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Southern Health and Social Care Trust

Medical Directorate

Dr D Corrigan
Consultant in Public Health Medicine
Public Health Agency
Southern Office
Towerhill
Armagh

Dear Dr Corrigan

The following is an updated position of the Trust's investigation and resolution of clinical matters within our urology services, about which we have spoken and corresponded. I refer to your letter of 01st September 2010.

IV fluid and anti-biotic patient group

All of these patients have been formally reviewed and the clinical management of each member of the cohort taken forward within a multi-disciplinary team chaired by the Clinical Director of Surgery [nursing, urological surgery and microbiology]. Patients are reviewed if symptomatic, and then managed on an agreed clinical pathway, which is initiated by a specialist nurse. Admission to the ward is possible but only if outpatient or day case management fails – usually in cases of severe sepsis. Antibiotic use is determined by surgeon and microbiologist in agreement and in line with the Trust's guidelines. The two patients with central venous access have had the venous cannulae removed last autumn.

There are no patients therefore remaining in the old group which was treated with episodic IV fluids and antibiotics.

Review of cystectomies.

The Trust has already confirmed that all urology patients with the potential for radical resection of the bladder for malignant disease are referred to the Belfast Trust for definitive treatment and follow up.

Also since last September 2010 all patients with benign disease and potential for cystectomy are referred to the Belfast Trust. The Southern Trust, therefore does not do any cystectomies, and this has been the position since last September 2010.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI / Fax: Personal Information redacted by the USI / Email: Personal Information redacted by the USI

2.11. Overall care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.
Please also include any other information that you think is important or relevant.

This is an interesting case.

At initial diagnosis, the case was reviewed at MDT as a T3N0M0 high risk Gleason 4+4 with capsular invasion on MRI. It would be standard practice to recommend hormones and radiotherapy for this case as was the conclusion of the MDT. This was not followed which would be regarded as 'poor' practice. Active surveillance would not be recommended because of the apparent high risk nature of the disease. Instead monotherapy with bicalutamide was given - which in this case would be on licence but not first choice.

As it transpires, the PSA has been extremely well controlled over the 10 year period and the patient has remained well. For the last two years, the hormone therapy has been stopped, and the PSA has risen only slightly to 0.19ng/ml. In an 88 year old patient, it is extremely unlikely that the disease would advance quickly and if it did, hormones could be reintroduced as suggested by Mr Haines. The patient has done very well - and has not had the risk of complications from radiotherapy.

The question therefore is whether he has had 10 years of hormones unnecessarily? The answer to this is almost certainly 'no'. Had he not had the bicalutamide, I suspect that the tumour would have progressed in the 10 year period, being already locally advanced at diagnosis.

In this instance we must ask whether he had been better off having the hormone therapy for 10 years, the side effects of bicalutamide being minimal compared with the alternative LHRH partial agonists; or whether he would have been better off having radiotherapy - with its potential well recognised side effects?

This man was fortunate in that his tumour, though advanced, was, and remained, hormone sensitive over the 10 year period. I therefore believe, with hindsight, he had the correct treatment. Evidence would suggest however that this would not be the case for the majority.

Did AoB know something that we don't? I find it difficult to mark this as 'poor' care on this form when the patient has, admittedly with hindsight, had the better treatment. I have therefore marked it as adequate.

Irrigating fluids used in urological procedures

Craigavon Area Hospital Urologists comments (January 2014)

A commentary from the Urology Unit, Craigavon Area Hospital has been requested with reference to the use of irrigating fluids for endoscopic procedures. The Consultants' in the unit have had the opportunity to discuss this as a group. The background to this request is understood to relate to the unfortunate death of a young lady from hyponatraemia and bleeding as part of a gynaecological procedure. We are not in a position to directly comment on this particular case, but will be passing general comments on certain principles.

Irrigating fluids are used in an array of urological endoscopic procedures. These procedures include cystoscopy, TUR Prostate, TUR for Bladder Tumours, Bladder Neck Incision, Rigid Ureteroscopy, Flexible Ureterorenoscopy and Percutaneous Renal Surgery. Irrigating fluids used are Glycine, Normal Saline and Water. The particular choice of irrigating fluid to be used is chosen depending on the particular action to be carried out during the endoscopic procedure.

Water is infrequently used but its properties are similar to Glycine in terms of electrical impedance. It is use, in small volumes (300 mls), to flush specimen samples of prostatic chippings or bladder tumour out of the bladder at the end of a procedure.

The choice between Glycine and Normal Saline pertains to the precise technology to be used for a procedure. Normal Saline is used for ureteroscopic surgery as well as percutaneous renal surgery. This is because the use of laser fragmentation of stones and ultrasound disintegration of stones is best achieved in this fluid medium as well as noting it is as isotonic and compatible with human blood.

Glycine is used for resection of prostatic tissue and bladder tumours. It is used because of its compatibility with monopolar diathermy resection. Normal Saline for resection is used with a bipolar diathermy technology and would be used as part of laser endoscopic prostatectomies.

It is understood that Glycine is hypotonic and if absorbed can cause hyponatraemia. Glycine has been used for several decades as an irrigating fluid for resection surgery in urology. The condition of TURP Syndrome is indeed well recognised and in urological terms has been used as opposed to the term hyponatraemia. Glycine is used worldwide and urologists, as part of their training, are taught to recognise how this occurs, avoidance principles, its signs and symptoms and to lay out a management plan for its therapy.

It is appreciated by all that technologies and techniques change, but this does not necessarily negate the need for older techniques and technology to be lost.

All the urologists in Craigavon throughout their training and in consultant practice have been using Glycine for endoscopic resection. It is appreciated that a few patients have had TURP Syndrome but to our knowledge there have been no adverse long-term effects from this in any patient.

There are several key points to highlight in our practice in Craigavon. Firstly, it is recognised that there is a team approach to providing patient care. It starts with a team briefing i.e. the WHO checklist, all personel in the theatre environment are therefore aware of the operation and the need for a coordinated patient management policy. The commencement of resection time is noted and throughout the whole procedure it is appreciated that time is a significant factor. With regards to TUR Prostates, we will generally not resect beyond the hour. The 'clock is watched' throughout the procedure. The irrigating fluid bag is hung between 50 and 100cm above the patient's waist. The matching of the fluids running in and the fluids retrieved have in recent years not been precisely monitored but in general terms, nursing staff will monitor what is known as the in's and out's and surgeons generally ask if there is any mismatch throughout the procedure. The specific recognition of excessive bleeding and a capsular perforation is of particular importance to the operating surgeon. This bleeding risk, capsular perforation, and the increase in resection time, are all recognised as causing an increased risk of absorption. We also regard the use of the continuous irrigating scope as a major advance in TUR Prostate procedure. The use of the continuous irrigating scope has resulted in resection time being shortened and also keeps the bladder pressure constant. This we regard as decreasing the risk of absorption.

The surgical technique of bipolar TURP using Saline and monopolar TURP using Glycine is by the same surgical technique i.e. loops of prostate or bladder tumour being resected and these chips are then washed out. However on looking at the finer nuances of the procedure commented on by severalurologists, do note that the cutting mechanism is not as precise especially in the setting for bladder tumours and that the haemostasis diathermy used is not as good when using the bipolar technology in Saline. This is noted both intra-operatively as well as in the post-operative phase and as such has led to the complication of excessive bleeding. This extrapolated would theoretically increase the risk of transfusion and potential return to theatre for cautery.

We do appreciate that there could be room for improvement in intra-operative monitoring e.g. more precise real time regard for the fluid input matching output and the potential for intra-operative blood testing. There are several scientific papers dating back over the decades on these precise topics. Our understanding is that this has not been particularly productive albeit that we recognise it is a very reasonably practical monitoring modem.

Our experience tells us that the 3 litre bags do not precisely contain 3 litres, inadvertent irrigation fluid spillage on the floor from inadequate capture by the drape system combined with the natural production of urine and surgical blood loss volumes, will all lead to a discrepancy in the input/output volumes.

Re-instigating the previous regime of the theatre staff more formally being in charge of monitoring, in real time, the number of bags used and volume drained out would keep a closer 'eye on' the situation. We are aware of new technologies that monitor the fluids 'in and out', in real time, are now available but these have not been trialled by our department nor are we aware of other units using them. Intra-operative intravenous sampling to measure sodium and other electrolytes has been researched in the past and could be re-introduced and we would welcome our anaesthetic colleagues view on this.

We would like to point out that we regard TUR Prostate and bladder tumour to be a different operation to the gynaecological TCRE, albeit that they are all endoscopic resection techniques. We regard the TCRE as endoscopy in a smaller cavity where the tissue is more vascular and sinusoidal in its anatomical configuration. All these features we regard as increasing the risk of absorption. TUR Prostate, especially with the continuous irrigating scope is at a lower pressure. Deep resection and capsular perforation are much less of a feature in modern day TUR Prostates. The use of haemostatic diathermy in the procedure is more often performed. In conclusion Transurethral Resection of Prostate and bladder tumours are one of the main core surgical techniques taught during urology training. All aspects of management are taught to a high level; this includes surgical technique and management of potential complications. The use of Glycine has been used worldwide for TUR Prostates and bladder tumours for decades. Surgical technique has been well tried and tested. We appreciate that some urologists may wish to use the bipolar Saline surgical technique but this should not hinder others from using Glycine, a surgical technique they have been well used to using.

Since we first discussed this topic in our department a month ago (hence the above notation), changes have already been proactively undertaken. Fluid management is dynamically monitored with a record being written on a specifically designed fluid chart. This is formally recorded after each 3l bag of Glycine but is also inspected continuously via the suction drainage bottle. Spillage is kept to a minimum by capture in the drape system. Being conscious of the bag height being kept at less than 100cm is also at the forefront in setting up for the procedure. Surgeons are kept informed about the time as the procedure progresses rather than being told 'it's coming close to an hour'. The anaesthetic service has already introduced blood sampling before and at defined time intervals throughout the procedure (and more often if clinical thought prudent) as a mechanism of identifying the potential for this particular risk occurring. Therefore the theatre department in Craigavon Area Hospital has proactively taken measures to reduce the

risk of hyponataemia occurring in the first place and the risk of its development is continuously assessed throughout the procedure and into the recovery ward. Identification using these assessment tools will identify if there is an issue as soon as possible.

M Young on behalf of the Urologist Southern Trust 5.2.2014

From: Avril Frizell <[redacted]>
Sent: Tuesday, December 19, 2023 12:51 PM
To: Donnelly, Anne <[redacted]>; Murphy, Eoin <[redacted]>; Benson, Shauna <[redacted]>
Cc: Emmet Fox <[redacted]>; Keeva Wilson <[redacted]>
Subject: C Hagan Ureteric stone patient
Importance: High

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

Dear Anne

You will recall that Mr Chris Hagan, Medical Director BHSCT, states in his S.21 Statement that:

> "I described my experience with the lithoclast, which has a zero risk of ureteric

> perforation, and questioned why he would not use it, as it was very cheap technology. Again, I found Mr. O'Brien to be dismissive of my concerns. Mr. O'Brien did not accept my view. Unfortunately, when carrying out a left ureteric stone case, with Mr. O'Brien directly supervising me, he told me to use the EHL probe to break up the stone. As instructed, I did this and the discharge of the energy source caused a very large perforation in the upper third of the ureter. Mr. O'Brien took over the case and was unable to negotiate a ureteric stent into the kidney due to the size of the defect. This then required the patient to have an open surgical repair of his ureter. I was very distressed by this complication, as I felt very much to blame for it, even though I had carried out the instructions of the supervising Consultant. Mr. O'Brien spoke to the patient afterwards, as he was ultimately responsible for the operation. I was not present. I don't know what Mr. O'Brien said to the patient. With hindsight, it is clear to me that the direction I received from the supervising Consultant, to use the EHL, was not appropriate in the situation and that this was an entirely avoidable complication."

The Trust has investigated this issue and has been able to locate the chart and the operation note in respect of what the Trust believes to be the patient in question. To that end, I have attached copy of the redacted operation note completed by Mr Hagan, as well as the redacted correspondence from Mr O'Brien to Dr Poots, General Practitioner, dated 3 August 2000. As you will see from these two documents, there is no mention of Mr O'Brien, either listed as supervising consultant or as being present in theatre at the time of the operation. You will note the comment at the end of the operation note completed by Mr Hagan which confirms that Mr O'Brien was informed.

