

team. The MDT pathway is a contract between the medical team and the patient. It is based on international best practice guidelines. Individuals do not have the right to deviate from that.

Patient 1's Daughter talked about her wedding, it was to be in February 2021 but they brought it forward. She described how her father was so fit and healthy and very clever and well known. People were shocked when they heard.

Dr Hughes advised you may go home and think and you may have more questions you may want to ask. You can contact us at any time.

Patient 1's Daughter advised it has being difficult working full time.

Patricia Kingsnorth offered psychological support to deal with grief and all that has happened.

Patient 1's Daughter – welcomed this as she was paying privately for psychological support. She advised her mother may also benefit from some support. Patricia will explore and get back to them.

Dr Hughes advised that he would want to include the problems that the covid restrictions placed on Patient 1 and his family within the review.

Patient 1's Daughter advised family were not allowed in to visit her father when he was in Daisy Hill Hospital for 5 days. He was admitted before his wife's Person at birthday. He was very upset.

Dr Hughes consoled, it must have been hard.

Patient 1's Wife advised that when someone is dying it should be different. Patient 1 thought I had abandoned him. That upset her. She advised about visiting him in the SWAH and that the ward sister let her visit him.

Patricia advised that was the humane thing to do.

Patient 1's Daughter advised they could not get a care package in place. The only nurse available was the rapid response nurse, she went out-side her duties and she washed dad, she went over and above her job. District nurse could not come out.

Dr Hughes agreed covid was caused problems; people won't access care and care stopped in some areas.

Patient 1's Daughter talked about the pressures it has caused on cancer services.

Patient 1's Daughter advised to manage, 2 people would sit with her dad, neighbours and extended family helped with this.

Patricia asked were any of the family or neighbours nurses?

Wamsley, Chris

From: Cardwell, David
Sent: 24 January 2022 14:32
To: Wamsley, Chris
Subject: FW: ENCRYPTION

From: Kingsnorth, Patricia <[REDACTED] Personal Information redacted by the USI >
Sent: 14 December 2020 10:38
To: Cardwell, David <[REDACTED] Personal Information redacted by the USI >; Connolly, Carly <[REDACTED] Personal Information redacted by the USI >
Subject: FW: ENCRYPTION

Guys a bit more information about [REDACTED] Patient 112
We need to understand the outcome for [REDACTED] Patient 112 – tumour size etc.

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital



From: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST) <[REDACTED] Personal Information redacted by the USI >
Sent: 14 December 2020 10:36
To: Kingsnorth, Patricia
Subject: Re: ENCRYPTION

Dear Patricia

Please regard this as a preliminary conclusion. It would be better that I see the images as there seems to be some about the measurements of the lesion.

KR, Hugh

From: Kingsnorth, Patricia <[REDACTED] Personal Information redacted by the USI >
Sent: 14 December 2020 09:04
To: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST) <[REDACTED] Personal Information redacted by the USI >
Subject: RE: ENCRYPTION

Thank you Hugh
This is very helpful
Glad you're feeling better. See you at 2pm

Kind regards
Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

Personal Information redacted by USI



From: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST)
Sent: 13 December 2020 23:48
To: Kingsnorth, Patricia
Subject: Re: ENCRYPTION

Personal Information redacted by USI

Dear Patricia

Apologies for the delay; I think I am getting better now.

This case does not raise any alarms in my head.

The patient presented to the haematologists in March 2019 with LN enlargement and a biopsy (April 2019) confirmed a follicular lymphoma. As part of his assessment a CT had shown a renal lesion, which was further characterised by a PET CT and pointed to a coincidental kidney cancer. This was discussed at the urology MDT and a biopsy was recommended.

Significantly, the patient had low Factor VIII (haemophilia) and was about to start 6 cycles of chemotherapy for the lymphoma. He also had a cardiomyopathy and a past history of papillary thyroid cancer.

He was seen by AOB with the written plan to reassess after restaging. It is reasonable to assume he meant post chemo staging. The biopsy was, in my opinion, reasonably deferred; the potential complications infection, haematoma spread during immunosuppression, or even loss of the kidney outweighed any benefit in knowing the histology.

A letter describing this plan was not generated until October 2019. This caused unnecessary concern and work for AOB's colleagues.

Nephrectomy proceeded after the chemotherapy (successful) was completed.

There is a nodule in the lung fields, which may represent a metastasis. This must be discussed at a specialist MDT (Belfast) to consider the timing of adjuvant treatment.

My only observation is that the reasonable change of plan should have been discussed in the MDT in a timely fashion. I don't think the patient suffered any harm as a consequence of this omission. I don't think this amounts to a SAI.

As an aside, I would be very interested in the histology of the kidney tumour. The combination of papillary thyroid cancer, renal neoplasia and follicular lymphoma points towards a genetic cause.

KR, Hugh

From: Kingsnorth, Patricia

Personal Information redacted by USI

Sent: 03 December 2020 14:23

To: GILBERT, Hugh (GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST)

Personal Information redacted by USI

Subject: ENCRYPTION

Dear Hugh

I have been asked if you could assist me some independent view regarding screening for this case. He will not be part of the SAI group but may need to have an SAI separately if required.

I apologise that I am adding to your busy workload and will understand if this is not appropriate to ask the question. Just delete the email if that is the case.

This is a gentleman has a renal carcinoma. He was also attending haematology with lymphoma and preparing for chemotherapy when a CT scan showed a renal lesion which required biopsy.

MDM made a recommendation to biopsy the kidney. This did not happen as the consultant (in his letter dated 16 August 2019) explained why this didn't happen in view of the patient currently undergoing chemo therapy and with his factor V111 condition. This was not fed back to MDM.

The question is given what appears to be a reasonable reason for the delay to action MDM outcome and not feedback to the MDM does that make this an SAI? However I will point out the letter was not written until October 2019.

There does not appear to be a proper process for feeding back to MDM and this will be one of the learning from SAI. Can you advise if this was a reasonable approach for this gentleman particularly if it had been with any other practitioner?

Kind regards

Patricia

Patricia Kingsnorth
Acting Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

Personal Information redacted by USI

CIRCULAR HSS(TC8) 11/01**To: HSS Boards**

Chief Executive
Director of Public Health
Director of Human Resources
Director of Dental Services

HSS Trusts

Chief Executive
Director of Human Resources
Director of Medical Services

Special Agencies
NI Council for Postgraduate Medical & Dental Education
British Medical Association
British Dental Association
Faculty of Medicine & Health Sciences, QUB
Central Services Agency

29 May 2001

Dear Colleague

Consultants' Contract: Annual Appraisal for Consultants**Summary**

1. Employers were notified about the introduction of appraisal for all consultants on 12 March 2001 (see circular HSS(TC8) 3/01). In that circular, those HPSS employers who needed to implement appraisal - that is, all those employing consultants - were asked to begin preparations for impending implementation. The further advice and documentation referred to in that circular is now enclosed.
2. The documentation is designed to provide a systematic approach to the collection and presentation of information for appraisal. It will be of immediate use in the next round of annual appraisals and is also designed to be the vehicle for the delivery of GMC revalidation in due course.

Action for Chief Executives

3. HSS(TC8) 3/01 allowed some limited local flexibility to adapt existing appraisal schemes to comply fully with the national model. However, it is essential that the national documentation is used in full to ensure that there is a consistent, transparent approach to the collection and use of information and in the application of clear, shared standards and

practices. Chief Executives are asked to ensure this action is taken immediately to ensure the documentation is put into practice.

4. The documentation is self-explanatory with further guidance contained in an introduction. Its object is to enable the collection of information for appraisal in a folder followed by appraisal and job planning discussions leading to agreement on a personal development plan, a job plan and, finally, to allow the major portion of the documentation to provide the evidence for GMC revalidation without unnecessary or burdensome extra work by doctors.
5. The Department appreciates that many organisations and individual doctors will need time to build up knowledge and expertise in the operation of appraisal. The documentation, agreed with the BMA, is intended to provide a steer on the important elements that need to be addressed. The Department shall keep developments under review and, if necessary, will offer further guidance when we have all had the opportunity to experience and reflect on the new processes.

Support and development

6. HSS(TC8) 3/01 also explained that a support and development programme would be announced. A training and support programme is being developed. This will be followed by support to Trusts in running local training programmes and establishing good practice.
7. The documentation enclosed is designed primarily with clinicians in mind. Guidance on public health consultants will be issued very shortly.

Distribution and Enquiries

8. A copy of this letter can be obtained at the Department's website at <http://www.dhsspsni.gov.uk>. Employers should provide locally any further copies they require.
9. Practitioners should direct enquiries to their employing authorities and trusts. Any enquiries which cannot be resolved locally should be directed to Paul Cassidy on Personal Information redacted by the USI (e-mail paul.cassidy@dhsspsni.gov.uk) Personal Information redacted by the USI

Yours sincerely

H J VANCE
Deputy Director

[AL(MD) 5/01]

ANNEX A

APPRAISAL FOR CONSULTANTS

Introduction

This set of documents reflects the agreement on appraisal for HPSS consultants issued with circular HSS(TC8) 3/01. That circular said there would be standard documentation to ensure consistency:

"Appraisal must follow a standardised format if it is to be applied consistently and satisfy the GMC's requirements for revalidation. Standardised documentation will be issued in time for use as of April 2001. This documentation will support appraisal and will, in due course, be the vehicle for the delivery of the GMC's revalidation requirements. The use of standardised documentation will ensure that information from a variety of HPSS employers will be recorded and expressed consistently.

"Employers, in liaison with the Medical Staff Committee (or equivalent), Local Negotiating Committee and where appropriate the university should consider whether they wish to retain any existing appraisal scheme for continued use after 1 April 2001. They should consider whether the existing scheme complies with the requirements of the attached agreement, bearing in mind the following:

- If local schemes are retained they must be adapted to comply with the requirements of the national agreement or be replaced in full;
- Where an existing scheme is retained, it will be necessary to adopt the standardised documentation;
- It will be necessary for the purposes of revalidation that the doctor's work be considered under the headings of the GMC's "Good Medical Practice" set out in paragraph 3 of the attached agreement.

"Exceptionally, where MSC and LNC cannot reach agreement (*ie with employers*) on those local schemes departing from the national model, referral should be made to the Department for advice and guidance. Every attempt should be made to resolve local difficulties before referral is made. While there is scope, within the national agreement, for discretion over the operation of appraisal locally, we intend before April 2001 to issue standardised documentation as described above."

The documentation foreshadowed in the circular is now attached. It is designed to provide a formal, supportive, consistent structure to the appraisal process. It covers the process in sequence and suggests the information and evidence that the parties to appraisal will wish to bring to the process.

Appraisal documentation

This documentation is part of an overall process that will include training for appraisers and appraisees. Completing the documents is an important facet of appraisal, not least as it provides a written agreement and encourages consistency, but the dialogue between individuals and the exchange of views is equally important.

Every consultant being appraised should prepare an *appraisal folder*. This is a systematically recorded set of all the documents: information, evidence and data that will help inform the appraisal process. Once the folder has been set up it can be updated as necessary. The documentation will allow access to the original documents in the folder in a structured way, record what the appraisal process concluded from them and, finally what action was agreed as the outcome following discussion.

The appraisal process will not of itself result in the generation of significant amounts of new evidence or information, rather it will capture the information that already exists. What goes into the folder will, for the most part, be available from clinical governance activity, the job planning process and other existing sources. One result of the appraisal process will be to identify areas where there are gaps to be filled or where perhaps data needs to be better collated or presented. This is likely to be more apparent in the early years after appraisal is launched.

Consultants will need to consider which documents they will need to collect for the appraisal process, in the light of this guidance. Documents issued prior to the publication of this guidance may no longer be accessible and may, therefore, not be available for the first appraisal under this scheme.

Preparing for appraisal

Successful appraisal depends on both the parties giving their contribution some thought beforehand. Both parties should give themselves enough time to produce, exchange and consider any documents necessary for the appraisal - a few weeks rather than a few days in advance is best. Where, for whatever reason, a third party needs to contribute to an appraisal - or, indeed, where a special appraiser has to be called in - this should also be discussed and agreed well in advance.

We suggest that it would greatly help the process if both the appraiser and the appraisee thought through the following questions before the interview:

- how good a consultant am I?
- how well do I perform?
- how up to date am I?
- how well do I work in a team?
- what resources and support do I need?
- how well am I meeting my service objectives?
- what are my development needs?

It is very important that the discussion, a vital component of appraisal, is planned in diaries well-ahead and protected. Ad hoc arrangements will fail the appraisee and the appraiser.

Essentially, the timing, location and people involved in the appraisal need to be discussed and confirmed about a month beforehand.

Circular HSS(TC8) 3/01, Annex A paragraph 13, explains that "To be successful, the appraisal scheme must be introduced with an appropriate level of support to appraisers and appraisees. Adequate time should be allocated for the preparation...". It is essential, therefore, that adequate time is allocated for preparation, both for the appraiser and the appraisee. Employers must recognise that preparation time and time for carrying out the appraisal are instead of, rather than additional to the consultant's existing duties and workload, and therefore should take place during usual working hours. In order to prepare for appraisals individuals should be explicitly released from other duties for a specified period of time. In the first year of the scheme it must be recognised that appraisees will require further time for work involved in setting up their appraisal folders.

Using the documentation

The Chief Executive has overall accountability for ensuring appraisal takes place and will receive copies of the forms *summarising* the outcome of the appraisal. This means that Appraisal **Forms 1-4** only will be forwarded to the Chief Executive.

Job planning and comparative data

The introduction of an appraisal scheme for consultants is linked closely with job planning arrangements. The appraisal process and the interview provide an important opportunity to draw together information and data from which the job plan and a work programme are shaped. The documentation here - **Form 5** - provides for a record of the basic information underpinning discussion of the job plan - including any pertinent

internal and external comparative information - so that it can be used as a cross-reference between this and the other parts of the appraisal process.

Should concerns arise during appraisal

Both the appraiser and the appraisee need to recognise that as registered medical or dental practitioners they must protect patients when they believe that a colleague's health, conduct or performance is a threat to patients (*GMC Good Medical Practice paragraph 23; GDC Maintaining Standards paragraph 2.4*). If, as a result of the appraisal process the appraiser believes that the activities of the appraisee are such as to put patients at risk, the appraisal process should be stopped and action taken. If the situation is then remedied the appraisal process can continue. Nothing in the operation of the appraisal process can over-ride the basic professional obligation to protect patients.

Public health physicians

Circular HSS(TC8) 3/01 covers consultants in public health medicine. However, the nature of their practice means that the information and evidence brought to the appraisal process will in some respects differ from colleagues in other clinical specialties. For example, public health consultants will wish to refer to *Good Public Health Practice* published by the Faculty of Public Health Medicine of the RCP(UK). Some sections of the appraisal forms are not relevant for public health physicians. References to *Good Medical Practice* and to maintaining *Good Medical Practice* clearly refer in the case of public health consultants to public health medicine practice.

We provide at appropriate points on *Forms 4 and 6* space for public health consultants to comment on and record action against any other headings of *Good Public Health Practice* not covered elsewhere. Further guidance will be available on public health medicine shortly.

GMC Revalidation

The documentation has been prepared in the light of proposals by the GMC to introduce revalidation for all doctors.

Briefly, the GMC's proposals call for a five-yearly demonstration of all doctors' fitness to practise. Under the scheme currently being proposed, this will be based on information and evidence to be seen by GMC panels. As far as is possible, we have designed the documentation to allow the information and evidence gathering processes of appraisal and the summaries of outcomes to fulfil the requirements of revalidation as soon as it is introduced. This means that doctors will be able to produce the evidence they need for revalidation as part of a seamless process that avoids complexity and duplication. For example, *Forms 1-4* should be able to provide the evidence required for revalidation.

While there is a clear connection between revalidation and appraisal there are also differences. Revalidation concerns itself with a standard measured against the framework of the GMC's guidance *Good Medical Practice* while appraisal takes, in addition to this, a broader look at a doctor's work and service delivery.

It is UK Health Departments' policy to support the GMC's plans to introduce revalidation and to make sure that the practical arrangements are as simple and straightforward to operate as possible. It is expected that further guidance will be issued by the GMC on revalidation before its scheme is introduced.

Personal Information

From: Maxwell, Sharon (Mr I Stirling's Sec.)
Personal Information redacted by the USI
Sent: 01 February 2006 10:05
To: O'Reilly, S MR; Connolly, Ivan; Epanomeritakis, Manos; Young, Michael; O'Brien, Aidan
Subject: Appraisal

Could you please contact me to arrange a suitable date for your appraisal with Mr Stirling. One hour will be required.

Many thanks.

Sharon

Sharon Maxwell
Secretary to
W J I STIRLING FRCS
CONSULTANT SURGEON

Direct Line:

Fax:

Personal Information redacted by the USI

Personal Information redacted by the USI

APPRAISAL FOLDER

FORM 1 – BACKGROUND DETAILS

The aim of this form is to provide:

- the basic background information to identify you individually
- brief details of your career and professional status
- the opportunity for you to supplement this with other information you think is helpful. You can provide at 1ii any other personal details that help describe your current practice. For example, membership of medical and specialist societies.

i. Personal Details

Name:

Aidan O'Brien

Registered address (and contact address if different)

Personal information redacted by USI

Main employer

Southern Health and Social Care Trust.

Other employers/places of work

None

Date of primary medical or dental qualification (in the UK or elsewhere).
GMC/GDC Registration (Type of registration currently held, registration number and date of first full registration)

Queen's University, Belfast, December 1978.

GMC Full Registration.

GMC Reference Number 1394911

Date of first full registration: 27 February 1980

Starting date of first appointment as a substantive consultant in the HPSS, including honorary appointment (*pre 1997 please also give specialty; 1997 and after, please also give date of specialism registration, and specialties in which registered*)

06 July 1992

Date of appointment to post currently held, if different

As above

Title of post currently held (for example, consultant physician with a special interest in gastro-enterology)

Consultant Urologist

Date and country of grant of any specialist registration/qualification outside the UK and specialty in which you were registered

None

Any other specialties or sub-specialties in which you are registered

None

Has your registration been called into question since your last appraisal? (*If this is the first appraisal, is your registration currently under question?*)

No

Date of last revalidation (if applicable)

Not applicable

List all the posts in which you have been employed (including honorary and part-time posts) in the HPSS and elsewhere in the past five years.

Consultant Urologist

Craigavon Area Hospital Group Trust / Southern Health and Social Care Trust

Craigavon Area Hospital

Craigavon

BT63 5QQ

(since date of appointment: 06 July 1992)

ii. Other relevant personal details

Fellowship of Royal College of Surgeons in Ireland awarded 1983
Fellow of Ulster Medical Society 1984
Fellow of Royal Academy of Medicine in Ireland 1986
Fellow of Irish Society of Urology 1992
Member of Bristol Urological Institute 1992
Director of CURE 1995

FORM 2 - DETAILS OF YOUR CURRENT MEDICAL ACTIVITIES

The aim of this form is to provide you with an opportunity to describe your post(s) in the HPSS, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held, or held in the past year. You should explain what you do and where you practise.

Your descriptions should cover your practice at all locations since your last appraisal. You may wish to comment on the environment in which you practise, including:

- factors which you believe affect the provision of good health care, including your views (supported by information and evidence) on the resources available;
- action taken by you to address any obstacles to the provision of good health care.

You should keep a copy of your job plan in this section of your folder

Please provide:

1. A short description of your work in your specialty and your actual practice. What different types of activity do you undertake?

I am a Consultant Urologist in a Urological Department / Service providing for a population of approximately 340,000. The service is provided by three consultant urologists with the support of two registrars, two nurse specialists, and one GP with specialist interest in addition to other nursing staff and more junior medical staff. My practice includes acute and elective, inpatient, operative and non-operative management, day case surgery, flexible cystoscopies, urodynamic studies, general and specialist outpatient clinics, in addition to participating in radiological meetings, oncology MDM and team / departmental management.

2. Sub-specialist skills and commitments

I share with my colleagues responsibility for the provision of all urological cancer assessment, diagnosis and management (apart from radical pelvic surgery), with participation in weekly MDM and specialist cancer review clinics. I am increasingly interested in the assessment and management of lower urinary tract dysfunction, providing urodynamic studies integrated into specialist clinics, with the objective of providing definitive diagnosis, and planning definitive management.

3. Details of emergency, on-call and out-of-hours responsibilities

With my two consultant colleagues, we provide continuous emergency / acute care for the entire population of patients admitted to and within Craigavon Area Hospital, in addition to those similarly requiring acute care in / transfer from other hospitals within the Trust. Increasingly, we also provide advice concerning the management of patients in the Erne Hospital, Enniskillen, and accepting transfer of patients from there if required. The emergency / acute / on-call service is provided by each consultant in 1 in 3 rota. Much of this commitment arises from the management of acute, obstructive uropathy.

4. Details of out-patient work

Outreach clinics in Banbridge Polyclinic and in Armagh Community Hospital on first, second and fifth Mondays of each month.
Outpatient clinic at Craigavon Area Hospital every Tuesday.
Specialist clinic (urodynamic studies and cancer review) on Fridays (except when on call).

5. Details of any other clinical work

6. In which non-HPSS hospitals and clinics do you enjoy practising privileges? To which hospitals and clinics do you have admitting rights and what is the nature of those rights? *If your practice differs from your HPSS practice at some or all of these locations please give details*

None

7. Details of non-clinical work that you undertake as a consultant, for example, teaching/academic work, management activities, research, examining

In service supervision and training of specialty registrars.
Participation in weekly, departmental, management meetings.
Investigator: Randomised, double-blind, placebo-controlled study of RAD001 in the treatment of angiomyolipoma in patients with either tuberose sclerosis complex (TSC) or sporadic lymphangiomyolipomatosis.

8. Work for regional, national or international organisations

None

9. Other professional activities

Director of CURE

JOB PLAN SCHEDULE**AIDAN O'BRIEN****September 2007****MONDAY**

- 9.00 am: Ward Rounds
Appointments with patients' relatives
Administration
- 11.30 am: Multidisciplinary ward meeting
- 2.00 pm: Histopathology meeting
- 3.00 pm: Histology reviews
Administration
- 6.00 pm onwards: Administration of urodynamic studies
Organisation of inpatient admissions

(FIRST, SECOND AND FIFTH MONDAYS)

- 9.00 am: Urodynamic study
- 10.30 am: Urodynamic study
- 12.00 md: Mictiometry, scanning, other procedure
- 1.00 pm: Urodynamic study
- 3.00 pm: Urodynamic study
- 4.00 pm: Change of catheter, other procedure

TUESDAY

- 9.00 am: Operating session, Day Surgical Unit
- 2.00 pm: Outpatient clinic, Craigavon Area Hospital
- 6.00 pm onwards: Dictation and administration of clinic
Organisation of Day Surgical Admissions

WEDNESDAY

9.00 am – 5.30 pm:

Inpatient operating, Craigavon Area Hospital

5.30 pm:

Postoperative round

6.30 pm

onwards:

Organisation of admissions for flexible cystoscopies
Other administration**THURSDAY**

8.30 am:

Radiology meeting

10.00 am:

Grand ward round

12.30 pm:

Implementation group meeting

2.00 pm:

Outreach Clinics (First, Second and Fifth Thursdays)
Review of Newly Diagnosed Prostate Cancer Patients after
Staging (Third and Fourth Thursdays)

6.00 pm:

Administration

*TRIAGE OF REFERRAL LETTERS***FRIDAY**

9.00 am:

Ward Rounds
Postgraduate Teaching
Rita Assessments
Research Review

Or

Public patient consultations / review

1.00 pm:

Appointment with Medical Representative

2.00 pm:

Private patient consultation

3.00 pm:

Private patient consultation

4.00 pm:

Private patient consultation

SATURDAY

11.00 am onwards:

Inpatient management
Administration

SUNDAY

Emergencies only

Current Job Plan / Work Programme

Monday

Am: Outreach general urology clinic in Banbridge / Armagh (twice monthly)

Ward rounds and administration (twice monthly)

Pm: Ward attenders / Ward rounds / administration

Management meeting at 5 pm

Tuesday

Am: Day Surgery (twice monthly)

Pm: General urology outpatient clinic

Wednesday

Am: Inpatient operating

Pm: Inpatient operating

Thursday

Am: Uroradiology meeting at 8.30 am

Grand ward round at 10.00 am

Departmental meeting at 12.00 noon.

Pm: MDM Urological oncology

Friday

Am: Urodynamic studies all day

Pm: Oncology outpatient reviews all day

FORM 3 - RECORD OF REFERENCE DOCUMENTATION SUPPORTING THE APPRAISAL AND REPORT ON DEVELOPMENT ACTION IN THE PAST YEAR

The aim of this form is to record the background evidence and information that will help to inform your appraisal discussions. You should list at 3i the documents in your appraisal folder, these provide evidence in the terms set out in the GMC's Good Medical Practice. You should at 3ii set out your personal development activity for the past year, this will provide a baseline for discussion of future needs.

You should do this for all fields of practice within which you work for the NPSS. If you have management or research responsibilities or if you work in more than one specialty then you will need to include information - under the headings of *Good Medical Practice* - for each field.

You should include relevant information and evidence from your practice outside the HPSS; this should cover medical-related activities relevant to your HPSS practice, to help give an overall picture of you and your development needs.

RECORD OF REFERENCE DOCUMENTATION**GOOD MEDICAL PRACTICE****1. Good medical care**

Examples of documentation which may be appropriate:

- current job plan/work programme (*this will be kept behind Form 2 in your folder*).
- indicative information regarding annual caseload/workload.
- up to date audit data including information on audit methodology if available.
- record of how results of audit have resulted in changes to practice (if applicable).
- results of clinical outcomes as compared to relevant royal college, faculty or specialty association recommendations where available.
- evidence of any resource shortfalls that may have compromised outcomes.
- evidence of how any in-service educational activity may have affected service delivery.

- records of outcome of any investigated formal complaints in which the investigation has been completed in the past twelve months, or since your last appraisal.
- a description of how the outcome of any complaints has resulted in changes to practice.
- outcome of external reviews (peer and otherwise).
- a description of any issues arising in relation to adherence to employer clinical governance policies.
- record of how relevant clinical guidelines are reviewed by the appraisee and his/her team and how these have affected practice.
- records of any relevant critical incident reports.
- any other routine indicators of the standards of your care which *you yourself* use.

<i>List below each document, in the order they appear in your folder</i>	
1.	Job Plan Schedule: September2007
2.	Current Job Plan / Work Schedule May 2011
3.	Audit of prostatic needle biopsies 2003
4.	Record of all operations performed on patients under my care during 2008
5.	Record of all operations performed on patients under my care during 2009
6.	Record of all operations performed on patients under my care during 2010

2. Maintaining good medical practice

The purpose of this section is to record CPD/CME activities undertaken since the last appraisal. Any difficulties in attending CPD/CME activities should be recorded, with reasons.

Examples of documentation which may be appropriate *(if available)*:

- examples of participation in appropriate Continuing Professional Development, this might include individual development activity, locally based development and participation in college or specialty association activities. List all CPD courses attended, and points awarded for each attendance.

List below each document, in the order they appear in your folder. Continue on a separate sheet if necessary

1.	Certificate of Attendance, Annual EAU Congress, Paris, France, 2006
2.	Certificate of Attendance, Uses of Holmium in Urology, Malaga, Spain, 2006
3.	Record of Attendance, Laser Safety, Craigavon Area Hospital, 2007
4.	Certificate of Attendance, Annual EAU Congress, Milan, Italy, 2008
5.	Certificate of Participation, ESU course on Chronic Pelvic Pain Syndromes with special focus on Chronic Prostatitis and Painful Bladder Syndrome / Interstitial Cystitis, Milan, Italy, 2008
6	Certificate of Attendance, Leading Lights in Urology Meeting, Oslo, Norway, 2008
7	Certificate of Attendance and Chairing, Annual Meeting, Irish Society of Urology, Kilkenny, 2008
8.	Organiser, CURE Conference, Portadown, 2008
9.	Certificate of Attendance, Annual EAU Congress, Stockholm, Sweden 2009

10.	Certificate of Haemovigilance Competencies, Craigavon Area Hospital, 2009
11.	Certificate of Training, Female Incontinence Surgery, Barcelona, Spain, 2010
12.	Certificate of Completion, Good Clinical Practice Awareness Seminar, Belfast Health and Social Care Trust, 2010
13.	Certificate of Attendance, Annual EAU Congress, Vienna, Austria, 2011
14.	Certificate of Attendance, ESU Course, Surgery or Radiotherapy for Localised and Locally Advanced Prostate Cancer, Vienna, Austria, 2011
15.	Letter of Invitation of Participation in UROCON 2011, Annual Meeting of Pakistan Association of Urological Surgeons (PAUS), Karachi, Pakistan, 2011
16.	Certificate of Presentation, 'What's Wrong with PSA?', UROCON 2011, Karachi, Pakistan, 2011
17.	Certificate of Panellist, Live Operating Session, 'Radical Cystectomy with Orthotopic Neobladder', UROCON 2011, Karachi, Pakistan, 2011
18.	Certificate of Panellist, PAUS Education Office Seminar, 'Urology Residency and Beyond', UROCON 2011, Karachi, Pakistan, 2011
19.	Certificate of Attendance, Advanced Communications Skills Training Course, Templepatrick, 2011

3. Working relationships with colleagues

The purpose of this section is to reflect on your relationships with your colleagues. Examples of documentation which may be appropriate:

- a description of the setting within which you work and the team structure within which you practice.

- any other documentary evidence that may be available (such as records of any formal peer reviews or discussions) should be included here, otherwise a record of the discussion and any other action agreed should form part of the summary in Form 4.

<i>List below each document, in the order they appear in your folder</i>
1. See the Attached description
2.
3.
4.
5.etc

4. Relationships with patients

The purpose of this section is to reflect on your relationships with your patients.

Examples of documentation that may be appropriate:

- any examples of good practice or concern in your relationships with patients
- a description of your approach to handling informed consent.

This might include validated patient surveys, your assessment of any changes in your practice as a result of any investigated complaint, compliments from patients, peer review/surveys.

<i>List below each document, in the order they appear in your folder</i>	
1.	Collection of cards and letters of gratitude and appreciation enclosed
2.	
3.	
4.	
5.etc	

5. Teaching and training

The purpose of this section is to reflect on your teaching and training activities since your last appraisal. Any difficulties in arranging cover for your clinical work whilst undertaking teaching and training (including educational activities for the HPSS generally) should be recorded.

Examples of documentation that may be appropriate:

- A summary of formal teaching/lecturing activities, supervision/mentoring duties, any recorded feedback from those taught.

<i>List below each document, in the order they appear in your folder</i>
1.
2.
3.
4.
5.etc

6. Probity]
7. Health]

You should note here any concerns raised or problems encountered during the year on either of these issues and include any records.

List below each document, in the order they appear in your folder. Continue on a separate sheet if necessary

Probity

1. None

2.

3.

4.etc

Health

1. Documentation of Inoculation History

2.

3.

4.

5.
etc

MANAGEMENT ACTIVITY

Examples of documentation that may be appropriate:

- information about your formal management commitments, records of any noteworthy achievements and any recorded feedback if available.

You will already have covered much or all of your management activity in earlier sections of **Form 3**. This section provides an opportunity to add any further information, including any difficulties in arranging cover for your clinical work whilst undertaking management activity (including activities for the HPSS regionally and nationally). To avoid duplication you should cross-reference here any documentation listed earlier which refer to your management activity.

List below each document, in the order they appear in your folder. Continue on a separate sheet if necessary

1.

2.

3.

4.

5.etc

see also documents... .. above.

RESEARCH

Examples of documentation that may be appropriate:

- evidence of formal research commitments
- record of any research ongoing or completed in the previous year
- record of funding arrangements for research
- record of noteworthy achievements
- confirmation that appropriate ethical approval has been secured for all research undertaken.

You will already have covered much or all of your research activity earlier on **Form 3**. To avoid duplication you should cross-reference here any documents already listed that refer to your research activity.

List below each document, in the order they appear in your folder. Continue on a separate sheet if necessary

1. Approval of National Research Ethics Service for 'A randomised, double-blind, placebo-controlled study of RAD001 in the treatment of angiomyolipoma in patients with either tuberose sclerosis complex (TSC) or sporadic lymphangioleiomyomatosis (LAM): Principal Investigator

2.

3.

4.

5.etc

see also documents... .. above.

REPORT ON DEVELOPMENT ACTION IN THE PAST YEAR

You should summarise here the development action agreed at the last appraisal (or at any interim meeting) or include your personal development plan. This will facilitate discussion on progress towards development goals. You should record where it is agreed that goals have been achieved or where further action is required. It is assumed that where a development need has not been met in full it will remain a need and will either be reflected in the coming year's plan or have resulted in other action.

SIGN OFF

We confirm that the above information is an accurate record of the documentation provided by the appraisee and used in the appraisal process, and of the appraisee's position with regard to development action in the course of the past year.

Signed:

Date:

Appraisee

Signed:

Date:

Appraiser



CRAIGAVON
AREA HOSPITAL
HSS TRUST

Caring Through Commitment

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREEE AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on Form 3 and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in Form 3 informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary: -

Care is provided to a population which probably exceeds the capacity of the service to provide. Once on the list care provided is professional and caring. Getting on the list is a problem. & management of 'how' is a problem.

Action agreed:

To be assessed by process of Review of the Urology Service.

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT63 500

Personal Information redacted by USI



CRAIGAVON
AREA HOSPITAL
GROUP TRUST

Caring Through Commitment

2. Maintaining good medical practice

Commentary:

Don maintain CPD. attends main meeting in Europe / USA. This year attended American Urological Meeting in Chicago & presented a paper at same. - CPD - points maintained

Action agreed:

3. Working relationships with colleagues .

Commentary:

No specific problems.
Good team in urology.

Action agreed:

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT63 5QQ

Personal Information redacted by

USI



CRAIGAVON
AREA HOSPITAL
GROUP TRUST

Caring Through Commitment

4. Relations with patients

Commentary:

Not a problem. - maybe a problem
with time management.

Action agreed:

N/A

5. Teaching and training

Commentary:

Teaching mostly by SpR. for students
Involved in - post grad teaching - generic
Schemes in urology in N. Ireland.

Action agreed:

N/A

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT63 5QQ

Personal Information redacted by
USI



**CRAIGAVON
AREA HOSPITAL
GROUP TRUST**

Caring Through Commitment

6. Probity

Commentary:

Good

Action agreed:

7. Health

Commentary:

Good.

Action agreed:

Headquarters:

Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ

Personal Information redacted by USI



CRAIGAVON
AREA HOSPITAL
GROUP TRUST

Caring Through Commitment

8. Any other points

Commentary:

Major concern as to how services of urology is provided/developed & is a frustration in lack of progress in assessing the service & future provision of same..

Action agreed:

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT63 5QQ

Personal information redacted by USI

**CRAIGAVON
AREA HOSPITAL
GROUP TRUST***Caring Through Commitment***PERSONAL DEVELOPMENT PLAN**

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which will relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions that could be taken to retain their contribution to the HPSS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT61 5QQ
Personal Information redacted by
USI

PERSONAL DEVELOPMENT TEMPLATE

This should be used to inform discussion on development provided for on Form 4. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
<i>Explain the need.</i>	<i>Explain how you will take action, and what resources you will need.</i>	<i>The date agreed with your appraiser for achieving the development goal.</i>	<i>How will your practice change as a result of the development activity?</i>	<i>Agreement from your appraiser that the development need has been met.</i>
1. Development of service rather than personally - immediate responsibility.				
2.				
3.				
4. etc				

**CRAIGAVON
AREA HOSPITAL
GROUP TRUST**
Caring Through Commitment



**CRAIGAVON
AREA HOSPITAL
GROUP TRUST***Caring Through Commitment***SIGN OFF**

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser: _____

Personal Information redacted by USI

Date: _____

23.12.03

GMC/GDC Number: _____

1366 486

Appraisee: _____

Personal Information redacted by USI

Date: _____

23.12.03

Record here the names of any third parties who contributed to the appraisal and indicate the capacity in which they did so.

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon, BT63 5QQ

Personal Information redacted
by USI



REPORT ON DEVELOPMENT ACTION IN THE PAST YEAR

**CRAIGAVON
AREA HOSPITAL
GROUP TRUST**

You should summarise here the development action agreed at the last appraisal (or at any interim meeting) or include your personal development plan. This will facilitate discussion on progress towards development goals. You should record where it is agreed that goals have been achieved or where further action is required. It is assumed that where a development need has not been met in full it will remain a need and will either be reflected in the coming year's plan or have resulted in other action.

SIGN OFF

We confirm that the above information is an accurate record of the documentation provided by the appraisee and used in the appraisal process, and of the appraiser's position with regard to development action in the course of the past year.

Signed:

Personal Information redacted by USI

Date:

Personal Information redacted by USI

Appraisee

Signed:

Personal Information redacted by USI

Date:

23.12.03

Appraiser

Headquarters:

Craigavon Area Hospital Group HSS Trust

Craigavon BT63 500

Personal Information redacted by USI

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

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SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary: -

Care given to individual patients is not a problem.

There is a problem in urology in managing acute/emergency management of patients in the periods on call - often without registrar cover.

There are no objective measures of quality of medical care - because of lack of time/facilities/IT etc.

Action agreed: /

Some issues may be addressed as result of the Urology Review

2. Maintaining good medical practice :-

Commentary:

- Continuing to keep up to date via journals etc in interests of urological oncology.

Invited to speak 2/12 at international meeting in Dublin.

Been to European Meeting in oncology -

CPD - points OK

Action agreed:

3. Working relationships with colleagues

Commentary:

No obvious problems that I am aware of in both medical / nursing colleagues.

Action agreed:

4. Relations with patients

Commentary:~

Mostly relates to communication with patients which is good.

I'm not aware of any complaints in relation to medical management. in the past several years most relate to waiting times etc.

Action agreed:

5. Teaching and training

Commentary:

Training unit for registrars on rotation in clinical setting - first back from registrars suggests good training programme offered in OH.

N.I. teaching programme - involved in as 1:8 for N.I. registrars on Friday AMs.

Involved in education in primary health care.

Action agreed:

6. Probity

Commentary:

Now aware of any problems with regard to probity.

Action agreed:

7. Health

Commentary:

- Good -

Action agreed:

8. Any other points

Commentary:

Ongoing concerns re volume of work,
 + of the volume of work involved in on-call
 at weekend with no registrar - which involves
 consultant working as a registrar, - with
 no monetary recompense

Still haven't got the extra 4 Beds following MAU opening!

Action agreed: Await expectation the implementation
 of the Urology Review.

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

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This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary:

External Service Review recommended a 4th consultant to take up post in 2007. The 3rd consultant post is starting this month. Concerns re meeting and maintaining Access Targets.

Action agreed:

2. Maintaining good medical practice**Commentary:**

Maintaining good medical practice through internal and external meetings etc.

Action agreed:**3. Working relationships with colleagues****Commentary:**

No specific problems.

Action agreed:

4. Relations with patients

Commentary:

No problems because of Biden's non time management.

Action agreed:

N/A

5. Teaching and training

Commentary:

Involvement in post grad teaching;
Training of registrars (ST3 + ST5)

Action agreed:

N/A

6. Probity

Commentary:

Good

Action agreed:

7. Health

Commentary:

Good

Action agreed:

8. Any other points

Commentary:

Still frustrated by lack of consultant engineers:

Action agreed:

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser:

Personal Information redacted by USI

Date:

14/4/7

GMC/GDC Number:

2646042

Appraisee:

Personal Information redacted by USI

Date:

15.09.07

Record here the names of any third parties who contributed to the appraisal and indicate the capacity in which they did so.

REPORT ON DEVELOPMENT ACTION IN THE PAST YEAR

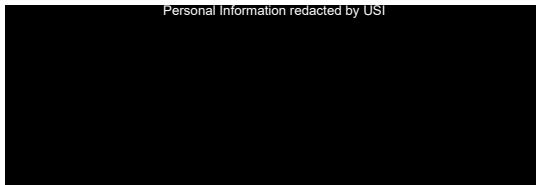
You should summarise here the development action agreed at the last appraisal (or at any interim meeting) or include your personal development plan. This will facilitate discussion on progress towards development goals. You should record where it is agreed that goals have been achieved or where further action is required. It is assumed that where a development need has not been met in full it will remain a need and will either be reflected in the coming year's plan or have resulted in other action.

SIGN OFF

We confirm that the above information is an accurate record of the documentation provided by the appraisee and used in the appraisal process, and of the appraisee's position with regard to development action in the course of the past year.

Signed:

Personal Information redacted by USI

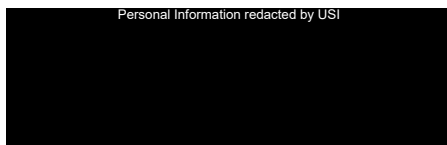

Appraisee

Date:

19.09.07

Signed:

Personal Information redacted by USI


Appraiser

Date:

19/9/07

21 NOV 2011

ANNUAL APPRAISAL 2010

MR. AIDAN O'BRIEN

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary:

Aidan qualified in 1978, holds full GMC registration and has been in the same Consultant Urologist post since 1992. He is a Fellow of the RCS in Ireland, and is a member of several general and urological societies. Description of his job reflects a broad urological practice. This includes MDM oncology involvement and a special interest in lower urinary tract dysfunction. Current rota is 1:3. The population base covered is geographically wide, and hence patients are from both urban and rural backgrounds.

A log of individual list of operations performed for 2008, 2009 and 2010 is impressively long, defining a constant and hard working pattern.

No formal complaints nor critical incidents are logged by the Trust. The Trust however has had discussions with reference to patients being treated with IV fluids and antibiotics. This has been satisfactorily concluded.

An audit of prostate biopsy outcomes is recorded. Several of the hospital mandatory courses have been attended.

Action agreed: For next appraisal

- log of total volume of outpatient activity, day cases and operations.
- audits in current time frame
- log Defence Organisation
- formally log mandatory courses

2. Maintaining good medical practice**Commentary:**

Aidan has maintained a constant approach to CPD, attending major, well recognised conferences – annual scientific meetings of the European Association of Urology 2009 (and 2010 was planned, but cancelled due to ‘ash cloud’) and of the Irish Society of Urology 2008. Aidan hosted the annual CURE meeting 2008. In 2010, attended a training course in incontinence surgery in Barcelona.

Safety courses include Laser protection / Holmium laser usage and has completed competency 4 in blood transfusion

On a regional basis, Aidan has been involved in discussions on bladder dysfunction MDT. General regional audit for urology has recently been instigated.

Action agreed:

- To further develop LUT dysfunction interest
- Join either EAU or BAUS

3. Working relationships with colleagues**Commentary:**

Has been on a 1:3 rota for several years now and is an active member in a unit which has a team approach to delivering its service. Aidan has a good relationship with colleagues, nurses and ancillary staff. This has all been tested in recent times by ward reconfigurations. (see later in section 8).

No individual issues were raised .

Action agreed:

Nil required.

4. Relations with patients**Commentary:**

A selection of 'Thank-you' letters and cards are provided.

Aidan has a recognised, good relationship with his patients, which frequently goes beyond standard practice.

Recent, certified participant in Advanced Communication Skills course as required of clinicians involved in management of cancer patients.

Two complaints are recorded, one relating to a delay in outpatient review (a known Trust issue) and the second was from a relative. Both complaints are resolved.

Action agreed:

No action required

5. Teaching and training**Commentary:**

Has undertaken a course on Introduction to Good Clinical Practice for Investigators.

Aidan is a clinical supervisor of Urology SPRs in our unit and for our GPWSI.

Action agreed:

No action required

6. Probity

Commentary:

No issues raised

Action agreed:

To complete this section with the official GMC form

7. Health

Commentary:

Inoculation history: up-to-date

No days off

Action agreed:

To include information on GP

To complete this section with the official GMC form

8. Any other points

Aidan is the Principal Investigator at Craigavon Area Hospital of an international study into a new drug treatment for Angiomyolipoma (Ref 09/H0502/82).

IV fluids/Antibiotic issue

Aidan has regarded the changes resulting from the ward reconfigurations of 2009 as particularly disruptive, since it had taken many years to build and had predicted the deleterious effects of such changes. Eventual restoration to a definitive urology unit has been a very important point, and for the Trust to recognise this precise point.

A further major change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon Area Hospital, and negative consequences for patients. There is general discontentment in the decision making process conducted by the recent Regional Review of Urology. Aidan has concerns that this will have significant knock on effects for services in the area in the future.

Action agreed:

IV fluids/Antibiotic issue has been improved by a new care-pathway defined by the Trust.

PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which will relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions that could be taken to retain their contribution to the HPSS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice

PERSONAL DEVELOPMENT TEMPLATE

This should be used to inform discussion on development provided for on Form 4. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
<i>Explain the need.</i>	<i>Explain how you will take action, and what resources you will need.</i>	<i>The date agreed with your appraiser for achieving the development goal.</i>	<i>How will your practice change as a result of the development activity?</i>	<i>Agreement from your appraiser that the development need has been met.</i>
1. Urodynamic service needs to be improved on several fronts	To arrange meeting(s) of all stakeholders to identify agreed objectives for urodynamic service, and changes / needs required to meet the objectives. Identify additional nursing staff to be trained and certified as urodynamicists.	To have objectives agreed by December 2011. To have identified new trainees and have training commenced by March 2012. To have trainees certified by March 2013	To be able to increase capacity to meet demand for urodynamic studies to be conducted in a timely or clinically appropriate manner.	
2.				
3.				

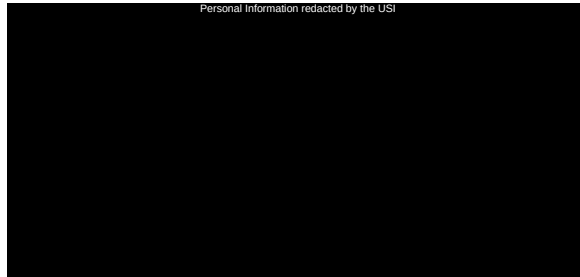
4. etc				

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser:

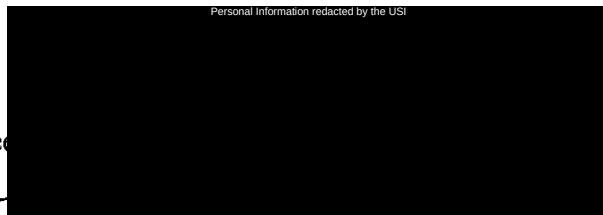
GMC/GDC



Date:

10-11-11
15-07-11
Appraisal Date.

Appraisee



Date:

17.11.11



Southern Health
and Social Care Trust

Medical Directorate

Memorandum

Our Ref	JS/KS
To:	Mr A O'Brien
Cc:	Mr M Young
From:	Dr John Simpson, Medical Director
Date:	12/04/13
Subject	APPRAISAL

Dear Mr O'Brien

Thank you for forwarding a copy of your Form 4 from your 2011 appraisal.

This document has been stored electronically in my office and I return the original for your files.

Personal Information redacted by the USI

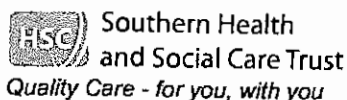
DR JOHN SIMPSON
Medical Director

Enc.

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



APPRAISAL DOCUMENTS

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FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information.

1.1	Full name	Aidan O'Brien
1.2	GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3	Main employer	Southern Health and Social Care Trust
1.4	Main place of work	Craigavon Area Hospital, Craigavon
1.5	Other employers/ places of work	Armagh Community Hospital, Banbridge Polyclinic and South West Acute Hospital, Enniskillen
1.6	Date of primary medical qualification	December 1978
1.7	GMC registration number and type	1394911 Full with specialist registration with licence to practise
1.8	Start date of first substantive appointment in HSC as a trained doctor	06 July 1992
1.8	GMC Registration date and specialties	07/08/2013 Urology
1.9	Title of current post and date appointed	Consultant Urologist 11/06/1992
1.10	For any specialist registration / qualification outside UK, please give date and specialty	Fellow of Royal College of Surgeons in Ireland November 1983
1.11	Please list any other specialties or sub-specialties in which you are registered	None
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	Not applicable
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any	Consultant Urologist, Craigavon Area Hospital

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

honorary and/or part-time posts)	

ANY ADDITIONAL INFORMATION

In addition to being awarded Fellowship of the Royal College of Surgeons in Ireland in November 1983, I became a

- Fellow of the Ulster Medical Society in 1984
- Fellow of the Royal Society of Medicine in Ireland in 1986
- Fellow of the Irish Society of Urology in 1992
- Member of the Bristol Urological Institute in 1992
- Founding Director of CURE in 1995

In addition to the duties arising from the post of Consultant Urologist at and from Craigavon Area Hospital during 2012 and 2013, I have been

- External Adviser to Royal College of Surgeons in Ireland in Specialist Registrar appointments in Republic of Ireland during 2012 and 2013
- Chair of Urological Cancer MDT of Southern Health and Social Care Trust since 01 April 2012
- Lead Clinician and Chair of Northern Ireland Cancer Network (NICaN) Urology Site Specific Group since 01 January 2013

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

2.1 Please give a short description of your work, including the different types of activity you undertake	The work includes elective and non-elective inpatient operating, elective day case operating, and non-operative management of inpatients admitted electively and as emergencies. This provision entails an extended, ten hour, inpatient operating session each week, in addition to two, elective, day surgical sessions each month. Outpatient activity includes conducting one, general urological, outpatient clinic per week at Craigavon Area Hospital and one, general urological, outpatient clinic per month at each of Armagh Community Hospital, Banbridge Polyclinic and South West Acute Hospital. As a consequence of commitment to urological oncology, I conduct an Oncology Review clinic at Craigavon Area Hospital each week, in addition to providing a one-stop urodynamic service once weekly. Since assuming the Chair of Southern Trust Urology MDT in April 2012, the supervision and overview of the provision of urological cancer services has added significantly to my work. Each week, 35 cancer cases are discussed at MDM. All aspects of each case are previewed by me before each MDM, presented by me at MDM, and the plan for each case signed off by me after each MDM so that each GP, and other specialists to whom a case may be referred, receives that communication one day later.
2.2 List your main sub-specialist skills and commitments / special interests	Urological Oncology Lower Urinary Tract Functional and Reconstructive Urology Paediatric Urology
2.3 Please give details of any emergency, on-call and out of hours responsibilities	I participate in a 1 in 4 on-call rotation I provide additional elective operating sessions at weekends Virtually all administrative work is conducted out of hours
2.4 Please give details of out-patient work if applicable	As detailed above, I conduct one clinic per week in non-oncological urology at Craigavon Area Hospital, one similar clinic per week at an outreach location and two clinic sessions per week in urological oncology, or a combination of urological oncology and urodynamic studies.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.5 Details of any other clinical work	I provide support to Clinical Nurse Specialist in Urology at South West Acute Hospital, Enniskillen, by having established the practice of having parallel clinics being conducted by the Nurse Specialist and the Consultant Urologist. This has enhanced the service provided by the Nurse Specialist by provided aspects of clinical assessment in which the Nurse Specialist may not have competence, in addition to the Nurse Specialist being able to enhance the assessment of patients attending the Consultant provided clinic. I have also found myself in the role of providing mentoring support to recently appointed consultants in major open surgical procedures, particularly in cases of renal cancer.
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	I do not have admission or practice rights in any private hospitals or clinics. I do conduct a private outpatient consultation practice at my home. I do so on Saturdays, once or twice per month, when not on call or providing any other service at Craigavon Area Hospital. When doing so, I would typically have 10 consultations. Not all would be private or fee paying patients, as I would use that opportunity to review professional colleagues who have become patients, out of professional courtesy and with respect to their privacy. There have been no adverse events or incidents or complaints arising from that practice, which is conducted in compliance with GMC's Good Medical Practice guidelines and with the Trust's Data Protection policies.
2.7 List any non-clinical work that you undertake which relates to teaching	Clinical Supervisor of Specialist Registrars in Urology
2.7.1 List any non-clinical work that you undertake which relates to management	Member of the Southern Trust's Implementation Group for Transforming Cancer Follow-Up in Prostate Cancer
2.7.2 List any non-clinical work that you undertake which relates to research	Principal Investigator of Study of Everolimus in the Treatment of Angiomyolipoma in Patients with Tuberous Sclerosis Complex. Participant in 'Living with and beyond Prostate Cancer: a Study of the Impact on Men of Increased and Variable Investigation and Treatment of Prostate Cancer in the Island of Ireland – Prostate Investigations Study'

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of Northern Ireland Cancer Network Site Specific Group in Urology External Assessor to the Royal College of Surgeons in Ireland for Specialist Registrar Appointments in Urology in Republic of Ireland
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Provision of expert medicolegal reports.

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

I have attached the proposed Job Plan which was to come into effect on 01 July 2011, and for a period of one year. This Job Plan provided for a total of 11.25 Programmed Activity sessions. Following facilitation in September 2011, the total number of Programmed Activity sessions was increased to 12.75 until 28 February 2012, reducing to 12 thereafter (letter attached). The current Job Plan (attached) was proposed to come into effect on 01 April 2013, providing for a total of 11.275 Programmed Activity sessions. However, that Job Plan was predicated on 5 Consultant Urologists in post, and which has only variously been the case since 01 April 2013. As a consequence, the initial job plan of 2011/12 remains in effect. However, that job plan has not been reviewed or amended to take account of changes in work patterns which have since developed, such as all day clinic sessions at South West Acute Hospital (rather than a half day) once monthly, extended inpatient operating sessions once weekly, and the additional work required in chairing Urology Multidisciplinary Team meetings.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is an ongoing cause for concern.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013



CONSULTANT JOB PLAN REVIEW TEMPLATE

Job Plan Dates	
This job plan is effective from:	1st July 2011
Next Job Plan Review Due on/before:	1st July 2012

Personal details:	
Name of doctor: Mr Aidan O'Brien	Contract Type: Whole Time
Directorate/Division & Location: Urology/ Surgery and Elective Care Division	

On-call rotas only - On-call availability supplement:	
Rota Frequency – i.e. Number of doctors on rota:	1 : 3
Rota Category:	Category A
<i>For info: More frequent than or equal to 1 in 4 = Category A: 8% Category B: 3% of basic salary</i> <i>Less frequent than 1 in 4 or equal to 1 in 8 = Category A: 5% Category B: 2% of basic salary</i> <i>1 in 9 or Less frequent = Category A: 3% Category B: 1% of basic salary</i>	

Summary of Programmed Activities:		
Direct Patient Care excluding on-call:	8.18 PA's	
Supporting Professional Activities:	1.5 PA's	Specific Roles:
On-Call Allocation:	<i>Predictable</i> PA's	<i>Unpredictable</i> 1.57 PA's
Any Annualised Activity & Reason	PA's	Reason:
Any Additional HCS Responsibilities:	PA's	Reason:
Any External Duties:	PA's	Reason:
TOTAL PA's:	11.25 PA's	



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

1. OBJECTIVES: Refer to Section 3 in Regional Job Planning Guidance.

Objectives should be specific, measurable, achievable, reasonable and time bound. They may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these should be reasonable and agreement should be sought.

Service Developments & Objectives

- Service developments and key targets which will impact on PAs

Personal Objectives

- Objectives against which PA's will be allocated [both DCC and all SPA's]
- E.g. Activity targets specifying an indicative activity for outpatient clinics, theatre lists.
- E.g. Quality objectives incorporating attainment of standards of quality of care.

Team Objectives

- As appropriate to the team job plan e.g. to guarantee to provide a fixed number of clinics or operating lists for the whole team over a year when achievable.

