is written for the specific purpose of being used to assess a service; to aid self assessment and team development; to be fair compared to visits to other services elsewhere and to past and future visits to the same service. Therefore, the measures have to:

- be objective
- be measurable
- be specific, clear and unambiguous
- be verifiable
- state who exactly is responsible for what
- be discriminating
- be achievable
- be developmental – encourage continuous quality improvement and not produce destructive competition or a sense of failure.

2.2 “The Responsibility for Assessment Purposes”

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task

– this can be delegated according to local discretion, unless it is clear that a given task really is limited to a certain group.

2.3 “Agreement”

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc. requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc.) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

2.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is undertaken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

2.5 “Quality” Aspects of Cancer Service Delivery

The peer review process recognises the qualitative as well as quantitative aspects of review and in addition to the objective recording of compliance against the measures there is a narrative part to the report that provides an overall summary of a team’s performance.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at <http://www.cquins.nhs.uk>

UROLOGY SPECIFIC MEASURES

Introduction

The NICE Improving Outcomes Guidance (IOG) for urological cancers outlines a network-wide structure of different MDT types, with instructions on how these teams should relate to each other. For some treatments, the guidance will result in referral of cases between individual networks, and the establishment of supranetwork teams. The specific configuration of teams in a given network may take different forms depending on catchment population of the network. The recommended minimum catchment population for teams delivering the specialist urology care defined below is one million. The minimum catchment population for the specialist treatment of testicular cancer is two million and of penile cancer, four million. These latter two areas of the service are described in the measures as supranetwork care, delivered by supranetwork teams, even though the teams may not, in all cases, deal with more than one network. The size of the catchment populations is estimated to provide at least a minimum viable case number for the respective teams involved. There is also a requirement for a specialist team to carry out a combined total of at least 50 radical prostatectomies and/or total cystectomies per year and an immediate requirement for surgeons performing five or less radical prostatectomies or five or less cystectomies per year to cease (the 'rule of five').

Implications of the IOG Urology Guidance

There are different levels of care; local care, specialist care and supranetwork care. They are intended to be provided by different types of MDT; local, specialist and supranetwork, with provisions which are outlined below. The different types of teams are characterised by certain criteria and qualifications, also outlined below.

Shape of the Service

(See also, Appendix—Ground Rules for Networking)

1. Local Urology Team

Local urological teams provide local care for their own catchment, referring patients to specialist urology teams for specialist care and to supranetwork teams for certain aspects of care for testicular and penile cancer. Some treatments for penile cancer and testicular cancer may be given by specialist teams with no supranetwork responsibility but all patients with these cancers should be discussed with the supranetwork team.

One important principle underlying the NICE IOG for urological cancers is the principle of the consolidation of services for relatively infrequent procedures. It follows on from this that there should not be more than one local urology team for its cancer site on or covering a given hospital site.

2. Specialist Urology Team

Specialist urological teams provide specialist care for their referring catchment. The principle of consolidation of services requires that there should not be more than one specialist team for its cancer site on or covering a given hospital site or for its specialist referral catchment area.

In order that specialist teams experience the full range of practice for the relevant urological cancers they are required to function as the local urology team for their cancer site, offering local care to their local secondary catchment population.

Another important principle underlying the NICE IOG is the principle of ensuring that the MDT method

of working adds its full potential value to patient care. This requires that for radical surgical aspects of specialist care, the surgical operations and immediate post-op care should all be carried out in the same host hospital of the team.

3. Supranetwork Testicular Team

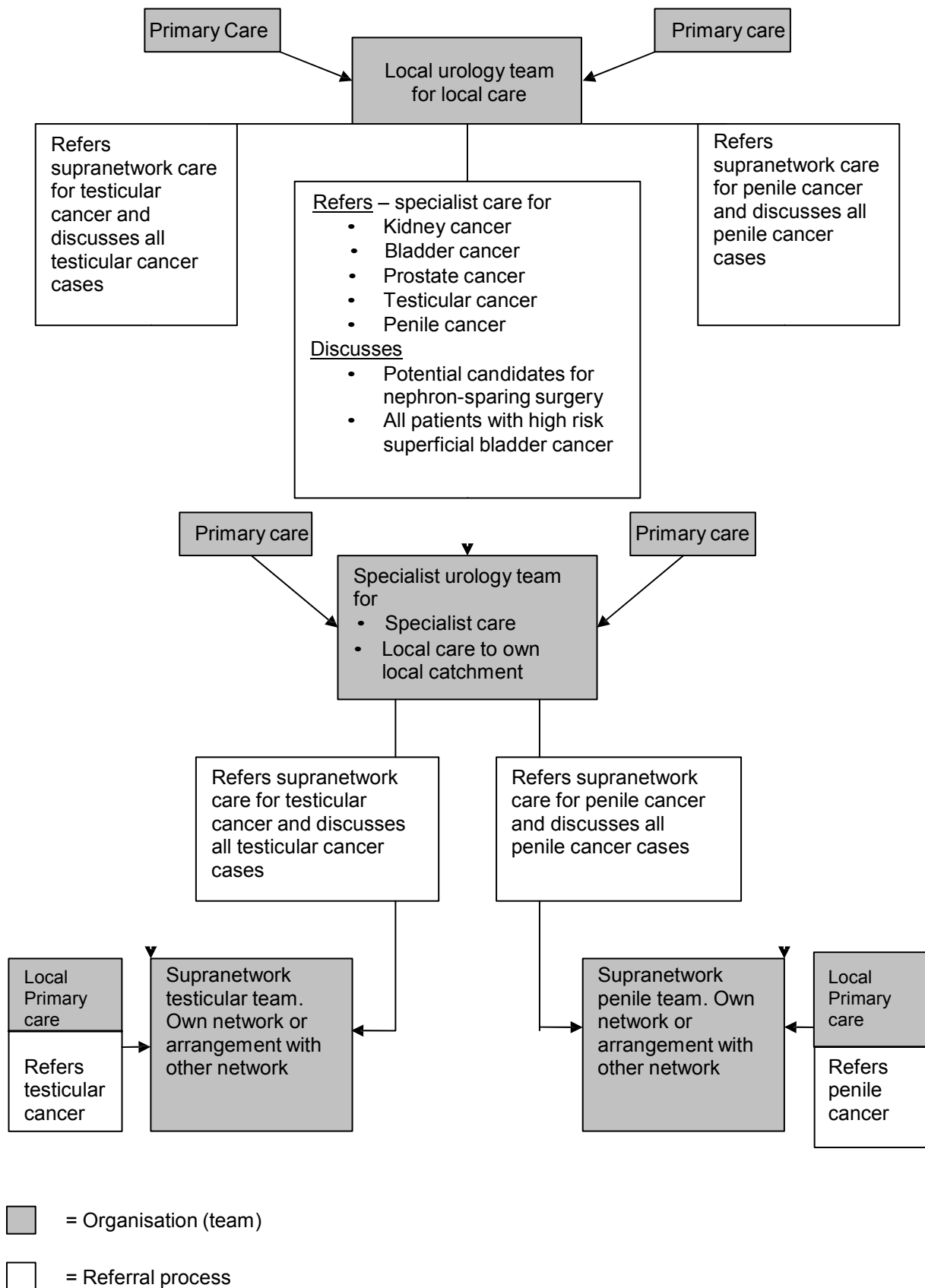
Supranetwork teams for testicular cancer deliver supranetwork care for their referring catchment. In order that supranetwork teams for testicular cancer experience the full range of practice for the disease, they are required to act as the local/specialist MDT, delivering all of the care including local and specialist care for testicular cancer for their own, secondary catchment population.

For testicular teams to add their full potential value to patient care, some surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

4. Supranetwork Penile Cancer Team

Supranetwork teams for penile cancer deliver supranetwork care to their referring catchment which should be a minimum of four million. For supranetwork penile cancer teams to experience the full range of practice for the disease, they are required to act as the local/specialist team, delivering all of the care, including local and specialist care, for penile cancer to their own, secondary catchment population. For the team to add their full potential value to patient care, the supranetwork surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

Team Relationships in Network Configuration



The team criteria for the network configuration

Local Urology team

- Should not be more than one in any one hospital.

Specialist Urology team

- Should not be more than one in any one hospital.
- Should be the only specialist team for its cancer site for its specialist catchment area
- Should act as the local urology team for its own local secondary catchment population as well as being a specialist team.
- Should have at least one million total catchment population, for specialist care and perform the 50 minimum combined total procedures. (It is estimated that this population will produce well over the 50 minimum combined total for prostatectomies and/or cystectomies.)

Supranetwork team for testicular cancer

- Should not be more than one in any one hospital.
- Should be the only supranetwork team for its cancer site in its supranetwork referral catchment area.
- Should act as the team responsible for all care of testicular cancer for its own secondary catchment population, as well as delivering supranetwork care.
- Should have at least two million total catchment population for supranetwork care.

Supranetwork team for penile cancer

- Should not be more than one in any one hospital.
- Should be the only supranetwork team for its cancer site in its supranetwork referral catchment area.
- Should act as the team responsible for all care for penile cancer for its own secondary catchment population as well as delivering supranetwork care.
- Should have at least four million total catchment population for supranetwork care.

Local Care

Provided it is agreed in the network guidelines, the procedures and treatments classed as local care may be delivered under the care of members of the local urology team. They should also be delivered by a specialist/supranetwork team for their own, secondary - i.e. "local" catchment population. They may also be delivered by the specialist urology team on behalf of referring local teams, with agreement in network guidelines.

The procedures and treatments classed in these measures as local care are:

For kidney cancer:

- The diagnostic process.
- Imaging for tumour extent.
- Nephrectomy, excluding the cases outlined below under "specialist care".
- Palliative chemotherapy and radiotherapy.
- Nephro-ureterectomy.

For bladder cancer:

- The diagnostic process.
- Trans-urethral resection (TUR):
 - o For the diagnosis of newly presenting patients with suspected bladder cancer and determining tumour grade and invasion depth.
 - o As treatment for those initial cancers found to be low risk superficial i.e. pTa (G1 or G2); T1 (G1 or G2).
 - o As a follow up procedure for low risk recurrent superficial cancers.

Note:

For high risk superficial bladder cancer: - pTa (G3); T1 (G3); extensive G2; multifocal G2; recurrent G2; and carcinoma in situ - the respective roles of the local team and the relevant specialist team in the ongoing management should be explicitly defined in the agreed network pathways.

The definition of high risk superficial bladder cancer is taken from IOG. It is acknowledged that histological grading of bladder cancer is liable to subjective interpretation and observer variation.

- Intravesical therapy for superficial bladder cancer.
- Palliative chemotherapy and radiotherapy.

For prostate cancer:

- The diagnostic process.
- Active monitoring.
- Orchiectomy.
- Medical hormone therapy.
- Palliative chemotherapy and radiotherapy.

For testicular cancer and penile cancer, see special sections below.

Specialist Care

This should only be delivered under the care of members of the specialist urology team and this is not subject to change by the network's own pathways. There are two categories of specialist procedures:

(i) Procedures which, in addition to being under the care of specialist core team members, should only be carried out in the host hospital of the specialist team:

For kidney cancer

- Resection of primary tumours which have or are suspected to have invaded renal vein, vena cava or heart.
- Resection of metastatic disease.
- Resection of both primary and associated metastatic disease.
- Resection of bilateral primaries.
- Resection of any primary where it is predicted that the patient will subsequently require dialysis.
- Surgical management of patients with von Hippel-Lindau disease or hereditary papillary tumours.
- Resection of urothelial cancers of the upper urology tract.
- Resection by nephron-sparing surgery.
- Resection of non-renal cell kidney cancer, excluding transitional cell carcinoma of the kidney, treated by nephro-ureterectomy.

For bladder cancer

(For the management of high risk superficial cancer see note above)

- Radical surgery (cystectomy).
- Bladder reconstruction.
- Surgery for urinary diversion.
- Resection of urethral cancer.
- Resection of squamous or adenocarcinoma.
- Partial cystectomy (indicated only for adenocarcinoma in the dome of the bladder).

For prostate cancer

- Radical prostatectomy.

For testicular & penile cancer, see special sections below

(ii) Procedures and treatments which should be delivered under the care of specialist team **core** members, but the site of delivery is determined by agreement in the network's guidelines.

For kidney cancer

- Adjuvant chemotherapy.
- Biological therapy.
- Non-surgical management of non-renal cell kidney cancer.

For bladder cancer

- Radical external beam radiotherapy.
 - Adjuvant chemotherapy.
 - Neo-adjuvant radiotherapy.*
 - Neo-adjuvant chemotherapy.
- * Recommended only as part of the clinical trial.

For prostate cancer

- Radical external beam radiotherapy.
- Radical brachytherapy. This is only available in a few networks. Many patients will need referring outside their own network for this therapy.

Supranetwork Care

Testicular cancer

Referral for treatment to another team

Note: Guidelines/pathways on this and on MDT discussion below should be circulated to all urologists in the network not just those who are members of urological cancer MDTs.

Patients being referred for treatment to specialist or supranetwork teams, as outlined below, should be made known to the receiving team within 24-hours of orchidectomy. 'High risk' patients (which should be precisely defined in the network guidelines) should be referred and made known to the supranetwork team pre-operatively, as soon as possible after diagnosis.

MDT Discussion

All cases of testicular cancer should have their case notes presented to and discussed at the next team meeting of the relevant supranetwork testicular team following their diagnosis. This discussion should not delay their management, however.

Local Care

This consists of:

- Diagnosis of all cases and
- Orchidectomy for non-high risk patients

It may be performed under the care of any urologist, not just those who are members of urological cancer MDTs.

Specialist care

This should be defined and agreed by each network as follows:

Patient pathways should be agreed by each urological network group in consultation with their relevant supranetwork testicular cancer team (which for some networks will be in another network). The pathways should determine:

- Regarding radiotherapy for seminoma; which categories of patients may be given radiotherapy under the care of one of a list of agreed specialist teams in the network and which categories of patients should be treated only by the supranetwork team.
- The agreed list of named specialist teams, referred to in the paragraph above.
- Regarding chemotherapy for germ cell cancer; an agreed list of named specialist teams in the network which may treat stage I and 'good prognosis' metastatic cases.
- The specific parameters which define 'good prognosis' as referred to in the paragraph above.

*The network may agree that certain of the treatments outlined above **should not** be delivered by specialist teams for their particular network but should only be delivered by the supranetwork team. Also, the 'specialist care' outlined above, may be given by the supranetwork team if agreed and desired by the patient and relevant consultants.*

Supranetwork care

This should only be given by the relevant supranetwork testicular cancer team and consists of:

- Orchidectomy on high risk patients referred pre-operatively.
- Surgical resection of post-chemotherapy residual masses. (It may be considered appropriate for only a small number of supranetwork teams to offer this in the country).
- Treatment of all post radiotherapy and post chemotherapy recurrences. (Treatment of first recurrences occurring during surveillance should follow the network's agreed guidelines as for newly diagnosed cases, depending on parameters of disease stage and type.)
- All other treatment by any modality, excluding local care and the network's particular arrangements for specialist care.

Surveillance

This is not a form of treatment and is dealt with separately, for clarity. The network urological cancer site-specific group should agree, as part of their referral guidelines, in consultation with the relevant supranetwork testicular team, a list of named specialist teams who may carry out surveillance and for which specific categories of patients. Otherwise it should be carried out by the supranetwork team. The network may agree that surveillance **should only** be carried out by the supranetwork team. Also, surveillance which might otherwise be carried out by an agreed specialist team, may be undertaken by the supranetwork team if desired and agreed by the patient and relevant consultants.

Penile cancer

All penile cancer cases should be discussed with the supranetwork team prior to proposed treatment if not referred directly to that team.

Local care

- i) The diagnostic process only.

Local care should be carried out by local teams for their catchment. It should also be carried out by specialist teams and supranetwork teams for their secondary catchment population.

Specialist care

- (i) Resection (except in cases needing penile reconstruction or lymph node resection). All resections should be carried out in the host hospital of the team.
- (ii) Radiotherapy and chemotherapy. The site(s) where this is carried out should be agreed in the network guidelines.

Specialist care may be delivered by:

- A specialist urological team without a supranetwork interest in penile cancer provided this is agreed in the network guidelines and with the relevant supranetwork team. It should not be delivered by local urological teams.
- A supranetwork team for referring specialist teams provided this is agreed in the network guidelines.
- The supranetwork team for their secondary catchment population.

Supranetwork

Resection in cases needing penile reconstruction or lymph node resection. All resections should be carried out in one of the hospitals named as part of the facilities of the host locality. All such operations should be carried out in the same hospital.

Supranetwork care should be delivered by the *supranetwork team only*. This is not subject to alteration by the network pathways.

Network Group Measures

Introduction The responsibility for review purposes for the measures dealing with the functions of the network group lies with the chair of the network group.		
Key Theme Structure and Function		
Objective <i>Patients have access to appropriate care supported by best practice guidance.</i>		
Measure	Notes	Evidence
14-1C-101g Network Configuration		
The Local Urology MDTs should be named, with their host hospitals and trusts and the named practices that refer to them. (1, 2) The Specialist and Supranetwork MDTs should be named with their host hospitals /trusts and their catchment populations which should be a minimum of one million for specialist teams, two million for testicular cancer teams and four million for penile cancer teams. (3,4) The relationship of the MDTs to their catchments and their hospitals should comply with the team criteria in the 'Shape of the Service' section of the introduction to the urology peer review measures. The specialist teams providing radiotherapy for seminoma patients according to specified categories should be named. (5) The specialist teams providing chemotherapy for stage 1 and 'good prognosis' metastatic germ cell. (5) The specialist teams who may treat penile cancer with surgery without penile reconstruction or lymph node resection should be named. (4) The specialist teams and the sites at which radiotherapy and chemotherapy for penile cancer may be delivered should be named. (4) A single network group should be named for the urology network under review, with its associated urology MDTs. The relationship between the network group with its associated MDTs should comply with the peer review ground rules for networking: (5) - the network group should be the only such network group for the MDTs which are associated with it; - the network group should be associated with more than one MDT. (6)	(1) <i>This includes specialist teams acting in their capacity as local teams for their own local (secondary) catchment population.</i> (2) <i>The principles of a given primary care practice stating that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of local and specialist MDTs can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations are counted once, for planning purposes. It is accepted that individual patients will on occasion be referred to different teams, depending on specific circumstances.</i> (3) <i>The population should be estimated in each case from the catchment populations from their referring local teams and their own local population which they serve.</i> (4) <i>The list of specialist teams need not include all teams in the network.</i> (5) <i>A full version of the ground rules for networking, for all types of MDT, network groups and also cross cutting</i>	

All the above arrangements, which constitute the configuration of the urology cancer clinical network, should be agreed by the director of the relevant area teams.	<i>service groups can be found in Appendix 1.</i> <i>(6) For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.</i> <i>The relevant parts of the ground rules for network groups should be fulfilled for each separate cancer site in measures covering a group of sites, such as for urology.</i>	
14-1C-102g	Network Group Membership	
There should be a single network group, having the following membership: (1) • a core member from each of the associated MDTs; • a urology nurse specialist; • a urology surgeon; • representation covering both clinical and medical oncology; • a radiologist; • a histopathologist; • two user representatives; (2) • there should be a named chair who should be a core member of one of the associated MDTs; • one of the NHS employed members of the network group should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the network group nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the network group; • named secretarial/administrative support. There should be terms of reference agreed for the network group which include: (3) • the provision of clinical opinion on issues relating to urology cancer for the network; • the development of patient pathways and clinical guidelines; • the co-ordination and consistency across the network for cancer policy, practice guidelines, audit, research and service development; • consulting with the relevant 'cross cutting' network groups where applicable.	<i>(1) There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.</i> <i>Any one individual may fulfil more than one of the roles on the list, compatible with their discipline and status.</i> <i>(2) If there are no user representatives, there should be an agreed mechanism for obtaining user advice.</i> <i>(3) There may be additional points in the agreed terms of reference.</i>	Constitution. Annual Report including meeting attendance spread sheet. The spread sheet should include names, roles and MDT represented.

14-1C-103g	Network Group Meetings		
The network group should meet regularly and record attendance.		<i>The attendance of MDT representatives is reviewed as part of the MDT measures.</i>	Constitution. Annual Report including meeting attendance spread sheet.
14-1C-104g	Work Programme and Annual Report		
The network group should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the medical director of the relevant area team. It should include details of any planned service developments and should specify the personnel responsible and the timescales for implementation. The network group should have produced an annual report for the SCN and relevant area team.			Work Programme. Annual Report including details of any service development.
Key Theme Co-ordination of Care / Patient Pathways			
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>			
Measure		Notes	Evidence
14-1C-105g	Clinical Guidelines for Kidney Cancer		
The network group should produce clinical guidelines for kidney cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease, including specific indications for CT, MRI and biopsy; • the parameters of disease stage and patient fitness, which determine when each of the treatments and procedures classified as local, and specialist care, in the introduction, are indicated; • the parameters which determine which patients are potential candidates for nephron sparing surgery and resection of primary and metastases.		<i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i> <i>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.</i>	Clinical Guidelines.
14-1C-106g	Clinical Guidelines for Bladder Cancer		
The network group should produce clinical guidelines for bladder cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease including indications, agreed with a network representative from primary care, for GP referral to the designated haematuria clinic (see topic 2G); • the parameters of disease stage and patient		<i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i> <i>Where there are nationally agreed requirements for clinical guidelines it is</i>	Clinical Guidelines.

fitness which determine when each of the treatments and procedures classified as local and specialist care in the introduction are indicated, including those patients with T2 muscle invasive cancer who are potential candidates for curative surgery and for radiotherapy; • protocols for frequency of cystoscopy during follow up.	<i>recommended that these are adopted.</i>	
14-1C-107g	Clinical Guidelines for Prostate Cancer	
The network group should produce clinical guidelines for prostate cancer (i.e. how a given patient should be clinically managed) The guidelines should include the following: • Protocols covering diagnosis and assessment of primary and recurrent disease, including indications for MRI and bone scans; • Protocols for GP referral to the designated prostate assessment clinic; (Measure 14-2G-107) • the parameters of disease stage and patient fitness which determine when each of the treatments and procedures classified as local and specialist care in the introduction are indicated, including those patients with organ-confined prostate cancer who are potential candidates for curative surgery or curative radiotherapy.	<i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i> <i>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.</i>	Clinical Guidelines.
14-1C-108g	Clinical Guidelines for Testicular Cancer	
The network group should produce clinical guidelines for testicular cancer (i.e. how a given patient should be clinically managed). The guidelines should include protocols for diagnosis and assessment of primary and recurrent disease which should cover at least the following: • specific indications for biopsy and agreed methods, uniform throughout the network, for the measurement of alpha-F-P, LDH and beta-HCG; • that there should be referral of orchidectomy specimen histology and histology of post-chemotherapy residual masses to a pathologist core member of the supranetwork team for review; • that there should be referral of any imaging of post chemotherapy residual masses to a radiologist core member of the supranetwork team for review.	<i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i> <i>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.</i>	Clinical Guidelines.
14-1C-109g	Clinical Guidelines for Penile Cancer	
The network group should produce clinical guidelines for penile cancer (i.e. how a given patient should be clinically managed). The guidelines should include the following: • protocols for diagnosis and assessment of primary and recurrent disease.	<i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i>	Clinical Guidelines.

		Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.	
14-1C-110g	Chemotherapy Treatment Algorithms		
The network group, in consultation with the relevant chemotherapy cross cutting groups should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.		Please see further details in appendix 3.	Annual Report. Work Programme. Examples of treatment algorithms should be seen at Internal Validation (IV) and Peer Review Visit (PR).
Objective <i>All patients receive co-ordinated care.</i>			
Measure		Notes	Evidence
14-1C-111g	Patient Pathways for Kidney Cancer		
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: - that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; - that all patients with kidney cancer potentially suitable for nephron sparing surgery should be discussed with a named specialist team, prior to either referral to that team or management by the local team; - that certain patients (as specified in measure 14-1C-105g) are referred for resection of the primary and metastases by a named specialist team; - the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); - the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services; - that any patient with metastatic carcinoma of unknown origin should be referred on for		(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group. (2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.	Constitution.

discussion by the carcinoma of unknown primary MDT.			
14-1C-112g	Patient Pathways for Bladder Cancer		
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: - that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; - the respective roles of the local and specialist teams in the management of high-risk superficial bladder cancer; - all patients diagnosed with high risk superficial bladder tumours should be discussed with a named specialist team prior to either referral to that team or management by the local team; (3) - for bladder reconstruction and urinary diversion, where they are not being provided by all specialist teams in the network, the specialist teams to which patients should be referred for these treatments; - the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); - the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services. - that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.		(1) <i>This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.</i> (2) <i>Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.</i> (3) <i>High risk superficial bladder cancer is defined as pTa (G3); T1 (G3); extensive G2, recurrent G2 or multifocal G2; and carcinoma-in-situ.</i>	Constitution.
14-1C-113g	Patient Pathways for Prostate Cancer		
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and include the following: - that patients are referred for local care and category (i) or (ii) specialist care according to the definitions in the introduction to these measures; - a list of local teams in the network which may		(1) <i>This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.</i> (2) <i>Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.</i> (3) <i>Specialist teams should counsel all patients from their own local catchment</i>	Constitution.

counsel patients in order for them to select their primary treatment option from curative surgery, curative radiotherapy or other options; (3) • a set of written arrangements governing which core team members, and on which occasions, will present the options and counsel patients (see topic 2G); (4) • for brachytherapy for prostate cancer, the named team in which named network, to whom patients may be referred for this treatment; • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.	<i>population. The list of teams need not include all local teams in the network.</i> <i>(4) The network may agree that for certain options, patients should be counselled by the specialist team. Patients who might otherwise be counselled by the local team may be counselled by the specialist team if agreed and desired by the patient and relevant consultants.</i>	
14-1C-114g	Patient Pathways for Testicular Cancer	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and cover the following: • that patients are referred for local care, specialist care, supranetwork care or surveillance, according to the definitions in the introduction to these measures; • that all cases of testicular cancer should have their case notes presented to and discussed at the next meeting of the relevant supranetwork testicular team following their diagnosis; • which categories of patients with seminoma may be given radiotherapy by named specialist teams and which categories should be treated only by the relevant supranetwork team; (3) • the parameters which define 'good prognosis' metastatic cases for germ cell cancer and in which particular exceptional circumstances (such as geographical considerations) named specialist teams may give chemotherapy for stage I and 'good prognosis' metastatic cases; (3) • those categories of patients and circumstances for which named specialist teams may carry out surveillance; (3) • the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); • the parameters which define 'high risk' (see introduction); • the network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the	<i>(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.</i> <i>(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.</i> <i>(3) The list of specialist teams need not include all those in the network. The network group may agree that certain of the treatments or surveillance should only be carried out by the relevant supranetwork team. Supranetwork teams should carry out specialist care for their own local catchment population.</i>	Constitution.

teenage and young adult (TYA), patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services; that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.		
14-1C-115g	Patient Pathways for Penile Cancer	
The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs (1,2) and cover the following: - that patients are referred for local care, category (i) or (ii) specialist care or supranetwork care, according to the definitions in the introduction to these measures; - that all patients diagnosed with penile cancer should have their case notes presented to, and case discussed by, the specialist team which is acting as the relevant supranetwork team at their next weekly meeting after the patient's diagnosis. - a set of written arrangements governing which specialist teams, and which core team members, on which occasions, will present the options and counsel patients in order for them to select their primary treatment option from curative surgery, curative radiotherapy; (3) - the follow up arrangements between the specialist/supranetwork teams and the referring local urology team(s); - a list of specialist teams for the network who may treat penile cancer with surgery without penile reconstruction or lymph node resection; - the named sites at which radiotherapy and chemotherapy may be delivered under the care of which named members of which named teams; - that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.	(1) <i>This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.</i> (2) <i>Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.</i> <i>The supranetwork team should counsel and treat all patients from their own local catchment population.</i> (3) <i>The network group may agree that certain of the treatments outlined above should only be carried out by the supranetwork team.</i>	Constitution.

Key Theme Patient Experience		
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
Measure	Notes	Evidence
14-1C-116g	Patient Experience	
In the course of their regular meetings, the network group should annually review patient feedback of their associated MDTs and any actions implemented, and should agree an improvement programme with them.		Annual Report.
Key Theme Clinical Outcomes / Indicators		
Objective <i>All patients receive treatments intended to provide the best possible outcomes, consistent across the MDTs.</i>		
Measure	Notes	Evidence
14-1C-117g	Clinical Outcomes Indicators and Audits	
In the course of their regular meetings, the network group should annually review the progress (or discuss the completed results, as relevant), of their associated MDTs' outcome indicators and audits, which should have been carried out, or the data examined across all its associated MDTs: - any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); - clinical indicators identified in section 2 of the measures; - testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.	<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i> <i>The compliance for this measure relates to the discussion of the data.</i>	Annual Report. Work Programme.
Objective <i>All patients have equitable access to treatments that could potentially improve outcome.</i>		
Measure	Notes	Evidence
14-1C-118g	Discussion of Clinical Trials	
The network group should discuss the MDT's report on clinical trials, annually with each of its associated MDTs and agree an improvement programme with them.		Annual Report. Work Programme.

Urology Local MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-101	Core Membership		
There should be a single named lead clinician with agreed list of responsibilities for the urology MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the urology cancer MDT should include: - at least two urological surgeons; - clinical oncologist who should be a core member of a specialist urology MDT; - medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). The medical oncologist should be a core member of a urology specialist MDT; - an imaging specialist; (3) - a histopathologist who should be taking part in the specialist EQA for urology cancer; (4) - a urology nurse specialist; - a MDT co-ordinator/secretary; (5) - at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6) - an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;		(1) <i>The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i> (2) <i>Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</i> <i>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</i> (3) <i>The role of the imaging specialist can be met by a group of named specialists.</i> (4) <i>The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</i> (5) <i>The co-ordinator/secretary</i>	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>

a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	<i>role needs different amounts of time depending on team workload.</i> <i>(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.</i> <i>The definition of the levels may be found in appendix 4.</i>	
14-2G-102	MDT Quorum	
The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover: (2) - one urology surgeon; - one clinical oncologist. - one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); - one imaging specialist; - one histopathologist; - one urology nurse specialist; - one MDT co-ordinator.	<i>(1) The % should be calculated over the 12 months prior to the assessment.</i> <i>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i> <i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-103	MDT Review	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion. (2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.	Operational Policy.

Objective <i>Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.</i>		
Measure	Notes	Evidence
14-2G-104	Core Members Attendance	
All core members of the MDT should attend at least two thirds of the number of meetings.	<i>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-105	Extended Membership of MDT	
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • stoma nurse; • psychosocial / psychosexual counsellor.		Operational Policy.
Key Theme Co-ordination of Care / Patient Pathways		
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>		
Measure	Notes	Evidence
14-2G-106	Clinical Guidelines	
The MDT should agree the clinical guidelines specified in measure 14-1C-105g to 14-1C-109g .	<i>Where available, these should reflect national guidelines and policy.</i>	Operational Policy. Clinical Guidelines should be available for IV and PR visit.
Objective <i>All patients receive co-ordinated care.</i>		
Measure	Notes	Evidence
14-2G-107	Regular Prostate Clinic	
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients potentially having prostate cancer;	<i>(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the</i>	Operational Policy.

ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	<i>conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.</i>	
14-2G-108	Regular Haematuria Clinic	
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients having haematuria; ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	<i>(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.</i>	Operational Policy.
14-2G-109	Agreed Policy for Patient Access to MDT to Discuss Treatment Options	
The MDT should have agreed a policy whereby patients with the following should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use: • early (organ-confined) prostate cancer; • early (stage I) penile cancer; • high risk superficial bladder cancer as defined in 'local care', bladder cancer, in the introduction to these measures; • muscle invasive bladder cancer.	<i>(1) The policy may be extended to other patients and circumstances at the MDT's discretion.</i>	Operational Policy.
14-2G-110	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-111g to 14-1C-115g.		Operational Policy.
14-2G-111	Treatment Planning	
The MDT should agree and record individual patient's treatment plans. The record should include: • the identity of patients discussed; • the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery,		Operational Policy. Example of treatment plan to be available for IV and PR visit.

radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); confirmation that the holistic needs has been taken into account.			
14-2G-112	Attendance at the Network Group		
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.			Annual Report including meeting attendance spread sheet.
Key Theme Patient Experience			
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>			
Measure		Notes	Evidence
14-2G-113	Key Worker		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR Visit.
14-2G-114	Patient Information		
The MDT should provide written material for patients and carers which includes: - information specific to that MDT about local provision of the services offering the treatment for that cancer site; - information about patient involvement groups and patient self-help groups; - information about the services offering psychological, social and spiritual/cultural support, if available; - information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); - information about services available to support the effects of living with cancer and dealing with its emotional effects.		<i>Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.</i> <i>It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.</i> <i>For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.</i>	Operational Policy. Examples should be available for IV and PR visit.