Finally, I have also attached emails regarding the Trust's purchase of laser and lithoclast. I would refer you in particular to the email from Madonna Haughian, Admin Business Manager Non-Medical Assets and Contracts, to Sister Latimer dated 12 October 2023. As you will see, laser and lithoclast were not in operation in the Southern Trust in 2000.

Please let me know whether you require any further information in respect of this matter.

Happy to discuss.

Kind Regards

Avril Frizell
Consultant Solicitor
Directorate of Legal Services
Business Services Organisation

2 Franklin Street | Belfast| BT2 8DQ
Direct Line: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

In light of ongoing remote working arrangements and in the interests of reducing environmental impact, please forward correspondence by email only.

OPERATION NOTES

HOSPITAL ..... CAH

Operations Performed
(L) URETEROSCOPIC LITHOTRIPSY

Date

Surgeon CHRIS HANAN

Anaesthetist

Assistant

Sister

Incision

Blood

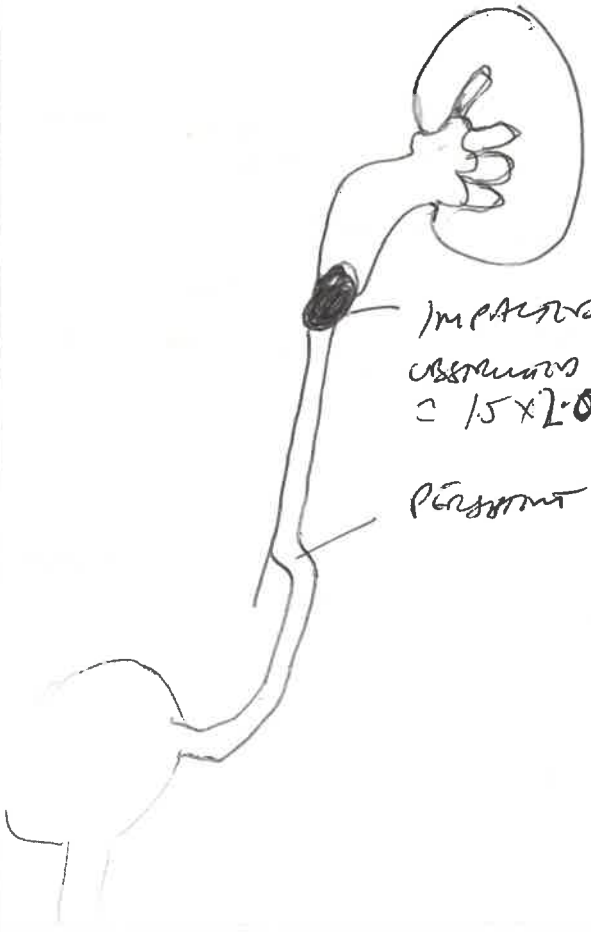
Findings non-functioning kidney
— IMPACTED STONE UPPER 1/3 (L) URETER
* URETERIC PERFORATION *

Drains

Packs

PROCEDURE FAILED JJ STENT

120mg IV Gent



IMPACTED OBSTRUCTING STONE ; OEDEMATOUS MUCOSA
c 1.5 x 2.0 cm.

PERFORATION MID URETERIC 1/3RD

PTD

Signature of Surgeon _____

Trimprint, Armagh

NSV Ref. No. WWW439

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

Mr Aidan O'Brien
Consultant Urologist – Discharge Summary

Patient's Name:
Address:
DOB:
UN:

Date typed: 04 August 2000
Date dictated: 03 August 2000

Dates of Admission: 1) 05 May 2000 2) 29 June 2000
Date of Discharge: 1) 12 May 2000 2) 19 July 2000

Diagnoses:
1) Left Upper Ureteric Calculus
2) Left Upper Ureteric Injury
3) Left Upper Ureteric Stricture

Operation:
1) Left Ureteroscopic Lithotripsy — Date: 06 May 2000
2) Left Percutaneous Nephrostomy Drainage — Date: 10 May 2000
3) Resection of Left Ureteric Stricture — Date: 08 July 2000

Personal Information redacted by the USI

Dear Dr Personal Information redacted by the USI

I write to you concerning this 46 year old gentleman who was admitted to Daisy Hill Hospital in Newry on 2 May this year following a two week history of increasingly severe left flank pain which radiated into the left groin. In fact, this gentleman reported in a long history of left ureteric colic associated with spontaneous passage of calculi over a period of some 26 years. He also had had a history of a urethral stricture.

Following his admission to Daisy Hill Hospital, intravenous urography revealed the presence of a stone located in the upper third of the left ureter, and causing virtually complete obstruction, there being minimal excretory function found. The right upper urinary tract was normal.

Personal Information redacted by the USI was transferred to our Department on 5 May. At left ureteroscopy on 6 May, he was found to have tortuousity of the middle third of the left ureter, rendering ureteroscopy difficult. The upper ureteric stone was reached. It was so impacted that it was impossible to pass a guidewire beyond the stone. Satisfactory fragmentation of the stone was achieved by electrohydraulic lithotripsy. Fragmentation of the stone enabled its dissimpaction. The ureter at the site of stone impaction was found to be markedly oedematous and inflamed. Following

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Direct Line: Personal Information redacted by the USI Fax: Personal Information redacted by the USI E-mail: Personal Information redacted by the USI

dissimpaction, it was evident that lithotripsy had resulted in a complete neural, posterior perforation of the ureter at the site of stone impaction. It was subsequently impossible to stent the perforated ureter. A left nephrostomy drain was inserted percutaneously post operatively.

Four days later, an attempt was made to stent the ureter antegradely. A nephrogram confirmed the persistent of a stone, measuring 1.5 cm in diameter, largely radiolucent, still located in the upper third of the left ureter. There was minimal extravasation of contrast at the site of ureteric perforation. Whilst it was possible to advance a guidewire past the stone from above, it was similarly impossible to stent the ureter antegradely. Prior to discharge, radioisotope renography revealed diminished function in the left kidney which contributed only 20% of overall renal function. Significantly, overall renal function itself was not biochemically normal, his serum creatinine being elevated at 150 umol/l, improving to 133 umol/l with nephrostomy drainage. Personal Information redacted by the USI was rendered comfortable by nephrostomy drainage. He was discharged on 12 May, arrangements having been made with my colleague, Mr Young, for his subsequent readmission for attempted retrieval of the left upper ureteric stone percuteously.

However, Personal Information redacted by the USI was readmitted on 29 June with increasingly intolerable, persistent left loin pain radiating to his left flank and groin. He had had a proven urinary tract infection in the interim, accompanied by right flank pain, which resolved with antibiotic therapy. On his readmission, there was found a further improvement in biochemical renal function, his serum creatinine being 124 umol/l. There was no significant urinary tract infection on urinary culture. A further attempt was made to antegradely stent the left ureter on 5 July. A left nephrostogram confirmed the presence of a tight stricture in the upper third of the left ureter. The stricture permitted passage of a guidewire, but not of stent. This being the case, I decided to explore the upper left ureter with a view to resecting the stricture.

Through a left flank incision on 8 July, I found extensive periureteric fibrosis surrounding the upper third of the left ureter. There was a very tight ureteric stricture of 1 cm in length, above the level of the pelvic brim. The stricture was resected. The renal pelvis was examined endoscopically, finding stone matrix in the renal pelvis. All stone material was removed. The left kidney and the entire ureter had to be mobilised in order to enable ureteric anastomosis, with minimal tension, over a ureteric stent.

A post operative nephrogram performed on 14 July confirmed relief of ureteric obstruction and absence of any anastomotic extravasation. The nephrostomy drain was subsequently clamped and removed.

Prior to Personal Information redacted by the USI discharge on 19 July, a further improvement in biochemical renal function was found, his serum creatinine falling to 108 umol/l by 11 July. This reflected an improvement in left renal differential function to 29%. On renography, left renal cortical scarring was evident, a probable reflection of a long history of left upper urinary tract stone disease. Personal Information redacted by the USI was fit for discharge on 19 July. I have arranged for him to return to the Day Surgical Unit on Friday 11 August for endoscopic removal of the left ureteric stent. I have also arranged for him to have subsequent intravenous urography, followed by review at my clinic at Craigavon Area Hospital on Tuesday 5 September.

Yours sincerely

[redacted]
dictated but not signed by

Mr Aidan O'Brien
Consultant Urologist
Secretary's Id: F Johnston

Copy to Mr M Young, Consultant Urologist

Craigavon Area Hospital Group Trust, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ
Direct Line: Personal Information redacted by the USI Fax: Personal Information redacted by the USI E-mail: Personal Information redacted by the USI

<[redacted]>
Cc: McArdle, SiobhanM <[redacted]>; McKenna, Michelle <[redacted]>; Lindsay, Steven <[redacted]>
Subject: RE: - Lumenis Laser asset 149184 MAINT. OF LASER EQUIPMENT – 1700604 CCBMS31560

Dear Sr. Latimer

- The greenlight laser asset 326415 was purchased January 2017 under PO NO CC01135 @ £66900
- Verapulse Holmium YAG asset 149184 was put into use in April 2006, according to the database, cost £176,194 we have no information on the purchase order no.
- EMS Swiss Lithoclast Laser, asset 311035 was purchased March 2014 under PO NO CC00382 @ £41,992
- Cyber HO 60 asset 341332 was purchased in February 2021 under CC02000 @ £62,500 but was replaced with upgraded version asset 346420 Cyber HO 100W @ £36,900 under CB168513

I trust this information is of assistance.

Kind Regards,

Madonna Haughian
Admin Business Manager Non-Medical Assets and Contracts
Estates Building | Lurgan Hospital
Internal/External Tel: [redacted] | Working Pattern: Monday – Thrusday 8:00am to 6:00pm
[redacted]
svsvdvsdvsdvdv3

Welcome to the MICAD HD Customer Portal
Medical Technical Services - Home

From: Latimer, Charlene <[redacted]>
Sent: 12 October 2023 02:50
To: Haughian, Madonna <[redacted]>; Lindsay, Steven

<[redacted]>
Cc: McArdle, SiobhanM <[redacted]>; McKenna, Michelle <[redacted]>
Subject: RE: - Lumenis Laser asset 149184 MAINT. OF LASER EQUIPMENT – 1700604 CCBMS31560

Madonna/Steven

Could I ask you about when the lasers below were purchased for use in CAH Theatres 1-4. I have been asked to provide this info and the previous urology sister has recently retired and she would have had all the records/emails for this and I can't find any of this info in previous Laser Folder?

AMS Green Light Laser

Lumenis Versapulse Powersuite (HOLMIUM:YAG) Laser

EMS Swiss Lithoclast Laser

Quanta System Cyber Ho 60W

This info is needed urgently so would really appreciate any info,
Kind regards and appreciate your help.

Charlene Latimer

the underlying lamina propria has been identified (pTa) while in a separate fragment muscularis propria is present which is not involved. Carcinoma in situ has not been identified. Prostatic urethra biopsies, Histological examination through levels shows fragments of urothelial mucosa within one of which the features are those of a grade 2 papillary transitional cell carcinoma. No invasion of the underlying lamina propria has been identified (pTa). Prostatic glands and stroma are present within which some of the epithelium exhibits metaplasia but there is no involvement of the prostatic tissue by tumour. Discussed at Urology MDM 15.10.15. Personal Information redacted by the USI has an intermediate risk non invasive bladder cancer. For OP with Mr O'Donoghue to offer a course of intravesical Mitomicin C and subsequent endoscopic surveillance. Personal Information redacted by the USI has remained under surveillance for his G2, pTa TCC bladder carcinoma. Treated with Mitomycin 6 week course. At cystoscopy there was an area of recurrence within his bladder. TURBT, 27.01.16 - Histological examination shows fragments of bladder mucosa with surface papillary urothelial carcinoma, WHO grade II. There is no infiltration into subepithelial tissues and the tumour is regarded as stage pTa. Small fragments of detrusor muscle are present and shows no evidence of involvement by tumour.