SUPPORTING RESOURCES

Facilities and resources required for delivery of duties and objectives	
1. Staffing support	
2. Accommodation	
3. Equipment	
4. Any other identified resources	



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

2. DIRECT CLINICAL CARE (Section 8 in Regional Job Planning Guidance.)

Emergency duties, including work during or arising from on-call, Operating Sessions including preoperative and postoperative care, Ward Rounds, Outpatient activities, Clinical diagnostic work, Other patient treatment, Public health duties, Multidisciplinary meeting about direct patient care, Any administration related to any of the above, including referrals & notes.

3. JOB PLAN TEMPLATE

This job plan is subject to review at least once per year by you and your Clinical manager. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter.

(If appropriate cut and paste your job plan into this space set out in the following format.)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total Hours	Prem
				DCC	SPA	APA	EPA		
Mon	8.30 – 9.00	Travel		0.5				9.0	
	9.00 - 1.00	Week 1 & 4 – Banbridge OPC	BPC	2					
		Week 2 & 3 – Armagh OPC	ACH	2					
		Return Travel		0.5					
	2.00 – 2.30	Admin	CAH	0.5					
	2.30 – 6.00	SPA	CAH		3.5				
Tues	9.00 – 1.00	Day Surgery (2 weeks per month)	CAH	2.0				7.00	
		Admin (2 weeks per month)	CAH	2.0					
	2.00 – 5.00	Outpatients clinic	CAH	3.0					
Wed	8.30 - 9.00	Pre op ward round	CAH	0.5				8.50	
	9.00 – 1.00	Theatre	CAH	4.0					
	1.00 – 5.00	Theatre	CAH	4.0					
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0				7.75	
	9.30 – 12.00	Grand Ward Round	CAH	2.5					
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	2.15 – 5.00	MDM	CAH	2.75					
Fri	9.00 – 1.00	Specialist clinic	CAH	4.0				6.5	
	1.00 – 6.00	SPA (Weeks 1 & 3) Off (Weeks 2 & 4)	CAH		2.5				



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

TOTAL HOURS:			32.75	6				38.75	
TOTAL PROGRAMMED ACTIVITIES:			8.18	1.5				9.68	

4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		1.57
TOTAL PA's for ON-CALL:			1.57

*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

On-call availability Supplement	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

5. SUPPORTING PROFESSIONAL ACTIVITIES (Section 9 in Regional Guidance)

- It is expected that PA's including SPA's will normally take place at a consultant's principal place of work if space, equipment and protected time are provided. Alternatives arrangements can be agreed with the Clinical Director.
- The Trust would expect that all consultants have a minimum allocation of 1.5 for supporting professional activities for maintaining a professional career. Where additional SPA's are undertaken to varying degrees by consultants these should be programmed into the Job Plan and agreed with the Clinical Manager.

Please provide full details on SPA responsibilities



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

6. **EXTERNAL DUTIES** – Please refer to Trust Guidance on approval for External Duties. An External Duties approval form must be completed on an annual basis.

Please provide full details on External Duties, time frames, funding arrangements etc

7. **Additional HPSS Responsibilities** – Please refer to Trust Guidance on approval of these duties. An HPSS Additional Responsibilities approval form must be completed on an annual basis.

Please provide full details on these duties, time frames, funding etc

8. PRIVATE PRACTICE & FEE PAYING SERVICES

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year you have agreed to inform the clinical director before any changes are made to your work-plan.	☐
You are currently undertaking regular private practice as outlined in your job plan and will undertake an additional PA if offered, up to a maximum of 11 PA's per week, as detailed in the terms and conditions of service.	☐
You are currently undertaking ad hoc private practice with the Trust and it is agreed that this practice will continue, provided it does not affect the efficiency of multidisciplinary team working. You have agreed to ensure that if any of your agreed NHS activity is displaced due to private practice you will carry out in NHS activity at an agreed later stage.	☐

9. AGREEMENT:

Signed: Doctor		Signed: Clinical Manager	
Date:		Date:	
Signed: Associate Medical Director & Director of Service			
Date:			

To be completed and forwarded to:

- The Medical Staffing Manager, Medical HR, Ground Floor, Trust HQ, CAH



Quality Care - for you, with you

12th October 2011

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

PRIVATE & CONFIDENTIAL

Dear Mr O'Brien,

I am writing to advise you that following your facilitation meeting on Wednesday 28 September 2011 and a subsequent meeting held with Mr Mackle on Friday 7 October 2011, I have considered the issues raised and reviewed all the necessary information.

I have compared your proposed job plan with those of your colleagues in Urology and am content that the time you have been allowed for administration seems appropriate. One of your colleagues has been allowed slightly more time; however he has agreed to undertake an additional clinic which will generate more administration.

I do accept however, that you have historically worked significant amounts of administrative time and as a result I feel it is appropriate for me to agree a transitional period to allow you time to adjust your working practices. I am therefore recommending that you should be offered an additional 0.75 PA per week for administration until 28 February 2012. This will result in a total of 2.75 PAs over and above 10 programmed activities. From 1 March 2012 however, you will reduce to 12 PAs per week.

This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.

In the meantime, it is important for you to be aware that if you are not satisfied with the outcome of the facilitation process and wish to proceed to a formal appeal, you must notify the Chief Executive in writing by Tuesday 25 October 2011.

Personal information redacted by the USI

A large black rectangular box redacting the signature of Dr PP Murphy.

Dr PP Murphy
Associate Medical Director
Medicine & Unscheduled Care



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Job Plan Dates

This job plan is effective from: **1st September 2011**

Next Job Plan Review Due on/before: **1st September 2012**

Personal details:

Name of doctor: **Mr Aidan O'Brien**

Contract Type:

Directorate/Division & Location: **Urology/ Surgery and
Elective Care Division**

Whole Time

On-call rotas only - On-call availability supplement:

Rota Frequency – i.e. Number of doctors on rota: **1 : 3**

Rota Category: **Category A**

For info: More frequent than or equal to 1 in 4

= Category A: 8%

Category B: 3% of basic salary

Less frequent than 1 in 4 or equal to 1 in 8

= Category A: 5%

Category B: 2% of basic salary

1 in 9 or Less frequent

= Category A: 3%

Category B: 1% of basic salary

Summary of Programmed Activities:

Direct Patient Care excluding on-call: **8.75 PA's**

Supporting Professional Activities: **1.50 PA's**

Specific Roles:

On-Call Allocation:

Predictable

Unpredictable

PA's

1.57 PA's

Any Annualised Activity & Reason

PA's

Reason:

Any Additional HCS Responsibilities:

PA's

Reason:

Any External Duties:

PA's

Reason:

TOTAL PA's:

12 PA's



CONSULTANT JOB PLAN REVIEW TEMPLATE

1. OBJECTIVES: Refer to Section 3 in Regional Job Planning Guidance.

Objectives should be specific, measurable, achievable, reasonable and time bound. They may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these should be reasonable and agreement should be sought.

Service Developments & Objectives

- Service developments and key targets which will impact on PAs

Personal Objectives

- Objectives against which PA's will be allocated [both DCC and all SPA's]
- E.g. Activity targets specifying an indicative activity for outpatient clinics, theatre lists.
- E.g. Quality objectives incorporating attainment of standards of quality of care.

Team Objectives

- As appropriate to the team job plan e.g. to guarantee to provide a fixed number of clinics or operating lists for the whole team over a year when achievable.

SUPPORTING RESOURCES

Facilities and resources required for delivery of duties and objectives	
1. Staffing support	
2. Accommodation	
3. Equipment	
4. Any other identified resources	



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

2. DIRECT CLINICAL CARE (Section 8 in Regional Job Planning Guidance.)

Emergency duties, including work during or arising from on-call, Operating Sessions including preoperative and postoperative care, Ward Rounds, Outpatient activities, Clinical diagnostic work, Other patient treatment, Public health duties, Multidisciplinary meeting about direct patient care, Any administration related to any of the above, including referrals & notes.

3. JOB PLAN TEMPLATE

This job plan is subject to review at least once per year by you and your Clinical manager. In the case of a new employee a review of the job plan will take place 3 months after commencement and annually thereafter.

(If appropriate cut and paste your job plan into this space set out in the following format.)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total Hours	Prem
				DCC	SPA	APA	EPA		
Mon	8.30 -9.00	Travel (Weeks 1,2,4 &5)	BPC	0.375				8.75	
	9.00 – 1.00	OPC BPC (Weeks 1 & 5)	BPC	1.0					
	9.00 – 1.00	OPC ACH (Weeks 2 & 4)	ACH	2.0					
	1.00 – 1.30	Travel (weeks 1,2,4 & 5)		0.375					
	9.30 – 1.30	SPA (week 3)	CAH		1.0				
	1.30 – 2.00	Ward round	CAH	0.5					
	2.00 – 5.30	SPA	CAH		3.5				
Tues	8.30 – 1.00	Day Surgery (2 weeks per month)	CAH	2.25				8.25	
	10.00 – 1.00	Admin (2 weeks per month)	CAH	1.5					
	1.0 - 1.30	Admin	CAH	0.5					
	1.30 – 5.30	Outpatients clinic	CAH	4.0					
	5.30-6.00	Ward Round	CAH	0.5					
Wed	8.30 - 9.00	Pre op ward round	CAH	0.5				9.5	
	9.00 – 5.00	Theatre	CAH	8.0					
	5.00 – 6.00	Post- op Ward round	CAH	1.0					
Thurs	8.30 – 9.30	Radiology meeting	CAH	1.0				9.0	

CONSULTANT JOB PLAN REVIEW TEMPLATE

	9.30 – 12.00	Grand Ward Round + SPA	CAH	1.0	1.5				
	12.00 – 1.30	Departmental Meeting	CAH	1.5					
	1.30 – 2.15	Admin	CAH	0.75					
	2.15 – 5.00	MDM	CAH	2.75					
	5.00 – 5.30	Admin	CAH	0.5					
FT	9.00 – 1.00	Specialist clinic	CAH	4.0					
	1.00 – 2.00	Admin	CAH	1.0					
	1.00 – 2.30	Ward Round	CAH	0.5					
	2.30	OFF							
TOTAL HOURS:				35	6			41.0	
TOTAL PROGRAMMED ACTIVITIES:				8.75	1.5			10.25	

4. EMERGENCY WORKLOAD

Type	Day/Time	Location	Allocated PAs
Predictable Emergency on-call Work*			
Unpredictable Emergency on-call Work*	11.4 hours per week		1.57
TOTAL PA's for ON-CALL:			1.57

*Please refer to Medical Staffing / Trust Guidance for method for calculating on-call so that prospective cover is included – this means cover will need to be provided for absent colleagues on annual leave and study leave.

On-call availability Supplement	
On-call Category	A
Agreed on-call Rota Frequency	1:3 Prospective
On-Call Supplement	8%

5. SUPPORTING PROFESSIONAL ACTIVITIES (Section 9 in Regional Guidance)

- It is expected that PA's including SPA's will normally take place at a consultant's principal place of work if space, equipment and protected time are provided. Alternatives arrangements can be agreed with the Clinical Director.



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CONSULTANT JOB PLAN REVIEW TEMPLATE

- The Trust would expect that all consultants have a minimum allocation of 1.5 for supporting professional activities for maintaining a professional career. Where additional SPA's are undertaken to varying degrees by consultants these should be programmed into the Job Plan and agreed with the Clinical Manager.

Please provide full details on SPA responsibilities

- 6. EXTERNAL DUTIES** – Please refer to Trust Guidance on approval for External Duties. An External Duties approval form must be completed on an annual basis.

Please provide full details on External Duties, time frames, funding arrangements etc

- 7. Additional HPSS Responsibilities** – Please refer to Trust Guidance on approval of these duties. An HPSS Additional Responsibilities approval form must be completed on an annual basis.

Please provide full details on these duties, time frames, funding etc

8. PRIVATE PRACTICE & FEE PAYING SERVICES

Type	Please Tick:
You are not currently undertaking regular private practice however if this changes during the year you have agreed to inform the clinical director before any changes are made to your work-plan.	☐
You are currently undertaking regular private practice as outlined in your job plan and will undertake an additional PA if offered, up to a maximum of 11 PA's per week, as detailed in the terms and conditions of service.	☐
You are currently undertaking ad hoc private practice with the Trust and it is agreed that this practice will continue, provided it does not affect the efficiency of multidisciplinary team working. You have agreed to ensure that if any of your agreed NHS activity is displaced due to private practice you will carry out in NHS activity at an agreed later stage.	☐

9. AGREEMENT:

Signed: Doctor		Signed: Clinical Manager	



Southern Health
and Social Care Trust

CONSULTANT JOB PLAN REVIEW TEMPLATE

Date:		Date:	
Signed: Associate Medical Director & Director of Service			
Date:			

To be completed and forwarded to:

- The Medical Staffing Manager, Medical HR, Ground Floor, Trust HQ, CAH

Southern Health and Social Care Trust.

This job plan started 01 April 2012.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	19 Feb 2013
Expected number of weeks in attendance	42
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

In 'Discussion' stage	5 Feb 2013	Mrs Zoe Parks

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.80	9.80	35:42
Supporting Professional Activities (SPA)	1.48	1.48	5:54
Total	11.28	11.28	41:36

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	Yes
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00

Do you work your on-call on a specific day?

No fixed day

Weekend on-call work:

What are your average hours of predictable emergency work per weekend on-call?

0:00

Does this work replace or run concurrently with other activities?

No

What are your average hours of unpredictable emergency work per weekend on-call?

0:00

Other Information:

Where does your on-call work take place?

Craigavon Area Hospital

Category

Category A (Return immediately to site or lengthy phone consultation)

PA Count:

The number of PAs arising from your predictable on-call work is:

0.00

The number of PAs arising from your unpredictable on-call work is:

1.00

Your on-call availability supplement is:

5%

Link your predictable on-call work to a personal or service objective:

No linked objective

Link your unpredictable on-call work to a personal or service objective:

No linked objective

Sign off

Role: Clinical Manager

Role: Clinical Manager

Role: Clinical Director

Name: Mr Brown, Robert

Name: Mr Mackle, Edward

Name: Dr Rankin, G

Signed:

Signed:

Signed:

Date:

Date:

Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00				Uro radiology meeting			
09:15							
09:30							
09:45							
10:00			Surgery MDT				
10:15							
10:30		Day					
	Patient related admin (reports,	surgery					

25/02/2013

Mr_O'Brien_19.2.13.htm

10:45 results etc)

Grand Round

11:00

11:15

11:30

Urodynamics

11:45

12:00

12:15

12:30

Planned in-patient operating sessions

12:45

Continuous professional development.

13:00

13:15

13:30

13:45

14:00

14:15

14:30

14:45 Continuous professional development.

Clinic

15:00

15:15

Surgery MDT

15:30

15:45

16:00

16:15

16:30

16:45

17:00

Post-op ward round

17:15

17:30

17:45

18:00

18:15

18:30

18:45

19:00

Week 2

Monday Tuesday

Wednesday

Thursday

Friday

Saturday Sunday

07:00

07:15

07:30

07:45

08:00

08:15			
08:30			
08:45			
09:00		Ur or radiology meeting	
09:15			
09:30			
09:45			
10:00	Day surgery	Surgery MDT	
10:15			
10:30			
10:45			
11:00		Grand Round	Clinic
11:15			
11:30			
11:45		Urodynamics	
12:00			
12:15			
12:30		Pre-op ward round	
12:45			Continuous professional development.
13:00			
13:15			
13:30			
13:45			
14:00			
14:15			
14:30			
14:45			
15:00	Clinic		Patient related admin (reports, results etc)
15:15			
15:30	Clinic	Surgery MDT	
15:45			
16:00			
16:15		Planned in-patient operating sessions	
16:30			
16:45			
17:00			
17:15			
17:30			
17:45			
18:00			
18:15			
18:30			

25/02/2013

Mr_O'Brien_19.2.13.htm

18:45

19:00

19:15

19:30

19:45

20:00

20:15

20:30

20:45

21:00

Post-op ward round

Week 3

Monday

Tuesday

Wednesday

Thursday

Friday Saturday Sunday

07:00

07:15

07:30

07:45

08:00

08:15

08:30

08:45

09:00

09:15

09:30

09:45

10:00

10:15

10:30

10:45 Patient related admin
11:00 (reports, results etc)

Continuous professional
development.

Grand Round

Clinic

11:15

11:30

11:45

12:00

12:15

12:30

12:45

13:00

13:15

13:30

13:45

14:00

Surgery MDT

Uro radiology meeting

Continuous professional
development.

Pre-op ward round

Continuous professional
development.

25/02/2013

Mr_O'Brien_19.2.13.htm

AOB-22343

14:15

14:30

14:45 Continuous professional
15:00 development.

Clinic

15:15

15:30

Surgery MDT

15:45

16:00

16:15

Planned in-patient
operating sessions

16:30

16:45

17:00

17:15

17:30

17:45

18:00

18:15

18:30

18:45

19:00

19:15

19:30

19:45

20:00

Post-op ward round

20:15

20:30

20:45

21:00

Week 4

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday Sunday

07:00

07:15

07:30

07:45

08:00

08:15

08:30

08:45

Uro radiology meeting

09:00

09:15

09:30

25/02/2013

Mr_O'Brien_19.2.13.htm

AOB-22344

09:45				
10:00			Surgery MDT	
10:15				
10:30				
10:45	Clinic	Continuous professional development.	Grand Round	Clinic
11:00				
11:15				
11:30			Urodynamics	
11:45				
12:00				
12:15				
12:30				
12:45			Pre-op ward round	Continuous professional development.
13:00				
13:15				
13:30				
13:45				
14:00				
14:15				
14:30				
14:45	Continuous professional development.	Clinic		Patient related admin (reports, results etc)
15:00				
15:15			Surgery MDT	
15:30				
15:45				
16:00				
16:15			Planned in-patient operating sessions	
16:30				
16:45				
17:00				
17:15				
17:30				
17:45				
18:00				
18:15				
18:30				
18:45				
19:00				
19:15				
19:30				
19:45				

25/02/2013

Mr_O'Brien_19.2.13.htm

AOB-22345

20:00 Post-op ward round
20:15
20:30
20:45
21:00

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00				Uro radiology meeting			
09:15							
09:30				Pre-op ward round			
09:45							
10:00							
10:15							
10:30							
10:45	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		Emergency operating sessions		
11:00							
11:15							
11:30							
11:45				Emergency operating sessions			
12:00							
12:15							
12:30							
12:45							
13:00							
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							
14:45	Clinic	Clinic	Day surgery		Planned in-patient operating sessions		
15:00							
15:15				Surgery MDT			

15:30
15:45
16:00
16:15
16:30
16:45
17:00
17:15
17:30
17:45
18:00
18:15
18:30
18:45
19:00

Post-op ward round

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Total:								10.28	40:48
Mon	07:15 - 13:00	2	Day surgery 75 minutes travel from Craigavon Area Hospital.	Southern He..	Erne Hospit..	OCC	8.4	0.29	1:09
Mon	08:30 - 13:00	4	Clinic 30 minutes travel from Craigavon Area Hospital.	Southern He..	Armagh Comm..	OCC	8.4	0.23	0:54
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency Operating, Triage and Virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 13:00	1, 3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	13:00 - 17:00	1, 3-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	25.2	0.60	2:24
Mon	13:00 - 18:15	2	Clinic 75 minutes travel to Craigavon Area Hospital.	Southern He..	Erne Hospit..	DCC	8.4	0.26	1:03
Tue	08:30 - 13:00	1	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.23	0:54
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: consultant of the week	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	09:00 - 13:00	4	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	09:00 - 13:00	3	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	13:00 - 17:00	1-4	Clinic	Southern He..	Craigavon A..	DCC	33.6	0.80	3:12
Tue	13:00 -	5	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48

	17:00		Comments: CONSULTANT OF THE WEEK							
Wed	09:00 - 11:00	1-4	Surgery MDT Comments: SURGERY MDT PREPARATION	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36	
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency operating, triage and virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48	
Wed	11:00 - 12:30	1	Urodynamics	Southern He..	Craigavon A..	DCC	8.4	0.08	0:18	
Wed	11:00 - 12:30	2, 4	Urodynamics	Southern He..	Craigavon A..	DCC	16.8	0.15	0:36	
Wed	11:00 - 12:30	3	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.08	0:18	
Wed	12:30 - 13:00	2-4	Pre-op ward round	Southern He..	Craigavon A..	DCC	25.2	0.08	0:18	
Wed	13:00 - 17:00	5	Day surgery Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48	
Wed	13:00 - 20:00	2-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	25.2	1.10	4:12	
Wed	20:00 - 20:30	2-4	Post-op ward round	Southern He..	Craigavon A..	DCC	25.2	0.10	0:18	
Thu	08:30 - 09:30	1-5	Uroradiology meeting	Southern He..	Craigavon A..	DCC	42	0.25	1:00	
Thu	09:30 - 10:00	5	Pre-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.03	0:06	
Thu	10:00 - 12:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36	
Thu	10:00 - 14:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48	
Thu	12:00 - 14:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36	
Thu	14:00 - 17:00	1-4	Surgery MDT	Southern He..	Craigavon A..	DCC	33.6	0.60	2:24	
Thu	14:00 - 17:00	5	Surgery MDT Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.15	0:36	
Fri	08:30 - 17:00	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.43	1:42	
Fri	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward round, Emergency Operating, Triage and Virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48	
Fri	09:00 - 13:00	2-4	Clinic	Southern He..	Craigavon A..	DCC	25.2	0.60	2:24	
Fri	13:00 - 17:00	5	Planned in-patient operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48	
Fri	13:00 - 17:00	2, 4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36	
Fri	17:00 - 17:30	1	Post-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.03	0:06	
Fri	17:00 - 17:30	5	Post-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.03	0:06	

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
Total:				1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

Resources

Staff

Equipment

Clinical Space

Other

Additional comments

None

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

DOMAIN 1 - Knowledge, Skills and Performance		
Attribute: 1.1 Maintain your professional performance		
Attribute: 1.2 Apply knowledge and experience to practice		
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.		
	List of Supporting Information	Applicable Date
1	Certificate of Attendance at the 27 th Annual Congress of the European Association of Urology, Paris, France	24-28 February 2012
2	Certificate of Attendance at the 9 th Meeting of the EAU Section of Oncological Urology, Hamburg, Germany	20-22 April 2012
3	Programme confirming Co-chairing of Session on Quality of Life, Safe Practice and Training at the Annual Meeting of the Irish Society of Urology, Holywood, Belfast	21-22 September '12
4	Certificate of Attendance at the 28 th Annual Congress of the European Association of Urology, Milan, Italy	15-19 March 2013
5	Certificate of Attendance at the 11 th Meeting of the EAU Section of Oncological Urology, Prague, Czech Republic	17-19 March 2014
6	Certificate of Attendance at Appraiser Training, Craigavon Area Hospital	23 January 2014
7	RCSI Continuous Professional Development Guidelines	
8	RCS Continuing Professional Development: a summary guide for surgery	
9	Elogbook Registration	18 April 2014
10	Structured Reflective Template relating to CPD	18 April 2014
11	Actual Job Schedule	2013 and 2014
13	CLIP Report	2012 - 2013
14	CLIP Report Structured Reflective Template	21 April 2014
15	Record of Attendance at Mortality and Morbidity Meetings	2012 and 2013
16	Application Record to attend Approved Conferences / Courses	2013
17	A Randomised, Double-blind, Placebo-controlled study of RAD001 in the Treatment of Angiomyolipoma in Patients with either Tuberous Sclerosis Complex (TSC) or Sporadic Lymphangiomyomatosis	2011 – 2014
18	Living with and beyond Prostate Cancer – A study of the impact on men of increased and variable investigation and treatment of prostate cancer in the island of Ireland – Prostate investigations study	2013 – 2014
19	Email announcement of appointment as Clinical Lead and Chair of NICaUrology	January 2013
Discussion I believe that I keep my knowledge base, relating to all areas of my clinical practice, up to date. I do so by reading at least one paper in European Urology and its Supplements each day, ensuring that I have completely read the monthly journal. I also read the British Journal of Urology International (BJUI) which is usually more clinically orientated, and therefore more interesting to read. I additionally avail of the Medscape Internet Site, which keeps one up to date with the more controversial publications that often make their way into mainstream media, and their critiques. I continue to attend the Annual Congress of the European Association of Urology, at least once every two years. As the Annual Congress covers the entire spectrum of Urology, it provides that opportunity to update my knowledge in those areas of which I would be less knowledgeable, or interested in. By way of contrast, the Annual Meeting of the Section of Oncological Urology has enabled me to keep abreast of knowledge and developments in the dominant area of sub-specialty interest. I have no doubt that all of these activities have enabled me to ensure that my practice, and the practice of my colleagues, whether senior or junior, is kept up to date, and reflected in the care that we deliver to our patients.		

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Whilst I have no doubt that the quantum of my involvement and participation in CPD activities, across the domains of clinical, academic and managerial, both internally and externally, will have met the minimum requirements of the Royal Colleges and the Federation of Surgical Specialty Association, I have decided to register with ELogbook so that all activities can be prospectively recorded. This will hopefully ensure that CPD activities are comprehensively balanced in such a way as to impacted positively on patient care.

Having filed an evolving range of Job Plans following Form 2, I have attached an Actual Job Schedule which is a truer reflection of the actual job required to produce the outcomes and performances detailed in the CLIP reports for the period October 2011 to September 2013. I have found global performance in all main domains to be very similar to, of better than, peer means. The only negative divergences continue to percentage day cases (49.9% compared to peer 75.7%), and new:review outpatient ratio (1:2.5 compared to peer 1:1.8). The new:review ratio has 'worsened' since review of patients with cancer has comprised an increased portion of my outpatient practice.

Actions Agreed

- Focussed attendance at conferences appropriate to clinical practice
- CPD has not been quantified in terms of credits. To attempt to do so prospectively during 2014
- Recent appraisal training relevant
- It is acknowledged that the recording of Day Cases is a Trust issue and may not be a true reflection of activity
- CLIP report shows good performance, and especially in Paediatric Urology which is 2.5 times greater than the peer mean, and which is a reflection of subspecialist competence
- No audit activity during the past two years, but this will be addressed by collaboration in Regional audit as Lead Clinician and Chair of NiCaN Urology
- Higher new:review outpatient ratio due to influence of oncology, and a vast improvement on previous years

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

Certificate of Attendance

The European Association of Urology, represented by
Prof. P-A. Abrahamsson, declares that:

Aidan O'Brien

participated in the 27th Annual Congress of the European
Association of Urology, 24-28 February 2012, Paris, France

Personal information redacted by the USI

Prof. P-A. Abrahamsson
EAU Secretary General



The EAU is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS). www.uems.net.

The 27th Annual Congress of the European Association of Urology is designated for a maximum of 27 European external CME credits.

Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

The EACCME credit system is based on 1 ECMEC per hour with a maximum of 3 ECMECs for half a day and 6 ECMECs for a full-day event.

EACCME credits are recognized by the American Medical Association towards the Physician's Recognition Award (PRA).

Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Section 1) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

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EAU@uroweb.org
www.uroweb.org



**European
Association
of Urology**

Certificate of Attendance

The European Association of Urology, represented by
Prof. M. Brausi and Prof. Dr. G. Mickisch, declares that:

Aidan O'Brien

participated in the 9th Meeting of the EAU Section of
Oncological Urology (ESOU), 20-22 April 2012, Hamburg,
Germany

Personal information redacted by the USI

Personal information redacted by the USI

Prof. M. Brausi
ESOU Chairman

Prof. Dr. G. Mickisch
Local Organiser



E B U

European Board of Urology

The EAU is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS). www.uems.net.

The 9th Meeting of the EAU Section of Oncological Urology (ESOU) is designated for a maximum of 12 European external CME credits.

Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

The EACCME credit system is based on 1 ECMEC per hour with a maximum of 3 ECMECs for half a day and 6 ECMECs for a full-day event.

EACCME credits are recognized by the American Medical Association towards the Physician's Recognition Award (PRA).

Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Section 2) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

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**European
Association
of Urology**

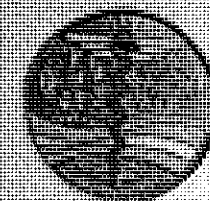
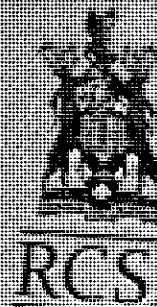


The Irish Society of Urology wishes to thank
the following for their support:

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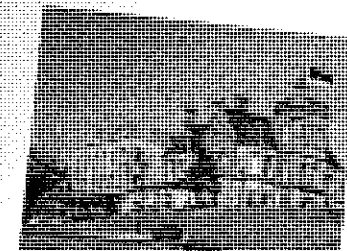
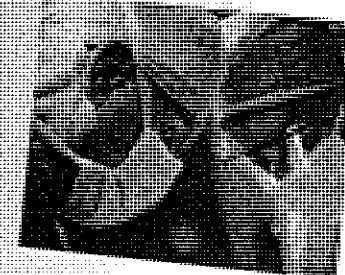
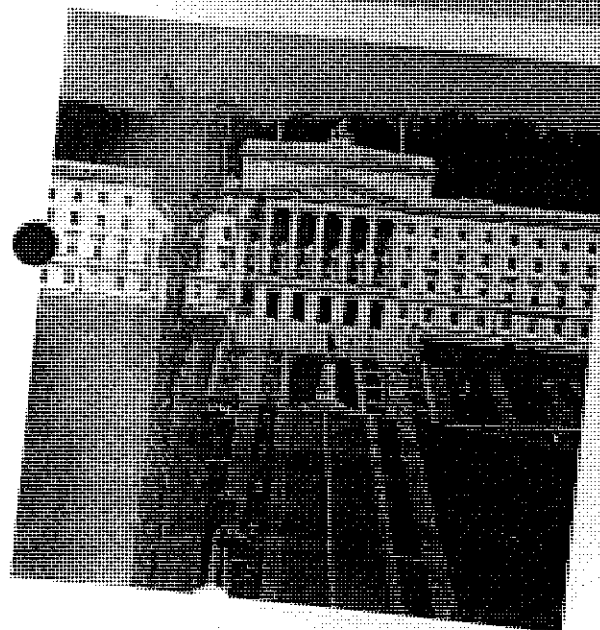
AOB-22353



ANNUAL MEETING OF THE IRISH SOCIETY OF UROLOGY

Culloden Estate & Spa, Holywood, Belfast
Friday 21st & 22nd September 2012

SCIENTIFIC PROGRAMME



MESSAGE OF WELCOME

Welcome to the 2012 annual meeting of The Irish Society of Urology. For the second year in a row we are holding the meeting in Ulster. The ISU is an all island society but for some years seemed to have become heavily weighted towards The Republic of Ireland. Hopefully by meeting further north than has been the case in recent years, the balance is being redressed.

We had a record number of abstracts submitted for consideration this year and unfortunately we were unable to accommodate a significant number in the programme. Hopefully this trend of increased numbers of submissions will continue into the future and in so doing, raise the scientific profile and standard of the meeting which is already high.

I am delighted to welcome Patrick Duffy as our main guest speaker, a truly home grown expert in his field who has been a leader in Paediatric Urology on the world stage. Brian Duggan whom I have invited to speak is again a local product and will explore the possibility of clinical guidelines for our island nation. Kate Fitzpatrick has been a close nursing colleague of mine for many years and will be bringing a European perspective as Chair of The European Association of Urology Nurses.

The social aspect of this meeting is extremely important and the two evening events promise great enjoyment. The unique opportunity to have our gala dinner in Stormont was one that we couldn't pass over!

I am again delighted to welcome members of The Irish Association of Urology Nurses to the meeting and hope this link will continue to grow.

Without the participation of our colleagues from the pharmaceutical and medical equipment industries, a meeting such as this would not be possible and we are very grateful for their involvement.

Thanks to all who will present and to my colleagues who will chair sessions. I hope that this meeting will prove to be both educational and enjoyable and that you all enjoy this beautiful area of County Down.

I invite you to join us for next years meeting which will take place in the Ritz-Carlton, Powerscourt, Co. Wicklow on the 20th & 21st September 2013.

Ron Grainger,
President Irish Society of Urology

PROGRAMME AT A GLANCE

Friday 21st September 2012

08.00 - 16.45	Registration * Stuart Suite
09.00 - 10.20	Session 1 - Lab Based and Clinical Research Stuart Suite
10.20 - 10.50	Refreshments & Exhibition Stuart Suite
10.50 - 12.20	Session 2 - Quality of Life, Safe Practice and Training Stuart Suite
12.20 - 12.50	Guest Lecture - Ms. Kate Fitzpatrick
12.50 - 13.20	Guest Lecture - Mr. Brian Duggan
13.20 - 14.15	Lunch & Exhibition Stuart Suite
14.15 - 16.00	Session 3 - Moderated Poster Session Stuart Suite
16.00 - 16.15	Refreshments & Exhibition Stuart Suite
16.15 - 16.45	Guest Lecture - Mr. Patrick Duffy
17.00 - 18.00	Council Meeting Cameron Suite
19.00	Conference Dinner Cumberland Suite

* In order to receive CPD credits all delegates must sign in at registration each day

08.00 - 12.10	Registration * Stuart Suite
08.30 - 09.00	Annual General Meeting Stuart Suite
09.00 - 09.40	Guest Lecture - Mr. Patrick Duffy Stuart Suite
09.40 - 10.30	Session 1 - Transplant and Paediatrics Stuart Suite
10.30 - 11.00	Refreshments & Exhibition Stuart Suite
11.00 - 12.10	Session 2 - Prostate Cancer and Minimally Invasive Surgery Stuart Suite
12.10	Lunch & Close of Meeting Stuart Suite
12.50	Departure for Golf Blackwood Golf Club
18.45	Departure for Gala Dinner Parliament Buildings Kindly sponsored by Mr. Edwin Poots MLA Minister for Health, Social Services and Public Safety

* In order to receive CPD credits all delegates must sign in at registration each day

Session 1 LAB BASED AND CLINICAL RESEARCH

09.00 - 10.20 Co-Chairs:

Mr. Frank O'Brien, *Cork University Hospital, Cork*
Mr. John Thornhill, *Clane General Hospital, Kildare*

- 09.00 - 09.10 REAL TIME EXPRESSION ANALYSIS OF A MICRORNA SIGNATURE OF PROSTATE CANCER IN PROSTATE CELL LINES AND TISSUE SPECIMENS**
¹Bolton EM, ¹Moran DC, ¹Meunier A, ¹O'Kelly F, ²Marignol L, ³Hollywood D, ²Lynch T.H, ¹Perry A.S
¹Prostate Molecular Oncology Group, Institute of Molecular Medicine, Trinity College Dublin
²Department of Urology, St. James's Hospital, Dublin
³Division of Radiation Therapy, School of Medicine, Trinity College, Dublin
- 09.10 - 09.20 THE USE OF PCA₃ MRNA AS A NEW PROSTATE SPECIFIC DIAGNOSTIC MARKER FOR PROSTATE CANCER**
¹Pahuja A, ²Crawley S, ¹Subin F, ¹Thomas B, ³Ryan M F
²Department of Clinical Biochemistry, ³Chemical Pathology and ¹Urology Northern Health and Social Care Trust, NI, UK
- 09.20 - 09.30 IDENTIFICATION AND VALIDATION OF A GENE SIGNATURE REGULATED BY TRUNCATED ANDROGEN RECEPTOR SPLICE VARIANTS LACKING THE LIGAND-BINDING DOMAIN IN PROSTATE CANCER**
¹Peter E. Lonergan, ¹Lucas P. Nacusi, ¹Lucy J. Schmidt, ¹Kevin M. Regan, ²Zhifu Sun, ¹Stephen A. Boorjian, ¹Donald J. Tindall
¹Department of Urology and ²Division of Biomedical Statistics and Informatics, Mayo Clinic, Rochester, Minnesota, USA
- 09.30 - 09.40 EPIGENETIC PROFILING IN URINE FOR THE DETECTION OF AGGRESSIVE PROSTATE CANCER: A PILOT EVALUATION**
¹Bolton E.M, ¹Moran D, ¹Meunier A, ¹Vajda A, ¹O'Kelly F, ¹Thurman J, ¹O'Connor R, ²Marignol L, ³Hollywood D, ²Lynch T.H, ¹Perry A.S
¹Prostate Molecular Oncology Group, Institute of Molecular Medicine, Trinity College Dublin
²Department of Urology, St. James's Hospital, Dublin
³Division of Radiation Therapy, School of Medicine, Trinity College, Dublin

09.40 - 09.50

GENETIC VARIANTS THAT PROMOTE PSA EXPRESSION ARE ASSOCIATED WITH MORE FAVORABLE PATHOLOGIC TUMOUR FEATURES

Barry B. McGuire, Brian T. Helfand, Qiaoyan Hu, Dae Y. Kim, Phillip R. Cooper, Matthias D. Hofer, William J. Catalona
The Department of Urology, Feinberg School of Medicine, Northwestern Memorial Hospital, Chicago

09.50 - 10.00

ASSESSING THE VALIDITY OF THE PCPT AND ERSRC RISK CALCULATORS FOR PROSTATE CANCER IN A COHORT OF THE POPULATION AT HIGHEST RISK OF PROSTATE CANCER IN EUROPE

^{1,2}Dara J London, ^{2,4}B Kelly, ³K O'Malley, ³N Hegarty, ¹D Quinlan, ²D Mulvin, ^{2,3}D Galvin, ⁴G Durkan, ⁴E Rogers, ⁴K Walsh.
¹ St. Vincent's University Hospital, Dublin
² University College Dublin, Dublin
³ Mater Misericordiae University Hospital, Dublin
⁴ University Hospital Galway

10.00 - 10.10

TRANSCRIPTOMIC PROFILING OF DOCETAXEL RESISTANT PROSTATE CANCER CELLS

¹DJ London, ¹M Prencipe, ¹S Madden, ¹A O'Neill, ²P Doolan, ²S Ahearne², ¹JM Fitzpatrick, ¹RW Watson
¹ UCD School of Medicine and Medical Science, University College Dublin
² National Institute for Cellular Biotechnology, Dublin City University

10.10 - 10.20

PATHOLOGICAL STAGE AND GRADE MIGRATION FOLLOWING RADICAL PROSTATECTOMY IN IRISH MEN AND COMPARATIVE ANALYSIS TO A MATCHED NORTH AMERICAN POPULATION FROM CONTEMPORARY AND EARLY PSA ERAS

¹Barry B. McGuire, ¹Breffini Anglim, ²Stacy Loeb, ³Brian T. Helfand, ¹Ronald Grainger, ¹Robert Flynn, ¹Ted McDermott, ²Qiaoyan Hu, ³Phillip R. Cooper, ¹Andrew Fennelly, ³William J. Catalona and ¹John Thornhill
¹The Department of Urology, Adelaide and Meath incorporating the National Children's Hospital, Dublin
²The Department of Urology, New York University, New York, USA
³The Department of Urology, Feinberg School of Medicine, Northwestern Memorial Hospital, Chicago

10.20 - 10.50

Refreshment Break & Exhibition

Session 2 QUALITY OF LIFE, SAFE PRACTICE & TRAINING

10.50 – 12.20 Co-Chairs:
Mr. Aidan O'Brien, Craigavon Area Hospital, Co. Armagh
Mr. Patrick Keane, Belfast City Hospital, Belfast

10.50 – 11.00 PATTERNS AND PREDICTORS OF HEALTH-RELATED QUALITY-OF-LIFE IN MEN WITH PROSTATE CANCER: PRELIMINARY RESULTS FROM THE PICTURE STUDY
Frances J Drummond, Heather Kinnear, Anna Gavin, Ciaran O'Neill, Linda Sharp
National Cancer Registry, Ireland, Building 6800, Airport Business Park, Kinsale Rd, Cork

11.00 – 11.10 WHICH FACTORS IMPACT ON PROSTATE CANCER TREATMENT RECEIPT? A NATIONAL POPULATION-BASED STUDY
Marianna de Camargo Cancela, Harry Comber, Linda Sharp
National Cancer Registry, Cork, Ireland, Building 6800, Cork Airport Business Park, Kinsale Road, Cork

11.10 – 11.20 FINANCIAL AND HUMAN TOLL OF NEGATIVE PROSTATE BIOPSIES AND REVIEW OF PROSTATE CANCER SCREENING
Alkhter W, Khan F, Khattak A, Turk S, Chinegwundoh F
Newham University Hospital, London, UK

11.20 – 11.30 AVOIDABLE IATROGENIC COMPLICATIONS OF URETHRAL CATHETERISATION AND INADEQUATE INTERN TRAINING: A 4-YEAR FOLLOW UP POST IMPLEMENTATION OF AN INTERN TRAINING PROGRAMME
Forde JC, Sullivan JF, Thomas AZ, Creagh TC.
Department of Urology and Renal Transplantation, Beaumont Hospital, Dublin

11.30–11.40 HOSPITAL EPISODE STATISTICS (HES) DATA ANALYSIS OF POSTOPERATIVE VENOUS THROMBOEMBOLUS (VTE) IN PATIENTS UNDERGOING UROLOGICAL SURGERY. A REVIEW OF 126891 CASES
James Dyer, Sacha Wyke, Ciaran Lynch
Department of Urology, Royal Liverpool University Hospital, Prescot Street, Liverpool

11.40 – 11.50

'PRE-OPERATIVE URINE CULTURE –AETIOLOGY AND SIGNIFICANCE OF GENTAMICIN RESISTANT POSITIVE CULTURES'
'Alsinnawi M, 'Egan S, 'Groarke E 'Dowling CM, 'McCullagh E, 'Fennell JF, 'Flynn R, 'McDermott T, 'Grainger R, 'Thornhill JA
'Department of Urology, 'Department of Pharmacy and 'Department of Microbiology, Tallaght Hospital, Dublin

11.50 – 12.00

SINGLE NIGHT STAY TURP - A CHALLENGE FOR MIST
'Curry D, 'Downey P
'Belfast City Hospital, 'Causeway Hospital Coleraine

12.00 – 12.10

TURP - "NOW AND THEN"
CM Dowling, A Walsh, M Alsinnawi, R Flynn, TED McDermott, R Grainger, J Thornhill
Department of Urology, Tallaght Hospital, Dublin

12.10 – 12.20

THE IMPACT OF ROLLING THEATRE CLOSURES ON CORE UROLOGY TRAINING
D. W. Good, N. Khan, E.A. Kiely, C.M. Brady
Department of Urology, Cork University Hospital, Wilton, Cork

GUEST LECTURE

12.20 – 12.50

Chair: Mr. Ron Grainger
President Irish Society of Urology

EUROPEAN ASSOCIATION OF UROLOGY NURSES.. RESPONDING TO NEEDS IN UROLOGICAL HEALTHCARE
Ms. Kate Fitzpatrick
Chair, European Association of Urology Nurses, Beacon Hospital, Dublin

GUEST LECTURE

12.50 – 13.20

Chair: Mr. Ron Grainger
President Irish Society of Urology

GUIDELINES IN UROLOGY IN NORTHERN IRELAND; CAN THEY CROSS THE BORDER?
Mr. Brian Duggan
Consultant Urological Surgeon, Belfast City Hospital, Belfast

13.20 – 14.15

Lunch & Poster Viewing

Session 3 MODERATED POSTER SESSION

14.15 – 16.00

Co-Chairs:

Mr. Brian Duggan, *Belfast City Hospital, Belfast*
Mr. Nicholas Hegarty, *Mater Private Hospital, Dublin*

- POSTER 1** **FERTILITY AND MALIGNANCY IN THE UNDESCENDED TESTIS – A SYSTEMATIC REVIEW AND META-ANALYSIS**
MS Floyd Jr, D Mullassery, MI Bader, PD Losty
Academic Paediatric Surgery - Alder Hey Children's Hospital and the University of Liverpool, UK
- POSTER 2** **EVALUATION OF ENDOSCOPIC LASER EXCISION OF POLYPROPYLENE MESH/SUTURES FOLLOWING ANTI-INCONTINENCE PROCEDURES**
Davis NF, Smyth LG, Giri SK, Flood HD
Department of Urology, Mid-Western Regional Hospital, Dooradoyle, Limerick
- POSTER 3** **UROLOGY READMISSION RATES IN A DGH; ARE WE MEETING THE NATIONAL STANDARD?**
MS Floyd Jr, M Raslan, S Itam, R Mukherjee, PP Irwin, SB Maddineni
Dept of Urology, Michael Heal Unit, Leighton Hospital, Mid Cheshire Hospital NHS Foundation Trust, Crewe, UK
- POSTER 4** **CHANGES IN KIDNEY FUNCTION POST RADICAL NEPHRECTOMY FOR RENAL CELL CARCINOMA: A THREE YEAR RETROSPECTIVE STUDY**
Coyle D, Quinlan MR, D'Arcy FT, Kelly BD, Corcoran M, Durkan G, Jaffry S, Walsh K, Rogers E
Urology SPR, Dept of Urology, University Hospital Galway
- POSTER 5** **THE ACCURACY OF MRI IN LOCALIZING PROSTATE CANCERS AND PREDICTING EXTRAPROSTATIC EXTENSION (EPE) IN PATIENTS UNDERGOING LAPAROSCOPIC RADICAL PROSTATECTOMY**
James Dyer, Mathew Thomas, Paul Mansour, Sean G. Vesey
Department of Urology, Southport and Formby District General Hospital, Town Lane, Kew, Southport

POSTER 6

IN PATIENTS WITH A PSA <15NG/ML AND GLEASON SCORE ≤7 AND WHO ARE ELIGIBLE FOR CURATIVE TREATMENT, IS THE USE OF MRI/BONE SCAN JUSTIFIED? AN ANALYSIS OF THE SVUH PROSTATE CANCER IMAGING COHORT 2009-2011
F. O'Kelly, A.Z. Thomas, D. Murray, P. Nicholson, G. Lennon, D. Galvin, D. Quinlan, D. Mulvin
Department of Urological Surgery, St. Vincent's University Hospital, Dublin

POSTER 7

THE PERFORMANCE OF MRI IN LOCAL STAGING OF PROSTATE CANCER – SINGLE CENTRE AUDIT
Aslam A., Davis N., Flood H., Drumm J., Akram CM., Kiely S., Giri S., Wallis F., Durkan GC.
Department of Urology, Mid-Western Regional Hospital Dooradoyle, Limerick

POSTER 8

THE ROLE OF 1.5T MRI-GUIDED PROSTATE BIOPSIES IN REPEATED TRUS-BIOPSY NEGATIVE MEN WITH HIGH/RISE PSA LEVELS: A PILOT PROSPECTIVE CLINICAL STUDY
F. O'Kelly, A.Z. Thomas, P. Nicholson, G. Lennon, D. Galvin, D. Mulvin, C. McMahon, D. Quinlan
Department of Urological Surgery, St. Vincent's University Hospital, Dublin

POSTER 9

URODYNAMICS ON THE IRISH ISLAND; AN AUDIT OF URODYNAMIC UNITS PRACTICE IN PUBLIC HOSPITALS IN NORTHERN IRELAND AND REPUBLIC OF IRELAND
Abogunrin F.A.1, Hennessey D.2, Woolsey St.
Urology Department, Belfast City Hospital, Belfast
Urology Department, Altnagelvin Area Hospital, Londonderry

POSTER 10

URINARY DIVERSION FOR INTERSTITIAL CYSTITIS/ PAINFUL BLADDER SYNDROME - A SINGLE CENTRE EXPERIENCE OF PATIENT SYMPTOMS AND SURGICAL OUTCOMES
Murray TE, Forde JC, Shields WP, Creagh TA
Department of Urology, Beaumont Hospital, Dublin

POSTER 11 CORRELATION BETWEEN SYMPTOMS AND URODYNAMICS FINDINGS IN PATIENTS WITH URINARY INCONTINENCE
Thomas BMK, Woolsey S
Urology Department, Belfast City Hospital

POSTER 12 LAPAROSCOPIC RADICAL PROSTATECTOMY, SERVICE ESTABLISHING SINGLE CENTRE EXPERIENCE IN WEST OF IRELAND
Nusrat NB, Kelly B, Durkan G, Rogers E, Walsh K, Jaffrey S, Corcoran M.
Department of Urology, University College Hospital Galway

POSTER 13 EVOLUTION OF PROSTATE CANCER MANAGEMENT IN THE NORTHWEST OF ENGLAND OVER A 10 YEAR PERIOD
M. Smolski, S. Bromage, A Thompson and GN Collins
Stepping Hill Hospital, Stockport

POSTER 14 SUPINE PCNL – INTRODUCTION INTO CLINICAL PRACTICE IN A SINGLE INSTITUTION
David Connolly^{1,2}, Katherine Rzetelski-West², Jacob Gleeson², Phillip McCahy²
¹Department of Urology, Craigavon Area Hospital
²Department of Urology, Casey Hospital, Berwick, Victoria, Australia

POSTER 15 CONVERTING FROM OPEN TO ROBOT-ASSISTED LAPAROSCOPIC RADICAL PROSTATECTOMY, EXPERIENCE OF A SINGLE SURGEON
Long RM, Nama G, McCrone L, O'Malley KJ
Mater Private Hospital, Dublin

POSTER 16 ONCOLOGICAL RESULTS OF 100 CONSECUTIVE CASES OF ROBOTIC ASSISTED RADICAL PROSTATECTOMY IN A SINGLE-SURGEON SERIES WITH A MINIMUM OF 1 YEAR FOLLOW UP
Peter Dawson, Paddy O'Malley
Galway Clinic, Doughiska, Galway

POSTER 17 MINIMALLY INVASIVE SURGERY FOR PROSTATE CANCER – THE INITIAL EXPERIENCE OF A SINGLE SURGEON WITH LAPAROSCOPIC RADICAL PROSTATECTOMY IN IRELAND
Forde JC, White S, Smyth GP.
Department of Urology, Beaumont Hospital, Dublin

POSTER 18 CHANGES IN PROSTATE CANCER CHARACTERISTICS, DIAGNOSIS AND TREATMENT PRE AND POST THE INTRODUCTION OF RAPID ACCESS PROSTATE CANCER CLINICS. AN OBSERVATION OF TRENDS IN A SINGLE TERTIARY REFERRAL CENTRE
SF Oon, Cullen IM, Moran D, Bolton E, McDermott TED, Grainger R, Lynch TH.
St. James's Hospital, Dublin

POSTER 19 PENILE CANCER - SINGLE CENTRE 10 YEAR EXPERIENCE
Breen KJ, O'Connor KM, Power DG, Rogers E, Sweeney P.
Department of Urology, Mercy University Hospital, Cork

POSTER 20 CLINICAL PRESENTATION AND MANAGEMENT STRATEGIES FOR URETHRAL DIVERTICULAE
Smyth, LG., Davis, N., Arif, Am., Akram, M., Drumm, J., Flood, HD.
Department of Urology, Mid-Western Regional Hospital, Dooradoyle, Limerick

POSTER 21 LAPAROSCOPIC NEPHRECTOMY IN LATERAL DECUBITUS POSITION WITHOUT FLEXION
Subhasis Giri^{1,2}, Niall Davis¹, Lisa Smith¹, Marian Holly¹, Munir Ahmed², Hugh Flood¹, Muhammad Akram¹, John Drumm¹,
¹Mid-Western Regional Hospital, Limerick
²Princess Royal University Hospital, South London Health Care Trust, UK

POSTER 22 PENILE PROSTHESIS SURGERY FOR ERECTILE DYSFUNCTION - A SINGLE SURGEON EXPERIENCE
BW Cham, JC Forde, P. Mohan
Department of Urology, Beaumont Hospital, Dublin

16.00 – 16.15 Refreshment Break and Exhibition

GUEST LECTURE

16.15 – 16.45 Chair: Mr. Ron Grainger
President Irish Society of Urology

POSTERIOR URETHRAL VALVES

Mr. Patrick Duffy
Consultant Paediatric Urologist
Great Ormond Street Hospital, United Kingdom

17.00 – 18.00 Council Meeting

19.00 Conference Dinner
Drinks reception kindly sponsored by Astellas Pharma Co. Ltd

SATURDAY 22nd SEPTEMBER 2012

08.30 – 9.00 Annual General Meeting

GUEST LECTURE

09.00 – 09.40 Chair: Mr. Ron Grainger
President Irish Society of Urology

WILMS' TUMOUR

Mr. Patrick Duffy
Consultant Paediatric Urologist
Great Ormond Street Hospital, United Kingdom

Symposium: TRANSPLANT AND PAEDIATRICS

09.40 – 10.40 Co-Chairmen:
Miss Tilly Lacle, Beaumont Hospital, Dublin
Mr. George Quinn, Our Lady's Children's Hospital, Crumlin

09.40 – 09.50 **LAPAROSCOPIC LIVING DONOR NEPHRECTOMY: THE INITIAL EXPERIENCE IN IRELAND**
Danapal M, Forde JC, Elwahab S, Shields WP, Power RE, Smyth GP, Eng MP, Hickey DP, Little DM.
Department of Urology and Transplantation, Beaumont Hospital, Dublin

09.50 – 10.00 **SINGLE CENTRE EXPERIENCE OF HYPOTHERMIC CONTINUOUS MACHINE PERFUSION OF KIDNEYS FROM EXTENDED CRITERIA DECEASED HEART-BEATING DONORS – A COMPARATIVE STUDY**
Forde JC, Shields WP, Daly PJ, Zimmermann JA, Smyth GP, Eng MP, Mohan P, Power RE, Hickey DP and Little DM.
National Kidney and Pancreas Transplantation Unit, Beaumont Hospital, Dublin

10.00 – 10.10 **RESPONSE TO BOTULINUM TOXIN – GENDER DIFFERENCE**
D.T. McDowell, F. Tareen, F. Quinn
Department of Paediatric Urology, Our Lady's Hospital for Sick Children, Crumlin, Dublin

- 10.10 - 10.20** **STRATEGIES FOR ACHIEVING URINARY CONTINENCE IN OLDER CHILDREN- A SPECIFIC ROLE FOR ADOLESCENT UROLOGISTS AND A STAGED APPROACH**
ST Patel, M Lyttle, C Sanders, S Doyle, C Ferguson, AD Baird
Aintree University Hospital NHS Foundation Trust, Aintree University Hospital, Longmoor Lane, Liverpool
- 10.20 - 10.30** **EVALUATING THE QUALITY OF INTERNET BASED INFORMATION FOR A COMMON PAEDIATRIC UROLOGY CONDITION**
Nason GJ, Tareen F, Walsh A, Quinn F
Department of Urology and Paediatric Surgery, Our Lady's, Children's Hospital, Crumlin, Dublin
- 10.30 - 11.00** **Refreshment Break and Exhibition**

Session 2 **PROSTATE CANCER AND MINIMALLY INVASIVE SURGERY**

11.00 - 12.00 **Co-Chair:**
Mr David Quinlan, Vice-President, Irish Society of Urology
St Vincent's Hospital, Dublin
Professor Thomas Lynch, St James's Hospital, Dublin

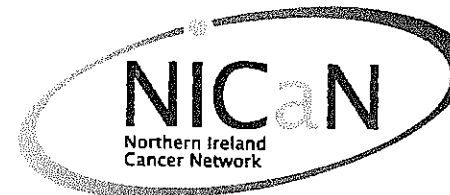
- 11.00 - 11.10** **DOES DELAYED REFERRAL WITH ABNORMAL PSA READINGS INFLUENCE SUBSEQUENT GLEASON GRADE? AN ANALYSIS OF THE RAPID ACCESS PROSTATE CLINIC IN ST. VINCENT'S UNIVERSITY HOSPITAL 2009-2011**
F.O'Kelly, A.Z. Thomas, D. Murray, P. Lee, R. Ffrench O'Carroll, G. Lennon, D. Galvin, D. Mulvin, D. Quinlan
Dept. of Urological Surgery, St. Vincent's University Hospital, Dublin
- 11.10 - 11.20** **OUTCOME OF CLINICAL T₃ PROSTATE CANCER FOLLOWING RADICAL PROSTATECTOMY**
D. Moran, G. Nama, K. O'Malley
Department of Urology, Mater Private Hospital, Dublin

- 11.20 - 11.30** **A SINGLE CENTRE EXPERIENCE IN IRELAND OF ACTIVE SURVEILLANCE FOR LOW RISK PROSTATE CANCER**
Forde JC¹, Daly PJ¹, White S¹, Smyth GP¹, O'Neill BD², Power RE¹
¹ Department of Urology, Beaumont Hospital, Dublin
² Department of Radiation Oncology, Beaumont Hospital, Dublin
- 11.30 - 11.40** **THE PSA TRACKER: THE ECONOMIC BENEFITS OF REMOTE FOLLOW UP OF PROSTATE CANCER**
Hennessey DB, Chambers K, Mulholland CK.
Department of Urology, Altnagelvin Hospital, Londonderry
- 11.40 - 11.50** **GREENLIGHT LASER (P.V.P.) ON MEN TAKING ANTI-COAGULANTS**
Mr. Barry Jones
Aut Even Hospital, Kilkenny and St. Francis Private Hospital, Co. Westmeath
- 11.50 - 12.00** **LAPAROSCOPIC PYELOPLASTY: THE SOUTHPORT AND ORMSKIRK HOSPITALS EXPERIENCE**
M. Christodoulidou¹, S.G. Vesey¹
¹Southport and Ormskirk Hospital NHS Trust, Merseyside, UK
- 12.00 - 12.10** **EARLY EXPERIENCE WITH LAPAROSCOPIC PARTIAL NEPHRECTOMY IN AN IRISH HOSPITAL SETTING**
A Walsh, CM Dowling, Oliver Welfare, R Flynn
The Department of Urology, Tallaght Hospital, Dublin
- 12.10** **Close of Meeting - Lunch & Exhibition**
- 12.50** **Departure for Golf**
Blackwood Golf Club
- 18.45** **Departure for Gala Dinner**
Parliament Buildings
Kindly sponsored by Mr. Edwin Poots MLA
Minister for Health, Social Services and Public Safety

Notes

*"An educational grant was provided by Allergan Ltd to the Irish Society of Urology to support this independent course.
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**WE ARE
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Aidan O'Brien

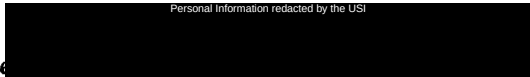
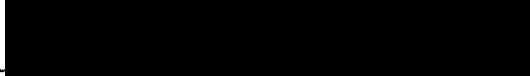
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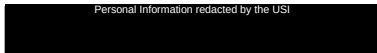
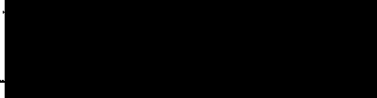
Advanced Communication Skills Training Course

29th June – 1st July 2011

Hilton Hotel, Templepatrick

Course Facilitators

Dr
Print Name 
Signature 

Print Name 
Signature 

Certificate of Attendance

The European Association of Urology, represented by
Prof. P-A. Abrahamsson and Prof. Dr. F. Montorsi, declares
that:

Aidan O'Brien

participated in the 28th Annual Congress of the European
Association of Urology, 15-19 March 2013, Milan, Italy

Personal information redacted by the USI

Prof. P-A. Abrahamsson
EAU Secretary General

Personal information redacted by the USI

Prof. Dr. F. Montorsi
Congress President



The EAU is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS), www.uems.net.