14-2G-115	Permanent Record of Consultation		
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.			Operational Policy.
14-2G-116	Patient Feedback		
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.		<i>The exercise may consist of a survey, questionnaire, focus group or other method.</i> <i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i> <i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i>	Annual Report / Service Profile.
Key Theme Clinical Outcomes / Indicators			
Objective <i>All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.</i>			
Measure		Notes	Evidence
14-2G-117	Clinical Indicators Review / Audit		
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings: • any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); • clinical indicators identified in section 2 of the measures; • testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.		<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i> <i>The compliance for this measure relates to the discussion of the data.</i>	Annual Report / Service Profile. Work Programme.

Objective		
<i>All patients have equitable access to treatments that could potentially improve outcomes</i>		
Measure	Notes	Evidence
14-2G-118	Discussion of Clinical Trials	
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include; • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG) (2,3).	(1) <i>For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</i> (2) <i>The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.</i> (3) <i>For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</i>	Annual Report.

Urology Specialist MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-201	Core Membership		
There should be a single named lead clinician with agreed list of responsibilities for the urology MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the urology cancer MDT should include: - at least two urological surgeons; - clinical oncologist who should be a core member of a specialist urology MDT; - medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). The medical oncologist should be a core member of a urology specialist MDT; - an imaging specialist; (3) - a histopathologist who should be taking part in the specialist EQA for urology cancer; (4) - a urology nurse specialist; - MDT co-ordinator/secretary; (5) - at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6) - an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;		(1) <i>The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i> (2) <i>Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</i> <i>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</i> (3) <i>The role of the imaging specialist can be met by a group of named specialists.</i> (4) <i>The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</i> (5) <i>The co-ordinator/secretary</i>	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>

a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	<i>role needs different amounts of time depending on team workload.</i> <i>(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.</i> <i>The definition of the levels may be found in appendix 4.</i>	
14-2G-202	MDT Quorum	
The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover; (2) - one urology surgeon; - one clinical oncologist; - one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); - one imaging specialist; - one histopathologist; - one urology nurse specialist; - one MDT co-ordinator.	<i>(1) The % should be calculated over the 12 months prior to the assessment.</i> <i>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i> <i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-203	MDT Review	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	<i>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.</i> <i>It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.</i> <i>(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.</i>	Operational Policy.

Objective		
<i>Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.</i>		
Measure	Notes	Evidence
14-2G-204	Core Members Attendance	
All core members of the MDT should attend at least two thirds of the number of meetings.	<i>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-205	Extended Membership of MDT	
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • stoma nurse; • psychosocial / psychosexual counsellor.		Operational Policy.
14-2G-206	Single Site Surgery and Post Operative Care	
The operations and acute post-operative care activities of the MDT, for category (1) specialist care procedures, for kidney, prostate and bladder cancer and operations and acute post-operative care for penile cancer resection (1) should all be carried out in the same hospital.	<i>(1) Except cases needing penile reconstruction or lymph node resection which should be carried out by the supranetwork MDT.</i>	Annual Report.
14-2G-207	Minimum Individual Workload	
Each surgical core member performing radical prostatectomies should undertake a minimum of 5 a year. Each surgical core member performing total cystectomies should undertake a minimum of 5 a year.	<i>The number of operative procedures should be calculated as follows:</i> • <i>It should be recorded separately for each individual core surgeon.</i> • <i>It should be averaged over the two complete calendar years prior to the review.</i> • <i>Only those procedures should count where the core surgical team member has scrubbed up, as evidenced by their name appearing on the</i>	Annual Report.

		operation notes, as a participating surgeon in the procedure. Emergency procedures count providing the other criteria are fulfilled. Procedures performed in the private sector count, providing the other criteria are fulfilled and the case is discussed at the regular meeting of the MDT under review. If only prostatectomies are performed by the individual or only cystectomies - the number performed should still be more than five.	
14-2G-208	MDT Minimum Workload		
The combined total of radical prostatectomies and/or total cystectomies performed under the care of the MDT should be at least 50 per year.			Annual Report.
Key Theme Co-ordination of Care / Patient Pathways			
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>			
Measure		Notes	Evidence
14-2G-209	Clinical Guidelines		
The MDT should agree the clinical guidelines specified in measure 14-1C-105g to 14-1C-109g .		Where available, these should reflect national guidelines and policy.	Operational Policy. Clinical Guidelines should be available for IV and PR visit.
Objective <i>All patients receive co-ordinated care.</i>			
Measure		Notes	Evidence
14-2G-210	Regular Prostate Clinic		
The MDT should hold a regular clinic (1) which: - should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients potentially having prostate cancer; - should have the patients to be referred to the clinic defined by the agreed guidelines; - should be identified in GP information with a contact point for GP referrals of the above patients; - should have bookable, numbered clinic slots		(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.	Operational Policy.

identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.		
14-2G-211	Regular Haematuria Clinic	
The MDT should hold a regular clinic (1) which: i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients having haematuria; ii) should have the patients to be referred to the clinic defined by the agreed guidelines; iii) should be identified in GP information with a contact point for GP referrals of the above patients; iv) should have bookable, numbered clinic slots identified for the above patients; v) should be run by surgical core member(s) of the MDT; vi) should be part of the work plan or timetable of a nurse specialist member of the MDT.	<i>(1) The clinic may be part of an existing clinic or both the prostate and haematuria assessment clinics may run together as long as the conditions in sections 1-6 can be fulfilled independently for each of the two sets of patients.</i>	Operational Policy.
14-2G-212	Agreed Policy for Patient Access to MDT to Discuss Treatment Options	
The MDT should have agreed a policy whereby patients with the following should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use: - early (organ-confined) prostate cancer; - early (stage I) penile cancer; - high risk superficial bladder cancer as defined in 'local care', bladder cancer, in the introduction to these measures; - muscle invasive bladder cancer.	<i>(1) The policy may be extended to other patients and circumstances at the MDT's discretion.</i>	Operational Policy.
14-2G-213	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-107g to 14-1C-115g.		Operational Policy.
14-2G-214	Treatment Planning	
The MDT should agree and record individual patient's treatment plans. The record should include: - the identity of patients discussed; - the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); - confirmation that the holistic needs have been taken into account; - in the case of patients referred for supranetwork		Operational Policy. Example of treatment plan to be available for IV and PR visit.

care to another team in the network or a neighbouring network, the team to which they are referred should be named.			
14-2G-215	Attendance at the Network Group		
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.			Annual Report including meeting attendance spread sheet.
Key Theme Patient Experience			
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>			
Measure		Notes	Evidence
14-2G-216	Key Worker		
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.			Operational Policy. Examples of patient notes should be available for IV and PR visit.
14-2G-217	Patient Information		
The MDT should provide written material for patients and carers which includes: - information specific to that MDT about local provision of the services offering the treatment for that cancer site; - information about patient involvement groups and patient self-help groups; - information about the services offering psychological, social and spiritual/cultural support, if available; - information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); - information about services available to support the effects of living with cancer and dealing with its emotional effects.		<i>Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.</i> <i>It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.</i> <i>For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.</i>	Operational Policy. Examples should be available for IV and PR visit.

14-2G-218	Permanent Record of Consultation	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.		Operational Policy.
14-2G-219	Patient Feedback	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.		<i>The exercise may consist of a survey, questionnaire, focus group or other method.</i> <i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i> <i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i> Annual Report / Service Profile.
Key Theme		
Clinical Outcomes / Indicators		
Objective		
<i>All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.</i>		
Measure		Notes
Evidence		
14-2G-220	Clinical Indicators Review / Audit	
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings: - any urology cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); - clinical indicators identified in section 2 of the measures; - testicular and penile collaborative audits as detailed in measures 14-2G-318 and 14-2G-415.		<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i> <i>The compliance for this measure relates to the discussion of the data.</i> Annual Report / Service Profile. Work Programme.

Objective		
<i>All patients have equitable access to treatments that could potentially improve outcomes.</i>		
Measure	Notes	Evidence
14-2G-221	Discussion of Clinical Trials	
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include: • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG). (2,3)	(1) <i>For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</i> (2) <i>The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.</i> (3) <i>For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</i>	Annual Report.

Supranetwork Testicular MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-301	Core Membership		
There should be a single named lead clinician with agreed list of responsibilities for the testicular MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The core team specific to the testicular cancer MDT should include: - at least two urological surgeons; - clinical oncologist; - medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member); - oncology representation covering both clinical and medical oncology; - an imaging specialist; (4) - a histopathologist who should be taking part in the specialist EQA for urology cancer (5) a testicular cancer nurse specialist; - MDT co-ordinator/secretary; (6) - at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7) - an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers; - a member of the core team nominated as the		(1) <i>The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i> (2) <i>Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</i> <i>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</i> (4) <i>The role of the imaging specialist can be met by a group of named specialists.</i> (5) <i>The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</i> (6) <i>The co-ordinator/secretary</i>	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>

person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	<i>role needs different amounts of time depending on team workload.</i> <i>(7) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.</i> <i>The definition of the levels may be found in appendix 4.</i>	
14-2G-302	MDT Quorum	
The MDT should meet at an agreed frequency. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology testicular cancer MDT is made up of the following core members, or their cover; (2) • one urology surgeon; • oncology representation covering both clinical and medical oncology; • one clinical oncologist; • one medical oncologist (where the responsibility for chemotherapy has not been taken by the clinical oncologist); • one imaging specialist; • one histopathologist; • one testicular cancer nurse specialist; • one MDT co-ordinator.	<i>(1) The % should be calculated over the 12 months prior to the assessment.</i> <i>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i> <i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-303	MDT Review	
There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	<i>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.</i> <i>It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.</i> <i>(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.</i>	Operational Policy.

Objective		
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.		
Measure	Notes	Evidence
14-2G-304	Core Members Attendance	
All core members of the MDT should attend at least two thirds of the number of meetings.	<i>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-305	Extended Membership of MDT	
The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: surgeon with responsibility for resection of post-chemotherapy residual masses.		Operational Policy.
14-2G-306	Named Hospital and Surgeons for Resection of Residual Mass Post-Chemotherapy	
Operations to resect residual masses post-chemotherapy for the team's patients should all be carried out in the same named hospital of the host trust. All consultant surgeons responsible for resection of post-chemotherapy residual masses should be either a core member of the testicular cancer team; or a member of the extended team for testicular cancer. Where the MDT is offering resection of post-chemotherapy masses it should provide: - the total number of such resections performed by the MDT's relevant surgical members during the previous year; - the same statistic by individual surgeon. (1)	<i>(1) Where such cases are referred to another named testicular team in another network, this should be a single named hospital in the host trust of that team.</i> <i>Resection of post-chemotherapy residual masses should be a highly specialised procedure and may involve the need for skills in thoraco-abdominal surgery.</i> <i>(2) It is strongly recommended that all of these resections are carried out by the same surgeon so that the number of individuals relevant to section 2 is one.</i>	Annual Report.

Key Theme Co-ordination of Care / Patient Pathways		
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>		
Measure	Notes	Evidence
14-2G-307	Clinical Guidelines	
The MDT should agree the clinical guidelines specified in measure 14-1C-108g .	Where available, these should reflect national guidelines and policy.	Operational Policy. Clinical Guidelines should be available for IV and PR visit.
Objective <i>All patients receive co-ordinated care.</i>		
Measure	Notes	Evidence
14-2G-308	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-110g .		Operational Policy.
14-2G-309	Patients Offered Sperm Storage	
The testicular team should offer patients the option of sperm storage prior to chemotherapy or radiotherapy or surgery for residual masses.		Annual Report.
14-2G-310	Treatment Planning	
The MDT should agree and record individual patient's treatment plans. The record should include: - the identity of patients discussed; - the diagnosis, including type of testicular cancer; - the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); - confirmation that the holistic needs have been taken into account; - in the case of patients referred for resection of post-chemotherapy masses to a team in another network, the team to which they are referred should be named.		Operational Policy. Example of treatment plan to be available for IV and PR visit.
14-2G-311	Attendance at the Network Group	
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.		Annual Report including meeting attendance spread sheet.

Key Theme		
Patient Experience		
Objective		
All patients receive patient centred care with respect and dignity which takes account of their holistic needs.		
Measure	Notes	Evidence
14-2G-312	Key Worker	
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.		Operational Policy. Examples of patient notes should be available for IV and PR visit.
14-2G-313	Patient Information	
The MDT should provide written material for patients and carers which includes: - information specific to that MDT about local provision of the services offering the treatment for that cancer site; - information about patient involvement groups and patient self-help groups; - information about the services offering psychological, social and spiritual/cultural support, if available; - information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); - information about services available to support the effects of living with cancer and dealing with its emotional effects. - Information that deals with: - Sperm storage in general; - Information including contact arrangements specific to the sperm storage facilities available to the team's patients	Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription. It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material. For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.	Operational Policy. Examples should be available for IV and PR visit.
14-2G-314	Permanent Record of Consultation	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: - diagnosis; - treatment options and plan; - relevant follow up (discharge) arrangements.		Operational Policy.

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14-2G-315	Patient Feedback		
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.		<i>The exercise may consist of a survey, questionnaire, focus group or other method.</i> <i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i> <i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i>	Annual Report / Service Profile.
Key Theme			
Clinical Outcomes / Indicators			
Objective			
<i>All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.</i>			
Measure		Notes	Evidence
14-2G-316	Clinical Indicators Review / Audit		
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings. The meeting should include a representative of any teams referring to the supranetwork team in question, whether from within the network or from a neighbouring network: • any testicular cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); • clinical indicators identified in section 2 of the measures; • a collaborative audit that includes: • whether all high risk cases were referred pre-operatively; • all other cases referred within 24-hours of orchidectomy; • that cases were referred and/or treated by teams according to the network guidelines.		<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i> <i>The compliance for this measure relates to the discussion of the data.</i>	Annual Report / Service Profile. Work Programme.

Objective		
<i>All patients have equitable access to treatments that could potentially improve outcomes.</i>		
Measure	Notes	Evidence
14-2G-317	Discussion of Clinical Trials	
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include: • details of the MDT's trials portfolio including the extent of local provision of the national portfolio; • the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; • the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1) In addition, applicable only to MDTs dealing with the following cancer sites: • Leukaemia; • Lymphoma; • Germ cell malignancy; • Bone and/or soft tissue sarcoma; • Brain and CNS malignancy; • Malignant melanoma. The MDT should produce a report on clinical trials covering the above points for TYA patients, for discussion at the teenage and young adults' cancer network co-ordinating group (TYA CNCG). (2,3)	(1) <i>For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</i> (2) <i>The TYA CNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.</i> (3) <i>For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</i>	Annual Report.

Supranetwork Penile MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

Measure		Notes	Evidence
14-2G-401	Core Membership		
There should be a single named lead clinician with agreed list of responsibilities for the penile MDT who should then be a core team member. (1) The MDT should provide the names of core team members and their cover for named roles in the team. (2) The supranetwork penile cancer team should have at least the following core members: - at least two urological surgeons; (3) - clinical oncologist; - medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member); - an imaging specialist; (4) - a histopathologist who should be taking part in the specialist EQA for urology cancer; (5) - a urology nurse specialist; - MDT co-ordinator/secretary; (6) - any consultant in the supranetwork catchment area of the MDT who is responsible for performing lymph node dissections and/or penile reconstruction should be a core member of the supranetwork penile cancer team; - at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7) - an NHS-employed member of the core or extended team should be nominated as having		(1) <i>The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i> (2) <i>Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</i> <i>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</i> (4) <i>The role of the imaging specialist can be met by a group of named specialists.</i> (5) <i>The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</i> (6) <i>The co-ordinator/secretary</i>	Operational Policy. Including confirmation of any specific requirements of the roles. Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>

specific responsibility for users' issues and information for patients and carers; a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.	<i>role needs different amounts of time depending on team workload.</i> <i>(7) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.</i> <i>The definition of the levels may be found in appendix 4.</i>	
14-2G-402	MDT Quorum	
The MDT should meet at an agreed frequency. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the urology cancer MDT is made up of the following core members, or their cover; (2) - one urology surgeon; - one clinical oncologist; - one medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncology core member). - one imaging specialist; - one histopathologist; - one urology nurse specialist; - one MDT co-ordinator.	<i>(1) The % should be calculated over the 12 months prior to the assessment.</i> <i>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i> <i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-403	MDT Review	
There should be an operational policy whereby all new patients should be discussed with the supranetwork penile MDT prior to proposed treatment or referred directly to the team. (1) The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)	<i>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.</i> <i>It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.</i> <i>(2) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.</i>	Operational Policy.

Objective <i>Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.</i>		
Measure	Notes	Evidence
14-2G-404	Core Members Attendance	
All core members of the MDT should attend at least two thirds of the number of meetings.	<i>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
14-2G-405	Individual Surgeon's Workload	
The MDT should provide the total number of the following procedures performed for penile cancer by the team and by individual surgeons during the previous year. i) penile reconstruction procedures; ii) lymphadenectomies.	<i>It is strongly recommended that all of these resections are carried out by the same surgeon so that the number of individuals relevant to section 2 is one.</i>	Annual Report.
14-2G-406	Named Hospital for Penile Surgical Procedures	
Operations for penile cancer involving lymphadenectomy and / or penile reconstruction should all be carried out in the same named hospital of the host trust.		Annual Report.
Key Theme Co-ordination of Care / Patient Pathways		
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>		
Measure	Notes	Evidence
14-2G-407	Clinical Guidelines	
The MDT should agree the clinical guidelines specified in measure 14-1C-109g .	<i>Where available, these should reflect national guidelines and policy.</i>	Operational Policy. Clinical Guidelines should be available for IV and PR visit.

Objective <i>All patients receive co-ordinated care.</i>		
Measure	Notes	Evidence
14-2G-408	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 14-1C-115g .	<i>This should include follow up and referral pathways.</i>	Operational Policy.
14-2G-409	Agreed Policy for Patient Access to MDT to Discuss Treatment Options	
The MDT should have agreed a policy whereby patients with early (stage I) penile cancer should be offered a joint meeting with the surgeon, oncologist and specialist nurse to discuss treatment options prior to deciding which modality of treatment to use. (1)	<i>(1) The policy may be extended to other patients and circumstances at the MDT's discretion.</i>	Operational Policy.
14-2G-410	Treatment Planning	
The MDT should agree and record individual patient's treatment plans. The record should include: - the identity of patients discussed; - the diagnosis, including type of testicular cancer; - the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); - confirmation that the holistic needs have been taken into account.		Operational Policy. Example of treatment plan to be available for IV and PR visit.
14-2G-411	Attendance at the Network Group	
The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.		Annual Report including meeting attendance spread sheet.
Key Theme Patient Experience		
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
Measure	Notes	Evidence
14-2G-412	Key Worker	
There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.		Operational Policy. Examples of patient notes should be available for IV and PR visit.

14-2G-413	Patient Information	
The MDT should provide written material for patients and carers which includes: • information specific to that MDT about local provision of the services offering the treatment for that cancer site; • information about patient involvement groups and patient self-help groups; • information about the services offering psychological, social and spiritual/cultural support, if available; • information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); • information about services available to support the effects of living with cancer and dealing with its emotional effects.	<i>Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.</i> <i>It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.</i> <i>For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.</i>	Operational Policy. Examples should be available for IV and PR visit.
14-2G-414	Permanent Record of Consultation	
The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed: • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements.		Operational Policy.
14-2G-415	Patient Feedback	
The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered. The exercise should at least ascertain whether patients were offered: • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.	<i>The exercise may consist of a survey, questionnaire, focus group or other method.</i> <i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i> <i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i>	Annual Report / Service Profile.

Key Theme**Clinical Outcomes / Indicators****Objective**

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

Measure		Notes	Evidence
14-2G-416	Clinical Indicators Review / Audit		
The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings. The meeting should include a representative of any teams referring to the supranetwork team in question, whether from within the network or from a neighbouring network: - any penile cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); - clinical indicators identified in section 2 of the measures; - a collaborative audit that includes: - whether all cases were discussed with them prior to referral or to proposed specialist care; - that cases were referred and/or treated by teams according to the network guidelines.		<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i> <i>The compliance for this measure relates to the discussion of the data.</i>	Annual Report / Service Profile. Work Programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes.

Measure		Notes	Evidence
14-2G-417	Discussion of Clinical Trials		
The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include; - details of the MDT's trials portfolio including the extent of local provision of the national portfolio; - the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; - the MDT's programme for improvement for the above, as proposed to the network group. The MDT should agree a final programme for improvement at the network group discussion meeting. (1)		<i>(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</i>	Annual Report.

Section 2 Clinical Indicators/Lines of Enquiry

Introduction

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self assessment report and any plans for improvement should be included in their work programme.

Clinical Indicators

TBA

Appendix 1 Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarized as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between network groups for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Network Groups

- The network group should be the only such network group for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the network group should be associated with more than one MDT.
- For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.
 - *Notes: The network group **need** only be associated with one specialist/supranetwork type MDT but **may** be associated with more than one.*

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with:

- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.
 - *Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.*

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
 - *Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances. This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.*

- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.
 - *Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.*
- The MDT should be associated with a single named network site specific group (network group) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
 - *Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one network group, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate network group for each of its specialty sites.*

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the 'local' type MDTs.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.
- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.
- The specialist MDT should act as the 'local' type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.
 - *Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site.*
- The specialist MDT should be associated with a single named network site specific group (network group), (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

Appendix 2 Roles and Responsibilities

Roles and Responsibilities

Introduction

Role of the network group

The network group should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all MDT leads from the relevant associated organisations.

The network group should:

- agree a set of clinical guidelines and patient pathways to support the delivery of high quality equitable services across the network;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;
- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure actions following peer review are implemented;
- review and discuss identified risks/untoward incidents to ensure learning is spread;
- agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Responsibilities of the MDT lead clinician

The MDT lead clinician should:

- ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
- ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
- ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that the MDT meetings and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- provide the link to the network group either by attendance at meetings or by nominating another MDT member to attend;
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported.

Appendix 3 Chemotherapy Treatment Algorithms

Introduction

Introduction; (Definitions). Regimens, Protocols and Algorithms

For the purposes of peer review, a chemotherapy **regimen** is defined by the therapeutic chemotherapy drugs used, often expressed as an acronym e.g. 'FEC'. A change of one or more of these drugs themselves would normally be necessary for it to be classed as a change of regimen. In some cases major changes in the dose or route of administration of one or more of the drugs effectively changes the regimen but these cases are generally known and recognised nationally. A given network is free to choose any further changes which they classify as changing the regimen, as long as it is in accord with the above definition and national exceptions; i.e. they are free to make their definition of a regimen narrower, but not wider. This is relevant to measures in the chemotherapy section ([Topic 3S](#)).

For the purposes of peer review, a chemotherapy **treatment protocol** is defined as constituting all the parameters specified in the bullet points in chemotherapy Treatment Protocols. A change in any of these parameters would change the treatment protocol but any change other than the therapeutic drugs themselves (apart from the national and local exceptions specified above) would change only the protocol, not the regimen as well.

For the purposes of peer review a chemotherapy **treatment algorithm** may be described as a guideline which specifies the acceptable range of regimens for each relevant step on the patient pathway. Treatment algorithms are cancer site-specific. They are not specific to individual patients, i.e. they are not individual treatment plans. Thus, a treatment algorithm for breast cancer would include a statement of the range of regimens agreed as acceptable for adjuvant chemotherapy and for first, second and third line palliative chemotherapy etc. Illustrative examples of treatment algorithms in different formats may be found in appendix 1 of the chemotherapy measures. There may be other formats which would be acceptable to the reviewers.

In practice, a change of regimen or order of regimens may no longer comply with a previously agreed treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply. The measure for the network group is concerned only with chemotherapy **algorithms**.

Notes: The intention is not to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.

The network group should produce the algorithms for its compliance with this measure and the relevant chemotherapy multi-professional teams should produce a compatible list of algorithms for the network group's cancer site for their own service. The relevant chemotherapy multi-professional teams should each agree lists with all the network group relevant to their practice, for compliance with their measure.

The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the network group agreed list.

This exercise should include oral chemotherapy.

This measure is assessed as part of the responsibility of each network group, but from the chemotherapy cross cutting group's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time. Updates require changes only when judged clinically necessary by the network group.

Appendix 4 Psychological Support Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels. The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note: Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.

The additional training is as follows:

I. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

PLUS

II. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the one of the national voluntary regulatory bodies for counselling;
- an NHS psychotherapist accredited by one of the national voluntary regulatory bodies for psychotherapy.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note: All of the above should have completed an induction at level 3. that meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.

1 A. So at the time of writing that, that was correct.

2 Mr. Tyson, who is one of our colleagues, has stepped
3 back from that, and there are now three consultants
4 rotating the Chairmanship.

5 239 Q. And you've explained that one of the advantages of 12:44
6 rotating the Chair is that it allows oversight of the
7 practise of all colleagues and permits challenge and
8 discussion?

9 A. Yeah.

10 240 Q. Does that mean that as Chair, you are responsible for 12:44
11 taking the patient's chart and relevant notes and
12 reading, as best you can, in the time allowed to you,
13 the background to the case?

14 A. So, I suppose a little bit of background to how this
15 developed is helpful. 12:45

16
17 So, prior to Mr. O'Brien being the Chair of this
18 meeting, there was a colleague called Mr. Akhtar who
19 chaired the meeting when it was set up, and I
20 understand that the practice at that time was for the 12:45
21 person who was Chairing the meeting to present all of
22 the cases. So that became very onerous for Mr. O'Brien
23 when he was the Chair, because clearly to do that every
24 week was a big workload, and he would do it
25 meticulously, he would spend a lot of time preparing 12:45
26 the cases. So, when I joined the MDT, and laterally
27 when Mr. Haynes and Mr. O'Donoghue joined the MDT, we
28 came to an agreement that rather than Mr. O'Brien
29 Chairing every meeting, that we would rotate the Chair.

1 Mrs. Corrigan had also attended - and says you have
2 agreed to not triage new referrals with the exception
3 of those named to yourself. Also to think about if any
4 additional admin support would assist him. Deborah
5 Burns directing her remarks to Michael Young says:

16:05

6
7 "I know this may place an additional burden on the rest
8 of the team but appreciate you accommodating".
9

10 So the measure that was being put in place, I think you
11 would call it in your witness statement at
12 paragraph 459, as a temporary measure to relieve you of
13 triage through Mr. Young, but it was only temporary and
14 it failed to address the underlying cause which was
15 progressively exacerbated by the additional roles we
16 looked at this morning - NICaN, Clinical Lead and Chair
17 of the MDT, MDM.

16:06

16:06

18
19 This pragmatic approach on the part of Mrs. Burns and
20 your colleague Mr. Young, that was helpful?

16:06

21 A. Very helpful, yes.

22 214 Q. In addition, you're being asked to consider whether
23 additional administrative support would assist you. Is
24 that something you gave consideration to?

25 A. Yes. With Martina, there was an offer can we make it
26 easier in some way to print referrals off for you or
27 that kind of thing. But it was just I didn't think it
28 was going to make any difference and someone else doing
29 it made an enormous difference. At this stage, I was

16:07

1 still spending three, four hours a week preparing for
2 MDM, as well as Chairing it and some period afterwards.
3 I was spending at least one hour per week as lead
4 clinician of NICaN. Detaching that from how that
5 relates to any hours allocated to administration and 16:08
6 any job plan, I mean if that weren't there, I may not
7 have needed that degree of help with triage at that
8 time. So, I was spending quite a bit of time in those
9 other roles, basically.

10 215 Q. That was the year then that you moved to urologist of 16:08
11 the week?

12 A. Yes.

13 216 Q. Mrs. Trouton recalls in her statement that your new
14 urology colleagues refused to let there be a situation
15 where you wouldn't triage. Does she recall that 16:08
16 correctly?

17 A. No. Sorry.

18 217 Q. We'll bring it up on the page. TRU-00806. Just go to
19 the bottom of the previous page and we'll catch the
20 full context. Thank you for that. I think just up a 16:09
21 little bit further. I think she's catching
22 Mr. Young's, at paragraph 10, intervention. The issues
23 were improved for a period of time. He says:

24
25 "While I was concerned about his practice, I was 16:09
26 content patients were being seen and red flags were
27 being done. As most referrals come in as red flags,
28 I was satisfied patients were being seen. I did have
29 a concern about upgraded referrals but there was no

2. SOUTHERN TRUST MDT AND MDM

A MDT for Urological Cancer at the Southern Trust was formally established in April 2010. Mr. Mehmood Akhtar, Consultant Urologist, was its Lead Clinician and the Chair of its MDM from April 2010 until March 2012. Since April 2012, Mr. Aidan O'Brien, Consultant Urologist, has been its Lead Clinician. With increasing numbers of consultant urologists, the functions of Lead Clinician and of Chair of MDM have been separated to enhance active participation in and responsibility for MDM. Since August 2014, a rota has been established for chairing MDMs by Mr. O'Brien and two colleagues, Mr. Anthony Glackin and Mr. Mark Haynes.

The MDM takes place every Thursday afternoon at 2.15 pm, with the exception of public holidays, and on the rare occasion when it is not possible to have a meeting due to some other significant event requiring the participation of MDT members. However, by 2015, it had been an increasing experience that the inability to hold a MDM on occasion for the above reasons, had a negative impact on the conduct of subsequent MDMs and on the assessment and management of patients being conducted in a timely manner. Since 2015, a Virtual MDM is conducted by an agreed Chair. The manner in which this is conducted is further described in Section 9.1 of this Policy.

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

When discussion of each patient at MDM has been completed, an agreed Plan of further assessment or management is appended in type to the previous clinical

In the case of referral of a patient for MDM discussion by a radiologist or histopathologist, the MDM co-ordinator will request the Consultant Urologist who may have already cared for the patient to provide a clinical summary, or the Chair of the MDM to provide a clinical summary if the patient is new to the Urological Service.

It is also the responsibility of clinicians to provide appropriate textual updates to the MDT Co-ordinator at significant junctures in patients' assessments and management, such as when treatment is initiated or when referral for treatment has been made. In particular, it is the responsibility of urological surgeons to provide dated, succinct, textual descriptions of operative findings and procedures.

It is the responsibility of the MDT Co-ordinator to ensure that patients have been given appointments for investigations at appropriate times, and to schedule those patients for MDM discussion as previously agreed. It is the responsibility of the MDM Co-ordinator to upload on CaPPS the reports of those investigations, such as radiological and histopathological reports.

When all such information, provided in appropriate format, has been uploaded onto CaPPS, it is the responsibility of the MDT Co-ordinator to disseminate the uploaded information to all MDT members one day prior to each MDM so that optimal preparation can be undertaken.

It is also the policy of the Urology MDT that the MDT Co-ordinator will identify those patients who are furthest along on their timed pathway and at greatest risk of breaching. The identity of these patients is also disseminated one day prior to each MDM so that plans for their further management can be scheduled by the responsible urological surgeon and notified to the MDT at the commencement of each MDM.

9.3 Chairing of Meetings

The chairing of MDMs has been shared by Mr. O'Brien, Mr. Glackin and Mr. Haynes on a rotational basis. Mr. O'Donoghue will join in chairing on a rotational basis during 2016. The person appointed to chair each MDM is decided at least one month

previously, when a period of time equivalent to one session should be allocated to the appointed Chair to preview all cases one day prior to the MDM. Adequate preparation time will be included in Job Plans and in a pro rata, annualised, quantitative manner.

9.4 Structure of Meetings

The Chair of each MDM welcomes MDT members at the commencement of the meeting at 2.15 pm. The meeting may begin with housekeeping announcements, such as confirmation of the next MDM and its Chair.