MDMAction

Discussed at Urology MDM 10.03.16. Personal Information redacted by the USI has recurrent intermediate risk non muscle invasive urothelial cancer of the bladder despite having received a course of intravesical MMC. Mr O'Donoghue to recommend a further 6 week course of MMC and ongoing flexible cystoscopic surveillance.

	Surgeon	Oncologist	Clinician	Palliative Medicine
Personal Information redacted by the USI	SURESH K DR Personal Information redacted by the	None	None	None
	DOB: Personal Information redacted by the USI Age: 75	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis: Prostate cancer
Staging:

MDMUpdate

CONSULTANT MR SURESH: This 75 year old man was seen in the clinic on 16/11/15 for mild voiding LUTS which he doesn't find bothersome. However his PSA had gone up from 7.6ng/ml to 10.2ng/ml within the previous 3 months in the absence of any UTI. He has not had any haematuria. He is known to have CKD with eGFR of 53. He had carotid endarterctomy in 2011 Examination of the abdomen and external genitalia were normal. DRE showed a large benign feeling prostate. It measured 67cc on ultrasound scan His uro-flow showed a Q-max of 19mls/sec leaving a moderate residual of 110mls . Further to MRI prostate he underwent TRUS and biopsy on 5/1/16. Prostate measured 65cc. Transrectal prostatic biopsy, 0S.01.16 - Maximum length of tumour 10 mm Gleason score 4+3=7, number of cores involved 6/26. Overall tumour volume 11% Lymphovascular invasion no. Perineural invasion no. Extraprostatic extension - no. Discussed at Urology MDM 21.01.16. This man has been found to have intermediate risk, prostatic carcinoma on recent biopsies. For review by Mr Suresh to repeat PSA and and to request a bone scan followed by further MDM discussion. Reviewed in the clinic on 22/2/16. Requested bone scan. Bone scan, 02.03.16 - No evidence of bony metastatic disease. There is degenerative tracer activity at both hips, more marked on the left.

MDMAction

Discussed at Urology MDM 10.03.16. Personal Information redacted by the USI has a non-metastatic intermediate risk prostate cancer. Mr Suresh to review in outpatients and recommend treatment with ADT and radiotherapy or watchful waiting.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	None	None	None	None
Patient 127	DOB: Personal Information redacted by the USI Age: 78	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis:
Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This 78 year old lady who has a history of recurrent urinary tract infections. She had several urinary tract infections particularly around the time she had her hip replaced back in August 2015. Her eGFR is >60 and creatinine of 79. She tells me her flow is intermittently good and bad and she describes storage type symptoms. She passes urine 2 or 3 times during the day and once or twice at night. On examination she is somewhat immobile consistent with her recent total hip replacement. She has had a flexible cystoscopy and that showed red vulva and the urethra looked alright. The bladder mucosa was very reddened in patches with a considerable amount of slough obscuring the views. Her eGFR was normal. Bladder biopsy, 16.02.16 - Overall, the features are of a poorly

differentiated carcinoma arising in a background of squamous metaplasia. The morphological features along with the immunohistochemical staining pattern are, while not totally specific, in keeping with poorly differentiated squamous cell carcinoma.

MDMAction

Discussed at Urology MDM 10.03.16. Patient 127 has a squamous cancer of the bladder. Mr O'Donoghue to arrange staging with a CT Chest abdomen and pelvis, Bone scan, assess suitability for radical cystectomy and for subsequent central MDM discussion.

prognosis for Personal Information redacted by the USI may well be lower than this but could also be impacted by nmore recent treatment options for castrate resistant disease.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR Personal Information redacted by the USI	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age: 79	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis: Renal clear cell carcinoma
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: This 79 year old lady was admitted to ICU Craigavon on 15th January 2016 with confusion, dehydration, hypotension and severe AKI (eGFR 6 from baseline 50). Diagnosed with E coli urosepsis, she made an excellent recovery with medical management. Ultrasound KUB on 18th January revealed an 8cm left renal mass. CT C/A/P, 28th January - confirmed an 8.5cm x 7cm left mid-pole renal tumour. No evidence of pulmonary or nodal metastases. The patient denies any loin pain, recurrent UTIs or visible haematuria. Has had unintentional weight loss over the last 6 years. On examination she was comfortable, BP well controlled and no palpable masses. She has severe thoracolumbar spondylosis and kyphosis so that her face is essentially parallel to the ground when standing. Hb 98, plts 398, Hct 0.299, creat 104, eGFR 44, Ca 2.20, ALP 152. Patient medical history includes IHD, NSTEMI 1998 + 2012, EF 55% 2012, CKD 3, HTN, OA. She is on Aspirin + Clopidogrel. Lifelong non-smoker and no EtOH. Discussed at Urology MDM 11.02.16. This lady has a left sided renal tumour. For review with Mr Glackin to organise bone scan, DMSA and assess appropriateness for surgery. Bone scan, 29.02.16 - No evidence of osteoblastic bony metastatic disease. Left laparoscopic nephrectomy, 08.04.16 - Clear cell adenocarcinoma. Fuhrman nuclear grade II. Tumour necrosis - no. Local invasion. pT2a Lymphovascular invasion - yes-tumour is seen within relatively large calibre but non-muscularised vascular channels adjacent to the tumour in blocks taken to include the renal hilum. These vessels were not grossly apparent. Lymph nodes - none submitted/identified Margins. Gerotas fascia - 12 mm. pT2a.

MDMAction

Discussed at Urology MDM 28.04.16. Personal Information redacted by the USI 's nephrectomy pathology shows a G2 T2a margin negative renal cancer. Mr Glackin to review and recommend a follow-up CT in 6 months.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR Personal Information redacted by the USI	None	None	None
Patient 127	DOB: Personal Information redacted by the USI Age: 78	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This 78 year old lady who has a history of recurrent urinary tract infections. She had several urinary tract infections particularly around the time she had her hip replaced back in August 2015. Her eGFR is >60 and creatinine of 79. She tells me her flow is intermittently good and bad and she describes storage type symptoms. She passes urine 2 or 3 times during the day and once or twice at night. On examination she is somewhat immobile consistent with her recent total hip replacement. She has had a flexible cystoscopy and that showed red vulva and the urethra looked alright. The bladder mucosa was very reddened in patches with a considerable amount of slough obscuring the views. Her eGFR was normal. Bladder biopsy, 16.02.16 - Overall, the features are of a poorly differentiated carcinoma arising in a background of squamous metaplasia. The morphological features along with the immunohistochemical staining pattern are, while not totally specific, in keeping with poorly differentiated squamous cell carcinoma. Discussed at Urology MDM 10.03.16. Patient 127 has a squamous cancer of the bladder. Mr O'Donoghue to arrange staging with a CT Chest abdomen and pelvis, Bone scan, assess suitability for radical cystectomy and for subsequent central MDM discussion. Patient 127 was reviewed in the clinic and surgery was discussed, she certainly is reasonably fit and I am sure would be a candidate in spite of her advanced years for cystectomy. Bone scan, 04.04.16 - Increased tracer uptake within the mid and lower lumbar spine is of uncertain significance and may reflect degenerative processes but up to date plain film evaluation or cross-sectional imaging is advised. CT C/A/P, 19.04.16 - 1. No definite metastatic disease.

Bladder wall thickening likely represents the primary lesion. 2. A couple of small pulmonary nodules are nonspecific and may be followed up with subsequent imaging.

MDMAction

Discussed at Urology MDM 28.04.16. Patient 127 has a squamous cell cancer of the bladder. There are small lung nodule which are felt to be non-specific which will need FU imaging post treatment. No metastases are seen on CT. The bone scan shows increased uptake in the left shoulder which may be degenerative. Mr O'Donoghue to review, arrange a plain film of the left shoulder, recommend cystectomy and for subsequent central MDM discussion.

April 2016. He had a poor flow-rate with a max of only 5ml per second voiding only 115ml. His post-void residual was significant at 583ml. For discussion for further management. Discussed at Urology MDM 21.04.16. Personal Information redacted by the USI has metastatic malignancy in keeping with metastatic renal cancer. Mr Young to review in SWAH OP and assess performance status with regards suitability for consideration of oncology referral and arrange referral to palliative care and consider a palliative blood transfusion for anaemia. Personal Information redacted by the USI was referred to Belfast City Hospital, patient needs regional discussion as he is not known to them.

MDMAction

Discussed at Urology MDM 12.05.16. For review with Mr Young to arrange renal biopsy to confirm a histological diagnosis and for subsequent MDM discussion.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR Personal Information redacted by the USI	None	None	None
Patient 127	DOB: Personal Information redacted by the USI Age: 78	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date

Diagnosis:
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This 78 year old lady who has a history of recurrent urinary tract infections. She had several urinary tract infections particularly around the time she had her hip replaced back in August 2015. Her eGFR is >60 and creatinine of 79. She tells me her flow is intermittently good and bad and she describes storage type symptoms. She passes urine 2 or 3 times during the day and once or twice at night. On examination she is somewhat immobile consistent with her recent total hip replacement. She has had a flexible cystoscopy and that showed red vulva and the urethra looked alright. The bladder mucosa was very reddened in patches with a considerable amount of slough obscuring the views. Her eGFR was normal. Bladder biopsy, 16.02.16 - Overall, the features are of a poorly differentiated carcinoma arising in a background of squamous metaplasia. The morphological features along with the immunohistochemical staining pattern are, while not totally specific, in keeping with poorly differentiated squamous cell carcinoma. Discussed at Urology MDM 10.03.16. Patient 127 has a squamous cancer of the bladder. Mr O'Donoghue to arrange staging with a CT Chest abdomen and pelvis, Bone scan, assess suitability for radical cystectomy and for subsequent central MDM discussion. Patient 127 was reviewed in the clinic and surgery was discussed, she certainly is reasonably fit and I am sure would be a candidate in spite of her advanced years for cystectomy. Bone scan, 04.04.16 - Increased tracer uptake within the mid and lower lumbar spine is of uncertain significance and may reflect degenerative processes but up to date plain film evaluation or cross-sectional imaging is advised. CT C/A/P, 19.04.16 - 1. No definite metastatic disease. Bladder wall thickening likely represents the primary lesion. 2. A couple of small pulmonary nodules are nonspecific and may be followed up with subsequent imaging. Discussed at Urology MDM 28.04.16. Patient 127 has a squamous cell cancer of the bladder. There are small lung nodule which are felt to be non-specific which will need FU imaging post treatment. No metastases are seen on CT. The bone scan shows increased uptake in the left shoulder which may be degenerative. Mr O'Donoghue to review, arrange a plain film of the left shoulder, recommend cystectomy and for subsequent central MDM discussion. Patient 127 was reviewed in clinic, on discussion with her regarding further anterior exaggeration or palliative. She hasn't made up her mind but she is very well and probably reasonably fit for surgery. She is certainly anxious to go and speak to the Urologist in Belfast City Hospital who does the procedure. I will have her discussed at Central MDM.