The 28th Annual Congress of the European Association of Urology is designated for a maximum of 28 European external CME credits.

Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

The EACCME credit system is based on 1 ECMEC per hour with a maximum of 3 ECMECs for half a day and 6 ECMECs for a full-day event.

EACCME credits are recognized by the American Medical Association towards the Physician's Recognition Award (PRA).

Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME (or ECMEC credits are deemed to be Accredited Group Learning Activities (Section 3) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

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www.uroweb.org



**European
Association
of Urology**

Certificate of Attendance

The European Association of Urology, represented by
Prof. M. Brausi and Prof. Dr. M. Babjuk, declares that:

Aidan O'Brien

participated in the 11th Meeting of the EAU Section of
Oncological Urology (ESOU), 17-19 January 2014, Prague,
Czech Republic

Personal Information redacted by the USI

Prof. M. Brausi
ESOU Chairman

Personal Information redacted by the USI

Prof. Dr. M. Babjuk
Local Organiser



The EAU is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS), www.uems.net.

The 11th Meeting of the EAU Section of Oncological Urology (ESOU) is designated for a maximum of 12 European external CME credits.

Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

The EACCME credit system is based on 1 ECMEC per hour with a maximum of 3 ECMECs for half a day and 6 ECMECs for a full-day event.

EACCME credits are recognized by the American Medical Association towards the Physician's Recognition Award (PRA).

Live educational activities occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Sections) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

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6.0 Continuous Professional Development (CPD)

CPD is recognized in four categories, three of which are mandatory and one recommended as outlined below:

- Category 1** External - Maintenance of Knowledge and Skills (Mandatory)
- Category 2** Internal - Practice Evaluation & Development (Mandatory)
- Category 3** Personal Learning (Mandatory)
- Category 4** Teaching and Research (Recommended)

Appendix 1 outlines examples of activities in each category

6.1 CPD Requirements

To achieve compliance, a practitioner is required to earn at a minimum:

50 credits per year

250 credits per five year cycle

Broken down as follows:

External – 20 credits per year minimum

Internal – 20 credits per year minimum

Personal Learning – five credits per year minimum

Research or Teaching – two credits per year desirable

Accumulated credits must be balanced within the five year cycle. Practitioners are encouraged to balance credits by the 30 month mark.

CPD credits will generally be calculated as one credit per one hour of activity.

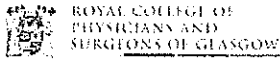
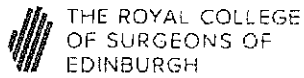
CPD requirements are the same for full time and part time surgeons.

APPENDIX 1: CPD CATEGORIES

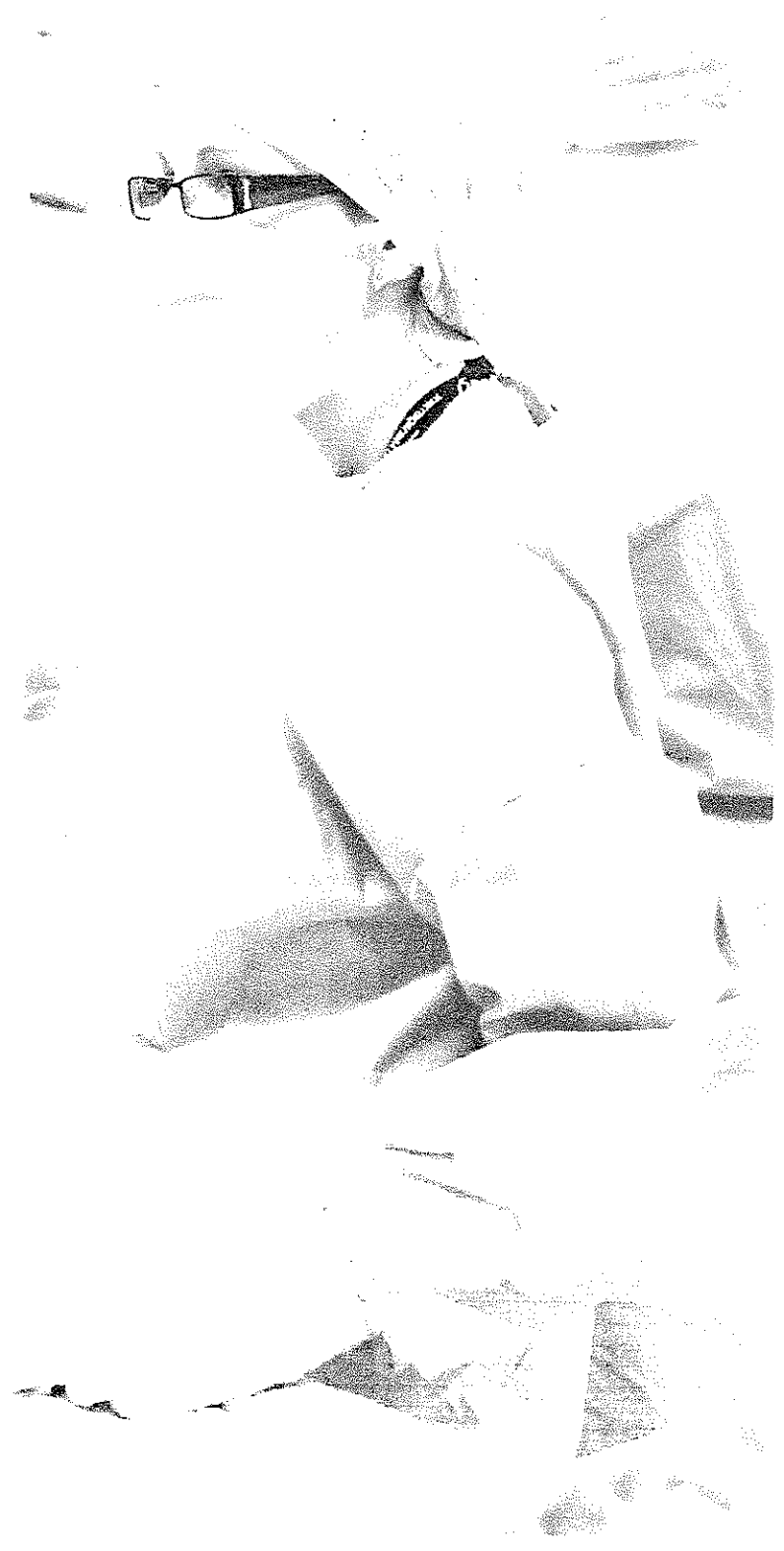
Category	Example Activities	Credits
External (Maintenance of Knowledge and Skills) Events / activities accredited by Training Bodies that meet educational standards	-International/National Meetings -Courses accredited by Training Body -College/Society meetings -Medically related advanced degrees -Online Courses	20 credits minimum per year/ term 100 credits minimum per five year cycle
Internal (Practice Evaluation & Development) Activities that develop and improve the quality of clinical practice	-Morbidity and Mortality Meetings -Clinical Risk Meetings -Case Presentations -Chart Reviews -Grand Rounds -Multi-disciplinary Meetings -Peer Review Groups -Activities related to analysing patient and/or department outcomes -Activities related to patient satisfaction surveys -Activities related to the organisation or review of surgical services, e.g. Head of Department and Clinical Unit meetings	20 credits minimum per year / term 100 credits minimum per five year cycle 1 hour of educational activity = 1 CPD credit
Personal Learning	-Self directed education, training or assessment activities (eg Journal reading) -Participation in professional development workshops/courses -Volunteer or outreach activities -Journal clubs -E-Learning	5 credits minimum per year /term 25 credits minimum per five year cycle 1 hour of educational activity = 1 CPD credit
Research or Teaching	-Accredited Postgraduate Trainer -Lectures -Examiner for Postgraduate Training Body -Publishing articles -Poster Presentation -Question Setting -Participation in the mentoring and counseling of surgical trainees	2 credits per year desirable 1 hour of educational activity = 1 CPD credit

Appendix 2 – Examples of documentary evidence of CPD

- Attendance certificates/registers for local/national/international educational meetings /courses
- E-learning self assessment certificates
- Attendance at examination as an examiner (e.g. exam timetable)
- Programmes of meetings if there are no attendance certificates
- Copies of proposals written for specific committees
- Copies of meeting agendas
- Protocols written
- Copies of papers and abstracts presented
- For Life Support Course instructing – copies of the course programme
- Research grants
- List of papers refereed
- Programmes of courses on which you have lectured
- Medically Related Advanced Degrees – copy of diploma or final transcript
- Research - Copy of published article's first page
- Poster Presentation - Copy of page from conference proceedings that lists the poster abstract and identifies the presenter
- Postgraduate Trainer/Examiner/Question Setting - Confirmed by relevant training body



Continuing professional development: a summary guide for surgery



Introduction

CPD is the engagement in a continuing learning process, outside formal undergraduate and postgraduate training, that enables individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour.

All surgeons in non-training grades who have a licence to practise and wish to remain on the GMC register must participate in CPD activities to meet the requirements of revalidation. The GMC will require documented proof of CPD as an essential part of successful appraisal and revalidation.

It is the responsibility of individual surgeons to keep abreast of new developments that apply to their roles and practice and ensure that they undertake a range of CPD activities that reflect the needs of their practice and their own learning. For a CPD scheme to be effective it should be flexible and largely based on self-evaluation.

Which activities qualify as CPD?

The colleges recognise any activity which provides educational benefit to the individual surgeon as eligible for CPD. These activities can vary from attending courses, clinical workshops, developing courses, mentoring, research, reading journal articles, peer reviewing journal papers etc. There is no exhaustive list of potential CPD activities.

The chosen CPD must be a genuinely developmental experience for the surgeon concerned. It must be relevant to a surgeon's actual practice and support their current skills and knowledge or their career development. Credit should not be claimed for activities that are not relevant to the surgeon's practice or for repeat activities (e.g. making a presentation several times) as these will have limited developmental value.

Some activities may be accredited by royal colleges and specialty associations. Accreditation of activities is not a mandatory part of the CPD requirements for revalidation but can guide surgeons to quality activities related to their practice. Surgeons should be able to justify to their appraisers that the activity contributed to their personal development.

Summary of requirements

CPD should include activities both within and outside the employing institution, where there is one. There should also be a balance of learning methods. CPD activities should include professional development outside narrower specialty interests.

Surgeons should aim to achieve a balance of activities across three categories of activities: Clinical; Academic and Professional (including Managerial); and three environments: Internal; External and Personal. These can be represented in a simple matrix:

	Internal	External	Personal
Clinical			
Academic			
Professional (including Managerial)			

There are no minima or maxima in any category but surgeons should aim for a balanced programme that reflects their practice and development needs. It would normally be expected that a surgeon's five-year CPD programme would include CPD activity within each category and environment (i.e. some entries in each box) but, depending on the surgeon's role, it is recognised that this may not always be possible. Planned programmes should be agreed between a surgeon and their appraiser when setting a Personal Development Plan (PDP).

Surgeons should accrue at least 50 credits each year and at least 250 credits each revalidation cycle (i.e. five years) although there can be some flexibility from year to year at the discretion of the surgeon's appraiser. Normally credits given are based on one credit equating to one hour of educational activity.

There are no limits on the number of hours that can be claimed for the same type of activity. However, to encourage a balanced programme, normally no more than 20 of the minimum 50 hours per year should come from a single type of activity. For example, a surgeon might publish three articles (30 hours) but an appraiser should be looking for a further 30 (rather than 20) to come from different sources.

It is expected that most surgeons in full time active practice would easily exceed the 50 hour minimum.

Recording CPD

Surgeons are required to collect evidence of their CPD activity and the credits that are attributed to it. It is recommended that surgeons record data about their CPD activity using the Surgeons' Portfolio or a similar tool provided by their Trust. Supporting information such as certificates should be uploaded or retained by the surgeon in hard copy as proof.

Depending on the nature of each CPD activity recording can take place through a number of ways:

For verifiable activities (such as courses, events, committee meetings, or other types of activities organised by external providers) - Documentation to demonstrate participation in CPD activity may include certificates of attendance, letters from organisers, event programmes, attendance lists and minutes of meetings, printouts of participation in exams or college activities etc.

For non-verifiable activities (such as journal reading and information through the internet, or other types of activities that are organised and carried out personally by the surgeon) – Documentation to demonstrate CPD activity may include the surgeon's self-recording of hours spent on the activity.

Recording of CPD activity should include a reflection on the learning gained from each activity and the likely effect on the surgeon's professional work. The Surgeons' Portfolio provides space for guided reflection. The following points may be used to reflect on the activity:

Brief description of the activity including why you selected this activity for CPD.

What was the learning need or objective that was addressed?

What was the outcome of this activity?

Outline any further learning or development needs highlighted by the activity.

How do you intend to address these?

Planning and reviewing CPD at appraisal

A CPD programme should be planned and agreed between a surgeon and their appraiser during the annual appraisal, and as part of the surgeon's Personal Development Plan (PDP). The PDP should outline a series of development aims and how the surgeon intends to achieve these aims, including a summary of CPD activities planned for the coming year.

When it comes to reviewing the CPD activities, surgeons are not required to submit information on their CPD to their College for certification. Instead, surgeons should present a summary of the CPD undertaken for discussion and assessment at their appraisal. The discussion with the appraiser should include the learning and/or changes in practice that have arisen from the activities. The appraiser will also assess the relevance of the chosen CPD activities to the surgeon's practice and development needs.

Responsibilities of employers

In its guidance on continuing professional development, published in 2012, the GMC states:

Employers and contractors of doctors' services are responsible for making sure their workforce is competent, up to date and able to meet the needs of the service. They should maintain and develop the skills of all of their medical staff whether they are consultants, staff grade, specialty or associate specialist (SAS) doctors, sessional general practitioners (GPs), locum doctors or trainees. They should also facilitate access to the resources (including the time to learn) that will support this.

Employers and contractors should use the appraisal system, alongside job planning and PDPs, to plan and coordinate the CPD needs of their staff, to discuss how best those needs should be met, and to monitor the effectiveness of doctors' CPD activities.

The responsibility for fulfilling CPD requirements and achieving learning needs rests with the individual doctor. However, the employing organisation (including locum agencies, where applicable) should provide support for professional development in partnership with other relevant bodies.

Special circumstances

Surgeons working less than full time have an equal obligation to provide high quality patient care as do those working full time, and should maintain the same commitment to their CPD. Colleges and faculties as well as employers, should be as flexible as possible in enabling this commitment to be met for all surgeons. The use of a rolling five-year cycle can allow the average amount of activity to be maintained over five years if a shortfall occurs.

Any deficit in CPD activity should be made up over the remainder of the five-year cycle. Where the absence is for more than a year, advice from the college or faculty should be sought.

If a retired surgeon wishes to retain a licence to practise, then the CPD requirements of the College or Faculty should be met.

In some circumstances the type of CPD activity available may not conform to the quality standards set by the colleges or specialty associations. The surgeon should self-accredit as much CPD as appears justifiable in terms of the learning achieved. Any shortfall should be made up on return to the UK. Periods of absence of more than one year may require specific CPD as agreed with the surgeon's appraiser.

CPD checklist

Choice of CPD activities	Do the activities chosen qualify as CPD? Have the activities developed the surgeon's knowledge, skills or behaviour? Are the activities relevant to the surgeon's practice? Has the CPD addressed the learning needs identified in the surgeon's Personal Development Plan?
Balance of CPD activities	Has the surgeon undertaken an appropriate balance of CPD i.e. between Clinical, Professional and Academic and between internal, external and personal? Does this reflect the surgeon's practice and development needs? Has the surgeon met the CPD targets for each category of CPD set at their previous appraisal?
Number of Credits	Has the surgeon accrued the minimum of 50 CPD hours each year? Are the credits from a sufficient range of activities (i.e. no more than 20 of the minimum 50 CPD hours from the same activity)? If there have been significant periods of absence, has it been possible for the surgeon to make up the lost credits?
Recording and Reflection of CPD activities	Has the activity been appropriately documented and described? Is additional supporting information needed? Is there justification for the activity chosen? Is the learning need or objective clear? What was the outcome of the CPD activity? Has the CPD reinforced aspects of current practice? Has the CPD led to actual or potential changes in practice? What has been the impact on quality and patient care/safety? Has the surgeon identified any further learning or development needs? If so how will these be addressed?

Further information

For any questions about CPD for appraisal or revalidation you can contact the helpdesks of the surgical royal colleges at:

Edinburgh:

England:

Glasgow:

More information on the Surgeons' Portfolio can be found at:

Website:

Helpdesk:

More information about the GMC requirements for CPD can be found on the GMC website:



My Details

Update Changes

Title Mr

First name Aidan

Surname O'Brien

Address Craigavon Area Hospital,
Craigavon,
County Armagh,
Northern Ireland.

Postcode BT6 5QQ

Gender ☒ Male ☐ Female

Username

Personal Information redacted by the USI

Email

Personal Information redacted by the USI

Default Specialty

Area in which you work

Training Programme

Grade

Verified Grade

Not Verified

If this grade is not correct please use
the [support request form](#) to request a change

RCSI Access ☒ Allow The Royal College of Surgeons of Ireland
access to my logbook data for the purposes of
monitoring my surgical training progress and experience

Update Changes

Personal Development Plan structured reflective template
Requirement: annual

Name of doctor: Aidan O'Brien

Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: 2014

Having accumulated the certificates of attendance at Urological Conferences, and having reviewed the Continuing Professional Development Guidelines of the Royal Colleges and of the Federation of Surgical Specialty Associations, I believe that I have been engaged in many activities that have been inadequately documented, particularly in relation to internal, departmental / management roles. I have therefore registered with Elogbook so that all activities can be recorded prospectively. I hope that this will enable me to ensure that my CPD has achieved the correct balance across clinical, academic and managerial domains, as recommended.

Date of reflection: 18 April 2014

Final outcome after discussion at appraisal:

(To complete at appraisal considering how your approach will improve patient care)

By having a registered and prospectively entered, CPD record, I hope that achieving a comprehensive spread of CPD activity will be reflected in ongoing improvements in patient care.

Actual Job Schedule 2013 and 2014

Monday

- Outpatient Clinic Banbridge Polyclinic 9.00 – 13.00 first Monday each month
- Outpatient Clinic Armagh Community Hospital 9.00 – 13.00 second Monday each month
- Outpatient Clinic South West Acute Hospital 10.00 – 17.00 fourth Monday each month
- Outpatient Clinic Banbridge Polyclinic 9.00 – 13.00 fifth Monday of month

Tuesday

- Day Surgical Operating 9.00 – 13.00 two Tuesdays per month
- Outpatient Clinic Craigavon Area Hospital 13.30 – 17.30 every Tuesday

Wednesday

- Inpatient Operating 9.00 – 19.00 every Wednesday
- MDM Preview 21.00 – 23.00 every Wednesday

Thursday

- Radiology Conference 8.30 – 9.30 every Thursday
- Grand Ward Round 10.00 – 12.30 every Thursday
- Departmental Meeting 12.30 – 14.00 every Thursday
- Urology MDM 14.15 – 17.00 every Thursday
- MDM sign off 19.00 – 19.30 every Thursday

Friday

- Oncology Review Clinic and Urodynamic Studies 9.00 – 17.00 every Friday

Out of Hours

- Daily inpatient care
- Addressing telephone queries from patients, relatives, family doctors
- Dictation
- Arranging elective inpatient and day surgical admissions and operating schedules
- Previewing MDM cases
- Signing off MDM outcome plans to family doctors
- Selecting patients to attend for oncology review
- Selecting and arranging patients to attend for urodynamic studies
- Triage of letters of referral



CHKS Consultant Level Indicator Programme

The Southern Trust

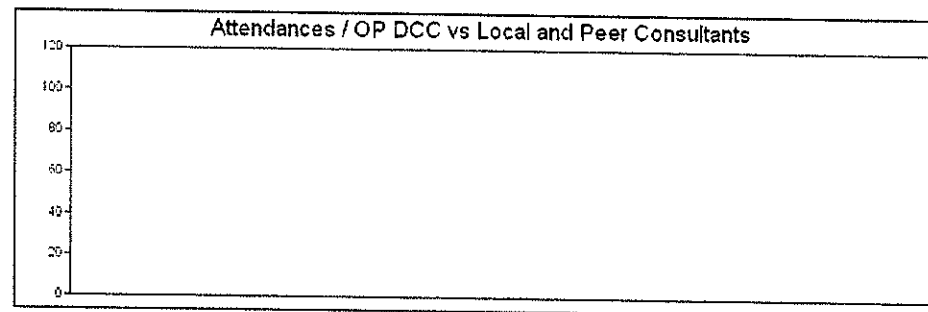
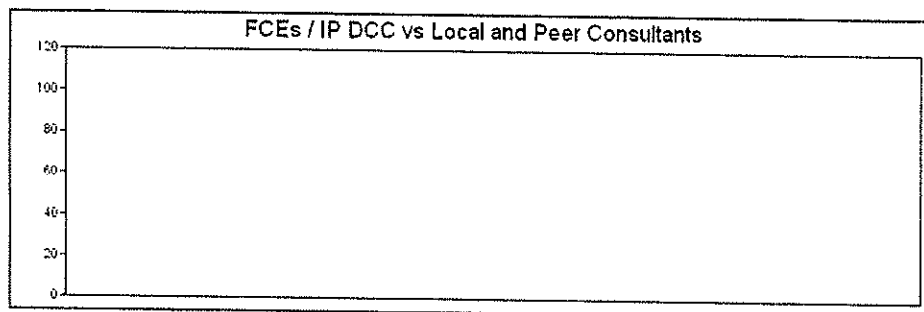
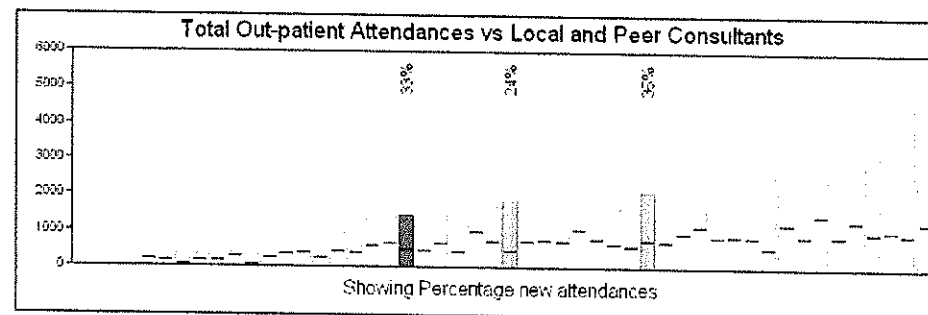
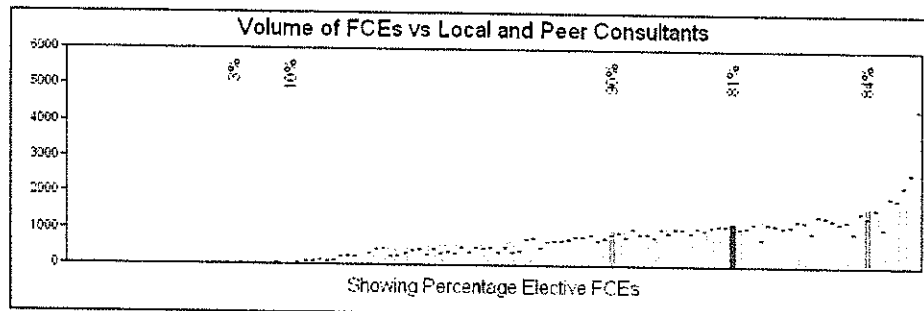
October 2011 to September 2012

Personal Information redacted
by the USI

: Mr A O'Brien

Urology

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Workload Volumes	Consultant	2011	2012	2013
Total Number of FCEs	1224			
Elective FCEs	988	80.7%	82.5%	82.1%
In-Patients	385	39.0%	29.2%	25.1%
Day Cases	603	61.0%	70.8%	74.9%
Emergency FCEs	215	17.6%	15.9%	17.8%
Other FCEs	21	1.7%	1.6%	0.1%
* Regular Attendances	12	1.2%	5.5%	0.1%

* Regular Attendances are counted **only** in this report line
 They are expressed as a percentage of Elective FCEs (above) + Regular Attendances
 They are NOT aggregated into any other data line or chart

In-Patient Details	Consultant	2011	2012	2013
FCEs - Male	845	69.0%	70.4%	73.3%
FCEs - Female	379	31.0%	29.6%	26.7%
FCEs - Child (0-18)	47	3.8%	3.2%	2.6%
FCEs - Adult (19-74)	929	75.9%	77.6%	66.6%
FCEs - Elderly (75+)	248	20.3%	19.2%	30.8%

Outpatient workload	Consultant	2011	2012	2013
Total Attendances	1482		1341	1983
New Attendances	492	33.2%	30.1%	34.5%
Follow-up Attendances	990	66.8%	69.9%	65.5%
Attendances with Procedure				17.2%

Consultant Total FCEs : 1,224

89,488 : Peer FCEs

Performance Indicators

	Consultant	Local	Peer	Target
FCE Inpatient ALoS (DC trimmed)		3.5	3.1	2.6
Average Length of Stay (Zero trimmed)		4.1	3.6	3.4
Elective		3.5	2.8	2.6
Non-Elective		5.0	4.6	4.4
Risk Adjusted Length of Stay *		120.5	110.8	77.6
Day Case Rate	603	61.0%	70.8%	74.9%
Day Case Overlays	51	7.8%	6.6%	6.2%
Average Elective Pre-Operative LoS		0.3	0.1	0.2
Elective IP Spells with no Procedure	16	6.2	3.3	1.0
Elective Inpatient spells - procedure not carried out	2	0.8%	0.5%	1.1%
Patient Cause				0.1%
Other Reason	2	0.8%	0.5%	1.0%

Governance Indicators

	Consultant	Local	Peer	Target
Mortality Rate *	2	0.2%	0.1%	0.2%
Elective			0.0%	0.0%
Non-Elective	2	1.0%	0.2%	1.5%
Risk Adjusted Mortality Index *	0	0.0	19.6	59.7
Elective	0	0.0	61.8	38.1
Non-Elective	0	0.0		67.5
Attributed Complications *	11	0.9%	0.5%	1.0%
Misadventures *	3	0.2%	0.1%	0.2%
Readmissions *	48	4.0%	3.9%	5.7%

* Spell based indicators. See definitions for activity attribution criteria

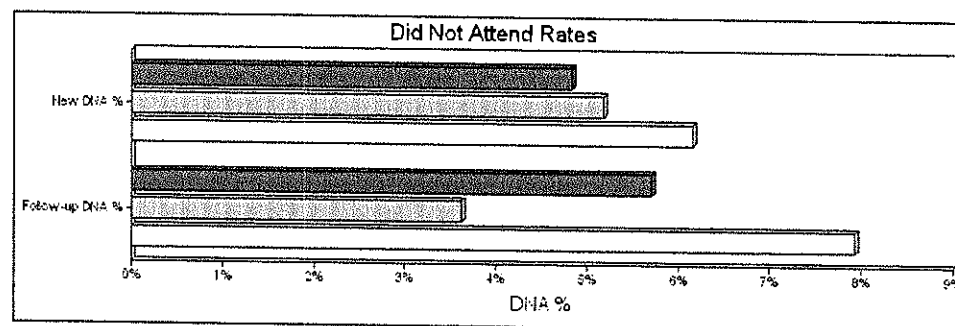
High Volume Procedures

Day Case Procedures	Actual Day Cases						Day Case Overlays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	256	243.3	281.4	89.8%	88.9%	94.6%	5	8.5	5.3	2.0	1.3	1.9
M49 - Other operations on bladder	145	45.5	56.9	90.6%	89.2%	97.3%	2	1.0	1.9	1.5	2.0	2.3
N30 - Operations on prepuce	30	32.0	29.9	75.0%	79.0%	90.5%	4	2.5	2.1	1.0	1.0	1.3
M43 - Endoscopic operations to increase capacity of bladder	25	29.5	11.3	47.2%	92.2%	78.5%	4	3.0	2.4	1.2	1.3	1.4
M47 - Urethral catheterisation of bladder	22	33.0	33.9	68.8%	91.7%	86.7%	3		1.7	5.7		2.0
X29 - Continuous Infusion of therapeutic substance	17	4.0	24.5	100.0%	100.0%	98.0%						
M27 - Therapeutic ureteroscopic operations on ureter	15	17.0	7.3	32.6%	26.8%	36.6%	3	18.0	5.8	1.7	1.3	1.7
M79 - Other operations on urethra	13	2.0	7.2	38.2%	50.0%	75.6%	7	1.0	1.6	1.9	1.0	1.4
N17 - Excision of vas deferens	12	8.0	7.9	100.0%	88.9%	97.2%		1.0	1.0		1.0	1.0
N11 - Operations on hydrocele sac	9	2.0	7.5	75.0%	57.1%	81.9%	1		1.5	1.0		1.2

In-Patient Procedures	Number			Pre-Op Average LoS			IP Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M27 - Therapeutic ureteroscopic operations on ureter	57	33.2	13.4	0.8	0.8	0.5	2.6	2.7	2.0
M65 - Endoscopic resection of outlet of male bladder	57	21.0	27.7	0.3	0.0	0.2	4.7	2.8	2.8
M42 - Endoscopic extirpation of lesion of bladder	47	17.6	29.5	0.6	0.2	0.3	3.2	2.2	2.6
M45 - Diagnostic endoscopic examination of bladder	36	23.2	17.4	0.6	0.9	1.5	3.7	1.6	2.1
M43 - Endoscopic operations to increase capacity of bladder	29	1.0	2.1	0.1	0.4	0.2	1.1	0.8	1.2
U21 - Diagnostic imaging procedures	26	11.4	16.0	9.0	1.7	3.3	6.3	3.2	3.2
M79 - Other operations on urethra	22	0.8	1.8	0.5	0.0	0.1	2.2	0.8	1.0
M49 - Other operations on bladder	17	2.8	2.5	0.2	0.6	0.4	2.3	1.7	1.6
M30 - Diagnostic endoscopic examination of ureter	15	7.0	1.8	3.4	0.1	0.8	3.1	1.9	1.4
M47 - Urethral catheterisation of bladder	15	2.4	24.2		7.0	3.6	2.0	5.0	2.3

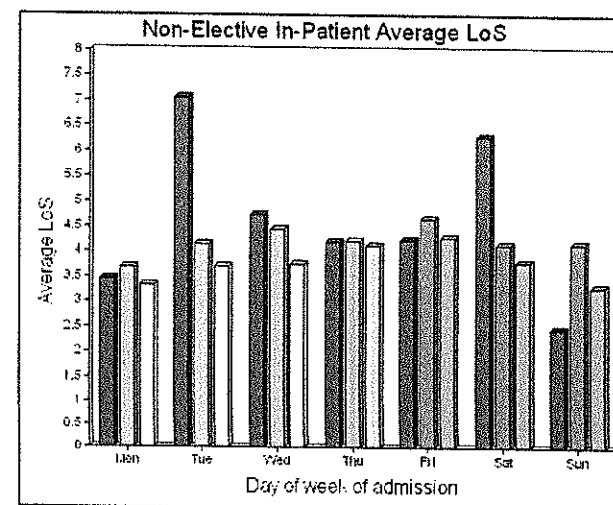
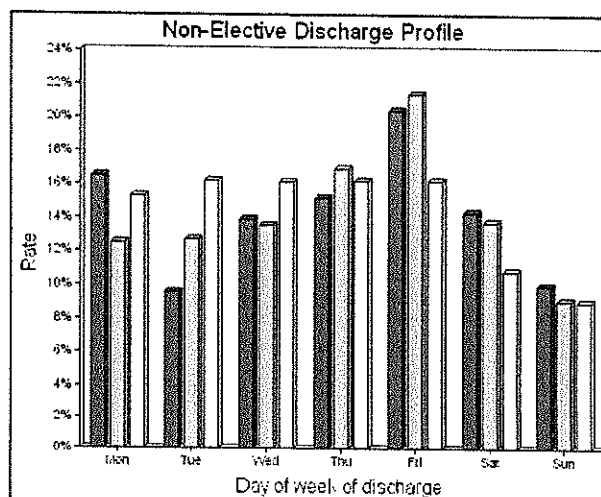
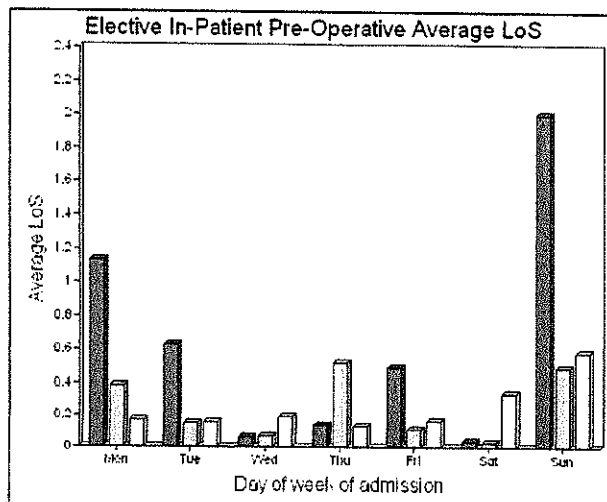
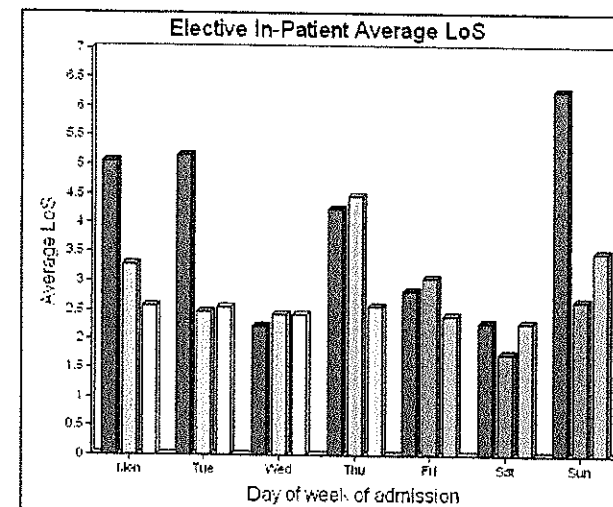
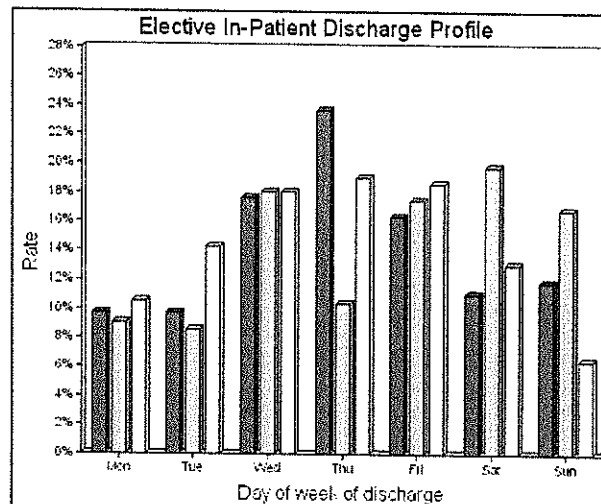
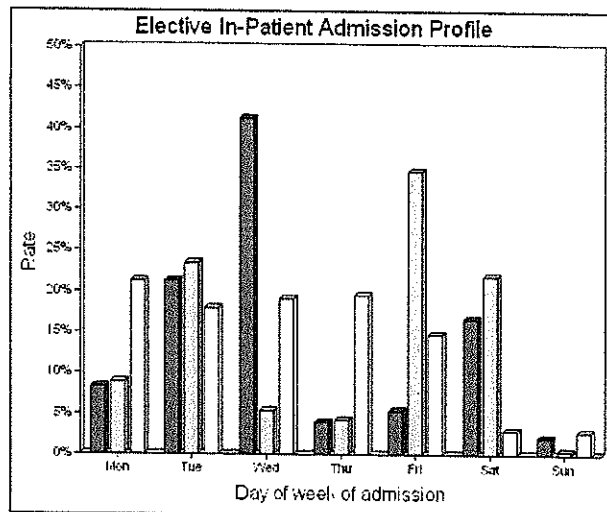
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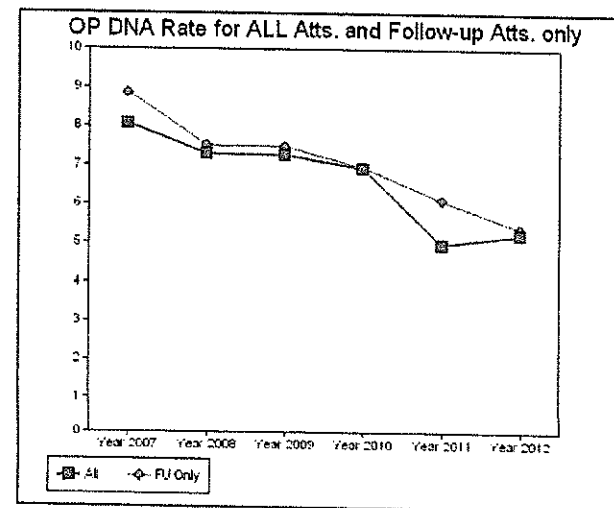
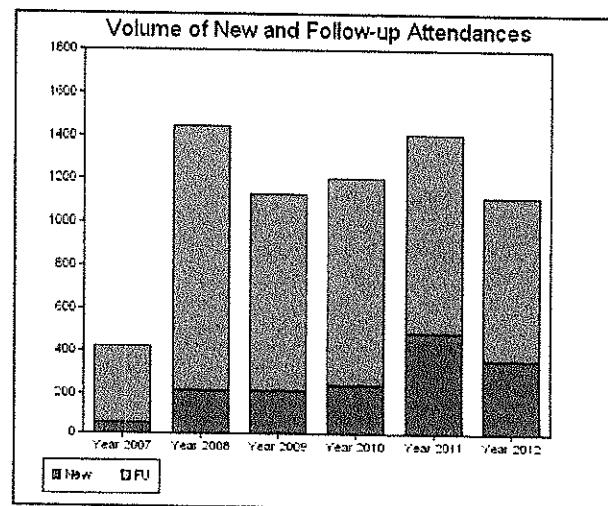
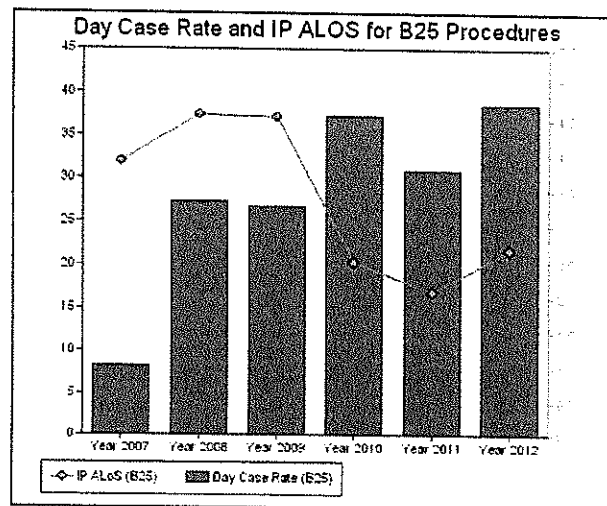
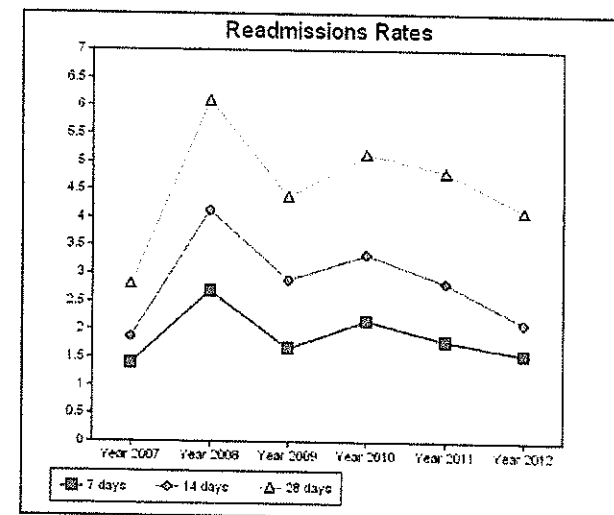
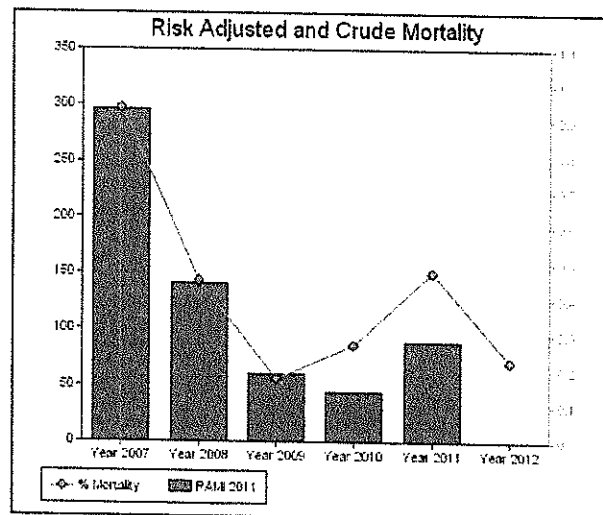
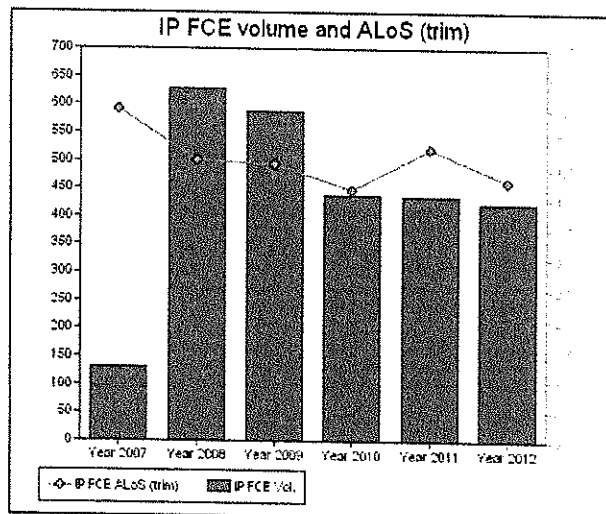
	Consultant		Local Peer			
	Volume	Percentage / Rate	Average / Range	Percentage / Rate		
Total Attendances	1482		1341		1983	
New Attendances	492	33.2%	403	30.1%	685	34.5%
Referred by General Practitioner	268	54.5%	396	65.6%	530	73.9%
With Procedures Recorded					152	21.2%
Average Procedure per coded attendance						2.2
Did Not Attend	25	4.8%	33	5.2%	47	6.2%
Follow-Up Attendances	990	66.8%	938	69.9%	1298	65.5%
With Procedures Recorded					195	15.0%
Average Procedure per coded attendance						2.1
Did Not Attend	60	5.7%	35	3.6%	112	7.9%
New : Follow-Up Ratio	990	1 : 2.0	1402	1 : 2.3	1356	1 : 1.9



Top ten Procedures Reported (Volume)			
	Consultant	Local	
M47 - Urethral catheterisation of bladder	0	0	10
U08 - Diagnostic imaging of abdomen	0	0	6
X37 - Intramuscular injection	0	0	2
NUL -			
M45 - Diagnostic endoscopic examination of bladder			285
U26 - Diagnostic testing of genitourinary system			126
X62 - Assessment			67
M70 - Other operations on outlet of male bladder			55
U12 - Diagnostic imaging of genitourinary system			29
R43 - Ultrasound monitoring			20
			19

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**CLIP (Consultant Led Indicator Programme) Report structured
reflective template**

Requirement: One annually

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of report: October 2011 – September 2012	
What issues can I identify from the report? Whilst the overall performance in terms of FCEs is consistently satisfactory at 1224 relative to previous years, and whilst the percentage of day cases is higher at 61% relative to the year 2012/13, it is still less than peer mean of 74.9%. The limited capacity of the Trust for day case surgery, and the method of recording day case surgery, may be contributing factors. Average length of stay of 4.1 days was higher than peer mean of 3.4 days, and may be contributed to by geographical distance of hospital from patients' homes. Outpatient performance is satisfactorily comparable to peer means, and new:review ratio of 1:2.0 is comparable to peer mean of 1:1.9 What actions will I undertake? As the main 'negative' issue remains the proportion of day case surgery, I intend to: • Request IT Department of Trust to provide data pertaining to proportion of patients admitted and discharged on same date. • Prospectively accumulate my own data from use of Elogbook Final outcome after discussion at appraisal: (Complete at appraisal) As above	



CHKS Consultant Level Indicator Programme

The Southern Trust

October 2012 to September 2013

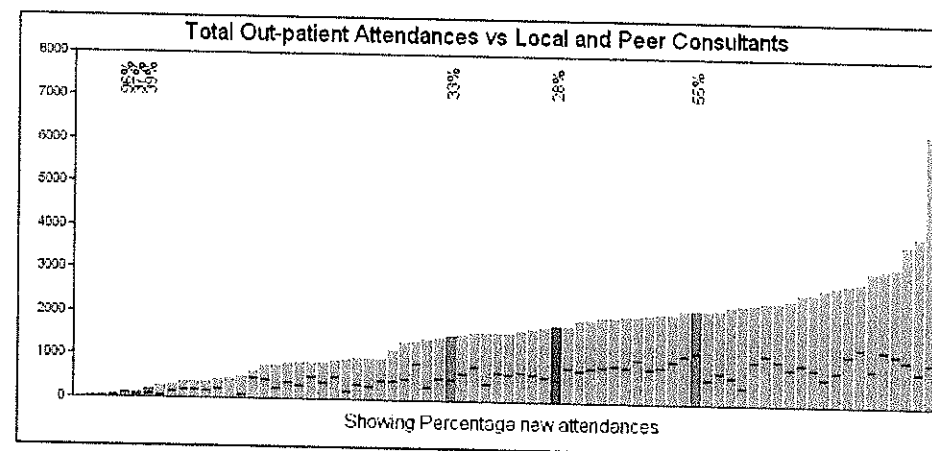
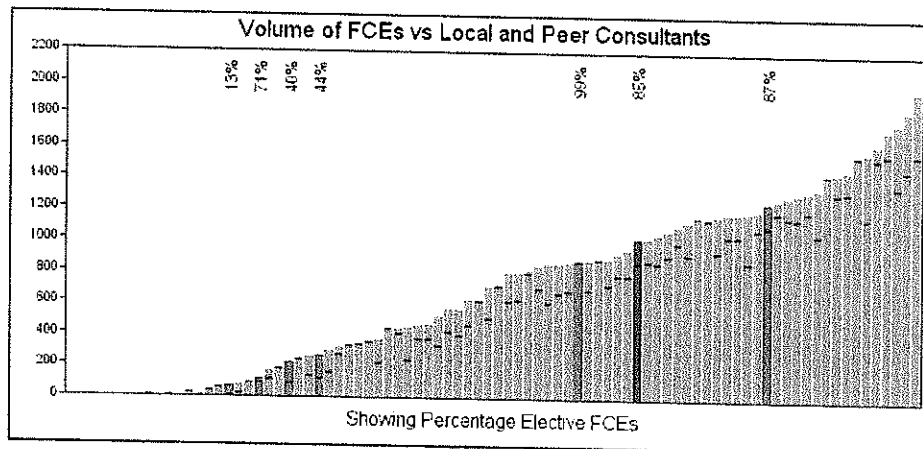
Personal Information
redacted by the USI : **Mr A O'Brien**

Urology

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 Mr A O'Brien - Urology
 October 2012 to September 2013



Workload Volumes	Consultant		Local	
Total Number of FCEs	1026			
Elective FCEs	870	84.8%	80.3%	84.6%
In-Patients	436	50.1%	30.9%	24.3%
Day Cases	434	49.9%	69.1%	75.7%
Emergency FCEs	129	12.6%	17.1%	14.7%
Other FCEs	27	2.6%	2.6%	0.7%
* Regular Attendances	9	1.0%	3.1%	0.4%

* Regular Attendances are counted **only** in this report line

They are expressed as a percentage of Elective FCEs (above) + Regular Attendances

They are NOT aggregated into any other data line or chart

In-Patient Details	Consultant		Local	
FCEs - Male	718	70.0%	71.0%	69.9%
FCEs - Female	308	30.0	29.0	30.1
FCEs - Child (0-18)	40	3.9%	2.4%	1.5%
FCEs - Adult (19-74)	728	71.0%	75.7%	69.1%
FCEs - Elderly (75+)	258	25.1%	21.9%	29.4%

Outpatient workload	Consultant		Local	
Total Attendances	1783		840	1696
New Attendances	507	28.4%	46.3%	35.8%
Follow-up Attendances	1276	71.6%	53.7%	64.2%
Attendances with Procedure	42	2.4%	1.9%	21.6%

Consultant Total FCEs : 1,026

57,235 : Peer FCEs

Performance Indicators

	Consultant	Local	Peer
FCE Inpatient ALoS (DC trimmed)	3.1	3.3	2.8
Average Length of Stay (Zero trimmed)	4.3	3.8	3.4
Elective	3.3	2.8	2.9
Non-Elective	6.2	4.9	4.1
Risk Adjusted Length of Stay *	90.0	84.1	71.0
Day Case Rate	434	49.9%	69.1%
Day Case Overstays	32	6.9%	8.8%
Average Elective Pre-Operative LoS	0.3	0.1	0.2
Elective IP Spells with no Procedure	11	5.1	2.7
Elective Inpatient spells - procedure not carried out	3	1.4%	0.5%
Patient Cause	1	0.5%	1.7%
Other Reason	2	0.9%	0.5%

Governance Indicators

	Consultant	Local	Peer
Mortality Rate *	5	0.5%	0.2%
Elective	1	0.1%	0.0%
Non-Elective	4	3.1%	1.2%
Risk Adjusted Mortality Index *	2	90.4	49.1
Elective	0	0.0	32.1
Non-Elective	2	134.8	59.8
Attributed Complications *	9	0.9%	1.0%
Misadventures		0.1%	0.1%
Readmissions *	33	3.3%	4.9%

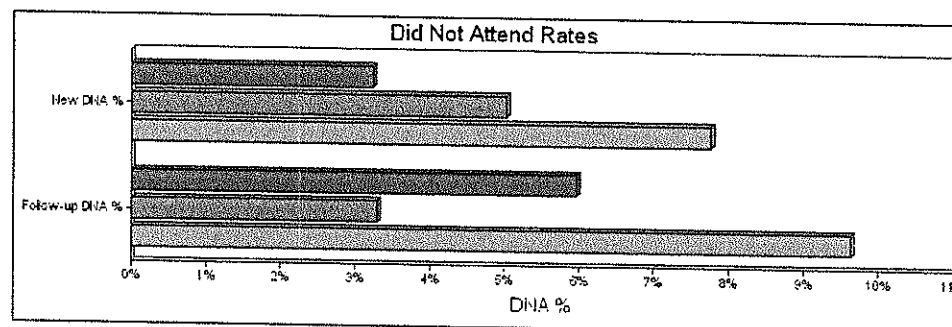
* Spell based indicators. See definitions for activity attribution criteria