The Chair will raise the issue of any patients at risk of breaching their target timeline. If the responsible surgeon is unable to review the patient within an appropriate time, the Chair exercises the right to make other arrangements for the patient's review. Similarly, if a patient cannot be scheduled for surgery within an appropriate time, the Chair exercises the right to make alternative arrangements, if possible. Any such action will be communicated to the initial surgeon and to his / her secretary.

The Chair may then preview any patients that may be scheduled for discussion with the Specialist MDT by video link later in the afternoon, in order to ensure that all information is available for that discussion.

9.5 Patient Assessment and Treatment Planning 14-2G-111

The Chair then proceeds with the discussion of each listed patient. Having previewed each case, the Chair will have familiarised himself with the detail of each case, and will be able to focus on the pertinent issues for discussion. It is the responsibility of the Chair to ensure that each patient is adequately discussed. It is the responsibility of the Chair to ensure that all of the patient's needs are discussed, in so far as is possible. It is the responsibility of the Chair to ensure that an agreed Plan of management is concluded, and documented in real time as the MDM Plan.

The MDM Plan should include identification or reaffirmation of the patient's Key Worker, or the need to have a Key Worker identified at next patient consultation, and

- f) October 2002 – October 2003 Registrar in Urology, Churchill Hospital, Oxford
- g) October 2003 – February 2007 Research Fellow in Urology, Department of Pharmacology, University of Oxford
- h) March 2007 – September 2012 Oxford Urology Specialist Registrar Training Program
- i) October 2012 – March 2013 BAUS Fellowship in Female and Functional Urology, Leicester General Hospital
- j) April 2013 – August 2013 Specialist Registrar in Urology, Royal Berkshire Hospital, Reading
- k) August 2013 – July 2014 Locum Consultant Urological Surgeon, Watford General Hospital/St Albans Hospital/Hemel Hempstead Hospital

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 I am a Consultant Urological Surgeon in the Southern Health & Social Care Trust since 4th August 2014.

5.2 My duties and responsibilities include inpatient and outpatient care, 1: 7 on call for Urological emergencies, administrative duties, audit/research and teaching/supervision of undergraduate/ postgraduates doctors. Since 2015, I have been on the rota to chair the Uro-Oncology MDM. I have been Chair of the Patient Safety Meeting since October 2021. I have been Educational/Clinical Supervisor to Foundation Doctors since 2017. I have also been a clinical supervisor to Specialist Registrars in Urology since I began in the Trust in 2014.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments,

9.1 Time and Venue of Meetings

The MDM takes place in the Medical Education Centre at Craigavon Area Hospital each Thursday afternoon, except on those occasions described elsewhere in this Policy. The Meeting takes place in a room with Video Conferencing facilities, enabling communication by video to Daisy Hill Hospital, Newry, and with the Specialist MDM in Belfast.

The MDM commences at 2.15 pm. Video conferencing with the Specialist MDT is scheduled to take place at 3.30 pm, or as soon as is mutually convenient thereafter. It is the policy of the Southern MDT that all MDMs should finish by 5 pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 40 in order to enable the MDM to finish by 5 pm.

9.2 Preparation for Meetings 14-2G-109

It has been agreed by MDT core members that it is the responsibility of urological surgeons to provide a clinical summary regarding each patient to be discussed at MDM for the first time, and an update when patients are to be discussed again at a later juncture in their clinical course. The clinical summaries and updates are to be provided to the MDT Co-ordinator. They are to be provided in a textual format suitable for uploading unto CaPPS as a permanent record and suitable as a correspondence to Family Doctors and to other clinicians to whom patients may be referred at a later date. It is therefore optimal that text is in the dated past tense and in the third person. It is not the responsibility of the MDT co-ordinator to construct either a clinical summary or update from dictated correspondence as the latter is usually contextually different and unsuitable for CaPPS.

Patients may also be referred to the Co-ordinator by other clinicians, whether Urology MDT members, such as oncologists, or clinicians from other specialties or hospitals. It is the responsibility of the MDT Co-ordinator to request provision of a clinical summary adequate to enable MDM discussion.

chemotherapy), imaging specialist, histopathologist, clinical nurse specialist and MDT Co-ordinator.

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

1.5 Chairing of meetings

The chairing of MDMs is shared by Mr Glackin, Mr O'Donoghue and Mr Haynes on a rotational basis. The person appointed to chair each MDM is decided at least one month previously. Adequate preparation time is included in Job Plans in a pro rata, annualised, quantitative manner.

1.6 MDT Review

(14-2G-103)

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

Video conferencing with the Specialist Urological Cancer MDT is scheduled to take place at 3.30 pm every Thursday. Testis Cancer cases are discussed by video-conference at 2pm every other Thursday.

It is the policy of the Southern MDT that all MDMs should finish by 5pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 40 in order to enable the MDM to finish by 5pm.

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

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

Responsibilities of the MDT Coordinator:

- Ensuring all cancer patients are discussed at the MDT meeting
- Inserting notes onto the pro forma and ensuring it has been signed-off as being a correct record of the meeting's discussion (this forms the main body of the MDT letter to GP)
- Insertion of clinical summaries and updates onto CaPPs
- Filing the pro forma into the relevant notes and forwarding a copy to the oncology department of those patients who need to be referred to the oncologists



Urology Services Inquiry

- j. Supporting professional activity to meet the requirements of annual appraisal and medical revalidation
- 1.3 The duties are described in my job plan in terms of the time allocated per week to each activity. My job plan has evolved over time. My job plan does not and did not ever describe: accountability arrangements, objectives, supporting resources, expected volumes of activity, timeframes for completion of triage of referrals or correspondence for results etc.
- 1.4 I held the role of Lead Clinician for Urology Morbidity and Mortality meeting from April 2015 to September 2021. I have not been provided with a job description for this role. I refer to my answer to Q7.
- 1.5 I have held the role of Lead Clinician for Urology Cancer MDT from 16th November 2016 to date. I have not been provided with a job description for this role. I refer to paragraphs 7.7 and 7.8 below. Since 2021 I have worked with Dr Tariq, AMD for Cancer Services to develop a Job Description for all Cancer MDT Lead Clinicians in the SHSCT. This work is almost complete and has formed part of the SHSCT Task and Finish response to the recommendations made by Dr Hughes's Independent Review into 9 SAls.
- 1.6 I took up the post of Urology Training Programme Director at the Northern Ireland Medical and Dental Training Agency in February 2019. I have 3 hours per week in my job plan for this role which is adequate. NIMDTA provide training which has enhanced my ability to manage doctors in training with difficulties and also to keep me up to date with best practice in equality, recruitment and selection. One shortcoming of the role is the lack of administrative support available to me as TPD.
- 1.7 I have had patient safety concerns, since 2012, related to the long waiting lists for appointments and procedures within the Urology Department. I also have concerns regarding inadequate numbers of Consultants in the Department to deliver a safe timely service. Since my first experience of working in the

APPENDIX 1: Clinical Lead appointment letter



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

October 2016

Dear Mr Glackin

Re: Clinical Lead for the Urology Cancer Team

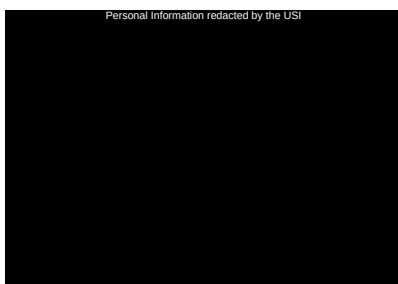
Further to our recent discussion, I understand that the Urology cancer team members have nominated you as the clinical lead for the service.

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

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

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

Yours sincerely



Rory Convery (Dr)
Clinical Director
Cancer Services

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

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

Personal Information redacted by the USI

Signed

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

Signed

Personal Information redacted by
the USI

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

Personal Information redacted by the USI

Signed

The MDT members agreed this Operational Policy on:

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

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

Background

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

Southern Trust Urological Cancer Services

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

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

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

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

SECTION 1: STRUCTURE AND FUNCTION OF THE MDT

1.0 Purpose of the MDT

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

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

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

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

1.1 Membership Arrangements

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

Core Membership

(14-2G-101)

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

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

* *Lead Clinician*

** *Lead for clinical trial recruitment*

****Lead for patient involvement, information & service improvement*

Extended Membership

(14-2G-105)

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

1.2 Leadership Arrangements and Responsibilities

(14-2G-101)

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

Key Responsibilities of the Lead Clinician:

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

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

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

1.4 MDT Quorum and Attendance

(14-2G-102) (14-2G-104)

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

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

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

1.5 Chairing of meetings

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

1.6 MDT Review

(14-2G-103)

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

Video conferencing with the Specialist MDT is scheduled to take place at 3.30 pm, or as soon as is mutually convenient thereafter.

It is the policy of the Southern MDT that all MDMs should finish by 5 pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 40 in order to enable the MDM to finish by 5 pm.

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

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

Responsibilities of the MDT Coordinator:

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

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

Referrals to the MDT meeting

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

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

MDM Documentation

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

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

1.7 Protocol for taking action between meetings

(14-21-203)

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

1.8 Virtual MDM

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

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

SECTION 2: CO-ORDINATION OF CARE/PATIENT PATHWAYS

2.1 Clinical Guidelines and Pathways

(14-2G-106) (14-2G-110)

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

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

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

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

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

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

Patient Review following MDM discussion

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

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

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

2.4 Treatment Planning

(14-2G-111)

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

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

The MDT should agree and record the multidisciplinary treatment planning decision (i.e. to which modality of treatment - surgery, oncology, best supportive care). The CaPPS system is used for collecting data on patients and documenting MDT decisions.

The MDT outcome report (Appendix 2) acts as the patient's individual treatment plan and includes:

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

Investigation plans and treatment recommendations are formulated during the meeting and recorded in narrative format by the MDT Co-coordinator.

The chairperson should articulate a summary of the recommendations arising from the discussion before proceeding to the next case.

2.5 Attendance at the Network

(14-2G-110)

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

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

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

2.6 Supportive Care and Rehabilitation Services

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

2.6.1 Physiotherapy Services

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

2.6.2 Stoma Care Services

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

2.6.3 Clinical Psychology & Counselling Services

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

2.6.4 Community Continence Services

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

2.6.5 Pre-chemotherapy Education Sessions & Helpline

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

2.6.6 Complimentary Therapies

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

2.6.7 Welfare Services

Citizens Advice Bureau (CAB) representative offers financial and benefits advice. Referrals are e-mailed to a central Macmillan/CAB address and allocated from there. The CAB representative contacts the patient to arrange a suitable appointment.

2.6.8 Macmillan Cancer Support

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

2.6.9 Other Support Services

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

SECTION 3: PATIENT EXPERIENCE

3.1 Key Worker

(14-2G-113)

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

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

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

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

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

Key responsibilities of the Key Worker:

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

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

3.2 Patient Information

(14-2G-114)

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

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

For patients with sensory, cognitive or language difficulties bespoke information can be arranged via the Macmillan Health & Wellbeing Manager.

Additionally a regional interpreting service is offered with trained health related interpreters. The Trust also has a contract with the 24 hour telephone interpreting service to ensure that patients have support in the planned or emergency situation.

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

3.3 Permanent Record of Consultation

(14-2G-115)

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

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

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

3.4 Patient Feedback

(14-2G-116)

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

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

Complaints and compliments will be monitored by the Head of Service and lessons learned will be discussed in the Operational Meetings.

There is the opportunity via the Cancer Services User Forum to present new service developments or information leaflets to capture patients' views.

SECTION 4: CLINICAL OUTCOMES/INDICATORS

4.1 Clinical Indicators Review/Audit

(14-2G-217)

The MDT will annually review its data and discuss progress of audits or discuss the completed results, as relevant, of audits. These should be presented at one of the regular network group meetings.

Data on compliance with the Cancer Access Standards in relation to the 31 and 62 day targets will also be reviewed.

4.2 Clinical Trials

(14-2G-218)

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

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

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

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

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

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

5.0 DESCRIPTION OF INCIDENT/CASE

during XX's life expectancy and, therefore, would not be anticipated to require any treatment) and surveillance with PSA monitoring was recommended. Dr.3 asked for the next PSA level to be done in December 2020 and said that he would review the result.

6.0 FINDINGS

- The management of XX's lower urinary tract symptoms followed a standard pathway.
- XX was appropriately listed for TURP but appears to have remained on the waiting list for over 5 years, despite requests for an expedited admission.
- XX was not followed up following his TURP in January 2020. He was not advised of his diagnosis until a review in August 2020. The operation notes specify a planned review in April 2020. This did not happen.
- The TURP histology showed well-differentiated adenocarcinoma in just under 5% of the tissue resected. This in the light of the stable PSA must be regarded as a co-incidental diagnosis with a low probability of any impact on XX's life expectancy or quality of life.
- The review team considered the MDM plan for surveillance appropriate.
- The review team considered whether the Covid pandemic played any part in this delay. At that time telephone virtual clinics were in place which allowed reviews to continue.
- The review questioned why the histology had not automatically entered XX onto the MDT database to allow prompt discussion.
- This usually falls to the laboratory to search all urology patients on a weekly basis by SNOMED code for cancer and site.
- The review team questioned whether the mechanisms for post-operative follow up were robust.
- The delays and omissions are matters of the operational policies of the department and/or Trust rather than any individual.
- The review team met with XX on two occasions and have established that the delay in being reviewed did cause him considerable anxiety.
- When he was advised of his malignancy diagnosis 8 months after his surgery XX described being very shocked by it. However, he was reassured about the

he was getting rescanned and -- but as for any detail around that, no, I don't remember that.

69 Q. You eloquently say about all the catheter problems?

A. Yeah.

70 Q. So he would have seen a specialist nurse, not a cancer 12:05
nurse for the catheter?

A. I understand.

71 Q. Was there a link with her in the Department that was relatively easy? You say --

A. No.

72 Q. -- your dealings were mainly through?

A. It was A&E.

73 Q. A&E.

A. He would get to a point that he would decide do you know what, I can't deal with this anymore, I am going to A&E to get this out. I mean he was driving through the night at times. He was driving on the wrong side of the road. He really, really was in a terrible condition by this stage. That was his only access to healthcare. There really was no -- he was contacting, as I understand it, Mr. O'Brien's secretary. I know he sent an e-mail. That's what he had recorded. I remember him saying that to me at the time. Yeah, his only access to care was through A&E. There certainly was no -- he didn't have access to any nurse.

74 Q. Okay. Then he has a slight prolonged stay after the TURP operation, a bit of a fever and things. Just a couple of things, was that where he first met Mr. Haynes, he attended him in hospital --

EXTERNAL VERIFICATION REPORT

(MULTI-DISCIPLINARY TEAM)

Network	NICaN
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (N14-2G-1) - 2016
Compliance	
UROLOGY LOCAL MDT MEASURES	Self Assessment 55.0% (11/20)
Zonal Statement	
Completed By	Clare Langslow
Job Title	Quality Manager
Date Completed	13 October 2016
Agreed By (Clinical Lead/Quality Director)	Sally Edwards
Date Agreed	15 November 2016
NPRP Team Comment	
Key Indicator	
Structure and Function	

SA Agreed with exception

Assessment

Core membership complete but there is no listed cover for the radiologist or the clinical oncologist so therefore attendance and quoracy remain an issue. Only 42 MDT meetings were held in 2015 with a four week gap in December. 43% meetings had no radiologist present and 19% no oncologist. Overall quoracy was only 48%.

Key Indicator
Co-ordination of Care/Patient Pathways

SA Agreed with exception

Assessment

Guidelines and pathways are still under discussion regionally as nephron sparing surgery is still undertaken at more than one trust.

Key Indicator

Patient Experience

SA Agreed

Assessment

Patient feedback reviewed and actioned.

Key Indicator

Clinical Outcomes/Indicators

SA Agreed

Assessment

Ongoin audit programme to be agreed.

Key Indicator

Communication

SA Agreed

Assessment

Attendance at advanced communication skills training remains challenging.

Outcome

Significant Issue

(Any significant issue or >1
theme agreed with exceptions)

Concerns

Concern

Immediate Risk at SA

Identified: No

Resolved: Not Applicable

Comments

Serious Concerns at SA

Identified: No

Resolved: Not Applicable

Comments

Four serious concerns were raised at the peer review visit in 2015.

1. There is a single handed radiologist supporting the Urology MDT with no cover arrangements in place. - This is not resolved.
2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. - Not resolved but quoracy up to 48%
3. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. - partially addressed as referrals to the Trust are triaged by consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients.
4. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the draft NCC clinical guidelines. - Not resolved across the region.

Recommended Action

EV

Comments

MDT should self assess next year to check whether issues have been resolved.

EXTERNAL VERIFICATION REPORT NICaN 2017

Organisation	Southern HSCT	
Team	Urology MDT	
Self-Assessment Compliance	70%	
Report Completed By	Clare Langslow	
Job Title	Interim Senior Quality Manager	
Date Completed	03 October 2017	
EV RAG rating (and EV % compliance)	Red	65%
Recommended Action for 2018	Repeat SA	

Structure and Function

EV comments

Core membership is complete although the named clinical oncologist is a locum. There is no cover for the oncologist or the radiologist.

Individual attendance of the surgeons, histopathologist and CNS is good. The greatest challenge for the MDT during the past year remains the inability to have a clinical oncologist and or radiologist at the MDT meetings. This is due to the inability to recruit adequate numbers of clinical oncologists and radiologists to the posts where they are required both in the Trust and regionally. This has been escalated to trust senior management team and is being addressed with the appointment authorities.

With radiologists missing from 23 meetings and oncology from 35 meetings, only five MDT meetings were quorate in 2016 and this is a discernible deterioration from previous year's attendance. This raises concerns over the multidisciplinary discussion and decision making process at the MDT and by implication discussion and decisions must take place outside of the MDT meetings.

SA not agreed

Co-ordination of Care/Patient Pathways

EV comments

Network guidelines and pathways being followed. Nephron sparing surgery is no longer being undertaken locally as one of the SHSCT surgeons is providing support and undertakes nephron sparing surgery at Belfast City Hospital.

SA Agreed

Patient Experience

EV comments

As well as acting on the results of the national survey in 2015, a local patient survey was undertaken in 2016. Response rates were overall complimentary of the service provided. Results have been reviewed and discussed at an operational meeting and an action plan developed to address areas of weakness.

SA Agreed

Clinical Outcomes/Indicators

EV comments

Audit activity has been reviewed and two audits were presented in 2016; Audit on Bladder Cancer Access Standards for non-superficial disease and an Audit of Nurse Provided TRUS Biopsy Service in 2016.

Data was also submitted to the British Association of Urological Surgeons (BAUS) Data and Audit database.

Urology clinical research activity is limited due to limited attendance of the clinical oncologist at the MDT meetings. 16 patients were recruited to trials in 2016.

Trust performance on the 62 day cancer waiting times targets was below the 95% required. The table in the annual report contained formatting errors in the total number of patient on the pathway. Verification showed that 81% of patients were treated within the target.

SA Agreed

Communications

EV comments

The consultant radiologist needs to undertake Advanced Communications Skills training as must be undertaking interventional procedures.

SA Agreed

Concerns raised at SA 2017

Immediate Risk at SA

None identified

Serious Concerns at SA

Identified: Yes

Updates on previous SCs raised, see below.

Not all Resolved

Risks raised at Peer Review Visit 2015 Resolved?

Immediate Risk

None identified.

Serious Concerns

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

This remains a problem as radiology cover is a regional issue.

Not Resolved

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

Arrangements have been made with Belfast Trust to ensure clinical oncology representation at MDT meetings.

Not Resolved

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

All urology referrals to the Trust are triaged by the consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients. Data provided shows waits have reduced.

Resolved

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

This no longer happens as one of the SHSCT surgeons is providing support to undertake nephron sparing surgery at Belfast City Hospital.

Resolved

Overall Outcome

SA not agreed - Red

Recommended Action for 2018

An accurate assessment completed, whilst compliance is 65%, SCs have not all been resolved and there are concerns over true multidisciplinary discussions at MDT. Therefore recommend Red rating and further SA in 2018 to check

- cover for oncology and radiology core members
- individual attendance
- quoracy of the MDT meetings
- full resolution of SCs.

7.0 CONCLUSIONS

The Review Team would like to thank the patients and their families for their contribution to the report and their willingness to share their experiences. The process was difficult and at times traumatic for them. The review team acknowledge that this report may cause distress to the patient and their families, however the team has endeavoured to produce a complete and transparent account of each patient's journey.

The Review of nine patients has detailed significant healthcare deficits while under the care of one individual in a system. The learning and recommendations are focused on improving systems of multidisciplinary care and its governance. It is designed to deliver what was asked of the Review Team by patients and families - "to ensure that this does not happen again or that another patient suffers".

The Patients in this review received uni-professional care despite a multidisciplinary resource being available to all others. Best Practice Guidance was not followed and recommendations from MDM were frequently not implemented or alternative treatments chosen. There was knowledge of that prescribing practice varied from regional and national guidelines in the Southern Health and Social care Trust, as well as more widely across the Cancer Network. This was challenged locally and regionally, but not effectively, to provide safe care for all patients. Inappropriate non referral of patients to oncology and palliative care was unknown.

The primary duty of all doctors, nurses and healthcare professionals is for the care and safety of patients. Whatever their role, they must raise and act on concerns about patient safety. This did not happen over a period of years resulting in MDM recommendations not being actioned, off guidance therapy being given and patients not being appropriately referred to specialists for care. Patients were unaware that their care varied from recommendations and guidance. They could not and did not give informed consent to this.

The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer review were not based on systematic audit of care given by all.

While it is of little solace to the patients and families in this review, The Review team sought and received assurances that care provided to others adhered to recommendations on MDM and Regional / National Guidance.

Four of the nine patients suffered serious and significant deficits in their care. All patients had sub-optimal care that varied from regional and national guidelines.

As part of the Serious Adverse Incident process, the Review Team had requested input from Dr 1. This related to the timelines of care, for the nine patients involved in the SAI reviews and specifically formed part of the root cause analysis. This fell under professional requirements to contribute to and comply with systems to protect patients and to respond to risks to safety. To date a response has not been received.

Angela Kerr

From: O'Brien, Aidan <[REDACTED]>
Sent: 30 June 2016 18:37
To: Haughey, Mary
Cc: Corrigan, Martina; Reddick, Fiona
Subject: RE: Urology MDT Membership

Mary,

Further to your email and to our recent chat by telephone, I do believe that this is an important issue for several members and for several reasons.

I have since had the opportunity of discussing this matter with colleagues in the following specialties:

- Gareth McClean, Consultant Pathologist.

Gareth has a total of five contractual hours in his job plan allocated to Urology MDM, two for preparation and three for the meeting.

He feels that this is adequate.

However, a separate issue is or will be whether there will be leave cover in the future, and whether that cover has adequate time allocated.

In considering that aspect, it is worth bearing in mind that we do have Virtual MDMs when it is not possible to have a Real MDM.

I believe that these work well on balance, particularly as the outcomes are shared on line for consultation by all before circulation.

So we have at least 50 MDMs per year, requiring the input of a pathologist, who requires a remunerated time allocation per MDM as above.

- Marc Williams, Consultant Radiologist.

Marc has recently had an increased preparation time allocation of three hours agreed, in addition to three hours for the meeting, a total of six hours.

The previous allocation of two hours for preparation proved inadequate.

Marc feels that the total of six hours is probably appropriate.

The same issues relating to leave cover and Virtual MDM pertain even more severely as there is no other urologist available to provide cover, though it may be possible to have an input from a radiologist in SWAH and who may be able provide cover in the future.

- Jolyne O'Hare, Consultant Oncologist.

Due to the inability to appoint an acute oncologist at CAH, Jolyne is unable to link in to every MDM, or for the entire duration of those she can link in to.

If human resource were adequate, Jolyne believes that at least one hour of preparation time would be required, resulting in a total of four hours.

- Chairs of MDM

Irrespective of who chairs MDM, it has been my experience that it requires longer to prepare for MDM than the duration of the MDM.

This is all the more so if it is known or anticipated in advance that particular core members will be absent. For me, it takes four hours to prepare, three for the MDM and one for verification of outcomes, a total of eight hours.

- Urologists who do not chair.



Urology Services Inquiry

Tony Glackin, Chair of the Urology MDT, I discussed this issue with Dr Imran Yousuf in his role as Clinical Director for Radiology. Dr Yousuf manages the Consultant Radiologists and he is best placed to review the rotas and to improve Radiology cover at the Urology MDT.

40.8 Since my time in Cancer and Clinical Services (from 1 June 2018), 11 attempts have been made to recruit Radiologists (usually trawls per year) including three attempts more specifically for Radiologists with expertise in Urology – the radiology specific trawls were held in April 2019, February 2020 and January 2021. The timing of all of the trawls for these posts would be in line with trainees that were due to complete their training and be eligible for consultant posts. Radiology attendance at each MDT is important as it enables the MDT to discuss cases and for the Radiologist to comment on their report in person as necessary. In January 2021 the Trust was successful in appointing a Consultant Radiologist with expertise in Urology. Before taking up post, the successful candidate travelled to Australia with his wife to gain further experience as a Consultant Radiologist before commencing his job with SHSCT from April 2022. This will enable improved cover for the Urology MDT during 2022.

a. Pathology - There are major challenges regionally and nationally with the recruitment of Consultant Pathologists. There should be at least one Pathologist in attendance at each Cancer MDT to support further discussion on pathology reports if necessary. I approached the Director of Acute Services in April 2021 to seek approval to advertise for an additional Cellular Pathologist. Like most services, Cellular Pathology were struggling to meet the demands on their services and additional reporting sessions were being done each month to meet the demand. It was also proving difficult to have a Pathologist at every Cancer MDT given the competing demands on their services. Approval for one additional consultant post would help address these pressures and improve cover to the Cancer MDTs. This approval was given by Director of Acute services (Mrs Melanie McClements) on 5 May 2021. The timing of the trawl was deferred until early 2022 in order to target trainees that were due to qualify and be eligible to apply for consultant posts in spring 2022.

40.9 The approach was made to the Director of Acute Services as I was seeking approval to commit resources in excess of my budget – essentially to put additional resource in place at financial risk which required Director approval. An interview for an additional Cellular Pathologist was held on 7 April 2022 but no appointment was made. The post was re-advertised in May 2022 and further interviews are scheduled for 28 June 2022. In the interim, a locum Consultant Cellular Pathologist has been appointed and has been in post from 6 April 2022 providing 30 hours additional cover per week. A fulltime consultant works 40 hours per week. The service would prefer a fulltime locum, however only 30 hours locum cover was available. This additional capacity will support improved pathology cover to Cancer MDTs during 2022.

1 A. No, there was no guidance. To be honest, a lot of
2 clinicians, not just in urology, felt sometimes that
3 peer review was a tick box exercise because there were
4 things out with our control that required commissioning
5 that just wasn't forthcoming. So, there wasn't really 12:01
6 any control from peer review to say no, don't do this
7 any longer or, you know, stop it, it's not viable.
8 There was no direction.

9 163 Q. Do you think, looking back, that might have been
10 something that they should have done? 12:01

11 A. Yes, I think that would have been helpful. You know,
12 we did explore working with the Cancer Centre to see,
13 you know, if they could have taken on more of our
14 urology. But all MDTs are, you know, they're just --
15 the numbers are so large and there's so many 12:02
16 discussions. I think over recent years there's a lot
17 more complex discussions, you know. What would have
18 been a five-minute conversation before can now be 15/20
19 minutes. That hasn't really been taken into
20 consideration as time has went on and as the years went 12:02
21 on. There are a lot of patients with other
22 comorbidities and other quite complex cases.

23

24 We did try to explore, you know, the Cancer Centre
25 taking some of our MDT discussions, but it wasn't -- 12:02
26 they were already fully filled to capacity with
27 discussions in the centre as well.

28 164 Q. Okay. Just one last thing. You said on the CaPPS
29 system, there was a field there that you can say a key



Southern Health and Social Care Trust

Reference No: 73512039

JOB DESCRIPTION

JOB TITLE: Head of Cancer Services

BAND: 8b

INITIAL LOCATION: Craigavon Area Hospital

DIRECTORATE: Acute Services

REPORTS TO: Assistant Director of Cancer & Clinical Services

Job Summary

- To be responsible for the operational / performance management and strategic development of Cancer services to include Chemotherapy Services.
- To be responsible for the cancer tracking of patients through the cancer pathways
- To be responsible for leadership, service provision and service development of Cancer services and ensuring high quality patient centred services.
- To be responsible for the operational Line Management of the Clinical Nurse Specialists and Palliative Care Nurses working within Acute Services
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and guidelines
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a cancer service strategy, which support the Trust's and Division's overall strategic cancer direction and ensures the provision of a high quality responsive service to patients within resources.

As a Head of Service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY RESULT AREAS

1. Quality & Governance

Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.

Be committed to supporting honest, open communication and effective multi-disciplinary working.



Southern Health and Social Care Trust

Develop appropriate mechanism/forums for accessing the views of and engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

Support the Assistant Director with the implementation of quality initiatives such as Investors in People and PPI Initiatives.

2. Leading & People Management

Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.

Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.

Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.

Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.

Ensure the division implements and adheres to Trust HR policies and procedures.

Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Performance Management

Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.

Support the Assistant Director in achieving key access and performance targets applicable to the service area through robust planning, service improvement and collaboration through Acute Services

Make sure that services are delivered to the standard and quality expected by the HSCB – PHA, DHSSPS and Trust Board.

Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.

Identify and contribute to local, regional and national development initiatives e.g. clinical networks and national programmes.

Make sure that all recommendations arising from RQIA/External bodies inspections e.g. Cancer Peer Review/NEPOD and are implemented in a timely manner.



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Act as a member of the division's senior management team and contribute to its policy development processes.

Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.

Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

Assist with the development of the strategic cancer plan including the introduction of new cancer therapies, for the delivery of operational cancer services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSCB - PHA priorities.

Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic cancer planning initiatives and targets e.g. Cancer Standard Framework Document

Work with members of relevant teams on the innovative development of new and existing services e.g. the implementation of the Acute Oncology Model

5. Operational Management of Clinical Nurse Specialists and Palliative Care Nurses

As Line Manager of the above nurses ensure that systems and processes are in place that enables safe, appropriate input to patient care across Acute Services.

As Line Manager ensure that the above nurses in the service receives appropriate training and on-going development to enable them to competently and safely fulfil their roles.

As Line Manager ensure that the above nurses in the service receive annual appraisals and clinical supervision programmes are in place with regular evaluation processes to support them.

Promote a culture of lifelong learning within these teams of nurses and to contribute to the standardisation of cancer nursing within the region.

To responsible for the delivery of cancer research within the Trust working closely with the AMD for R&D.



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6. Financial & Resource Management

Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.

Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.

Participate in contract and service level negotiations with commissioners.

Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.

Update and monitor the operational policies of the Division and take account of risk management needs.

Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

Ensure that environmental standards are appropriate for safe & clean care delivery.

7. Information Management

Ensure the effective implementation of all Trust information management policies and procedures within the Division.

Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

8. Corporate & Divisional Responsibilities

Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Cancer & Clinical Services.

Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.

Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.



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Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.

Participate in and comply with requirements in the production of performance reports.

Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.

Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

9. General Management Responsibilities

Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

Ensure that the review of performance identified above is performed for all levels of staff within your remit of responsibility in accordance with the Trust policy.

Maintain good staff relationships and morale amongst the staff reporting to you.

Ensure that the opportunities for talent to be developed are provided to ensure the service continues to develop.

Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

Delegate appropriate responsibility and authority to the level of staff within your control consistent with effective decision making whilst retaining responsibility and accountability for results.

Participate as required in the selection and appointment of staff reporting to you in accordance with procedures laid down by the Trust.

Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Promote the Trust's policy on equality of opportunity through your own actions and ensure that this policy is adhered to by staff for whom you are responsible.



Southern Health and Social Care Trust

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
9. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.



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10. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.



Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE Head of Cancer Services, Band 8b

DIRECTORATE Acute Services

INITIAL LOCATION Craigavon Area Hospital

SALARY £45,254 - £55,945 per annum

HOURS Full Time

Ref No: 73512039

May 2012

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage.