MDMAction

Discussed at Urology MDM 12.05.16. Mr O'Donoghue to arrange CT of left scapula and shoulder.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	HAYNES M D MR Personal Information redacted by the USI	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age: 85	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date 27/06/2016

Diagnosis:
Staging:
MDMUpdate

Patient 127 DOB: Personal Information redacted by the USI Age: 78 Personal Information redacted by the USI Personal Information redacted by the USI Target Date

Diagnosis: Uncertain at present
Staging:
MDMUpdate

CONSULTANT MR O'DONOGHUE: This 78 year old lady who has a history of recurrent urinary tract infections. She had several urinary tract infections particularly around the time she had her hip replaced back in August 2015. Her eGFR is >60 and creatinine of 79. She tells me her flow is intermittently good and bad and she describes storage type symptoms. She passes urine 2 or 3 times during the day and once or twice at night. On examination she is somewhat immobile consistent with her recent total hip replacement. She has had a flexible cystoscopy and that showed red vulva and the urethra looked alright. The bladder mucosa was very reddened in patches with a considerable amount of slough obscuring the views. Her eGFR was normal. Bladder biopsy, 16.02.16 - Overall, the features are of a poorly differentiated carcinoma arising in a background of squamous metaplasia. The morphological features along with the immunohistochemical staining pattern are, while not totally specific, in keeping with poorly differentiated squamous cell carcinoma. Discussed at Urology MDM 10.03.16. Patient 127 has a squamous cancer of the bladder. Mr O'Donoghue to arrange staging with a CT Chest abdomen and pelvis, Bone scan, assess suitability for radical cystectomy and for subsequent central MDM discussion. Patient 127 was reviewed in the clinic and surgery was discussed, she certainly is reasonably fit and I am sure would be a candidate in spite of her advanced years for cystectomy. Bone scan, 04.04.16 - Increased tracer uptake within the mid and lower lumbar spine is of uncertain significance and may reflect degenerative processes but up to date plain film evaluation or cross-sectional imaging is advised. CT C/A/P, 19.04.16 - 1. No definite metastatic disease. Bladder wall thickening likely represents the primary lesion. 2. A couple of small pulmonary nodules are nonspecific and may be followed up with subsequent imaging. Discussed at Urology MDM 28.04.16. Patient 127 has a squamous cell cancer of the bladder. There are small lung nodule which are felt to be non-specific which will need FU imaging post treatment. No metastases are seen on CT. The bone scan shows increased uptake in the left shoulder which may be degenerative. Mr O'Donoghue to review, arrange a plain film of the left shoulder, recommend cystectomy and for subsequent central MDM discussion. Patient 127 was reviewed in clinic, on discussion with her regarding further anterior exaggeration or palliative. She hasn't made up her mind but she is very well and probably reasonably fit for surgery. She is certainly anxious to go and speak to the Urologist in Belfast City Hospital who does the procedure. I will have her discussed at Central MDM. Discussed at Urology MDM 12.05.16. Mr O'Donoghue to arrange CT of left scapula and shoulder. This lady has now had imaging of her shoulder as per central MDT. She needs to be put back on now for central discussion.

MDMAction

Discussed at Urology MDM 09.06.16. Patient 127 has a Squamous Cell Carcinoma of the bladder with no evidence of metastases on her staging investigations. For Direct referral to BCH surgeons to discuss radical cystectomy.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	GLACKIN A.J MR	None	None	None

Personal Information redacted by the USI Personal Information redacted by the USI DOB: Personal Information redacted by the USI Age: 53 Personal Information redacted by the USI Personal Information redacted by the USI Target Date

Diagnosis: TCC Bladder pTa Grade 2
Staging:
MDMUpdate

CONSULTANT MR GLACKIN: 53 year old man with a history of pTa G2 TCC bladder, diagnosed in October 2011. Was electively admitted for rigid cystoscopy and biopsy following an abnormal urinary cytology performed in June 2012. Cystoscopy was performed 19.02.13 and was clear. Random biopsies were performed and reports no evidence of papillary or invasive transitional cell carcinoma. There are minor degrees of nuclear irregularity and cell maturation within the urothelium. There is no evidence of urothelial dysplasia or carcinoma in situ. Discussed @ Urology MDM 07.03.13. There was no evidence of any malignancy on recent bladder mucosa biopsies. For histology review. For flexible cystoscopy in August 2013. Personal Information redacted by the USI with history of pTa grade 2 TCC resected October 2011. This gentleman has recurrence of papillary TCC in the region of his previous resection. This gentleman's examination confirmed a single papillary bladder lesion on the left lateral wall which was resected in 2 parts. The specimens were sent for histology. TURBT for recurrent papillary TCC bladder, 27.05.16 - part 1, Histology shows fragments of bladder mucosa in which a small superficial papillary urothelial carcinoma is

Appendix 13

Key Worker Policy
NICaN Guidelines

Version 2.0 March 2014
Review March 2016

Introduction

Supportive care impacts on all services, both specialist and generalist, that may be required to support people with cancer and their carers. It is not a response to a particular stage of disease, but is based on the assumption that people have needs for supportive care from the time that the possibility of cancer is first raised.

NICE Improving Supportive and Palliative Care for Adults with Cancer (2004) requires that cancer services have processes in place to ensure effective coordination
between all professionals involved in the care of the patient.

These guidelines set out the agreed approach to care co-ordination within the Northern Ireland Cancer Network (NICaN). They specify the standard of care co-ordination that should be achieved by any organisation involved in delivering cancer services and the role of the 'key worker' (Appendix 10).

These guidelines apply to the delivery of both supportive and palliative care, and therefore cover the needs of patients who are expected to be discharged from treatment, as well as those requiring end of life care.

Peer Review Measure

In preparation for Peer Review it was agreed that there are difficulties in assigning key workers for patients without a full complement of Clinical Nurse Specialists and that a regional policy would be beneficial to provide guidance. The following guidelines, gleaned from reviewing several existing policies, may assist your MDT's in developing a Key Worker Policy.

"*There should be an operational policy whereby a single named key worker for the patients' 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 patients'*

case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s).”

Definition:

The Key Worker is a “person who, with patient’s consent and agreement, takes a key role in co-ordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice.” (**NICE, 2004).**

Scope of the Policy

Supportive care is not a distinct speciality but is the responsibility of all health and social care professionals delivering care. Care for patients with cancer often needs to be continued over many years, across organisational and professional boundaries. Continuity of care is essential during treatment, follow-up and palliative care.There is a need to ensure integration and co-ordination of care, throughout the patient’s cancer journey. This may be within and between primary, secondary and tertiary care settings, between statutory and voluntary sector and across health and social care settings.

The key worker process supports the following principles for patient-centred care:

- personalised care ; i.e. care organised around the felt and expressed needs of individual patients and carers, which is delivered (via speech and action) with sensitivity, compassion and respect for the dignity of the patient and carer;
- holistic care; i.e. care which not only meets the health/clinical needs of the patient, but which also addresses wider emotional, practical, psychological and spiritual concerns arising from the cancer patient's diagnosis, treatment and after-care;
- Choice in care: i.e. care consistent with the patient's and carers' choices concerning their involvement in decision-making about their treatment and care.

This document should be read in conjunction with the following:

- Manual for Cancer Service Standards 2004
- NICE Improving Supportive and Palliative Care for Adults with Cancer 2004
- Locally produced MDT/key worker leaflets (information for patients)

Who Should the Key Worker Be?

The Key Worker must be a core member of the MDT team. In most instances the Key Worker shall be a CNS, but as appropriate, the Key Worker may be an Allied Health Professional, the Community Specialist Palliative Care Team, or the Medical Consultant. The National Peer Review Team has indicated that in the absence of a CNS the Medical Consultant should remain as the Key Worker.

Role of the Key Worker:

The NICE Supportive and Palliative Care Guidance for Adults with Cancer

(2004) suggests that the key worker role may include:

- Orchestrating assessments to ensure patients' needs are elicited
- Ensuring care plans have been agreed with patients
- Ensuring findings from assessments and care plans are communicated to others involved in patient care (including the GP).
- Ensuring patients know who to contact when help or advice is needed, whether the 'key worker' or other appropriate personnel/ Act as key point of contact for patients and their carers.
- Managing transition of care
- Contribute to the MDT discussion and decision about the patient's care plan.
- Be present when the cancer diagnosis is discussed and at any other key points in the patient's journey.
- Provide verbal and written information with regard to diagnosis, investigations, treatment options and support groups.
- Lead in patient communication issues and co-ordination of the patient pathway.

There are a number of challenges in meeting the above definition of a key worker. It may not always be possible for a key worker nominated at the time of diagnosis to provide ongoing care co-ordination and continuity as the patient may receive care in a number of different care settings. Therefore the key worker may change at different points in the patient care trajectory.

The single named key worker will provide care co-ordination, information and communication with the patient and be an integral member of the patient's multi-disciplinary team. The aim should be to provide continuity of care throughout the patient pathway.

Core responsibilities of the Key Worker

The responsibilities of a key worker within Northern Ireland are as follows:

- *Continuity of care:* to achieve continuity of care, so that the patient knows who to contact for information or support. To introduce themselves proactively to the patient and provide contact details.
- *Breaking bad news:* whenever possible, to be present when the patient is given their diagnosis.
- *Initial assessment:* to ensure that a holistic assessment is carried out of the patient's needs.

- *Ongoing assessment:* to ensure that a holistic assessment is repeated at regular intervals to maintain an up-to-date picture of the patient's needs.
- *Care planning:* to ensure that a care plan is drawn up, in conjunction with the patient and based on information obtained from the initial assessment. To ensure that patients are given the opportunity to participate in decision making. To ensure that the care plan is updated at regular intervals.
- *Preferences and choices:* to ensure that patients' preferences and choices are elicited, especially in relation to end of life care. To ensure that these preferences and choices are documented.
- *Care monitoring:* to assess the patient's response to their diagnosis and monitor how they are coping. To refer on for specialist psychosocial support where appropriate. To provide opportunities for the patient to discuss the progress of their disease and treatment.
- *Liaise with primary care:* to establish and maintain contact with the patient's GP so that they are kept informed of key developments in treatment and prognosis.
- *Provide information*: to provide timely information to meet needs expressed by the patient, family members and carers.
- *Provide support*: to provide general emotional and psychological support, both proactively and as requested by the patient, family members and carers.

Process for Identifying Key Worker:
The Peer Review Measure states that the responsibility for ensuring that the Key Worker is identified should be that of the nurse MDT member(s).

The Key Worker's name should be recorded in all relevant patient records and relevant health professionals informed of the name (e.g., letters to GP). The recording of the Key Worker information could easily be accomplished by using a patient checklist in the notes addressing the following:
a) Patient has been offered a key worker
b) Information offered about the MDT
c) The opportunity of a permanent record or summary of a consultation at which patient's treatment options were discussed
d) Patient offered range of information related to diagnosis, treatment, support groups, financial support, etc.

With the patient's agreement, the patient should be informed of the name of their Key Worker verbally and be provided with a written version of their name and contact number, including what arrangements have been made for cover, after-hours, etc.

Changes to the Key Worker:
It is quite likely that over the course of the patient's care pathway, for various reasons, the Key Worker will change. Your policy should address this by stating how the patient, their carers, and other relevant health professionals will be informed of

any change. Additionally, such changes should be documented in the patient notes. Ideally, such changes would be kept to a minimum.

Evidence required to demonstrate compliance with this Measure:
Two pieces of evidence are required to show full compliance with this measure:

- **Operational Policy:** written Key Worker policy contained in MDT Operational Policy;
- **Case note review undertaken by reviewers on the day of the visit:** reviewers will expect to see a record of the patient's key worker in their notes.

Key Worker Review/Handover Responsibilities
As stated previously the key worker will act as the main point of contact for the patient and their carers for all or an identified period in the cancer journey. There are a number of challenges in meeting the key worker role. It may not always be possible for a key worker nominated at the time of diagnosis to provide ongoing care co-ordination and continuity as the patient may receive care in a number of different care settings. Therefore the key worker may change at different points in the patient care trajectory. The importance of ensuring the patient is at all times aware of their named key worker & their contact details, is pivotal to providing a patient-centred service. When reviewing role or handing over care, key workers should ensure the following:

- *Arrange a new key worker:* liaise within or between multi-disciplinary teams to identify who is best placed to take on the key worker role from the original person, e.g. when responsibility for care transfers from one MDT to another, from a cancer unit to a cancer centre, or into the community or a hospice. N.B. sometimes the original key worker at a cancer unit may remain responsible for liaising with the patient even though care is now being provided by a cancer centre. When this is agreed it should be clearly documented.
- *Notify a change of key worker:* whenever a change of key worker is proposed, the original key worker should seek agreement from the patient and the new key worker. Once agreed, the original key worker should notify all professionals involved in the patient's care.
- *Respond to patient choice:* make the patient aware that they can request a change of key worker if they feel the existing arrangement is not working successfully, and to act upon any such request.
- *Discharge patient:* where the patient has come to the end of their active treatment or surveillance, explain how the patient should re-access services in the event of future problems and make the patient aware of ongoing sources of support. To obtain feedback that could help improve services for other patients in future.