High Volume Procedures

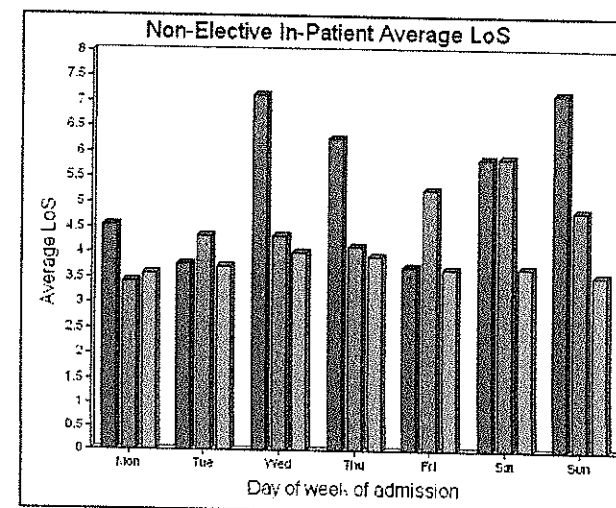
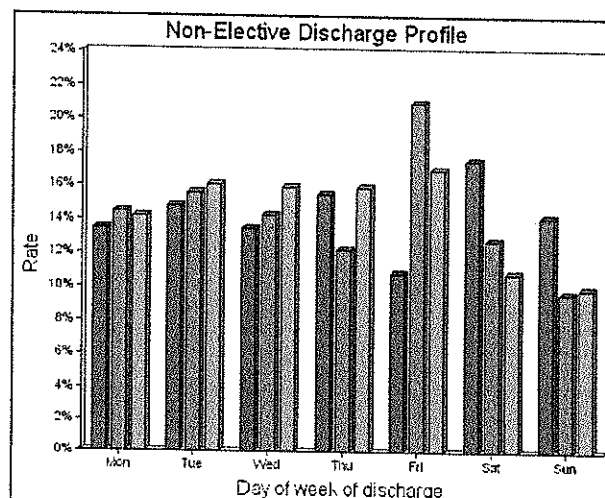
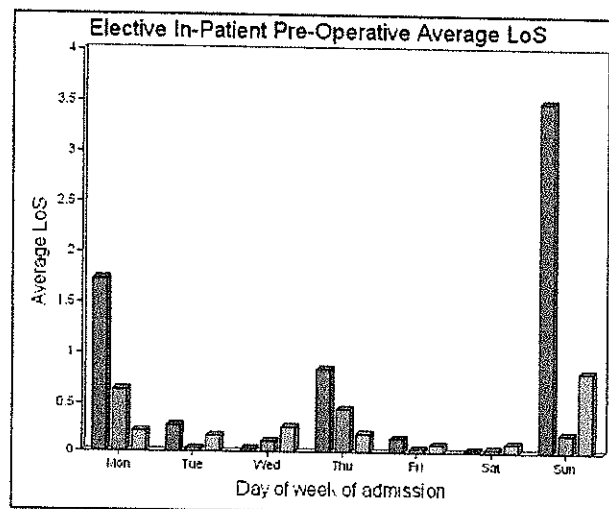
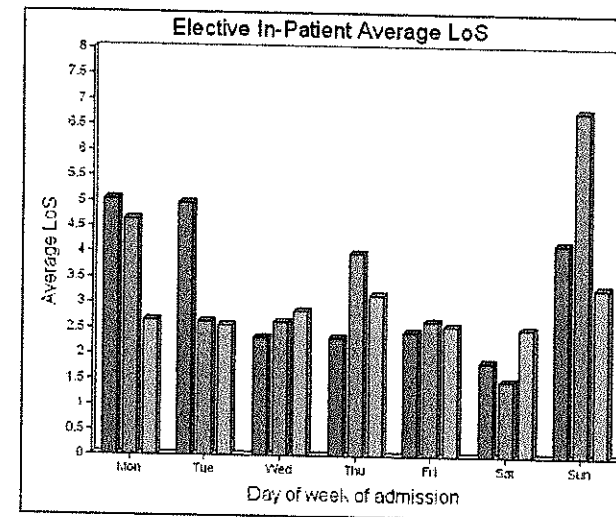
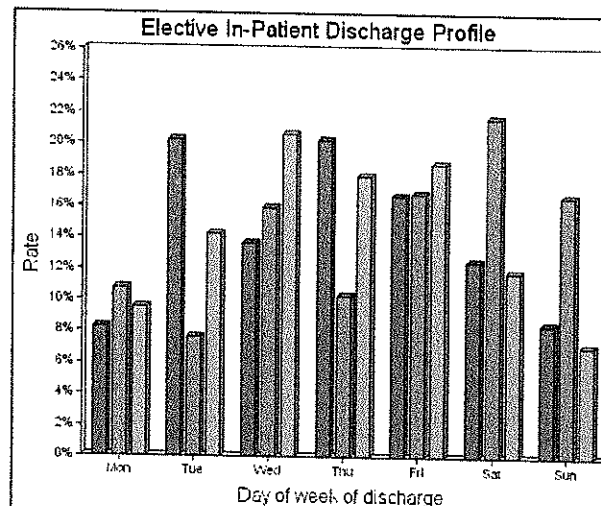
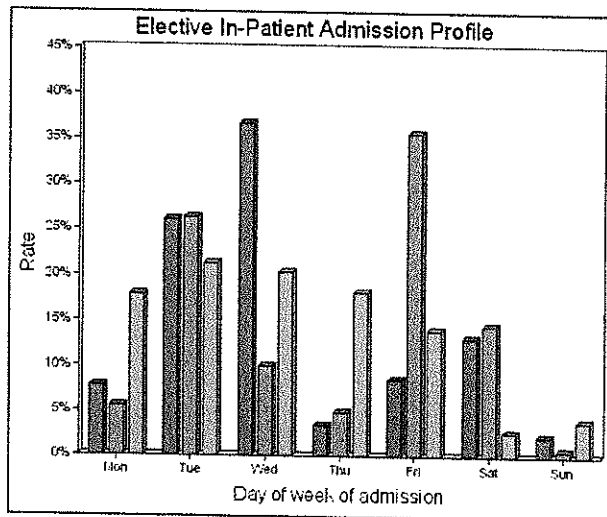
Day Case Procedures	Actual Day Cases			Day Case Overstays		
	Number	Rate of All Elective FCEs	Average LoS	Number	Average LoS	
	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	211	107.0	223.3	84.1%	89.0%	94.1%
M49 - Other operations on bladder	58	17.5	101.5	39.7%	90.9%	95.2%
M43 - Endoscopic operations to increase capacity of bladder	34	9.0	12.8	54.8%	84.4%	81.0%
N30 - Operations on prepuce	25	12.4	19.9	69.4%	89.9%	87.6%
M47 - Urethral catheterisation of bladder	16	19.2	47.9	53.3%	92.3%	93.7%
N17 - Excision of vas deferens	12	4.7	9.6	100.0%	93.3%	97.8%
M27 - Therapeutic ureteroscopic operations on ureter	10	11.7	3.0	31.2%	34.7%	19.6%
N15 - Operations on epididymis	6	2.0	3.9	75.0%	100.0%	89.7%
M76 - Therapeutic endoscopic operations on urethra	5	2.2	8.7	45.5%	40.9%	59.2%
M29 - Other therapeutic endoscopic operations on ureter	4	5.3	13.7	44.4%	64.0%	57.6%

In-Patient Procedures	Number			Pre-Op Average LoS			IP Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M49 - Other operations on bladder	88	1.7	4.7	0.1	0.0	0.1	0.4	0.8	3.1
M65 - Endoscopic resection of outlet of male bladder	52	12.5	18.6	0.2	0.3	0.2	2.8	2.9	2.8
M45 - Diagnostic endoscopic examination of bladder	47	17.7	13.7	1.0	0.3	0.8	2.3	2.8	1.5
M27 - Therapeutic ureteroscopic operations on ureter	34	31.3	9.1	0.8	0.3	0.4	2.3	2.1	1.9
M42 - Endoscopic extirpation of lesion of bladder	32	15.3	28.7	0.5	0.5	0.3	4.0	3.7	2.5
M43 - Endoscopic operations to increase capacity of bladder	28	1.0	1.8	0.1	0.7	0.4	1.0	1.2	1.5
M47 - Urethral catheterisation of bladder	15	3.8	19.0	4.0		4.1	1.8	4.0	2.7
N30 - Operations on prepuce	14	1.5	2.7	0.2	0.0	0.2	1.5	1.0	1.2
U21 - Diagnostic imaging procedures	13	11.8	14.3	5.5	3.1	4.7	11.1	4.5	2.8
M30 - Diagnostic endoscopic examination of ureter	12	4.3	1.2	0.0	0.0	0.0	2.1	2.1	1.7

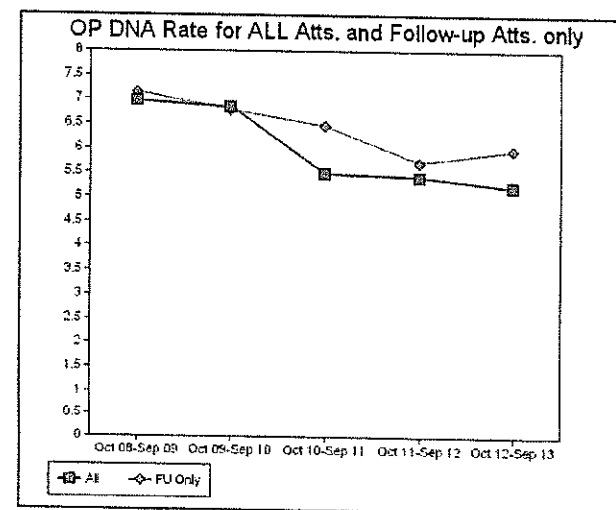
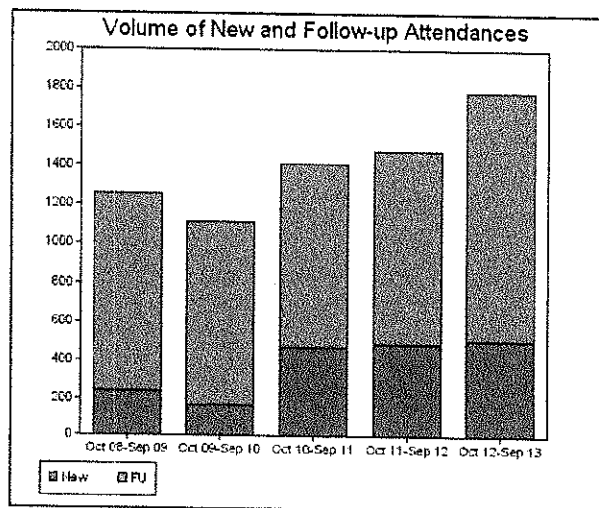
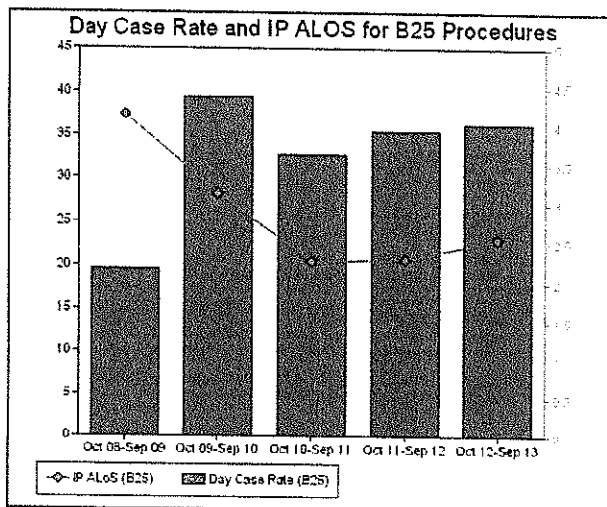
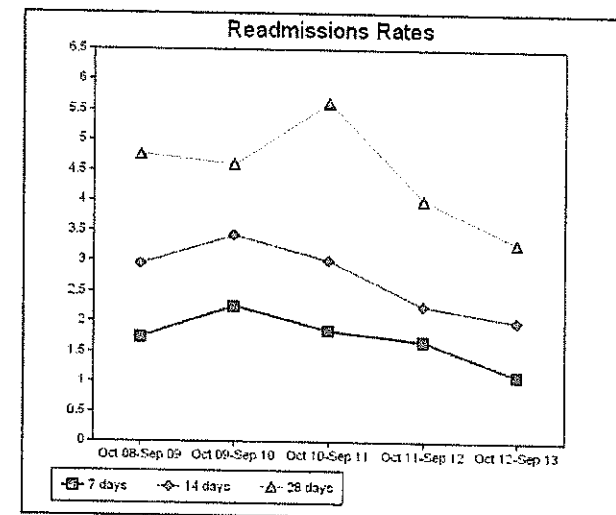
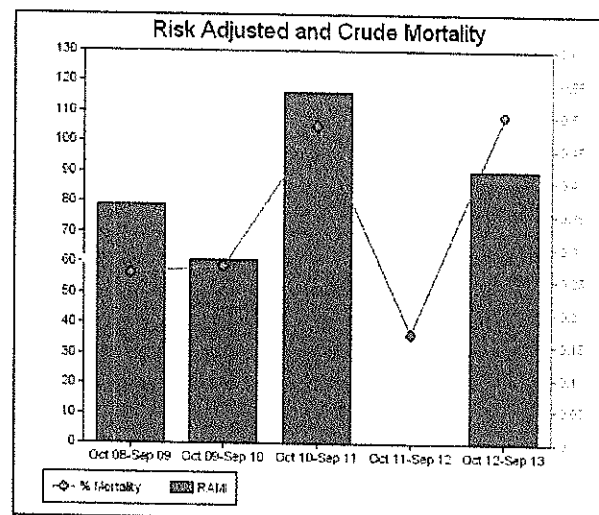
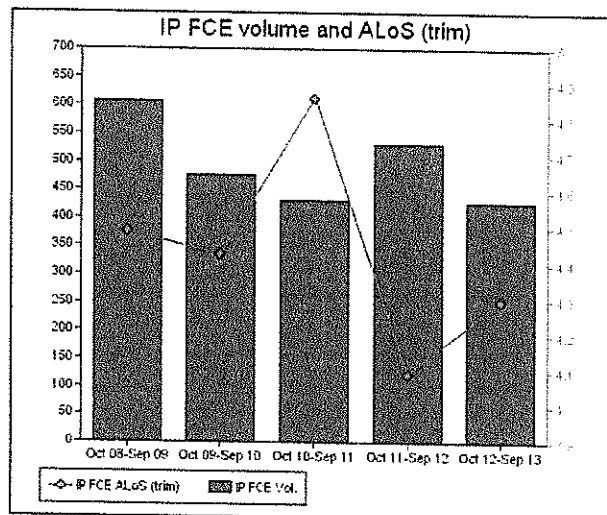
	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	1783		840		1696	
New Attendances	507	28.4%	389	46.3%	607	35.8%
Referred by General Practitioner	285	56.2%	286	73.6%	404	66.6%
With Procedures Recorded	38	7.5%	7	1.7%	126	20.8%
Average Procedure per coded attendance		1.0		1.0		1.1
Did Not Attend	17	3.2%	21	5.0%	51	7.8%
Follow-Up Attendances	1276	71.6%	451	53.7%	1089	64.2%
With Procedures Recorded	4	0.3%	9	2.0%	244	22.1%
Average Procedure per coded attendance		1.0		1.0		1.1
Did Not Attend	81	6.0%	15	3.3%	118	9.6%
New : Follow-Up Ratio	1276	1 : 2.5	451	1 : 1.2	1089	1 : 1.8



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	42	9	24
M70 - Other operations on outlet of male bladder	0	4	3
U26 - Diagnostic testing of genitourinary system	0	0	11
X36 - Blood withdrawal	0	0	10
Q55 - Other examination of female genital tract	0	0	1
X38 - Subcutaneous injection	0	0	1
X62 - Assessment			188
M45 - Diagnostic endoscopic examination of bladder			123
M48 - Operations on bladder			21
U32 - Diagnostic blood tests			19



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CHKS CLIP Programme :- Indicator definitions

Report Indicator Definitions (Surgical)

Workload Volumes

Total FCEs

Numerator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

FCEs (incl. day cases) per inpatient DCC

Numerator: Count of FCEs / 52 (weeks in year)

Denominator: Number of inpatient direct clinical care (DCC) sessions

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective FCEs

Numerator: Count of elective FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases

Denominator: Count of elective FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Day Case Rate

Numerator: Count of elective day case FCEs

Denominator: Count of elective FCEs

Exclusions: Well babies and regular attenders

Emergency FCEs

Numerator: Count of emergency FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Other FCEs

Numerator: Count of OTHER (not elective or emergency) FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Regular attendances

Numerator: Count of regular attenders

Denominator: Total elective FCEs including regular attenders

Exclusions: Well babies

CHKS CLIP Programme :- Indicator definitions cont.

In-patient Details

Male FCEs

Numerator: Count of Male FCEs

Denominator: Count of Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Female FCEs

Numerator: Count of Female FCEs

Denominator: Count of Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Children FCEs

Numerator: Count of Childrens FCEs - age on admission ≥ 0 and ≤ 18

Denominator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis

Adult FCEs

Numerator: Count of Adult FCEs - age on admission ≥ 19 and ≤ 74

Denominator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis

Elderly FCEs

Numerator: Count of Elderly FCEs with age on admission 75+

Denominator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.

Outpatient Workload

Total attendances

Count of outpatient attendances

Total attendances per out-patient DCC

Numerator: Count of outpatient attendances / 52 (weeks in year)

Denominator: Number of outpatient direct clinical care (DCC) sessions

New attendances

Numerator: Count of total new outpatient attendances

Denominator: Total outpatient attendances

Follow-up attendances

Numerator: Count of total follow-up attendances

Denominator: Total attendances

Attendances with a procedure

Numerator: Count of attendances with a valid OPCS4 procedure code

Denominator: Total attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters and
- procedure code 'X999-No outpatient procedure carried out'.

CHKS CLIP Programme :- Indicator definitions cont.

Performance Indicators

FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days

Denominator: Total IP FCEs

Exclusions:

- day cases
- Well babies, regular attenders and renal dialysis

ALoS (zero trimmed)

Numerator: Count of bed days

Denominator: Total FCEs with LoS > zero

Exclusions to numerator and denominator:

- Zero LoS FCE
- Well babies, regular attenders and renal dialysis

Elective ALoS (zero trimmed)

Numerator: Count of bed days - elective

Denominator: Elective FCEs and LoS > zero

Exclusions :

- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

Non-elective ALoS (zero trimmed)

Numerator: Count of bed days - non- elective

Denominator: Non-Elective FCEs and LoS > zero

Exclusions:

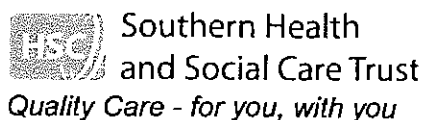
- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

Risk Adjusted ALoS

Numerator: observed spell bed days

Denominator: expected bed days

Exclusions: The following types of criteria are excluded from the risk adjusted Length of Stay model: Mental Health specialties , maternity admissions, other admissions, neonates who died < 2 days old, stillbirths, day cases, regular attenders, length of stay >100 , HRG defined exclusions, HRG's beginning with U and invalid primary diagnosis codes.



CLIP (Consultant Led Indicator Programme) Report structured reflective template

Requirement: One annually

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of report: October 2012 – September 2013	
What issues can I identify from the report? I have been satisfied to learn that my performances are very comparable to the mean of peer activity in all domains but two: my percentage day case rate was 49.9% (peer mean 75.7%) and my new:review outpatient ratio was 1:2.5 (peer mean 1:1.8). I believe that the explanation for the former is that the definition of a day case is determined by whether the intent at the time of commitment to admission is as a day case or otherwise, rather than whether the patient actually is admitted and discharged on the same day. I believe that that latter comprises a greater proportion of the total than is reflected in the CLIP report. I believe that my new:review outpatient ratio is a reflection of urological oncology being a significant portion of my practice. Indeed, if I did have the capacity to review all those patients who should have been reviewed when intended, the ratio would be 'worse'. What actions will I undertake? I hope to ask the Trust's IT Department to provide me with data relating to the numbers of patient's admitted and discharged on same calendar date, to determine whether the proportion is significantly different from that quoted in CLIP report. Final outcome after discussion at appraisal: (Complete at appraisal) To investigate as above.	



CHKS Consultant Level Indicator Programme

The Southern Trust

October 2013 to December 2013

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by the USI

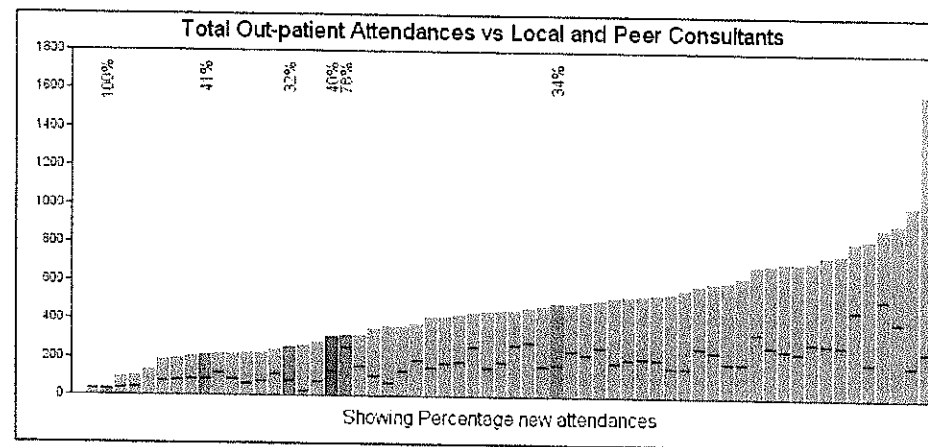
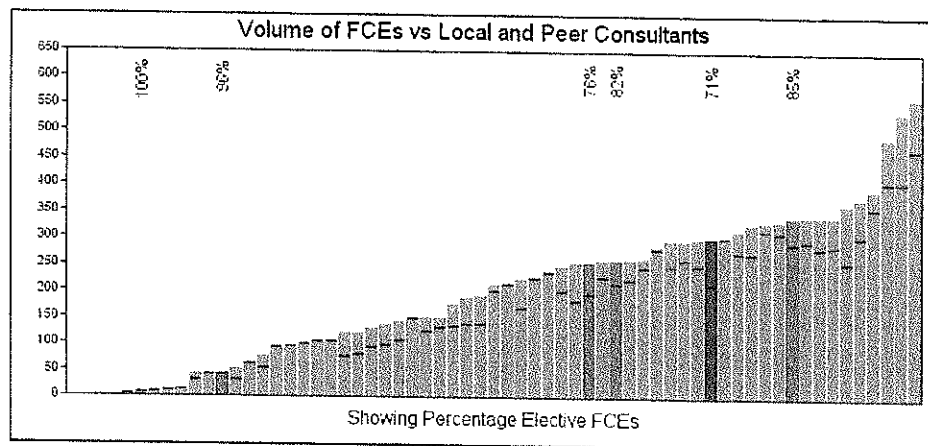
: Mr A O'Brien

Urology

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The Southern Trust
 Personal Information
 redacted by the USI
 : Mr A O'Brien - Urology
 October 2013 to December 2013



Workload Volumes	Consultant	Local	
Total Number of FCEs	302		
Elective FCEs	214	70.9%	82.2% 84.1%
In-Patients	112	52.3%	26.1% 27.2%
Day Cases	102	47.7%	73.9% 72.8%
Emergency FCEs	77	25.5%	15.9% 15.1%
Other FCEs	11	3.6%	1.9% 0.7%
* Regular Attendances			4.7% 1.6%

* Regular Attendances are counted **only** in this report line
 They are expressed as a percentage of Elective FCEs (above) + Regular Attendances
 They are NOT aggregated into any other data line or chart

In-Patient Details	Consultant	Local	
FCEs - Male	213	70.5%	66.0% 70.5%
FCEs - Female	89	29.5	34.0 29.5
FCEs - Child (0-18)	14	4.6%	1.4% 1.8%
FCEs - Adult (19-74)	215	71.2%	78.5% 68.7%
FCEs - Elderly (75+)	73	24.2%	20.1% 29.5%

Outpatient workload	Consultant	Local	
Total Attendances	316		263 561
New Attendances	127	40.2%	47.1% 37.8%
Follow-up Attendances	189	59.8%	52.9% 62.2%
Attendances with Procedure	1	0.3%	2.1% 25.8%

Consultant Total FCEs : 302 13,172 : Peer FCEs

Performance Indicators

		Consultant	Local	Peer
FCE Inpatient ALoS (DC trimmed)		3.7	3.3	2.7
Average Length of Stay (Zero trimmed)		4.4	4.0	3.3
Elective		3.9	2.7	2.8
Non-Elective		5.0	5.2	4.1
Risk Adjusted Length of Stay *		103.9	89.1	66.3
Day Case Rate	102	47.7%	73.9%	72.8%
Day Case Overstays	13	11.3%	7.5%	4.9%
Average Elective Pre-Operative LoS		0.1	0.1	0.3
Elective IP Spells with no Procedure			1.0	1.3
Elective Inpatient spells - procedure not carried out	1	1.6%	1.0%	1.4%
Patient Cause				
Other Reason	1	1.6%	1.0%	1.4%

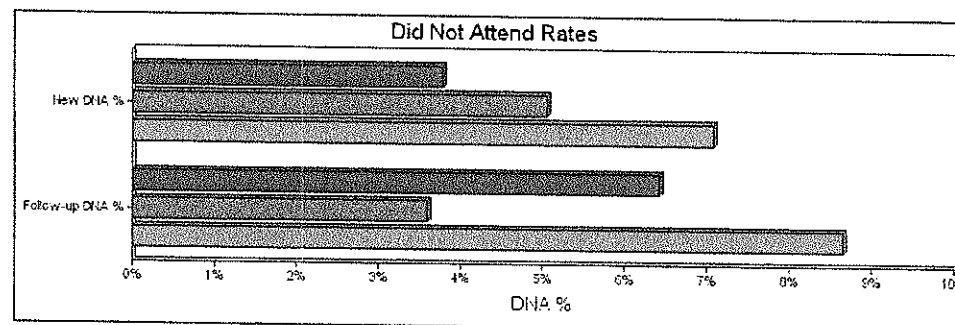
High Volume Procedures

Day Case Procedures	Actual Day Cases						Day Case Overstays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	54	62.2	58.1	85.7%	92.3%	90.7%	2	3.0	2.3	1.5	1.2	1.6
M43 - Endoscopic operations to increase capacity of bladder	14	2.0	6.5	63.6%	72.7%	81.3%	1		1.1	1.0		1.4
M49 - Other operations on bladder	10	5.3	38.3	55.6%	80.0%	97.6%		1.0	1.2		1.0	1.6
M47 - Urethral catheterisation of bladder	4	8.0	14.0	36.4%	84.2%	91.3%	1	1.0	1.3	1.0	3.5	2.6
N30 - Operations on prepuce	2	4.0	7.0	50.0%	75.0%	87.8%			1.3			1.2
M27 - Therapeutic ureteroscopic operations on ureter	2	2.8	1.1	28.6%	22.4%	22.8%		5.7	1.7		1.6	1.0
N15 - Operations on epididymis	2	1.0	1.9	100.0%	100.0%	94.2%			1.0			1.0
N28 - Plastic operations on penis	2		2.0	66.7%		91.7%						
N17 - Excision of vas deferens	1	1.0	4.0	100.0%	100.0%	97.0%						
M79 - Other operations on urethra	1	0.5	2.5	25.0%	33.3%	81.5%	2	1.0	1.2	1.5	4.0	2.3

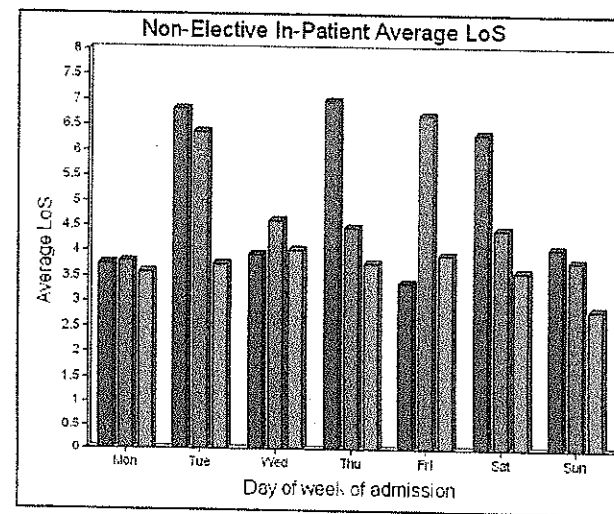
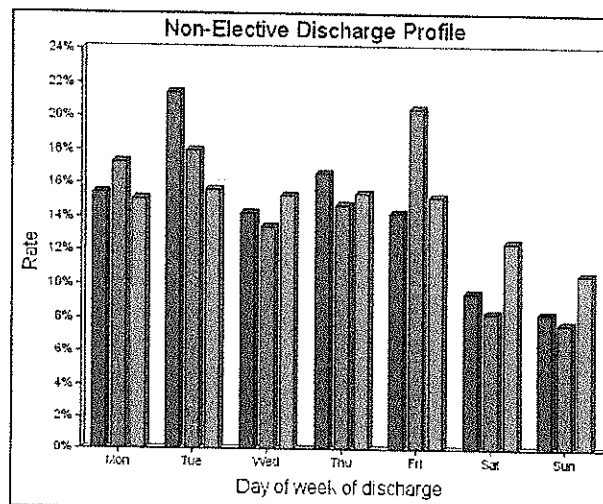
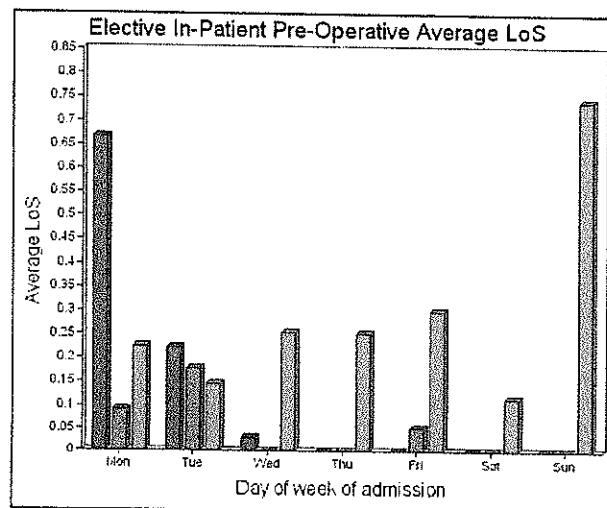
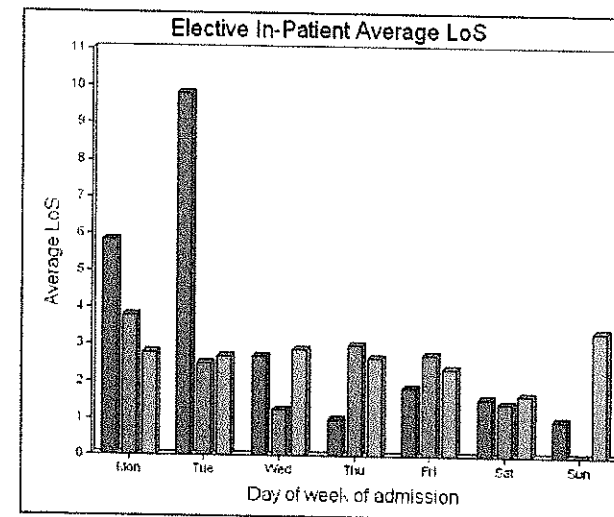
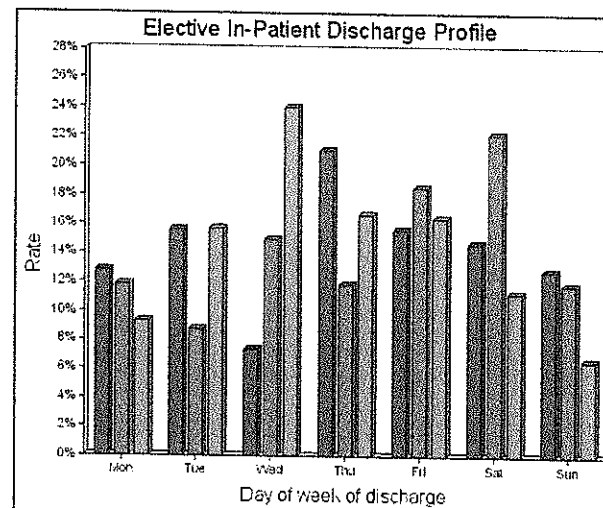
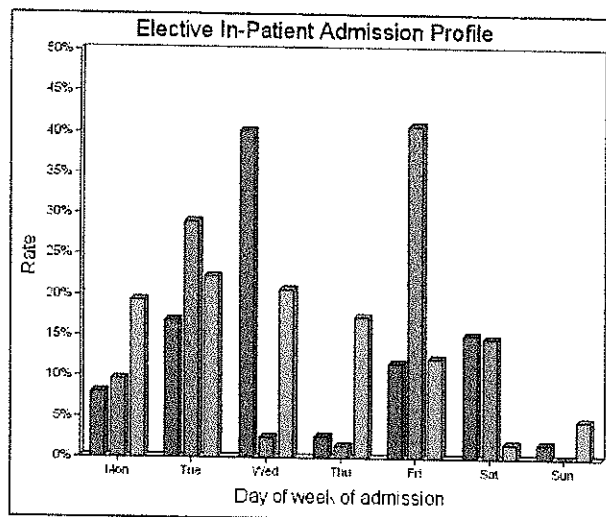
In-Patient Procedures	Number			Pre-Op Average LoS			IP Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M65 - Endoscopic resection of outlet of male bladder	23	3.7	6.8	0.0	0.0	0.2	4.1	2.5	2.6
M27 - Therapeutic ureteroscopic operations on ureter	18	9.8	2.2	0.8	0.4	0.4	8.1	2.4	1.8
M42 - Endoscopic extirpation of lesion of bladder	12	4.8	9.8	0.9	0.6	0.3	7.4	2.9	2.4
U21 - Diagnostic imaging procedures	10	3.3	4.7	1.0	5.8	5.1	2.4	4.3	2.7
M45 - Diagnostic endoscopic examination of bladder	9	5.8	6.1	0.0	0.0	0.8	1.2	2.3	1.1
M49 - Other operations on bladder	8	0.7	1.2	0.0	0.0	0.2	0.0	1.5	1.3
M43 - Endoscopic operations to increase capacity of bladder	8	0.5	0.7	0.0	0.0	0.4	0.6	0.0	1.3
M47 - Urethral catheterisation of bladder	7	1.5	7.1			3.7	0.7	2.1	2.9
M76 - Therapeutic endoscopic operations on urethra	5	0.7	1.6	0.0	0.0	0.3	1.2	1.0	3.9
M30 - Diagnostic endoscopic examination of ureter	4	1.7	0.4		0.0	0.0	2.5	1.3	1.4

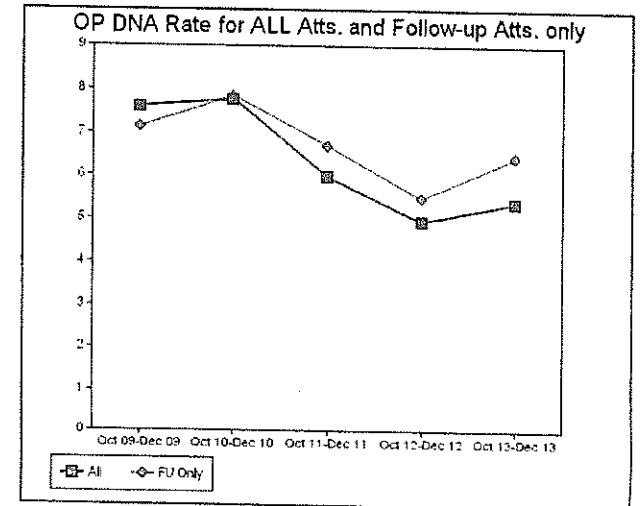
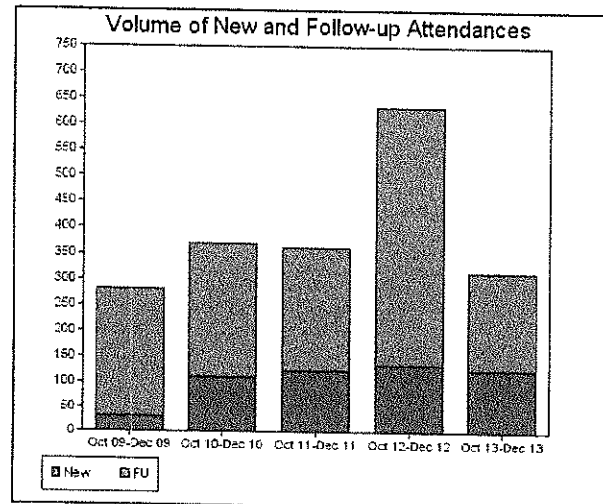
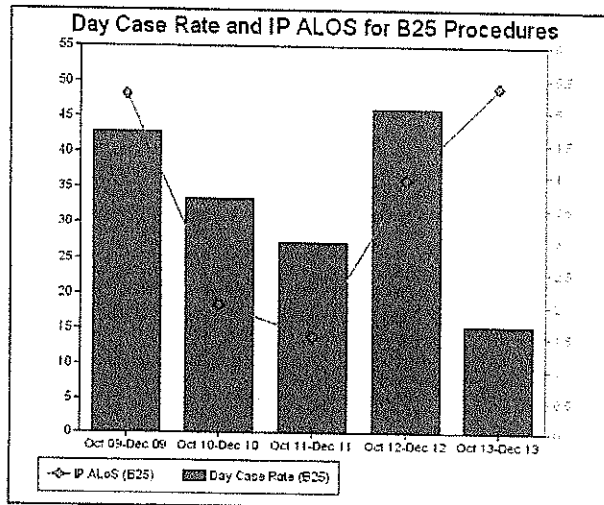
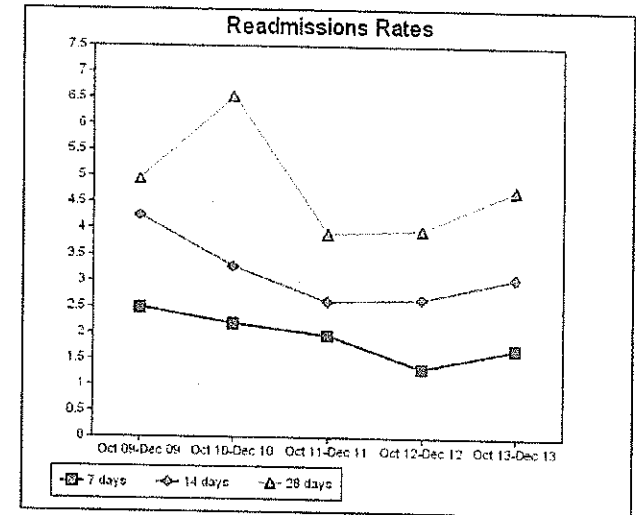
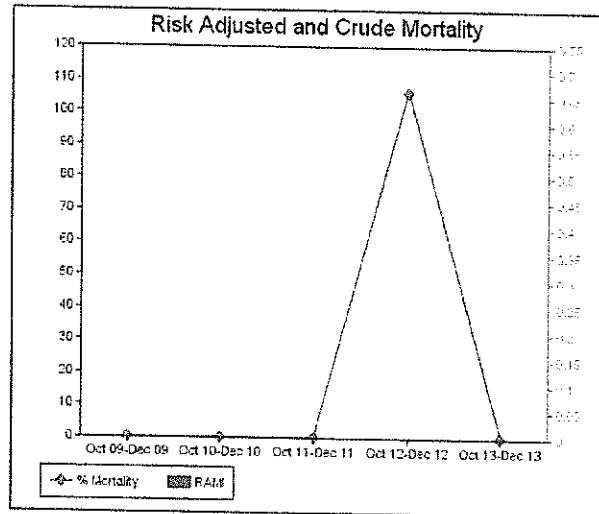
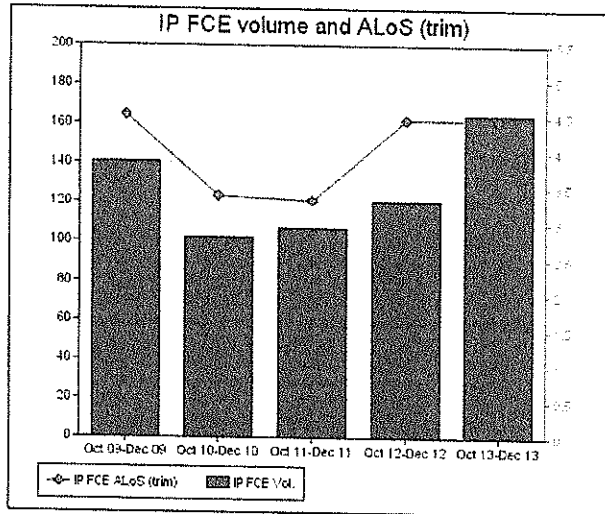
Personal information
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	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	316		263		561	
New Attendances	127	40.2%	124	47.1%	212	37.8%
Referred by General Practitioner	63	49.6%	83	66.7%	146	68.8%
With Procedures Recorded			3	2.3%	51	24.0%
Average Procedure per coded attendance				1.0		1.1
Did Not Attend	5	3.8%	7	5.1%	16	7.1%
Follow-Up Attendances	189	59.8%	139	52.9%	348	62.2%
With Procedures Recorded	1	0.5%	4	2.0%	97	26.9%
Average Procedure per coded attendance		1.0		1.0		1.0
Did Not Attend	13	6.4%	6	3.6%	34	8.7%
New : Follow-Up Ratio	189	1 : 1.5	139	1 : 1.1	348	1 : 1.6



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	1	3	8
M70 - Other operations on outlet of male bladder	0	1	3
X36 - Blood withdrawal	0	0	3
X62 - Assessment			94
M45 - Diagnostic endoscopic examination of bladder			45
U32 - Diagnostic blood tests			10
U26 - Diagnostic testing of genitourinary system			7
U12 - Diagnostic imaging of genitourinary system			1
M83 - Other operations on urinary tract			1
N32 - Other operations on penis			1







Southern Health
and Social Care Trust

Quality Care - for you, with you

Record of Attendance Morbidity and Mortality Meetings 2012

Craigavon Area Hospital

UROLOGY

DR AIDAN O'BRIEN

4 out of 12 = 33% meetings attended

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.

MM Certificate 2013



Southern Health
and Social Care Trust

Quality Care - for you, with you

Record of Attendance

Morbidity and Mortality

Meetings 2013

Craigavon Area Hospital

Surgery & Elective Care

Mr A O'Brien

6 meetings attended

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.



Southern Health
and Social Care Trust

APPLICATION TO ATTEND COURSE/CONFERENCE/VISIT

Copy to MR A O'Brien, Copy to HR, copy filed 12-3-13 @

PART 1 PERSONAL DETAILS

(to be completed by applicant)

T1303/13/14

SURNAME (Dr/Mr/Mrs/Miss/Ms): O'Brien	FORENAMES Aidan
JOB TITLE & GRADE Consultant Urologist	
FULL STAFF NUMBER: Personal information redacted by the USI	DIRECTORATE Surgery and Elective Care
BASE: Craigavon Area Hospital	EMAIL: aidanpobrien Personal information redacted by the USI
CONTACT NUMBERS (including extension): Personal information redacted by the USI	CME PERIOD: 2013 CME CREDITS CURRENTLY HELD: None INCLUDED IN PDP YES ☐ ☐
3 YEAR STUDY LEAVE PERIOD 1 APRIL 2010 TO 31 MARCH 2013 STUDY LEAVE DAYS TAKEN TO DATE	TOTAL EXPENSES REIMBURSED TO YOU BY THE TRUSYT DURING THE ABOVE PERIOD None

PART 2 DETAILS COURSE/CONFERENCE/VISIT

(to be completed by applicant)

TITLE/DESCRIPTION Annual Meeting of European Association of Urology			
VENUE/LOCATION OF EVENT Milan, Italy			
NAME OF ORGANISING BODY European Association of Urology			
CME CREDITS AVAILABLE FROM COURSE		NUMBER OF DAYS LEAVE REQUIRED 2	
INCLUSIVE DATES ON WHICH LEAVE IS REQUIRED FROM:		TO:	
DATE: : 15 March 2013 09.00 AM/PM	TIME	DATE: 19 March 2013 AM/PM	TIME 18.00
Please state why you wish to attend this course and how it will help deliver your Personal Development Plan as agreed at your most recent appraisal:			
I wish to attend as the Annual Meeting of the European Association of Urology is the premier urological conference in Europe each year. It is the opportunity to keep abreast of latest developments and thinking in Urology, and the vehicle to ensure that one is aware of current guidelines across urological practice.			

IS A GRANT TOWARDS EXPENSES PAYABLE BY AN OUTSIDE ORGANISATION?		YES ☐ NO ☐
IF YES, AMOUNT GRANTED/ PLEASE ADD TOTAL ESTIMATED COST		£
NAME OF SPONSOR, ENDOWMENT & GIFTS FUND OR OTHER FUND (ATTACH EVIDENCE) Invited to Conference by Takeda UK Limited		

PART 3 ESTIMATE OF EXPENSES TO BE INCURRED (to be completed by applicant)	
Please note: No Single application for study leave funding should exceed £1200	

11-3-13
 HK O'Brien has requested
 course people to find
 out course fees.

COURSE/CONFERENCE FEES:	None	Irrelevant information redacted by USI
FLIGHTS:	None	Irrelevant information redacted by USI
RAIL:	None	
MILEAGE:	None	
OTHER TRAVEL COSTS:	None	
SUBSISTENCE:	None	Irrelevant information redacted by USI
OTHER EXPENSES:	None	
TOTAL:	None	

NB: it is the responsibility of the applicant to make all necessary bookings concerning the application and should only be booked once the application is approved by the Director/Chief Executive/Associate

DATE:

12.02.13

PART 4 LINE MANAGER APPROVAL (for Medical Staff – Clinical Director)

DO YOU SUPPORT THE ABOVE APPLICATION?	YES ☒ NO ☐
IF NO, Please advise the applicant of your decision. [e.g failure to give adequate advance notice]	
IF YES, Please confirm that satisfactory arrangements are in place for the doctor's duties to be carried out in his/her absence and that overtime/locum	YES ☐

cover or WLI work is not required to cover for the absence.

NO ☐

REMARKS:

SIGNATURE & DATE

DESIGNATION

PART 5 BUDGET HOLDER APPROVAL (For Medical Staff – Associate Medical Director)

(to be completed by the Budget Holder - CEO/Director/AD/)

DO YOU CONFIRM YOUR APPROVAL OF THE ABOVE APPLICATION?

YES ☒
NO ☐

IF NO, Please advise the applicant of your decision.

APPROVAL REFERENCE NUMBER

(ie Directorate/Initials Director/Assistant Director/Financial Year/Unique Number) e.g.HROD/KD/0910/0001

TB03/13/14

Personal Information redacted by the USI

11/3/13

DESIGNATION

ADMD

PART 6 OPERATIONAL DIRECTOR APPROVAL (For Overseas Courses Only)

DO YOU CONFIRM YOUR APPROVAL OF THE ABOVE APPLICATION?

YES ☐
NO ☐

IF NO, Please advise the applicant of your decision.

APPROVAL REFERENCE NUMBER

TB03/13/14

Personal Information redacted by the USI

12 3 13

DESIGNATION

Director

NOTE:

When the Course form has been approved, you will then receive a Copy from the Medical Executive Administrators with an approval reference Number. And also an Expenses claim form.

To receive fees and travel expenses for this course you must complete the Course expenses claim form and attach the copy of the approved course form with reference number and all receipts for expenses occurred on this trip and return to your Medical Executive Administrator at the relevant office to be processed.

Craigavon Area
Hospital

Karen Haugh

Personal Information redacted by the USI

Daisy Hill
Hospital

Roisin Feely

Personal Information redacted by the USI

Bluestone
Unit/ St Luke's

Caroline Burton

Personal Information redacted by the USI

CONSULTANTS NAME: MR A O'BRIENDEPARTMENT: UROLOGY

DATE STARTED WITH CAH:

Date of Course/Conf.	Course/Conference Attending (brief details)	Est Cost	Total Claimed	CME points	No of Days
	<u>APRIL 2001 – MARCH 2002</u>				
17-22/03/11	Annual Conference of European Association Of Urology VIENNA- full expenses by Sponsor TAKED PHARMA LTD	Nil	Nil	?	3
28/03/11 to 04/04/11	UROCON 2011- KARDCHI, Pakistan Association of Urology Surgeons Was given an invitation to speak at annual conference	Nil	Nil	?	6
23-28/02/12	Annual Meeting of European Association of Urology PARIS- Sponsor TAKEDA UK Ltd	Nil	Nil	?	4
15-19/03/13	Annual meeting European association Urology MILAN Full Sponsorship	irrelevant information re	nil		2
16-3-13 Dr Rankin Can you please sign Mr O'Brien Course leave form (6) if approved Kind Regards					
Personal Information redacted by the USI					



**Southern Health
and Social Care Trust**

Research Office

Mr Aiden O'Brien
Consultant Urologist
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

24 June 2011

Our Ref: ST1011/07/IK/VH **Your Ref:**

Dear Mr O'Brien

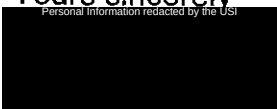
Re: ST1011 / 07 – A Randomised, Double-blind, Placebo-controlled study of RAD001 in the Treatment of Angiomyolipoma in Patients with either Tuberous Sclerosis Complex (TSC) or Sporadic Lymphangi leiomyomatosis

Following review today by the Chair of the Research Governance Committee I wish to confirm acknowledgment of the Substantial Amendment given favourable approval by Southampton & South West Hampshire Research Ethics Committee in their letter dated 30 March 2011 based on the following support documentation:

Document	Version	Date
Investigator Brochure	9	14 December 2010
Notification of Substantial Amendment Form	PF2011/107	07 March 2011
Participant Information Sheet: Representative	3	04 March 2011
Participant Information Sheet: Competent Adult	3	04 March 2011
Participant Information Sheet: Level 1	3	04 March 2011
Participant Information Sheet: Level 2	3	04 March 2011
GP / Consultant Information Sheets	4	04 March 2011
Covering Letter		07 March 2011

Yours sincerely

Personal information redacted by the USI



**Miss I Knox
Research Manager**

Copy to:

Dr John. C. Kingswood
Consultant Physician
Brighton and Sussex University Hospitals
Trust
Royal Sussex County Hospital
Brighton BN2 5BE

Karen L McAlister
Senior Clinical Research Associate
PAREXEL International Ltd
The Quays, 101-105 Oxford Road
Uxbridge, Middlesex
UB8 1LZ

Research & Development Office Ramone Building Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ

Tel: Personal information redacted by the USI

Email: Personal information redacted by the USI

Dr Charles Shepherd
Consultant Paediatrician
Ramone Building
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

Valerie Alcorn
Clinical Trials Pharmacist
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients

Attribute: 2.2 Respond to risks to safety

Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
1	Record of Attendance at Mortality and Morbidity Meetings in 2012	2012
2	Record of Attendance at Mortality and Morbidity Meetings in 2013	2013
3	Antibiotic Ward Round Summaries	2013
4	Record of Attendance at Urology Multidisciplinary Meetings	2012 and 2013
5	Certificates of Membership of Medical Protection Society	2012 and 2013
6	Mandatory Training Passport	2013
7	Guidelines for Nurse Led Assessment and Follow up of Patients with Prostate Cancer	2013
8	Prostate Cancer: diagnosis and treatment: NICE Clinical Guidelines	January 2014
9	Certification of Registration with General Practitioner	
10	Inoculation History	
11.	Record of Complaints and Incidents	Oct'11 – Sept'12
12	Record of Complaints and Incidents	Oct'12 – Sept'13
13	Complaint Report Structured Reflective Template	20 April 2014
14	Significant Event / Incident Structured Reflective Template	20 April 2014
15	Certificate of Completion of Good Clinical Practice Awareness Seminar	18 August 2010

Discussion

I always make every effort to deliver a safe level of care, and of the highest quality, to my patients. I believe that the factor which most threatens that level of quality and safety is the disjoint between demand and capacity. I have found that disparity to be an ongoing challenge. Nevertheless, it remains ever important to make every effort to ensure that review and criticism by self, colleagues and peers is not excused by overwhelming demand (as outlined in GMC's Good Medical Practice). Participation in Mortality and Morbidity Meetings, Grand Rounds and Multidisciplinary Meetings go a significant way to ensuring that is so. Independently conducted reviews can assist in improving performance, as demonstrated by the Antibiotic Ward Round Summaries (enclosed) confirming improved compliance.

In March 2012, it was agreed by my multidisciplinary colleagues that I would assume the Chair of the Urology Multidisciplinary Team for the Southern Trust. It has been a heavy responsibility since, but one which has been very rewarding. Diagnosis, investigation, staging and management of patients with urological cancers can be complex and challenging. Preparation for Multidisciplinary Meetings is consuming for several specialists involved, particularly pathologists, radiologists and oncologists. I have made every effort to preview each case in a scrupulous manner and to chair meetings with the singular intent of optimizing diagnosis and prognosis. I did so in 1,530 cases from April 2012 to March 2013. Since April 2013, we have continued to discuss 35 cases each week, and so the numbers will be similar. I do hope that I have made a contribution to patient care. I have certainly learned to improve the care to my patients by doing so.

I was appointed by the Department of Health to the post of Lead Clinician and Chair of the Northern Ireland Cancer Network Site Specific Group in Urology from 01 January 2013. During 2013, I chaired Regional Meetings with the sole purpose of achieving multidisciplinary consensus for new pathways of following up patients with prostate cancer, and so that increased review would be conducted by Clinical Nurse Specialists, and which would remain compliant with EAU and NICE guidelines. As Lead Clinician, I also had the opportunity to be consulted and have input into the final NICE guidelines in Prostate Cancer Diagnosis and Treatment published in January 2014 (enclosed). By the end of 2013, we had agreed on 6 pathways which will be implemented throughout Northern Ireland during 2014 (document and pathways enclosed).

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**Actions Agreed**

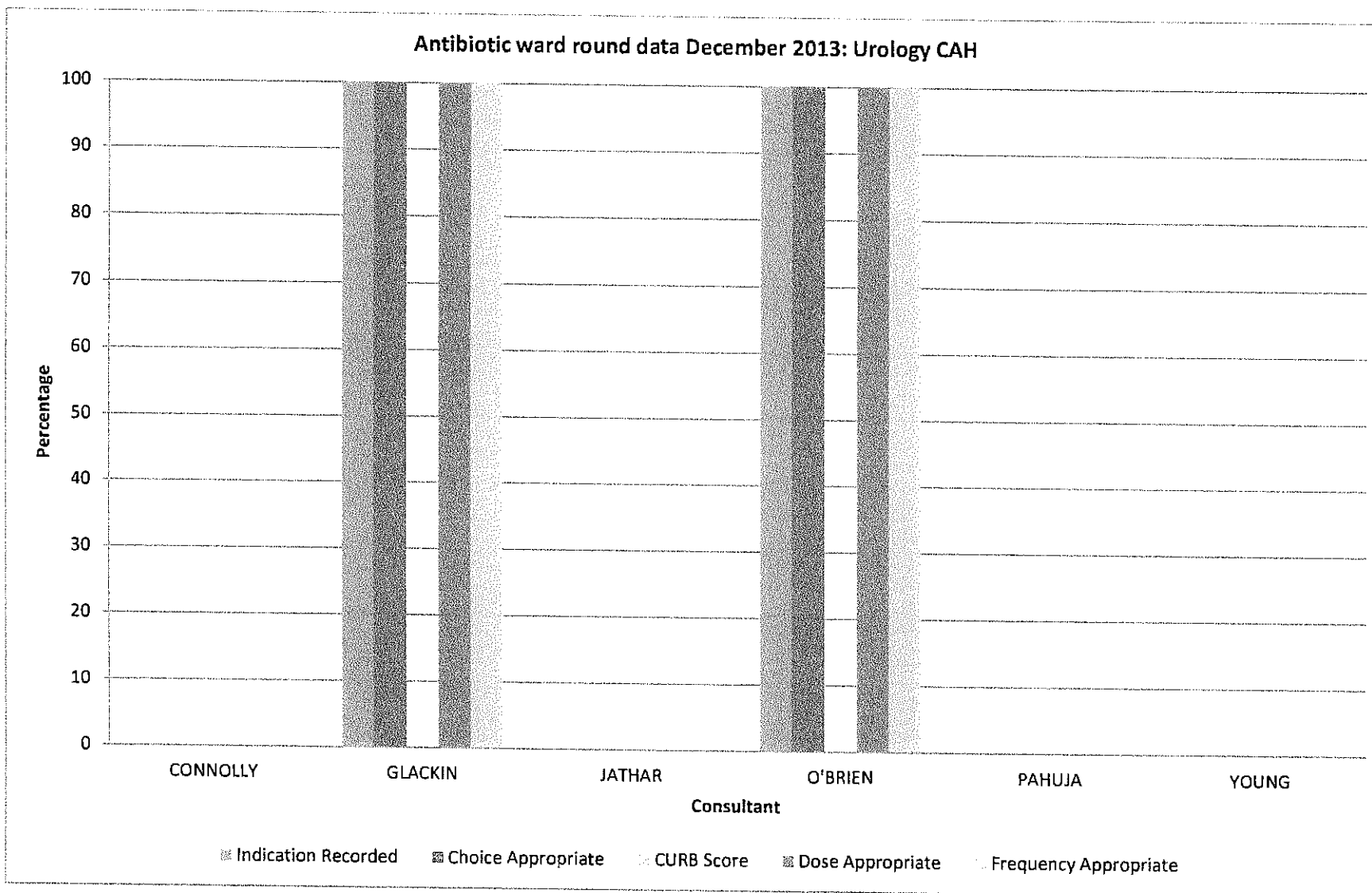
- Attendance at M&M has been a problem for all urologists in Northern Ireland due to attendance at Regional Audit at the same time. Arrangements have been agreed and established to have attendance at Regional Audit recorded in lieu of attendance at M&M
- Attendance at M&M by Mr. O'Brien has additionally been compromised by annual leave usually taken during third week of the calendar month to minimise impact on clinical service provision.
- Attendance at MDM has been well recorded. Non-attendance compliant with NICaN meetings and annual leave.
- Additional time will be required for ongoing work as Lead Clinician and Chair of NICaN Urology, particularly in period to June 2015 when Urological Oncology Services in Northern Ireland are subjected to Peer Review

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

- Connolly: No patients.
- Glackin: 1 patient. CURB score n/a.
 - Indication not recorded and compliance not assessable in 1pt:
 - 1pt on IV co-amoxiclav 1.2g TID, no documentation of antibiotics in notes, no documented evidence of infection.
- Jathar: 1 patient. CURB score n/a.
- O'Brien: 3 patients. CURB score n/a.
 - Indication not recorded and compliance not assessable in 1pt:
 - 1pt on IV tazocin 4.5g TID, no documentation of antibiotics in notes, no documented evidence of infection.
 - Frequency non-compliant in 1 pt:
 - 1pt on IV tazocin 4.5g BD (eGFR 30), TID dosing recommended unless eGFR<20.
- Pahuja: 1 patients. CURB score n/a.
- Young: 3 patients. CURB score n/a.
 - Indication not recorded and compliance not assessable in 1pt:
 - 1pt on IV gentamicin 240mg OD + PO co-amoxiclav 625mg TID, no documentation of antibiotics in notes, no documented evidence of infection.