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Applicants must provide evidence by the closing date for application that they are employed within a Health & Social Care organisation as defined¹
2. Be on Part 1 (Adult) of the live NMC Register or be eligible to re-register
3. Hold a university degree or recognised professional qualification in a health or social care related area AND have a minimum of 2 years' experience in a senior role at Band 7 level or equivalent in a health and social care setting **OR** have a minimum of 5 years' experience in a Senior role at Band 7 level or equivalent in a health and social care setting

¹ This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the NI Social Care Council



Southern Health and Social Care Trust

4. Have a minimum of 1 years' experience in a lead role delivering objectives which have led to a significant² improvement in service.
5. Have a minimum of 1 years' experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant² change initiative.
6. Have a minimum of 2 years' experience in staff management.
7. Hold a full current driving licence valid for use in the UK and have access to a car on appointment³.

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE / SKILLS / ABILITIES

8. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.
9. Have an ability to provide effective leadership.
10. Demonstrate evidence of highly effective planning and organisational skills.
11. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

**Successful applicants may be required to attend for a Health Assessment
All staff are required to comply with the Trusts Smoke Free Policy**

PLEASE NOTE:

It is intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the standards set out in the NHS Leadership Framework, against all seven domains.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

² 'Significant' is defined as contributing directly to key Directorate objectives

³ This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.



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JOB DESCRIPTION

POST	Macmillan Cancer Service Improvement Manager
GRADE	Band 8A
REPORTS TO	Head of Cancer Services
RESPONSIBLE TO	Assistant Director – Cancer and Clinical Services
LOCATION	Craigavon Area Hospital
DURATION	37.5
HOURS	Full time



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JOB SUMMARY

The post holder will have a lead role in:-

- Identifying and implementing service improvement initiatives, which will make a significant contribution to transformational change within Cancer Services to support the delivery of efficient and effective working and delivery of services to patients with a cancer diagnosis in line with the strategic services direction set out in Transforming Your Care.
- Work with Head of Cancer Services, Assistant Director of Cancer Services and Clinical lead for cancer services and other managerial and clinical staff, providing leadership and support in relation to service
- Development and improvement initiatives to be taken forward across a number of specialist teams.
- Work with clinical teams to review current patient pathways; identifying areas for modernisation and improvement, in line with Transforming Cancer Follow up and benchmark best practice.
- The post holder will have a key role in facilitating excellent communication within and across Directorates regarding transformational change.
- Promote and develop effective multi-professional team working within and across the Directorates.

Setting direction

- Contribute to the development of a modernisation plan for Cancer Services which will support the delivery of service change in line with the strategic direction set out in Transforming Your Care.
- Identify best practice in the development of a modernisation plan in areas that will lead to efficient and effective care pathways for patients
- Lead on the implementation of identified service improvement initiatives within Acute Hospital Service that will contribute to efficient and effective working, including the development of new care pathways which will provide alternatives to hospital outpatient visits, admission / reductions in LOS etc.



Southern Health
and Social Care Trust

TRU-02598

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MAIN DUTIES/RESPONSIBILITIES:

The post holder will :-

- Have lead responsibility for the development, implementation and monitoring of a number of cancer services improvement programmes across the Northern Health and Social Care Trust.
- Have a lead role in supporting the continued modernisation and redesign of a number of cancer pathways, including cancer follow up, the recovery package, patient experience and cancer survivorship agenda.
- Provide support to the Trust's Lead Cancer Team to identify and respond to other regional and local priorities such as the introduction of Acute oncology services.
- Provide support to the Trust's Lead Cancer Clinician and General manager in the establishment of effective governance structures and the facilitation and encouragement of innovative practice across the patient pathway within cancer services
- To identify, develop and implement systems to monitor and report on performance and service delivery.
- Analyse available information to identify areas of service development and improvement for areas providing services to cancer patients.
- Implement a programme of service improvement with robust project Management arrangements and clear measurable outcomes.
- Work with key stakeholders to enable them to learn in and from their practice identify the things that need to be changed, the necessary steps required to effect the change how to evaluate the effectiveness of the change and critically, how to sustain the change.
- Provide support and act as a resource to the Trust's teams delivering care to cancer Patients and key stakeholders in the use of service improvement tools and techniques that deliver high impact change thus helping to build capacity to improve service quality through service redesign.
- Develop collaborative working relationships with other regional and modernisation initiatives/programmes to ensure the integration of the cancer services improvement programme to these initiatives.
- Develop excellent working relationships and communication strategies with both internal and external stakeholders, clinicians and administration staff and service users, to encourage collaborative working to improve service delivery. Work as a member of the cancer service management team in the delivery and development of sustainable safe and effective services.
- Provide leadership to staff in the development of a service that operates in the context of a whole system approach.
- As a Macmillan funded professional and as part of the Trusts Lead Cancer Team the post holder will foster partnership working, ensuring that the patient and carer's voice and needs are at the heart of service improvement activity in line with HSCNI strategy and Macmillan's vision.



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Generic managerial responsibilities both within an operational and strategic context.

- Adhere to the Code of Conduct for HPSS managers which states that managers will be expected to work with integrity, honesty and openness, probity, accountability and respect, available on www.dhsspsni.gov.uk or in the HR Policies and Procedures Handbook.
- Ensure staff are aware of and act in accordance with all relevant policies, procedures, guidelines, protocols, codes of conduct and nursing strategy
- Participate as required in developing policies, protocols and guidelines to ensure safe and effective care
- Promote and facilitate good staff relationships and morale amongst staff
- Participate as required in the selection, supervision and retention of staff in accordance with Trust policies
- Observe for signs of ill health in colleagues and take appropriate action with staff or management
- Monitor delegated budgets, as required, to ensure effective and efficient use of resources
- Ensure the appropriate governance and risk management arrangements are in place for the services you are responsible for and take appropriate action to identify and manage risk and to maintain safety of users, staff and others in accordance with relevant regulations, policies and procedures
- Take responsibility for ensuring appropriate standards of environmental cleanliness and for encouraging staff to maintain standards in their work area. Have an awareness of environmental issues and take appropriate action, for example to ensure the efficient use of energy and other resources, recycling etc.
- Make sure that staff are aware of trust policies regarding the Data Protection Act 1998, the



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Freedom of
Information

Act 2000, the Environmental Information Regulations 2004 and Records Management and that they must not disclose, withhold, retain or dispose of any information unless legally authorised.

- Ensure systems are in place for the safe use of medical devices, incidents & accidents are recorded and reported in line with Trust policy
- Ensure the necessary arrangements are in place in regard to the 'Knowledge and Skills Framework' outlines, where this applies, for the posts for which you have management responsibility and ensure that each member of the team has an annual development and performance review, a personal development plan and that arrangements are in place to ensure that staff have maximum opportunity to progress through gateways in their pay bands and to contribute effectively towards our objectives
- Promote a culture of continuous service improvement amongst the team, encouraging their participation and that of service users in reviewing and modernising current services and in service development
- Delegate appropriate responsibility and authority to staff in order to ensure optimum and effective service delivery and decision-making, whilst retaining overall accountability and responsibility for outcomes
- Promote equality of opportunity for all by personal action, both in the management of your staff and in the provision of care to service users in accordance with the Trust's Equality of Opportunity Policy and Equality Scheme;
- Ensure pre & post registration students receive relevant clinical experience
- Participate in research to support continuous improvement activities as required
- Promote and participate in practice development
- Promote the use of evidence based practice and audit to identify opportunities to enhance patient / client care or service

- * **Applicants please note:** Shortlisting will be carried out on the basis of the essential criteria set out above, using the information given on the application form. You should therefore address the requirements when completing the application form, as failure to do so may result in you not being shortlisted. Appointments are subject to verification of appropriate qualifications.

December 2014

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY**JOB DESCRIPTION**

JOB TITLE:	Clinical Director – Cancer Services
BASE:	Southern Health & Social Care Trust Area
DIRECTORATE:	Acute Services
RESPONSIBLE TO:	Director of Acute Services
OPERATIONALLY RESPONSIBLE TO:	Associate Medical Director – Cancer & Clinical Care
ACCOUNTABLE TO:	Chief Executive
HOURS:	Salaried Part-time position

JOB SUMMARY

The appointee will provide clinical leadership and contribute to the strategic development of Cancer Services across the Trust.

He/She will:

- Participate as a member of the Cancer & Clinical Care Divisional Team;
- Be responsible for medical operational issues within Cancer services the Trust;
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues relating to Cancer services
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

KEY RESPONSIBILITIES**Setting Direction:**

- To support the Trust in the development of a high quality, responsive services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures within Cancer services
- Provide leadership and direction to consultants and other medical staff within the specialty.

Service Delivery:

- To function as a member of the Divisional management team with responsibility for medical operational and professional issues within Cancer services.
- Work with the Associate Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the Division.
- Work with the Divisional Team to use the resources of the Division to deliver, in both quality and quantity, the activity and targets agreed for the Division.
- Work with the Divisional team to deliver efficient, effective services within the agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.
- Work with the Divisional Team in supporting the modernisation of related services.
- To support the Trust in planning a response to major incidents and outbreaks.

Quality, Communication and information management

- Provide clinical leadership to ensure the implementation of patient safety initiatives.
- Support the Associate Medical Director to ensure a programme of multi-professional clinical audit is implemented within the Division that supports the Southern Trust integrated governance strategy and support the development of benchmarking activities within the Division.
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the specialty.

Professional Leadership

- Support the Associate Medical Director to ensure the highest standards of clinical effectiveness and medical practice in the Division, including the consideration / implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- To place Patient Safety at the centre of specialty activity

Medical Education and Research

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the specialty, ensuring the appropriate Governance arrangements are in place

Leading the Medical Team

- Support the Associate Medical Director in the implementation of the consultant contract within the specialty, ensuring the contract supports modernisation, quality improvement and achievement of access targets.
- Support the Associate Medical Director in the effective implementation and monitoring of modernising medical careers (MMC) and EWTD for junior doctors.
- Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Where required, take part in the recruitment process for new doctors or ensure that other colleagues do so effectively.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- Work with the Associate Medical Director to ensure a system of induction is in place for all doctors within the specialty.
- Work with the Associate Medical Director to develop and lead a team of Specialty/Site Leads to assist the Trust in the redesign, modernisation and improvement of service delivery.
- Support the Associate Medical Director in the appraisal of all grades of designated doctors, including locum tenens, in line with regional guidance.
- Ensure that doctors within the specialty comply with arrangements for the assessment of fitness for clinical work.
- Work with the Associate Medical Director and Assistant Director of Cancer & Clinical Care to ensure the equitable and fair management of annual, discretionary and study leave process which meets the needs of the service and the development needs of the medical workforce within the Trust.

Collaborative Working

- Actively promote the development of clinical and professional networks between the Trust hospital sites.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated.
- Support the development of effective multi-professional team working and communication across both acute hospital sites

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

Responsibility Allowance

- Responsibility Allowance: **£7,600 per annum** (This is a pensionable allowance)
- Dedicated time within job plans between **0.25 PA and up to a maximum of 1 PA per week**. This time allocation will be timetabled into the job plan as additional HPSS responsibilities and will be proportionate to the demands of the role, size of the division etc.
- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

PERSONNEL SPECIFICATION

JOB TITLE: Clinical Director – Cancer services – Southern Health & Social Care Trust

DIRECTORATE: Acute Services

November 2017

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust
2. Hold a medical qualification, GMC registration and specialist accreditation (CCT)
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Clinical Directors in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Laura Wight on Personal information redacted by the UoI as soon as possible.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from <http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/>

The successful candidate will be appointed for a period of 1 year subject to satisfactory performance and delivery against the key elements in the Job Summary.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

JOB DESCRIPTION

POST:	Divisional Medical Director –Cancer and Clinical Services (Fixed Term Post 3 Years)
DIRECTORATE:	Acute Services (Under Review)
RESPONSIBLE TO:	Director of Acute Care (Under Review)
ACCOUNTABLE TO:	Medical Director
COMMITMENT:	3 PAs
LOCATION:	Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the “right culture” where everyone's “internal culture” or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the “right” culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To provide robust clinical leadership in reviewing and improving cancer and clinical services in the context of the Urology Public Inquiry.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding
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Specific Divisional Responsibilities

- Provide oversight and development of a workforce strategy for the division that meets the needs of the changing health and social care landscape
- Promote, develop and strengthen effective multi-professional team working and assurance mechanisms to strengthen governance arrangements surrounding Cancer MDT processes
- Provide leadership and guidance regarding the development of Radiology, Pathology and Cancer services within the Trust

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and

staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
 - (a) delivery of safe, high quality and effective person-centred care
 - (b) secures activity and performance
 - (c) maintains ongoing financial viability
 - (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals

annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
Annual Leave
Study Leave
Performance
Sickness absence
Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy

- IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
 6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
 7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
 8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
 9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director – Cancer and Clinical Services

DIRECTORATE Acute Services

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O’Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal information redacted by the UoI

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from <http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA’s and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER



Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – Cancer Services

DIRECTORATE: Acute Services Directorate – Cancer & Clinical Services Division

RESPONSIBLE TO: Divisional Medical Director Cancer & Clinical Services Division

ACCOUNTABLE TO: Medical Director

COMMITMENT: 2PAs

LOCATION: Trust wide

Context:

The Clinical Director (CD) on behalf of the Divisional Medical Director (Div MD) will be a leader in Divisional Management Team and member of the Directorate Senior Management Team. The CD will report to the Div MD and will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The CD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviors. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The CD will have delegated responsibility on behalf of the Div MD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the Div MD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Specialties / Areas Responsible For

- Southern Trust Acute Oncology Services
- Southern Trust Palliative Care Services
- Mandeville Unit

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding
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Specific Divisional Responsibilities

- Contribute to strategy development for Cancer Services in the Southern Trust as part of the Divisional Senior Management Team
- To advise the Management Team of Divisional priorities and pressures within Cancer Services
- Provide leadership and direction to consultants and other medical staff within Cancer Services
- To function as a member of the Divisional management team with responsibility for the delivery of Cancer services across the Trust
- Work with the Divisional Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of Cancer MDT's
- Work with the Cancer & Clinical Services Divisional Team in supporting the modernisation of Cancer services.

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of

continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.

- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
 - (a) delivery of safe, high quality and effective person-centered care
 - (b) secures activity and performance
 - (c) maintains ongoing financial viability
 - (d) is aligned to corporate goals
- The Clinical Director will work with the Divisional Medical Director and the Assistant Director and professional leads, in partnership, to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of CD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Consultants and any other relevant medical staff.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
Annual Leave
Study Leave
Performance
Sickness absence
Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the

Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Clinical Director – Cancer Services

DIRECTORATE Acute Services – Cancer & Clinical Services Division

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant or SAS Grade with the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT) **OR** undertaking a Certificate of Eligibility for Specialist Registration.
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Shahid Tariq, Divisional Medical Director to allow further discussion of the role. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please email Dr Tariq –

Personal Information redacted by the UoI

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from <http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 2PA's and a fixed management allowance of £7,400 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement (subject to change) – which will then apply for the duration of the contract.

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COMMITTEE REPORT SUMMARY SHEET

Meeting:	Performance Committee
Date:	19 March 2020
Title:	Cancer Services
Lead Director:	Melanie McClements Director of Acute Services
Corporate Objective:	Improving Our Services Making Best Use of Our Resources Promoting Safe, High Quality Care
Purpose:	Assurance

Overview:

To provide information to the Performance Committee in exercising its function of overseeing the Trust's performance management arrangements monitoring Cancer Services performance and key issues, risks and actions.

Outcomes from SMT Discussions:

- Concern regarding sustained decreased in performance against the 62-day pathway target from 2018/2019 to current reflected in actual performance and in reduced performance trajectory target set for 2019/2020;
- Review of actions being undertaken, to address identified issues, within the scope of the Trust's ability;
- Assurance regarding direction of capacity to Red Flag and Urgent demand, in the first instance, in light of on-going reduced core and additional capacity;
- Concern regarding competing demand for diagnostics and additional capacity required to support;
- Concern regarding named Clinical Nurse Specialist (CNS) contact and actions taken to improve this in terms communication, and or CNS capacity.
- Assurance around processes for regional MDT meetings, which with Trust consultants will interface for regional cancers sought

Key areas for Committee consideration:

Cancer Services continue to present challenges at a Regional and local level. Significant improvement will not be enabled in the absence of service wide transformation.

- **Key Risks** within Cancer Services continue to relate to:
 - Demand in excess of capacity and ability to see patients within the recommended pathway timescales, with potential of impacting on patient's outcomes;
 - Increasing demand for assessment/referral (circa 2000+ patients in the system at any one time) and impact on fixed out-patient and diagnostic capacity;
 - Key diagnostic capacity gap, for example Regional PET, local endoscopy, CT Colongraphy, all impacting on pathway capacity and competing demands for capacity across the unscheduled and elective care pathways.

- Workforce and unscheduled care challenges impacting theatre capacity and reducing available theatre hours for red flag and urgent surgery. Infrastructure challenges also limit theatre capacity;
 - Lengthening waiting lists for urgent and routine patients and risk associated with emergent risk in this cohort;
 - Regional review of pathway guidance indicates potential for introduction of the National Institute for Health and Care Excellence (NICE) NG12 which has potential to increase the level of red flag referrals received in the Trust, which in turn will place further pressure on the system;
 - Regional and local workforce challenges, for example, Oncology capacity, requiring need for system-wide support measures and impacting on delivery of local services; and
 - Lack of recurrent investment within the Bowel Cancer Screening Programme with increasing access times for patients with an initial positive result.
- **Key Actions** that are being undertaken within the Trust to address issues/risks for Cancer Services are:
- Development and embedding of the SHSCT Cancer Strategic Forum;
 - Development of local Cancer Services Improvement Plan with identified local improvement and on-going engagement in Clinical Reference Groups (CRGs) and review of best practice;
 - Review of pathways with consideration to One-Stop services; 'Direct to Test'; and implementation of advanced clinical practice with extension of roles;
 - Optimisation of available capacity and modernisation of clinical practice;
 - Maximisation of non-recurrent funded capacity and validation of waiting lists;
 - Improved communication to Primary Care and patients regarding access times;

The Trust continues to manage risks in line with the Performance Management framework and associated risks are identified on the corporate risk register.

Human Rights/Equality:

None noted.

Concerns

- 25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.**

25.1 I would escalate my concern to the Assistant Director for Cancer Services as he is my line manager. Following this I would complete a Datix independently or in conjunction with the Assistant Director.

- 26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, or any other matter regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.**

25.2 Having responsibility for cancer access targets I continuously flagged delays for first appointments at Cancer Performance meetings both at local and HSCB level. A breach report is completed each time that a patient breaches the cancer access ministerial target which is 62 days from date of referral to first definitive treatment. They are prepared by the cancer administration team. These reports are shared at the monthly Cancer Performance meeting. Breach reports were examined and shared in order to find improved ways of working. The issue of late triaging within Urology service has been escalated via Assistant Director to Director of Acute Services on various occasions. I would have been aware of this when examining breach reports and delays in first appointment to Urology service. The cancer team flagged and escalated delays regularly with the Urology Head of Service. MDM attendance (Urology) - there have been challenges with attendance at Urology MDM meetings in particular from Radiology and Oncology. This was escalated to HSCB and there were regular regional Oncology Pressures meetings to try to address this. There was also some regional work done to explore other ways of working

within MDTs - set up pathways. Urology MDTs were explored but this work was not taken forward by HSCB as clinicians were concerned that there would be too many protocols required for Urology patients as pathways were multi-faceted. There is an ongoing challenge with recruitment of Oncologists across the region and this has been well recognised at Department of Health level, and this continues.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

27.1 I was not made aware or have been privy to any individual's practice within Urology services as this would have been managed within the Speciality and would not have been shared with me.

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

28.1 I highlighted the concern of delays in getting Urology patients triaged by Mr O'Brien, for further detail please see Question 29..

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

29.1 The issue of late triaging within Urology service has been escalated via Assistant Director to Director of Acute Services on various occasions. I would have been aware of this when examining breach reports and delays in first appointment to the Urology service. The cancer tracking team flagged

1 information of May 2018. We can look at that at
2 WIT-91043. This is a document -- is this a document
3 you completed?

4 A. Yes. This was an action plan completed on the back of
5 the serious concerns that were raised. 10:53

6 83 Q. This was updated in May 2018. Can I just ask before we
7 go to May 2018, do you have any knowledge of what
8 happened after the peer review when these serious
9 concerns were highlighted in October 2017? Was there
10 any action taken at that point? 10:53

11 A. Yes. From a point of view of the oncologist gaps and
12 the radiologist, unfortunately at that time we did have
13 deficits in Oncology. The Oncology Services obviously,
14 it's like a hub and spoke model, the Cancer Centre was
15 in Belfast and the oncologist came out from the Cancer 10:54
16 Centre to the units. At that time, 2015, there was a
17 regional roll-out of acute oncology consultants. We
18 also were preparing to open the Northwest Cancer
19 Centre, and there just wasn't enough oncologists to
20 meet all of those needs. That was highlighted various 10:54
21 times to Health and Social Care Board. Indeed, there
22 was oncology pressures meetings regularly to see how we
23 could cover the demand for services, and there just
24 wasn't enough cover to meet all of the demands from a
25 clinic provision, acute oncology, to MDT cover. There 10:55
26 were gaps. Those were well recognised at department
27 level.

28
29 we did have then a piece of work started in 2018 led by

1 the Health and Social Care Board, looking at oncology
 2 transformation and how we could try to bridge some of
 3 the gaps. That was a huge piece of work and there were
 4 lots of deficits. There was also a paper shared by the
 5 Health and Social Care Board where Cancer Research UK 10:55
 6 done a scoping exercise looking at how we could
 7 actually make our MDTs more effective. There were a
 8 few workshops here where there was suggestions looking
 9 at protocolised discussions, and we were talking about
 10 piloting some of that. However, that never really was 10:56
 11 taken forward; it didn't really go anywhere.

12
 13 We were trying and we were escalating and we were
 14 trying to actually see how we could improve the quoracy
 15 within MDT. So, there were lots of regional 10:56
 16 discussions to try and address some of the gaps.

17 84 Q. If we just look at this plan again that's completed
 18 just seven months after the peer review. There's four
 19 serious concerns on it; three are of interest for our
 20 purposes. The first one is "No cover in place for the 10:56
 21 clinical oncologists and the consultant radiologist."

22
 23 The update of May 2018:

24
 25 "Clinical oncology representation core and cover 10:57
 26 provided through the regional oncology centre when
 27 possible but it is not the same person each time and is
 28 still not consistent. For consultant radiology
 29 representation, no cover for the radiologists, though

1 prioritise the acute work and your attendance on the
 2 acute work rather than attendance at an MDT?

3 A. Well, it would usually be one of two things. It would
 4 usually be an acute CT list, so inpatients who needed a
 5 scan, needed a radiologist for that list. The other 14:04
 6 was we have a thing called general inquiries, which is
 7 a radiologist available basically for inquiries, so
 8 doctors to come and speak to a radiologist. Also, just
 9 to come and mop up any emergency work that is falling
 10 outside of the CT work, so urgent cases that needed to 14:04
 11 be done. So we always have an acute CT radiologist for
 12 every session, and some sessions usually -- I think in
 13 the afternoons now we have a radiologist for the
 14 inquiries session.

15 234 Q. The fact that on occasions you had to fill in on the 14:04
 16 clinical side rather than be granted time to get on
 17 with prep for MDT, is that a reflection of the fact
 18 that the Trust had been unable to recruit sufficient
 19 radiologists or a urologist to divide the labour?

20 A. I think it's a combination of things. As the MDT was 14:05
 21 kind of in its infancy in the first few years, I think
 22 the Trust was probably still prioritising the acute
 23 work. It probably didn't, as I said, didn't really
 24 appreciate the need to keep both my Wednesday afternoon
 25 and the Thursday afternoon sessions free so as not to 14:05
 26 take my prep time. They maybe didn't appreciate that.
 27 In addition, I was the sole person available. I will
 28 just summarise the other things so I can tell you
 29 there. So, if I took leave on a Wednesday afternoon or

1 a Thursday afternoon or study leave on either of those
2 days. So, all of those things were the reason why I
3 wouldn't be at an MDT.

4 235 Q. Yes. Could I seek your views on something Dr. Hughes
5 has told the Inquiry? Dr. Hughes, you may know, was the 14:06
6 senior reviewer on a series of serious adverse
7 incidents which were reviewed in 2020 in the Trust and
8 into 2021. He addressed the issue of quoracy in his
9 evidence. If we go to TRA-02027. Just halfway down
10 the page, the Chair asks a question in relation to 14:06
11 quoracy. I think upon reading Dr. Hughes' answer, the
12 question incorrectly refers to radiology as opposed to
13 oncology. So, oncologists were expected to attend the
14 MDT; isn't that right?

15 A. Yes. 14:07

16 236 Q. The answer that Dr. Hughes gives in relation to this
17 issue was that the urology service is a very large
18 service. And, again, I think that should be oncology.
19 It's a bit confused.

20
21 "The oncology service is a very large service and they
22 did the lung cancer service in the afternoon, which is
23 very large and complex as well and they simply didn't
24 have the time. As well as that, it was staffed by
25 rotating locums so there was no continuity. Even 14:07
26 though it may have been quorate one or two times, it
27 may not have been the same professional. In essence,
28 you didn't have embedded oncology within the team on a
29 stable basis."



Urology Services Inquiry

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

20.1 The uroradiological aspects of my job would be discussed with individual urologists (in person or by email) or at the Urology MDT. I have no formal meetings with the urologists other than the MDT. These meetings are weekly (on a Thursday afternoon) and patients are listed for discussion by urologists. I attend when I am not on leave. When I am on leave, another radiologist now attends, unless that person is also on leave.

20.2 If there are issues to raise in regard to uroradiological practice then these will be discussed with the urologists in person or by email. Such issues would relate to overall and not individual practice, for example how a service could be improved. An example would be the multiplicity of examinations to answer the same clinical question, for example general practitioners requesting ultrasound and a urologist requesting a CT scan.

20.3 When only a single radiologist (me) attended the MDT and that radiologist was on leave, there would not be a radiologist present. The issue with a lack of attendance by a radiologist was an issue for a prolonged period of time (I do not know the interval) and this was mentioned at the MDT on a number of occasions (I do not recall when, by whom specifically (although most likely Mr O'Brien and Mr Glackin) or how often) but this was not solvable in the absence of an appointment of an additional radiologist, which was the Trust's responsibility and I cannot comment as to how much effort the trust made to achieve this but I am of the opinion that the Trust did not do all it could to appoint an additional radiologist by making an attractive job, particularly when in competition with other Trusts both within Northern Ireland and the UK. I think, but I cannot be sure, that the MDT chair (both Mr O'Brien and Mr Glackin) have raised the issue of radiology cover with the relevant

1 A. Yes, and I think that's true. The problem is that
 2 radiology is -- there's a shortage, a big shortage of
 3 radiologists and a lot of places don't even advertise
 4 any more because they just can't fill their posts. So,
 5 newly qualified radiologists can almost pick and choose 14:12
 6 where they want to work. The departments have to make
 7 themselves as attractive as possible to those people
 8 who are coming, which, it's difficult, you know, in
 9 Northern Ireland, because they're relying, you know,
 10 mostly to the extent on northern Irish trainees coming 14:12
 11 through the programme who generally don't have much of
 12 an interest in uro-radiology as opposed to the UK -- to
 13 England, sorry, where there are a lot of
 14 uro-radiologists. But here there seem to be quite few,
 15 you know, if any really. So they're perhaps not 14:12
 16 exposed to that specialty and, therefore, not really
 17 enthused to do it. I think, you know, there is a sort
 18 of combination of factors.

19
 20 So, to be in competition with other Trusts within 14:12
 21 Northern Ireland and the rest of the UK, you have to do
 22 something extra to make your job appealing, whether it
 23 be an attractive job plan, the on-call is good.
 24 Because the on-call is always a problem and it's
 25 something, you know, applicants will look at, whether 14:13
 26 there's ability to work at home; any financial
 27 remuneration, things like that. You know, a good job
 28 advert, for example.

29 240 Q. We can see from some of the materials that have been

1 unfortunately, they are associated with a higher
2 discrepancy rate. It would take me longer to review
3 those cases rather than me having reported them in the
4 first -- I mean, I had to review the whole case. There
5 could be anything on them, right, wrong or miss, false 14:37
6 positive, false negative, anything. So, it took me a
7 lot longer when that was happening.

8
9 I don't think the urologists trusted the reports
10 either. So, I think there were issues with the reports 14:37
11 that were done outside of the hospital.

12 260 Q. Yes. The question, if I can go back to the question I
13 asked, which was do you think it was the intention of
14 the Trust in asking the independent sector to become
15 involved, was that with a view to trying to free up 14:38
16 your time, and the time of others perhaps, to address
17 this demand issue, even if the consequence was, as
18 you've described, leaving you to deal with poor quality
19 reporting and costing you more time in the long run?
20 The question is focused on what was the intention in 14:38
21 going to the independent sector.

22 A. I'm not sure why they did that. I think it certainly
23 wouldn't have any impact on the Urology MDT. The two
24 are completely independent. Obviously, if you send
25 work out, then it gets rid of your backlog. That's the 14:38
26 only reason really you would send it out.

27
28 I think the problem was that whilst work was being sent
29 out, what the Trust did at that time was they stopped

1 the waiting lists in combination with the outsourcing
2 of the urology work. There was actually no problem
3 really in us reporting it, because we did it as sort of
4 extra work. So, when I couldn't do -- when the
5 (inaudible) became too much, we took it on as the extra 14:39
6 work and reported it to the same high standard that I
7 would have done however or, you know, on whatever basis
8 I reported it at. When it was outsourced, I think the
9 additional work we were able to do was then stopped, so
10 it was kind of an alternative to that. 14:39

11
12 I don't think there's any doubt that, you know, the
13 outsourcing of work helps clear the backlog of work.
14 There's no doubt about that. It just depends on what
15 quality of work you want. 14:39

16 261 Q. We can see WIT-89905. This is 22nd November 2017 and
17 you're writing to David Gracey again. You're referring
18 to an email below with your comments contained in red.
19 I don't think we need to go down to the detail of that
20 for present purpose. But what you're saying, in a 14:40
21 nutshell, is that:

22
23 "We should be in no doubt that the outsourcing of these
24 examinations has caused significant quality issues and
25 prevents the further improvement of our service to the 14:40
26 best it can be. We are already ahead of any Trust in
27 Northern Ireland and we could have done better. I have
28 worked hard to get us to this position and I can do
29 nothing more now. Ask any urologist if they are happy

1 with the service. Managers need to rethink what is
2 happening here. The Trust could always try and
3 recruit."

4
5 So, a number of issues are brought together there. 14:41
6 You're unhappy with the quality of the reporting on the
7 part of the independent sector provider, it's something
8 that could be done better in-house, and things would be
9 much assisted with the recruitment of an additional
10 urologist. Is that the thrust of your response? 14:41

11 A. I think the way I recall is that since I came to the
12 Southern Trust, you know, we have spent a lot of time
13 trying to get the prostate MR service the best it could
14 be, you know, with the assistance of the urologists; to
15 try and make the service the best it could be for 14:41
16 patients. Which, you know, the way that things were a
17 changing from kind of Trust first, then MRIs later, to
18 pre-biopsy MRI is what we'd achieved, and we were
19 trying to move further ahead of that by progressing
20 with fusion techniques to try and locate tumours and 14:42
21 doing reduced numbers of biopsies in targeting tumours,
22 and all of that fell apart as a result of the
23 outsource, basically. That's the way I kind of saw it.

24 262 Q. Yes.

25 A. You know, I felt quite frustrated that all the work had 14:42
26 been put in, to sort of lose that quality.

27 263 Q. If we go to WIT-89464. If we just scroll down to 17.4,
28 please. Or 17.8. Thank you. Dr. Gracey, addressing
29 this, says:

1 anything anyway. The lack of another radiologist was
2 well known without me having to comment on it.