Designating the Key Worker

Providers should ensure that:

- Each patient will have a named key worker who will be identified at the MDT where the initial cancer diagnosis is made and treatment planning decisions discussed. The key worker will ideally be a Clinical Nurse Specialist.
- The nominated Key workers should be reviewed at key points in the patient's cancer journey and these identification points are:
  - Around the time of diagnosis
  - Commencement of treatment
  - Completion of the primary treatment plan
  - Each new episode of disease recurrence
  - Disease recurrence
  - The point of recognition of incurability
  - The beginning of the end of life
  - The point at which dying is diagnosed
  - At any other point requested by the patient
  - At any other time that a professional carer may judge necessary.
- With the patient's agreement, they will be informed of the name of their key worker verbally and will be provided with written information of the name and contact number. The patient should be aware that they can request a change of key worker if they feel the existing arrangement is not working successfully.
- Re-allocation of a key worker, at the patient's request, should take place within seven working days of the request and is the responsibility of the existing key worker.
- The key worker's name will be recorded in the medical notes in an appropriate place, by the CNS. Other health professionals will be informed of the name of the key worker as appropriate (e.g. patient hand held key worker card, letters to the patient's GP).

Key Worker Competencies

As a minimum standard, the key worker must be a clinical practitioner, i.e. a doctor, nurse or allied health professional. The key worker cannot be a secretary or healthcare assistant, although the key worker can delegate tasks to them whilst retaining overall responsibility.

The minimum required competencies for the key worker role are:

- Work as an integral member of the MDT to ensure continuity of patient care.
- Initiate and participate in MDT discussion and case conferences with all professionals involved in the delivery of patient care.
- Communicate and co-ordinate information to patients and carers, evaluating their levels of understanding and utilising a range of skills/techniques to overcome any communication difficulties.
- Demonstrate ability to verbally summarise patient information to facilitate understanding.
- Act as an advocate for the patient who has or may have cancer.
- Act as a communication resource and co-ordinator for other members of the multi-professional team in the care of the key worker's patient caseload.

- In conjunction with the MDT, provide patients with comprehensive information on the options available to them for treatment and care.
- Be aware of any relevant clinical trials within the speciality.
- Utilise specialist knowledge and skills regarding disclosure of information.
- Co-ordinate the onward referral of patient and/or family members to appropriate clinical or support services.
- Ensure accurate follow-up documentation is maintained including any changes in the named key worker.
- Utilise support strategies and interventions available to care for patients with complex needs.
- Demonstrate knowledge of holistic cancer care relating to areas such as screening, curative and palliative treatment, spiritual care, aspects of nutrition and pharmacology, rehabilitation, discharge and collaborative working.
- Utilise all forms of patient information to enable the patient to have a better understanding of their diagnosis and treatment plan. This will include the use of specific resources for patients/carers from minority groups.
- Facilitate the development of teaching and learning skills used to educate patients and other personnel.

7. OPERATIONAL POLICY FOR KEY WORKERS 14-2G-113

This guideline details the roles and responsibilities of the Key Worker. For the purpose of this policy, the Key Worker will be defined as 'the person who, with the patient's consent and agreement, takes a key role in co-ordinating the patient's care and promoting continuity, ensuring the patient knows who to access for information and advice' (Manual of Cancer Standards).

7.1 Identification of the Key Worker

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.

Due to the lack of Key Workers, it will be a priority of the MDT Lead Clinician and Nurse Member to advocate with the Southern Trust the training and/or appointment of adequate numbers of Key Workers to ensure that the standards of practice, detailed in this Section, are fulfilled.

7.2 Main responsibilities of Key Workers

- Act as the main contact person for the patient and carer at a specific point in the pathway.
- Offer support, advice and provide information for patients and their carers, accessing services as required.
- Ensure continuity of care along the patient's pathway and that all relevant plans are communicated to all members of the MDT involved in that patient's 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.
- Ensure that the next Key Worker has the appropriate information about the patient to fulfil the role.
- 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.
- Assist to empower patients as appropriate.
- To ensure that the Record of Patient Management is completed for each new patient.

SAI Urology Review
30 November 2020 at 12:45
Telephone Conversation

Chair – Dr Dermot Hughes
Facilitator Mrs Patricia Kingsnorth – Acting Acute Clinical Governance and Social Care Coordinator (note taker).

Phone Conversation with Mr Anthony Glacken (AG) Consultant Urologist SHSCT

Notes of the Meeting.

Patricia and Dr Hughes thanked AG for taking the time to converse with the Chair of the SAI.

Dr Hughes (DH) advised that as part of the SAI review the panel had met with the families and they each said that they had not been involved with a Clinical Nurse Specialist in Urology was this unusual for one consultant.

Mr Glackin (AG)- advised that there were only two urology clinical specialist nurses in the Trust to support urology cancer patients and recently the trust have appointed a new clinical specialist nurse from the SET. The nurses are available for clinics held in the acute setting. However, there would be no nurse available to attend any clinics held off site –either in STH, Banbridge, ACH or SWAH.

DH advised that AOB prescribed off guidance which didn't adhere to NICAN guidelines. He appeared to ignore the recommendations from MDT in relation to the prescription of bicalutamide without patient informed consent?
AG – advised this would have been challenged at MDT. He advised the practice for presenting to MDT changed in last 6 years. The cases are discussed using NIECR for information. Each case is reviewed in advance by a Consultant Urologist who chairs the meeting on a rotational basis with colleagues. This was done to share the workload as opposed to monitor the practice of colleagues. The question around bicalutamide 50mgs use would have been challenged but not minuted. He went on to say that once a patient's care was discussed at MDT, this was left to the named consultant to continue the patient's care. No one was looking over the shoulders of others to check that the work was done.
DH advised that often the patients involved in the review were not represented to MDT when their conditions deteriorated.
AG – said he couldn't comment on that. If patients returned to theatre or had a deterioration- there was no way of capturing that if their case was not represented by their consultant.

DH advised the patients all described not being able to access appropriate care – 2 had died and 2 were palliative.
AG- can only speak for himself – his patients have access to CNS and are referred to palliative colleagues for support.
He went on to describe as AOB as "holistic physician/clinician" -
AG and other colleagues would work with multidisciplinary teams, they would deal with the surgical management but would refer to medical colleagues.

SAI Urology Review

Meeting with Dr Shahid Tariq
Tuesday 29 December 2020 at 1:45pm

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
Shahid Tariq (ST)

Dr Hughes thanked Dr Tariq for facilitating the meeting. He explained the overview of the SAI review in relation to the themes identified during the review. He advised that the NICAN peer review adapted by the Regional group was signed off by the Trust. Mr OB signed off the peer review; however, he did not adhere to the recommendations and standards.

He advised that some of the issues were in relation to the patients not having access to a specialist nurse/ key worker. Therefore when the patient's condition deteriorated there was no referral back to MDT

DH asked did the MDT know that Mr OB was not adhering to guidelines or the recommendations from the MDT. He advised that there was challenge but questioned who was it escalated to?
ST – he was not aware of any concerns mentioned. Any clinical concerns would go through the speciality management structure route.

ST did advise in 2019 he set up a cancer strategic forum which would meet twice a year.
This was to bring together different tumour site specialities under one umbrella, to look at good practice and to identify the need for additional resources for them. They only had one meeting in 2019 and planned to meet in March 2020 but this was cancelled due to covid.

DH advised that some of the patients did not receive the appropriate drug therapy in relation to androgen deprivation therapy. Mr OB chose not to involve other professionals in the patients care. There are now 5 specialist nurses in post.

DH asked if the urology team asked for additional support. The specialist nurses were used by all the clinicians except one. The specialist nurse is a safety net for when things are missed. Do you know if there were any concerns raised by the specialist nurses?
ST – No. was not aware.

DH asked did the chair of the MDM have a pa in their job plan

SAI Urology Review

Meeting with Mr David McCaul
Monday 4 January 2021

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
David McCaul (DM)

DH thanks DM for meeting with him and explained the process to date regarding the SAI review involving 9 patients (one with penile cancer, 1 testicular cancer, 5 prostate cancers and 2 renal cancers). He explained that in all cases the recommendations from the MDM were not actioned and that there was a delay in referring patients to oncology / specialist services. None of the patients had access to a key worker/ specialist nurse. This was unique to this consultant. Other concerns raised were inappropriate diagnostics, issues around hormone therapy, using treatments outside of licence and not according to guidance. When the patients deteriorated they were not referred back to MDT.
He advised that two patients had died and 2 are currently palliative.

DH – asked if DM was made aware of any concerns about Mr OB?
DM advised he was not made aware of any concerns, the first he became aware of any issues was from the Irish News. DM went on to advise that his role as clinical director of clinical cancer services was limited to Peer Review and outcomes of business meetings. His role had no power to control or influence pathways or change. He advised that he has control over acute oncology and he had an under preforming doctor which he sorted.

DM advised that firstly he had no idea Mr OB had issues because it was not communicated to him and secondly as there is no role in job-planning/day to day running of urology it would not have been his role anyway, unlike acute oncology/palliative care whose doctors I do job plans etc..

DH advised that the peer review document in 2017 provided assurances to the board that all patients had access to a key worker/ specialist nurse. This didn't happen. There was no one to support these patients on their journey and who would have been able to follow up results.

DH advised that there was a previous SAI which showed issues regarding delays in triage and asked if DM was aware of it.
DM was not aware of any SAI relating to the consultant.
DH advised that he had spoken with the Chair of the urology MDM and advised that practices were challenged but not minuted. Were these concerns escalated?

DM advised that any issues with the consultant must have been addressed within the speciality and not escalated to him.

DM noted the only urology issues escalated to him was in relation to lack of radiographer for attending MDM. Also issues about centralization of nephrectomy services and these issues were not escalated to me formally, but I was aware of them through conversations with other urology consultants, these issues where being dealt with through NICAN regional urology group.

DH thanked him for meeting with him.

SAI Urology Review

Interview with Mrs Martina Corrigan (MC) Head of Service for Urology

18 January 2021 at 12 Midday via zoom

Dr Dermot Hughes (DH)and Patricia Kingsnorth

Dr Hughes provided Martina with an update to date – he advised that there are 9 families involved in the process and that there are similar themes; one being that Mr O' Brien worked in isolation despite MDT involvement and being the Chair of the MDT for a number of years. Martina confirmed that Mr O'Brien never involved a specialist nurse and had always been the case from she had started in the Trust.

Martina advised that she worked in SHSCT for 11 years, and confirmed that during that time Mr O'Brien never recognised the role of the Clinical Nurse Specialists. She confirmed that he never involved them in his oncology clinics. She is aware that some of the Clinical Nurse Specialists would have asked to be at the clinics but Mr O'Brien never included them.

Dr Hughes advised that many of the patients that have been reviewed were given hormone therapy off licence and often without their knowledge and that this treatment was in variance to guidance. He also advised that some of the patients were not referred onwards to oncology when their disease progressed and they had no access to coordinated care. This meant that patient's had difficulty accessing care and the GPs couldn't help which resulted in patients having no option but to go to the Emergency Department during covid which was not appropriate.

Dr Hughes asked if anyone expressed concerns about excluding nurses from the clinics.

Martina advised that two of the Clinical Nurse Specialists did report that they did regularly challenge Mr O'Brien and asked him if he needed them to be in the clinic to assist with the follow-up of the patients but it got to the stage were staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change.

Martina advised that in her opinion that Mr O'Brien could be quite arrogant and that was a big part of the issues with his practice.

Dr Hughes advised that the Clinical Nurse Specialists are so important on the patient's journey.

Martina agreed and said that this support from the CNS was vital both for oncology and for benign conditions, and advised that Mr O'Brien did include the CNS in

SAI Urology Review

Discussion with Ronan Carroll (RC) AD for Surgical and Elective Care

Dr Dermot Hughes (DH) and Patricia Kingsnorth (PK)

Monday 18 January 2021 @ 13:45

Dr Hughes provided a summary of where we are regarding the SAI review and summarising the cases involved in the review. He explained that many of the patient's pathway did not follow the recommendations set out by the regional urology pathway. He explained that AOB was the Chair of the regional urology MDM up until 2016. He signed off the guidance for peer review in 2017 but did not adhere to the standards agreed.

DH described the issues regarding the lack of specialised nurse for AOB's patients and the impact this had on the patients and family when trying to access services. He advised that AOB use of ADT was highlighted by the oncologist in Belfast Trust who wrote to AOB to highlight issues. But this wasn't escalated further.