SUMMARY: Ward rounds conducted on 10th December.
5/19 patients on antibiotics.

- Connolly: No patients.
- Glackin: 1 patient. CURB score n/a.
- Jathar: No patients.
- O'Brien: 4 patients. CURB score n/a.
- Pahuja: No patients.
- Young: No patients.

Mr O'Brien MDM Attendances 2012 & 2013

2012 MDM Date	Attended?	2013 MDM Date	Attended?
05/01/2012	Yes	03/01/2013	Yes
12/01/2012	No	10/01/2013	Yes
19/01/2012	No	17/01/2013	Yes
26/01/2012	No	24/01/2013	Yes
02/02/2012	Yes	31/01/2013	Yes
09/02/2012	No	07/02/2013	Yes
16/02/2012	Yes	14/02/2013	Yes
23/02/2012	No	28/02/2013	Yes
01/03/2012	Yes	07/03/2013	Yes
08/03/2012	Yes	14/03/2013	Yes
15/03/2012	Yes	21/03/2013	Yes
22/03/2012	No	28/03/2013	Yes
29/03/2012	Yes	04/04/2013	Yes
12/04/2012	No	11/04/2013	Yes
26/04/2012	Yes	18/04/2013	No
03/05/2012	Yes	25/04/2013	No
10/05/2012	Yes	02/05/2013	Yes
17/05/2012	Yes	16/05/2013	Yes
24/05/2012	No	23/05/2013	Yes
31/05/2012	Yes	30/05/2013	Yes
07/06/2012	No	06/06/2013	Yes
14/06/2012	Yes	13/06/2013	Yes
21/06/2012	Yes	20/06/2013	No
28/06/2012	Yes	27/06/2013	Yes
05/07/2012	No	04/07/2013	Yes
19/07/2012	Yes	11/07/2013	Yes
26/07/2012	Yes	18/07/2013	Yes
02/08/2012	No	25/07/2013	Yes
09/08/2012	Yes	01/08/2013	No
16/08/2012	Yes	08/08/2013	No
23/08/2012	Yes	15/08/2013	No
30/08/2012	Yes	22/08/2013	No
06/09/2012	Yes	05/09/2013	Yes
13/09/2012	Yes	12/09/2013	Yes
27/09/2012	Yes	19/09/2013	Yes
04/10/2012	No	26/09/2013	No
11/10/2012	Yes	03/10/2013	No
18/10/2012	No	10/10/2013	Yes
25/10/2012	Yes	17/10/2013	Yes
01/11/2012	Yes	24/10/2013	Yes
08/11/2012	Yes	31/10/2013	Yes
15/11/2012	Yes	07/11/2013	Yes
22/11/2012	Yes	14/11/2013	Yes
29/11/2012	Yes	21/11/2013	No

06/12/2012	Yes	28/11/2013	No
13/12/2012	Yes	05/12/2013	Yes
20/12/2012	No	12/12/2013	Yes
		19/12/2013	Yes

Your certificate of MPS membership

PROFESSIONAL SUPPORT AND EXPERT ADVICE

MPS



Mr A O'Brien

Personal information redacted by the USI

Name: Mr Aidan O'Brien

Membership number:

Personal information redacted by the USI

Period of membership: 01/09/11-31/08/12

Subscription:

Personal information redacted by the USI

Country of practice: United Kingdom

Region:

Grade: CA2

Grade description: Consultant/private specialist - group 2

Additional information: Your rate is determined according to your specialty and the amount you earn from specialist unindemnified practice (gross income less legitimate practice expenses)

Your MPS membership

MEDICAL PROTECTION SOCIETY

Granary Wharf House, Leeds LS11 5PY, UK
 Membership helpline (UK) 0845 718 7187
 Membership helpline (IR) 1800 509 441
 International code +44 (0)113 243 6436
 Facsimile +44 (0) 113 241 0500

www.mps.org.uk
www.medicalprotection.org
member.help@mps.org.uk

Professional support and expert advice

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world. We are a mutual, not-for-profit organisation offering more than 270,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm. MPS is **not** an insurance company. The benefits of membership are discretionary – this allows us the flexibility to provide help and support even in unusual circumstances.

You are eligible to apply for the benefits of membership subject to the Memorandum and Articles of MPS and upon payment of the appropriate subscription.

If you are practising in the United Kingdom

Any questions you may have about your membership should be addressed to: Head of Membership Services, Medical Protection Society, Granary Wharf House, Leeds LS11 5PY. You can telephone the membership helpline on 0845 718 7187.

For assistance with medicolegal matters, please write to the Medical Director at whichever of the following addresses is nearer you: Medical Protection Society, 33 Cavendish Square, London W1G 0PS. Facsimile 020 7399 1301. Medical Protection Society, Granary Wharf House, Leeds LS11 5PY. Facsimile 0113 241 0500. Alternatively, you can telephone 0845 605 4000. Calls to both 0845 numbers are charged at lo-call rates irrespective of where in the UK you call from.

If you are practising in Ireland

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Data Protection information

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By renewing your MPS membership you consent to the processing of personal data, including sensitive personal data, for the purposes outlined above.

You have the right under the Data Protection Act to obtain disclosure of personal data that we have relating to you, for which we make a nominal charge.

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MEDICAL PROTECTIVE SOCIETY
PROFESSIONAL RESPECT AND EFFICIENT ADVICE

Certificate of MPS membership

MPS**Putting members first**

Mr A. O'Brien

Personal information redacted by the USI

Name:

Mr Aidan O'Brien

Membership number:

Personal information redacted by the USI

Period of membership:

01/09/12-31/08/13

Subscription:

Personal information redacted by the USI

Country of practice:

United Kingdom

Region:**Grade:**

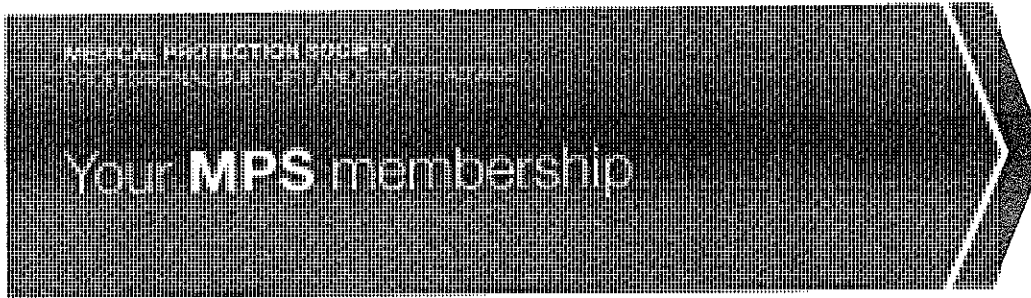
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Your rate is determined according to your specialty and the amount you earn from specialist unindemnified practice (gross income less legitimate practice expenses)



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Calls to Membership Services may be recorded for monitoring and training purposes.

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Mandatory Training Passport

Competencies

[illegible]

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099
1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	

FIND OUT

CORE MODULES

ADDITIONAL MODULES

Module	Date	Date Renewal	Module	Date	Date Renewal	Module	Date	Module	Date
FIRE	08/10/2013	08/10/2014	FRAUD AWARENESS			NEWS		PRESCRIBING	
INFECTION CONTROL	08/10/2013	08/10/2015	MAPA			OEWs		CLINICAL TRIALS	
SAFEGUARDING	29/04/2014	28/04/2017	EQUALITY	13/03/2014	12/03/2017	PEWS		VTE	
INFORMATION GOVERNANCE	17/04/2014	16/04/2017	RECRUITMENT SELECTION			CONSENT	06/07/2010	SAFE SEDATION	
H&S COSHH	08/10/2013	07/10/2016	SICKNESS ABSENTEEISM			BLOOD CULTURE		GASTRO ENDOSCOPY	
BACKCARE	13/03/2014	12/03/2017	HYPONATRAEMIA			PERIPHERAL LINE		CHEST DRAIN	
RPRB DESIST?			ENTER CPR COURSE NAME, COMPLETED DATE AND RENEWAL DATE BELOW			USE OF ANTICOAGs		BLOOD GAS	
RPRB THEORY	16/04/2014	16/10/2015				NG TUBE		APPRAISER	
RPRB COMPETENCY	16/04/2014	15/04/2017	Complaints / Incidents	08/10/2013		ACTIONS FOLLOWING DEATH PM CONSENT		APPRAISEE NEGLIGENCE	23/01/2014

Appendix 1 Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (18 month refresher required)	Learn Blood Transfusion Module	Core Module	
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff	Core Module	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face – Trust Mandatory Training Day	Core Module	
2 Yearly Updates	Method	Core / Optional	Date Completed
Infection Prevention and Control	Face to Face – Trust Mandatory Training Day	Core Module	
Resuscitation	Face to Face		
Safeguarding Children & Vulnerable Adults	Face to Face – Trust Mandatory Training Day	Core Module	
3 Yearly Updates	Method	Core / Optional	Date Completed
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module	Core Module	
Moving and Handling	SHSCT E-Learning Module	Core Module	
Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module	Core Module	
Discovering Diversity	HSC E-Learning Module		
Recruitment & Selection	HSC E-Learning Module		
Hyponatraemia	BMJ E-Learning Module		
Management of Actual or Potential Aggression	Face to Face		
Fraud Awareness	HSC E-Learning Module		
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module		
Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning		
Obstetrics Early Warning System	OEWS e-learning		
Paediatrics Early Warning System	PEWS e-learning		
Consent	In House E-Learning module		
Blood Culture	In House E-Learning module		
Peripheral Line	In House E-Learning module		
Anticoag (Starting and Maintaining)	BMJ E-Learning Module		
Naso Gastric Tube Placement	Merck & In House E-Learning module		
Protocol following death of patient	In House E-Learning module		
Guide to Prescribing in SHSCT	In House E-Learning module		

Patients enrolled in Clinical Trials	In House E-Learning module		
VTE	E-learning for Health		
Safe Sedation [Module 1,2 & 3]	In House E-Learning module		
Gastrointestinal endoscopy	Face to face		
Chest Drain Insertion	Face to face		
Blood Gas Instrument	Face to face		
Appraiser Training	Face to face		
Appraisee Training	Face to face		
Fraud Awareness	HSC Module		
Modules proposed for E-Learning	Method	Core / Optional	Date Completed
Better Communication/Complaint Handling	Face to face		
Incident Reporting	Face to face		
Clinical Negligence	Not currently available		
Infection Prevention and Control	Face to face		
Waste Management	Not currently available		

Links to the various e-learning modules and information regarding face-to-face training can be found [here](#). Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@southerntrust.hscni.net

TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

APPRAISEE

Signature of Appraisee: _____ Date: _____

APPRAISER

Signature of Appraiser: _____ Date: _____

PRINT NAME OF APPRAISER: _____

Name:

GMC Number:

Appraisal Period :

Page 2

Manual Handling Awareness Exam

To be added to the Moving and Handling Awareness Section

Participant: O'BRIEN AIDAN

Personal Information
redacted by the USI

Date: 13-Mar-2014

Section 1: MH Awareness

1. When we bend forwards, the bodies of the vertebrae are moved closer together at the front, squeezing the:

Please select one of the answers below.

- ☒ Disc
- ☐ Nerve
- ☐ Ligament
- ☐ Facet joint

Points: 1

2. It is the employee's responsibility to:

Which one of the answers below is **false**?

- ☒ Avoid all moving and handling tasks
- ☐ Adhere to moving and handling policies and procedures
- ☐ Take care of their own safety
- ☐ Identify and report risk

Points: 1

3. The Process of looking at the 'potential dangers' of moving and handling is called:

Please select one of the answers below.

- ☐ Incident Reporting
- ☐ TULIP
- ☒ Risk Assessment
- ☐ Risk Averse

Points: 1

4. When lifting an object from the floor the level of risk can be reduced by:

Which one of the answers below is **false**?

- ☐ Keeping your spine in line
- ☐ Keeping the load close
- ☐ Bending from your knees fully
- ☒ Dividing the load into smaller lifts

Points: 0

5. Which of the following statements is true?

Please select one of the answers below.

- ☐ Our everyday tasks do not put us at risk from moving and handling
- ☒ All of us are at risk from moving and handling
- ☐ Only those people who lift heavy objects are at risk from moving and handling
- ☐ Only those people who lift patients are at risk from moving and handling

Points: 1

6. A load is:

Please select one of the answers below.

- ☐ Something heavy
- ☐ A weight
- ☒ Any object, person or animal that must be moved
- ☐ A large object

Points: 1

7. MHOR (NI) 1992 require employers to apply the following 'framework' to moving and handling tasks;

Please select one of the answers below.

- ☐ Task, Individual, Load, Environment and Obvious
- ☐ Avoid or take care
- ☒ Avoid, assess, reduce, review
- ☐ Task, Individual, Load, Equal and Other

Points: 1

8. The Spine is usually:

Please select one of the answers below.

- ☐ 'r' shaped
- ☐ 'l' shaped
- ☐ 'c' shaped
- ☒ 's' shaped

Points: 1

9. In order to increase our stability when standing we could:

Please select one of the answers below.

- ☐ Raise our arms
- ☐ Move our feet closer together
- ☐ Bend forwards slightly
- ☒ Place our feet apart, with one foot in front of the other

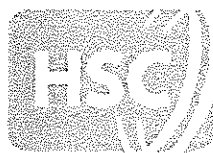
Points: 1

10. Which of these answers is false: The discs between the vertebrae...?

Please select one of the answers below.

- ☐ Have a gel-like centre
- ☐ Act as a shock absorber
- ☒ Protect the spinal cord
- ☐ Act as a spacer

Points: 1



**Discovering
Diversity**
Health & Social Care in Northern Ireland



Certificate of Completion

This is to certify that on 12 March 2014

Aidan O'Brien

From

Southern Health and Social Care Trust

Completed the

**Discovering Diversity
programme**





Certificate of Achievement

Name:	Aidan O'Brien	Division / Trust:	Southern HSC Trust
Health Service:	NHS Northern Ireland	Hospital:	Craigavon Area Hospital
Registration Date:	14/04/2014 19:44:04	Ward:	3 South Surgical
Job Family:	Medical Staff	Sub Family:	Doctor
Role:	Consultant	Date Generated:	14/04/2014 23:43:10

Successfully Completed Assessments:

Consent for Transfusion

All Assessments Completed. This course will elapse on 14/04/16 and will expire on 14/04/17.

Consent for Transfusion - Passed on 14/04/14 at 19:51

Module 1 Safe Transfusion Practice

All Assessments Completed. This course will elapse on 14/10/15 and will expire on 14/04/16.

Haemovigilance in the UK and ROI - Passed on 14/04/14 at 22:15

Blood Group Serology - Passed on 14/04/14 at 22:27

Requesting Procedure - Passed on 14/04/14 at 22:37

Sampling Procedures - Passed on 14/04/14 at 22:50

Collection Procedure - Passed on 14/04/14 at 22:58

Administration Procedure - Passed on 14/04/14 at 23:17

Management of Transfused Patient - Passed on 14/04/14 at 23:33

Version 4. Reviewed by SHSCT Transfusion Team. July 2013

**Framework Proforma
COMPETENCY FOUR**

Preparing and Administering a Transfusion of a Blood Component

Name of candidate: MR Aidan O'Brien		Name of assessor: John WDA	
Job title: Consultant		Job title: Area Haemaphysal Practice	
Grade/Band		Contact details: CAH	
Contact details: CAH Woburn		Assessment carried out in clinical area Y/N	
Date of assessment: 16/04/2014		Assessment carried out during simulation of process (Y)	
Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy: Yes / No ☒ Yes ☐ No AND Attended 'face to face' Blood Administration education session: Yes / No ☒ Yes ☐ No Date: OR Medical Staff Completed Module 1 of e-learning program: (LearnProNHS) Safe Transfusion Practice Yes / No ☒ Yes ☐ No Date: Nursing/Midwifery Staff Completed SHSCT Safe Blood Administration (RPRB) e-learning Module Yes / No ☒ Yes ☐ No Date: E- Learning certificate available? Yes / No ☒ Yes ☐ No 14/4/14			

Core Questions Competency 4

The candidate must successfully answer the following questions: -

1. Why is it necessary to use open-ended questions when identifying patients?

Version 4. Reviewed by SHSCT Transfusion Team. July 2013

2. What is the timescale for commencing administration of a unit of red cells after it has been collected from the blood fridge? ☒
3. What would you do if a patient is unconscious or unable to give verbal identification? ☒
4. What are the risks associated with only checking the blood traceability record against the blood component and omitting to check the patient's wristband? ☒
5. Why is it important that the patient's vital signs are monitored at particular stages during the transfusion process? ☒
6. What is the maximum timescale for administering a unit of red cells? ☒

Version 4. Reviewed by SHSCT Transfusion Team. July 2013

Verbal Knowledge Assessment Competency 4

The following questions need to be completed if the candidate has not completed the relevant e-learning programme. (Passmark 80%)

(See page 1)

1. Group O blood can be used to transfuse a patient in a life-threatening situation when the blood group is unknown T / F
2. Red blood cells should only be stored in an authorised blood fridge T / F
3. It is safe to store platelets in a blood fridge until they are transfused. T / F
4. If there are any discrepancies when checking a blood component, the Hospital Transfusion Laboratory should be contacted prior to commencing the transfusion. T / F
5. The identification check prior to administration must always be at the patient's bedside. T / F
6. If you are interrupted during the final patient identity check you must start the checking procedure again. T / F
7. A patient who attends for regular blood transfusions and is able to state their name and date of birth is not required to wear a wristband during the transfusion episode T / F
8. The patient's temperature, blood pressure, respirations and pulse should be recorded 15 minutes after the commencement of the transfusion T / F
9. It is necessary to advise the patient of any potential adverse effects of transfusion T / F
10. If you suspect a transfusion reaction your first action should be to stop the transfusion. T / F

Version 4. Reviewed by SHSCT Transfusion Team. July 2013

Core competency Observational assessment	Was the task observed?		Notes for assessors	
1. Did the candidate carry out the following pre-transfusion checks: Personal: clean hands, wear personal protective equipment and adhere to infection control guidelines at all times? Equipment: check that all equipment is clean and available (i.e. Integrated blood prescription record, giving set, drip stand, disposable bags) Patient: carry out a baseline assessment of the patient; check venous access has been obtained prior to blood being collected from the fridge; check details of the prescription; check prescription for special requirements; and check that the patient understands they are going to receive a transfusion? Blood component: check bag for signs of damage, leaks, discolouration or clumping, check the expiry date, and any special transfusion requirements? Vital signs: check & record baseline - Blood pressure? - Temperature? - Pulse? - Respirations?	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
2 Patient identification for the <u>conscious patient</u> Did the candidate ask the patient to state their: - Full name? - Date of birth? Did the candidate check: - The details on the wristband? - The information on the blood component with the patient and wristband details?	☒ Yes	No	Ask either question 2 or 3. (whichever is relevant)	N/A
	☒ Yes	No		N/A
	☒ Yes	No		N/A
	☒ Yes	No		N/A

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3. Patient identification for <u>unconscious patients or patients unable to verbally respond</u>. Did the candidate check: - The details on the wristband? <i>At least their:</i> - Full name? - Date of birth? - Health and Care number / Hospital number? - The information on the blood component against the patient and wristband details?	Yes Yes Yes Yes	No No No No	N/A N/A N/A N/A
4. Did the candidate check that the details on the patient's wristband comply with the patient identification details on: - The prescription chart? - The blood bag compatibility label? - The traceability record?	Yes Yes Yes	No No No	

Core competency	Was the task observed?	Notes for assessors
5. Did the candidate check the unit of blood for: The ABO group & Rhesus status of: - Donor blood unit? - Blood compatibility label? - Traceability record? The donation number of the: - Donor blood unit? - Blood compatibility label? - Traceability record? - Special requirements (if appropriate)	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No
6. Did the candidate use the appropriate administration set to transfuse the blood component?	Yes	No
7. Did the candidate record the patient's vital signs at a minimum of 15 minutes after commencement and at the end of the unit?	Yes	No
7(a) Did the candidate record the following on all occasions - Blood pressure? - Temperature? - Pulse rate? - Respirations?	Yes Yes Yes Yes	No No No No
8. Administering the blood transfusion Did the candidate ensure that the blood transfusion was completed within: 4 hours of removal from cold chain storage (red cells) 30 minutes for platelets?	Yes Yes	No No

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• 30 minutes for FFP? • 30 minutes for Cyro?	☒ Yes ☒ Yes ☒ Yes	No No No	
Did the candidate dispose of equipment safely?	☒ Yes		
9. Documentation Did the candidate sign the appropriate sections of the traceability record?			
• Did the candidate place the appropriate section of the traceability record onto the integrated blood prescription record?	☒ Yes		
• Did the candidate record on the observation chart the stop time of the transfusion?	☒ Yes		
• Did the member of staff return the blood component collection form and the laboratory report section of the traceability record with the empty/partially used pack to the Blood Bank?	☒ Yes		

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Has the candidate successfully completed the following?

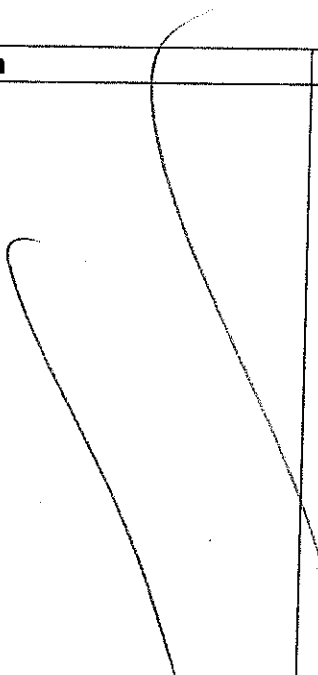
Theoretical aspect Yes / No

Knowledge and understanding assessment Yes / No

Observational assessment Yes / No

If 'Yes' to all of the above please complete Certification of Clinical Competency Assessment

If 'No' to any of the above please complete and sign the action plan below

Action Plan	Completion date
	
Signature of assessor: 	
Signature of member of staff: 	
Date of signatures: 	

Version 4. Reviewed by SHSCT Transfusion Team. July 2013

Certificate of Clinical Competency Assessment
Preparing and Administering a Blood Component for Transfusion
Competency Four

Clinical Area

Theoretical & Knowledge Assessment

Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy

And

Completed *either* Option 1 or Option 2

Option 1 ☐

Attended 'face to face' Blood Administration education session

And

Completed Verbal Knowledge Assessment with assessor

Or

Option 2 ☒

Completed on-line knowledge assessment of either
Medical Staff- LearnProNHS E- learning Module 1- Safe Transfusion Practice
Nurses/Midwives- SHSCT Safe Blood Administration (RPRB) Module E-
 Learning

Practical assessment

Competency assessed for preparing and administering a blood component for transfusion.

I confirm that (use block capitals)

MR AIDAN O'BRIEN

Staff No:

Has successfully completed the required theoretical and practical assessment and achieved understanding and competence in preparing and administering a blood component for transfusion

Signature of assessor:

Date: 16/04/2014

Signature of member of

Date: 16.04.14

This competency requires updating on or before 16th April 2014
 (Date to be 3 years on from current assessment)

Version 4
Revised by the SHSCT Transfusion Team. July 2013

**Framework Proforma
COMPETENCY TWO**

Organising a Request for a Blood Component for Transfusion

Name of candidate: Mr Aidan O'Brien	Name of assessor: John Hatt
Job title: Consultant	Job title: Head Haematology
Grade/Band	Contact details Tel [REDACTED] CAK
Contact details: CAH Wology	Assessment carried out in clinical area Y/N
Date of assessment: 16/04/2014	Assessment carried out during simulation of process (Y)N

Theoretical Aspect

Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy

Yes / No
(Yes)

AND

Attended 'face to face' Blood Administration education session:

Yes / No
Date: **(Yes)**

OR

Medical Staff

Completed Module 1 of e-learning program: (LearnProNHS)
Safe Transfusion Practice

Yes / No
Date:

Nursing/Midwifery Staff

Completed SHSCT Safe Blood Administration (RPRB theory) e-learning Module

Yes / No
(Yes)

Date:

E-Learning certificate available?

Yes / No
(Yes)

Version 4
Revised by the SHSCT Transfusion Team. July 2013

Core Questions Competency 2

The candidate must successfully answer the following questions: -

- Why do you use open-ended questions when identifying patients? ☒
- Why is it important for all the information on the blood component collection form to be completed accurately? ☒
- Why is it essential that all patient identifiers on the blood component collection form correspond with the patient identification details on the blood component? ☒
- What are the potential risks in the blood collection process? ☒

Verbal Knowledge Assessment Competency 2

The following questions need to be completed if the candidate *has not completed the relevant e-learning programme.* (Passmark 80%)

(See page 1)

1. The prescription of blood components is the responsibility of Medical staff and/or Registered nurses/midwives who have successfully obtained their certificate of competence for the written authorization of blood components T / F
2. The reason for transfusion should be clearly recorded in the patient's case notes. T / F
3. Every patient has the right to have the risks, benefits and possible alternatives to blood transfusion explained to them before the transfusion episode commences. T / F
4. Red blood cells are usually transfused over 2-3 hours, but must be completed within 4 hours of removal from cold storage. T / F
5. Crossmatched blood takes approximately 45 minutes to prepare from receipt of the sample (providing no atypical antibodies are found) T / F

Version 4

Revised by the SHSCT Transfusion Team. July 2013

6. All patients undergoing blood transfusions must be wearing an identification wrist band
T / F

7. Transfusions during the night should be avoided unless clinically indicated.
T / F

8. The greatest risk to the transfused patient is receiving the wrong Blood Component.
T / F

Core competency Observational Assessment	Was the task observed?		Notes for assessors	
1. Blood component ready for collection Did the candidate confirm that the blood component was ready for collection?	☒ Yes	No		
2. Patient identification for <u>conscious patient</u>. Did the candidate ask the patient to state their: - Full name? - Date of birth? Did the candidate check: - The details provided with the information on the blood component collection form. - That the information provided by the patient matched the information on the wristband?	☒ Yes	No	Ask either question 2 or 3. (whichever is relevant)	N/A
	☒ Yes	No		N/A
	☒ Yes	No		N/A
	☒ Yes	No		N/A
3. Patient identification check for <u>unconscious patient or patient unable to verbally respond</u> did the candidate check: - Patient identification details on the patients wristband. <i>At least their</i> - Full name? - Date of birth? - Health and Care number/ Hospital number?	Yes	No		☒ N/A
	Yes	No		☒ N/A
	Yes	No		☒ N/A
	Yes	No		☒ N/A
4. Blood component collection form (if applicable) Did the candidate understand what information is required for the blood component collection form by describing that it should contain: - The patient's full name? - Date of birth? - Patient identification number? - Signature of the person requesting the blood component? - Ward/ department?	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		
	☒ Yes	No		

Version 4

Revised by the SHSCT Transfusion Team. July 2013

5. Collection of blood component Did the candidate identify an appropriate member of staff to collect the blood component? and ensure that the appropriate box on Section A of the form was ticked to indicate the required component?	Yes	No		
6. Receipt of blood component (in clinical area) Did the candidate respond promptly to the delivery of the blood component by: • Checking that the details on the delivered blood component are correct? • Ensuring that receipt of the blood component in the clinical area was documented according to the relevant Southern Health and Social Care Trust Blood Transfusion Policy.	Yes	No		
	Yes	No		

Version 4

Revised by the SHSCT Transfusion Team. July 2013

Has the candidate successfully completed the following?

Theoretical Aspect

☒ Yes / No

Knowledge and Understanding Assessment

☒ Yes / No

Observational assessment

☒ Yes / No

If 'Yes' to all of the above please complete Certification of Clinical Competency Assessment

If 'No' to any of the above please complete and sign the action plan below

Action Plan	Completion date
Signature of assessor:	
Signature of member of staff:	
Date of signatures:	

Version 4

Revised by the SHSCT Transfusion Team. July 2013

**Certification of Clinical Competency Assessment
Organising a request for a blood component for transfusion
Competency Two**

Clinical Area

Theoretical & Knowledge Assessment

Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy

And

Completed *either* Option 1 or Option 2

Option 1 ☐

Attended 'face to face' Blood Administration education session
And

Completed Verbal Knowledge Assessment with assessor
Or

Option 2 ☒

Completed on-line knowledge assessment of either
Medical Staff- LearnProNHS E- learning Module 1- Safe Transfusion Practice
Nurses/Midwives- SHSCT Safe Blood Administration (RPRB) Module E- Learning

Practical assessment

Competency assessed for organising a request for a blood component for transfusion.

I confirm that (use block capitals)

MR Aidan O'Brien

Staff No:

Has successfully completed the required theoretical and practical assessment and achieved understanding and competence in organising a request for a blood component for transfusion.

Signature of assessor:

Date: 16/4/2014

Signature of member of

Date:

This competency requires updating on or before
(Date to be 3 years on from current assessment date)

16th April 2014

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

Framework Pro forma
Obtaining a venous sample for pre-transfusion testing
COMPETENCY ONE

Name of candidate: Mr Aidan O'Brien	Name of assessor: Patricia Liff
Job title:	Job title: Area Head of Haematology
Grade/Band Consultant	Contact details CAH
Contact Details CAH	Assessed carried out in clinical area Y/N
Date of assessment 16/04/2014	Assessment carried out during simulation of process Y/N

Theoretical Aspect

Completed venepuncture course or cannulation training or deems him/her self proficient by virtue of experience/practice: **Yes / No**

AND

Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy **Yes / No**

AND

Attended 'face to face' Blood Administration education session: **Yes / No**
Date:

OR

Medical Staff

Completed Module 1 of E-learning program: (LearnProNHS) Safe Transfusion Practice **Yes / No**
Date:

Nursing/Midwifery Staff

Completed SHSCT Safe Blood Administration (RPRB theory) E- learning Module **Yes / No**
Date:

E- Learning certificate available? **Yes / No**
14/4/14

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

Core Questions Competency 1

The candidate must successfully answer the following questions: -

1. Why do you need to use open-ended questions when identifying patients?

☒

2. Why must the patient details required on the sample tube be handwritten and not pre-labelled? ☒

3. Why is it important to be extra vigilant when checking positive patient identification when a patient is unconscious? ☒

4. Why is it important to only bleed one patient at a time? ☒

5. What is the correct action to take if the information identifying a patient is missing? ☒

The following questions need to be completed if the candidate has not completed the relevant e-learning programme. (Passmark 80%)

(See page 1)

Verbal Knowledge Assessment Competency 1

1. Verbal identification (whenever possible) must be obtained from a patient before taking the blood sample **T / F**

2. It is acceptable to use a sample tube that has been pre-labelled with the patient's details **T / F**

3. The patient details must be checked against the identification wristband before taking the sample **T / F**

4. Labelling a transfusion sample with incorrect information can result in death or serious harm to the patient. **T / F**

5. It is important that the patient's details match exactly on both the sample tube and request form and corresponds with the identification details on the patient's wristband. **T / F**

6. The signature of the person taking the sample is required on the request form. **T / F**

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

7. Any discrepancy in sample or request form labelling will result in the sample not being processed by the Hospital Transfusion Laboratory T / F

8. Written consent for transfusion is a legal requirement in the UK T / F

Observational Assessment

Core competency	Was the task observed?		Notes for assessors		
1. Did the candidate complete the following on the request form: • Full name • Date of birth • Health and Care number / Hospital number	Yes Yes Yes	No No No	Please note that Phlebotomy staff do not complete the patients details on the request form, it is the responsibility of the Medical/Nursing staff to complete this section of the form. The Phlebotomist will adhere fully with all of the remaining requirements and sign the relevant section of the request form, confirming that the patient identification details on the sample tube and request form and wristband correspond.		
2. Patient identification for <u>conscious patient</u>. Did the candidate <u>ask the patient to state their</u>: • Full name? • Date of birth? Did the candidate check: • Details on the wristband? • The information on the wristband against the request form?	Yes Yes Yes Yes	No No No No	Ask either question 2 or 3 (whichever is relevant)		N/A N/A N/A N/A
3. Patient identification for <u>unconscious patient or patient unable to verbally respond</u>. Did the candidate check: Details on the wristband? <i>At least their</i> • Full name? • Date of birth? • Hospital number? • The information on the wristband against the request form?	Yes Yes Yes Yes Yes	No No No No No			N/A N/A N/A N/A N/A
4. Did the candidate bleed only one patient?	Yes	No			

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

5. Labelling the venous sample • Did the candidate label the venous sample as soon as it was taken? • Does the candidate handwrite the sample label ensuring it contained the following information • Full name? • Date of birth? • Health and Care number / Hospital number? • Date? • Signature of member of staff who took sample? 5a. Request form • Did the candidate sign the request form, confirming that the patient identification details on the sample tube, request form and wristband correspond? 5b. Component request • Did the candidate complete the component request section of the request form? (if applicable)	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No	
6. Packaging and documentation • Did the candidate take the sample to the correct collection point? • Did the candidate record the following information in the patient's notes? ○ Why the sample has been taken? ○ When the sample was taken? ○ Who took the sample?	Yes Yes Yes Yes	No No No No	N/A Please note that the phlebotomists do not document in the patients notes.

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

Has the candidate successfully completed the following?

Theoretical Aspect

☒ Yes / No

Knowledge and Understanding Assessment

☒ Yes / No

Observational assessment

☒ Yes / No

If 'Yes' to all of the above please complete Certification of Clinical Competency Assessment

If 'No' to any of the above please complete and sign the action plan below

Action Plan	Completion date
Signature of assessor: Signature of member of staff: Date of signatures:	

Version 4.

Revised by the SHSCT Transfusion Team. July 2013

**Certification of Clinical Competency Assessment
Obtaining a Venous Sample for Pre-Transfusion Testing
Competency One**

Clinical Area

Theoretical & Knowledge Assessment

Read the relevant Southern Health and Social Care Trust Blood Transfusion Policy

And

Completed *either* Option 1 or Option 2

Option 1 ☐

**Attended 'face to face' Blood Administration education session
And**

Completed Verbal Knowledge Assessment with assessor

Or

Option 2 ☒

**Completed on-line knowledge assessment of either
Medical Staff- LearnProNHS E- learning Module 1- Safe Transfusion Practice
Nurses/Midwives- SHSCT Safe Blood Administration (RPRB theory) e-learning
Module**

Practical assessment

Competency assessed for obtaining a venous sample for pre-transfusion testing.

I confirm that (use block capitals)

MR. AIDAN O'BRIEN

Staff No:

Has successfully completed the required theoretical and practical assessment and achieved understanding and competence in safe venous sampling for pre-transfusion testing.

Signature of assessor

Date: 16/04/2014

Signature of member

Date:

**This competency requires updating on or before
(Date to be 3 years on from current assessment date)**

16th April 2014

RED ALERT – A quick guide for CAH

RED ALERT: What is it?

Red alert massive blood loss may be defined as:

The loss of one blood volume within a 24 hour period (approx. 5 litres in an adult) or

The loss of 50% of blood volume within 3 hours or

The loss of blood at a rate in excess of 150 ml per minute

RED ALERT: What is the point?

The goal is early haemostasis with restoration of an adequate circulating volume by appropriate fluid and blood component replacement. To ensure there is no delay in the provision of blood components contact the blood transfusion laboratory staff immediately a massive blood loss event occurs and ensure correct sampling and labelling of all patient bloods.

RED ALERT: How do I activate it?

Telephone the blood bank on #6566 (day or night). Alternate number Tel 2666.

The Trigger phrase that should be used in the event of a massive blood loss event is:

'This is a massive blood loss, **RED ALERT** and state clinical area and patient details'

All subsequent calls should be preceded with the phrase, this call relates to the massive blood loss event in, state the clinical area and the name of the patient.

RED ALERT: Who else do I need to tell?

Contact the porters on bleep 1414 (day or night). Alternate numbers Tel 2009 or Tel 2010 and when the term **RED ALERT** is used then a porter will be assigned to the emergency until it is over. The porter will also take the patient's blood samples to the blood bank and wait on the blood components.

The consultant should be informed if a red alert massive haemorrhage occurs.

RED ALERT: What happens when I call it?

The blood bank will issue the following:

4 units of blood available in 10 mins (group specific) from receipt of sample.

A further 6 units available in 40 mins (crossmatched).

4 units of FFP thawed available in 40mins

2 units of platelets will be requested from the NIBTS

RED ALERT: What happens when things are under control?

Once the patient is stabilised then the red alert must be called off. Otherwise the laboratory staff may continue to prepare blood components unnecessarily and the porter will be unnecessarily occupied.

RED ALERT: What if I call a RED ALERT by mistake?

A red alert can be cancelled at any time. All red alert situations will be reviewed and any learning shared with specialist teams.

Jan 2012 K Loane adapted by the Trust Transfusion Team March 2012.

The Massive Blood Transfusion Guidelines (2012) are available on the Haemovigilance section the intranet site.

Trust Logo

Policy Code / Reference No:

Add Trust Name

Title:	Guidelines for Nurse Led Assessment and Follow up of patients with stable Prostate Cancer		
Author(s)	Adapted from SET		
Ownership:			
Approval by:	NICaN Urology NSSG Group	Approval date:	29 th November 2013
Operational Date:		Next Review:	
Version No.	3	Supersedes	N/A
Links to other policies	Policy for consent to examination, Treatment and Care, European Association of Urologists (Feb, 2012) Guidelines on Prostate Cancer		

1.0 INTRODUCTION / PURPOSE OF GUIDELINE

This document outlines the guiding principles for nurse led prostate cancer follow-up and should be closely followed. However these guidelines are only a foundation and it is recommended that nurses maintain their continuing education in this specialist area of care.

The aim of this guideline is to set a minimum standard for nurse led assessment and follow up of patients with prostate cancer which will:

- Enable the follow up of patients with prostate cancer who are on the watchful wait or hormone treatment pathway
- Promote the education of patients about their disease management and potential for self directed aftercare
- Monitor patient progress and enable detection of progression and refer to the appropriate Consultant Urologist
- Enable holistic assessment
- Identify late effects of treatment quickly, provide support and signpost to the appropriate service if necessary
- Inform patients about and refer them to specialists services that can help with their medical, practical, emotional and rehabilitation needs
- Support patients living with and beyond cancer
- Offer patients a choice of follow-up

1.1 Objectives

The objectives of this guideline are to improve and maintain standards of clinical practice and quality of care patients receive by:

- Providing evidence based guidance for establishing and maintaining a nurse led clinic for the assessment of patients with prostate cancer, promoting excellence in the care that is delivered
- Reducing variation in clinical practice and encouraging uniformity of practice
- Providing a framework from which individual practitioners can apply their own level of clinical expertise and competency
- To ensure that all patients entering the prostate cancer follow up service are on the appropriate risk stratified pathway (Appendix 5 & 6)
- Helping nurses and health care providers to make informed decisions, aiding the education process and reducing the risk of clinical negligence
- Identifying competencies for nursing care
- Aiding development of locally agreed guidelines
- Promoting audit

1.2 Background

The NHS is undergoing radical changes particularly in its approach to cancer. Traditional nursing roles are being challenged in a bid to meet the demands of the changing NHS climate. Prostate cancer follow up forms a substantial part of the urology outpatient workload. Nurse led clinics are becoming increasingly common, offering patients an alternative method of follow up either via more convenient clinics or the telephone. By developing these new roles and services, nurse are playing a key role in increasing patient choice, reducing waiting times, increasing accessibility to services and improving the quality of care

New standards have been developed within the Cancer Services Framework that are intended to ensure that patients experience the best possible quality of life after treatment by:

- providing new models of follow-up which focus on health and wellbeing
- improving access to psychological support

2.0 DEFINITIONS/SCOPE OF THE GUIDELINE

These guidelines should be used by suitably trained health care professionals who are providing nurse led follow up to patients with prostate cancer. Patients will enter nurse led follow up services on a clearly defined follow up pathway following discussion at MDM.

Recommended exclusion criteria

- Patients who do not wish to be followed up by a nurse
- Patients who require adjuvant treatment in the form of radiotherapy or chemotherapy
- Patients with dementia/short term memory loss (unless meeting patients with carer present)
- Patients who develop resistance to Hormone Therapy during follow up and require referral to oncologist
- Patients deemed unsuitable for review at a nurse led clinic by the consultant in charge

3.0 ROLES/RESPONSIBILITIES

Implementation of these guidelines is the responsibility of those involved in nurse led follow-up of prostate cancer patients.

Accountability is a key concern for all registered nurses today. Professional accountability is defined as being responsible for your actions and for the outcomes of these actions as part of the framework of clinical Governance, which aims to provide good quality, cost-effective evidence based care (Tilley & Watson 2004)

Nurses need to be aware of their limitations as well as their clinical competence. If there are any areas in which they do not feel clinically competent to undertake an activity they should decline the activity until the appropriate learning and practice activities have been achieved to demonstrate competency (NMC 2008)

Nurses are responsible for ensuring their own educational preparation and experience to safely perform the role. They should maintain documented evidence of completion of continuing education and of demonstrating clinical competence

Competencies required for assessing patients with prostate cancer can be found in (Appendix 2)

4.0 KEY GUIDELINE PRINCIPLES

4.1 Key Policy Statement

The purpose of the nurse led clinic is to enhance the quality of care and to promote the health and well being of patients who have been treated for prostate cancer. The clinic will also facilitate the provision of emotional support for patients and their families/carers requiring the opportunity to discuss treatment or care options

Nurse led clinics have been shown to improve the quality of care in the following ways

- Provide continuity of care for patients and their family
- Provide information, education and support
- Be accessible to patients and their family
- Release consultant time to see more complex patients
- Apply the principles of transforming cancer follow up

A risk stratified model of aftercare in line with the National Cancer Survivorship Initiative will be utilised and patients will be stratified into different arms of the follow up pathway according to their staging and personal characteristics by the Consultant.

Risk stratified means that the clinical team and the person living with cancer make a decision about the best form of aftercare based on their knowledge of the disease, (what type of cancer and what is likely to happen next), the treatment (what the effects or consequences may be both in the short term and long term) and the person (whether they have other illnesses or conditions, and how much support that they feel they need).

This will include the ongoing follow up of patients who are clinically stable and are stratified into the relevant pathway

Watchful waiting	(Pathway 1)
Active surveillance	(Pathway 2)
Raised PSA – negative biopsy	(Pathway 3)
Post radical surgery	(Pathway 4)
Post brachytherapy	(Pathway 5)
Post radical radiotherapy	(Pathway 6)

4.2 Policy Principles

Patients with prostate cancer who are on the pathways outlined above will be risk stratified into a pathway as discussed below

- Self-Care with Support and Open Access
 - No routine outpatient attendances
 - Stable disease pattern
 - After treatment with curative intent
 - Holistic assessment completed and care plan agreed
 - Information and/or some form of educational intervention
 - Surveillance tests with results by post or phone co-ordinated by a provider
 - Ability to re access system with/without reference to GP
- Shared Care – where patients continue to have face to face or telephone contact with professionals as part of continuing follow up.
 - Planned follow up either as an outpatient or planned phone follow up
 - Clinical examination required
 - High clinical or individual risks identified (disease, treatment, person)
 - Multi professional input required
 - Patients with co-morbidities
 - Those who decline or are considered to be unable to self manage

4.3 Long-term follow-up

Definitive guidance on the long term follow-up for patients with prostate cancer is included within the pathways which are concordant with NICE and European Association of Urologists Clinical Management Guidelines on Prostate Cancer.

4.4 Telephone Review Protocol

A telephone review service enables the Clinical Nurse Specialist to follow up patients through an alternative route and thereby reduce unnecessary hospital appointments for patients who have stable disease and are not fit to travel.

This service will be offered to those patients referred to the nurse led clinic and a telephone assessment protocol will be utilised. See appendix 7

4.5 Holistic Needs assessment (HNA)

The HNA is used to identify and address patient's needs and concerns. The HNA may build on action plans developed from previous assessments. The HNA should be conducted during the follow-up appointment. The patient or carer is encouraged to complete the form and the assessor uses this as a guide to explore their needs and collaboratively develop an appropriate action or care plan

An agreed Holistic Needs Assessment (HNA) tool will be utilised within the aftercare pathways

4.6 Support information and education

The consultant or clinical nurse specialist should offer patients support information tailored to the individual. This should cover as a minimum:

- Disease Progression
- Fatigue
- Pain
- Urinary Symptoms
- Finances/benefits

- Nutrition/exercise
- Signposting
- Health and well being

4.7 Rapid Access Protocol

Prostate cancer follow-up is the responsibility of the MDT. All patients should be able to access the Consultant responsible for their care through the Urology CNS. Any patient that contacts the Urology CNS with worrying symptoms will be seen by a Consultant promptly. If necessary, their case should be discussed by the MDT.

4.8 Triage Protocol

Each patient will be able to contact the Urology CNS outside of scheduled follow up appointments. The Urology CNS will triage the patient on their concerns/issues to the most appropriate member of the Urology team or refer on to other agencies accordingly. Outcomes may include:

- Face to face consultant appointment promptly
- Face to face Nurse led clinic (where appropriate)
- Advised to contact GP
- Advised to attend the emergency department
- Signpost to other support agencies e.g. Citizens Advice Bureau (CAB), AHP, Counselling

Only clinical issues will result in a clinical appointment.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Urology Clinical Nurse Specialists
Urology Consultants
Oncologists

6.0 MONITORING

Monitoring of these guidelines is the responsibility of the Urology Nurse under the direction of the line manager

7.0 EVIDENCE BASE / REFERENCES

Evidence:

BAUN (2008) Guidelines for nurse-led assessment and follow up of men with stable prostate cancer British Association for Urological Nurses

Cox A, Jenkins V, Catt S, Langridge C, Fallowfield LJ Information needs and experiences: an audit of UK cancer patients. European Journal of Oncology Nursing 2006; 10(4):263-72, doi:10.1016/j.ejon.2005.10.007
[http://www.ejcnologynursing.com/article/S1462-3889\(05\)00140-7/abstract](http://www.ejcnologynursing.com/article/S1462-3889(05)00140-7/abstract)

CSCIP (2005) Applying High Impact Changes in Cancer Care
http://www.cancerimprovement.nhs.uk/documents/CSC_High_Impact.pdf

Department of Health (2004) Manual for Cancer Services

Department of Health Cancer Action Team (2007) Holistic Common Assessment Of Supportive & Palliative Care needs for Adults with Cancer Assessment Guidance p19

Department of Health (2007) Draft Rehabilitation Measure for the Manual for Cancer Standards

http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_079108

Department of Health (2007) Cancer Reform Strategy

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

Department of Health (2006) Tackling cancer: improving the patient journey

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105421

Department of Health (2005) The NHS Cancer Plan

http://www.nao.org.uk/publications/0405/the_nhs_cancer_plan.aspx

Department of Health (2006) Modernising Nursing Careers: Setting the direction

DHSSPS (2006) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland

http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_egia.pdf

European Association of Urologists (Feb, 2012) Guidelines on Prostate Cancer

<http://www.uroweb.org>

National Audit Office (2005) Tackling Cancer – Improving the patient journey

http://www.nao.org.uk/publications/0405/tackling_cancer.aspx

National Cancer Survivorship Initiative (NCSI Vision) Jan 2010

National Institute for Health and Clinical Excellence (NICE) Prostate Cancer diagnosis and treatment <http://guidance.nice.org.uk/CG58>

NI Cancer Registry (2007) Survival of cancer patients in Northern Ireland:

1993-2004 <http://www.qub.ac.uk/researchcentres/nicr/FileStore/PDF/Survival/Filetoupload,81422,en.pdf>

Nursing and Midwifery Council (NMC): The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)

Service Framework for Cancer Prevention, Treatment and Care (2011)

Tilley, S. Watson, R. (2004) Accountability in Nursing and Midwifery. 2nd Edition. London: Blackwell Publishing.

8.0 CONSULTATION PROCESS

Cancer Services User Forum
NICaN Regional Urology Group

9.0 APPENDICES / ATTACHMENTS

See attached

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☐

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Name
Title: **Date:**

Name
Title: **Date:**

Name
Title: **Date:**

Name
Title: **Date:**

Appendix 1

Prostate Cancer Review Assessment Form

Name.....
Unit No.....
DOB.....

Consultant..... GP.....

Date:..... Time.....

Type of review: Telephone ☐ Clinic Contact ☐

Treatment Pathway: Hormone Treatment ☐ Watchful Waiting ☐

Histology Gleason's Score TNM

PSA

PSA Trigger.....

Date of PSA..... Current PSA..... Previous PSA.....

PSA obtained from ECR.....

Record what was discussed with patient

Changes in Urinary Symptoms

Storage	Yes / No
Voiding	Yes / No
Pain	Yes / No
Haematuria	Yes / No

If yes to any of the above, please comment and record advice given

General Symptoms

Hot Flushes	Yes/No
Tiredness	Yes/No
Weight gain	Yes/No
Breast Pain	Yes/No
Bone pain	Yes/No
Sexual Problems	Yes/No
Change in bowel pattern	Yes/No

Additional comments

Problems and concerns

Has patient had a Holistic Needs Assessment Yes/No

If yes, Date of HNA

Discuss resolution of any problems identified in previous HNA ☐

Are there any new concerns Yes/No

- Financial
- Psychological
- Information and Support

Please record any issues

Follow up

Nurse Led follow up 3 months yes/no 6months Yes/No

Referral to:

Urologist Yes/No

Oncologist Yes/No

Letter to GP ☐

Letter to Consultant ☐

Signature of CNS.....

Appendix 2**Competencies for Nurse-led Follow-up**

Competencies required assessing patients with stable prostate cancer include:

- Advanced nurse practitioner/clinical nurse specialist having been employed for a minimum of twelve months working with a urologist/oncologist in the follow up setting
- Demonstrate a full understanding of the network site specific group pathways for prostate cancer. As agreed by the local tumour network
- To be enrolled in or be undertaking, a programme of study in their specialist area of nursing practice which has been accredited for at least 20 CAT points at level 3 (DH2004) e.g. Health Assessment module
- Have advanced communication skills – to have enrolled in, or be undertaking a recognised course/module in communication skills (DH 2004)
- In order to run a clinic the individual must be a core member or extended member of the urology multidisciplinary team
- To be able to demonstrate knowledge of the disease trajectory in Prostate Cancer
- To be able to demonstrate knowledge of risk stratified pathways
- To have competent consultation and symptom analysis skills. To have worked under supervision for a minimum of six months and have been deemed competent by the consultant urologist/oncologist
- To be able to demonstrate knowledge of the tests and investigation required during follow up of prostate cancer patients
- To be competent at performing DRE (if appropriate)
- To be competent in the assessment of lower urinary tract symptoms (LUTS) and facilitate onward referral to LUTS clinic is required
- To be competent in bladder palpation
- To be competent in the assessment of bladder emptying
- To demonstrate ability to advise on erectile dysfunction and know where and how to refer to appropriate service
- To be able to demonstrate knowledge of survivorship issues
- To be able to demonstrate knowledge of rehabilitation services
- Demonstrate knowledge of drugs and treatments used in prostate cancer including side effect

Appendix 3

Guideline for Nurse Led Assessment Protocol

Actions
Discuss • Nurse led clinic • History/treatment to date • Timeline for routine follow up such as PSA, DRE and Admission Profile
Physical Examination
Carry out physical assessment including: • Digital Rectal Examination (DRE) • International Prostate Symptom Score (IPSS) if required
Symptoms
Is the patient experiencing any symptoms . • Hot Flushes • Ask about pain – any new pain lasting more than a week (use locally agreed pain scale) • Weight loss/gain • Fatigue • Sexual dysfunction • Neurological symptoms – Numbness, tingling or odd sensations in limbs • Lower Urinary tract symptoms • Haematuria • Gynaecomastia • Change in bowel habit • Deterioration in renal function Is the patient experiencing any symptoms suggestive of local or metastatic disease • Abdominal /Pelvic /Skeletal pain • Weight loss • Anorexia • Nausea or vomiting Ask about any other symptoms/concerns
Tests and investigations
• PSA at each visit if rising discuss with consultant • Admission Profile at each visit • FBP at first visit • Ultrasound renal tracts following discussion with Consultant
Holistic Assessment
Perform holistic assessment suggested tools: • Macmillan Concerns Checklist & Care-plan

Information
Nurse to check information has been provided and tailored to the individual patient. This will include information about: - Timeline for tests and investigations - Survivorship programme - Rapid Access to service - Contact numbers - What symptoms need to be reported - Consequences and side effects of the treatment - Holistic Assessment - Rehabilitation services
Rehabilitation
Discuss and offer referral to: • Community Health and Well-being Clinics • Signposting to other services
Documentation
Care plan Letter to patient Letter to GP & referring consultant with copy of assessment form, To include: • Date and time of nurse consultation • Patients identifiable details • Diagnosis • Treatment, • Assessment summary, • Most recent PSA reading • Date of next nurse appointment • Potential or actual problems identified during the consultation.