3 274 Q. Your answer there suggests that, I think you said in an
4 earlier answer, maybe four or five occasions when
5 general radiologists would have attended if you weren't 14:50
6 available. You point there to a number of examples,
7 two examples, of misdiagnosis or inappropriate outcomes
8 arising from their consideration of cases when, is it
9 fair to say, they weren't sufficiently expert to give
10 the opinion? 14:51

11 A. Yes, I think that's true. I mean, I do recall both of
12 those cases actually. You know, these are infrequent
13 but they're just an example of why, if you have a
14 specialist MDT, you need a specialist radiologist at
15 that MDT. I fully appreciate, you know, my colleagues' 14:51
16 attempts to cover the MDT and why they would do it for
17 the service but it's not always helpful. I think just
18 having the knowledge and the expertise and breadth of
19 the cases, you know, helps you make decision-making.

20
21 In regard to the nephrectomy, I think it was again
22 probably because there was a review of imaging without
23 a radiologist present, and I think maybe the report was
24 maybe sort of taken as fact. But, you know, again
25 opinions vary. 14:52

26 275 Q. Well, is it your firm view upon consideration of this
27 in the presence of pathology that a nephrectomy was
28 unnecessary?

29 A. Well, I mean, that would be a very easy assumption to

1 make if you had the pathology. But no, I saw the
2 imaging first and thought I don't think this is going
3 to be malignant.

4 276 Q. Yes.

5 A. But, you know, again I'm not the definitive opinion. 14:52
6 Other radiologists may hold a different view.

7 277 Q. But I suppose in an appropriately resourced MDT, you
8 would have two radiologists present, hopefully both
9 with some expertise in uro-radiology or some interest in
10 uro-radiology, and that would be talked through and the 14:52
11 right answer arrived at, whereas what you're pointing
12 to here was a situation where a general radiologist was
13 present, no doubt doing their best to assist to
14 progress the case in these resource-challenged
15 circumstances, but the right answer not being arrived 14:53
16 at?

17 A. Well, I mean, I don't think there was any radiologist
18 there for the nephrectomy case. I think, you know, the
19 answer is, I mean, the gold standard would be having
20 two to three radiologists at every MDT, with each one 14:53
21 having prepped all the cases and come to an opinion on
22 each one and then those cases discussed. But I'm not
23 aware of anywhere that that happens.

24 278 Q. Hmm.

25 A. I don't know if any radiology department could manage 14:53
26 that.

27 279 Q. If you could help the Inquiry with this: Is that
28 situation, or both those situations but maybe focusing
29 on the major surgical intervention that a nephrectomy

1 involves, is that kind of thing very uncommon where a
2 uroradiologist is present at the MDT, that kind of
3 mistake?

4 A. I don't think these cases would be common. They
5 wouldn't be a common occurrence. I mean, we review a 14:54
6 lot of cystic lesions in MDTs and we suggest whether we
7 should continue with follow-up or whether something
8 more needs to be thought about. I think we hardly ever
9 would see patients with nephrectomy for a benign
10 lesion; it does happen. The most common example would 14:54
11 be on a cytoma, for example. I think that would be
12 acceptable. But I don't think I ever see cysts that
13 are benign; hardly ever see that.

14 280 Q. Yes. A case or cases like this - and you can only
15 think of two examples where a general radiologist may 14:55
16 have expressed a view on it - would they have gone, the
17 latter, into the governance system to be queried and
18 questioned whether an incident report or leading to an
19 SAI, or how would issues like that have been handled?
20 Because they are reflective, are they not, of an MDT 14:55
21 and of a process that's not well-resourced leading to
22 harm to patients?

23 A. Yes. I mean, I think if there was -- yeah, if there
24 was a radiological discrepancy that resulted in harm,
25 then there would be an incident report. We do fill in 14:56
26 Datix for the odd occasions that something happens like
27 that.

28
29 For a surgical one, I would never do that one myself,

1 testicular lesion for which follow-up was suggested and
 2 none was required, and a patient given a nephrectomy
 3 for a benign lesion.

4
 5 "In regard to the latter, the case was rediscussed at 14:49
 6 the Urology MDT with histology, where I reviewed the
 7 kidney lesion for which the nephrectomy was performed
 8 and I considered it unlikely to be malignant."

9
 10 To pick up with issues arising from that paragraph. 14:49
 11 where you say you didn't have a personal concern about
 12 the quoracy issue, can you explain what you meant by
 13 that?

14 A. Yeah, I think I probably haven't phrased that in the
 15 right way necessarily, it appears rather blunt. What I 14:49
 16 mean is it kind of -- I mean it wasn't sort of my
 17 responsibility to solve the problem. Obviously it was
 18 a concern that, you know, I was the sole person and the
 19 Trust could do better than it was doing. I mean that I
 20 had raised the issue and it wasn't my issue, it wasn't 14:49
 21 my problem to sort, it was someone else's problem.

22 272 Q. Yes.

23 A. In fact, there was nothing I could actually do to solve
 24 it anyway.

25 273 Q. We can see that you brought issues to the table and 14:50
 26 raised concerns. From your perspective, you weren't
 27 able to achieve change around that?

28 A. It wasn't within -- I had no ability to make any
 29 change. You know, I actually didn't really need to do

1 A. External Beam Radiotherapy.

2 407 Q. I'm obliged. The patient had been started on
3 Bicalutamide high dose to 150 prior to the MDM, ran
4 into side effects and was reduced to 50mg, and then up
5 to 100. There was - I use these words advisedly - 15:56
6 there was a bit of play with the Bicalutamide.

7 A. Titration might be the term I would use.

8 408 Q. The upshot was that the patient was not referred --

9 A. Yeah.

10 409 Q. -- to radiotherapy until the summer of 2020, when he 15:56
11 had disease progression?

12 A. Yes.

13 410 Q. And the prospects were bleak, and was referred at that
14 point by Mr. Haynes, I think in June or July 2020...

15 A. Okay. 15:57

16 411 Q. -- eight months after the MDM.

17 A. Yeah.

18 412 Q. Can I ask you this: Do you support the recommendation
19 or the conclusion of the MDM - sorry, the SAI, I should
20 say - that in cases like that, to use that as a 15:57
21 scenario, any deferment or variation from the MDM
22 decision should, first of all, be recorded in the
23 clinical notes?

24 A. Yeah, if you're going to vary from a recommendation,
25 you'd need very good grounds to do it, and you need to 15:57
26 record that, you need the consent of the patient. And
27 I think as we've said, you would bring it back to the
28 meeting if there's a significant variation.

29 413 Q. Yes. I know you've explained that that would not

1 always have been your practice --

2 A. I think when there were minor variations.

3 414 Q. Yes, that's what --

4 A. Patients unfit for treatment, you know, you're clearly

5 not suitable, then I would record that in the notes. 15:58

6 It would be very clear to anybody coming behind me that

7 this is the reason I've made this decision.

8 415 Q. Was there - I think you've described your practice now

9 as "any variation" and invariably bring it back --

10 A. More or less, yes. 15:58

11 416 Q. To avoid criticism, and maybe implied within that is

12 that you don't always think it's necessary because it's

13 a minor turn in the road as opposed to a fundamental

14 turn in the road. Can you --

15 A. Yeah, it's removal somewhat of our clinical judgment, 15:58

16 but there you go.

17 417 Q. Yes. Can you outline for us perhaps the test that you

18 would have applied, before your more universal approach

19 now, in determining whether I need to go back for

20 revalidation of the approach? 15:59

21 A. Yeah, I think now it's pretty much everything,

22 Mr. Wolfe.

23 418 Q. Yes. I get that point. But what was it before that?

24 what was the fundamental?

25 A. Take, for instance, a case where it was quite clear 15:59

26 that a patient was - had an advanced cancer that was

27 going to require palliative care, rather than referring

28 them for the likes of external beam radiotherapy for

29 bladder cancer or something like that. So my practice

6.0 FINDINGS

for initial biopsy.

- The patient's care was through a Multidisciplinary Team process but unfortunately they did not benefit from it. The Multidisciplinary Meeting failed in its primary purpose to ensure patients received best care as defined by Regional and National Guidelines.
- The Urology MDM was under resourced and frequently non quorate due to lack of professionals. The MDM had quorate rates of 11% in 2017, 22% in 2018 0% in 2019 and 5% in 2020. This was usually due to lack of clinical oncology and medical oncology. Radiology had only one Urology Cancer Specialist Radiologist impacting on attendance but critically meaning there was no independent Quality Assurance of images by a second radiologist prior to MDM.
- The Urology MDM was under resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment (that is 31 and 62 day targets). It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care.
- Safe cancer patient care and pathway tracking is usually delivered by a three pronged approach of MDT tracking, Consultants and their Secretaries and Urology Specialist Nurses, in a Key Worker role. The Review found that these 9 patients were not referred to Specialist Nurses and contact telephone numbers were not given. Therefore the CNS were not given the opportunity to provide support and discharge duties to the 9 patients who suffered as a consequence. The MDM tracking system was limited. The consultant / secretary led process was variable and resulted in deficits. The weakness of the latter component was known from previous review.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non implementation of these MDM recommendations was unknown to others in the MDM. One patient D presented as an emergency and his care was changed to the MDM recommendation by another consultant.

Multidisciplinary working and referral

- The review team noted repeated failure to appropriately refer patients
- Service User A should have been referred to oncology initially and then to palliative care as his disease progressed.
- Service User B should have had an earlier diagnosis and referral to oncology.
- Service User D should have been referred to oncology and palliative care.
- Service User E should have been referred to oncology for time critical care.
- Service User F should have been referred to oncology.
- Service User G should have been referred to the Small Renal Mass Team.
- Patient H should have been referred to the Regional / Supra-Regional Penile Cancer Network according to NICAN Urology cancer guidelines 2016 but a

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Regional Penile Cancer Pathway was only agreed in January 2020. Patient H should have been referred to the Regional / Supra-Regional Penile Cancer Network according to NICAN Urology cancer guidelines 2016 and, although a Regional Penile Cancer Pathway was only agreed in January 2020, referral to a specialist with appropriate experience should have been pursued.

- Patients were not aware that the care given varied from Regional Standards and MDM recommendations. They could not have given informed consent to this.
- All patients were not referred to Urology Cancer Nurse Specialists despite this resource being increased by the Southern Health and Social Care Trust. Peer Review 2017 was informed that this resource was available to all. Their contact numbers were not made available.
- As patients were not re-discussed at MDM and Urology Cancer Nurse Specialist were not involved in care, non referral was an unknown to others within the MDM.

Patient Support and Experience

All patients or families reported a positive experience with their treating consultant initially.

All patients and families were unaware of the additional support available to other patients.

Where patients had disease progression, they expressed concern at the disjointed nature of service provision and the inability to access supportive care. As they were unaware of the normal support mechanisms they believed this to be the normal standard of care or a standard that had been compromised by Covid 19 Pandemic.

All patients and their families were shocked by the fact that their care was not supported and that the care did not follow MDM recommendations. This was especially true when appropriate care should have entailed onward referral to oncology or palliative care.

Affects of Covid

- Some patient's planned review appointments did not go ahead but were rescheduled virtually. Some of the patients did not have their planned review in March / April 2020.
- The review team after speaking with the families and hearing their stories learned that for many of these patients they could not access services in their locality due to the covid restrictions. At the time two families described having difficulty accessing district nursing services for intravenous antibiotics in the community as services were stood down. One family expressed dismay at having difficulties visiting their loved one prior to his passing in hospital due to the covid restrictions and the emotional impact this has had on their grieving process. Others described how when catheters blocked they could not access

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BACKGROUND & CONTEXT

In relation to the Southern Trust’s Urology Lookback Review and process called a Structured Clinical Record Review, which was adapted from the Royal College of Physician’s Structure Judgement Review methodology, is utilised in the place of the more common SAI review methodology to ascertain more information about cases that meet the threshold for review (the same threshold as an SAI).

OBJECTIVES OF STRUCTURED CLINICAL RECORD REVIEW

- i. To evaluate the safety and quality of care provided to urology patients under Consultant A, to provide information about the gaps, problems and/or difficulty in the process, the specialty and across the service.
- ii. To provide the Trust with a determination on whether areas of concerns identified at the various phases of care resulted to patients being harmed. This determination will enable the Trust to take action to mitigate the harm and to prevent other patients from being exposed to similar harm.
- iii. Identify learning themes to inform changes to policy and practice

SUMMARY OF LEARNING THEMES

The following clinical themes have been gleaned from the analysis of the completed SCRR that have been returned to the Trust extracted from returned SCRR Reports received:

- Delays or absence of reports/ investigations;
- Lack of / poor communication;
- Incorrect treatment;
- Un-actioned MDM outcomes including onward referrals and planned reviews;
- Delays / omissions in triage;
- Not following up on / actioning outcomes of diagnostic scans;
- Prolonged use of antibiotics;
- Practice in relation to operative procedures, including the removal of stents and gaining consent;
- Prescription of unlicensed medication as an incorrect form of treatment;
- Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions;
- Not providing patients with options and choice in relation to their treatment pathway (informed consent);
- Not following NICE guidelines.
- Unjustified rationale for deferring treatment (new theme)
- Unorthodox treatment pathway (new theme)

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This table describes the reason(s) why a case was screened into the SCRR process and the clinical shortcomings identified / documented within the returned SCRR Report.

1.	Patient t.68 Personal information redacted by the USI	- Initial diagnosis in 2011. Treated with Bicalutamide 150mg then subsequent LHRH. Had non metastatic disease at presentation. - No discussion of radiotherapy until 3-4 years later. Referral then made to Radiotherapy 2016/2017. High risk localised cancer. - MDM Outcome not followed and could have been off treatment if referred to radiotherapy earlier. - Radiotherapy was recommended, no mechanism for tracking MDM outcomes. - Patient has now been treated and is currently on appropriate treatment.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Incorrect treatment; - Not following NICE guidelines. - Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions;	- Plan to start hormone manipulation with LHRH analogue and refer to Oncologist for consideration of Radiotherapy was recommended. - Surgery does not appear to have been advised as a suitable option although in some centres this may have been considered as a treatment modality. - There does not appear to have been discussions around treatment options or referral to Oncology as per MDM. - No return discussion to MDM and a letter to indicate a review in March 2013 is not located. - Hand written notes indicate possible referral to Radiotherapy but no letters to support. - In Oct 2015 a letter indicates the 1st discussion regarding Radiotherapy described as “Ambivalent”. There does not appear to be a full discussion or counselling of different objectives. Also notes requirement for further investigations related to GI bleeding, however in subsequent review in Feb 2016 this again suggests referral to GI team but there is no letter to support. - Delayed dictation June to Dec 2016. Included referral to Oncology and notes patients’ preference to initially not go ahead with radiotherapy and to have hormone treatment. Patient was eventually “persuaded” to consider this. - The patient was seen 6 years after diagnosis by the Oncology team. - Patient was not allocated CNS. - MDM recommendations were not followed. - Numerous long delays in follow up appointments and associated correspondence. - Prolonged Hormone therapy - Earlier treatment would have delivered a superior clinical outcome. - It will take numerous years of follow up to determine if these delays have compromised outcome	Yes	Poor Care	SCRR Report noted the lack of Urology CNS involvement Also noted: - Delayed dictation - No subsequent MDM referral/discussion

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2.	Patient 43 Personal Information redacted by the USI	- Admitted and catheterised for high pressure retention. Had 2 TURP procedures and CVA after 2nd TURP. Commenced on off license Bicalutamide which resulted in patient experiencing dizziness. - No evidence of discussion regarding off license use or risks. - No offer of alternatives to TURP for large glands. - Prostate volume not assessed formally on initial admission. - If had of been offered Holum Eucleation treatment would only of required 1 general anaesthetic. - NICE guidelines recommend prostate volume of greater than 80 that alternative treatment to be used. The patient could of avoided a 2nd GA which resulted in a stroke. - Cardiovascular complications increase after 1st GA. Patient was 87 years at the time.	- Prescription of unlicensed medication as an incorrect form of treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Lack of / poor communication	- Numerous opportunities to consider TURP and enhanced risks in context of large prostate gland. - Poor documentation of counselling and balanced decision making. - Concern patient had a 2nd TURP. - Opportunities to take stock of prostate volumes and impact of this on decision making seem to have been overlooked or missed as part of counselling. No mention of using BAUS leaflets to help. - Patient consent form falls far below acceptable standards - Perioperative management of Apixiban appears unclear and may have contributed to problems of secondary bleeding (x2) as drug started very soon after surgery. - Cannot see reference to an apology or exploration of duty of candour. - The use of Bicalutamide as a treatment option for BPH is not recognised.	Yes	Very Poor Care	SCRR Report identified the issue with Consent for the 2nd TURP procedure. SCRR Report also noted the potential impact the Apixiban had on the bleeding experienced post operatively. Also noted: - Delayed dictation - Prolonged hormone therapy

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SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
3.	Patient 17 Personal Information redacted by the USI	82 year old with known history prostate adenocarcinoma from March 2011. Patient is on Bicalutamide 50mg. - From March 2012 PSA rising. MDM advised hormones and radiotherapy. - Not clear is patient was ever brought back to MDM. No mechanism at present to check or follow up of recommendations.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment - Lack of / poor communication - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions; - Not following NICE guidelines	- The patient had the diagnosis explained but there was no involvement of trained CNS or “Keyworker”. - The patient was put on hormone treatment but not referred to Oncology. - No further treatment was discussed, offered or documented. - Poor recording of a number of follow up consultations. - After a long period of time it was identified that the patient had not been referred and had been kept on hormones alone inappropriately. - Denied option of a cure of his prostate cancer however may have been exposed to the risks and side effects of overtreatment if he had gone ahead with radiotherapy.	Yes	Very Poor Care	SCRR Report noted the lack of Urology CNS involvement

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SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
4.	Patient 4 Personal Information redacted by the USI	- Prostate cancer on androgen deprivation therapy, Bicalutamide and Tamoxifen. - Commenced on low dose Bicalutamide then increased to 150mg. Patient should have been offered radical treatment in 2014. - Subsequent coincidental finding of renal tumour on review and restaging of prostate cancer.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Delays / omissions in triage - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Not following NICE guidelines.	- No input of Oncologist until 2021. The patient was not triaged to a prostate cancer pathway at the outset with delay in initial diagnosis as a consequence. - Following biopsies the patient did not receive any form of discussion regarding standard treatment options for intermediate risk localised prostate cancer ie surveillance vs radiotherapy. - For no apparent reason the patient was started on Bicalutamide 50mg once daily as monotherapy which is not recognised as a treatment for localised prostate cancer. There is no discussion of radiotherapy as a potentially curative treatment option. - Clinician acting in isolation and not delivering prostate cancer treatment according to the guidelines or medical evidence. The MDT outcome was not adequate in terms of treatment advice. - If the patient had an informed decision and correct treatment options, he may have selected surveillance with no treatment and no side effects or he may have chosen radical radiotherapy with a short period of hormone ablation therapy of perhaps 12 months. - If the patient had chosen radical radiotherapy in 2014 then they may have had a better prognosis with a longer cancer specific survival.	Yes	Poor Care	SCRR noted the triage issue which lead to the delay in diagnosis.

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	Patient ID: 35 Personal Information redacted by the USI	- Initial diagnosis in 2009. Gleason 7 T2. USS biopsy in 2012 Gleason 7 and PSA of 3.9. Received lower and unlicensed dose of Bicalutamide. - No record of discussion of surgery Delay in referral to radiotherapy.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Lack of / poor communication; - Not following NICE guidelines.	- Localised prostate cancer not treated in accordance with standard practice. - No offer of radical treatment for a fit 59 year old with localised T2 Gleason 7 Prostate Cancer. - Radical treatment given 5 years later in the form of radical radiotherapy. - This delay may have well had a significant adverse impact on cancer specific survival. Although radical treatment in 2009 may not of been curative, earlier treatment would of improved prognosis. - Inappropriate use of Bicalutamide Monotherapy. And could have avoided side effects of Bicalutamide. - Poor communication with patient and the MDM. - Cancer treatment guidelines were not followed, patient denied potential curative treatment option. - Patient developed metastatic disease in 2019 with bone metastases. Suboptimal management may have contributed to early progression of disease. - The patient did not receive standard of care for localised prostate cancer diagnosed in 2009. At that point the case should of been fully discussed at the MDM and been offered active radical treatment in the form of either radical prostatectomy or radical radiotherapy. For some reason his did not take place and the patient was placed on active surveillance which would of only been appropriate in the presence of extensive comorbidities limiting life expectancy.	Yes	Very Poor Care	
5 (b)	Patient ID: 35 Personal Information redacted by the USI	- Separate issue discovered following review of prostate cancer management. - Unclear rationale for proceeding with Partial Nephrectomy procedure in 2009. - External reviewer completed 10 Ques PRF on this specific treatment and determined that the surgical procedure was potentially inappropriate and there should be a further review of the indication, pre operative education and consent.	Lack of / poor communication	- Missing record to GP following review in October 2008. This was unreasonable. - Letter written in hindsight in Nov 2008. States biopsy of lesion was arranged- this would only be considered reasonable if cancer was considered. There is no record of discussion with the patient or the MDM regarding this. - Further letter dictated in retrospect on the 3.11.2009 following clinic on 11.9.2009. - Rationale for surgery in the referral letter to the pain team was partly pain relief and partly concern over whether the lesion was neoplastic- this is the first time this was mentioned. - Although the size of the cyst would not commonly be the cause of pain and the majority of urologists would not advise treatment. It is not unreasonable if the patients pain was so problematic and in the absence of any other identifiable cause to offer an aspiration. - There may have been an undercurrent of concern that this may have been malignant but this was not recorded as factored into the decision making. - The risks of pain not resolving were included on summary of decision to proceed to surgery based on fact that this may be the only way to diagnose the cause of the pain.	No	Adequate Care	

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6.	Patient 66 Personal Information redacted by the USI	Commenced on low dose Bicalutamide and placed on waiting list for TURP with the intent that the TURP would improve the urinary symptoms and to obtain tissue for pathology with regards to prostate cancer diagnosis being likely.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Not following NICE guidelines. - Not following up on / actioning outcomes of diagnostic scans; - Delays / omissions in triage	- Late triage of referral. Delayed outpatient triage and the decision to await histology from TURP. - Delay in histological diagnosis with no urgent biopsy. - Inappropriate hormone ablation therapy with low dose Bicalutamide. No requirement to start this treatment. - No offer of radical treatment. - Poor communication and no definitive MDM treatment plan. - No impact on overall survival but the side effects of hormone treatment could have been avoided for a prolonged period of time. - Prostate cancer management was not standard practice.	Yes	Very Poor Care	SCRR Report noted the delay in original triage. Referred 11th June and not seen in clinic until 2nd August. 8 week delay is not compatible with cancer guidelines. SCRR Report also identified that initial assessment was suggestive of locally advanced prostate cancer. Appropriate imaging requested but biopsy not undertaken. Instead listed for a TURP.

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7.	Patient 18 Personal Information redacted by the USI	- Initial hormone treatment with Bicalutamide 50mg. Patient discontinued themselves due to side effects. - Later referral for radiotherapy. - Diagnosed September 2011 and then seen in November 2012 for discussion for surgery. Then referred for Radiotherapy. This was a delay in referral for radical treatment.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Not following NICE guidelines.	- Patient was not started on appropriate androgen blockade and was given a low dose of Bicalutamide which provided side effects with no clinical improvement. These side effects were for 7 months and when he wrote to the surgeon he was then reviewed and referred to Radiotherapy. - The patient was not referred to radiotherapy as suggested by the MDM. - The dose of Bicalutamide was a small dose that should have been followed by LHRH analogues to prepare for radiotherapy.	Yes	Very Poor Care	

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8.	Patient 76 Personal Information redacted by the USI	• Urodynamic studies showed no evidence of bladder issues in 2012. • In 2014 added to the waiting list for a TURP. No evidence to support consent and discussion of risks or benefits. • Patient now has incontinence. • Potential decision making not clear as there is no indication/ justification for the procedure in the notes and investigations showed no obstruction. • Cancer was an incidental finding.	• Not following NICE guidelines. • Lack of / poor communication; • Un-actioned MDM outcomes including onward referrals and planned reviews; • Practice in relation to operative procedures, including the removal of stents and gaining consent;	• Patient had urodynamics that didn't prove bladder outlet obstruction, had a cystoscopy given the symptoms and it showed a large obstructing prostate. • Patient listed for TURP in 2014 and had this in 2019 and there was an incidental finding of low grade prostate cancer. • No record of discussion on justification of the surgery with the patient/ family. Not clear if pro's and con's were discussed. • Long delay between listing for surgery and having this. No records of discussion of management options. • No clear justification to proceed to TURP.	Yes	Poor Care	

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SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
9.	Page 11 of 28 Personal Information redacted by the USI	• Metastatic prostate cancer, commenced on Bicalutamide 50mg. • MDM recommended LHRHa but remained on Bicalutamide . • No documentation of consultation regarding inferior outcomes of this treatment. • No referral to Oncology.	• Un-actioned MDM outcomes including onward referrals and planned reviews; • Prescription of unlicensed medication as an incorrect form of treatment • Incorrect treatment; • Not providing patients with options and choice in relation to their treatment pathway (informed consent);	• Patient started on Bicalutamide rather than LHRH analogues. Treatment provided is suboptimal and not the recommended treatment for metastatic prostate cancer. • There was no evidence of referral to Oncology to offer further treatment.	Yes	Very Poor Care	

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SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
10.	Patient 23 Personal Information redacted by the USI	• Patient is on watchful waiting following diagnosis of localised prostate cancer in 2011. • Initial discussions about treatment and radiotherapy. • Had a TURP in 2013. • Patient stopped ADT himself and default to surveillance. • Initially prescribed 50mg Bicalutamide which is not a licensed dose.	• Un-actioned MDM outcomes including onward referrals and planned reviews; • Incorrect treatment; • Prescription of unlicensed medication as an incorrect form of treatment; • Not providing patients with options and choice in relation to their treatment pathway (informed consent); • Not following NICE guidelines.	• Unnecessary delay in referral to Oncology to start treatment, due to LUTS symptoms and Stones (total delay of 18 months approx.) • Discussed at MDM but unnecessary delay in referral to Oncology. Was started on Bicalutamide 50mg which is not an adequate dose to achieve androgen deprivation therapy. • Not started on LHRH analogues or referred to radiotherapy in a timely manner. • Dose was adjusted around 18 months after diagnosis.	Yes	Very Poor Care	SCRR Report identified the recorded reasons for delayed Oncology referral were not be appropriate reasons.

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11.	Patient nt 32 Personal Information redacted by the USI	- Intermediate risk prostate Cancer. Started on Bicalutamide 50mg Feb 2014. Switched to LHRHa in May 2015 and radiotherapy in Dec 2015. - Off license dose of Bicalutamide	- Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment	- Patient prescribed low dose Bicalutamide instead of LHRH analogue or dose of antiandrogens of 150mg to achieve deprivation. - Patient was not referred to radiotherapy and delayed to 18 months.	Yes	Very Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
12.	Patient nt 26 Personal Information redacted by the USI	On prolonged dose of unlicensed dose of Bicalutamide	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines.	- Patient given suboptimal dose of Bicalutamide providing no benefit but the side effects of the treatment. - Dose was unlicensed.	Yes	Very Poor Care	

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	Patient 25 Personal Information redacted by the USI	- Off license dose of Bicalutamide 50mg. - Delay in referral for radiotherapy	- Incorrect treatment; - Not following NICE guidelines. - Prescription of unlicensed medication as an incorrect form of treatment; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Delays or absence of reports/ investigations; - Delays / omissions in triage	- Delay of 10 weeks from GP referral to review in clinic despite high PSA & suspected cancer - Not discussed at MDM - Commenced on suboptimal/ unlicensed dose of Bicalutamide 50mg - No clinical benefit of dose and resulted in same side effects of antiandrogens - Long delay in referral to Oncology team for consideration for radiotherapy	Yes	Very Poor Care	SCRR Report noted the delay in referral to review of 10 weeks which is outside of triage guidelines for suspected cancer.
14.	Patient 40 Personal Information redacted by the USI	- Commenced on Bicalutamide 50mg in 2008 on diagnosis. - Referred to Oncology in 2012. Patient raised concerns about delay from 2008 to 2012 for Oncology referral.	- Incorrect treatment; - Not following NICE guidelines. - Prescription of unlicensed medication as an incorrect form of treatment; - Un-actioned MDM outcomes including onward referrals and planned reviews;	- Unlicensed dose of Bicalutamide 50mg - suboptimal dose. - Dose was increased in 2011 to 150mg. - No onwards referral to Oncology to discuss Radiotherapy until 2013 - Management not in accordance with management guidelines. - Delays in follow up appointments	Yes	Very Poor Care	SCRR Report highlighted increased dose of Bicalutamide and that management was not in keeping with guidance at that time.

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15.	Patient 82 Personal Information redacted by the USI	- Treated with low dose Bicalutamide - Not offered radical treatment	- Incorrect treatment; - Not following NICE guidelines. - Prescription of unlicensed medication as an incorrect form of treatment; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Delays or absence of reports/ investigations;	- Referral letter triaged to a routine prostate clinic which is not appropriate with the elevated PSA of 10.8 and the irregular firm prostate. - Referral letter indicated clearly this was likely cancer should have been managed as urgent. - Notes record MDM recommendations of active surveillance however no MDM record is found. - Commenced on low dose Bicalutamide 50mg on basis PSA had not risen above 10. No repeat staging investigations. - No MDM discussion. Patient not advised of treatment options, benefits and risks. - Minimal androgen blockade therapy at 50mg for patient with intermediate risk prostate cancer not standard treatment. - Regular review appointments PSA levels checked but advice on treatment not in keeping with the standard clinical practice at that time.	Yes	Poor Care	SCRR Report noted the missing restaging diagnostics that should have been completed and the missing MDM discussions. SCRR Report highlighted that management was not in keeping with guidance at that time.

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SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
16.	Patient 42 Personal Information redacted by the USI	• Patient in 2017 had raised PSA and had USS completed. • In March 2018 patient went on holiday and had further bloods done in August 2018. • Letter noted bloods to be done in June 2018 and if PSA was elevated to have MRI arranged. • Patient attempted to make contact with Consultant to get results, attempted secretary and still got no response on multiple attempts from Consultant. • Unclear if secretary passed info to Consultant or if the patient was added to the DARO list to ensure follow up following tests. • Head of Service arranged review with another Consultant. • Patient diagnosed and treated for Prostate Cancer and received radiotherapy.	• Un-actioned MDM outcomes including onward referrals and planned reviews; • Lack of / poor communication; • Delays or absence of reports/ investigations; • Delays / omissions in triage • Not following NICE guidelines	• Decision at initial review post triage was to monitor PSA rather than biopsy Patient was not offered early scan and biopsy following discussion of options which could of included surveillance at patient's choice. • No evidence of discussion that potentially could be a localised prostate cancer Gap in PSA monitoring in June 2018 due to patient circumstances but had difficulty in obtaining a follow up appointment and felt uncomfortable with his reviews with the Consultant which resulted in a transfer to another Consultant. • Management following review with new Consultant in accordance with guidelines.	Yes	Adequate Care	Also noted: • Prolonged hormone therapy

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17.	Patient 36 Personal Information redacted by the USI	- MDM recommendation of Surveillance pathway. - Commenced on Hormone therapy - Prolonged hormone treatment and not offered option of surveillance or radiotherapy.	- Lack of / poor communication; - Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment;	- Guidelines not followed - Little interaction with the MDT at the time - Hormone therapy using Bicalutamide for intermediate risk prostate with the patients known comorbidities was not appropriate. No reasonable argument as to why early hormone ablation decision was taken. - Watchful waiting would have been the standard treatment care but the option of discussion with the Oncologist regarding radiotherapy was also a reasonable option to consider. - No discussion with patient regarding options.	Yes	Poor Care	SCRR Report noted lack of communication with the patient regarding options and rationale for treatment.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
18.	Patient 36 Personal Information redacted by the USI	- Bicalutamide 150mg for managing prostate cancer ongoing from 2009. - PSA currently 11.6. - Requires restaging and discussion of options following MDM discussion and recommendation to stop Bicalutamide .	- Not following NICE guidelines. - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Lack of / poor communication	50mg Bicalutamide was initially given before increasing to 150mg dosage. This is not a licensed treatment for localised prostate cancer. Doses changed when PSA values increased. - No discussion with the patient in 2009 of treatment options. The patient had no concept that there was options. - Patient had ongoing side effects of prolonged Bicalutamide including Diarrhoea and required GI referral. - Treatment not delivered in accordance with evidence base. - Lost opportunity for possible radical radiotherapy	Yes	Very Poor Care	SCRR Report noted the increasing dose of Bicalutamide and the additional required referrals due to side effects of prolonged hormone therapy.