DH- asked how did AOB practice this way?

RC- believed everyone made excuses for AOB the consensus was that he was a very strong personality who could be spiteful and even vindictive. Many of the CNS were afraid of him. But RC was unaware that the CNS were excluded from seeing AOB's patients.

DH explained the SAI process that we are looking at the cancer pathway and benchmarking against the standards regarding diagnosis/ staging/ MDT. He explained that some of the patients were not referred on for palliative care when their disease progressed. AOB was referred to by one of his colleagues as a "holistic physician" who care for the patients in uni-professional manner, but really he was working outside of his scope of practice.

RC speculated about AOB that there was a sense of arrogance/ commanded respect almost "God like" when he walked the corridors.

RC said he wasn't aware of the issues identified by the SAI review and was quite shocked when the issues were identified by PK during the update of early learning from the SAI. He advised that the patients under the care of Mr OB were often elderly and held him in high esteem "the big doctor". He went on to say that staff appeared to be habitualised by AOB's behaviour, that they avoided challenge at MDT.

Meeting with Mr Mark Haynes AMD SEC and Dr Dermot Hughes Chair of Urology SAI Panel
Note Taker- Mrs Patricia Kingsnorth
Via zoom
18 January 2021 at 11:00

Dr Hughes thanked Mr Haynes for meeting with him a briefly outlined the SAI review and the issues to date.
He advised that Mr OB did not work with specialist nurses and patients did not feel supported in terms of knowledge of their disease. The patients deteriorated in the community with lack of support. In relation to ADT, Dr Hughes advised Mr Haynes that after speaking with the oncologist in Belfast who had known about Mr OB practice for 17 years. . He advised that this practice was off guidance and that patients were treated without informed consent.
Mr OB ignored the recommendations of the MDT and did not bring patients back for discussion.
Dr Hughes asked were there any concerns raised about this practice.
Mr Haynes – advised that he was the person who raised the concerns. He had taken over from AOB as chair of the urology cancer group approx. 3 years ago.
Mr Haynes advised that he works in a different system. He works in a more team based approach with 3 consultants and 5 specialist nurses) Mr AOB worked as more individual. There was non-involvement with any other members of the team which meant that his practice was not scrutinised.
Mr Haynes advised there were a number of concerns about how AOB practiced. But was not acutely aware about his lack of conformities to standard treatments. The benefit from covid is that it encouraged shared working practices.

Dr Hughes advised that cancer care is benchmarked – there is an agreed level of care which is peer reviewed.
Mr Haynes advised that AOB didn't use other people to assist him with his role. He took everything on himself. All queries came to him.
Mr Haynes advised that the MDT did disagree with Mr AOB decision making regarding ADT. He recalled a disagreement with AOB in relation to his use of ADT for a patient he said that Mr AOB became entrenched in his decision making and he never accepted their challenges.

Mr Haynes explained the functions of their MDM. They have a rotating chair who will chair the meeting and represent urology input. They will prepare the week to week cases (40 patients) it's a clinical role. Those patients would have been reviewed. The main Chair has oversight and is responsible for peer review etc – Mr Glackin.

Mr Haynes advised that the challenges were that patients weren't brought back to MDT but there was no correspondence on NIECR, delayed letter writing which were put on NIECR retrospectively.

Dr Hughes advised that patients didn't get staging scans at appropriate times.
Mr Haynes said this was awful and he couldn't understand why that would be.

When asked what is a virtual MDT Mr Haynes advised when they can't run an MDT session either due to bank holiday or clinical audit day – rather than put the case on hold the chair would move patients on through the system to get the treatment and diagnostics to move the patient on to the pathway- MRI / biopsy etc. It would be protocol driven as opposed to discussion with a team. There would be no notes or minutes taken.

Dr Hughes advised about patient Patient 5 - that his haematuria symptoms in ED didn't include PSA. Mr Haynes advised that if the DRE was normal it would not prompt a PSA. There was a normal DRE finding.
Dr Hughes that his CT scan result wasn't actioned and 8 months delay is significant for a man of 90 years.

Dr Hughes queried how patient Patient 2 was referred to oncology- was it Belfast who referred him or Mr OB. Mr Haynes advised that he emailed the oncologists and escalated to the regional MDT.
Dr Hughes wanted to know if Belfast raised a datix about the delay?

Dr Hughes advised that Patient 3 wasn't referred to the regional penile cancer service.

Some patients met their 31/62 day targets.

Dr Hughes said that there should have been oversight from the CD and AMD of cancer services. There needed to be assurance audits / no governance oversight.

Dr Hughes enquired if by raising these concerns Mr Haynes suffered any deficits from his team. He advised that he did not.
But advised that a concern for the team is that they will be criticised.
He advised that AOB was difficult to work with.
His practice would be to involve the CNS in his clinics to support patients and involved in the decision making process.

Mr OB did not involve the CNS- he had a different view of their work -

Dr Hughes thanked Mr Haynes for his time.

Southern Health and Social Care Trust

Acute Governance
Cancer Nurse Specialists
22 February 2021 @ 11am
Zoom

PRESENT: **Dr Hughes (Chair)**
Patricia Kingsnorth Acute Clinical Governance Co-Ordinator
Roisin Farrell, Governance Officer
Patricia Thompson
Martina Corrigan
Kate O'Neill
Leanne McCourt
Jenny McMahon
Jason

Patricia Kingsnorth thanked all for attending, she explained she tried to arrange the meeting in January but it had to be cancelled due to COVID. She advised the meeting that the CNS care was not brought into question.

Dr Hughes advised he was asked to chair the review. He advised he was previously Medical Director in the NHSCT and Director of NI Cancer Network. He has a pathology background.
He explained there was a huge deficit with not having Nurse Specialist's involvement in the patients care.
He gave a background to patients involved in the SAI review.

Patient 1 – Prostate cancer patient. His disease progressed and was not referred back or provided palliative care. The patient has since died. He did not get best care pathway.

Patient 9 – 70 year old Biochemical, PSA & potential prostate care. TRP came back negative. Variety of reasons things were missed. He later attended ED with query rectal cancer but was diagnosed with prostate cancer. The disease has progressed.

Patient 5 – Had a large renal cancer, he was treated exemplary. He attended ED no PSA or scan, was missed for 8 months. PSA was over 100 he probable had prostate cancer from start. Never got CNS.
Kate O'Neill believes she had met this man late last summer with Mr Haynes.

Patient 4 – High grade cancer. Should have been referred to oncology, didn't happen. Disease progressed and spread. He wasn't referred back to MDM and no referral to palliative.
Dr Hughes believes issues with lack of onward referrals.

Patient 2 – Very good first time care. He has rheumatoid disease and arthritis. He has been diagnosed with testicular cancer, recommendation referral for treatment, was not referred for treatment and was identified by BHSCT. No CNS assigned.

Patient 6 – elderly with possibility of prostate cancer. MDM suggested active surveillance. No CNS for support. No LRH. Doing reasonably well.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail a Personal Information redacted by the USI

Meeting with Mrs Heather Trouton Executive Director of Nursing SHSCT
Dr Dermot Hughes – Chair of SAI review

Note taker – Patricia Kingsnorth Acute Clinical Governance Coordinator

23 February 2021 at 13:30 via zoom

Patricia welcomed Mrs Trouton and introduced her to Dr Hughes and explained that he was chairing the SAI review and that he had some questions he needed clarification for.

Dr Hughes provided a summary of the urology review to date in relation to meeting 8 of the 9 the families twice and understanding their experiences of their care and also to feed back on the learning to date of the review he wanted to know what was known about this deficit. Who was aware?.

He explained that the main concern was around the patient's access to a cancer nurse specialist. None of the 9 patients received the services of a cancer nurse specialist and therefore they were not supported on their cancer journey which for some caused serious distress.

Dr Hughes explained that as part of the review the quality of care provided was not in question as patients did not receive any care.
He explained that the NICAN guidance recommended that every patient with a cancer diagnosis was provided support from a cancer nurse specialist. This assurance was provided to the peer review in 2017 that additional specialist nurses were resourced to provide this service. This was signed off by the chief executive. But the reality was that Mr OB patients were not given access to a specialist nurse. There were not checks and balances in the system to quality assure that this was happening.

Mrs Trouton advised that she was assistant director of Surgical and Elective Care until March 2016 when she moved to IMWH division. She advised that she was not in post when the NICAN guidance was implemented and could not comment on it. She advised that prior to leaving her post there were only two specialist nurses in post. One who was responsible for uroscopy and one who was responsible for cancer care.
Mrs Trouton asked for some clarification in relation to what capacity does Dr Hughes wish her to comment. Was it in relation to her AD role or her Executive Director of Nursing role?

She went on to advise that as a director of nursing she would expect any nurse to provide care in their professional role. Dr Hughes advised that he did not have an issue with the standard of care that the specialist nurses provided . His issue was that they did not receive any referrals from Mr O'Brien and therefore did not provide any care. I asked if Dr Hughes thought that they should have sought referrals . He replied that no they should not but there should have been a system of checks and balances in place to ensure that Mr'OBriens patients were being referred .

Southern Health and Social Care Trust

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

Organisation's Unique Case Identifier:

[redacted]
Personal Information redacted by the USI

Date of Incident/Event: Multiple dates

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: Male Age:

Responsible Lead Officer: Dr Dermot Hughes

Designation: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN)

Report Author: The Review Team

Date report signed off: 26 February 2021

Date submitted to HSCB: 1 March 2021

3.0 SAI REVIEW TERMS OF REFERENCE

quality care.

- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/ Medical Director of SHSCT/ HSCB/ Patients and families involved/ Staff involved.

4.0 REVIEW METHODOLOGY

The review will follow a review methodology as per the Regional Serious Adverse Incident Framework (2016) and will be cognisant of the rights of all involved to privacy and confidentiality and will follow fair procedures. The review will commence in October 2020 and will be expected to last for a period of 4 months approximately, provided unforeseen circumstances do not arise. Following completion of the review, an anonymised draft report will be prepared by the review team outlining the chronology, findings and recommendations. All who participated in the review will have an opportunity to provide input to the extracts from the report relevant to them to ensure that they are factually accurate and fair from their perspective.

Prior to finalising the report, the Lead Reviewer will ensure that the Review Team apply Trust quality assurance processes to ensure compliance of the review process with regional guidance prior to delivery of the final report to the Review Commissioner. The Review Commissioner will seek assurance that the quality assurance process has been completed.

6.0 FINDINGS

support from their GP and where hence referred to the Emergency Department which the review team agree was not the best place for them. The review team are of the opinion that access to a specialist nurse could have offered support for these families and provide direction to the appropriate services.

Governance / Leadership

- The review team considered the treatment and care of 9 patients who were treated under the care of Dr 1 Consultant Urologist. Individual reviews were conducted on each patient. The review team identified a number of recurrent themes following each review.
- The treatment provided to 8 out of 9 patients was contrary to the NICAN Urology Cancer Clinical Guidelines (2016). This Guidance was adopted by the Southern Health and Social Care Trust Urology Multidisciplinary Team and evidenced by them as their protocols for Cancer Peer review (2017). The Guidance was issued following Dr.1 & Chairmanship of the Northern Ireland Cancer Network Urology Cancer Clinical Reference Group.
- The Urology MDM made recommendations that were deemed appropriate in 8 of 9 cases and were made with contribution and knowledge of Dr.1. Many of the recommendations were not actioned or alternative therapies given. There was no system to track if recommendations were appropriately completed.
- The MDT guidelines indicate “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”. None of the 9 patients had access to a Key Worker or Cancer Nurse Specialist. The use of a CNS is common for all other urologists in the SHSCT urology multidisciplinary team allowing any questions or concerns that patients’ have to be addressed. This did not happen.
- The review team considered if this was endemic within the Multidisciplinary Team and concluded that it was not. Patients booked under other consultant urologists had access to a specialist nurse to assist them with their cancer journey.
- Statements to Urology Cancer Peer Review (2017) indicated that all patients had access to a Key worker / Urology Cancer Nurse Specialist. This was not the case and was known to be so.
- The Urology Cancer Nurse Specialist play an integral role of the MDT and should be facilitated on all the MDM to advocate on patient’s best interest throughout the patient’s journey. This should include independently referring and discussing patients at MDT.
- The Review Team regard absence of Specialist Nurse from care to be a clinical risk which was not fully understood by Senior Service Managers and the Professional Leads. The Review team have heard differing reports around escalation of this issue but are clear that patients suffered significant deficit because of non inclusion of nurses in their care. While this is the primary responsibility of the referring consultant, there is a responsibility on the SHSCT

Queries/ Comments in relation to SAI reports

1. Terms of Reference (TOR)

The SAI TOR makes reference to interviews with staff – just to clarify that the CNS team have not been interviewed at any stage throughout the process. We were however introduced to the review team via zoom meeting on 22.2.21.