Adapted from BAUN (British Association for Urological Nurses) - Guidelines for nurse-led assessment and follow up of men with stable prostate cancer (2008)

Appendix 4

Problem Management Plan

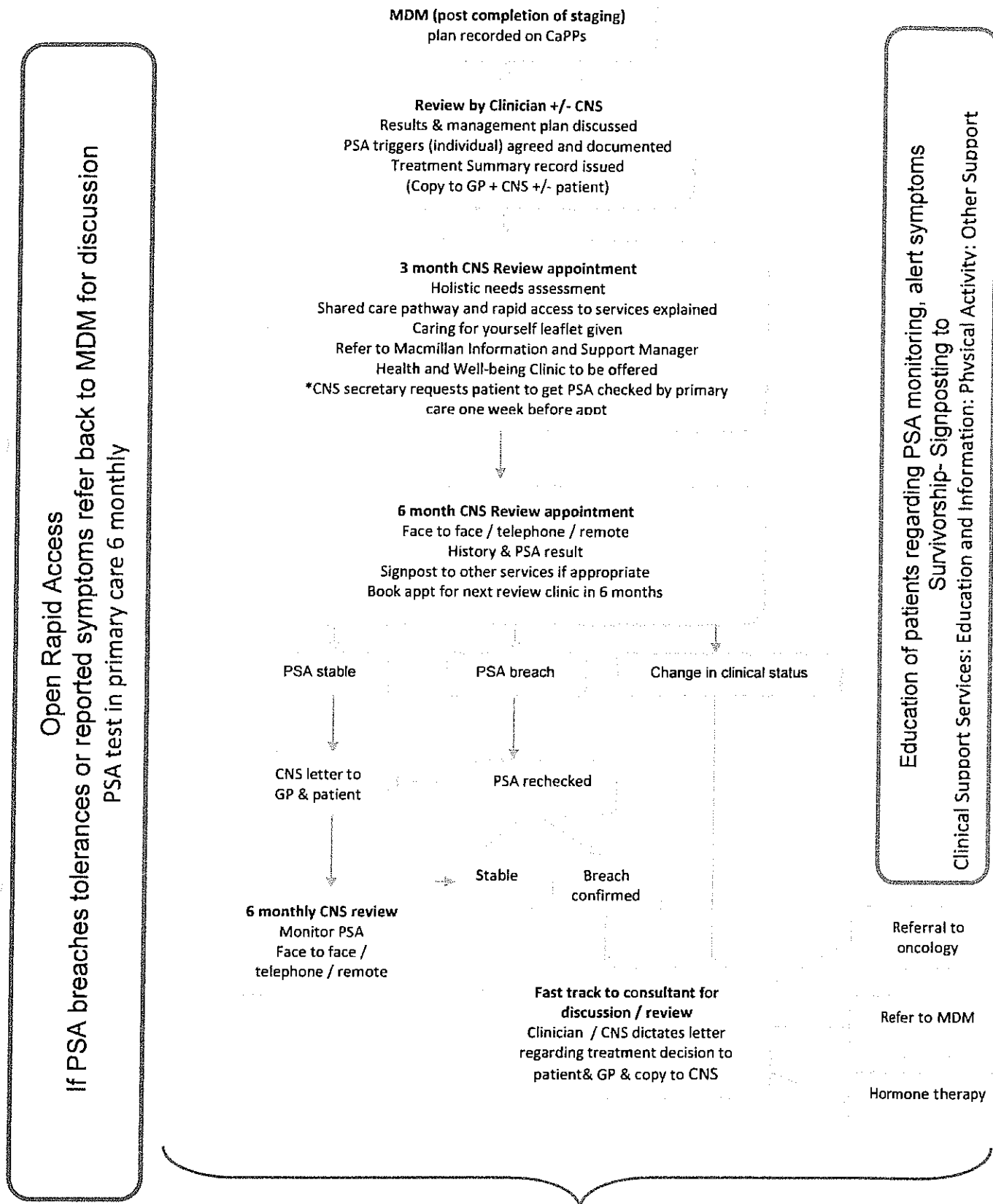
This plan will help to identify the appropriate actions when there is a change in the patients condition/needs during nurse led assessment and follow-up of patients with prostate cancer.

Problem	Management plan
Sudden Rise in PSA	Repeat PSA as determined by consultant
Lower urinary tract symptoms that are more bothersome to the patient	Refer to LUTS clinic Urinalysis to exclude UTI Refer or discuss with appropriate consultant
Haematuria	Exclude UTI Assess lower urinary tract symptoms Refer for investigations
Hot flushes	Give support and advice and discuss with consultant
Pain - new onset bone pain	Request investigations – bone profile, pain and neurological assessment(use locally agreed pain scale) Consider MSCC Appropriate referral to urologist/ oncologist for further management
Change in bowel habit	Assess asking about change in consistency regularly. Give advice or refer to specialist as appropriate
Weight loss	If unexplained weight loss refer to consultant. Refer to dietician if appropriate
Gynaecomastia	Discuss with consultant and if required refer to oncologist
Deterioration in renal function	Discuss and if appropriate refer back to urologist Assess for poor bladder emptying by post void residual scan Order USS of renal tracts if appropriate
Weight gain, fatigue general malaise and anaemia	Give advice Consider referral for physical activity programme Check haemoglobin and if below normal levels discuss with consultant
Sexual Dysfunction	Assess for erectile dysfunction Give advice and consider referral to ED clinic if appropriate
Psychological needs	At time of the assessment any psychological concerns identified through use of NICaN Concerns Checklist will be discussed with the patient. Refer as appropriate to: Health and well being clinics Support groups Counselling Service Clinical psychologist
Financial concerns	Refer to CAB
Information needs	Discuss information needs Give written information if appropriate Consider onward referral if required Refer to Macmillan Information and Support Centre

Adapted from BAUN (British Association for Urological Nurses) - Guidelines for nurse-led assessment and follow up of men with stable prostate cancer (2008)

Pathway 1

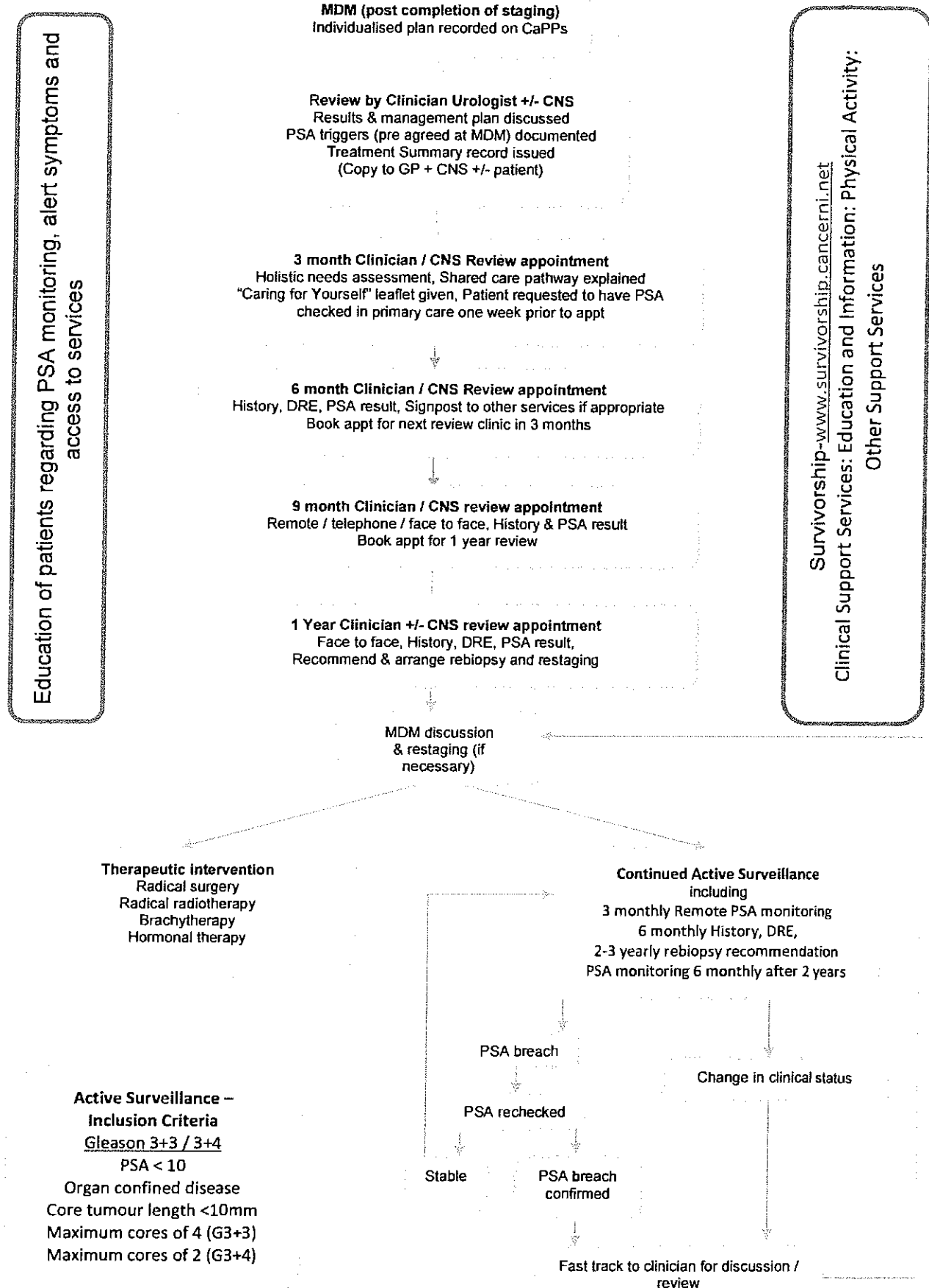
Prostate Cancer: Watchful Wait

**Watchful waiting – Adapted from NICE Guidance 2008**

'Watchful Waiting is the form of continued review of Prostate Cancer patients for whom future therapeutic intervention with curative intent has been considered to be inappropriate'.

Pathway 2

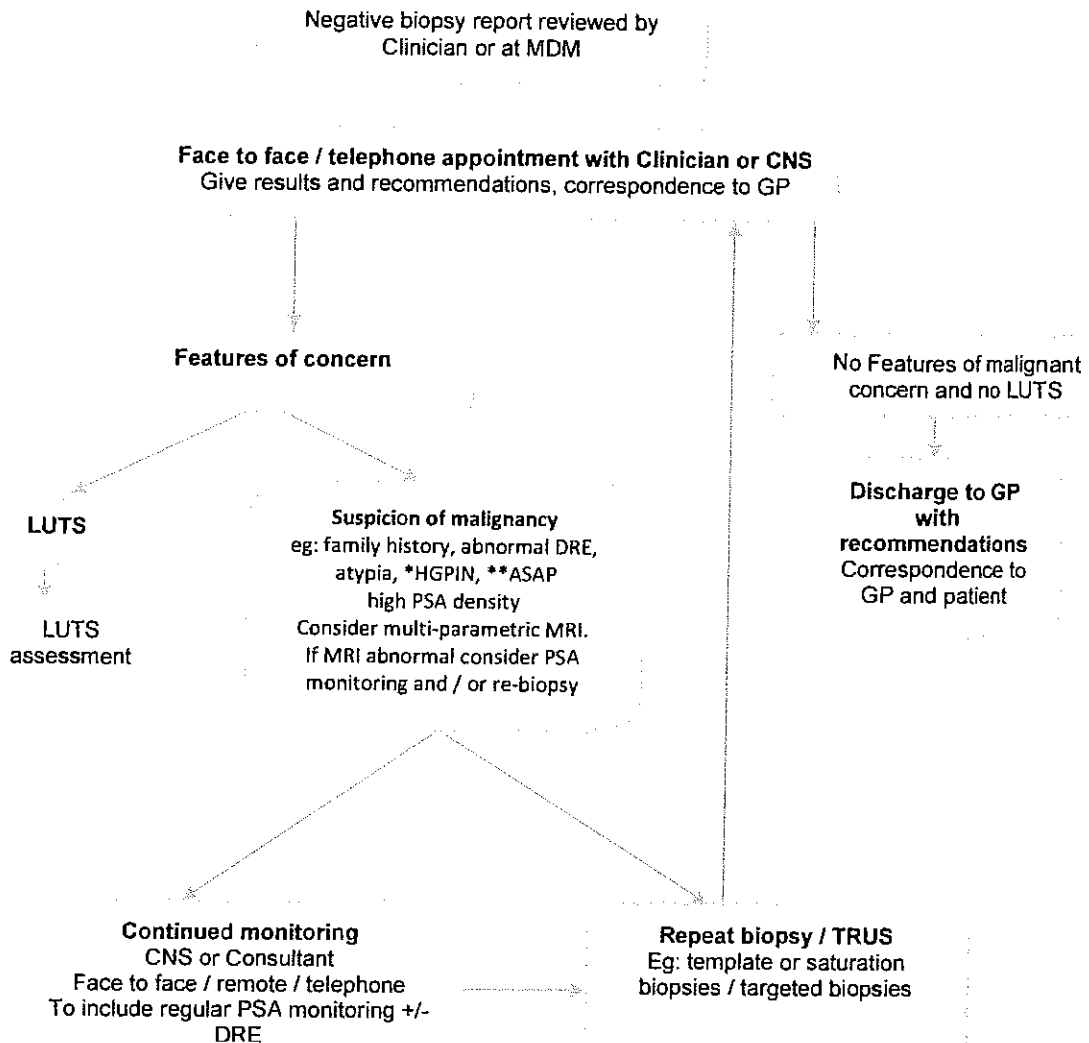
Prostate Cancer: Active Surveillance



Pathway 3

Raised PSA & Negative Biopsy

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



*HGPIN – High grade prostatic intra-epithelial neoplasia

**ASAP – Atypical small acinar proliferation

Pathway 4

Prostate Cancer: Radical Surgery – Negative margins

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

Radical Prostatectomy performed regionally in BCH

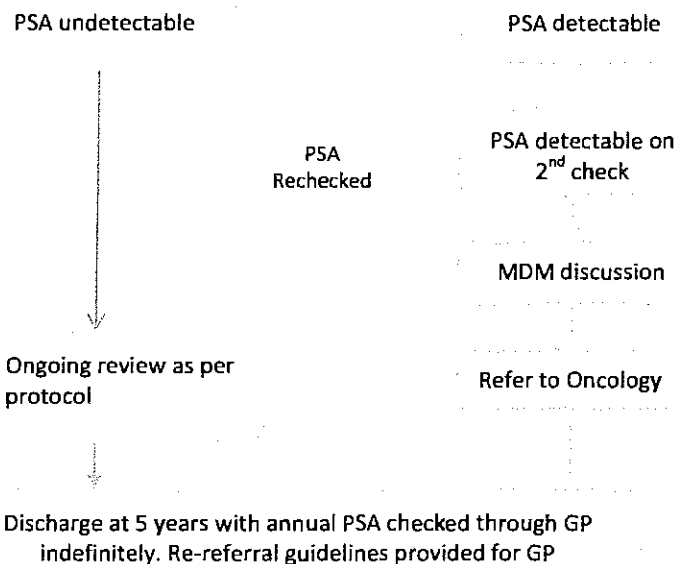
6 weekly review with Urologist and CNS
Results, PSA, Assessment, Follow Up Plan discussed, Treatment Summary completed copy to patient and GP

3 month review with CNS
Holistic needs assessment
Shared care pathway and rapid access to services explained
"Caring for Yourself" leaflet given
Refer to Macmillan Information and Support Manager
Health and Well-being Event to be offered
CNS advises patient to have PSA checked in primary care one week prior to appt

6 monthly review with CNS for 2 years including;
Face to face, telephone / remote, assessment of continence, ED, PSA, psychological issues, financial issues, returning to work etc.
(As per NICE Guidelines)

Annual review with CNS for 3 years including;
Assessment of continence, ED, PSA

Survivorship-www.survivorship.cancer.ni.net
Clinical Support Services: Education and Information: Physical Activity:
Other Support Services



Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)

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

**Permanent Prostate Brachytherapy
Implant performed
(Pt discharged)**

Post implant AUR
management if required

4week Post implant CT scan and QA/peer review
(PSA, IPSS, Dosimetry to database)

3month - Radiographer telephone review
(PSA to database)

6month - Consultant led clinical review
(PSA, IPSS, IIEF, EPIC to database)

6monthly Consultant led clinical review.
GP check PSA every 3-6months
(PSA, IPSS, IIEF, EPIC to database)
Transfer to annual review at 3years if PSA
<1ng/ml & falling

Rising PSA Year 0 - 3 could be benign PSA bounce.
PSA 3monthly with clinical review.
MRI/CT/IBS if:

- 1 PSA level >10ng/ml
 - 2 Clinically indicated
 - 3 PSA failed to fall at 3years post implant
- Return to 6monthly review when PSA achieves new nadir

Survivorship-www.survivorship.cancer.ni.net
Clinical Support Services: Education and Information: Physical Activity:
Other Support Services

12monthly clinical review
GP check PSA every 6 months
(PSA, IPSS, IIEF, EPIC to database)
Discharge to GP care at 5 years if PSA <1ng/ml
& falling

GP information letter re biochemical and
clinical triggers and re-referral pathway

Sigmoidoscopy by experienced practitioner
at year 5, 10, 15 If deemed fit for procedure

**Selection criteria for Permanent
Prostate Brachytherapy**

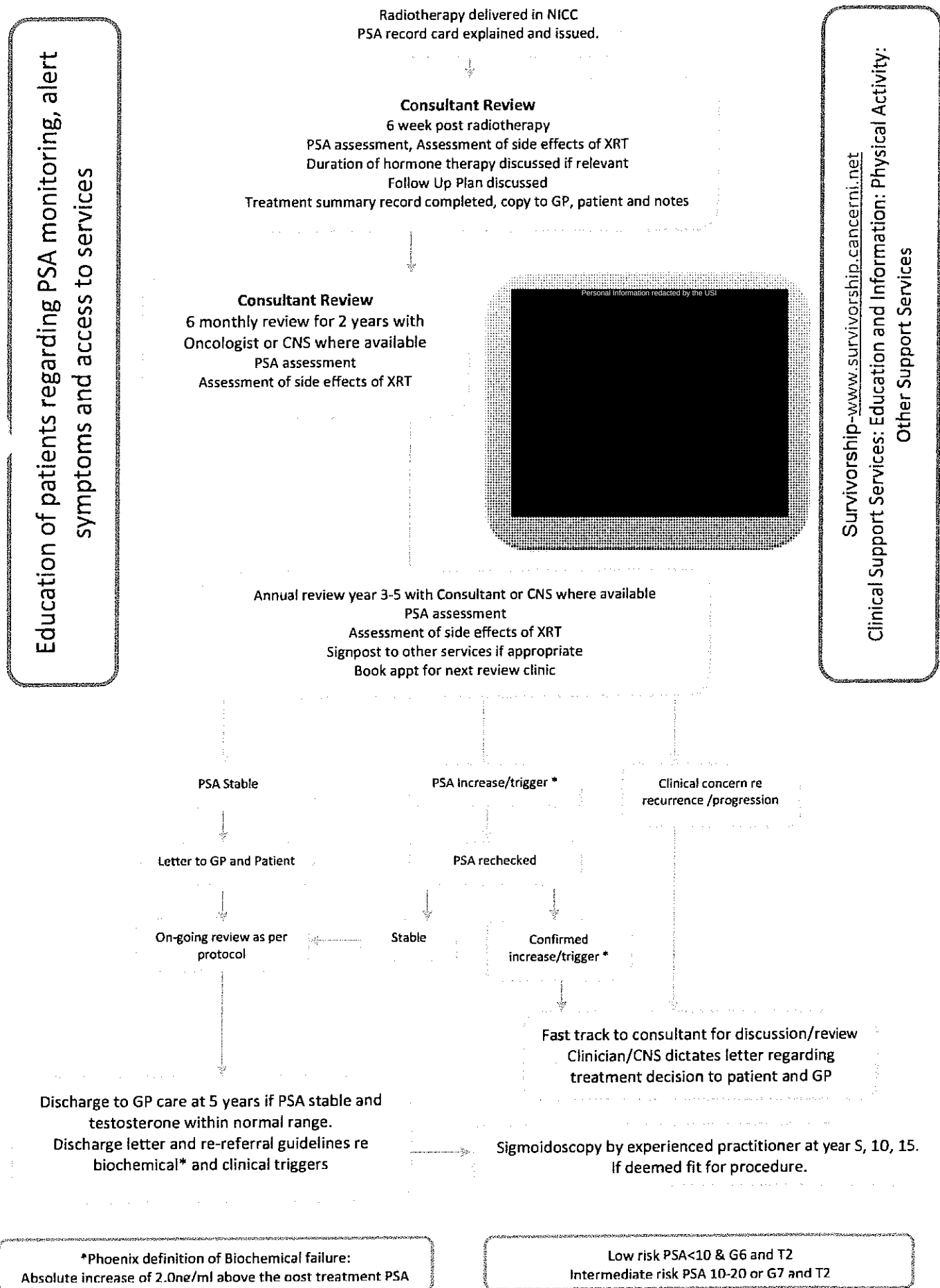
Clinical inclusion criteria:
Organ confined prostate cancer T1 or T2
Estimated life expectancy >10yrs
Gleason 6 and PSA <15ng/ml
Gleason 7 and PSA <15ng/ml

Clinical exclusion criteria for brachytherapy:
Prostate volume >50ml (> 65ml prior to
hormonal cytreduction)
IPSS >9. (Would consider for implant is <15 &
Qmax >12ml/sec)
Life expectancy <5years
Large or poorly healed TURP defect
Unacceptable operative risk
Relative contraindications for brachytherapy:
Large median lobe
Previous pelvic irradiation

**Selection criteria for combined
Permanent Prostate Brachytherapy +
EBRT**

Selected men with:
High volume Gleason 7 or
Low volume Gleason >7 or
Early T3a disease
May be suitable for dose escalation
with combination therapy and should
be referred for discussion to central
brachytherapy team

Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)



Prostate cancer: diagnosis and treatment

Issued: January 2014

NICE clinical guideline 175

guidance.nice.org.uk/cg175

NICE has accredited the process used by the Centre for Clinical Practice at NICE to produce guidelines. Accreditation is valid for 5 years from September 2009 and applies to guidelines produced since April 2007 using the processes described in NICE's 'The guidelines manual' (2007, updated 2009). More information on accreditation can be viewed at www.nice.org.uk/accreditation

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Introduction

This guideline updates and replaces 'Prostate cancer' (NICE clinical guideline 58). The recommendations are labelled according to when they were originally published (see [About this guideline](#) for details).

Prostate cancer is the most common cancer in men and makes up 26% of all male cancer diagnoses in the UK. In 2008, 34,335 men were diagnosed with prostate cancer and there were 9376 deaths from prostate cancer in England, Wales and Northern Ireland. This figure increased to 9632 deaths in 2010.

Prostate cancer is predominantly a disease of older men (aged 65–79 years) but around 25% of cases occur in men younger than 65. There is also higher incidence of and mortality from prostate cancer in men of black African-Caribbean family origin compared with white Caucasian men.

Prostate cancer is usually diagnosed after a blood test in primary care has shown elevated prostate-specific antigen (PSA) levels. The introduction of PSA testing has significantly reduced the number of men presenting with metastatic cancer since the 1980s. Most prostate cancers are now either localised or locally advanced at diagnosis, with no evidence of spread beyond the pelvis.

A number of treatments are available for localised disease, including: active surveillance, radical prostatectomy, external beam radiotherapy and brachytherapy. Hormone therapy (androgen deprivation or anti-androgens) is the usual primary treatment for metastatic prostate cancer, but is also increasingly being used for men with locally advanced, non-metastatic disease.

This updated guidance includes several treatments that have been licensed for the management of hormone-relapsed metastatic prostate cancer since the publication of NICE clinical guideline 58 (2008). It also aims to reduce the uncertainty and variations in practice that remain in some areas of prostate cancer diagnosis and management. Updated recommendations are provided on:

- pre-biopsy imaging

- management after an initial negative biopsy
- imaging for T and N staging
- groups for whom active surveillance is suitable and a protocol for active surveillance
- the most effective radical prostatectomy method
- the combination of external beam radiotherapy and brachytherapy in non-metastatic prostate cancer
- management of radiation-induced enteropathy
- the combination of hormone therapy and external beam radiotherapy in non-metastatic prostate cancer
- intermittent compared with continuous hormone therapy for men having long-term hormone therapy
- management of side effects resulting from long-term androgen deprivation therapy.

This guideline covers the care of men referred to secondary care with suspected or diagnosed prostate cancer, including follow-up in primary care for men with diagnosed prostate cancer. The guideline does not cover men with an abnormal PSA (prostate-specific antigen) level detected in primary care who have no symptoms and are not referred for subsequent investigation.

An update of [Referral for suspected cancer](#) (NICE clinical guideline 27) is in development. For more information see [clinical guidelines in development](#) on the NICE website.

Drug recommendations

The guideline assumes that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the care of men referred to secondary care with suspected or diagnosed prostate cancer, including follow-up in primary care for men with diagnosed prostate cancer.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in Patient experience in adult NHS services.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in [section 1](#).

Information and decision support for men with prostate cancer, their partners and carers

Decision support

- Discuss all relevant management options recommended in this guideline with men with prostate cancer and their partners or carers, irrespective of whether they are available through local services. [2008]

Assessment

Diagnosis

Magnetic resonance imaging for rebiopsy

- Consider multiparametric MRI (using T2- and diffusion-weighted imaging) for men with a negative transrectal ultrasound 10–12 core biopsy to determine whether another biopsy is needed. [new 2014]

Staging

- Consider multiparametric MRI, or CT if MRI is contraindicated, for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. [new 2014]

Localised and locally advanced prostate cancer**Low-risk localised prostate cancer****Active surveillance**

- Offer active surveillance (in line with the following recommendation) as an option to men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable. **[new 2014]**
- Consider using the protocol in table 2 for men who have chosen active surveillance. **[new 2014]**

Table 2 Protocol for active surveillance

Timing	Tests ¹
At enrolment in active surveillance	Multiparametric MRI if not previously performed
Year 1 of active surveillance	Every 3–4 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 6–12 months: DRE⁴ At 12 months: prostate rebiopsy
Years 2–4 of active surveillance	Every 3–6 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 6–12 months: DRE⁴
Year 5 and every year thereafter until active surveillance ends	Every 6 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 12 months: DRE⁴
¹ If there is concern about clinical or PSA (prostate-specific antigen) changes at any time during active surveillance, reassess with multiparametric MRI and/or rebiopsy. ² May be carried out in primary care if there are agreed shared-care protocols and recall systems. ³ May include PSA doubling time and velocity. ⁴ Should be performed by a healthcare professional with expertise and confidence in performing DRE (digital rectal examination).	

Intermediate- and high-risk localised prostate cancer

Active surveillance

- Consider active surveillance (in line with the recommendation above) for men with intermediate-risk localised prostate cancer who do not wish to have immediate radical prostatectomy or radical radiotherapy. **[new 2014]**

Radical treatment

- Offer men with intermediate- and high-risk localised prostate cancer a combination of radical radiotherapy and androgen deprivation therapy, rather than radical radiotherapy or androgen deprivation therapy alone. **[new 2014]**

Managing adverse effects of radical treatment

Sexual dysfunction

- Ensure that men have early and ongoing access to specialist erectile dysfunction services. **[2008, amended 2014]**

Radiation-induced enteropathy

- Ensure that men with signs or symptoms of radiation-induced enteropathy are offered care from a team of professionals with expertise in radiation-induced enteropathy (who may include oncologists, gastroenterologists, bowel surgeons, dietitians and specialist nurses). **[new 2014]**

Men having hormone therapy

- Consider intermittent therapy for men having long-term androgen deprivation therapy (not in the adjuvant setting), and include discussion with the man, and his partner, family or carers if he wishes, about:
 - the rationale for intermittent therapy **and**
 - the limited evidence for reduction in side effects from intermittent therapy **and**
 - the effect of intermittent therapy on progression of prostate cancer. **[new 2014]**

1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

The recommendations apply to men referred to secondary care with suspected or diagnosed prostate cancer, including follow-up in primary care for men with diagnosed prostate cancer. The recommendations do not apply to men with an abnormal PSA (prostate-specific antigen) level detected in primary care who have no symptoms and are not referred for subsequent investigation.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See [About this guideline](#) for details.

1.1 *Information and decision support for men with prostate cancer, their partners and carers*

Information

- 1.1.1 Follow the recommendations on communication and patient-centred care in the NICE cancer service guidance [Improving outcomes in urological cancers](#) and [Improving supportive and palliative care for adults with cancer](#) throughout the patient journey. **[2008]**
- 1.1.2 Offer men with prostate cancer individualised information tailored to their own needs. This information should be given by a healthcare professional (for example, a consultant or specialist nurse) and may be supported by written and visual media (for example, slide sets or DVDs). **[2008]**
- 1.1.3 Offer men with prostate cancer advice on how to access information and support from websites, local and national cancer information services, and from cancer support groups. **[2008]**

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- 1.1.4 Before choosing or recommending information resources for men with prostate cancer, check that their content is clear, reliable and up to date. Seek feedback from men with prostate cancer and their carers to identify the highest quality information resources. **[2008]**

Decision support

- 1.1.5 Ascertain the extent to which the man wishes to be involved in decision-making and ensure that he has sufficient information to do so. **[2008]**
- 1.1.6 Use a validated, up-to-date decision aid¹ in all urological cancer multidisciplinary teams (MDTs). Healthcare professionals trained in its use should offer it to men with localised prostate cancer when making treatment decisions. **[2008]**
- 1.1.7 Nomograms may be used by healthcare professionals in partnership with men with prostate cancer to:
- aid decision-making
 - help predict biopsy results
 - help predict pathological stage
 - help predict risk of treatment failure. **[2008]**
- 1.1.8 When nomograms are used, clearly explain the reliability, validity and limitations of the prediction. **[2008]**
- 1.1.9 Discuss all relevant management options recommended in this guideline with men with prostate cancer and their partners or carers, irrespective of whether they are available through local services. **[2008]**
- 1.1.10 Tell men:
- about treatment options and their risks and benefits¹ in an objective, unbiased manner **and**
 - that there is limited evidence for some treatment options. **[new 2014]**

¹ A decision aid for men with localised prostate cancer is available from [NHS Shared decision making](#).

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- 1.1.11 Ensure that mechanisms are in place to allow men with prostate cancer and their primary care providers to gain access to specialist services throughout the course of their disease. [2008]
 - 1.1.12 Adequately inform men with prostate cancer and their partners or carers about the effects of prostate cancer and the treatment options on their sexual function, physical appearance, continence and other aspects of masculinity. Support men and their partners or carers in making treatment decisions, taking into account the effects on quality of life as well as survival. [2008]
 - 1.1.13 Offer men with prostate cancer and their partners or carers the opportunity to talk to a healthcare professional experienced in dealing with psychosexual issues at any stage of the illness and its treatment. [2008]

1.2 *Assessment*

Diagnosis

Biopsy

- 1.2.1 To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors (including increasing age and black African-Caribbean family origin) and any history of a previous negative prostate biopsy. Do not automatically offer a prostate biopsy on the basis of serum PSA level alone. [2008]
- 1.2.2 Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy. Include an explanation of the risks (including the increased chance of having to live with the diagnosis of clinically insignificant prostate cancer) and benefits of prostate biopsy. [2008]
- 1.2.3 If the clinical suspicion of prostate cancer is high, because of a high PSA value and evidence of bone metastases (identified by a positive isotope bone scan or sclerotic metastases on plain radiographs), do not offer prostate biopsy for histological confirmation, unless this is required as part of a clinical trial. [2008]

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- 1.2.4 Carry out prostate biopsy following the procedure recommended by the Prostate Cancer Risk Management Programme in Undertaking a transrectal ultrasound guided biopsy of the prostate. **[2008]**
- 1.2.5 A core member of the urological cancer MDT should review the risk factors of all men who have had a negative first prostate biopsy, and discuss with the man that:
- there is still a risk that prostate cancer is present **and**
 - the risk is slightly higher if any of the following risk factors are present:
 - the biopsy showed high-grade prostatic intra-epithelial neoplasia (HGPIN)
 - the biopsy showed atypical small acinar proliferation (ASAP)
 - abnormal digital rectal examination. **[new 2014]**

Magnetic resonance imaging for rebiopsy

- 1.2.6 Consider multiparametric MRI (using T2- and diffusion-weighted imaging) for men with a negative transrectal ultrasound 10–12 core biopsy to determine whether another biopsy is needed. **[new 2014]**
- 1.2.7 Do not offer another biopsy if the multiparametric MRI (using T2- and diffusion-weighted imaging) is negative, unless any of the risk factors listed in recommendation 1.2.5 are present. **[new 2014]**

Staging

- 1.2.8 Determine the provisional treatment intent (radical or non-radical) before decisions on imaging are made. **[2008]**
- 1.2.9 Do not routinely offer imaging to men who are not candidates for radical treatment. **[2008]**
- 1.2.10 Offer isotope bone scans when hormonal therapy is being deferred through watchful waiting to asymptomatic men who are at high risk of developing bone complications. **[2008]**

- 1.2.11 Consider multiparametric MRI, or CT if MRI is contraindicated, for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. **[new 2014]**
- 1.2.12 Urological cancer MDTs should assign a risk category (see table 1) to all newly diagnosed men with localised prostate cancer. **[2008]**

Table 1 Risk stratification for men with localised prostate cancer

Level of risk	PSA		Gleason score		Clinical stage
Low risk	<10 ng/ml	and	≤6	and	T1–T2a
Intermediate risk	10–20 ng/ml	or	7	or	T2b
High risk ¹	>20 ng/ml	or	8–10	or	≥T2c
¹ High-risk localised prostate cancer is also included in the definition of locally advanced prostate cancer.					

- 1.2.13 Do not offer CT of the pelvis to men with low- or intermediate-risk localised prostate cancer (see table 1). **[2008]**
- 1.2.14 Do not routinely offer isotope bone scans to men with low-risk localised prostate cancer. **[2008]**
- 1.2.15 Do not offer positron emission tomography imaging for prostate cancer in routine clinical practice. **[2008]**

1.3 Localised and locally advanced prostate cancer

- 1.3.1 Prior to radical treatment, warn men and, if they wish, their partner, that radical treatment for prostate cancer will result in an alteration of sexual experience, and may result in loss of sexual function. **[2008, amended 2014]**

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- 1.3.2 Warn men and, if they wish, their partner, about the potential loss of ejaculation and fertility associated with radical treatment for prostate cancer. Offer sperm storage. **[2008, amended 2014]**
 - 1.3.3 Warn men undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. **[2008, amended 2014]**
 - 1.3.4 Offer men experiencing troublesome urinary symptoms before treatment a urological assessment. **[2008]**
 - 1.3.5 Given the range of treatment modalities and their serious side effects, men with prostate cancer who are candidates for radical treatment should have the opportunity to discuss their treatment options with a specialist surgical oncologist and a specialist clinical oncologist. **[2008]**
 - 1.3.6 Tell men that there is a small increase in the risk of colorectal cancer after radical external beam radiotherapy for prostate cancer. **[new 2014]**

Low-risk localised prostate cancer

Active surveillance

- 1.3.7 Offer active surveillance (in line with recommendation 1.3.8) as an option to men with low-risk localised prostate cancer for whom radical prostatectomy or radical radiotherapy is suitable. **[new 2014]**
- 1.3.8 Consider using the protocol in table 2 for men who have chosen active surveillance. **[new 2014]**

Table 2 Protocol for active surveillance

Timing	Tests ¹
At enrolment in active surveillance	Multiparametric MRI if not previously performed
Year 1 of active surveillance	Every 3–4 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 6–12 months: DRE⁴ At 12 months: prostate rebiopsy
Years 2–4 of active surveillance	Every 3–6 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 6–12 months: DRE⁴
Year 5 and every year thereafter until active surveillance ends	Every 6 months: measure PSA² Throughout active surveillance: monitor PSA kinetics³ Every 12 months: DRE⁴
¹ If there is concern about clinical or PSA changes at any time during active surveillance, reassess with multiparametric MRI and/or rebiopsy. ² May be carried out in primary care if there are agreed shared-care protocols and recall systems. ³ May include PSA doubling time and velocity. ⁴ Should be performed by a healthcare professional with expertise and confidence in performing DRE.	

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- 1.3.9 The decision to proceed from an active surveillance regimen to radical treatment should be made in the light of the individual man's personal preferences, comorbidities and life expectancy. **[2008]**

Radical treatment

- 1.3.10 Offer radical treatment to men with localised prostate cancer who have chosen an active surveillance regimen and who have evidence of disease progression. **[2008, amended 2014]**

Intermediate- and high-risk localised prostate cancer

Active surveillance

- 1.3.11 Consider active surveillance (in line with recommendation 1.3.8) for men with intermediate-risk localised prostate cancer who do not wish to have immediate radical prostatectomy or radical radiotherapy. **[new 2014]**
- 1.3.12 Do not offer active surveillance to men with high-risk localised prostate cancer. **[2014]**

Radical treatment

- 1.3.13 Offer radical prostatectomy or radical radiotherapy to men with intermediate-risk localised prostate cancer. **[2008]**
- 1.3.14 Offer radical prostatectomy or radical radiotherapy to men with high-risk localised prostate cancer when there is a realistic prospect of long-term disease control. **[2008]**
- 1.3.15 Commissioners of urology services should consider providing robotic surgery to treat localised prostate cancer. **[new 2014]**
- 1.3.16 Commissioners should ensure that robotic systems for the surgical treatment of localised prostate cancer are cost effective by basing them in centres that are expected to perform at least 150 robot-assisted laparoscopic radical prostatectomies per year. **[new 2014]**

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- 1.3.17 Offer men undergoing radical external beam radiotherapy for localised prostate cancer a minimum dose of 74 Gy to the prostate at no more than 2 Gy per fraction. **[2008]**
- 1.3.18 For men with localised prostate cancer² receiving radical external beam radiotherapy with curative intent, offer planned treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage. **[2008]**
- 1.3.19 Offer men with intermediate- and high-risk localised prostate cancer a combination of radical radiotherapy and androgen deprivation therapy, rather than radical radiotherapy or androgen deprivation therapy alone. **[new 2014]**
- 1.3.20 Offer men with intermediate- and high-risk localised prostate cancer 6 months of androgen deprivation therapy before, during or after radical external beam radiotherapy. **[new 2014]**
- 1.3.21 Consider continuing androgen deprivation therapy for up to 3 years for men with high-risk localised prostate cancer and discuss the benefits and risks of this option with them. **[new 2014]**
- 1.3.22 Consider high-dose rate brachytherapy in combination with external beam radiotherapy for men with intermediate- and high-risk localised prostate cancer. **[new 2014]**
- 1.3.23 Do not offer brachytherapy alone to men with high-risk localised prostate cancer. **[2008]**
- 1.3.24 Do not offer high-intensity focused ultrasound and cryotherapy to men with localised prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions³. **[2008]**

² This may also apply to some men with locally advanced prostate cancer.

³ NICE interventional procedure guidance [118](#), [119](#) and [145](#) evaluated the safety and efficacy of cryotherapy and high-intensity focused ultrasound for the treatment of prostate cancer. NICE clinical guidelines provide guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS. As there was a lack of evidence on quality of life benefits and long-term survival, these interventions are not recommended in this guideline.

Watchful waiting

- 1.3.25 A member of the urological cancer MDT should review men with localised prostate cancer who have chosen a watchful waiting regimen and who have evidence of significant disease progression (that is, rapidly rising PSA level or bone pain). [2008]

Locally advanced prostate cancer

- 1.3.26 Clinical oncologists should consider pelvic radiotherapy in men with locally advanced prostate cancer who have a higher than 15% risk of pelvic lymph node involvement⁴ and who are to receive neoadjuvant hormonal therapy and radical radiotherapy. [2008]
- 1.3.27 Do not offer immediate post-operative radiotherapy after radical prostatectomy, even to men with margin-positive disease, other than in the context of a clinical trial. [2008]
- 1.3.28 Do not offer adjuvant hormonal therapy in addition to radical prostatectomy, even to men with margin-positive disease, other than in the context of a clinical trial. [2008]
- 1.3.29 Do not offer high-intensity focused ultrasound and cryotherapy to men with locally advanced prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions³. [2008]
- 1.3.30 Do not offer bisphosphonates for the prevention of bone metastases in men with prostate cancer. [2008]

Managing adverse effects of radical treatment**Sexual dysfunction**

- 1.3.31 Ensure that men have early and ongoing access to specialist erectile dysfunction services. [2008, amended 2014]
- 1.3.32 Offer men with prostate cancer who experience loss of erectile function phosphodiesterase type 5 (PDE5) inhibitors to improve their chance of spontaneous erections. [2008]

⁴ Estimated using the Roach formula; %LN risk = $2/3 \text{ PSA} + (10 \times [\text{Gleason score} - 6])$

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- 1.3.33 If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer men vacuum devices, intraurethral inserts or penile injections, or penile prostheses as an alternative. **[2008]**

Urinary incontinence

- 1.3.34 Ensure that men with troublesome urinary symptoms after treatment have access to specialist continence services for assessment, diagnosis and conservative treatment. This may include coping strategies, along with pelvic floor muscle re-education, bladder retraining and pharmacotherapy. **[2008]**
- 1.3.35 Refer men with intractable stress incontinence to a specialist surgeon for consideration of an artificial urinary sphincter. **[2008]**
- 1.3.36 Do not offer injection of bulking agents into the distal urinary sphincter to treat stress incontinence. **[2008]**

Radiation-induced enteropathy

- 1.3.37 Ensure that men with signs or symptoms of radiation-induced enteropathy are offered care from a team of professionals with expertise in radiation-induced enteropathy (who may include oncologists, gastroenterologists, bowel surgeons, dietitians and specialist nurses). **[new 2014]**
- 1.3.38 The nature and treatment of radiation-induced enteropathy should be included in the training programmes for oncologists and gastroenterologists. **[2014]**
- 1.3.39 Carry out full investigations, including flexible sigmoidoscopy, in men who have symptoms of radiation-induced enteropathy to exclude inflammatory bowel disease or malignancy of the large bowel and to ascertain the nature of the radiation injury. Use caution when performing anterior wall rectal biopsy after brachytherapy because of the risk of fistulation. **[2014]**

Follow-up

- 1.3.40 Discuss the purpose, duration, frequency and location of follow-up with each man with localised prostate cancer², and if he wishes, his partner or carers. **[2008]**

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- 1.3.41 Clearly advise men with prostate cancer about potential longer-term adverse effects of treatment and when and how to report them. **[2008]**
 - 1.3.42 Men with prostate cancer who have chosen a watchful waiting regimen with no curative intent should normally be followed up in primary care in accordance with protocols agreed by the local urological cancer MDT and the relevant primary care organisation(s). Their PSA should be measured at least once a year. **[2008]**
 - 1.3.43 Check PSA levels for all men with prostate cancer who are having radical treatment at the earliest 6 weeks following treatment, at least every 6 months for the first 2 years and then at least once a year thereafter. **[2008]**
 - 1.3.44 Do not routinely offer DRE to men with localised prostate cancer while the PSA remains at baseline levels. **[2008]**
 - 1.3.45 After at least 2 years, offer follow-up outside hospital (for example, in primary care) by telephone or secure electronic communications to men with a stable PSA who have had no significant treatment complications, unless they are taking part in a clinical trial that requires formal clinic-based follow-up. Direct access to the urological cancer MDT should be offered and explained. **[2008]**

Managing relapse after radical treatment

- 1.3.46 Analyse serial PSA levels after radical treatment using the same assay technique. **[2008]**
- 1.3.47 Do not offer biopsy of the prostatic bed to men with prostate cancer who have had a radical prostatectomy. **[2008]**
- 1.3.48 Offer biopsy of the prostate after radiotherapy only to men with prostate cancer who are being considered for local salvage therapy in the context of a clinical trial. **[2008]**
- 1.3.49 For men with evidence of biochemical relapse following radical treatment and who are considering radical salvage therapy:
 - do not offer routine MRI scanning prior to salvage radiotherapy in men with prostate cancer

- offer an isotope bone scan if symptoms or PSA trends are suggestive of metastases. [2008]

- 1.3.50 Biochemical relapse (a rising PSA) alone should not necessarily prompt an immediate change in treatment. [2008]
- 1.3.51 Biochemical relapse should trigger an estimate of PSA doubling time, based on a minimum of 3 measurements over at least a 6-month period. [2008]
- 1.3.52 Offer men with biochemical relapse after radical prostatectomy, with no known metastases, radical radiotherapy to the prostatic bed. [2008]
- 1.3.53 Men with biochemical relapse should be considered for entry to appropriate clinical trials. [2008]
- 1.3.54 Do not routinely offer hormonal therapy to men with prostate cancer who have a biochemical relapse unless they have:
- symptomatic local disease progression, or
 - any proven metastases, or
 - a PSA doubling time of less than 3 months. [2008]

1.4 *Men having hormone therapy*

- 1.4.1 Consider intermittent therapy for men having long-term androgen deprivation therapy (not in the adjuvant setting), and include discussion with the man, and his partner, family or carers if he wishes, about:
- the rationale for intermittent therapy and
 - the limited evidence for reduction in side effects from intermittent therapy and
 - the effect of intermittent therapy on progression of prostate cancer. [new 2014]
- 1.4.2 For men who are having intermittent androgen deprivation therapy:
- measure PSA every 3 months and

-
- restart androgen deprivation therapy if PSA is 10 ng/ml or above, or if there is symptomatic progression. **[new 2014]**

Managing adverse effects of hormone therapy

Hot flushes

- 1.4.3 Offer medroxyprogesterone⁵ (20 mg per day), initially for 10 weeks, to manage troublesome hot flushes caused by long-term androgen suppression and evaluate the effect at the end of the treatment period. **[new 2014]**
- 1.4.4 Consider cyproterone acetate or megestrol acetate⁶ (20 mg twice a day for 4 weeks) to treat troublesome hot flushes if medroxyprogesterone is not effective or not tolerated. **[new 2014]**
- 1.4.5 Tell men that there is no good-quality evidence for the use of complementary therapies to treat troublesome hot flushes. **[new 2014]**

Sexual dysfunction

- 1.4.6 Before starting androgen deprivation therapy, tell men and, if they wish, their partner, that long-term androgen deprivation will cause a reduction in libido and possible loss of sexual function. **[new 2014]**
- 1.4.7 Advise men and, if they wish, their partner, about the potential loss of ejaculation and fertility associated with long-term androgen deprivation and offer sperm storage. **[new 2014]**
- 1.4.8 Ensure that men starting androgen deprivation therapy have access to specialist erectile dysfunction services. **[new 2014]**

⁵ At the time of publication (January 2014), medroxyprogesterone did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

⁶ At the time of publication (January 2014), megestrol acetate did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

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- 1.4.9 Consider referring men who are having long-term androgen deprivation therapy, and their partners, for psychosexual counselling. **[new 2014]**
- 1.4.10 Offer PDE5 inhibitors to men having long-term androgen deprivation therapy who experience loss of erectile function. **[new 2014]**
- 1.4.11 If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer a choice of:
- intraurethral inserts
 - penile injections
 - penile prostheses
 - vacuum devices. **[new 2014]**

Osteoporosis

- 1.4.12 Do not routinely offer bisphosphonates to prevent osteoporosis in men with prostate cancer having androgen deprivation therapy. **[2008]**
- 1.4.13 Consider assessing fracture risk in men with prostate cancer who are having androgen deprivation therapy, in line with Osteoporosis (NICE clinical guideline 146). **[new 2014]**
- 1.4.14 Offer bisphosphonates to men who are having androgen deprivation therapy and have osteoporosis. **[new 2014]**
- 1.4.15 Consider denosumab for men who are having androgen deprivation therapy and have osteoporosis if bisphosphonates are contraindicated or not tolerated. **[new 2014]**

Gynaecomastia

- 1.4.16 For men starting long-term bicalutamide monotherapy (longer than 6 months), offer prophylactic radiotherapy to both breast buds within the first month of treatment. Choose a single fraction of 8 Gy using orthovoltage or electron beam radiotherapy. **[2008]**

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- 1.4.17 If radiotherapy is unsuccessful in preventing gynaecomastia, weekly tamoxifen⁷ should be considered. [2008]

Fatigue

- 1.4.18 Tell men who are starting androgen deprivation therapy that fatigue is a recognised side effect of this therapy and not necessarily a result of prostate cancer. [new 2014]
- 1.4.19 Offer men who are starting or having androgen deprivation therapy supervised resistance and aerobic exercise at least twice a week for 12 weeks to reduce fatigue and improve quality of life. [new 2014]

1.5 *Metastatic prostate cancer*

Information and support

- 1.5.1 Offer men with metastatic prostate cancer tailored information and access to specialist urology and palliative care teams to address the specific needs of men with metastatic prostate cancer. Offer them the opportunity to discuss any significant changes in their disease status or symptoms as these occur. [2008]
- 1.5.2 Integrate palliative interventions at any stage into coordinated care, and facilitate any transitions between care settings as smoothly as possible. [2008]
- 1.5.3 Discuss personal preferences for palliative care as early as possible with men with metastatic prostate cancer, their partners and carers. Tailor treatment/care plans accordingly and identify the preferred place of care. [2008]
- 1.5.4 Ensure that palliative care is available when needed and is not limited to the end of life. It should not be restricted to being associated with hospice care. [2008]
- 1.5.5 Offer a regular assessment of needs to men with metastatic prostate cancer. [2008]

⁷ At the time of publication (January 2014), tamoxifen did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

Treatment

- 1.5.6 Offer bilateral orchidectomy to all men with metastatic prostate cancer as an alternative to continuous luteinising hormone-releasing hormone agonist therapy. [2008]
- 1.5.7 Do not offer combined androgen blockade as a first-line treatment for men with metastatic prostate cancer. [2008]
- 1.5.8 For men with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia in the hope of retaining sexual function, offer anti-androgen monotherapy with bicalutamide⁸ (150 mg). [2008]
- 1.5.9 Begin androgen deprivation therapy and stop bicalutamide treatment in men with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function. [2008]

Hormone-relapsed metastatic prostate cancer

Recommendations in this section marked with an asterisk are from [Docetaxel for the treatment of hormone-refractory metastatic prostate cancer](#) (NICE technology appraisal guidance 101).

- 1.5.10 When men with prostate cancer develop biochemical evidence of hormone-relapsed disease, their treatment options should be discussed by the urological cancer MDT with a view to seeking an oncologist and/or specialist palliative care opinion, as appropriate. [2008]
- 1.5.11 Docetaxel is recommended, within its licensed indications, as a treatment option for men with hormone-refractory prostate cancer only if their Karnofsky performance-status score is 60% or more. [2008]*
- 1.5.12 It is recommended that treatment with docetaxel should be stopped:
- at the completion of planned treatment of up to 10 cycles, or
 - if severe adverse events occur, or

⁸ At the time of publication (January 2014), bicalutamide did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

- in the presence of progression of disease as evidenced by clinical or laboratory criteria, or by imaging studies. [2008]*

- 1.5.13 Repeat cycles of treatment with docetaxel are not recommended if the disease recurs after completion of the planned course of chemotherapy. [2008]*
- 1.5.14 Offer a corticosteroid such as dexamethasone (0.5 mg daily) as third-line hormonal therapy after androgen deprivation therapy and anti-androgen therapy to men with hormone-relapsed prostate cancer. [2008]
- 1.5.15 Offer spinal MRI to men with hormone-relapsed prostate cancer shown to have extensive metastases in the spine (for example, on a bone scan) if they develop any spinal-related symptoms. [2008]
- 1.5.16 Do not routinely offer spinal MRI to all men with hormone-relapsed prostate cancer and known bone metastases. [2008]

Bone-targeted therapies

- 1.5.17 Do not offer bisphosphonates to prevent or reduce the complications of bone metastases in men with hormone-relapsed prostate cancer. [2008]
- 1.5.18 Bisphosphonates for pain relief may be considered for men with hormone-relapsed prostate cancer when other treatments (including analgesics and palliative radiotherapy) have failed. Choose the oral or intravenous route of administration according to convenience, tolerability and cost. [2008]
- 1.5.19 Strontium-89 should be considered for men with hormone-relapsed prostate cancer and painful bone metastases, especially those men who are unlikely to receive myelosuppressive chemotherapy. [2008]

Pelvic-targeted therapies

- 1.5.20 Offer decompression of the upper urinary tract by percutaneous nephrostomy or by insertion of a double J stent to men with obstructive uropathy secondary to hormone-relapsed prostate cancer. [2008]

- 1.5.21 The option of no intervention should also be discussed with men with obstructive uropathy secondary to hormone-relapsed prostate cancer and remains a choice for some. [2008]

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

2.1 *Prognostic indicators*

Further research is required into the identification of prognostic indicators in order to differentiate effectively between men who may die with prostate cancer and those who might die from prostate cancer. [2008]

Why this is important

The greatest uncertainties in managing prostate cancer are around the identification of which cancers are of clinical significance and over the choice of radical treatment, and in which settings they are appropriate. With the diagnosis of prostate cancer being made more frequently in asymptomatic men, it is of growing importance to know which of these men are likely to benefit from aggressive treatment.

2.2 *Androgen deprivation therapy and/or brachytherapy added to radiotherapy for men with intermediate- and high-risk localised non-metastatic prostate cancer*

Does the addition of androgen deprivation therapy and/or brachytherapy to high-dose external beam radiotherapy improve outcomes for men with intermediate- and high-risk localised non-metastatic prostate cancer? Outcomes of interest are biochemical disease-free survival, metastasis-free survival, overall survival, side effects and quality of life. [new 2014]

Why this is important

There is insufficient evidence on the effectiveness of adding androgen deprivation therapy or brachytherapy, or both, to external beam radiotherapy (using current optimal techniques) in men with intermediate- and high-risk localised non-metastatic prostate cancer.

Randomised controlled trials should compare the effectiveness of the following:

- external beam radiotherapy combined with androgen deprivation therapy
- external beam radiotherapy combined with brachytherapy
- external beam radiotherapy combined with androgen deprivation therapy and brachytherapy
- external beam radiotherapy alone.

2.3 *Local salvage therapies in men with biochemical relapse after radiotherapy*

Clinical trials should be set up to examine the effect of local salvage therapies on survival and quality of life in men with biochemical relapse after radiotherapy. [2008]

Why this is important

Salvage local therapies after radiotherapy include radical prostatectomy, cryotherapy and high-intensity focused ultrasound, but little evidence exists to support their use, and there may be a higher risk of incontinence, impotence and rectal damage than when used as primary treatment.

2.4 *Bisphosphonates and denosumab to treat osteoporosis*

What is the clinical and cost effectiveness of standard care with bisphosphonates compared with denosumab to treat osteoporosis caused by long-term androgen deprivation therapy? Outcomes of interest are bone mineral density, fracture risk, tolerability and skeletal-related events. [new 2014]

Why this is important

Men having long-term androgen deprivation therapy for prostate cancer have an increased fracture risk. Osteoporosis (NICE clinical guideline 146) recommends that fracture risk be

assessed when starting long-term androgen deprivation therapy but the effectiveness of interventions such as bisphosphonates and denosumab in men with an increased fracture risk is not known.

2.5 *Duration of exercise to combat fatigue in men having androgen deprivation therapy*

Does a longer (more than 12 weeks) programme of supervised aerobic resistance exercise reduce fatigue more effectively than a 12-week programme in men having androgen deprivation therapy? Outcomes of interest are measures of fatigue, aerobic capacity, cardiovascular function and quality of life. [new 2014]

Why this is important

A 12-week programme of supervised aerobic resistance exercise given for 12 weeks has been shown to improve quality of life and reduce side effects for men having androgen deprivation therapy for prostate cancer. It is not clear whether continuing the exercise programme beyond 12 weeks will result in further improvements.