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19.	Patient 134 Personal information redacted by the USI	- Commenced on off license dose of Bicalutamide in 2013. - Delayed referral to Radiotherapy.	- Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews; - Delays or absence of reports/ investigations; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment;	- Delay in referral TRUS and biopsy. - Bicalutamide dose increased to 150mg but patient remained on hormones for a prolonged time period - Only increased when lack of response on lower dose. - Unexplained delay in referral to Oncology for consideration of Radiotherapy.	Yes	Very Poor Care	SCRR Report noted the increasing dose of Bicalutamide and the delay in referral for TRUS and biopsy as part of diagnostic pathway.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
20.	Patient 91 Personal information redacted by the USI	Received unlicensed dose of Bicalutamide	- Not following NICE guidelines - Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment;	- Very long delay from the MDM decision to proceed for radical treatment and the referral to Radiotherapy. - Patient started on suboptimal and unlicensed dose of antiandrogen which did not provide complete blockade. - Treatment was not in accordance with good clinical practice or guidelines.	Yes	Very Poor Care	SCRR Report noted the time delay in referral to Radiotherapy SCRR Report highlighted that management was not in keeping with guidance at that time.

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	Patient 46 Personal Information redacted by the USI	Received Bicalutamide 50mg from 2014 to 2019.	- Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews; - Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Lack of / poor communication;	- No discussion of options for treatment of Grade 2 Prostate Cancer Including options of surveillance and radical treatment. - MDM recommendation not followed. - Unlicensed low-dose of Bicalutamide - Side effects of prolonged hormones not discussed	Yes	Very Poor Care	SCRR report noted the lack of communication with the patient and lack of involvement in the decision making process with regards to treatment.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
22.	Patient 37 Personal Information redacted by the USI	- Diagnosed Feb 2020 with high risk locally advanced Prostate Cancer. - MDM recommended radical treatment or surveillance as options but patient was started on hormones with Bicalutamide 150mg and not referred for Radiotherapy. - Since 2015 the PRO7 study specifically details the well-known management of hormones plus Radiotherapy.	- Incorrect treatment; - Lack of / poor communication; - Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	- Outdated management of Prostate Cancer and not following the MDM recommendations. - No discussion of diagnostic tests at presentation. - Patient was denied Radiotherapy option at an early opportunity. - Inappropriate use of Bicalutamide . - Should had surveillance or Radiotherapy plus hormone ablation. - No evidence of patient having had opportunity to discuss treatment options.	Yes	Very Poor Care	SCRR noted that initial presentation in 2016 with rising PSA did not result in discussion for MRI or biopsy. In 2020 PSA had almost doubled patient was discussed at MDM recommendations not followed. Patient could have had an earlier diagnosis or been on surveillance from 2016.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
23.	Patient 61 Personal Information redacted by the USI	- Not offered Radical treatment at the time of diagnosis. Other options would have been surveillance. - Received prolonged dose of ADT which was not indicated. - MDT in 2012 recommended radiotherapy but was not followed up	- Not following NICE guidelines. - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Lack of / poor communication;	- Standard practice in 2012 with a patient of this age and performance status would have been a period of surveillance with option of hormone ablation if there was evidence of disease progression. - Patient did not receive standard care and was not involved in a discussion regarding treatment. - The option of radiotherapy as per MDT recommendation as not communicated to the patient. - There may have been a survival advantage to having radiotherapy sooner. - Patient could have had a time frame with less side effects associated with hormone therapy. - No evidence of shared decision making.	Yes	Poor Care	SCRR Noted the lack of communication with the patient and the involvement of them within the treatment decision making process.

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24.	Patient 64 Personal Information redacted by the USI	- Missing letters from Consultant. - No evidence results were actioned in 2017 (significant PSA increase) until review in 2018. - High Risk Prostate Cancer treated with diagnostic investigation TURP, not standard practice at that time. - Had patient had earlier management in 2017 would be in a different position.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Lack of / poor communication; - Not following up on / actioning outcomes of diagnostic scans; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	- Diagnosed low risk cancer 2018- 5 years from referral. 6 months later disease considered high risk. - Radiotherapy completed 7 years from referral - Delayed referral to Oncology (5 months). Investigations for haematuria requested but could have been in parallel to these. - Staging inaccuracies in records. Unclear what was communicated to patient in regards to anticipated outcomes. - Radiotherapy has not cured him, biochemical failure in Nov 2021. Now side effects from hormone therapy. - Issues with communication and documentation over course of clinical journey. Including discussions with NOK and decisions made without patient. - Could be argued that N1 disease may not have evolved if diagnosed earlier.	Yes	Poor Care	SCRR noted the inaccuracies in staging. Also the delay (years) in diagnosis and onward referral to Oncology.
• Report Updated 23.1.2023							
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
25.	Patient 39 Personal Information redacted by the USI	- Treated with prolonged dose of hormones. - Unlicensed low dose 50mg - Delayed referral to Oncology. Done in 2021 and diagnosed in 2008. - Patient developed metastatic disease.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- Commenced on Bicalutamide 2011 at 50mg. Options from MDM were for continued surveillance or treatment with curative intent. - No evidence that the patient was advised of the risk benefit of each option. - Treatment with this continued until 2014. An MRI scan was requested and repeat biopsies. Gleason score remained as per 2011 biopsy results. - PSA continued to rise in 2015 and 2016. Review in 2017 resulted in increase of Bicalutamide to 150mg. Patient had locally confined curable disease at this stage. - This would have been another opportunity to refer for Radiotherapy consideration. - Reviews in 2018 and 2019 continued on Bicalutamide 150mg. 2020 was restaged as PSA rising. Disease progressed. Changed to LHRH Analogue. 2021 referred for palliative radiotherapy as PSA still rising. - Patient came to harm. Side effects of prolonged hormones and also potentially prevented the progression of the disease being recognised. - Failed to proceed to radiotherapy as early as 2014, increased risk of progression, which would of likely been curable with earlier therapy, and increased survival length of life and reducing need for antiandrogen therapy at that time.	Yes	Very Poor Care	SCRR noted that patient is RIP and no death cert available. Recognised the potential that cause was metastatic prostate cancer this would be a direct result of the care delivered. This should be considered as an SAI.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
26.	Patient 20 Personal Information redacted by the USI	2014 High Risk Gleason 4+3 cancer. PSA remained stable on monitoring. - Treated with Bicalutamide 150mg. - Options at that time as per MDM was surveillance or radical treatment.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment;	- From receiving of referral with PSA of 31 it was 6 weeks until first review. Unreasonable timeframe. - Review of scans by the MDM was delayed by 3 months. - Missing letters to the GP detailing the MDM discussion. - Commenced on Bicalutamide 150mg and plan to review in 3 months was not reasonable as there was no evidence of any curative options being discussed with the patient as per the MDM recommendations. - No action made to refer for Radiotherapy.	Yes	Very Poor Care	SCRR noted the inaccuracies in grading.

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		- No evidence of offering treatment as per MDM recommendations. - Radiotherapy completed in 2021, 7 years delay. - Patient had remained on hormones until radiotherapy offered.	- Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Not following up on / actioning outcomes of diagnostic scans	- Delay in reviews from 2014 to 2017. Had remained on hormones during this time. At this time a plan was for restaging MRI, but the patient was advised to review again in 4 months. - MRI was not completed until 6 months later. - From 2018 until review with new Consultant in 2021 the patient remained on hormones inappropriately. - The grading of the disease was inaccurately recorded. - Radiotherapy completed in 2021. Patient had years of unnecessary antiandrogen therapy and a significant delay in completing radiotherapy. - The patient can also be considered as been subjected to harm in the reduced efficacy of radiotherapy treatment which may increase the chance of tumour recurrence and potential need for extra antiandrogen deprivation in the future.			
27.	Patient not 51 Personal information redacted by the USI	2013 diagnosed with Gleason 3+4 prostate cancer. - Treated with hormone therapy alone. - Options at the time of MDM were for surveillance or radical treatment. - Remained on Bicalutamide until 2020.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- Time to biopsy was 2 months after confirmed of raised PSA. Too long. - MDM in 2013 recommended active treatment including surveillance. - Ongoing review over 18 months noted PSA rise in 2015. Commenced on Bicalutamide 150mg. - Patient should of been restaged and either remained on surveillance or considered curative options of radiotherapy or surgery. - Remained on Bicalutamide 150mg until 2021. - Restaged in 2021 and moved to surveillance pathway. - Bicalutamide was an inappropriate treatment and also masked any potential progression of the disease. - Patient had 6 years of hormone treatment with associated side effects. The delay in referral and completion of Radiotherapy may lead to a reduced disease free survival and may increase the need for androgen deprivation in the future.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
28.	Patient not 51 Personal information redacted by the USI	- No PSA check from 2017. - No MDM records. - Delayed Radiotherapy. - Commenced on hormones alone, Bicalutamide 50mg at unlicensed dose. - Patient was only 63 at time of diagnosis and should have been offered radical treatment.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation	- Referral in July 2006 not seen in clinic until Jan 2007. Unreasonable delay. 2 episodes of inappropriate review timescales given the PSA level (6 months suggested but not seen for a year then a further 6 month review suggested). Biopsy not completed for a total of 3 years. 2009 started on Bicalutamide 50mg. Increased to 150mg in 2010. - Hormones continued on review in 2011 and 2012. - MRI scan completed in 2012. MDM suggests continue treatment- they note this is not accurate according to the patients disease. 2016 histology from TURP discussed at MDM and recommended radiotherapy. Patient was advised to continue hormone therapy and was not offered radiotherapy in discussion. - Last review in 2020 noted PSA continues to rise.	Yes	Very Poor Care	SCRR noted the issue with consent for the TURP procedure

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			to their treatment pathway (informed consent); • Delays / omissions in triage • Practice in relation to operative procedures, including the removal of stents and gaining consent	• TURP consent form does not provide any explanation for the procedure, benefits, risks and is not signed by the Consultant. The operation note is also scanty and contains insufficient information. • Patient denied option of curative treatment and may have missed this opportunity and remained on hormones for 10 years.			
29.	Patient 72 Personal information redacted by the USI	• Treated initially in 2006 with surveillance following referral with LUTS and raised PSA. • Biopsy positive Gleason 3+3, initial plan for prostatectomy but delayed due to other health conditions. PSA however remained stable. • In 2012 commenced on Bicalutamide 50mg off license dose for prolonged period prior to referral for Radiotherapy, which was also delayed.	• Lack of / poor communication; • Delays or absence of reports/ investigations; • Un-actioned MDM outcomes including onward referrals and planned reviews; • Incorrect treatment; • Prescription of unlicensed medication as an incorrect form of treatment; • Not following NICE guidelines • Not providing patients with options and choice in relation to their treatment pathway (informed consent);	• Time from listing for biopsy to completing was 4 months. This was too long given the suspicion of cancer. • Staging exams of MRI and bone scan were not done until 10 months post diagnosis. • No evidence of MDM review at this initial stage. • No evidence in 2007 that the patient was advised of the options of active surveillance as well as prostatectomy. • Delay in communication to Primary Care of 8 months. • Delay in Urology reviews due to patient waiting for Coronary Artery stenting which was unreasonable. • The records from clinic reviews detail summary of the care delivered rather than the plan for treatment. One letter notes the patient is not on the waiting list for the planned prostatectomy which was unreasonable. • The Bicalutamide was increased to 100mg at a point, again this was unlicensed dosage. • Referral to Oncology for consideration of Radiotherapy was delayed by a further 6 months in 2014 (total delay of 18 months). • Patient did come to harm as it is probable that closer monitoring would have resulted in the upgrading of the tumour potentially 3 years earlier. Radiotherapy could have been completed 2 years earlier. Definitive treatment delay of 5 years with 2 years of associated side effects of hormone treatment at an unlicensed dose. There was likely a high grade cancer present for 4 years. With the PSA slowly rising it is likely that there remains residual prostate cancer and the odds of this have been increased by the delay to the treatment.	Yes	Poor Care	SCRR noted a further increase to Bicalutamide dosage to 100mg, which again was unlicensed.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
30.	Patient 70 Personal information redacted by the USI	• 2013 Diagnosis of prostate cancer. Treated with Bicalutamide 50mg until switch to LHRH in 2016. • Prolonged treatment with hormones. • Not offered Radiotherapy.	• Lack of / poor communication; • Delays or absence of reports/ investigations; • Un-actioned MDM outcomes including onward referrals and planned reviews; • Incorrect treatment; • Prescription of unlicensed medication as an incorrect form of treatment; • Not following NICE guidelines	• Referred with a raised PSA but was not seen at clinic for 3 months. Unreasonable due to concern over cancer. • Letters missing to GP to advise of clinic reviews. Patient started on Bicalutamide 50mg. No consideration for referral to Oncology for Radiotherapy consideration. • No follow up after 2013 until re-referred by GP in 2015. Had been on Bicalutamide 50mg throughout this time. Next review in 2016 noted PSA rising. Restaged and LHRH commenced. No evidence of metastatic or locally advanced disease. Given plan to continue on Bicalutamide 50mg and review in 2017. Unreasonable as on maximum dose for locally confined disease. • 2017 patient advised of the same which was again not appropriate as on maximum dose for locally confined disease. • Appears lost to follow up again until re-referral in 2019. Again patient advised to continue on the same medication, which remained unreasonable management. • Patient had a PE in 2020, Tamoxifen stopped (had been on since commencement of Bicalutamide). Bicalutamide stopped 11 months later.	Yes	Very Poor Care	SCRR noted the episodes the patient was lost to follow up which required 2 further referrals from the GP.

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			- Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Delays / omissions in triage	- The addition of Tamoxifen to counteract the side effects of Bicalutamide has risks including VTE. - This patient missed the opportunity for potentially curative radiotherapy. Treated with inappropriate androgen blockade for 8 years with associated side effects. - This patient has been impacted by harm with the increased risk of PE. Potential for bone demineralisation also. Patient now has castrate resistant prostate cancer.			
31.	Patient 57 Personal Information redacted by the USI	- Patient treated with Bicalutamide 50mg which was off license. - Prolonged treatment for 6 months. - Referred for Radiotherapy in 2014 which was delayed.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Delays / omissions in triage	- Patient was referred with raised PSA and was not seen at clinic for 5 months. This was unreasonable due to potential presence of cancer. - MDM plan in 2012 recommended consideration for radiotherapy. Treated with Bicalutamide 50mg. Clinic letter states plan to refer for radiotherapy. This was not actioned. - Review in 2013 increased Bicalutamide dose to 150mg. This was not indicated for the type of cancer this patient had. - Next review in Oct 2014 which was an unreasonable delay, changed to LHRH analogue. - Referral for Radiotherapy in July 2015. - Patient had 1.5 years of unlicensed and unproven Bicalutamide treatment and 2 years delay to radical radiotherapy. - Patient was impacted as they had excess side effects of Bicalutamide.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
32.	Patient 33 Personal Information redacted by the USI	2014 Intermediate risk Localised Prostate Cancer. - Treated with low dose Bicalutamide at 50mg from 2014. - Unlicensed dose.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- Delay in dictation of over 1 month from clinic in Dec 2014 (not done until end of Jan 2015). - Patient had intermediate risk disease and standard options would have been surveillance, radical treatment, or monotherapy with Bicalutamide at 150mg. 50mg was off license and unreasonable. - One further review recorded Oct 2015 but no associated letter. Gap in review then until 2017. Bicalutamide continued until review in 2020 when another Consultant advised the patient of this inappropriate dose, standard treatment options and was then switched to surveillance. - Patient had a less than effective dose for treatment firstly and also denied options of active monitoring or radical treatment.	Yes	Poor Care	

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33.	Patient 60 Personal Information redacted by the USI	- Diagnosed high risk locally advanced prostate cancer. - Treatment recommended was for curative intent. - Patient treated with hormones only.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- MDM recommended that patient was a candidate for curative treatment. - The patient was not informed of all treatment options except for the continuation of the Bicalutamide which had been commenced prior to the MDM discussion. - Further management was focused on management of the voiding symptoms. In 2019 there was a slight rise in the PSA for which a consideration for referral for radiotherapy is recorded. Patient continued on Bicalutamide and no referral was actioned. - The evidence suggests that delaying the introduction of radiotherapy this may lead to a reduced survival but in this case may not prove significant as the PSA is currently low.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
34.	Patient 119 Personal Information redacted by the USI	2011 Organ confined Gleason 7 Prostate Cancer. - Managed on Bicalutamide 150mg monotherapy since diagnosis. - MDM recommendations for surveillance, hormones with radiotherapy or ADT. - Patient sustained fractured NOF after 9 years.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- MDM recommendations for disease staging were surveillance, radical treatment with hormones and radiotherapy or ADT. - Commenced on Bicalutamide 150mg, whilst reasonable for the patients cancer, there was no evidence of any discussion of other options. Patient appears to have not been offered the choices available. - Noted that Bicalutamide is not associated with osteoporosis as other forms of ADT and is unlikely to be fully attributable to the fracture NOF.	Partially	Adequate Care	SCRR did note good practice in that patient reported back pain, and subsequent referral to spinal team resulted in diagnosis of a benign nerve sheath tumour.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
35.	Patient 124 Personal Information redacted by the USI	- High risk Gleason 4+4 Prostate Cancer. 2 years of hormone therapy prior to Radical Prostatectomy. - Biochemical recurrence in 2007 and had salvage radiotherapy.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment;	- Missing records relating to Urodynamic studies. - No evidence that the patient was offered alternative options besides prostatectomy, including radiotherapy. Given the PSA level the chance of a curative operation may be low but the surgery may have been the best option for local control. - Surgery did not take place until a year later, which would be unreasonable given the disease, however records note bed shortages and flu pandemic as reasons for delays, however the assumption would be that high risk disease would have been given a higher priority. - There were gaps in follow up post Prostatectomy however DNA's are noted also.	Partially	Adequate Care	

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			- Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	The reviewer classed this as adequate care. Noting that it would not of been unreasonable to treat with hormones up to the point of surgery. As this was delayed then it would have been reasonable to remain on these hormones.			
36.	Patient 145 Personal Information redacted by the USI	2015 Diagnosed with intermediate risk prostate cancer Gleason 4+3 non metastatic. - Options recommended of radical treatment or surveillance. - Received hormones. - No referral for Radiotherapy.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	- No communication to Primary care until 2019 (initial reviews happened in 2015). And hormones started in 2015 which was not communicated to Primary care. - Patient was not offered options of radiotherapy or watchful waiting as alternatives to hormones. The MDM report notes need to discuss radiotherapy with patient but no evidence of this happening. - Reviewer notes that if the decision was to continue with hormones at dose of 150mg would have been reasonable if the patient was deemed unsuitable for other therapies, but there is no evidence to support assessment or discussion of this. - Unlikely that the patient has come to harm. Noted fractured NOF in 2020 which may have partially contributed to use of Leuprorelin since 2015. Unlikely that patients longevity has been impacted by the slow progression of the disease.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
37.	Patient 59 Personal Information redacted by the USI	- Low risk prostate cancer in 2006 upgraded to intermediate risk in 2012. - Commenced on low dose off license dose of Bicalutamide. - Options of radical treatment or surveillance not considered.	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- Patient lost to follow up from 2008 to 2011. Unclear why. - Started Dutasteride in 2007 for mild obstructive symptoms which reduced the PSA. Follow up to 2008 where at last clinic advised review in 6 months, this did not happen and next review was in 2011. - At this stage biopsy was requested. Discussed at MDM on diagnosis of Gleason 3+4. Patient remained in surveillance but there was no record of any discussion of options with the patient. - Another episode of lost to follow up until 2019 whereby GP referred back in red flag with a PSA of 15.22. No evidence why there was no follow up 2011 to 2019. - Patient was staged and started on Bicalutamide 50mg, which is off license. There should have been a further MDM discussion with further options of either continued surveillance, hormones and radiotherapy of total androgen blockade.	Yes	Very Poor Care	SCRR noted 2 periods of lost to follow up and noted no MDM re-discussion post staging investigations in 2019.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
38.	Patient 91 Personal Information redacted by the USI	- Intermediate risk prostate cancer 2012 - Treated with Bicalutamide 50mg.	- Lack of / poor communication; - Delays or absence of reports/ investigations;	- Off license dose of Bicalutamide at 50mg. - Missing clinic letters relating to Urodynamic testing. - No evidence that Radiotherapy was discussed with the patient or indeed a referral made in 2017. Instead the dose of hormones was increased to 150mg. This was now 5 years of a low dose at 50mg.	Yes	Poor Care	SCRR noted issues with consent and pre procedure planning and patient education.

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		- No referral to Oncology for consideration of Radiotherapy. - Unlicensed dose of hormones.	- Un-actioned MDM outcomes including onward referrals and planned reviews; - Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Practice in relation to operative procedures, including the removal of stents and gaining consent	- Patient had a TURP procedure in 2014. They note the consent form does not record any information with regards to potential complications. The patient also received Botox treatment and there was no evidence that they received any education of clean ISC prior to the treatment which should have been done. - Radiotherapy was mentioned several times throughout the records but the patient was never referred. Even if they were considered unsuitable for this, the other options of treatment were not offered or discussed. - Very sporadic clinic letters also which was poor.			
39.	Patient 48 Personal information redacted by the USI	- Diagnosed at 76 non metastatic prostate cancer. - Commenced on hormones. Consultant recorded no need for Radiotherapy, but no evidence of benefit of treating with hormones alone. - Patient never offered opportunity for radiotherapy. - Now on surveillance pathway. 10 years of unnecessary hormones.	- Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Un-actioned MDM outcomes including onward referrals and planned reviews;	“Interesting case” - Standard practice to recommend hormones and radiotherapy, as per conclusion of MDT. This was not followed. - Bicalutamide dose was licensed but not first choice of treatment. - Determined the patient did not receive 10 years of hormone unnecessarily, had they not had this they suspect the tumour would have progressed in the 10 year period, having been locally advanced at time of diagnosis. - Tumour remained hormone sensitive over the 10 years (fortunate). The patient has done very well, and has not had the risk of complications of radiotherapy. - Reviewer stated difficult to mark this as poor care, when the patient has, in hindsight, had the better treatment. Evidence would suggest however that this was not the case for the majority.	Partially	Adequate Care	Noted that the patient was not referred as a “Red Flag” but was subsequently diagnosed as Cancer.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
40.	Patient 55 Personal information redacted by the USI	3 Month delay in PSA checks. - Delayed referral as result of 8 month delay in letter dictation following clinic review. - Patient did DNA an appointment but recognised the delay in the	- Lack of / poor communication; - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews;	2 clinics without corresponding letters back to primary care but this was considered minor. - However there is a lot of additional letters written to the patient to encourage engagement. - There was a delay between diagnosis and potential curative treatment but this is not the fault of the clinical staff involved. - It is interesting to note that the original referral letter in 2012, it was remarked that the patient had been due to have prostate biopsies in 2011 (presumably elsewhere) when the PSA was 9 but had DNA’d. The time was already ticking back then.	No	Good Care	

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		letter may have portrayed as “non-urgency” to the patient. • Letter does not account for the delay nor the non-action of the MDM recommendations.					
41.	Patient 38 Personal Information redacted by the USI	- Localised prostate cancer, commenced on low dose Bicalutamide then increased to 150mg. - Patient should have been offered radiotherapy.	- Incorrect treatment; - Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent);	- Failure to discuss all treatment options and offer radiotherapy when the patient was re-investigated in 2017 and found to have more active disease. - Off license dose of Bicalutamide in 2017, which was then increased to 150mg. However this would have been another opportunity to consider radiotherapy. - No communication with primary care until 2017. - Noted that so far the patient has not come to harm given that the last PSA is low demonstrating a relatively slow progression of the disease and the patients age. The question would be whether the prostate cancer metastasised during the 4 years delay in undergoing radiotherapy. The risk given the details of the case is small, but will only become apparent in the coming years.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
42.	Patient 47 Personal Information redacted by the USI	- Likely private patient as records are limited however patient diagnosed in 2010 with non-metastatic disease. - Should have been offered radical treatment but no evidence of this ever happening. - Patient had scans and diagnostics on NHS lists. - Primary Hormone treatment only.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines	- Reviewer states they believe the patient was managed appropriately. There was no lack of communication between the Consultant, however cannot account for what happened between 2016 and 2020. - Given the patients co-morbidities the treatment with Bicalutamide 150mg and then LHRH analogue seems sensible. - It also appears radiotherapy was discussed on a number of occasions but felt not to be appropriate, as well as the suggestion that the patient did not want it. - A dose of Bicalutamide 50mg was initiated, whilst off license, under these circumstances, they believed this was reasonable and would give some assurance to the patient that “something was being done” and could state that he was under treatment which may have been important for a travel insurance purposes.	Partially	Adequate Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
43.	Patient 75 Personal Information redacted by the USI	- No MDM Discussion in 2011. - Patient received Bicalutamide 50mg. - Radiotherapy in 2014 which was delayed from 2011 and received prolonged unlicensed dose of Bicalutamide . - Following radiotherapy in 2014 was to remain on	- Prescription of unlicensed medication as an incorrect form of treatment; - Not following NICE guidelines - Incorrect treatment; - Un-actioned MDM outcomes including onward referrals and planned reviews;	- High risk disease was not presented at MDM - Not offered Radiotherapy on initial diagnosis - Managed on unlicensed dose of Bicalutamide for 3 years. This was increased by the Oncology Team on review. - Focus on overactive bladder symptoms and concerns regarding coronary heart disease rather than the prostate cancer. Hormone therapy should not be given for more than 3 months prior to radiotherapy, the patient had 18 months of this since diagnosis. - No reason why LUTS was the reasoning for not offering radiotherapy.	Yes	Poor Care	SCRR noted that the referral to Oncology came from another Consultant.

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		Bicalutamide 150mg for 3 years, this was stopped in 2015. Patient died suddenly in Personal Information.		- Referred to Oncology by a route other than the Urologist in charge. Notes that in clinic letter “patient referred by some mechanism for radiotherapy” suggesting that it was not their intention for the patient to be treated with radiotherapy. - Whilst the decisions made were unorthodox in managing the cancer, there was no harm to the patient.			
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
	Patient 6 Personal Information redacted by the ULSI	- Intermediate risk organ confined prostate cancer. - Commenced on Bicalutamide 50mg then increased to 150mg. - Options for treatment at this time was radical treatment or surveillance. - Patient has not been treated or monitored. - Now on surveillance.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Delays or absence of reports/ investigations; - Un-actioned MDM outcomes including onward referrals and planned reviews;	- Treated with Bicalutamide 50mg which was not indicated for this. - Curative options were suggested by the MDM, it does not appear they were discussed with the patient. There is no recording to support this. - It is recorded that radiotherapy was deemed to be appropriate treatment by the Consultant, however no referral was made. - Continued on unlicensed Bicalutimide dose. This has no benefit in the treatment of locally confined prostate cancer and may be detrimental not only for side effects but masking the tumour progression thereby delaying radiotherapy. - Patient has been subjected to harm. In that they underwent 6 months of unnecessary anti-androgen treatment and tamoxifen treatment. If the patient had not stopped this themselves then treatment would have been longer. Patient has got progressing PSA and is likely to require radical radiotherapy at some point. This may be less effective than had he had early radiotherapy in 2019 and as such may require further androgen deprivation in future.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
	Patient 56 Personal Information redacted by the ULSI	- Low risk prostate cancer in 2003. - Commenced Bicalutamide 50mg and remained on this for 16 years. - Patient should have been offered surveillance pathway as most appropriate option.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Delays or absence of reports/ investigations	- Histologically this grade of disease rarely leads to harm if left untreated. - Treated with maximum androgen blockade with LHRH and Bicalutamide combination for 9 years based on a single post-operative blood test. - This line of treatment is indicated for patients with metastatic disease showing resistance to treatment with LHRH analogue alone. To use as a first line treatment is unreasonable. - Failure to adequately restage and/ or confirm accuracy of the blood test by repeating, but instead commencing this treatment is unreasonable. - The reviews were performed by inexperienced clinicians and the level of supervision is not recorded. - Recognised “over treatment” in 2014 and LHRH was stopped. However Bicalutamide continued at 50mg, which was also not indicated. At this stage surveillance without androgens or restaging would have been the standard treatment. - Patient had subsequent 6 years of inappropriate treatment of Bicalutamide 50mg.	Yes	Very Poor Care	SCRR noted that reviews were conducted by inexperienced clinicians and there was no evidence of supervision.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
46.	Patient 77 Personal Information redacted by the ULSI	Patient started on hormone medication without evidence of metastatic disease.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment;	- Referred as urgent case in Dec 2017 with a PSA of 22. Seen May 2018 which was unreasonable delay. - Reviewer commented that this was a reasonable treatment for non-metastatic locally advanced disease.	Partially	Adequate Care	SCRR report noted that referral was sent as “urgent” with a PSA of 22

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		- Patient had breast growth with Bicalutamide, suspect that dose of Bicalutamide was reduced as a result to reduce complications. - Patient is on watchful waiting pathway now.	- Not following NICE guidelines - Delays / omissions in triage	- No histology was taken which would have been reasonable given the certainty of clinical diagnosis and the risk of biopsy. - The patient effectively took himself off therapy and switched onto watchful waiting after 12 months. - In essence this patient had been treated with intermittent anti androgen therapy. This disease as would be expected, has progressed and the patient is now on LHRH analogue. - The Bicalutamide management was reasonable and would not adversely affect his length of life nor need for ongoing treatments.			which continued as an “urgent” post triage and delay in first review of 5 months.
47.	Patient t80 Personal Information redacted by the USI	- Intermediate risk small volume localised prostate cancer. - Treated with low dose Bicalutamide 50mg and this continued for a prolonged period. - Options at the time were surveillance or radical treatment.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Delays / omissions in triage - Delays or absence of reports/ investigations - Un-actioned MDM outcomes including onward referrals and planned reviews;	- Unreasonable delay from referral to clinic review of 5 months. - MRI was cancelled due to insufficient information on the request. Took 2 months for further request to be completed. - Lack of communication with primary care, in particular between 2012-2017. - Patient has moderate/ mild LUTS and marked co-morbidity. - Standard treatment options were radical curative therapy or surveillance, the addition of Bicalutamide 50mg was not reasonable. - The surveillance was inadequate with too long between appointments and no planned radiological or histological review as part of the surveillance. - In effect the patient had 8 years of unlicensed therapy with Bicalutamide 50mg daily and tamoxifen. - No evidence/ record of the patient being offered Radical Radiotherapy option as per MDM advice. - Significant gaps in the reviews. In 2013 a 12 month timescale was unreasonable post diagnosis. Bicalutamide continued at 50mg, this was ongoing through to reviews in 2017, 2018 and 2019.	Yes	Poor Care	SCRR report noted the significant extended periods of time between the reviews and the delayed initial review following triage.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
48.	Patient t41 Personal Information redacted by the USI	- No MRI completed for staging and CT completed instead. - Initially commenced on Bicalutamide but then discontinued followed by a restart at a dose of 50mg. - Recommendations at that time were for watchful waiting or hormone with radiotherapy. - MDM in 2014 to discuss histology results/ Plan. No subsequent MDM. - Patient now on watchful waiting.	- Prescription of unlicensed medication as an incorrect form of treatment; - Incorrect treatment; - Not following NICE guidelines - Not providing patients with options and choice in relation to their treatment pathway (informed consent); - Un-actioned MDM outcomes including onward referrals and planned reviews; - Delays / omissions in triage	- Referral in 2007 with raised PSA, but this seems to have been missed as the review was booked for LUTS clinic. The need for biopsy was identified yet did not occur either as a planned procedure or during the 2 in patient procedures on bladder stones and TURP even though there was a mention in clinic letters of performing this. - If the biopsy had of been performed at either the Lithaloplaxy or TURP is it likely that this prostate cancer would have been detected then. Therefore the final diagnosis was therefore problem delayed by up to 7 years. - There is little evidence to support the pros and cons of the options being discussed with the patient. - Once side effects became intolerable the option to drop to 50mg was not indicated as it is not appropriate for monotherapy for this stage or grade of disease. - Referral initially with raised PSA over 10 in Dec 2007 but not seen at clinic until August 2008. This was unreasonable delay. - The patient was not consented for biopsies. - Missing follow up in Nov 2009 with a raise in PSA. - Extensive delays noted in the ongoing reviews in 2014 and 2015.	Yes	Poor Care	SCRR report noted the lack of biopsies and issues with initial referral and first review.