Please note for proof reading, some TOR are repeated twice within individual case presentations and some also still include patient initials rather than XX.

Specialists Nurses were specifically represented on the SAI Review team with ongoing feedback throughout the process around details and specifics

2. Roles & Responsibilities of CNS/Keyworker

Regarding responsibilities of the Uro-oncology Specialist Nurses, NICaN Urology Cancer Clinical Guidelines March 2016 advise:

All patients should be assigned a key worker (usually a CNS) at the time of diagnosis, and appropriate arrangements should be in place to facilitate easy access to the key worker during working hours and an appropriate source of advice in his/her absence, as per National Cancer Peer Review standards.

All patients should be offered a holistic needs assessment (HNA) at diagnosis and subsequently if their disease status changes.

Patients should be offered advice and support to address any immediate concerns – physical, mental, spiritual or financial – on completion of the HNA with onward referrals made as necessary.

The responsibilities of the uro-oncology CNS include, ensuring patients undergoing investigations for suspected cancers have adequate information and support.

On diagnosis, the CNS has a supportive role and will help ensure that the patient and significant others are equipped to make informed decisions regarding their ongoing treatment and care.

The CNS may have a role in the review of patients following treatment for urological cancer. The CNS also has a key role in equipping the patient to live with and beyond the urological cancer, as advocated by the National Cancer Survivorship Initiative (2011). National Cancer Survivorship Initiative (2011) has also recommended the use of Holistic Needs Assessment (HNA) by the CNS to assess patient's needs for

3. Other considerations from report

- Case Personal Information redacted by the USI The review team have been informed that Dr 1 excluded all CNSs from the care of his patients at clinics.

The CNS team do not believe this to be an accurate representation as we would have been introduced to patients when there was a need for interventions such as catheter changes, nephrostomy tube management, dressings, onward referral to for example to community continence or district nursing services or other AHP service.

The review findings are based on the experience the 9 patients – they did not have access to Specialist nurses for the for the responsibilities detailed by yourself above: 2 Roles and Responsibilities of Specialist Nurses / Key workers – sadly many did not have access to specialists nurses for hands on nursing issues as well.

- Overarching report findings 10 : Governance / Leadership Point 4/5/6.
  The review team have stated that the use of a CNS is common for all other urologists within the SHSCT MDM team.

The CNS team with recent expansion is more readily available to provide this resource in person if required however this has not always been the case due to other services running parallel / competing demands on the CNS time. However if the CNS was not available on the day, the keyworker contact number / Thorndale unit number would have been available to all urologists to provide. Point 8 in this report acknowledges that it is the primary responsibility of the consultant to enlist the support of the CNS.

- Point 8. The review team regard the absence of a specialist nurse from care to be a clinical risk which was not fully understood by Senior Service Managers/Professional Leads. The review team have heard differing reports around the escalation of this issue.

The CNS team are not clear on what is meant by the ‘differing’ reports regarding escalations or the potential implications this may have had on their role.

There were differing reports from management about knowledge of non-use of Specialist nurses – this was a statement of conflict of opinion about the issue.

- Recommendation 4.

Should this also include sufficient oncology input at MDM meetings?

This was implied in all meetings should be quorate but we can take this on board

Dr Hughes read out the response from the Cancer team and his response to each individual comment and rationale for each.

Comments discussed and agreed by all present.

Dr Hughes explained Clinical nurse specialists have highlighted they were never given an opportunity to be involved in patients care and would like this to be reflective in the report.

Mrs Kingsnorth shared [redacted] response to the report. The family felt abandoned by the Health service. [redacted] had his catheter in for a long period of time and this had a severe impact on his mental health. Family did try to contact the consultant in charge for removal but received no response. He had no CNS and therefore no other point of contact.

Agreed this impact can be added to family narrative of the report.

Hugh advised this issue is a deficit all over the UK and not just this particular patient. Waiting lists for catheter removal are extensive, capacity issues for TURP. There are many men waiting for this procedure and who have had long term catheters in place as a consequence. This is not the fault/ capability issue of one individual but rather capacity issuesacross the UK.

Dr Hughes highlighted [redacted] had no key worker and appreciates this may be a capacity issue. However, if CNS details had been provided this would have offered some support and lessened anxiety for the patient.

Mrs Thompson advised a key worker could have done a trial removal of catheter had one been appointed to [redacted].

Mrs Sloan advised Jane advised there was no support from community, the family felt unsupported, there were no contact details given and this was the main issue.

Mrs Thompson agreed a key worker for point of contact is a major loss and therefore can have psychological impact on patients.

Dr Hughes advised the report should address what should have happened, what care should have been provided to [redacted].

Mrs Kingsnorth advised she would link in with Mrs Thompson to conclude a form of words to reflect this.

Mrs Kingsnorth shared the clinical nurse comments.

Dr Hughes read out nurses comments and explained his response and rationale for same. All in agreement with responses provided. All agreed to change wording in report to highlight nurses were not given an opportunity to be part of patients care and are not the ultimate failsafe in patient pathway journey.

Mrs Kingsnorth asked Mrs Thompson if caseloads were shared, asking the question what happens when CNS is off on leave.

Patricia Thompson advised they are currently setting up new job plans, if on leave nurses will pass case load on to another colleagues.

Mrs Kingsnorth advised she would review reports and reword as agreed today in relation to CNS roles and responsibilities . Mrs Sloan will link in with [redacted] family.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: [redacted]
E-mail [redacted]

From: O"Brien, Aidan
To: Reid, Stephanie; ONeill, Kate
Subject: FW: [redacted]
Date: 01 March 2020 13:56:11

Stephanie and Kate,

This 85 year old man was found to have Gleason 5+5, prostatic adenocarcinoma when he had his prostate gland resected in June 2019.
His preoperative serum PSA had been normal at 2.79 ng/ml in December 2018, a reflection of a poorly secreting adenocarcinoma.
There was no evidence of metastatic disease on postoperative staging.
He continued to have chronic urinary retention postoperatively.
He managed twice daily, self-catheterisation very well.
His serum PSA level had decreased to 0.86 ng/ml by December 2019 on Bicalutamide alone.

He has deteriorated significantly since then.
He was acutely admitted in January 2020 in acute urinary retention and with an acute deterioration in his renal function due to bilateral ureteric obstruction due to local progression of his prostatic carcinoma.
He had the left ureteric obstruction relieved by a further prostatic resection, enabling the left ureter to be stented.
He required right nephrostomy drainage to relieve right upper tract obstruction.
The right ureter was then antegradely stented.
As you will note from the email below, he has not been able to manage with the right nephrostomy drain capped on 27 February 2020.
Free drainage of the right nephrostomy drain has been restored on 29 February 2020.

Even though Bicalutamide was replaced by Degarelix in January 2020, his serum PSA level has more than tripled since December 2019.
That increase is reflected in a general deterioration in his general health.
His appetite is poor, and he is losing weight.
He is rapidly becoming increasingly frail.
I have written to the GP requesting that he prescribe Dexamethasone in addition to Folic Acid, of which he is deficient.

He lives at home with his wife.
He has a son and daughter who are supportive.
However, I believe that they will require increased support at home.
I would be grateful if you would be able to arrange an assessment of holistic need and support required.

His daughter, [redacted] is the most useful contact.
She may be contacted at [redacted].

I would be most appreciative of any support that you may be able to arrange for [redacted] and his wife.

Thank you,

From: Anne-Marie Phillips
To: Lorna Nevin; Denise Boulter
Cc: Shannon Magee; Elaine Hamilton (HSCB); serious incidents
Subject: RE: Meeting re Urology SAI"s and findings regarding Cancer Nurse Specialists
Date: 22 March 2022 12:49:44
Attachments: image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

Hi Lorna
[redacted]

Thank you for this really useful update which has also been shared with Elaine who is co-chairing the Acute Level 2/3 SAI group along with Dr Louise Herron.

Elaine please note response below from Lorna to share at todays Acute Level 2/3 group meeting – it regards item 4A on the agenda

HSCB REFERENCE NUMBER
[redacted]

Many thanks
Anne-Marie

From: Lorna Nevin
Sent: 22 March 2022 12:00
To: Anne-Marie Phillips
Cc: Denise Boulter; Shannon Magee; Elaine Hamilton (HSCB); serious incidents
Subject: RE: Meeting re Urology SAI's and findings regarding Cancer Nurse Specialists

Apologies Anne- Maire, just getting computer on, as spent morning in ED [redacted].
SHSCT held a CNs workshop yesterday which I attended in Craigavon which referenced the SAI and the need for CNS keyworker role and focus on Holistic Needs assessment. The pending launch of the Cancer Strategy will reference the need for all patients with a cancer diagnosis to have a CNS keyworker. The nurse should also be part of the local MDM.
Workforce analysis has also been looking at the increase need for CNS roles.
These conversations are not only with the SHSCT but will impact across all Trusts.

Hope this is of help

Kind Regards Lorna

From: Anne-Marie Phillips
Sent: 22 March 2022 08:19
To: Lorna Nevin
Cc: Denise Boulter; Shannon Magee; Elaine Hamilton (HSCB); serious incidents
Subject: RE: Meeting re Urology SAI's and findings regarding Cancer Nurse Specialists

Good morning Lorna
You will recall we had a conversation last year in relation to the SHSCT Urology SAI's HSCB ref number below:

HSCB REFERENCE NUMBER
[redacted]

The action from the Acute meeting was that Denise and myself would discuss the findings of the reviews in

PAT-001382

October 2019

Week 41

9 Wednesday

(282 - 83)

[redacted]

Spoke with Specialist Nurse - advised taking tablets @ night - to alleviate dizziness

2019 October

Thursday 10

Dr Leonard @ 11:00 Am

(283 - 82)

[redacted]

PAT-001385

October 2019

Week 42

18 Friday

(291 - 74)

[redacted]

* Phone Leone (LEAVE) @ Thorndale — Caregiver ✓

Dual

(1) Phone Practise Nurse for Blood Test. = Kidney function BT (due) - 8:30am ✓

(2) Contact X-ray Dept @ SWAH After Blood Test above ✓

[redacted]

October

M	.	7	14	21	28	.
T	1	8	15	22	29	.
W	2	9	16	23	30	.
T	3	10	17	24	31	.
F	4	11	18	25	.	.
S	5	12	19	26	.	.
S	6	13	20	27	.	.
Wk	40	41	42	43	44	.