3 Other information

3.1 *Scope and how this guideline was developed*

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

Groups that will be covered

- Men referred from primary care for investigation of possible prostate cancer, in line with Referral guidelines for suspected cancer (NICE clinical guideline 27).
- Men with a biopsy-proven diagnosis of primary adenocarcinoma of the prostate, or an agreed clinical diagnosis⁹ if biopsy is inappropriate.
- Consideration will be given to men of African-Caribbean family origin.

⁹ Agreed clinical diagnosis on the basis of, for example, digital rectal examination, high PSA levels and known metastases.

Groups that will not be covered

- Asymptomatic men with an abnormal PSA level detected in primary care who are not referred for subsequent investigation.
- Men with metastatic disease of different primary origin involving the prostate.
- Men with rare malignant tumours of the prostate, such as small cell carcinoma and rhabdomyosarcoma.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Cancer to develop this guideline. The Centre established a Guideline Development Group (see [section 4](#)), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

3.2 Related NICE guidance

Details are correct at the time of publication (January 2014). Further information is available on the [NICE website](#).

Published

General

- [Patient experience in adult NHS services](#). NICE clinical guidance 138 (2012).
- [Medicines adherence](#). NICE clinical guideline 76 (2009).

Condition-specific

- [Opioids in palliative care](#). NICE clinical guideline 140 (2012).
- [Osteoporosis fragility fracture](#). NICE clinical guideline 146 (2012).
- [Bone metastases from solid tumours – denosumab](#). NICE technology appraisal guidance 265 (2012).
- [Prostate cancer \(metastatic, castration resistant\) – abiraterone \(following cytotoxic therapy\)](#). NICE technology appraisal guidance 259 (2012).

-
- Prostate cancer – cabazitaxel. NICE technology appraisal guidance 255 (2012).
 - Focal therapy using cryoablation for localised stage prostate cancer. NICE interventional procedure guidance 423 (2012).
 - Focal therapy using high-intensity focused ultrasound (HIFU) for localised prostate cancer. NICE interventional procedure guidance 424 (2012).
 - Metastatic spinal cord compression. NICE clinical guideline 75 (2008).
 - Intraoperative red blood cell salvage during radical prostatectomy or radical cystectomy. NICE interventional procedure guidance 258 (2008).
 - Laparoscopic radical prostatectomy. NICE interventional procedure guidance 193 (2006).
 - High dose rate brachytherapy in combination with external-beam radiotherapy for localised prostate cancer. NICE interventional procedure guidance 174 (2006).
 - Cryotherapy as a primary treatment for prostate cancer. NICE interventional procedure guidance 145 (2005).
 - Low dose rate brachytherapy for localised prostate cancer. NICE interventional procedure guidance 132 (2005).
 - Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005).
 - Cryotherapy for recurrent prostate cancer. NICE interventional procedure guidance 119 (2005).
 - High-intensity focused ultrasound for prostate cancer. NICE interventional procedure guidance 118 (2005).
 - Improving supportive and palliative care for adults with cancer. NICE cancer service guidance (2004).
 - Transurethral electrovaporisation of the prostate. NICE interventional procedure guidance 14 (2003).
 - Improving outcomes in urological cancers. NICE cancer service guidance (2002).

Under development

NICE is developing the following guidance (details available from the [NICE website](#)):

- Prostate cancer (hormone relapsed, metastatic) – enzalutamide (after docetaxel). NICE technology appraisal guidance. Publication expected February 2014.

-
- Prostate cancer (hormone relapsed, bone metastases) – radium-223 dichloride. NICE technology appraisal guidance. Publication expected February 2014.
 - Prostate cancer (metastatic, hormone relapsed) – sipuleucel-T (first line). NICE technology appraisal guidance. Publication expected February 2014.
 - Prostate cancer (advanced, hormone dependent) – degarelix depot. NICE technology appraisal guidance. Publication expected May 2014.
 - Suspected cancer. NICE clinical guideline. Publication date to be confirmed.

4 The Guideline Development Group, National Collaborating Centre and NICE project team

4.1 *Guideline Development Group*

The Guideline Development Group members listed are those for the 2014 update. For the composition of the previous Guideline Development Group, see the [full guideline](#).

Hugh Butcher

Patient and carer member

Sarah Cant

Patient and carer member, Head of Policy and Campaigns, Prostate Cancer UK

Sean Duffy

GDG Chair (until March 2013), Yorkshire Cancer Network

John Graham

GDG Chair (from March 2013), Consultant Lead Clinical Oncologist, Taunton and Somerset NHS Trust

Peter Hoskin

Consultant Oncologist, Mount Vernon Cancer Centre

Nicola James

Nurse Consultant, Chesterfield Royal Hospital, Derbyshire

Peter Kirkbride

GDG Lead Clinician, Medical Director, Clatterbridge Cancer Centre, Merseyside

Howard Kynaston

Professor of Urological Surgery, Cardiff University

Brian McGlynn

Nurse Consultant Urology Oncology, The Ayr Hospital, Ayr

David Neal

Professor of Surgical Oncology, University of Cambridge

Kathleen Nuttall

Director, Lancashire and South Cumbria Cancer Network

Jon Oxley

Consultant in Cellular Pathology, Southmead Hospital, Bristol

Jonathan Richenberg

Consultant Uroradiologist, Brighton and Sussex University Hospital NHS Trust

4.2 *National Collaborating Centre for Cancer***John Graham**

Director

Andrew Champion

Centre Manager

Angela Bennett

Assistant Centre Manager

Victoria Titshall

Project Manager (until December 2012)

Jenny Stock

Project Manager (from December 2012)

Nathan Bromham

Senior Researcher

Kimberley Cann

Researcher

Mia Schmidt-Hansen

Researcher

Jennifer Hilgart

Researcher

Elise Hasler

Information Specialist

Stephanie Arnold

Information Specialist

Sabine Berendse

Information Specialist

Bernadette Coles

Site Librarian, Cancer Research Wales Library

Matthew Prettyjohns

Health Economist

4.3 NICE project team**Nicole Elliott**

Guideline Lead (until July 2013)

Sharon Summers-Ma

Guideline Lead (from August 2013)

Mark Baker

Clinical Adviser

Katie Perryman Ford

Guideline Commissioning Manager (from June 2013)

Claire Ruiz

Guideline Commissioning Manager (until May 2013)

Carl Dawood

Guideline Coordinator (until August 2013)

Anthony Gildea

Guideline Coordinator (from September 2013)

Steven Barnes

Technical Lead (from January 2013)

Toni Tan

Technical Lead (until December 2012)

Prashanth Kandaswamy

Health Economist (until April 2013)

Bhash Naidoo

Health Economist (from May 2013)

Judy McBride

Editor

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

This guideline was developed by the National Collaborating Centre for Cancer. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff,

which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

This guideline updates and replaces NICE clinical guideline 58 (published February 2008).

Recommendations are marked as **[new 2014]**, **[2014]**, **[2008]** or **[2008, amended 2014]**:

- **[new 2014]** indicates that the evidence has been reviewed and the recommendation has been added or updated
- **[2014]** indicates that the evidence has been reviewed but no change has been made to the recommended action
- **[2008]** indicates that the evidence has not been reviewed since 2008
- **[2008, amended 2014]** indicates that the evidence has not been reviewed since 2008, but changes have been made to the recommendation wording that change the meaning (see below).

Recommendations from NICE clinical guideline 58 that have been amended

Recommendations are labelled **[2008, amended 2014]** if the evidence has not been reviewed since 2008 but changes have been made to the recommendation wording that change the meaning.

Recommendation in NICE clinical guideline 58	Recommendation in current guideline	Reason for change
Men with localised prostate cancer who have chosen an active surveillance regimen and who have evidence of disease progression (that is, a rise in PSA level or adverse findings on biopsy) should be offered radical treatment. [1.3.9]	Offer radical treatment to men with localised prostate cancer who have chosen an active surveillance regimen and who have evidence of disease progression. [1.3.10] [2008, amended 2014]	The text 'that is, a rise in PSA level or adverse findings on biopsy' has been deleted because it is now inconsistent with the protocol recommended for active surveillance.
Prior to treatment, men and their partners should be warned that treatment for prostate cancer will result in an alteration of sexual experience, and may result in loss of sexual function. [1.4.6]	Prior to radical treatment, warn men and, if they wish, their partner, that radical treatment for prostate cancer will result in an alteration of sexual experience, and may result in loss of sexual function. [1.3.1] [2008, amended 2014]	The original wording has been amended to clarify that partners are covered by the recommendation only if the man wishes this to be the case. Wording has also been amended to clarify this recommendation relates to radical treatment.
Men and their partners should be warned about the potential loss of ejaculation and fertility associated with treatment for prostate cancer. Sperm	Warn men and, if they wish, their partner, about the potential loss of ejaculation and fertility associated with radical treatment for prostate	The original wording has been amended to clarify that partners are covered by the recommendation only if the man wishes this

storage should be offered. [1.4.7]	cancer. Offer sperm storage. [1.3.2] [2008, amended 2014]	to be the case. Wording has also been amended to clarify this recommendation relates to radical treatment.
Men undergoing treatment for prostate cancer should be warned of the likely effects of the treatment on their urinary function. [1.4.12]	Warn men undergoing radical treatment for prostate cancer of the likely effects of the treatment on their urinary function. [1.3.3] [2008, amended 2014]	Wording has also been amended to clarify this recommendation relates to radical treatment.
Healthcare professionals should ensure that men and their partners have early and ongoing access to specialist erectile dysfunction services. [1.4.8]	Ensure that men have early and ongoing access to specialist erectile dysfunction services. [1.3.31] [2008, amended 2014]	The text 'and their partners' has been deleted as this only applies to the man.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also Patient-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer...') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations ending **[2008]** (see [Update information](#) above for details about how recommendations are labelled). In particular, for recommendations labelled **[2008]** the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Other versions of this guideline

The full guideline 'Prostate cancer: diagnosis and treatment' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Cancer.

The recommendations from this guideline have been incorporated into a [NICE Pathway](#).

We have produced information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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ISBN: xxxx

COMPLAINTS
Consultant Appraisal 1 October 2011 - 30 september 2012
Mr Aidan O'Brien

ID	First received	Record name	Description	Outcome
Personal Information redacted by the USI	21-May-2012	Personal Information redacted by the USI	Complainant unhappy with treatment given for kidney stones whilst he was a patient on ward. Also unhappy with the delays experience in getting an appointment for follow up care.	Apology give for delay in responding to complaint. Apology give for conflicting information in the ED and for any misunderstanding which has arisen. Doctor give patient information to keep him updated. Patient has been treated and will be reviewed in 1 year.
	24-Sep-2012		Complainant unhappy with length of time he is having to wait for review appointments.	The 3 issues raised by complainant of treatment for carpal Tunnel Syndrome, treatment at pain clinic and urology. Complainant has been advised further correspondence will be read and filed. Complainant advised of the complaints guidelines, April 2009.
	1-Jan-2012		Complainant unhappy with delay in provision of an appointment for her father. Also unhappy that his hopes were raised for successful treatment by given false expectations.	Thanked the complainant for her positive experience of the Haematology Dept. Apology given for delay in patients treatment and the breakdown in communication. Acknowledged that the consultant is in direct contact with patient.

INCIDENTS
Consultant Appraisal 1 October 2011 - 30 September 2012
Mr Aidan O'Brien

Personal Information	SCRUB NURSE IN THEATRE WAS DUE OFF DUTY AT 1400HRS. SHE HAD SET UP THE TRAY AND SURGERY HAD COMMENCED AT 1128. NEEDLES, SWABS AND INSTRUMENTS WERE COUNTED AND CHECKED WITH THE SECOND NURSE (NURSE TAKING OVER) AND ALL THE SAME WAS CORRECT AT TIME OF HANDOVER. THE FIRST NURSE DE-SCRUBBED AND WENT OFF DUTY. AT APPROXIMATELY 1600HRS THE SURGEON ASKED THE SECOND NURSE FOR A BLADE IN ORDER TO INSERT A DRAIN. THE BLADE WAS ALREADY ON THE BP HANDLE AT TIME OF HANDOVER AND SEEMED SECURE. THE BLADE WAS GIVEN IN THE CORRECT MANOR; HOWEVER THE BLADE DISLODGED INTO THE PATIENT AND WAS RETREIVED. ON INSPECTION THE BP HANDLE WAS NOTED TO BE WORN. NO HARM CAME TO THE PATIENT AND THE INCIDENT WAS REPORTED TO SENIOR STAFF AND CSSD.	REPORTED TO SR MULHOLLAND REPORTED TO NURSE IN CHARGE OF THEATRE AT THAT TIME FILLED IN IR1 FORM COMPLAINTS FORM FILLED IN TO CSSD AND INFORMED VERBALLY REGARDING SAME BP HANDLE TO BE REMOVED FROM CIRCULATION AS PER CSSD	16-May-2012

COMPLAINTS
CONSULTANT APPRAISAL 1 OCTOBER 2012 - 30 SEPTEMBER 2013

Dr AIDEN O'BRIEN

ID	First received	Record name	Description	Outcome
Personal Information redacted by the USI	13/05/2013	Personal Information redacted by the USI	Complainant wishes to have his constituents operation brought forward and is not happy that there could be a delay in provision of same.	MLA advised it was explained to patient and family his prognosis and treatment.

**INCIDENTS
CONSULTANT APPRAISAL 1 OCTOBER 2012 - 30 SEPTEMBER 2013**

Dr AIDAN O'BRIEN

Nil

Complaint report structured reflective template

Requirement: one for each complaint you have received.

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of complaint: 15 January 2012	
Nature of complaint: The complaint was made by the daughter of a man who had developed acute urinary retention, requiring catheterisation, in August 2011. The patient found it very difficult to accept indwelling catheterisation for any period of time, and certainly until review as an outpatient in October 2011, when I advised the patient that I hoped to have been able to have him admitted for surgery in November 2011, an aspiration which was not realised. In discomfort and frustration, he had the catheter removed by a practice nurse, only to require to be recatheterised 5 days later. However, as a consequence of the progressive effects of pharmacological management, he was eventually able to pass urine satisfactorily without recourse to surgery. When last review, he was entirely asymptomatic. Apart from the inherent length of time required for medication to take effect, the complaint listed the lack of appreciation of the trauma associated with indwelling catheterisation, the lack of counselling and support, and her father having to wear a leg bag rather than having a valved spigot	
Status of complaint: On-going / resolved Resolved	
Involvement of other bodies: Responsible organisation / GMC / Other None	
If resolved, what were the findings? Expression of regret	
How will my practice change? My practice has changed in several respects as a consequence. Unfortunately, it is still the case that the reflex reaction to catheterisation is to arrange a trial removal of catheter without an adequate assessment of the likelihood of success. Even success can be short lived as in this case. Short lived success or initial failure adds to the patient's frustration.	



Southern Health
and Social Care Trust

Quality Care - for you, with you

When receiving a request for trial removal of catheter, I make an assessment of the probability of success, based upon previous history of symptoms, circumstances in which retention occurred, comorbidity and performance status, and prostatic volume. I arrange trial removal if success is probable, and an urgent outpatient appointment if not, in order to arrange trial removal with the capacity to arrange prostatic resection if unsuccessful.

In most cases, a bladder does not require continuous drainage by catheter, no more than does a bladder without an indwelling catheter. In comorbid patients with compromised performance status, continuous drainage may be preferred by patient and carers. However, in the active patient, a continuous drainage bag may be more inconvenient and traumatic for the patient, as was the case here. If preferred, we now fit a valved spigot in the outpatient department, and arrange to have patient supplied.

Lastly, this case brought home to me the extent to which we underestimate the negative impact that indwelling catheterisation can have upon a patient. We are fortunate to have an excellent community continence service who have the capacity and enthusiasm to provide domiciliary counsel and support, and who can be immediately notified at continence.lurgan [REDACTED]

Personal Information redacted by the USI

Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

In addition to the above improvements in the management of those who develop acute urinary retention requiring catheterisation, it is our department's collective intent, with the appointment of additional consultant staff, to be able to expedite the care of these patients, including surgery if required or considered likely to be required



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

Significant event audit (SEA) structured reflective template
Requirement: one annually

Name of doctor: Aidan O'Brien	GMC No: 1394911
SEA Title: Dislodgement of scalpel blade from handle	
Date of incident: 12 May 2012	
Description of events: It was only on requesting that a blade be mounted on a scalpel handle for the purpose of making an incision for the purpose of insertion of an intraperitoneal drain at the end of an operation, was it appreciated that the blade was missing as a consequence of having become dislodged from the handle on withdrawal through a similar, earlier incision. The blade was located within the abdominal cavity and removed. It had not caused any visceral injury.	
What went well? The vigilance of the scrub nurse alerted the operating team to the fact that the blade was missing, leading to its early, intraoperative location.	
What could have been done better? The dislodgement was due to the fact that the handle was relatively old, resulting in the blade mounting slot to have become worn, rendering the mounted blade less secure. It would have been better if that risk relating to the condition of the handle had recognised by all personnel, from CSSD to the surgeon.	
What changes have been agreed? Personally: To check on the security of the mounted blade prior to use, and after, use	



Southern Health
and Social Care Trust

Quality Care - for you, with you

For the team:

Having had the incident reported to CSSD, staff there have endeavoured to do likewise, in addition to the operating team

Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

I was unaware of the risk of dislodgement associated with lack of confluence between new blade and worn handle. I have been since this incident. I check it on each occasion since, to ensure that no harm comes to any patient as a consequence.

Belfast Health & Social Care Trust

Certificate of Completion

This is to certify that:

Aidan O'Brien

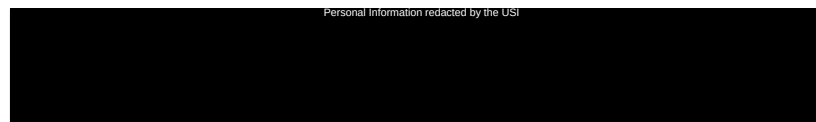
Has successfully completed

Good Clinical Practice Awareness Seminar

18 August 2010



**Belfast Health and
Social Care Trust**



Dr Paul Biagioni, NICRN Manager

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 3 - Communication, Partnership and Teamwork		
Attribute: 3.1 Communicate effectively		
Attribute: 3.2 Work constructively with colleagues and delegate effectively		
Attribute: 3.3 Establish and maintain partnerships with patients		
	List of Supporting Information	Applicable Date
1	Certificate of Completion of Discovering Diversity Programme	12 March 2014
2	GMC Colleague Feedback Report	25 February 2014
3	Multisource Feedback Structured Reflective Template	21 April 2014
4	Patient Feedback Questionnaire Report	March – April 2014
5	Patient or Client Survey Structured Reflective Template	21 April 2014
6	Advanced Communications Skills Training Course Certificate	29 June 2011 to 01 July 2011
7		
8		
9		
10		
Discussion I believe that my relationships with my many colleagues of many disciplines, is at least satisfactory. Even though I have on occasion been outspoken in my views, particularly in relation to patient care, I have endeavoured to do so in a non-confrontational manner, and hopefully with minimal offense to others. I have found it increasingly difficult to keep apace with the expectation to respond to an ever increasing emailed communication, but continue to try. I have learned much in interpersonal relationships since becoming chair of MDM and of NICaN, learning how to ensure inclusiveness, how to arrive at consensus and to make progress on foot of consensus. I have completed the Discovering Diversity Programme. I have found the Colleague Feedback to be reassuring. I believe that I am a good communicator with patients. I certainly invest much time in communicating with patients, because I enjoy doing so, and because I believe that it is the heart of the relationship between doctor and patient. It is the ability to communicate well, in both directions, that enables trust to be established. It therefore becomes a central part of the patient's management. While this pertains to all areas of clinical practice, it is particularly relevant in dealing with patients diagnosed with cancer. I found the three day, Advanced Communication Skills Training Course to be particularly relevant. I have found the Patient Feedback Questionnaire to be very reassuring.		

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**Actions Agreed**

- **Advanced Communications Skills Training Course particularly relevant to practice in Oncology**
- **Aidan is a very important member of our Urology Team, and participates fully in Departmental Meetings. To continue to do so.**

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients

Attribute:4.2 Treat patients and colleagues fairly and without discrimination

Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Folder containing Letters of Appreciation	2012 and 2013
2	Folder containing Thank You Cards	2012 and 2013
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

I believe that I have always treated patients in a respectful manner, and I can honestly claim not to be discriminatory. I hope that I have succeeded in both. Having completed the Discovering Diversity Programme, I was taken aback to find that many see difference as cause for discrimination rather than celebration. I hope that the few complaints over the years are a reflection of the manner with which I have treated patients. The Patient Feedback Survey has been reassuring in that regard.

I have been fortunate to receive many expressions of appreciation and gratitude from patients over the years. I have enclosed some from these past two years.

Statements of Probity and Health are contained in Form 5.

Actions Agreed

- Complaints received relate to waiting times which is a consequence of inadequate capacity relative to demand, and which will hopefully be addressed by the appointment to two additional consultants.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
To develop Operational Policy for Urological Cancer MDM	To collaborate with Head of Cancer Services to develop Operational Policy	Partially. It has not been possible to complete this task due to lack of time.
To consolidate conduct of Urological Cancer MDM	To continue to preview cases so that patient management is optimized, and communicated with family doctors in timely manner	Yes

Name:

GMC Number:

Appraisal Period :

Page 9

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead

Development needs	Actions agreed	Target dates
To prepare Southern Trust Urology MDM for Peer Review in June 2015	To arrange MDM Annual General Meeting.	May 2014
	To complete of MDM operational policy with Head of Cancer Services.	June 2014
	To assess performance against outcome measures for Southern Trust Service, and delegate subspecialty aspects to specialists (pathologists, radiologists).	August 2014
	To launch audit of GP satisfaction with MDM outcomes	September 2014
I need to work with colleagues to eliminate inequity of access to urological cancer management within the Trust	To establish monthly reports of waiting times for cancer procedures, to address inequities	June 2014
I need to oversee implementation of Prostate Cancer Follow Up pathways, by Southern Trust, and Regionally.	As member of TCFU Implementation Group, to drive structured implementation of ongoing care of patients with prostate (and other) cancers	Full implementation to be achieved by December 2014
I have been charged with the responsibility of ensuring that all urological cancer services in Northern Ireland are IOG and National Cancer Programme compliant by Peer Review June 2015	To work with NICA and Trusts' staff during coming 12 months to ensure that we meet challenge of Peer Review. Will require reduced service commitment.	First Peer Review Meeting arranged for Monday 19 May 2014. Monthly meetings intended thereafter.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013



Southern Health
and Social Care Trust

Quality Care - for you, with you

Personal Development Plan structured reflective template

Requirement: annual

Name of doctor: Aidan O'Brien

Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year:

The major tasks which I am obliged to attend to in coming year are all components of the process to ensure that Urological Cancer Services, both by the Southern Trust and throughout Northern Ireland, are found to be satisfactorily compliant with the National Cancer Programme when subjected to Peer Review in June 2015.

I have initiated a programme of work to be undertaken by myself and by members of the Urology MDT, with deadlines, to ensure that the Southern Trust will be found to be compliant.

I have similarly initiated a regional process, by having a meeting with NICaN administrative staff, on Monday 19 May 2014, to review Outcome Measures, so that Trusts may begin the process of mining data relating to cancer service provision.

Date of reflection: 20 April 2014

Final outcome after discussion at appraisal:

(To complete at appraisal considering how your approach will improve patient care)

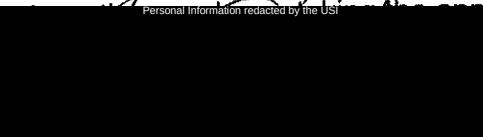
With the appointment of two additional consultants, to explore methods of having others service commitments reduced during coming year to facilitate this work

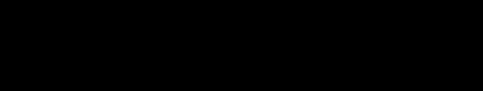
HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 5- HEALTH AND PROBITY STATEMENTS**HEALTH DECLARATION****Professional Obligations**

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.
79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and  taking appropriate action.

Signature: 

Date: ... 12/03/14.....

Name in capitals ...Aidan O'Brien.....

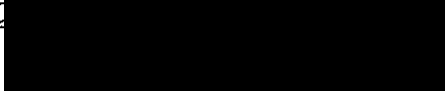
Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR 

If I have been so, I have discussed these with my appraiser.

Signature: 

Date: ... 12/03/14.....

Name in capitals ...Aidan O'Brien.....

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**PROBITY DECLARATION****Professional obligations**

I accept the professional obligations set out in paragraphs 56 to 76 of *Good Medical Practice* (2013) Personal Information redacted by the USI

Signature: Personal Information redacted by the USI Date ... 12/03/2014.....

Name in Capitals Aidan O'Brien.....

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: Personal Information redacted by the USI Date ... 12/03/14.....

Name in Capitals Aidan O'Brien.....

Name: GMC Number: Appraisal Period :



Southern Health
and Social Care Trust

Medical Directorate

Memorandum

Our Ref	JS/KS
To:	Mr A O'Brien
Cc:	Mr M Young
From:	Dr John Simpson, Medical Director
Date:	12/04/13
Subject	APPRAISAL

Dear Mr O'Brien

Thank you for forwarding a copy of your Form 4 from your 2011 appraisal.

This document has been stored electronically in my office and I return the original for your files.

Personal Information redacted by the USI

DR JOHN SIMPSON
Medical Director

Enc.

2. Maintaining good medical practice

Commentary:

Fellow of several Urological and General Surgical Societies.
 Attendance at Annual Congress of European Association of Urology (regarded as a significant impact meeting for education)
 Chairmanship contribution to a major Urological International Meeting
 Regularly reads European Urology Journal

Action agreed:

Record of M&M meetings attended to be added to this year's appraisal folder
 Personal / local urology education documentation

3. Working relationships with colleagues

Commentary:

Document recording clear relationship with other members of the team included.

Action agreed:

Nil required

4. Relations with patients

Commentary:

Plenty of cards and letters of support and thanks.

Any complaints received attended to with resolution.

Action agreed:

To maintain record of complaints.

5. Teaching and training

Commentary:

No documents included, however known role in department to teach Specialist Registrars in theatre, ward rounds and outpatients as well as at regional audit

Action agreed:

To maintain record of procedures and topics supervised and submitted to ISCP

6. Probity

Commentary:

An issue relating to the inappropriate disposal of patient related information had resulted in an informal warning. The discussions relating to this issue have been accepted, resolved and the warning is now time expired.

Otherwise there are no issues

Action agreed:

Nil

7. Health

Commentary:

Health form signed

Inoculation record enclosed.

Confirmation letter from GP enclosed

Action agreed:

Nil

8. Any other points

Commentary:

Research contribution to national study on therapy for AML in Tuberous Sclerosis patients.

MPS document enclosed.

Action agreed:

Nil

PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which will relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions that could be taken to retain their contribution to the HPSS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice

PERSONAL DEVELOPMENT TEMPLATE

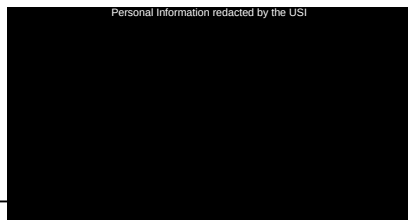
This should be used to inform discussion on development provided for on Form 4. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
<i>Explain the need.</i>	<i>Explain how you will take action, and what resources you will need.</i>	<i>The date agreed with your appraiser for achieving the development goal.</i>	<i>How will your practice change as a result of the development activity?</i>	<i>Agreement from your appraiser that the development need has been met.</i>
1. Maintain education programme by attending EAU	Study leave allocation			
2. Focus on full documentation for next appraisal	Time to collect data			
3.				
4. etc				

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser: _____



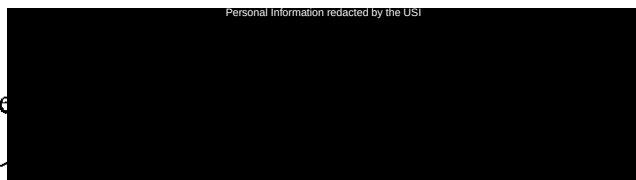
Date: _____

5/4/13

GMC/GDC Number: _____

2864 63 8/5

Appraisee _____



Date: _____

05.04.13

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE
None		22 April 2014

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			Yes
Quality improvement activity			Yes
Significant events review			Yes
Review of complaints and compliments			Yes
Feedback from colleagues	Year undertaken OR Planned Year:	2014	Yes
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	2014	Yes

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	Yes
Ensure the previous year's Personal Development Plan has been reviewed.	Yes
Forward required Forms according to the organisation's appraisal policy.	Yes

APPRAISAL COMPLETION	
We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.	
APPRAISEE Signature of Appraisee: _____ Date: 22 April 2014 APPRAISER Signature of Appraiser: _____ Name of Appraiser: Mr. Michael Young GMC Number: 254963851 Date: 22 April 2014	
CO-APPRAISER (if applicable) Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____ GMC Number: _____ Organisation: _____	

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 7- REVALIDATION PROGRESS**Year 1**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2013 has been satisfactorily completed.

Current Outstanding Issues:**Action Required****Resolution**

Signature of Appraiser:

Personal information redacted by the USI

Name of Appraiser:

M. Young

GMC Number:

2846385

Date:

22-4-14**Year 2**

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:**Action Required****Resolution**

Signature of Appraiser: _____

Name of Appraiser: _____

GMC Number: _____

Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:**Action Required****Resolution**

Signature of Appraiser: _____

Name of Appraiser: _____

GMC Number: _____

Date: _____

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 & 2013

Appendix 1 Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (18 month refresher required)	Learn Blood Transfusion Module	Core Module	
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff	Core Module	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face – Trust Mandatory Training Day	Core Module	
2 Yearly Updates	Method	Core / Optional	Date Completed
Infection Prevention and Control	Face to Face – Trust Mandatory Training Day	Core Module	
Resuscitation	Face to Face		
Safeguarding Children & Vulnerable Adults	Face to Face – Trust Mandatory Training Day	Core Module	
3 Yearly Updates	Method	Core / Optional	Date Completed
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module	Core Module	
Moving and Handling	SHSCT E-Learning Module	Core Module	
Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module	Core Module	
Discovering Diversity	HSC E-Learning Module		
Recruitment & Selection	HSC E-Learning Module		
Hyponatraemia	BMJ E-Learning Module		
Management of Actual or Potential Aggression	Face to Face		
Fraud Awareness	HSC E-Learning Module		
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module		
Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning		
Obstetrics Early Warning System	OEWS e-learning		
Paediatrics Early Warning System	PEWS e-learning		
Consent	In House E-Learning module		
Blood Culture	In House E-Learning module		
Peripheral Line	In House E-Learning module		
Anticoag (Starting and Maintaining)	BMJ E-Learning Module		
Naso Gastric Tube Placement	Merck & In House E-Learning module		
Protocol following death of patient	In House E-Learning module		
Guide to Prescribing in SHSCT	In House E-Learning module		

Patients enrolled in Clinical Trials	In House E-Learning module		
VTE	E-learning for Health		
Safe Sedation [Module 1,2 & 3]	In House E-Learning module		
Gastrointestinal endoscopy	Face to face		
Chest Drain Insertion	Face to face		
Blood Gas Instrument	Face to face		
Appraiser Training	Face to face		
Appraisee Training	Face to face		
Fraud Awareness	HSC Module		
Modules proposed for E-Learning	Method	Core / Optional	Date Completed
Better Communication/Complaint Handling	Face to face		
Incident Reporting	Face to face		
Clinical Negligence	Not currently available		
Infection Prevention and Control	Face to face		
Waste Management	Not currently available		

Links to the various e-learning modules and information regarding face-to-face training can be found [here](#). Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@southerntrust.hscni.net

TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

APPRAISEE

Signature of Appraisee:

Personal Information redacted by the USI

Date: 22 APRIL 14

APPRAISER

Signature of Appraiser:

Personal Information redacted by the USI

Date: 22 APRIL 14

PRINT NAME OF APPRAISER:

MICHAEL YOUNG

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : 2012 /13

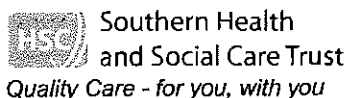
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APPRAISAL 2014

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



APPRAISAL DOCUMENTS

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FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information.

1.1	Full name	Aidan O'Brien
1.2	GMC Registered address (contact address if different)	Personal information redacted by the USI
1.3	Main employer	Southern Health and Social Care Trust
1.4	Main place of work	Craigavon Area Hospital
1.5	Other employers/ places of work	Armagh Community Hospital, Armagh South West Acute Hospital, Enniskillen
1.6	Date of primary medical qualification	December 1978
1.7	GMC registration number and type	1394911 Full with Specialist Registration
1.8	Start date of first substantive appointment in HSC as a trained doctor	06 July 1992
1.8	GMC Registration date and specialties	07 August 2013 Urology
1.9	Title of current post and date appointed	Consultant Urologist on 11 June 1992
1.10	For any specialist registration / qualification outside UK, please give date and specialty	Fellow of Royal College of Surgeons in Ireland November 1983
1.11	Please list any other specialties or sub-specialties in which you are registered	None
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	May 2014
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Consultant Urologist, Craigavon Area Hospital

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 Page 1

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**ANY ADDITIONAL INFORMATION**

In addition to being awarded Fellowship of the Royal College of Surgeons in Ireland in November 1983, I became a

- Fellow of the Ulster Medical Society in 1984
- Fellow of the Royal Society of Medicine in Ireland in 1986
- Fellow of the Irish Society of Urology in 1992
- Member of the Bristol Urological Institute in 1992
- Founding Director of CURE in 1995
- External Adviser to Royal College of Surgeons in Ireland in Specialist Registrar appointments in Republic of Ireland in 2012
- Lead Clinician of Urological Cancer MDT of Southern Health and Social Care Trust since April 2012
- Lead Clinician and Chair of Northern Ireland Cancer Network's Clinical Reference Group for Urology since January 2013

MEDICAL PROTECTION SOCIETY
PROFESSIONAL LIABILITY INSURANCE

Certificate of MPS membership

MPS**Putting members first****Mr A O'Brien**

Personal information redacted by the USI

Name: Mr Aidan O'Brien

Membership number:

Personal information redacted by the USI

Period of membership: 01/09/13-31/08/14

Subscription:

Personal information redacted by the USI

Country of practice: United Kingdom

Region:

Grade: CA2

Grade description: Consultant/private specialist - group 2

Additional information: Your rate is determined according to your specialty and the amount you earn from specialist unindemnified practice (gross income less legitimate practice expenses)

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

2.1 Please give a short description of your work, including the different types of activity you undertake	The work includes emergency and elective inpatient operating, and elective day case operating, in addition to the non-operative management of inpatients admitted electively and as emergencies. The clinical and operative management of acute urological admissions has been greatly enhanced by the introduction of a urologist-of-the-week system in September 2014. The provision of elective surgery entails an extended, eight to eleven hour, inpatient operating session each week, in addition to two, day surgical sessions each month. Outpatient activity changed during 2014 with the appointment of two more consultant urologists during the year. The outpatient schedule since September 2014 is detailed in Section 2.4 below.
2.2 List your main sub-specialist skills and commitments / special interests	Urological Cancer Paediatric Urology Lower Urinary Tract Functional and Reconstructive urology
2.3 Please give details of any emergency, on-call and out of hours responsibilities	I participate in the Urologist-of-the-Week system whereby one consultant urologist is responsible for the clinical and operative management of all acute admissions during that week, in addition to the similar management of all inpatients during that week. I also deal with queries and requests from patients and their relatives, family doctors and other consultants on a daily basis, and invariably out of hours.
2.4 Please give details of out-patient work if applicable	Since September 2014, the configuration of outpatient activity has been amended to ensure that each consultant participates in a New Patient clinic, has a clinic for review of cancer patients, has a general urological review clinic and an opportunity for review of other specialist interest. I conduct a review clinic at Armagh Community Hospital each month, a similar all-day review clinic at South West Acute Hospital each month and two general review clinics at Craigavon Area Hospital each month, in addition to one New Clinic and one Cancer review clinic each week.
2.5 Details of any other clinical work	I arrange one Flexible Cystoscopy session each month. I arrange and review three patients following urodynamic studies each week.
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical	I do not have admission or practice rights in any private hospitals or clinics. I do conduct a private outpatient consultation practice at my home. I do so on Saturdays, typically twice monthly, when not on call or providing any other service at Craigavon Area Hospital. I do not conduct any private practice or provide any fee-paying service within Craigavon Area Hospital or any other Southern Health and Social Care premises. There have been no adverse events or incidents or complaints arising from private practice, which is conducted in compliance with the GMC's Good Medical Practice guidelines and with the Trust's Data Protection policies.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 : Page 3

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

practice or working relationships with colleagues	
2.7 List any non-clinical work that you undertake which relates to teaching	Clinical Supervisor of Specialist Registrars in urology
2.7.1 List any non-clinical work that you undertake which relates to management	As Lead Clinician of Urological Cancer MDT, I liaise with management and with Cancer Coordinators to ensure that the maximum numbers of patients on Cancer Pathways are managed within required timelines. As a consequence, the Southern Trust reached 100% compliance by January 2015, and would have done so earlier but for additionally providing the radical and partial nephrectomy service for the South Eastern Trust during the latter half of 2014 when it was unable to provide that service.
2.7.2 List any non-clinical work that you undertake which relates to research	Principal Investigator of Study of Everolimus in the Treatment of Angiomyolipoma in Patients with Tuberous Sclerosis Complex (completed in 2014). Participant in 'Living With and Beyond Prostate Cancer: a Study of the Impact on Men of Increased and Variable Investigation and Treatment of Prostate cancer in Ireland (reported in 2015)
2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of the Northern Ireland Cancer Network's Clinical Reference Group for Urology
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Provision of expert medicolegal reports.

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

The most recently proposed Job Plan is attached.
I have not had an opportunity to have it reviewed or agreed.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The factors impacting upon the delivery of patient care have been the same for years. They have not changed from year to year, or perhaps more precisely, the only change has been that they impact more and more negatively. Even though I, like all of my colleagues, have increasingly long waiting lists for surgery and increasing numbers of patients waiting longer periods of time for review, the relentless expectation is to take us increasing numbers of new patients and do so in within stipulated time periods, and only to join the lengthening queues for surgery and review, and to the extent that the wait impacts negatively upon their care and outcomes. I work long hours every day, contracted or otherwise, paid and unpaid, in an attempt to mitigate the worst outcomes.

Southern Health and Social Care Trust.

This job plan started 01 April 2013.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	23 Jan 2014
Expected number of weeks in attendance	42 weeks
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		20 Mar 2013	Mr Malcolm Clegg

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.800	9.800	38:54
Supporting Professional Activities (SPA)	1.475	1.475	5:54
Total	11.275	11.275	44:48

On-call availability

Works on-call?	Yes
General Settings:	
Do you work on-call at weekends?	Yes
What is your on-call frequency?	1 in 5
Weekday predictable on-call work:	
What are your average hours of predictable emergency work per weekday on-call?	0:00
How much of this work takes place between 19:00 & 07:00?	0:00
Does this work replace or run concurrently with other activities?	No
How much work replaces or runs concurrently with other activities?	0:00
Weekday unpredictable on-call work:	
What are your average hours of unpredictable emergency work per weekday on-call?	0:39
How much of this work takes place between 19:00 & 07:00?	0:00
Do you work your on-call on a specific day?	No fixed day
Weekend on-call work:	
What are your average hours of predictable emergency work per weekend on-call?	0:00
Does this work replace or run concurrently with other activities?	No
What are your average hours of unpredictable emergency work per weekend on-call?	0:00
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)

PA Count:

The number of PAs arising from your predictable on-call work is:	0.000
The number of PAs arising from your unpredictable on-call work is:	1.000
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Manager
 Name: Mr Brown, Robin
 Signed:
 Date:

Role: Clinical Manager
 Name: Mr Mackie, Edward
 Signed:
 Date:

Role: Board Member
 Name: Mrs Trouton, Heather
 Signed:
 Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00				Uroradiology meeting			
09:15							
09:30							
09:45							
10:00			Surgery MDT				
10:15							
10:30							
10:45		Day surgery					
11:00	Patient related admin (reports, results etc)			Grand Round			
11:15							
11:30							
11:45			Urodynamics				
12:00							
12:15							
12:30							
12:45				Continuous professional development.	Planned in-patient operating sessions		
13:00							
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							
14:45							
15:00	Continuous professional development.	Clinic					
15:15							
15:30				Surgery MDT			
15:45							
16:00							
16:15							
16:30							
16:45							

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 18:00
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 18:30
 18:45
 19:00

Post-op ward round

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45							
09:00				Uroradiology meeting			
09:15							
09:30							
09:45							
10:00	Day surgery		Surgery MDT				
10:15							
10:30							
10:45							
11:00				Grand Round	Clinic		
11:15							
11:30							
11:45			Urodynamics				
12:00							
12:15							
12:30							
12:45			Pre-op ward round				
13:00				Continuous professional development.			
13:15							
13:30							
13:45							
14:00							
14:15							
14:30							
14:45							
15:00		Clinic			Patient related admin (reports, results etc)		
15:15							
15:30	Clinic			Surgery MDT			
15:45			Planned in-patient operating sessions				
16:00							
16:15							
16:30							
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21:00

Post-op ward round

Week 3

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

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Patient related admin
(reports, results etc)

Continuous
professional
development.

Surgery MDT

Uroradiology meeting

Grand Round

Clinic

Continuous
professional
development.

Pre-op ward round

Continuous
professional
development.

Continuous
professional
development.

Clinic

Planned in-patient
operating sessions

Surgery MDT

18:30							
18:45							
19:00							
19:15							
19:30							
19:45							
20:00			Post-op ward round				
20:15							
20:30							
20:45							
21:00							
Week 4							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30							
08:45				Uroradiology meeting			
09:00							
09:15							
09:30							
09:45							
10:00			Surgery MDT				
10:15							
10:30							
10:45	Clinic	Continuous professional development.		Grand Round	Clinic		
11:00							
11:15							
11:30			Urodynamics				
11:45							
12:00							
12:15							
12:30			Pre-op ward round				
12:45				Continuous professional development.			
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14:30							
14:45	Continuous professional development.				Patient related admin (reports, results etc)		
15:00		Clinic					
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15:30			Planned in-patient operating sessions	Surgery MDT			
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21:00

Post-op ward round

Week 5

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

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Emergency operating sessions

Emergency operating sessions

Emergency operating sessions

Emergency operating sessions

Uroradiology meeting

Pre-op ward round

Emergency operating sessions

Clinic

Clinic

Day surgery

Planned in-patient operating sessions

Surgery MDT

Post-op ward round

18:00
18:15
18:30
18:45
19:00

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Mon	07:15 - 13:00	2	Day surgery 75 minutes travel from Craigavon Area Hospital.	Southern He..	Erne Hospit..	DCC	8.4	0.288	1:09
Mon	08:30 - 13:00	4	Clinic 30 minutes travel from Craigavon Area Hospital.	Southern He..	Armagh Comm..	DCC	8.4	0.225	0:54
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency Operating, Triage and Virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Mon	09:00 - 13:00	1, 3	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.400	1:36
Mon	13:00 - 17:00	1, 3-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	25.2	0.600	2:24
Mon	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Mon	13:00 - 18:15	2	Clinic 75 minutes travel to Craigavon Area Hospital.	Southern He..	Erne Hospit..	DCC	8.4	0.263	1:03
Tue	08:30 - 13:00	1	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.225	0:54
Tue	09:00 - 13:00	4	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.200	0:48
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: consultant of the week	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Tue	09:00 - 13:00	3	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.200	0:48
Tue	13:00 - 17:00	1-4	Clinic	Southern He..	Craigavon A..	DCC	33.6	0.800	3:12
Tue	13:00 - 17:00	5	Clinic Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Wed	09:00 - 11:00	1-4	Surgery MDT Comments: SURGERY MDT PREPARATION	Southern He..	Craigavon A..	DCC	33.6	0.400	1:36
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency operating, triage and virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Wed	11:00 - 12:30	1	Urodynamics	Southern He..	Craigavon A..	DCC	8.4	0.075	0:18
Wed	11:00 - 12:30	2, 4	Urodynamics	Southern He..	Craigavon A..	DCC	16.8	0.150	0:36
Wed	11:00 - 12:30	3	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.075	0:18
Wed	12:30 - 13:00	2-4	Pre-op ward round	Southern He..	Craigavon A..	DCC	25.2	0.075	0:18
Wed	13:00 - 17:00	5	Day surgery Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Wed	13:00 - 20:00	2-4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	25.2	1.100	4:12
Wed	20:00 - 20:30	2-4	Post-op ward round	Southern He..	Craigavon A..	DCC	25.2	0.100	0:18
Thu	08:30 - 09:30	1-5	Uroradiology meeting	Southern He..	Craigavon A..	DCC	42	0.250	1:00
Thu	09:30 - 10:00	5	Pre-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.025	0:06
Thu	10:00 - 12:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.400	1:36
Thu	10:00 - 14:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Thu	12:00 - 14:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.400	1:36
Thu	14:00 - 17:00	1-4	Surgery MDT	Southern He..	Craigavon A..	DCC	33.6	0.600	2:24
Thu	14:00 - 17:00	5	Surgery MDT Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.150	0:36
Fri	08:30 - 17:00	1	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	8.4	0.425	1:42
Fri	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward round, Emergency Operating, Triage and Virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.200	0:48
Fri	09:00 - 13:00	2-4	Clinic	Southern He..	Craigavon A..	DCC	25.2	0.600	2:24
								Total:	10.275 40:48

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Fri	13:00 - 17:00	5	Planned in-patient operating sessions Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	DCC	8.4	0.200	0:18
Fri	13:00 - 17:00	2, 4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.400	1:36
Fri	17:00 - 17:30	1	Post-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.025	0:06
Fri	17:00 - 17:30	5	Post-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.025	0:06
Total:								10.275	40:48

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.000
Total:				1.000

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

1 of 1 100%

Find | Next



Mr O'Brien, Aidan

Urology

Job Plan Start Date: 1 April 2013

Report Date: 23 January 2014

Personal Objectives:

This is a list of personal objectives, the activities they are linked to and any service objectives they are linked to.

There are no linked personal objectives.

Non Linked Personal Objectives:

This is a list of personal objectives which are not linked to activities. These objectives may be linked to service objectives.

There are no non-linked personal objectives.

Service Objectives Linked Activities:

This is a list of service objectives which are linked to activities. These objectives are not linked to personal objectives.

There are no service objective linked activities.

Non-Linked Activities:

This is a list of the doctors activities which are not linked to any objective.

Non-Linked Activities	No of activities	Duration	Total time	PA Values	Dept PAs
Clinic	1	04:30	04:30	0.225	38.35
Clinic	1	05:15	05:15	0.262	38.35
Clinic	4	04:00	16:00	1.8	38.35
Continuous professional development.	1	01:30	01:30	0.075	23.575
Continuous professional development.	1	02:00	02:00	0.4	23.575
Continuous professional development.	3	04:00	12:00	1	23.575
Day surgery	1	04:00	04:00	0.2	16.85
Day surgery	1	04:30	04:30	0.225	16.85
Day surgery	1	05:45	05:45	0.288	16.85
Emergency operating sessions	5	04:00	20:00	1	20.467
Grand Round	1	02:00	02:00	0.4	5.6
Patient related admin (reports, results etc)	2	04:00	08:00	0.8	13.825
Planned in-patient operating sessions	1	04:00	04:00	0.2	24.175
Planned in-patient operating sessions	1	08:30	08:30	0.425	24.175
Planned in-patient operating sessions	1	07:00	07:00	1.1	24.175

Objectives Activity Report

Post-op ward round	3	00:30	01:30	0.15	1.758
Predictable Emergency Work	1	00:00	00:00	0	1
Pre-op ward round	2	00:30	01:00	0.1	1.425
Surgery MDT	1	02:00	02:00	0.4	10.9
Surgery MDT	2	03:00	06:00	0.75	10.9
Unpredictable Emergency Work	1	00:39	00:39	1	16
Urodynamics	2	01:30	03:00	0.225	2.575
Uroradiology meeting	1	01:00	01:00	0.25	3.1

Legend:

Direct Clinical Care

Supporting Professional Activities

Additional HPSS Responsibilities

External Duties

Fee Paying Services

Private Professional Services

Trust Objectives:

There are no trust objectives.

Service Objectives:

There are no service objectives.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

DOMAIN 1 - Knowledge, Skills and Performance		
Attribute: 1.1 Maintain your professional performance		
Attribute: 1.2 Apply knowledge and experience to practice		
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.		
	List of Supporting Information	Applicable Date
1	Certificate of Attendance at 11 th Meeting of the European Section of Oncological Urology, Prague, Czech Republic	17-19 March 2014
2	Consultant Level Indicator Programme (CLIP) report for 2014	Jan-Dec 2014
3	CLIP Reflective Template for 2014	
4	Facilitator in 'Living with and beyond Prostate cancer – A study of the impact on men of increased and variable investigation and treatment of prostate cancer in the island of Ireland.'	2013 - 2014
5	Principal investigator in 'A randomized, double-blind, placebo-controlled study of Everolimus in the treatment of Angiomyolipoma in patients with Tuberous Sclerosis.'	2011 - 2014
6		
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Discussion

I have attended the EAU Section of Oncological Urology annually for several years for two reasons: firstly, having leadership roles in Oncological Urology both locally and regionally, I believed that it was obligatory to remain abreast of developments in knowledge and skills in that subspeciality; secondly, the meetings were excellent. In 2014, I attended the meeting in Prague, probably the best ESOU meeting to date. I have found that doing so has helped to ensure a balanced perspective in leadership roles in addition to enhancing my own practice.

The findings in the CLIP report for 2014 are similar to those of previous years and with similar variances. The relatively lower percentage day surgical rate remains a function of inadequate day surgical facilities. The continued new:review ratio of 1:2.1 appears to be difficult to reduce further though the need for oncological review and new outpatient formats introduced during 2014 may have contributed.

I have been an investigator and facilitator of two large research studies which completed in 2014 with interesting results which inform practice.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 Page 5

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**Actions Agreed**

In addition to continuing to maintain my knowledge and skill base, and maintaining performance in qualitative and quantitative terms, the main focus of my efforts during 2015 will be to lead the Urological Cancer MDT of the Southern Health and Social Care Trust successfully through Peer Review scheduled for June 2015.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 Page 6

Certificate of Attendance

The European Association of Urology, represented by
Prof. M. Brausi and Prof. Dr. M. Babjuk, declares that:

Aidan O'Brien

participated in the 11th Meeting of the EAU Section of
Oncological Urology (ESOU), 17-19 January 2014, Prague,
Czech Republic

Personal Information redacted by the USI

Personal Information redacted by the USI

Prof. M. Brausi
ESOU Chairman

Prof. Dr. M. Babjuk
Local Organiser



The EAU is accredited by the European Accreditation Council for Continuing Medical Education (EACCME) to provide the following CME activity for medical specialists. The EACCME is an institution of the European Union of Medical Specialists (UEMS), www.uems.net.

The 11th Meeting of the EAU Section of Oncological Urology (ESOU) is designated for a maximum of 22 European external CME credits.

Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

The EACCME credit system is based on 1 ECMEC per hour with a maximum of 3 ECMECs for half a day and 6 ECMECs for a full-day event.

EACCME credits are recognised by the American Medical Association towards the Physician's Recognition Award (PRA).

Live educational activities, occurring outside of Canada, recognized by the UEMS-EACCME for ECMEC credits are deemed to be Accredited Group Learning Activities (Section 3) as defined by the Maintenance of Certification Program of The Royal College of Physicians and Surgeons of Canada.