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			- Delays or absence of reports/ investigations - Practice in relation to operative procedures, including the removal of stents and gaining consent				
49.	Patient 62 Personal Information redacted by the USI	- Patient had a Personal Information redacted by the USI . Referred by Cardiology with Personal Information redacted by the USI . In 2018 CT demonstrated thick bladder wall and proceeded to TURP July 2018. - Delay to diagnosis and management of potential bladder cancer. Should have had flexible cystoscopy considered on CT Urogram results. Patient would not have required a GA for this procedure and would have been considered a lower risk procedure for this patient post Personal Information redacted by the USI . - Patient was subsequently diagnosed with muscle invasive bladder cancer.	- Not following up on / actioning outcomes of diagnostic scans - Delays / omissions in triage - Delays or absence of reports/ investigations	- On initial review advised of a 4 weeks review. Unreasonable as the creatinine was raised but not factored into the decision. Ended up being re-referred as a result. The Obstruction was not appreciated by the Urology Registrar, resulting in a delay of 2 months. - This delay may have resulted in the loss of kidney function and the need for the Nephroureterectomy although the GFR was normal in May and acutely abnormal in October so the kidney may have been unsalvageable by then. - CT Done in Feb and patient not seen until June. Considered unreasonable as potential bladder malignancy noted on this CT. 4 month delay. This could increase cancer recurrence risk and upstaging of tumour. - The decision for a ureterostomy is not a standard one. It has led to repeated instrumentations/ stent changes and morbidity. This is learning. - Patient did result in harm. Percutaneous drainage could have protected renal function if acted on at referral/ triage. This loss led to neoadjuvant chemotherapy which may increase risk of recurrence risk. - This loss led to an operation with greater morbidity such as pain, malaise from Nephroureterectomy. May prevent further oncological treatment due to reduced GFR, and limited options should the other kidney been affected. - Most urologists would aim for curative treatment within 6 weeks if not having chemotherapy.	Yes	Poor Care	SCRR report noted the issues at triage and an inappropriate grade of Doctor completing reviews/ making decisions.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
50.	Patient 74 Personal Information redacted by the USI	- Non Muscle Invasive bladder cancer treated with TURBT and Radiotherapy. - Subsequent prostate cancer diagnosis. - Patient had TURP and is now incontinent. There was no clear justification for TURP. - Received Botox treatment and went into retention. - Bladder outflow obstruction was not proven, therefore was TURP necessary.	- Practice in relation to operative procedures, including the removal of stents and gaining consent - Lack of / poor communication - Not following up on / actioning outcomes of diagnostic scans - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Un-actioned MDM outcomes including onward referrals and planned reviews - Delays / omissions in triage	- Initial referral for Haematuria and raised PSA. Referred Jan 2011 and seen April 2011. Unreasonable given haematuria. - MDM recommended Mitomycin. BCG would have been considered a better option for oncological treatment over Mitomycin. Unclear what the rationale was for this. - MRI done in Nov 2013. Patient not seen and advised of result until June 2014. Unreasonable delay. Then further MRI and Bone Scan was requested and this was not communicated to the patient until March 2015. Again unreasonable delay. - Patient requested referral for radical Prostatectomy in April 2016, delayed and not seen by Mr O'K for this until Feb 2017. - Consent form for TURP does not include risks/ benefits, but is signed by AOB. Operation description states "TURP" only- unreasonable. Again for GA biopsies and Botox treatment in 2015 there was no risk/ benefit recorded. Signed by patient but no record of interpreter/ witness or patient information given. No evidence that patient was fully consented to the possible risks of TURP. - Resulted in patient experiencing worsening incontinence.	Yes	Poor Care	SCRR report noted the issues at triage and issues with consent

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51.	Patient 49 Personal Information redacted by the USI	- Radiological suspicion of localised disease. Not biopsied and started on Bicalutamide 50mg. - Unlicensed and prolonged treatment with hormones. - No evidence of consent, risks or benefits being explained. - PSA was 12. Now onto surveillance.	- Prescription of unlicensed medication as an incorrect form of treatment - Delays or absence of reports/ investigations - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Not following NICE guidelines - Incorrect treatment	- Decision to initiate “some degree of androgen blockade” was with an unlicensed dose of 50mg. - Treated for 5 years with this dose. - As there was not a histological diagnosis the reasonable option would be to actively monitor and if the PSA rose then consideration of additional therapy in form of Bicalutamide 150mg or if biopsied positive then consideration for Radiotherapy.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
52.	Patient 67 Personal Information redacted by the USI	- MDM advised in 2019 repeat of PSA. This was not done. - When completed it was significantly raised. - Patient proceeded to Prostate Cancer diagnosis. - Earlier diagnosis had the MDM advice been followed. - Delay in diagnosis and subsequent management.	- Delays or absence of reports/ investigations - Lack of / poor communication - Un-actioned MDM outcomes including onward referrals and planned reviews	- Delayed dictation following clinic reviews. (Clinic on 16.1.2019 not dictated until 26.2.2019) and MDM took place on 31.1.2019. - MDM records of recommendation to check PSA. This was not actioned and there is no evidence to support that GP was informed to monitor PSA. It appears that to speculate that the decision was made by AOB, who had already seen the patient prior to the MDM, and given primary pathology had now been dealt with by general surgeons and the PSA rise was due to inflammation.	Partially	Adequate Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
53.	Patient 63 Personal Information redacted by the USI	- Cystoprostatectomy and Ileal Conduit 20019. Surveillance CT's done 2010,2011,2013,2014 and showed no recurrence. - Delayed diagnosis of Lung Cancer following CT in 2017. Showed small nodule and recommended follow up CT in 3 months. - Not actioned. Next surveillance CT in 2018 reported lesion was larger. Again no action taken to follow up.	- Delays or absence of reports/ investigations - Lack of / poor communication - Not following up on / actioning outcomes of diagnostic scans	- Lapse In follow up between 2014 and 2017 for unclear reasons. CT and PSA were normal so was discharged by the ST7. However another review in 2017 with AOB noted a parastomal hernia for which a CT was requested. Plan to review in 2018 with result which did not happen. - The plural node on the CT was described as indeterminate and recommended repeat in 3 months. This did not happen. - A further review and CT took place in 2018, which again reported increase in size. This was not acted on. - The primary lung tumour could have been diagnosed 2 years sooner. - It is not clear where the responsibility lies for actioning this and cannot be deduced from the information available.	Yes	Poor Care	SCRR reviewer noted potential Inappropriate grade of Doctor completing reviews/ making decisions.

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		- Next surveillance CT in 2020 showed further enlargement. - Now referred to lung Team.					
54.	Patient 142 Personal Information redacted by the USI	- Missing Record of adding to waiting list for removal of stent, - No evidence to support urgency of review in 2017. - Based on scan which reported need for prompt action, however patient not reviewed until 2021. - Reducing kidney function. - Patient has not been located in NI and no records to advise whereabouts.	- Delays or absence of reports/ investigations - Incorrect treatment - Not following up on / actioning outcomes of diagnostic scans - Practice in relation to operative procedures, including the removal of stents and gaining consent - Delays / omissions in triage - Lack of / poor communication	- On diagnosis of stones was listed for Ureteroscopy which was inappropriate as a CT scan should have been performed and a DMSA scan to assess function of the kidney and stone morphology given the history of stone formation/ hydronephrosis. - Surgery performed without expected tests being performed. The CT showed the stone burden was so large and complex that it would have been unrealistic to expect a ureterscopy to clear it. - CT not reviewed prior plans for surgery to repeat the Ureteroscopy. This was not prioritised and was delayed by months leading to the stent becoming encrusted. - A further delay of 8 months until next ureterscopy. At this point all that could have been achieved was laser to the encrusted stent and a fresh one inserted. - This was unreasonable to leave the stent in without an early planned date for surgery or to arrange removal especially as the stents encrust so quickly. - Consent Form completed by AOB did not include any risk/benefit detail. - Discharge letter from 1st Ureteroscopy was done 3 months later by a Specialist Registrar. - Concern that this patient may have a fully encrusted right urinary system.	Yes	Very Poor Care	SCRR reviewer noted the lack of pre surgery investigations, and the review of these which would have highlighted the procedure planned was not appropriate for treating the stone. Also noted that the consent form completed by AOB did not include and risk/ benefit information. Also noted the 3 month delay in Discharge letter
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
55.	Patient 143 Personal Information redacted by the USI	- Patient had no evidence of metastatic disease on staging. - Not referred to Oncology and considered for Radical Radiotherapy. - Remained on Bicalutamide 150mg with LHRH analogue which was inaccurate.	- Incorrect treatment - Un-actioned MDM outcomes including onward referrals and planned reviews - Lack of / poor communication - Not following NICE guidelines	- Delayed letter to GP following clinic review on 23.12.19. Not completed until 3.2.20. No planned referral for consideration of radiotherapy. - Patient maintained on Bicalutamide as per clinic notes. If the patient was counselled and opted not for radiotherapy, then this would have been reasonable, but there is no evidence of this. - Clinic review 9.3.20 not dictated until 27.4.20. Notes waiting to refer for radiotherapy pending PSA response. This is not reasonable as ADT response is not a factor in determining radiotherapy timing. - Two subsequent clinic reviews on 27.4.20 and 26.8.20 no referral for radiotherapy. - On 23.9.20 had a new referral sent by GP as there was no mention of Oncology review and patient was anxious. - Seen by MDH Nov 2020 and stopped Bicalutamide and referred to Oncology. Delay of 12 months in referral and completion of Radiotherapy. - Bicalutamide was not indicated at the dose given in combination ADT. This should have been 50mg. This led to 10 months of unnecessary Bicalutamide.	Yes	Poor Care	SCRR reviewer noted the delay in dictations following clinic reviews. Also notes the second referral from GP regarding patients anxiety over lack of communication from Oncology.

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56.	Patient 144 Personal Information redacted by the USI	- Missing Clinic letters relating to reviews. - No MDM record found. - Commenced on Bicalutamide 50mg in 2016 which continued until 2019. - Commenced on Dexamethasone 500mcg.	- Delays or absence of reports/ investigations - Lack of / poor communication - Incorrect treatment - Un-actioned MDM outcomes including onward referrals and planned reviews - Prescription of unlicensed medication as an incorrect form of treatment	- Patient stated he had been on hormones since 2009. Longer than first thought. - Clinic review 11.11.19 letter not dictated to GP until 5.1.2020. - On starting Dexamethasone, this was probably as advancing cancer and was commonly used for tumouricidal effects. It was however kept in reserve until evidence of significant metastatic disease. There was no up to date staging performed and no consideration of third line systemic therapy. - No evidence of review of options by MDM or oncological referral. - No evidence of results of the bone scan or MRI. - In 2015 scan showed no evidence of metastatic disease it is likely on diagnosis had no metastasis and could therefore have been managed on surveillance only if, opted not to undergo Radiotherapy. - Patient had unnecessary treatment with LHRH analogue for a number of years. - When Dexamethasone was added to the treatment there was no indication that there was any palliation or for acute tumouricidal effect. There was no up to date staging. Treated for 30 months with this. - Having a PSA rise and being on maximum androgen blockade and not having re-staging nor consideration of novel systemic therapies was unreasonable. 30 months delay to treatment with novel systemic therapy	Yes	Poor Care	SCRR reviewer noted the delay in dictations following clinic reviews. Also notes the un-indicated use of Dexamethasone.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
57.	Patient 145 Personal Information redacted by the USI	- Diagnosed in early 2016. MDM recommendation for curative treatment. - Commenced on Bicalutamide 150mg. - No referral for consideration of Radiotherapy until March 2017. 9 months of hormone therapy not required.	- Lack of / poor communication - Prescription of unlicensed medication as an incorrect form of treatment - Not following NICE guidelines - Un-actioned MDM outcomes including onward referrals and planned reviews - Delays / omissions in triage - Incorrect treatment	- Referred on 28 July 2015 with raised PSA and irregular DRE. Seen 19.1.2016 which was unreasonable wait. Letter to GP for plan for MRI Prostate and Review in March wasn't done until 16.3.2016. - In clinic on 29.4.16 started on Bicalutamide 150mg and Tamoxifen 10mg daily. - This was not high risk disease and radiotherapy was not planned therefore there is no indication for Bicalutamide. - Active surveillance without any therapy would be an option if radical therapy was rejected by the patient however, there was no evidence this was discussed. There was no communication to the GP from this April 2016 clinic. - Clinic in Feb 2017 states patient wishes to continue on active surveillance and will continue on Bicalutamide and tamoxifen. This is incorrect as active surveillance does not involve any androgen manipulation. - Patient stated that he was offered surgery, radiotherapy or hormone treatment at time of diagnosis being under impression that they were all of equal curative treatments. - Total delay of 11 months to starting Radiotherapy. 11 months of unnecessary Bicalutamide and Tamoxifen. 2 months longer than initially thought. - Concern over use of term "active surveillance" to describe the care whilst in same sentence advised to continue on hormones. This would imply not being aware of the principal and protocol of active surveillance. - Numerous instances of non- cotemporaneous summary letters referring to a number of combined episodes under AOB. - Harm as a result of subsequent erectile dysfunction due to Bicalutamide treatment.	Yes	Poor Care	SCRR reviewer noted the delay in dictations following clinic reviews. Also noted the concern regarding the awareness of the principal and protocol of "active surveillance".

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58.	Patient 146 Personal Information redacted by the USI	- Diagnosed in 2014 Prostate Cancer (localised) - Treated with Bicalutamide alone since. - Patient advised never offered radical treatment including radiotherapy or watchful waiting option. - No follow up or review until late 2016 when he received a phonecall. - Not introduced to a Keyworker. - Patient's daughter who accompanied patient advised she was completely unaware he had been diagnosed with prostate cancer.	- Lack of / poor communication - Un-actioned MDM outcomes including onward referrals and planned reviews - Incorrect treatment - Prescription of unlicensed medication as an incorrect form of treatment - Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	- Review clinic of 1.8.2014 there was no letter associated with this review. Appears patient did not attend. A letter was sent to the patient informing of the scan results and starting on Bicalutamide and Tamoxifen. There was no explanation given as to the rationale for this treatment. - Patient's cancer was intermediate risk and options were surveillance or radical therapy. Bicalutamide treatment was not reasonable. - Clinic letter 22.9.2014 advises continued treatment on monotherapy. Not indicated if not considering radiotherapy. This was the same advice at clinic review on 9.12.2016. - Patient not seen until 2.3.2022 when patient advised of inaccurate treatment. Unreasonable timescale to review from 2016. - Patient advised was never informed or discussed radical radiotherapy nor watchful waiting. - Patient has not had the option initially of cure by radiotherapy which may prolong his life and would have reduced his need for further androgen deprivation or third line systemic treatment. - The Bicalutamide may have masked the disease progression which means he did not have an opportunity of cure that should have occurred on surveillance.	Yes	Poor Care	SCRR reviewer noted missing letters for clinic reviews.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
59.	Patient 147 Personal Information redacted by the USI	- Small renal mass in 2016 was placed on surveillance. - Repeat imaging in 2017 and then nothing further. - Renal mass has been increasing in size. - Partial nephrectomy advised but patient elected to continue on observation until/ if reaches over 4cm. - No follow up after MDM in July.	- Not following up on / actioning outcomes of diagnostic scans - Lack of / poor communication	- Renal and staging scan performed on 6.1.2016 and demonstrated increase in size. Patient does not appear to have been informed of the result, and was not reviewed back in clinic until 20.6.16. Written notes suggest a review was planned for Feb 16 but this may have been an admin issue. - MDM referral made at June 16 review. Further CT 7.12.16 showed further increase in size. The planned follow up in Jan 2017 did not happen, and there was no communication of the result to the patient or primary care. Not clear the reasoning for this admin failure which meant the next review wasn't until MDH 9.3.2022. - Patient appeared lost to follow up for 5.5 years. The plan for review and scans were recorded in noted before the patient went off the radar. The reason for this failure is not evident from the notes. 2 occurrences whereby the scans were performed but not acknowledged nor acted on by the requesting clinician, suggesting a failure of process, as the arrival of the result often would trigger an appropriate clinical review.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
60.	Patient 148 Personal Information redacted by the USI	- MDM in 2019 recommended curative treatment. Patient very young at the time. - BMI Personal Information redacted by the USI was reasonable not to refer for surgery due to this.	- Un-actioned MDM outcomes including onward referrals and planned reviews - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	MDM of 8.8.2019 advised that curative intent should be discussed with the patient. This review took place 3.9.2019 and recorded a number of treatment options including brachytherapy, External Beam radiotherapy and "augmented androgen blockade". I do not know what is meant by this, it is not a recognised term and if androgen blockade alone, would not represent a "curative" approach. No further action took place at this time to manage cancer diagnosis and potential curative treatment, which would be at odds with normal practice.	Yes	Poor Care	SCRR reviewer noted the concerns raised by the anaesthetist in regards to risk due to BMI which potentially could of

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		- Nothing happened between Aug 2019 and May/June 2020 when was commenced on Bicalutamide. - Dec 2019 patient noted to want radiotherapy referral, this was not done Until Feb 2020. - This was now during covid pandemic which impacted on completing treatment until Nov 2020.		- Patient was admitted for Botox under GA. Noted that the anaesthetist reported intubation as challenging due to high BMI and shortened neck. - It is not clear if the patient's bladder symptoms precluded proceeding with curative treatments for cancer, but can find no evidence of this. - Delay in referral for radiotherapy for 6 months. Relatively young man at the time of diagnosis with an intermediate risk tumour whose curative treatment was delayed.			ruled out surgical treatment for curative intent.
	Patient 149 Personal information redacted by the USI	2018 Lung Cancer diagnosis with chance finding of raised PSA. - Commenced on Bicalutamide 50mg, biopsies negative. - MDM advised stopping Bicalutamide however no correspondence to say this was done. - PSA was 6.3 in June 2019 so doubt if it was stopped.	Prescription of unlicensed medication as an incorrect form of treatment	- DRE noted benign feeling prostate. Patient was commenced on Bicalutamide 50mg for the presumed diagnosis of prostate cancer because of the increase of PSA over 3 months. - AOB stated that the low dose was minimal but preferred to introduce androgen blockade slowly because in a higher dose can result in respiratory compromise, and the dose can be increased at a later date or changed to LHRH antagonist. - Dose was off license, but it was reasonable in the case as patient had advanced lung cancer and a rapidly rising PSA. Treatment at this stage was considered to be premature and unnecessary, and as further investigation had been planned, waiting would have caused no harm. - MDM 23.8.18 confirmed MRI and biopsies showed no evidence of cancer. Lung cancer treatment was ongoing, AOB wrote to the GP and the patient on 10.9.18 indicating that Bicalutamide could be stopped. Plans made for review in Nov 2018. - Reviewer felt the only issue here was having Bicalutamide for short period unnecessarily. - The idea of starting it at a lower dose is clearly something that AOB favoured but there is no real evidence for this. - There was clear instruction to the GP to stop the Bicalutamide and the PSA level could have been as a result of a benign cause.	Partially	Good Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
62.	Patient 1150 Personal information redacted by the USI	- MDM recommended radiotherapy. Patient was not referred (AOB stated patient would not attend) - Jan 2017 Bicalutamide reduced to 50mg - Radiotherapy completed Oct 2017	Lack of / poor communication	- Biopsies and MDM discussion happened within 3 weeks of referral but there was no letters to the GP advising of this. - Patient had marked LUTS symptoms. AOB correctly concluded that it would not be appropriate to proceed to radiotherapy until these were sorted and arranged UDS and potential TURP required. - TURP occurred nearly a year later, this was unreasonable given that the patient had a malignancy and was awaiting potential curative therapy. From records it states due to wait for UDS but this should have been prioritised. TURP did not resolve symptoms and a repeat was carried out 6 weeks later.	Partially	Good Care	SCRR reviewer commented that TURP procedure was potentially carried out by a Junior member of staff

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				- Symptoms persisted, following patient DNA's and once finally attended AOB recorded if symptoms remained stable by Jan 2016 he would be able to refer for radiotherapy. AOB recued the Bicalutamide to 50mg for unclear reasons. - A lot of the delays were due to the patients DNA and anxieties with hospital attendance and mental health issues. - The intention was there to refer for radiotherapy. Commenced on Bicalutamide in anticipation for radiotherapy but continued on correctly, although he probably did not need both Bicalutamide and LHRH agonist at this stage. - Noted that the first TURP was suspected to have been performed by a member of junior staff and insufficient tissue was removed.			
63.	Patient 152 Personal Information redacted by the USI	- Radical prostatectomy in 2005 for Gleason 3+3 prostate cancer. - On Bicalutamide 50mg since 2011. Tamoxifen stopped in 2021 due to drug interaction and then referred to MDM. - Patient onto surveillance.	- Delays / omissions in triage - Prescription of unlicensed medication as an incorrect form of treatment	- Patient aged 61 on referral in 2004. Seen 6 month later and then referred for biopsies. Long interval between referral and clinic, but if not red flagged may be consistent with waiting times at that time. - In 2005 decision made that patient required radical prostatectomy. Because of the delay patient started on Bicalutamide 50mg. At this time this was often given with no evidence, just to offer reassurance to the patient whilst waiting. This seems to be the case here. - Follow up over next 5 years was appropriate, then in 2011 PSA was rising and AOB suggested that patient may need further treatment due to potential local recurrence. MRI confirmed this and MDM discussion in June 2011. - It could be argued that the investigation of local recurrence could have been actioned earlier, but they suspect this management would be echoed in many centres. - The biopsy results were discussed with the patient in a private clinic. It was here the decision was made not to refer for radiotherapy but instead start an off license dose of Bicalutamide. The rationale is explained in a letter dated 19.10.2011. They can understand the decision made and although the dose was unlicensed there were reasons given. The only "curative" option was salvage radiotherapy, they agree with AOB in a patient with post prostatectomy incontinence, radiotherapy would have made this significantly worse. If this happened there was no easy remedy available so the patient may have opted against this. - Hormone therapy in the full licensed dose would impact on the patient's already troublesome Patient 152 Personal Information redacted by the USI . AOB opted for a "half way house" dose. Therefore whilst off license it is not totally unreasonable given that a "cure" was no longer on the cards, and it has to be borne in mind that the patient actually did very well. - Had surveillance been adopted, with the PSA doubling time as it is, the patient would most likely have been started on full dose hormones after 6 or 7 years. The patient may have had 6 or 7 years of years of hormone therapy unnecessarily. - Patient had a Patient 152 Personal Information redacted by the USI in 2021 and it is conceivable that the tamoxifen he was taking may have been a contributory factor.	Partially	Adequate Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
64.	Patient 152 Personal Information redacted by the USI	Radiotherapy referral delayed due to "hot flushes".	- Lack of / poor communication - Un-actioned MDM outcomes including onward referrals and planned reviews	- Reviewer noted that the patient was not referred for radiotherapy as PSA was not below 1ng/ml. - This was considered unreasonable as PSA is not an indicator of radiotherapy requirement.	Partially	Adequate Care	

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		- Unclear rationale why this was considered reasonable. - Treated with Bicalutamide during the delay. Earlier radiotherapy would have allowed stopping of hormones sooner.	- Unjustified rationale for deferring treatment. - Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions	- Reviewer noted that post radiotherapy the Bicalutamide continued for an additional 8 months over the recommended 36 month treatment. - Whilst referral was delayed by 6 weeks, and patient had Bicalutamide during this time, and the associated side effects. This was compared to the 8 months the patient received Bicalutamide unnecessarily post radiotherapy.			
65.	Patient 153 Personal Information redacted by the USI	- Referral to Oncology for Radiotherapy was delayed due to LUTS symptoms. - Unclear why the patient was not referred as recommended, and Oncology Team to determine if appropriate to proceed. - Screening group agreed it was an unjustified rationale for deferring treatment.	- Un-actioned MDM outcomes including onward referrals and planned reviews - Unjustified rationale for deferring treatment. - Not utilising / referring to the cancer nurse specialists for support and nurse-led interventions	- To try and address LUTS prior to Radiotherapy is reasonable, balancing quality of life over survival advantage. However if leading to a delay of more than 6 months (the period for which hormone therapy is typically given prior to radiotherapy) the decision to defer treatment should be made in full consultation with the MDT and the patient. - MDT was not involved after initial diagnosis and staging and only one mention of the discussion of options with the patient. Assumption made that robotic radical prostatectomy was not available at this time. - The surgeon can be criticised for not involving the MDT and Oncology in the decision to delay treatment and there could have been another MRI Scan performed to assess the local disease progression. - The rising PSA despite Bicalutamide prompted referral for ERBT and as predicted LUTS was much worse 18 months later. - Commented that the delay to ERBT relived the patient of several years of increased LUTS. It is unlikely that earlier ERBT would have had any survival advantage.	Partially	Adequate Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
66.	Patient 154 Personal Information redacted by the USI	- USS result available pre listing for surgery (Oct 2018). Reported no hydrocele, minimal 3mm cyst and normal testes. - Surgery in Nov 2019 showed no hydrocele or surgically correctable cause of swelling. - Patient developed post op infection. - Why operate with a normal scan result. - Patient came to harm as had unnecessary surgery and resulted in infected haematoma.	- Incorrect treatment - Practice in relation to operative procedures, including the removal of stents and gaining consent - Unorthodox Pathway	- No reference in notes to the USS scan performed. No suggestion of arranging a further scan and patient placed on a waiting list. - There is no records of the inpatient stay/ day case procedure of the scrotal exploration. - Appears an unnecessary operation. There is a suggestion from the patient pressurising operation but this is not a reason to proceed. - An up to date USS should have been performed to help with the decision and potentially avoid operation. - Experience of surgical re-exploration in this type of case is fraught with difficulty and is usually very unsatisfactory. - States that on hindsight it would appear that the decision to re-operate was the wrong one and they suspect the surgeon would agree. - States no long term harm.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
67.	Patient 155 Personal Information redacted by the USI	Urodynamic tests did not indicate the need for TURP.	Lack of / poor communication	Investigations inconclusive therefore management decisions are made difficult.	No	Good Care	

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		No evidence of bladder outlet obstruction. • Patient developed stricture post TURP. • Over activity Symptoms including incontinence and therefor by completing a TURP very high risk of worsening incontinence. • Options to exhaust every other option was not taken. • Consent form does not record risks, in particular of incontinence. • Noted that patient actually had 2 TURP's with no evidence of decision making with the patient. • Urethral injury sustained during procedure. This was considered harm as procedure not indicated.	• Incorrect treatment • Practice in relation to operative procedures, including the removal of stents and gaining consent • Not providing patients with options and choice in relation to their treatment pathway (informed consent) • Not following NICE guidelines • Unorthodox Pathway	• 160ml residual on previous CT/ USS is suggestive of obstruction but the flexi suggested moderately obstructive lateral lobes. No urodynamic tracings found. Computerised tomography was suggestive of obstruction. • First TURP was done under spinal and patient took a coughing fit and became unresponsive. Surgery was abandoned. Operation note explains the urethra was damaged close to the external sphincter which was then managed appropriately. • The importance is the duty of candour when the damage occurred. There is no record to indicate what was explained to the patient but this does not mean it did not happen. • This is what resulted in the development of the stricture and need for the 2nd procedure.			
68.	Patient 156 Personal Information redacted by the USI	• Missing Records from clinic reviews. • Consent form was found to be lacking in essential information. • No clear management plan. • Patient did have urodynamics completed but no clinical correspondence to indicate findings or plan.	• Delays or absence of reports/ investigations • Lack of / poor communication	• Delayed dictation of over 2 months. • Patient presenting with non-visible haematuria should have had investigation quicker than they did. • Cystoscopy and urodynamics completed 4.7.2014 but consent signed for 8.8.14. Unclear why this is the case. • No communication with GP or of follow up plan. Expectation patient would have been given conservative measures and medication to control symptoms, but it is not recorded. Patient then receives intravesical Botox. No record of actions/ effects pre Botox. • Consent form for Botox does not record potential side effects. • No record of patient being taught CISC prior to Botox as retention is a recognised side effect. • Patient did require to be taught this 2 weeks after Botox when they developed hypotonic bladder and needed CISC. • Query if the Botox dose (500u) was high. Assuming the standard preparation of Botox A, the patient would most likely develop retention.	Yes	Poor Care	Reviewer identified issues with Botox dose. Also noted that CISC was not taught prior to Botox treatment and patient did go into retention.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
69.	Patient 157 Personal Information redacted by the USI	• Unclear why radiotherapy was not offered in 2008 and 2010. • MDM in 2013 recorded that radiotherapy not undertaken due to	• Lack of / poor communication • Incorrect treatment • Un-actioned MDM outcomes including onward referrals and planned reviews	• Entry indicating patient was informed that radiotherapy was not indicated. Not recorded why and no communication to GP (Multiple missing letters to GP). • Unreasonable delay to appointment with Oncology (13 Months from MDT). • Unreasonable delay to performing TURP. • Consent form for TURP (on 2 occasions in 2013 and 2014) missing all risks/ benefits/ complications.	Yes	Poor Care	Reviewer also identified the diagnosis of Personal Information redacted by the USI which is potentially related to the prolonged ADT.

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		compromised prospect of it being curative. • Bicalutamide 50mg from 2009. • Missing clinical records.	• Prescription of unlicensed medication as an incorrect form of treatment • Unjustified rationale for deferring treatment	• The decision to leave on ADT by Oncology was not unreasonable for high grade cancer but it would have also been reasonable to commence surveillance as no evidence of metastatic disease. • Conflicting opinions in notes. The communication between Urology, Oncology and the GP is poor. • Delay between investigations, procedures, referrals and opinions is unreasonable and led to 6 more years of ADT than needed. • Patient developed Personal Information redacted by the USI which could be contributed to the ADT, and subsequent Personal Information redacted by the USI. This should have been taken into account when continuing with this and the lack of proven benefit.			
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
	Patient 158 Personal Information redacted by the USI	• TURP potentially not indicated. Evidence of obstruction not proven. • Patient expressed he did not want TURP. • Consent form for GA Cystoscopy +/- TURBT +/- TURP. No evidence of discussion of TURP or risks/ benefits recorded on consent. • Patient's wife also spoken to and "gave consent" although patient appeared to have capacity. • Contradictory written communication regarding need for TURP and what was discussed with the patient's wife and what the patient had. • Patient very clearly did not want TURP and had this. Concern this is potentially assault.	• Lack of / poor communication • Incorrect treatment • Practice in relation to operative procedures, including the removal of stents and gaining consent • Not providing patients with options and choice in relation to their treatment pathway (informed consent) • Unorthodox Pathway	• It is not recorded that the patient was spoken to or indeed that patient lacked capacity to have a conversation when recording conversation with patient's wife. • No evidence or recording of patient being informed of risks or benefits. • The possibility of worse outcomes because of the patient Personal Information redacted by the USI was not mentioned. • NICE guidelines would recommend CISC be considered prior to TURP but this was not discussed or explored. • Assessment of the patients LUTS with invasive bladder pressure/ flow rate urodynamics was not performed. Given that the patient had a Personal Information redacted by the USI a strong recommendation is made by the European Association of Urology Guidelines to complete urodynamics. • The consent form is dated 13.5.2020 on the day of surgery. This was considered unreasonable. Clinician signing does not record job title. • The procedure is not recorded as being explained to the patient nor have the benefits. • Operation note records that they are unable to examine bladder endoscopically due to large trilobar obstructing prostate gland. Prostate resected despite the patient not being counselled for this. • There is no evidence of bladder lesion and the bladder could have been thoroughly washed out under anaesthetic and flexible cystoscopy performed at this sitting. • Since surgery patient has been completed rendered incontinent reliant on catheterisation. • Procedure was undertaken without the consent of the patient. • Lead to harm as patient will now need to consider some form of controlled bladder drainage indefinitely.	Yes	Very Poor Care	This case has been noted by the reviewer to have lead to harm. It has also been made clear that the patient had a procedure they were not consented for.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
71.	Patient 159 Personal Information redacted by the USI	• Potential concern that procedure was not required. • Use of hydrodistension is for diagnostic purposes combined generally with Botox treatment (as per NICE guidance)	• Incorrect treatment • Not following NICE guidelines • Unorthodox Pathway • Practice in relation to operative procedures, including the removal of stents and gaining consent	• This would have been an unusual presentation of interstitial cystitis in this age group. Whilst the cystoscopy was reasonable the role of cystodistension is debatable and would not be performed by many Urologists. • Urethral dilatation was not performed which is unusual as this is often part of the cystodistension treatment, but the evidence behind urethral dilation is anecdotal at best. • The consent form signed by the patient records no indications or risks.	Yes	Poor Care	Reviewer also noted the use of medication that requires counselling as was being used off license.