[redacted]

2019 October

Saturday 19

(292 - 73)

Sunday 20

(293 - 72)

November

M	.	4	11	18	25	.
T	.	5	12	19	26	.
W	.	6	13	20	27	.
T	.	7	14	21	28	.
F	1	8	15	22	29	.
S	2	9	16	23	30	.
S	3	10	17	24	.	.
Wk	44	45	46	47	48	.

forward comments prior to next meeting to Sarah for discussion/ sign off. Suggested including a communication chain link to the Inquiry team

Work to Date

Ronan updated everyone on what has been done to date in respect of the recommendations:

- Update on action plan. Ronan shared the template which is very much a first draft of a brainstorming exercise where we established what elements we needs to consider. The purpose is to ensure we are confident that we have covered everything and if audited we are not found wanting. Lisa advised we need to maximise what service users can add to this.
- Susannah gave feedback on the action plan template and agreed to send through her comments to Sarah for review. Susannah expressed she wanted to see evidence, actions and targets and mapping to the supporting guidance. Feels that significant time has passed and progress is limited. Agenda was also sent out close to the meeting which didn't allow much time to review.
- Ronan advised this is a start, Sarah is now dedicated to this role and will be "adding the meat to the bones". Susannah expressed 3 things she wants to see:
    - Assurance on the MDT process
    - Quorum of the MDT and the policy followed
    - Every patient has a CNS
- Feedback on the jargon used in action plan was given for example "datix"- Ronan explained this is an incident reporting system. Susannah asked was our Whistleblowing policy live and felt that supervision sessions was not appropriate for raising concerns.
- Ronan expressed that we want service user involvement throughout this and we value honesty and feedback on the actions.
- Colm asked if the process of a Consultant passing a patient to a CNS was a lengthy one. Ronan advised that this is the process of an MDM. The entire MDT are present including a CNS and it is the responsibility of that nurse to link. There isn't a lot of effort for a consultant to know that a CNS is needed. Susannah advised this would lead her to question the oversight the MDM has.
- Susannah has requested the outcomes of the baseline MDT audits. Dr Tariq explained the process, the baseline we have established and we are now meeting with MDM chairs to feedback. The main issue identified is that there is not enough admin support. We have appointed 1 MDM Coordinator- but it is recognised we will need more. Quoracy is complex as its felt firstly not achievable due to multiple factors including resources, but also not desirable as some patients don't need to be brought to an MDM and therefore this si not conducive of some members time. Dr Tariq explained the widely recognised issues with Radiology and Pathology representation at MDM. There is simply not enough of these to attend.
- Dr Tariq provided update on the Job Description (JD) review. This was never reflected in the MDM chairs JD and therefore may not of been reflected in Job plans. Dr Tariq advised on his work with Liverpool teams and that they are experiencing the same challenges. Their biggest positive was having an MDM coordinator but recognised challenges with training. They identified the need

From: Haynes, Mark
To: Gishkori, Esther
Subject: RE: AMD
Date: 05 October 2018 16:49:09
Sensitivity: Confidential

Hi Esther

I have a clinic Monday morning and theatre in the afternoon. I don't have a mobile at the minute [redacted]. I will hold off until I speak to you but would not anticipate a change of heart I'm afraid. May find it difficult to meet next week as on Tuesday I have a meeting at HSCB with the PHA and prostate cancer UK following up concerns raised by PCUK about inequity of provision of prostate cancer services in NI compared to the rest of the NHS, I will be in CAH briefly before heading to Belfast and then it will depend upon the meeting / fallout as to when I leave Belfast, Wednesday I have theatre then OP, Thursday Theatre and then MDM, Friday theatre BCH am and theatre CAH pm.

Mark

From: Gishkori, Esther
Sent: 05 October 2018 13:51
To: Haynes, Mark
Subject: RE: AMD
Sensitivity: Confidential

Mark,
How are you?
I have been trying to contact you over the past week but accept that I have been extremely busy myself. [redacted]
Can you defer your decision until after we have a chat?
I would really miss you and always value your views and opinions.
I will of course respect any decision you wish to make and really understand how manic your week is. Really want a catch-up soon.
How are you fixed on Monday?
Best,
Esther.

From: Haynes, Mark
Sent: 05 October 2018 13:01
To: Gishkori, Esther
Subject: AMD
Sensitivity: Confidential

Hi Esther

I wanted to contact you before I let others know. I am going to resign from my position as AMD (I will remain as a Southern Trust urology consultant). I will be putting together a resignation letter over the weekend and trust you will keep this decision to yourself until I have sent it to all.

As you may be aware I was [redacted] last week and the past 7 days have

been extremely difficult, Personal Information redacted by the USI

Over the past week I have re-appraised my current situation. Looking at my workload it is apparent that I have been performing far in excess of what can be considered a realistic or sustainable level of activity. My typical week as AMD has evolved to become as below;

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
05:15 – 08:00 Admin / results / email (at home)	05:15 – 08:00 Admin / results / email (at home)	05:15 – 08:00 Admin / results / email (at home)	05:15 – 07:00 / 08:00 (alt weeks) Admin / results / email (at home)	05:15 – 07:00 Admin / results / email (at home)	05:00 – 08:30 Admin / NICAN CRG chair activity	20:00-22:00 Admin / results / email / OP clinic prep
09:00-13:00 New outpatient clinic CAH	09:00-16:00 AMD activity	08:30-13:30 Pre op ward round / theatre / post op ward round CAH	08:00-13:00 Pre op ward round / theatre / post op ward round BCH (week 2, 4) AMD activities weeks 1,3,5	08:00-13:00 Pre op ward round / theatre / post op ward round BCH (week 2, 4)		
13:00-17:30 Pre-op ward round / theatre / post op ward round CAH		13:30-17:30 Review OP clinic CAH	13:00-17:00 Travel to CAH then MDM CAH	13:00-17:00 Travel to CAH Admin with secretary / plan theatre lists / increasingly AMD activity		

In addition to this activity I have been making / receiving phone calls most evenings, attempting to keep up with my own CPD (which I am not getting done at any point during the week), work our 1:6 on-call rota, am clinical supervisor to 2 trainees at CAH, do my 1:6 weeks as Urologist of the week and perform triage during both my week as UoW and during our locum week (this all occurs outside of standard hours and at home). Personal information redacted by the USI didn't get any admin done over the weekend / Monday. The result was that on Tuesday 1 'caught up' with 138 radiology / pathology / blood results dictating >80 letters.

When I have put this activity into a job plan, even before I add in any AMD activity my working week is in excess of 50 hours. The AMD activity is supposed to amount to a further 12 hours per week.

Trying to fit everything in has not been healthy for me. I have had conversations with my children and wife over the course of the week and they have highlighted to me that I am regularly going without breakfast and lunch while I try to meet all the demands of fulfilling the roles I am performing.

As I have said to you before I am a Urologist first. Pressures on urology services in Northern Ireland are considerable and I cannot give up any of my current clinical activity, given the status of waiting times, while the consultant urology workforce is so far below that which is required to meet the needs of our patients. Additionally if I do not provide the specialist input in BCH for the work I do there, patients from Northern Ireland will have to travel to England for surgery which can and should be provided locally. This is not a situation I feel is acceptable.

I have therefore come to the conclusion I must resign from my role as AMD. In addition to this I am making changes to my work schedule such that I am no longer hot-footing it from one site of work to another. I am also now using the train for all commutes to Belfast.

I appreciate the challenges that are ahead of the Southern Trust and for you as Director of Acute services. Indeed, as I have witnessed, the only service that appears to be unable to say 'no, we cannot meet that demand' is acute services. There appears to be institutional blindness to the un-meetable expectations of delivering unscheduled and elective care with year on year increasing demand while capacity remains constant at best, and staffing becomes increasingly difficult. Acute services are constantly having to accept / adopt practices which would not be considered in a different environment (eg patients in un-staffed beds, extra beds in unsuitable environments etc). When services are reduced because of unscheduled care demands, putting patient safety as the main priority, institutionally, outside of acute services, there appears to be an inability (outside of acute services) to recognise and acknowledge the critical lack of capacity.

To you personally I can only apologise for having to come to the decision I have, and hope that the trust are able to appoint someone to take on the position and provide you with the clinical support that is required.

Mark

Personal Information redacted by the USI

26 March 2020

Ms. Martina Corrigan
Head of Service
Craigavon Area Hospital
Craigavon
County Armagh
BT63 5QQ

Dear Martina,

I write to confirm that I submitted to the Directorate of Human Resources on Friday 06 March 2020 completed Forms of Application to Withdrawal from Full Time Employment, and with the intent that my full time employment would end on Tuesday 30 June 2020.

In doing so, I formally advised that I would be prepared to return to Part Time Employment from Monday 03 August 2020. It do hope that I may be able to do so.

Since submitting the above Application, the impact of Covid 19 upon our urological services has become more immediate and substantive. In that regard, I will make myself available to be of assistance during July 2020, within the limitations permitted.

Yours Sincerely,

Personal Information redacted by USI

Aidan O'Brien

normal and they will just write to the patient.

MR O'BRIEN: And irony is, Colin, those who request in advance, well, I am going to have 60 scans coming back, hopefully without charts in the future, to my office. That's fair enough. That's my responsibility. I do appreciate that. But when I go and do my new clinic this afternoon, unfortunately it's not my new clinic because I am seeing people who have had nothing done, and others who do nothing, in advance, it's very, very frustrating. I am not the only one frustrated by it by the way.

This is -- I can tell you in nutshell -- this is a historical mistake. It is a historical mistake that triaging was -- in our speciality was concluded to be an appropriate duty whilst urologist of the week. And to put it in context, and Martina can back this up, at a time when we were giving birth to urologist of the week there was at a time a proposal that we would actually do an afternoon clinic. Because of a bizarre, for me, totally incomprehensible view point that there wouldn't enough for us to do whilst urologist of the week. So at least we're not doing another clinic except people can choose to do a hot clinic or see people urgently. That's entirely up to them and so forth. But we are receiving, you would have the figures, 120 to 160 -- about 140/150 I think is the average.

MARTINA CORRIGAN: Yes.

MR O'BRIEN: You know, if you spend five minutes on them, how many hours is that? If you spend ten minutes on them. It's just not adequate and we are failing people and it is a major concern.

But I have urged -- you know you get tired urging and I think it is going to be very, very difficult to -- I think actually the answer is somehow to have allocated time, protected time, ring-fenced time at another time, but it's a subject maybe for another discussion but it needs to be had because this is getting worse.

COLIN WEIR: Okay. Yes. I would need -- the group would need to decide if we set aside a fixed time for each person (inaudible) find time in their job plan. We would need to --

MR O'BRIEN: Just one other thing. And that is last weekend I was on call and, as you know, Colin, so were you. Working hard. I was ~~at~~ advised subsequent to that an investigation was being conducted into the emergency cases I was operating on, as to whether or not they were really emergencies. Do you know anything about that?

RONAN CARROLL: I don't think it was an investigation.

MR O'BRIEN: All right. What was it? You do know something about it?

RONAN CARROLL: Yeah, but there was -- I can't remember the origins of it but it was looking to see -- there seemed to be a lot of urology cases being done at the weekend.

MR O'BRIEN: Right.

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RONAN CARROLL: Someone's perception that there were a lot being done. So we asked to see what is the normal at the weekend. So we were waiting for that information. One set of figures on one weekend is neither here nor there.

MR O'BRIEN: Okay. So I just find it bizarre because like I was off on Friday the 14th, it being my birthday. I was burning bushes when I got a telephone call to say, it is okay, can you do these two obstructive cases tomorrow. We'll put them on the list. The irony was what I came in one of them hadn't been put on the list and then I find that I am being -- I was told I was being investigated. It had been reported that I actually had operated on a patient on the Saturday who had been admitted electively for an emergency operation. I found that sinister quite frankly. LONG SILENCE What do you think about it?

COLIN WEIR: All I can -- I was made aware that there was six or five cases on a Saturday or six on a Sunday.

MR O'BRIEN: There was eight for the whole weekend. Four of them got done on the Monday and Tuesday.

COLIN WEIR: I don't know what the exact figures are or what the -- anything like that. I think somebody has been asked to look at what they are or what they -- I think there were cases that were hanging over from Friday to Saturday and then some from Sunday to Monday.

MR O'BRIEN: Absolutely. As well as an appendectomy waiting from Friday until the early hours of Monday morning.

COLIN WEIR: Yes. So I think it's just looking at numbers.

MR O'BRIEN: Is everybody being looked at?

COLIN WEIR: I think they have looked at the whole weekend.

RONAN CARROLL: Yes.

MR O'BRIEN: At the whole of that weekend?

COLIN WEIR: Gynae and us and, yes.

MR O'BRIEN: And just one weekend?

COLIN WEIR: Just this past weekend because it has been busy.

MR O'BRIEN: I thought it was appalling. I think this hospital really needs to look at how it is providing acute services to those who particularly need them acutely and the inadequacy of it is --

RONAN CARROLL: I don't think anybody is going to disagree. We all know that we don't have enough of anything. We don't have enough clinicians, we don't have enough nurses, we don't have operating time and.

MARTINA CORRIGAN: (Inaudible).

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