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		- Not intended as single use treatment. - Procedure has fallen out of practice over past 10 years. - This patient had chronic retention, therefore it was considered illogical to do this procedure.		- Patient was commenced on alpha adrenergic inhibitor which is licensed for use in men with symptoms of outflow obstruction due to BPH. It is not unreasonable to try this off license if a patient is counselled. There is no evidence that they were. - The hydrodistension procedure had little merit, this was diagnostic and therapeutic test looking for inflammatory bladder disease which was not a likely diagnosis given the patients age, symptom complex and urodynamic findings. - Whilst no discernible side effects it results in the cystoscopy had to be performed under GA rather than local anaesthetic.			Also noted issues with consent form.
72.	Patient 160 Personal information redacted by the USI	15 year old receiving Botox. - Declined catheter previously and did not have pre Botox counselling or informed of risk of retention. - Should have been trained to self-catheterise. - Missing “basic” investigations and did not exhaust conservative measures/ medication before Botox. - Consent form incomplete.	- Unorthodox Pathway - Practice in relation to operative procedures, including the removal of stents and gaining consent - Delays or absence of reports/ investigations - Not providing patients with options and choice in relation to their treatment pathway (informed consent)	- Approach haphazard. - No basic testing of lower urinary tract function with volume charts. - No structured plan of review or assessment. - As patient declined catheterisation for Urodynamics other alternatives should have been explored including CT Urogram to assess structurally and micturating cystogram. - It is difficult to justify use of Botox therapy. - No proven detrusor over activity and pharmacology had not been exhausted. - No counselling in regards to retention and need for CISC was not discussed or taught. - Conservative measures was incomplete and poorly directed. Inadequate investigations and invasive procedure without counselling, preparation and assessment required to assess if she would have a reasonable chance of benefit. - It would have been more appropriate to refer to a specialist incontinence/ female urology service before this.	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
73.	Patient 161 Personal information redacted by the USI	- Missing investigations prior to TURP. - TURP at young age and potentially not indicated. - Was added to list for a 2nd TURP but was removed by another Consultant. - Urodynamics performed in 2017 showed bladder underactivity.	- Unorthodox Pathway - Delays or absence of reports/ investigations - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Practice in relation to operative procedures, including the removal of stents and gaining consent	- Urodynamic studies were equivocal however this does not rule out obstruction but does imply that there may be a higher failure rate from de-obstructing surgery. - Not unreasonable to have TURP/ Bladder Neck Incision at 40 however the level of informed consent is inadequate. Including the communication with the GP which is substandard. - Patients ability to make an informed decision was not reasonable	Yes	Poor Care	
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
74.	Patient 162 Personal information redacted by the USI	- Patient died as a result of metastatic prostate cancer. - Delay in referral to Oncology.	- Lack of / poor communication - Incorrect treatment - Un-actioned MDM outcomes including onward referrals and planned reviews	- In 2004 it was 2 years and a further PSA rise before the patient was referred to Urology. - Then a 6 month delay in first review appointment. PSA had climbed further. - In effect 30 month delay from 1st abnormal investigation to diagnosis.	Partially	Poor Care	Reviewer advised earlier treatment may not have prolonged life and may have resulted

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		- Should have been offered radical treatment in 2007. In 2007 however was started on Bicalutamide. - Letter to Oncology not dictated until Nov 2008. Had radiotherapy in 2009. - Patient dies earlier than expected, as if had radiotherapy when recommended their survival may have been over 15 years.	Prescription of unlicensed medication as an incorrect form of treatment	- Then an 8 month delay to being reviewed with staging results, therefore overall a 36 month delay from 1st suspicion to diagnosis and staging. Definitive treatment should have started then. - Commenced on Bicalutamide 50mg which is unlicensed. - GP communication is inadequate. - Disease recurrence after 4 years. - Delay to definitive treatment which subsequently failed. The delay did not affect the final outcome. - Had 1 year of unnecessary Bicalutamide 50mg. - With earlier diagnosis it is unlikely that this would have lengthened life expectancy although may have led to having treatment and side effects for longer.			in longer treatment and side effects.
	Patient 1163 Personal information redacted by the USI	- Patient received Bicalutamide and Prostatap for a period. Did not require both. - Decision making around removal of catheter was not normal. Recognising extensive inpatient waiting lists at that time, the outpatient TROC team based at SWAH was available. This option was not explored. Patient had catheter in situ for years as a result of the wait.	- Unorthodox Pathway - Delays or absence of reports/ investigations - Not providing patients with options and choice in relation to their treatment pathway (informed consent) - Incorrect treatment - Prescription of unlicensed medication as an incorrect form of treatment	- No arrangement or instruction was given for the Bicalutamide and Dutasteride to stop and patient remained on this for 3 years. - Failure to give clear instruction with regards to ongoing medication led to several years of unnecessary drugs being administered. - Multiple problems with catheter could have possibly been avoided should the patient have had a TURP at the outset. - Case could have been made for androgen blockade being started earlier.	Partially	Adequate Care	Reviewer advised that overall management was satisfactory and cancer management was appropriate.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
76.	Patient 1164 Personal information redacted by the USI	- Records state Gleason 5, concern that this is not a common grade. With PSA of 23 it is unlikely. Potentially higher grade disease. - Patient was receiving Bicalutamide 50mg and continued post Prostatectomy. Treatment doesn't make sense. - Recurrence occurred very soon after Prostatectomy, no referral for radiotherapy until substantial time after and should have been pre hormones.	- Delays or absence of reports/ investigations - Lack of / poor communication - Incorrect treatment - Un-actioned MDM outcomes including onward referrals and planned reviews - Unorthodox Pathway	- The MRI completed at the RVH but does not appear to have been clearly communicated to the patient or the Urology Team. Patient not seen until 18 months later when result was still not known. - Patient continued on Bicalutamide (low dose) throughout. - In Feb 2006 MRI shows no recurrence and Bicalutamide increased to 150mg and no referral for radiotherapy is made. - No follow up recorded for 2 years until 2008. - In 2012 referred to Oncology for consideration of radiotherapy. Oncology decided to continue on same management. Last Oncology clinic Jan 2014. - GP red Flag referral in March 2019 with increased PSA. Imaging suggests metastatic disease. MDT discussion and advised referral to Oncology for consideration of further treatment May 2019. Limited records until admission and RIP in April 2021. - Issue with 2 year delay in completion of MRI and action taken. Reviewer states unclear if this was an issue with access to scans at the time, but this was very unsatisfactory and should have been chased. - Administration of hormones prior to prostatectomy made interpretation of the PSA difficult. The increasing of this 18 months to 2 years post-surgery likely reflected the withdrawal of hormones rather than disease progression.	Partially	Adequate Care	Reviewer commented that although dose of Bicalutamide was unorthodox practice they believe it would have had very little long term impact on disease progression.

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		Survival potentially should have been longer if it was a Gleason 5 disease.		- The patient received an unlicensed low dose of Bicalutamide for 2 years prior to increasing. - The grade of prostate cancer remains in doubt. It is questionable if micro metastatic disease was already present by the time of surgery. However if there was still a significant PSA level in the first few months after surgery, investigation to determine if this was local disease or micro metastases would have happened several years earlier. - Likely moderate grade tumour with likely micro metastases prior to surgery which would have resulted in the patient needing hormone therapy but they could have had a number of years after surgery before restarting hormones, therefore saved some side effects.			
77.	Patient 165 Personal information redacted by the USI	- Bicalutamide 50mg given for a period before increasing to 150mg. - Remained on Bicalutamide for 4 years until Oncology stopped this. - Radiotherapy delay due to “risk with total hip replacements”. - Peculiar reason to delay radiotherapy referral.	- Unjustified rationale for deferring treatment - Incorrect treatment - Un-actioned MDM outcomes including onward referrals and planned reviews - Prescription of unlicensed medication as an incorrect form of treatment	- PSA increase in 2008 should have been investigated given the consideration for commencing Finasteride. Whilst an MRI would have been contraindicated (cardiac implant) but biopsies could have been completed earlier (done in 2010). - In Feb 2017 request for further biopsies due to nodule felt on DRE. Biopsies not done until July 2017 (4 month delay). - Reviews from August 2017 focused on LUTS. MDM recommendation was not followed, patient started on unlicensed dose of Bicalutamide. If there was a concern regarding LUTS, patient could have continued on surveillance. This would have been appropriate whilst further investigation and consideration took place. - On increasing of Bicalutamide dose to 150mg, whilst appropriate as a precursor to Radiotherapy, there is no mention of this being the plan. - Whilst severe LUTS can be a reason to avoid radiation, there are documented issues in achieving adequate radiation to the prostate in presence of metal prosthesis and could lead to more radiation to the rectum. However it depends entirely on the individual case and therefore the decision would have to be made having fully engaged with the radiotherapist. There is no direct evidence to suggest this that can be commented on. - Lack of evidence that options were fully discussed with the patient and shared with the MDT. - The Patient had a number of years of hormone therapy which they may not have needed. - There has been limited harm as the type of prostate cancer would have ultimately required hormone therapy at some point, however the side effect of gynaecomastia was sufficiently severe to warrant consideration of bilateral mastectomy.	Yes	Poor Care	Reviewer noted the referral made to consider bilateral mastectomy as a result of Gynaecomastia from hormone therapy.
SCRR Number	Initials & H&C Number	Reason Case Screened into SCRR Process	SCRR Screened-In Themes	Findings / Clinical Shortcomings Identified in Returned SCRR Report	Are Findings Consistent?	Overall Care Rating on SCRR Report	Further Comment
78.	Patient 167 Personal information redacted by the USI	- Unclear process in regards to the procedures the patient had. Including standard of consent. - Record review did not demonstrate clear discussion of the procedure intended, starting with the Mitrofanoff and	- Lack of / poor communication - Not following up on / actioning outcomes of diagnostic scans - Practice in relation to operative procedures, including the removal of stents and gaining consent	- Cystectomy and Mitrofanoff Conduit March 2005. No evidence of clear consent or decision making process. Appears to have went from Cystistast in Feb 2005 to cystectomy within a month. Unusual progression and escalation of treatment. - No operation note for removal of Mitrofanoff and from this point the patient had multiple admissions for planned intravenous antibiotics and procedures. - Reviewer notes 21 admissions for hydration and antibiotics and 9 admissions for cystoscopy and urethral dilatation. - The rationale behind moving to a radical procedure such as the cystectomy is difficult to follow. It is surprising that counselling including that of a continence	Yes	Very Poor Care	The reviewer detailed the harm that the patient has experienced as a result.

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		subsequent conversion including why this was required. • Patient waited significant period of time for admission and was admitted recurrently with infections and dehydration likely due to self-catheterisation and incomplete emptying. • Patient should have been offered ileal conduit long before. • Appears the first dilation failed to improve the symptoms and it would not seem reasonable to repeat as it had no impact. • Clear lack of discussion and full consent.	• Unorthodox Pathway	nurse specialists and/ or stoma therapists were not involved. There does seem to be an unusual speed of escalation from intravesical agents to cystectomy and neobladder formation. • No communication with primary care detailing the through process. • Following the cystectomy, the management of the Mitrofanoff is not well documented and appears to have failed leading to its removal rather than revision. This left patient catheterising through her painful urethra. • Patient had recurrent symptoms of suprapubic pain and proven infections and was treated by multiple admissions for intravenous antibiotics on a 6 weekly basis. This is difficult to understand as any root cause of the infections was nto being addressed. • The ongoing urethral dilatations and cystoscopies would again be difficult to justify as they were obviously failing to resolve the patient’s difficulties self-catheterising, pain on catheterising and infections. • It does not seem that a conversion of a neobladder to ileal conduit was discussed with the patient either as a potential before her cystectomy or as an option in light of the ongoing symptoms and repeated admissions and treatments. • Unless proven otherwise, there appears to be a major irreversible procedure performed without due consideration of the detrimental outcomes by the surgeon or counselling of them with the patient. • There has been a desperate attempt at multiple admissions and repeated urethral dilatations taken that obviously failed to resolve the issue rather than (or indeed possibly avoid) having a candid discussion with the patient regarding possible need for ileal conduit. • This certainly should have taken place much earlier in light of her debilitating symptoms including infection and catheterisation. • The reviewer highlighted that this has led to harm. The patient has had irreversible surgery that has left them with life altering symptoms and the possible need for permanent ileal urinary diversion with a stoma in the future. • The reviewer commented that they need seen by a Urology Consultant with a specialist interest in reconstructive surgery of the lower urinary tract in females. This is already actioned.			
This concludes the SCRR reporting analysis on all completed SCRR reports.							

1 "...would be resourced to provide appropriate tracking
2 of patients and to confirm that the recommendations and
3 actions are completed."

4
5 And scrolling down, the assurance is audit.

10:42

6
7 Help us with this, Mr. Glackin. We've heard I think
8 already from you that the MDT is better resourced with
9 the appointment of a Mr. Mark Quinn as a clinical audit
10 and information manager, Mrs. Muldrew as a specific MDT
11 focused admin support. In terms of the audit of the
12 kinds of things discussed in the SAI report, is that
13 being done? I think we've heard from you already that
14 audit is now much improved in the Trust. Is it
15 specific within MDT structures?

10:43

10:43

16 A. So following the appointment of Mark Quinn, and under
17 the direction of Angela Muldrew, we have a monthly
18 audit process of outcomes from MDT to ensure that the
19 outcomes are followed up and actioned. That report is
20 provided to me, and it's also provided to the whole of
21 the MDT, so that if there are any shortcomings or
22 points that have not yet been actioned, they can be
23 brought back to the meeting and discussed and actioned.
24 So, that's been in place for almost a year. So that is
25 working. We have a report from the Pathology
26 Department that's run I think on a weekly basis to
27 ensure that all pathology is brought to the meeting
28 that should be. So they're at least two of the reports
29 that are being supported by cancer services.

10:43

10:44

1 A. No. I know what happened with the patient.

2 100 Q. Yes, but in terms of the problem?

3 A. No.

4 101 Q. The problem for you was, you didn't have notes at the
5 time that the patient was in the bed, or in the chair 16:03
6 at your clinic, and you couldn't find anything in terms
7 of dictation of an outcome from her previous clinic
8 with Mr. O'Brien; is that the problem?

9 A. Yeah, and this particular patient, as evidenced in my
10 e-mail, I was able to review the results and I was able 16:04
11 to come to a view as to how she needed to be managed,
12 but the opportunity that had been missed was, had she
13 been referred to me as she believed she had been or
14 added to the waiting list for her kidney to be removed,
15 as was the decision that had been made, had that 16:04
16 happened she may have avoided that emergency admission.
17 It took her to be admitted as an emergency for me to
18 become even aware of, if you like, her existence and to
19 be able to make a plan for managing her.

20 102 Q. In terms of the incidents that you were reporting into 16:04
21 the system, the first use of a Datix that I have come
22 across concerns Patient 102. If we could bring the
23 Datix up, it's WIT-54874. You can see your name as the
24 reporter and what you have said here is the "patient
25 had been discussed at urological MDM on 20th November 16:05
26 2014." So that's a year-and-a-half earlier. Sorry,
27 a year earlier, I beg your pardon.

28

29 "The recorded outcome ... was restaging MRI scan as

1 shown. Organ confined prostate cancer and he is for
2 direct referral to Dr. H for radial radiotherapy and
3 for outpatient review with Mr. O'Brien".

4
5 You have recorded:

16:06

6
7 "Was reviewed by Mr. O'Brien in outpatients on 28th
8 November 2014. No correspondence created from this
9 appointment. Referral letter from the GP received 16th
10 October 2015 stated that the patient had not received
11 any appointments from oncology. He has now been
12 referred to oncology."

16:06

13
14 Just to unpack that a little. This was a case MDM had
15 made a recommendation, Mr. O'Brien had sat down with
16 the patient at review. What was discussed at that, we
17 can't say from this but there was no referral to
18 oncology, which was the expectation of MDM, and a year
19 later, the GP is writing on the patient's behalf saying
20 where is the oncological referral?

16:07

21 A. Yes. Within there I have talked about the outcome for
22 direct referral. What that refers to is a process
23 where, at MDT, a referral to the oncology team would be
24 generated. Okay. If you like, the first part of the
25 referral for that patient was generated at the
26 multidisciplinary team meeting. Certainly for myself,
27 for those patients where I'm seeing them like we're
28 seeing there, I would also then generate a letter
29 referring the patient to the oncologist as well. For

16:07

1 whatever reason, the direct referral here either wasn't
2 received or wasn't actioned, and so no oncology
3 appointment was received. In there being no letter
4 generated from the outpatient consultation, either
5 telling the GP or the oncologist that they have seen 16:08
6 that the patient has been seen as against again
7 a backstop, a second attempt, the patient didn't get
8 any oncology appointment, and then I received a GP
9 referral on 16th October 2015, and from that,
10 I generated a referral as stated in the second part, by 16:08
11 e-mail and letter.

12 103 Q. So, two issues. First of all, at the MDM, it's the
13 responsibility of the coordinator, in conjunction with
14 the Chairman, to ensure an Oncology referral?

15 A. The direct referral would have been generated, yes. 16:09

16 104 Q. Yes. That will go to presumably Belfast?

17 A. Yes.

18 105 Q. The treating clinician, in this case Mr. O'Brien,
19 speaks to the patient and good practice or required
20 practice to generate a specific dictation after that, 16:09
21 either to Oncology or the GP or both?

22 A. At the very least, good practice would be to generate
23 a letter, I would say generate a letter to the GP, to
24 the referring team, to the team you are referring to,
25 but also generally -- or I would endeavour to copy 16:09
26 patients in where appropriate, where they like, so that
27 would be good practice. My personal view is that it's
28 actually required practice. Part of contemporaneous
29 documentation of any consultation is the letter

1 I generate at the end.

2 106 Q. If we scroll down on this one, I want to ask you
3 a wider question about the process of incident
4 reporting. You have said in your witness statement,
5 Mr. Haynes -- just for the note, it's WIT-53932, at 16:10
6 paragraph 61.3, you have said in your statement that,
7 to this day, you remain unaware of how this concern
8 that you had raised was dealt with. Is that a weakness
9 of the reporting system that you are suggesting, that,
10 if you like, the reporter, in this case you, doesn't 16:11
11 get to hear the outcome, or is it unique to this
12 individual case or is it more general than that?

13 A. I think it's more general that there isn't feedback
14 provided to the reporter. My own personal reflection
15 on that would be that, in not knowing how it's been 16:11
16 dealt with, I don't know whether I need to be alert to
17 more. I don't know whether there's a process to be
18 monitoring for me not to be alert to more. It can also
19 act as a deterrent for people to raise concerns if they
20 are raising an incident report and then never hearing 16:11
21 anything back. They don't know whether that five to
22 ten minutes they have spent in filling in the long
23 electronic form has actually generated any action at
24 the end.

25 107 Q. If we look at the format, if we go down to 54879. If 16:12
26 we could pick up on the, using the left-hand margin,
27 11th December 2015 entry. There is a series of
28 entries, just for the Panel's ear, which reports on
29 various transactions that take place in association



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bespoke facilitation and safeguarding training to enable them to engage with their peers around specific issues and provide feedback of their findings to Macmillan and their partners. Peer-led engagement is based on the principles of shared understanding, empathy and respect for each individual's cancer experience, resulting in meaningful conversations about 'what matters'. It is hoped this will provide authentic feedback and reflection, and help inform future service improvements and developments. We hope to have the finalised report in the near future; this will be presented at the departmental meeting and an action plan developed in conjunction with Mary Haughey (Macmillan Service Improvement Lead) as to how best improve on any areas raised.

33.5 At our weekly departmental meeting, there is also a section for complaints and compliments and any relevant matters are brought to staff's attention.

33.6 The Datix system can also be a way of providing feedback, but exposure is limited as it usually only the persons concerned that are involved in addressing the Datix.

33.7 There are also regular patient safety communications via Trust email. These are normally concerned with medication incidents.

34. In your view, is there a potential for breakdown in communication for patients regarding their care if the CNS is not part of their care team? Do you consider that the absence of a CNS in a patient's care pathway presents a risk to patient care and safety? If yes, please provide examples.

34.1 In my view, there is a potential for breakdown in communication for patients if the CNS is not part of their care team but it should not be a risk to their care or safety.

34.2 According to the Macmillan CNS impact brief and the NICaN Clinical Guidelines 2016 and the MDM operation policy (*please see 35. Macmillan CNS impact brief, 21. NICaN Clinical Guidelines 2016 and 36. V2 Urology Cancer MDT Operational Policy 2020*) the role of the CNS as a keyworker is a supportive one. A patient's cancer journey can be complex and involve care from different teams at different points (e.g., Urologist and Clinical/Medical Oncologist). The CNS provides a constant link throughout this course and can achieve this by being a point of contact for queries or giving appropriate and relevant information. They can also liaise with other professionals involved in the patient's care. The CNS as a keyworker can also signpost/ refer patients to other services that can offer tailored support for their needs, e.g., counselling or benefits advice.

4. "Cancer Services can confirm that the patient attend clinic on 25/05/2019 and it was noted that the CT was to be requested. The request was not raised until 08/07/2019 as an urgent referral (not Red Flag). The CT was completed 18 days after the CT was requested"

The review included the overarching CT timeline, as the critical issue was that the patient had a potentially aggressive tumour and should have been on an appropriately timed pathway that was supported by tracking and assurance mechanisms. The 17week delay should not have happened and ideally systems would have been in place to prevent this.

The recommendations in the over-arching SAI review propose patient pathways should be tracked in real time and prevent such delays.

5. "Cancer Trackers will track patients on the 31 and 62 day pathways in line with what has been commissioned. This is confirmed to be the case in other Trusts in NI with the exception of Western Trust. The responsibility for following up other actions sits with the clinician and his / her secretary."

This is not the experience of the external members of the SAI review team in NI and UK. Critically the resource in SHSCT Urology MDM was unable to meet patient tracking need in these 9 SAIs and in a previous SAI of 2016. Patients came to harm. The review team believe it essential that enhanced resource is in place to improve MDM tracking, in concert with Key workers (usually Urology Cancer Nurse Specialists) and consultant secretaries. This has been shared with the Urology MDM and welcomed, given that several members had previous experience of this approach from the UK.

6 and 7 "It would be helpful if the report stated who was aware of this issue."

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

The above statement was made on behalf of the SHSCT to Urology Cancer Peer Review 2017 – it has proven to be inaccurate and not based on an assurance audit process. The review team appreciated the candour of those who admitted to being aware that not all care was supported by Cancer Nurse Specialists. They do expect that governance processes are enhanced to ensure that no patients receive cancer care unsupported and without linkages to other critical services.

PART TWO BACKGROUND

2.1

Identify the key issues / problems that currently have an impact on people affected by cancer that you are trying to address through the proposed project / service

The role of the Clinical Nurse Specialists (CNS) in contributing to high quality cancer care is now well acknowledged and understood. CNSs are at the front line of cancer care, they are the main point of contact for patients, significantly improved patient experience and deliver services for individual patients according to need and patient choice. They play a vital role in the coordination of patient care and successful implementation of initiatives to improve cancer services. To date CNS commissioning within Northern Ireland has been ad hoc and opportunistic with provision significantly lower than the rest of the UK.

The number of people diagnosed with cancer each year is rising, with one in three of the population developing some form of cancer by the time they reach 75 years of age. In Northern Ireland, 11,000 people are diagnosed with cancer. Driven by the ageing population, this number is expected to rise by 25% for men and by 24% for women by 2020. By 2035, the number of cases per year is projected to be 7,181 male and 6,967 for female cases, a 65% rise among men and 63% rise in women. The prevalent population in 2014 was reported as 63,500 people living with cancer, which is estimated to rise to 110,000 by 2030. In addition, cancer is responsible for approximately one quarter of all deaths occurring in Northern Ireland causing more deaths than any of ischemic heart disease, stroke or other diseases of the circulatory or respiratory systems.

In 2015, the NI Cancer Patient Experience Survey (CPES) reported 72% of patients having access to a CNS, much lower than England 89% (2014), and Wales 88% (2013). Key driver analysis demonstrates the support of a CNS is the most important contributing factor to people reporting a positive experience of care. In April 2014, the Macmillan Adult cancer CNS census of the Specialist Adult Cancer Workforce reported 57.4WTE in N.I. with the majority area of practice being Breast (33.8%), with minimal provision in Urology. This is significantly lower than other UK countries when incidence rates are compared to whole time equivalent posts.

This is further compounded by results from the 3 year NI Cancer Peer Review Programme of Multi Disciplinary Teams (Local and Specialist). Lack of access and single handed CNS provision were found as immediate risks or serious concerns in 17 out of the 30 MDTs Peer reviewed to date.

Currently in the Southern Trust, there is 1.0 WTE Nurse Specialist for the Urology service. Some progress has been made to implement the key worker role for cancer patients, but this has been limited due to lack of resources. Therefore not all patients are supported at key stages of their pathway including at the time of receiving their diagnosis and not all benefit from the skills, knowledge and expertise of a CNS.

The Transforming Cancer Follow Up (TCFU) Programme Evaluation (2015) has provided a strong evidence base for the effectiveness of risk stratified models of follow up within Breast and Prostate cancer. Risk stratification has the potential to improve patients experience, health and wellbeing and improve resource utilisation. Pivotal to the success of risk stratified models of follow up is the involvement and availability of CNSs. Urology nurse led follow-up pathways have been agreed regionally but have not been implemented in SHSCT due to lack of dedicated staff. For further development to occur, additional staff are required.

There is an overwhelming deficit in the number of CNSs within SHSCT. By increasing the number of nurse specialists and through inclusion of support worker roles within the CNS workforce plan this will support skill mix by assisting in the delivery and co-ordination of care, education and support, under the supervision of Clinical Nurse Specialists for patients with cancer.

Within SHSCT, there were 746 new patients with urological cancers diagnosed in 2016.

There are currently two Urology CNSs within the Trust providing care for patients with all urological disorders. Investment in a 1.0 WTE Urology CNS will further enhance the uro-oncology service and the development and co-ordination of the service. This CNS will work primarily with patients with prostate and renal cancer. The 0.25WTE band 3 support worker will provide administrative support for the team and act as a point of contact for patients to ensure the most effective use of resources.



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22.10 I am unsure if anything could have been done differently. It is necessary to recall the challenges in those years. The vacancy scrutiny in place from 2010 to 2015 and the turnover of Consultants were likely to have impacted upon the ability to progress development at the expected pace. Likewise, the delay of appointments in CNSs as proposed created significant gaps in service provision. Displacement of highly skilled urological nursing staff resulted in ongoing challenges to promote post-graduate urological education from that time forward. This occurred despite Jenny McMahon and I organising educational sessions in the Medical Education Centre, creating opportunities for ward based staff to spend time in the Thorndale Unit setting and promoting additional third level education.

22.11 When Martina Corrigan was appointed, these concerns were discussed with the Consultant and CNS team. At some later stage (possibly in 2010), urology beds were relocated to a 19 bedded area within 3 South, however the specialty had incurred a loss of highly skilled nursing staff during this period.

23. Do you consider that the role and functions of CNS were resourced properly from the outset? If not, what impact do you consider this had on service provision and patient care and safety generally?

23.1 I do not consider that the role and functions of the CNS were resourced properly from the outset. The absence of a unit manager, lack of dedicated clerical support and being counted within core nursing staff for all clinical activity severely restricted my ability to progress, advance and develop my role in providing independent nurse led services and to provide adequate keyworker input. The prolonged process to appoint additional CNS members contributed further to delays in service development.

23.2 As service development progress was delayed, the impact upon patient care would have been most evident in the inability to provide keyworker input for every patient with a cancer diagnosis.



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MDT meeting, I have no insight as to how these issues were addressed within the management structure.

25. If you did experience the issues at (i) – (v), what is your view of how those risks and serious concerns came about?

- 25.1 The ongoing recruitment issues for medical and nursing practitioners within the Trust contributed to the risks and serious concerns listed. Some issues may have been outside the remit of the Trust, such as Oncology input at MDT as my understanding is that this service was managed regionally.

26. In your view, what is or was the impact on patient safety and care planning of the issues at (i) – (v), and what was done or could have been done to address these problems? Please provide examples as relevant.

- 26.1 Given there was only one CNS with an Oncology focus, and the fact that this CNS still had managerial responsibility for the unit, it limited the ability to provide a CNS for each patient with a cancer diagnosis. While there were fluctuations as to how many Consultants were in place, during 2015 there were six, all holding one results clinic per week. At all times, Macmillan packs and information booklets containing contact cards were available within each consultation room. Where a CNS was not available this information could be provided by the Consultant. A focus to appoint additional CNSs at an earlier stage would have contributed to additional CNS input. This issue limited accessibility for patient access to a CNS for ongoing support throughout their cancer journey.
- 26.2 Demand and capacity issues would have had a direct impact on seeing routine referrals. This resulted in patients waiting many years to be assessed for conditions, that while considered routine, may have had a significant impact on their quality of life on a daily basis. Delays also resulted in ongoing anxiety for the patient while awaiting appointment. This meant that patient

1 cancers.

2 A. I would observe that we were grossly underserved by CNS
3 capacity at that time, and if you look at other
4 specialties, in particular breast cancer and
5 haematology, two specialities which have long had 11:16
6 better resources than we have had.

7 87 Q. Yes. If we go to your statement WIT-42304. You say at
8 26.2 that you understand that not all of your
9 colleagues worked in the same manner with urology
10 cancer CNSs. Kate O'Neill and Leanne McCourt told you 11:16
11 that they found the communication was difficult with
12 some consultants and that they were not invited to be
13 present at uro-oncology consultations. You've said
14 earlier that obviously you don't have the benefit of
15 being in the room with your colleagues as they consult 11:17
16 with their patients, so you can't know precisely what's
17 going on. What is contained within this paragraph
18 seems to be a reference to more than one consultant not
19 behaving in the same manner as you do in terms of their
20 use of CNSs? 11:17

21 A. So it came as more than a surprise to me that all of
22 these patients in Dr. Hughes' SAIs had not had a cancer
23 nurse specialist involved in their care. Around that
24 time I was aware that this Inquiry was going to be
25 announced, and I was also aware that we were being 11:17
26 interviewed by Dr. Hughes. So I was careful in the
27 discussions that I had with my CNS colleagues, because
28 I didn't want to colour their view or try and influence
29 how they perceived the situation. So I spoke

1 informally to both Kate and Leanne and asked them what
2 their experience was. Mr. O'Brien would not have had
3 the CNS in the room at his clinics on every occasion,
4 he may have invited them in for selected patients, and
5 that was what I understood from those conversations. 11:18

6
7 I also -- Leanne also relayed to me the encounter that
8 she had with Mr. O'Brien regarding the key worker
9 discussion, and she outlined that discussion which took
10 place -- from my recollection she described it taking 11:18
11 place in the small kitchen in the Thorndale Unit. So
12 that stuck in my mind as to a kind of important
13 interaction that they had had on the key worker role.

14 88 Q. Just outline that account for the benefit of...

15 A. So Leanne McCourt described to me that she had advised 11:19
16 Mr. O'Brien that she was available to be the key worker
17 for his clinic, and he in turn spoke to her, and I'm
18 relaying what she told me, that he didn't understand
19 what the key worker was. "What is the key worker?", is
20 the kind of substance of it. She was -- she described 11:19
21 feeling a little bit taken aback and shocked by his
22 language, and she relayed that story to me, and I think
23 she's relayed it to you here as well.

24
25 So that to me kind of laid out that perhaps he wasn't 11:19
26 as open to involving the CNSs as I was, that there was
27 a difference in his approach.

28
29 Kate also relayed to me at another time that when we