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The Netherlands

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F +31 (0) 26 389 0674

EAU@uroweb.org
www.uroweb.org



**European
Association
of Urology**



CHKS Consultant Level Indicator Programme

The Southern Trust

January 2014 to December 2014

Personal information redacted
by the USI

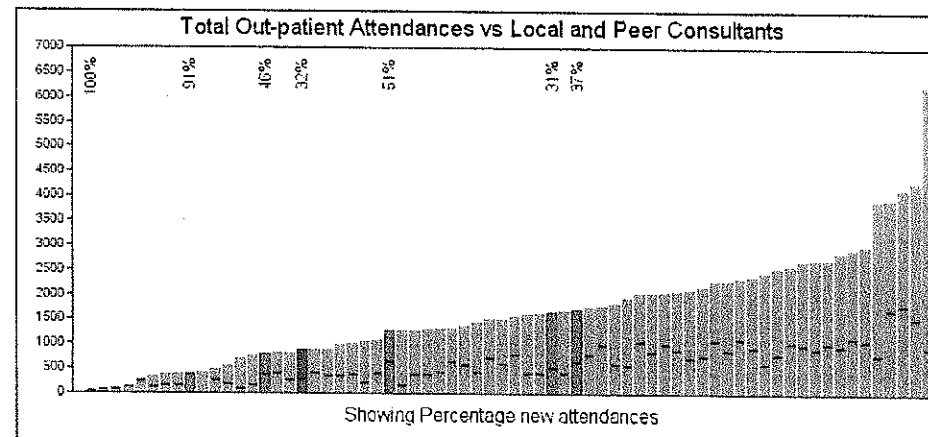
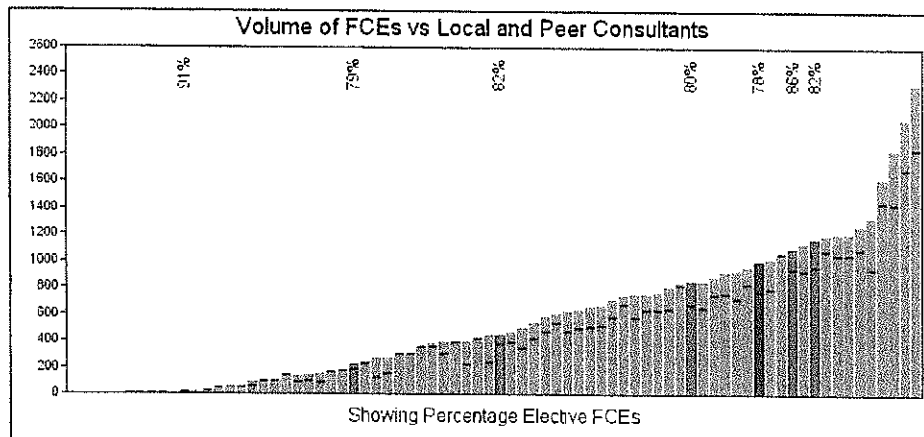
: Mr A O'Brien

Urology

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The Southern Trust
 : Mr A O'Brien - Urology
 January 2014 to December 2014



Workload Volumes	Consultant	Local	
Total Number of FCEs	1003		
Elective FCEs	778	77.6%	82.4%
In-Patients	370	47.6%	24.7%
Day Cases	408	52.4%	75.3%
Emergency FCEs	181	18.0%	14.9%
Other FCEs	44	4.4%	2.7%
* Regular Attendances	32	4.0%	5.1%

* Regular Attendances are counted **only** in this report line

They are expressed as a percentage of Elective FCEs (above) + Regular Attendances

They are NOT aggregated into any other data line or chart

In-Patient Details	Consultant	Local	
FCEs - Male	670	66.8%	68.4%
FCEs - Female	333	33.2	31.6
FCEs - Child (0-18)	32	3.2%	1.7%
FCEs - Adult (19-74)	682	68.0%	75.8%
FCEs - Elderly (75+)	289	28.8%	22.5%

Outpatient workload	Consultant	Local	
Total Attendances	899		996
New Attendances	285	31.7%	43.9%
Follow-up Attendances	614	68.3%	56.1%
Attendances with Procedure	39	4.3%	4.8%

Consultant Total FCEs : 1,003 45,718 : Peer FCEs

Performance Indicators

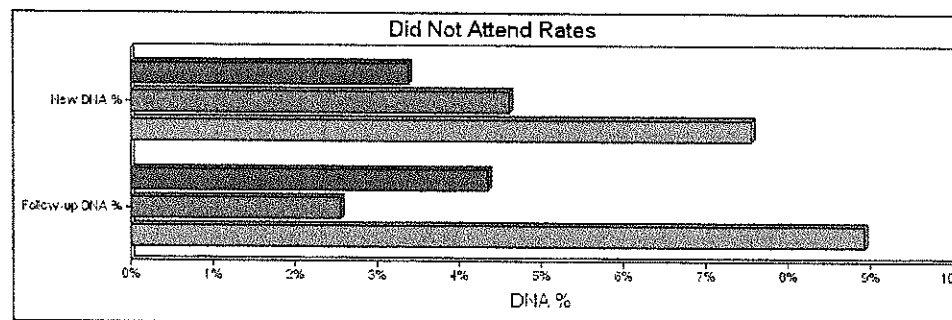
	Consultant	Local	Peer
FCE Inpatient ALoS (DC trimmed)	3.7	3.3	2.7
Average Length of Stay (Zero trimmed)	4.9	3.9	3.4
Elective	4.1	3.1	2.8
Non-Elective	5.8	4.6	4.1
Risk Adjusted Length of Stay *	139.8	125.0	97.0
Day Case Rate	408	52.4%	75.3%
Day Case Overstays	35	7.9%	6.8%
Average Elective Pre-Operative LoS	0.1	0.1	0.2
Elective IP Spells with no Procedure	11	5.9	2.6
Elective Inpatient spells - procedure not carried out	4	2.1%	0.5%
Patient Cause			0.1%
Other Reason	4	2.1%	0.5%

High Volume Procedures

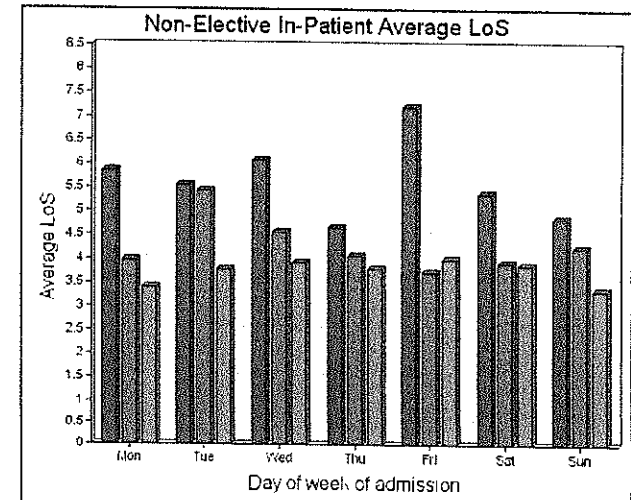
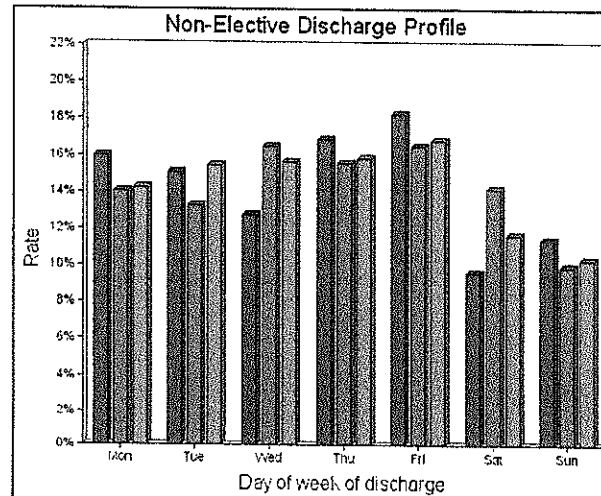
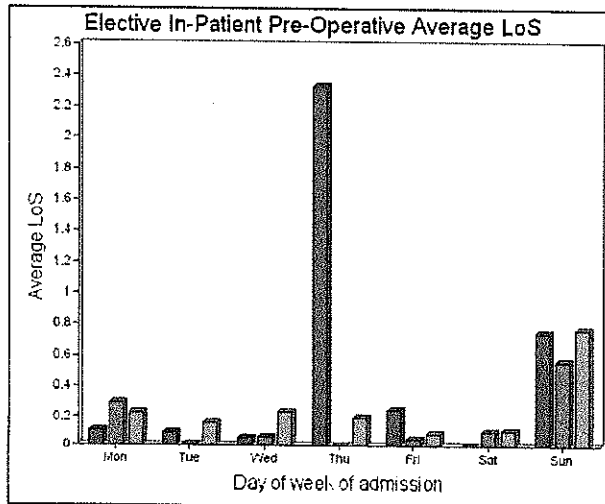
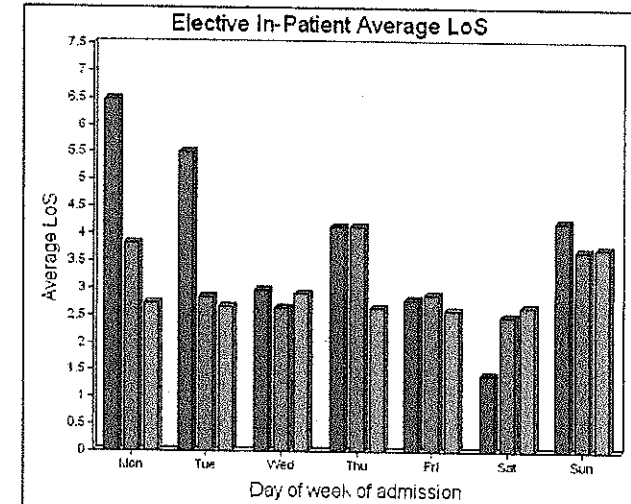
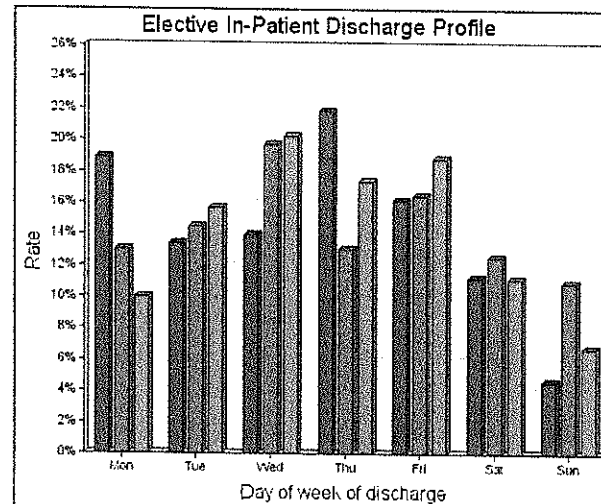
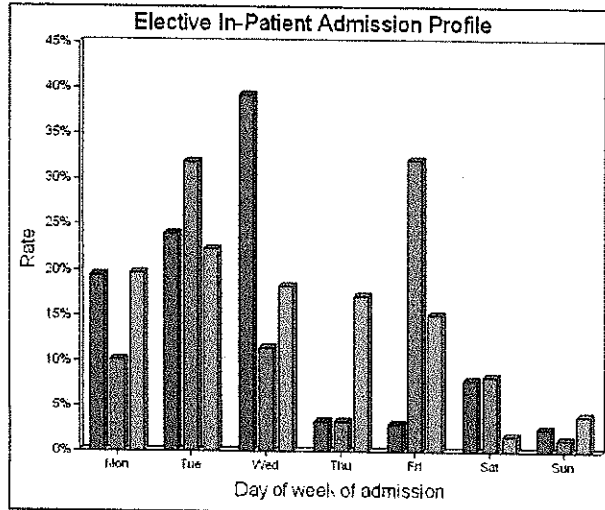
Day Case Procedures	Actual Day Cases						Day Case Overstays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	151	200.0	123.0	89.3%	96.0%	89.6%	2	3.0	4.2	1.0	3.8	1.4
M49 - Other operations on bladder	81	25.5	131.3	51.6%	81.0%	95.5%	1	1.0	1.7	1.0	2.2	2.5
M43 - Endoscopic operations to increase capacity of bladder	40	6.4	13.3	71.4%	88.9%	76.8%	5	1.0	2.1	1.6	3.0	1.4
N30 - Operations on prepuce	25	14.4	19.1	78.1%	81.8%	85.1%	2	2.7	1.8	1.0	2.8	1.2
M47 - Urethral catheterisation of bladder	20	16.7	39.4	76.9%	96.2%	92.7%	1	1.0	2.1	2.0	2.5	2.3
N17 - Excision of vas deferens	8	4.0	11.3	100.0%	100.0%	95.5%			1.5			1.2
M77 - Diagnostic endoscopic examination of urethra	5	3.0	2.0	100.0%	100.0%	86.8%			1.0			5.5
M79 - Other operations on urethra	5	1.8	4.0	41.7%	70.0%	70.0%	1	1.5	1.5	1.0	1.0	1.1
M29 - Other therapeutic endoscopic operations on ureter	4	7.3	11.5	100.0%	89.8%	53.9%		1.0	2.3		4.0	1.6
N11 - Operations on hydrocele sac	3	2.2	5.1	100.0%	92.9%	73.1%			1.9			1.2

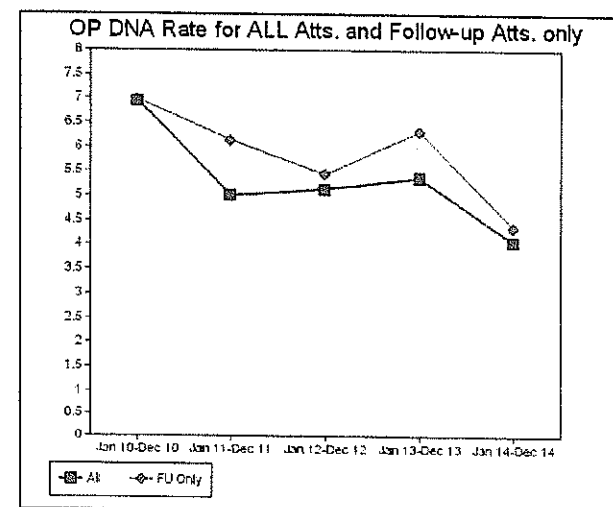
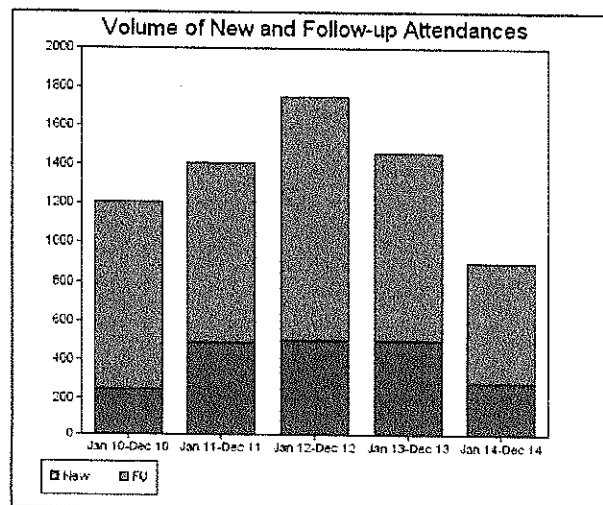
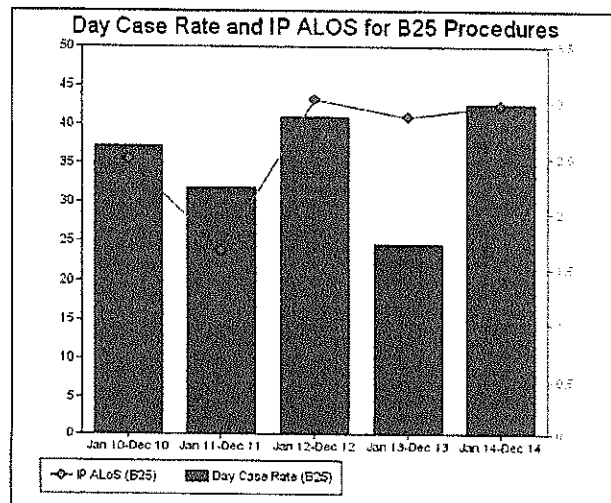
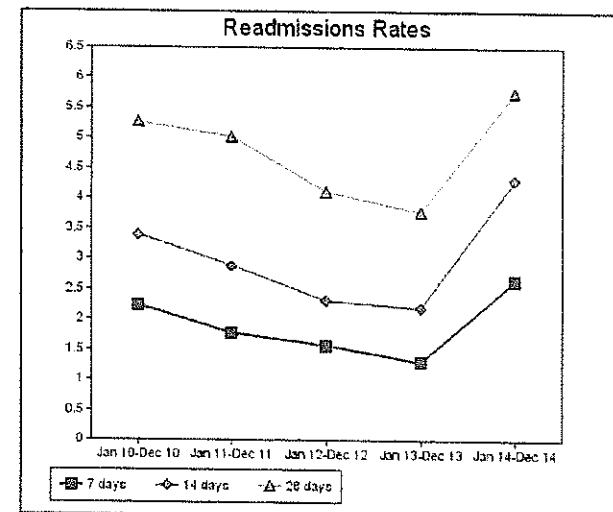
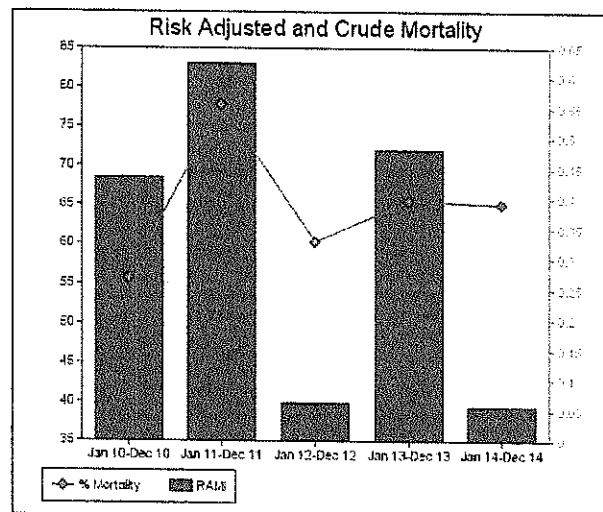
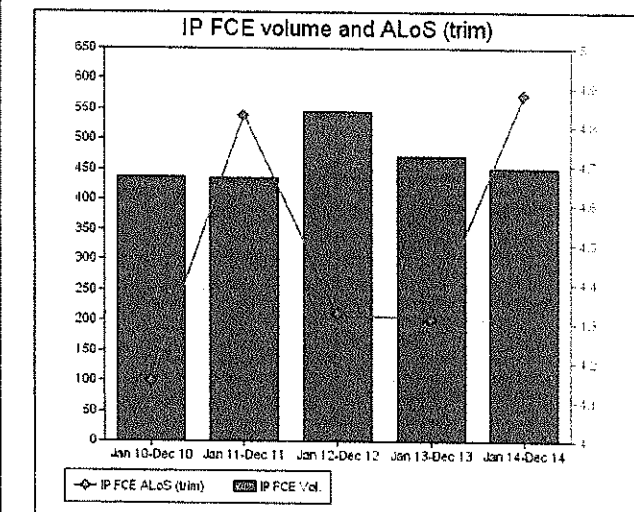
In-Patient Procedures	Number			Pre-Op Average LoS			IP Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M49 - Other operations on bladder	76	6.0	5.3	0.0	0.1	0.2	0.0	0.9	0.9
M27 - Therapeutic ureteroscopic operations on ureter	68	31.6	9.8	0.2	0.2	0.4	3.2	2.7	1.9
M65 - Endoscopic resection of outlet of male bladder	52	14.3	23.1	0.4	0.0	0.2	4.1	2.9	2.9
U21 - Diagnostic imaging procedures	46	17.3	14.0	2.7	2.1	3.3	4.4	4.1	2.8
M42 - Endoscopic extirpation of lesion of bladder	24	18.6	32.5	0.0	0.3	0.3	3.5	3.3	2.3
M45 - Diagnostic endoscopic examination of bladder	24	9.3	14.2	0.0	0.0	0.8	3.1	2.3	1.3
M43 - Endoscopic operations to increase capacity of bladder	17	0.6	2.6	0.0	0.0	0.5	3.5	2.0	1.6
M76 - Therapeutic endoscopic operations on urethra	11	2.1	6.0	0.0	0.0	0.2	1.5	2.3	1.4
M06 - Incision of kidney	10	1.9	0.6	1.0	0.1	1.0	8.8	5.9	6.1
M02 - Total excision of kidney	8	6.6	8.3	0.0	0.3	0.6	7.6	4.3	6.0

	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	899		996		2003	
New Attendances	285	31.7%	437	43.9%	724	36.1%
Referred by General Practitioner	137	48.1%	313	71.5%	501	68.1%
With Procedures Recorded	34	11.9%	12	2.8%	158	21.5%
Average Procedure per coded attendance		1.0		1.0		1.0
Did Not Attend	10	3.4%	21	4.6%	60	7.6%
Follow-Up Attendances	614	68.3%	559	56.1%	1279	63.9%
With Procedures Recorded	5	0.8%	43	6.4%	366	28.2%
Average Procedure per coded attendance		1.0		1.0		1.1
Did Not Attend	28	4.4%	18	2.6%	128	8.9%
New : Follow-Up Ratio	614	1 : 2.2	559	1 : 1.3	1300	1 : 1.8



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	39	9	24
M70 - Other operations on outlet of male bladder	0	32	15
M45 - Diagnostic endoscopic examination of bladder	0	1	208
X38 - Subcutaneous injection	0	0	1
Q55 - Other examination of female genital tract	0	0	1
X62 - Assessment			276
U32 - Diagnostic blood tests			23
U12 - Diagnostic imaging of genitourinary system			13
U26 - Diagnostic testing of genitourinary system			6
M49 - Other operations on bladder			2





CHKS CLIP Programme :- Indicator definitions
Report Indicator Definitions (Surgical)
Workload Volumes
Total FCEs

Numerator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

FCEs (incl. day cases) per inpatient DCC

Numerator: Count of FCEs / 52 (weeks in year)

Denominator: Number of inpatient direct clinical care (DCC) sessions

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective FCEs

Numerator: Count of elective FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases

Denominator: Count of elective FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Day Case Rate

Numerator: Count of elective day case FCEs

Denominator: Count of elective FCEs

Exclusions: Well babies and regular attenders

Emergency FCEs

Numerator: Count of emergency FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Other FCEs

Numerator: Count of OTHER (not elective or emergency) FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Regular attendances

Numerator: Count of regular attenders

Denominator: Total elective FCEs including regular attenders

Exclusions: Well babies

CHKS CLIP Programme :- Indicator definitions cont.**In-patient Details****Male FCEs**

Numerator: Count of Male FCEs
Denominator: Count of Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

Female FCEs

Numerator: Count of Female FCEs
Denominator: Count of Total FCEs
Exclusions: Well babies, regular attenders and renal dialysis patients

Children FCEs

Numerator: Count of Childrens FCEs - age on admission ≥ 0 and ≤ 18
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

Adult FCEs

Numerator: Count of Adult FCEs - age on admission ≥ 19 and ≤ 74
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

Elderly FCEs

Numerator: Count of Elderly FCEs with age on admission 75+
Denominator: Count of FCEs
Exclusions: Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.**Outpatient Workload****Total attendances**

Count of outpatient attendances

Total attendances per out-patient DCC

Numerator: Count of outpatient attendances / 52 (weeks in year)

Denominator: Number of outpatient direct clinical care (DCC) sessions

New attendances

Numerator: Count of total new outpatient attendances

Denominator: Total outpatient attendances

Follow-up attendances

Numerator: Count of total follow-up attendances

Denominator: Total attendances

Attendances with a procedure

Numerator: Count of attendances with a valid OPCS4 procedure code

Denominator: Total attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters and
- procedure code 'X999-No outpatient procedure carried out'.

CHKS CLIP Programme :- Indicator definitions cont.
Performance Indicators
FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days

Denominator: Total IP FCEs

Exclusions:

- day cases
- Well babies, regular attenders and renal dialysis

ALoS (zero trimmed)

Numerator: Count of bed days

Denominator: Total FCEs with LoS > zero

Exclusions to numerator and denominator:

- Zero LoS FCE
- Well babies, regular attenders and renal dialysis

Elective ALoS (zero trimmed)

Numerator: Count of bed days - elective

Denominator: Elective FCEs and LoS > zero

Exclusions :

- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

Non-elective ALoS (zero trimmed)

Numerator: Count of bed days - non- elective

Denominator: Non-Elective FCEs and LoS > zero

Exclusions:

- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

Risk Adjusted ALoS

Numerator: observed spell bed days

Denominator: expected bed days

Exclusions: The following types of criteria are excluded from the risk adjusted Length of Stay model:
 Mental Health specialties , maternity admissions, other admissions, neonates who died < 2 days old,
 stillbirths, day cases, regular attenders, length of stay >100 , HRG defined exclusions, HRG's beginning
 with U and invalid primary diagnosis codes.

CHKS CLIP Programme :- Indicator definitions cont.

Day Case Rate

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Day case overstay

Numerator: Count of elective episodes intended to be a day case with a provider spell LoS > 0.
Denominator: Numerator + actual day cases
Exclusions: Well babies, regular attenders and renal dialysis

Elective inpatient pre-operative ALoS

For elective IP spells only –
Numerator: Total pre-operative bed days.
Denominator: Spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions: Well babies, regular attenders and renal dialysis

Elective inpatient spells with no procedure

Numerator: Coded elective IP spells with no procedure
Denominator: Coded elective IP spells
Exclusions:
• Well babies, regular attenders and renal dialysis
• Exclude spells where spell HRG = S22 – planned procedure not carried out

Elective inpatient spells - procedure not carried out

Numerator: Coded elective IP spells with diagnosis including Z53
Denominator: Coded elective IP spells
Exclusions:
• Well babies, regular attenders and renal dialysis

Procedure not carried out - patient cause

Numerator: Coded elective IP spells with diagnosis including Z531 or Z532
Denominator: Coded elective IP spells
Exclusions :
- Well babies, regular attenders and renal dialysis

Elective inpatient spells- Procedure not carried out - other reason

Numerator: Coded elective IP spells with diagnosis including Z530, Z538 or Z539
Denominator: Coded elective IP spells
Exclusions:
- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.
Governance Indicators
Mortality Rate

Numerator: Spells with discharge method = death

Denominator: Total Spells

Exclusions :

- Well babies

Mortality Rate - Elective

Numerator: Elective spells that died

Denominator: Total elective spells

Exclusions :

- Well babies

Mortality Rate - Non-elective

Numerator: Non-elective spells that died

Denominator: Total non-elective spells

Exclusions:

- Well babies

Risk Adjusted Mortality Index

Numerator: observed deaths

Denominator: expected deaths (based on CHKS risk adjusted mortality model)

•Methodology Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Risk Adjusted Mortality Index - Elective

For elective spells only

Numerator: observed deaths

Denominator: expected deaths (based on CHKS risk adjusted mortality model)

•Methodology Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Risk Adjusted Mortality Index - Non-elective

For non-elective spells only

Numerator: observed deaths

Denominator: expected deaths (based on CHKS risk adjusted mortality model)

•Methodology Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

CHKS CLIP Programme :- Indicator definitions cont.**Attributed complication rate**

Numerator: Count of Spells with an attributed complication based on ICD10 and OPCS4 criteria

Denominator: Total Spells

Exclusions:

- Well babies, regular attenders and renal dialysis

Misadventure rate

Numerator: FCE with ICD10 codes classified as misadventures reported

Denominator: Total FCEs

Exclusions:

- Well babies, regular attenders and renal dialysis

Readmission rate

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 28 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.

Denominator: Total spells discharged within the time period

CHKS CLIP Programme :- Indicator definitions cont.**High Volume Procedures****Day Case Rate**

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Day case overstays

Numerator: Count of elective episodes intended to be a day case with a provider spell LoS > 0.
Denominator: Numerator + actual day cases
Exclusions: Well babies, regular attenders and renal dialysis

In-Patient Procedures

Top 10 elective Inpatient Procedures
(Total FCE's -Day Cases)

Inpatient pre-operative ALoS

Numerator: Total inpatient pre-operative bed days
Denominator: Inpatient spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions : Well babies, regular attenders and renal dialysis

FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days
Denominator: Total IP FCEs
Exclusions:
- day cases
- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.**Outpatient Profile and Performance****New attendances**

Numerator: Count of total new outpatient attendances

Denominator: Total outpatient attendances

New attendances referred by GP

Numerator = Total new outpatient attendances where the source of referral is GP

Denominator: Total new outpatient attendances

New attendances with a procedure

Numerator: Count of new attendances with a valid OPCS4 procedure code

Denominator: Total new attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters and
- procedure code 'X999-No outpatient procedure carried out'.

Average number of procedures - New attendances

Numerator: Count of valid OPCS4 procedure codes recorded for new attendances

Denominator: Total coded new attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters recorded in procedure 1
- procedure code 'X999-No outpatient procedure carried out'.

DNA rate - New attendances

Numerator: = DNAs - new attendances

Denominator = New attendances + DNAs for new attendances

Follow-up attendances

Numerator: Count of total follow-up attendances

Denominator: Total attendances

Follow-up attendances with a procedure

Numerator: Count of follow-up attendances with a valid OPCS4 procedure code

Denominator: Total follow-up attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters and
- procedure code 'X999-No outpatient procedure carried out'.

CHKS CLIP Programme :- Indicator definitions cont.**Average number of procedures - Follow-up attendances**

Numerator: Count of valid OPCS4 procedure codes recorded for follow-up attendances

Denominator: Total coded follow-up attendances

Exclusions:

- OPCS4 codes shown in the Y and Z chapters recorded in procedure 1
- procedure code 'X999-No outpatient procedure carried out'.

DNA rate - Follow-up attendances

Numerator: = DNAs - follow-up attendances

Denominator = Follow-up attendances + DNAs for follow-up attendances

New : Follow-up ratio

New to follow-up ratio = 1:n (for every new attendance there are n follow-ups)

Numerator: Follow-up attendances

Denominator: New attendances

DNA Chart**DNA rate - All attendances**

Numerator: = Total DNAs

Denominator = Total attendances + DNAs

CHKS CLIP Programme :- Indicator definitions cont.
Elective Admission Profile
Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases

Denominator: Count of elective FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective In-patient Pre-operative ALoS by Admission Day
Elective inpatient pre-operative ALoS

For elective IP spells only –

Numerator: Total pre-operative bed days.

Denominator: Spells with an operative procedure

Operative procedures as defined by CHKS

Exclusions: Well babies, regular attenders and renal dialysis

Discharge Profile - Elective In-Patient
Elective in-patient discharge profile

Numerator: Elective IP's by day of discharge

Exclusions:

- Well babies, regular attenders and renal dialysis

ALoS by Admission Day - Elective In-Patient
Elective ALoS (zero trimmed)

Numerator: Count of bed days - elective

Denominator: Elective FCEs and LoS > zero

Exclusions :

- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

Discharge Profile - Non-Elective
Non-elective in-patient discharge profile

Numerator: Non-elective IP's by day of discharge.

Exclusions:

- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.**ALoS by Admission Day - Non-Elective****Non-elective ALoS (zero trimmed)**

Numerator: Count of bed days - non- elective

Denominator: Non-Elective FCEs and LoS > zero

Exclusions:

- Zero LoS FCEs
- Well babies, regular attenders and renal dialysis

CHKS CLIP Programme :- Indicator definitions cont.
Revalidation Charts
IP FCE Volume and ALoS (trim)
In-patient FCEs
ALoS (zero trimmed)

Numerator: Count of bed days

Denominator: Total FCEs with LoS > zero

Exclusions to numerator and denominator:

- Zero LoS FCE
- Well babies, regular attenders and renal dialysis

Risk Adjusted and Crude Mortality
Risk Adjusted Mortality Index

Numerator: observed deaths

Denominator: expected deaths (based on CHKS risk adjusted mortality model)

•Methodology Exclusions - The following types of hospitals or facilities are excluded from the mortality model: Mental illness, learning difficulties, community trusts, maternity, neonates, stillbirths, day cases and Zero Risk of Death ICD-10 Diagnosis Codes.

Mortality Rate

Numerator: Spells with discharge method = death

Denominator: Total Spells

Exclusions :

- Well babies

Readmission Rates
Readmission rate within 7 days

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 7 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.

Denominator: Total spells discharged within the time period

Readmission rate within 14 days

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 14 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.

Denominator: Total spells discharged within the time period

CHKS CLIP Programme :- Indicator definitions cont.

Readmission rate

Numerator: Discharges subsequently readmitted - count of spells where the patient was readmitted as an emergency within 28 days of the date of discharge. The time period relates to the discharge date of the spell that was subsequently re-admitted and discharged within the time period of the report.

Denominator: Total spells discharged within the time period

Day Case Rate and IP ALOS for B25 Procedures

Day case rate for B25 directory procedures

Numerator: Elective Day Case Spells (MoA = 11,12 or 13, Intended management = 2 and spell length of stay =0) AND AND procedure meets criteria for inclusion in B25 (see appendix 1)

Denominator: Elective spells (MoA = 11,12 or 13) AND procedure meets criteria for inclusion in B25 (see appendix 1)

Exclusions: None

IP ALoS for B25 directory procedures

Numerator: Elective in-patient spell bed days (MoA = 11,12 or 13 AND NOT day case (intended management = 2 and spell length of stay =0) AND procedure meets criteria for inclusion in B25 (see appendix 1)

Denominator: Elective in-patient spells (MoA = 11,12 or 13 AND NOT day case (intended management = 2 and spell length of stay =0) AND procedure meets criteria for inclusion in B25 (see appendix 1)

Exclusions: None

Volume of New and Follow-up Attendances

New attendances

Numerator: Count of total new outpatient attendances

Denominator: Total outpatient attendances

Follow-up attendances

Numerator: Count of total follow-up attendances

Denominator: Total attendances

OP DNA Rate for ALL Atts. and Follow-up Atts. only

DNA rate - All attendances

Numerator: = Total DNAs

Denominator = Total attendances + DNAs

DNA rate - Follow-up attendances

Numerator: = DNAs - follow-up attendances

Denominator = Follow-up attendances + DNAs for follow-up attendances

Southern Health
and Social Care Trust

Research & Development Office

Dr Anna Gavin
Director, Northern Ireland Cancer Registry
Mulhouse Building
Queen's University Belfast
Grosvenor Road
Belfast BT12 6DP

12 March 2013

Our Ref: ST1213/08/IK/VMcD Your Ref:

Dear Dr Gavin

Study Title: Living with and beyond Prostate cancer - A study of the impact on men of increased and variable investigation and treatment of prostate cancer in the Island of Ireland - Prostate investigations study

HSC Trust Ref: ST1213/08 (Please quote this number in all future correspondence)

REC Ref: 12/NI/0106

I am pleased to advise that the Southern HSC Trust has given Research Governance Permission for the above project to commence. Permission is granted for the duration of the project to 31 May 2013.

The following documents have been approved for use in the project:

Document	Version	Date
Covering Letter	Signed Dr Heather Kinnear	26 June 2012
GP/Consultant Information Sheets	1	22 May 2012
Investigator CV	Dr Anna Gavin(CI), Dr Heather Kinnear, Dr Moyra Mills, Dr Gerard Gormley, Ellis McCaughan	
Letter from Sponsor	QUB	29 October 2010
Letter from Statistician	Dr Finian Bannon	26 June 2012
Letter of invitation to participant	2 (Pre Biopsy)	24 July 2012
Letter of invitation to participant	2 (Post-Biopsy)	24 July 2012
Letter from Funder	Prostate Cancer Charity	12 May 2010
Participant Consent Form	2 (Pre-Biopsy)	24 July 2012
Participant Consent Form	2 (Post-Biopsy)	24 July 2012
Participant Information Sheet	2 (Pre-Biopsy)	24 July 2012
Participant Information Sheet	2 (Post-Biopsy)	24 July 2012
Protocol	2	24 July 2012
Questionnaire	2 (Post-Biopsy)	24 July 2012
Questionnaire	2 (Pre-Biopsy)	24 July 2012
Response to Request for Further Information	Letter addressing response to Provisional Opinion	19 July 2012

Permission is granted subject to the attached conditions with which I would ask you to please ensure that all members of the research team make themselves familiar. Failure to abide by these conditions will invalidate permission and may result in the cessation of the research.

I wish you every success with your project.

Yours sincerely

Personal Information redacted by the USI

**Miss I Knox
Research Manager**

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Conditions of Permission

Research Governance permission is issued provided the researcher(s) involved adhere to and abide by the conditions below.

- The researcher(s) must adhere strictly to the research protocol.
- There must be no changes to the research protocol or approved study documentation without the prior consent of the Trust, the Research Ethics Committee and, where applicable, the MHRA.
- There must be no changes in research staff without prior consent of the Trust.
- The Research Office should be informed if the Chief Investigator or Principal Investigator(CI/PI) is unable to continue to fulfil his/her duties as CI/PI for any reason such as long term absence, change in employment etc.
- There must be no increase in the resources required without prior consent of the Trust.
- Researcher(s) must report all untoward incidents and serious adverse events to the Trust.
- Any concerns in relation to the research protocol must be reported to the Trust.
- Researcher(s) must adhere to good research practice principles in line with the ICH Good Clinical Practice (GCP) guidelines.
- Researcher(s) must adhere to the Trust's Research & Development Standard Operating Procedures (available from the Research Office on request)
- On request, researcher(s) must make their research project available to Trust appointed monitors.
- The lead researcher must make an annual report to the Research Office for the duration of the project.
- The lead researcher should inform the Research Office on completion or termination of the project. Completion reports must be sent to the Research Office, Research Ethics Committee and, if applicable, MHRA.



Southern Health and Social Care Trust

Research & Development Office

Mr Aiden O'Brien
Consultant Urologist
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

14 April 2014

Our Ref: ST1011/07/IK/MMCA **Your Ref:**

Dear Mr O'Brien

Re: Notification of Continued NHS Permission from the Southern Health & Social Care Trust

Study Ref: ST1011/07

Study Title: A randomized double-blind placebo-controlled study of RAD001 in the treatment of Angiomyolipoma in patients with either Tuberous Sclerosis Complex (TSC or Sporadic Lymphangioleiomyomatosis (LAM)

Following receipt of substantial amendments 3 and 4 which was given favourable ethical opinion by the NRES Committee South Central – Hampshire A, in a letter dated 02 April 2014, based on the following support documentation:

Documentation	Version	Date
Covering Letter		10 March 2014
European Commission Notification of Substantial Amendment Form	Amendment v3 and V4	15 January 2013
Menstrual Diary	Dia.S222_1	

The amendment was reviewed today by the Chair of the Research Governance Committee and I can now confirm this Trust's permission for the continuation of this study.

Yours sincerely

Personal Information redacted by the USI

Miss I Knox
Research Manager

Copy to:

Dr John. C. Kingswood
Consultant Physician
Brighton and Sussex University Hospitals
Trust
Royal Sussex County Hospital
Brighton BN2 5BE

Mrs Loraine Adair
Research Nurse
C/O Cardiology Department
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

Ms Sital Patel
GMO Clinical Support Associate
Novartis Pharmaceuticals UK Limited
200 Frimley Business Park
GB- Frimley/Camberley, Surrey GU16 7SR

Mrs Roisin McNulty
Clinical Trials Pharmacist
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients

Attribute: 2.2 Respond to risks to safety

Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

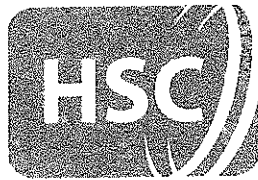
	List of Supporting Information	Applicable Date
1	Certificate of attendance at Appraisee Training	23 January 2014
2	Record of Inpatient Antibiotic Compliance	2014
3	Record of Attendance at Morbidity and Mortality Meetings	2014
4	Mandatory Training Passport	15 December 2015
5	Record of Complaints	Oct 13 – Dec 2014
6	Record of incidents	Oct 13 – Dec 2014
7	Statement of Health by GP	2014
8	Inoculation History	
9		
10		

Discussion

In January 2014, I attended the Appraisee Training Course in preparation for Revalidation. I embarked upon an intensive period of preparation which led successfully to Revalidation on 27 April 2014. Throughout 2014, I have endeavoured to provide a safe service to the patients under my care and to those of my colleagues. Doing so has not been easy or always successful due to increasing demands upon a service limited by time, manpower and capacity restrictions. Nevertheless, compliance with antibiotic guidelines, completion of core and optional Trust modules and the lack of Serious or Adverse Incidents may be considered a reflection of a degree of success. Complaints received during 2014 were a consequence of limitations in capacity rather than avoidable personal failings.

Actions Agreed

To continue to try to provide care to patients of the highest quality and safety permissible within capacity constraints.



Leadership Centre

Providing Management and
Organisation Development

This is to certify that

AIDAN O'BRIEN

attended

***1/2 day Appraisee Training
(Craigavon Area Hospital)***

23rd January 2014

Personal information redacted by the USI

**CHRISTINE McGOWAN
Principal Consultant
HSC Leadership Centre**

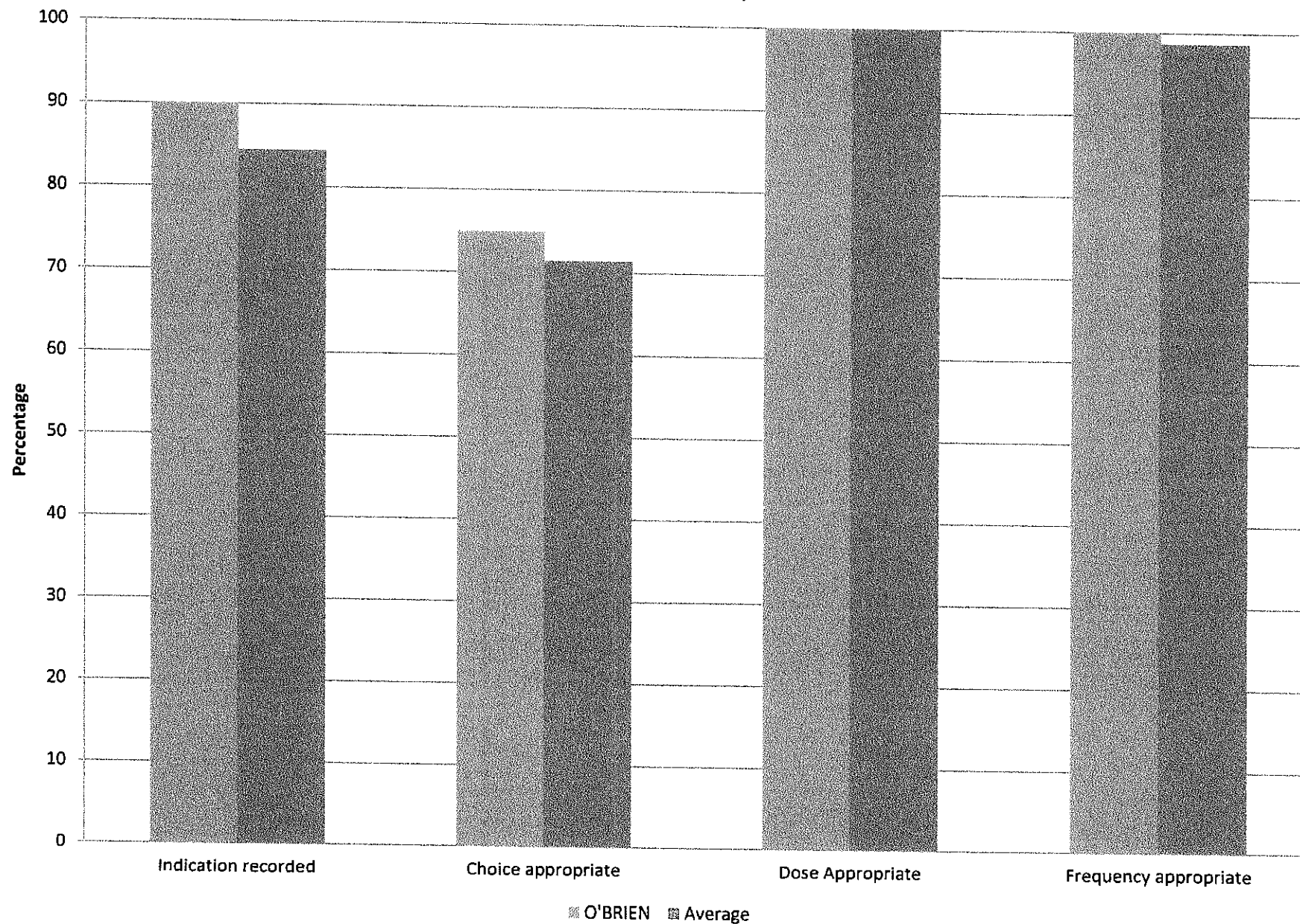


INVESTOR IN PEOPLE



ISO 9001 FS 36704

Ward Round Summary January-June 2014



6 monthly antibiotic ward round summary Urology (January to June 2014)

- Mr Glackin: 17 patients.
 - **Indication** not recorded in 2 patient.
 - **Choice** non-compliant in 5 patients.
 - **Frequency** non-compliant in 1 patient.

- Mr O'Brien: 20 patients.
 - **Indication** not recorded in 2 patients.
 - **Choice** non-compliant in 5 patients.

- Mr Suresh: 10 patients, CURB score n/a.
 - **Indication** not recorded in 4 patients.
 - **Choice** non-compliant in 7 patients.

- Mr Young: 21 patients.
 - **Indication** not recorded in 4 patients.
 - **Choice** non-compliant in 5 patients.



Quality Care - for you, with you

Record of Attendance Morbidity and Mortality Meetings 2014

CRAIGAVON AREA HOSPITAL

UROLOGY

MR AIDAN O'BRIEN

6 out of 12 = 50% meetings attended

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.

MM Certificate 2014

COMPLAINTS
APPRAISALS 1 October 2013 -31 December 2014
Mr Aidan O'Brien

ID	First received	Record name	Description	Outcome
Personal Information redacted by the USI	13/02/2014	Personal Information redacted by the USI	Unacceptable wait for appropriate treatment	Complainant advised patient has received appropriate treatment and care. Apology given for patient feeling he was not given adequate information on his treatment. Apology given for time patient had to wait at his appointment.
	30/04/2014		Complainant unhappy with the delay in a referral being sent from Craigavon Area Hospital to Belfast City Hospital leading to a further delay in receiving treatment for Prostrate Cancer.	Apology for delay in referral which was due to increased clinical commitments.
	02/12/2014		Patient diagnosed with a swollen lymph gland on outside of bladder in July 2014. Advised that a procedure would be performed in November 2014 however in the meantime patient was admitted to hospital and placed in palliative care. Patient now advised that he will be receiving radiotherapy because cancer was spread to his bone.	Red flag referral received from GP on 11.7.14. Patient attended appointment on 23.7.14 with consultant who admitted him to 2 south to have biopsy. On 30.7.14 patient had another procedure done. Results discussed with patient. After meeting with Belfast trust it was agreed patient treatment and care to be transferred to Belfast trust. Therefore unable to comment on the last points of complaint.
	21/05/2014		Complainant concerned about how long his constituent has had to wait for an outpatient appointment.	Complainant advised his constituent has been given an appointment for 21 July 2014.
	10/07/2014		Complainant unhappy to have to wait so long for a review appointment.	Complainant given a date for 6 August 2014. Apology given for delay.
	24/03/2014		Complainant unhappy at length of time he has had to wait for an appointment, he is constant pain.	Complainant advised the consultant is aware of his need for an appointment and is endeavouring to get him scheduled. Consultant contacted patient directly to reassure him.

INCIDENTS
APPRAISALS 1 October 2013 to 31 December 2014

Mr Aidan O'Brien

NIL

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively

Attribute: 3.2 Work constructively with colleagues and delegate effectively

Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
1	Annual Report (2015) for the Urology MDT in 2014	2014
2	Record of Suspect Cancer Referrals and of Confirmed Cancers	2014
3	Record of Urological Histopathological Specimens	2014
4	Average Waits for Urological Cancer Patients	2014
5	Regional Red Flag Longest Waits	2014
6	62 day Performance	2014
7	Regional Urology referrals	2014
8	Regional Red Flag Referrals	2014
9	NICaUrology Meeting Minutes	06 February 2014
10	NICaUrology Meeting Minutes	25 March 2014
11	NICaUrology Meeting Minutes	11 June 2015
12	NICaUrology Meeting Minutes	26 September 2014

Discussion

My main roles in this domain have been those of Lead Clinician of the Urological Cancer MDT for the Southern Health and Social Care Trust, and as Lead Clinician and Chair of the Northern Ireland Cancer Network (NICaU) Urology Clinical Reference Group.

As evidenced by the documentation above, the Southern Trust has had a progressive increase in the numbers of referrals of patients suspected of having cancer, the numbers confirmed of having cancer and the numbers managed. This increase has been the case across all urological malignancies, but was most pronounced in relation to renal tumours. In spite of this increase, we made very significant progress during 2014 in assessing and managing increasing proportions of all cases within the 62 day pathway, until we reached 100% compliance by January 2015.

During 2014, much of my effort was in constructing all of the organizational infrastructure and documentation in preparation for Peer Review in 2015.

Similarly, as Lead Clinician and Chair of NICaUrology, I led the development of agreed Referral Guidelines, Clinical Management Guidelines and Patient Pathways in preparation for Regional Peer Review in 2015.

Actions Agreed

To continue the work above in preparation for Peer Review.

To finalise agreed Clinical Management Guidelines and agreed Cancer Services Framework as a component of the Implementation of the Regional Urology Review.

SUSPECT CANCER REFERRALS

Urological Cancer		Jan 14	Feb 14	March 14	April 14	May 14	June 14	July 14	August 14	Sep 14	Oct 14	Nov 14	Dec 14
62DAY		136	138	114	93	94	107	119	106	122	126	117	128
31 DAY		402	371	350	351	405	435	496	368	492	518	468	446

CONFIRMED CANCERS 62 day

	JAN 14	FEB14	MAR14	APR 14	MAY 14	JUNE 14	JULY 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14
Urology	13	14	15	9	12	17	22	22	20	7	8	15

CONFIRMED CANCERS 31 DAY

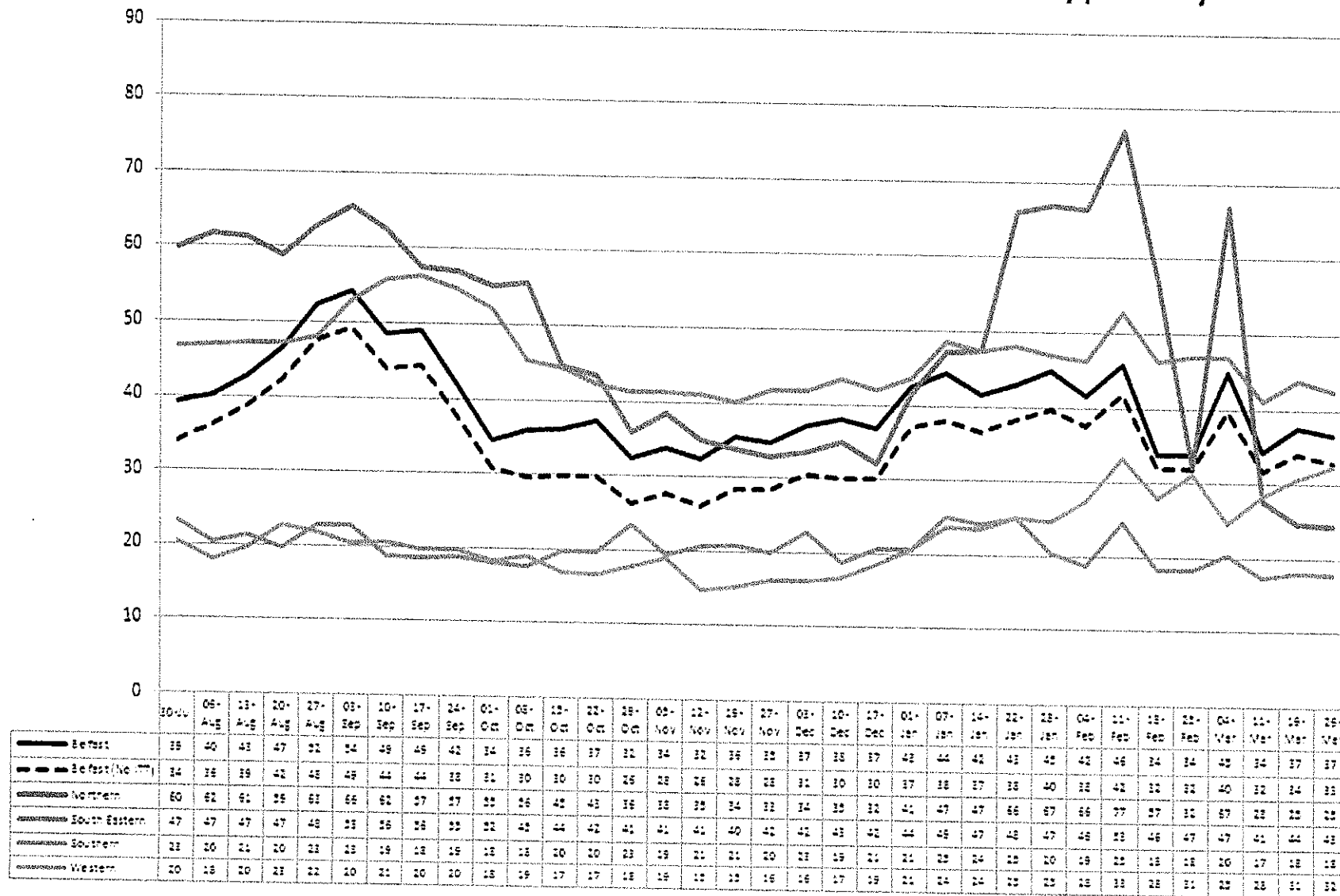
	JAN 14	FEB 14	MAR 14	APR 14	MAY 14	JUNE 14	JULY 14	AUG 14	SEP 14	OCT 14	NOV 14	DEC 14
Urology	8	15	14	13	11	13	14	14	14	10	12	17

Annual
Reports
2014/15

UROLOGY SPECIMENS
RECEIVED BY
CRAIGAVON CELLULAR PATHOLOGY LABORATORY
(APRIL – MARCH FISCAL YEARS)

SPECIMENS	2011/12	2012/13	2013/14	2014/15
PROSTATE BIOPSIES	345	225	248	340
TURP	158	141	163	176
BLADDER BIOPSIES	182	253	224	205
TURBT	78	70	115	120
TESTIS BIOPSIES	-	-	4	8
TESTIS	28	37	36	38
RENAL BIOPSIES	-	-	24	14
KIDNEY	28	33	46	76
PENILE BIOPSIES	6	9	13	13
PENIS	4	3	1	3

Average Wait (days) for Urological Cancer Active Waits on a 62 day pathway



Regional red flag longest waits

Longest Wait and Numbers over 62 days taken from weekly 62 day Active PTL (selected tumour sites) - Suspensions are excluded

Tumour site	Measure	Belfast Trust													
		02-Apr	30-Apr	28-May	25-Jun	24-Sep	29-Oct	27-Nov	01-Jan	28-Jan	25-Feb	11-Mar	19-Mar	26-Mar	Variance
Urology	Longest Wait	115	105	124	143	185	196	203	233	203	189	203	211	218	+103
	No over 62 days	14	20	22	30	67	25	36	61	70	29	30	43	42	+25
	Total Active Waits	202	215	240	260	269	187	250	300	295	283	296	317	303	+103
Tumour site	Measure	Northern Trust													
		02-Apr	30-Apr	28-May	25-Jun	24-Sep	29-Oct	27-Nov	01-Jan	28-Jan	25-Feb	11-Mar	19-Mar	26-Mar	Variance
Urology	Longest Wait	92	120	113	132	175	202	180	151	142	145	159	162	169	+77
	No over 62 days	14	37	66	90	69	13	18	27	46	7	10	6	2	
	Total Active Waits	178	225	255	309	185	97	125	162	76	36	57	71	63	+115
Tumour site	Measure	South Eastern Trust													
		02-Apr	30-Apr	28-May	25-Jun	24-Sep	29-Oct	27-Nov	01-Jan	28-Jan	25-Feb	11-Mar	19-Mar	26-Mar	Variance
Urology	Longest Wait	111	158	124	138	230	217	330	246	288	240	163	171	134	+73
	No over 62 days	18	50	50	63	112	65	69	77	103	99	66	79	84	+65
	Total Active Waits	191	255	261	273	300	305	342	350	375	342	335	340	346	+165
Tumour site	Measure	Southern Trust													
		02-Apr	30-Apr	28-May	25-Jun	24-Sep	29-Oct	27-Nov	01-Jan	28-Jan	25-Feb	11-Mar	19-Mar	26-Mar	Variance
Urology	Longest Wait	138	130	126	111	54	140	69	146	130	50	44	52	59	25
	No over 62 days	20	28	15	20	0	4	2	3	2	0	0	0	0	16
	Total Active Waits	198	165	105	98	82	156	97	104	118	125	116	136	149	50
Tumour site	Measure	Western Trust													
		02-Apr	30-Apr	28-May	25-Jun	24-Sep	29-Oct	27-Nov	01-Jan	28-Jan	25-Feb	11-Mar	19-Mar	26-Mar	Variance
Urology	Longest Wait	69	85	50	68	70	41	47	57	78	110	124	95	87	+18
	No over 62 days	1	1	0	1	1	0	0	0	3	9	3	4	3	+2
	Total Active Waits	64	76	57	71	71	59	70	76	201	234	206	208	198	+134

62 day performance (completed waits)

62 day Performance for the 2014/15 year up to the end of January 2015 (Completed Waits)

TRUST	TUMOURSITE	Nov-14	Dec-14	Jan-15	2014/15 YTD
Belfast	Urological Cancer	54%	40%	38%	50%
Northern	Urological Cancer	50%	29%	0%	24%
South Eastern	Urological Cancer	36%	36%	56%	44%
Southern	Urological Cancer	87%	87%	77%	70%
Western	Urological Cancer	100%	100%	100%	94%

Regional Urology Referrals

Total Referrals between January 2013 to January 2015 inclusive - BY TRUST

Information sourced from PAS via DWH download on 23rd February 2015

Duplicate Referrals based on same HCN, korner speciality and referral date +/- 7 days have been removed

Information based on PAS box on which referral has been recorded

ICATS excluded

Belfast Trauma and Orthopaedics excluded (under development)

Spec Group	UROLOGY	X
Urgency	(All)	▼
PCP	(All)	▼
Referral Month (Full Month)	(All)	▼ Note: Only January is available in the 2015 year
Referral Source Description (R)	(All)	▼ Select GP/Other

Sum of SumOfTotal Referrals	Column Labels ▼	
Row Labels	2013	2014
Belfast Health and Social Care Trust	7724	7751
Northern Health and Social Care Trust	4256	3740
South Eastern Health and Social Care Trust	5140	5258
Southern Health and Social Care Trust	3987	4695
Western Health and Social Care Trust	3492	3961
Grand Total	24599	25405

>= 10% increase have been highlighted in red
% Change 2013 to 2014
0%
-12%
2%
18%
13%
3%

Regional Red Flag

Spec Group UROLOGY
 Urgency Red Flag
 PCP (All)
 Referral Month (Full Month) (All)
 Referral Source Description (R) (All)

Note: Only January and February are available in the 2015 year
Select GP/Other

Sum of SumOfTotal Referrals	Column Labels	
Row Labels	2013	2014
Belfast Health and Social Care Trust	910	1169
Northern Health and Social Care Trust	442	554
South Eastern Health and Social Care Trust	751	952
Southern Health and Social Care Trust	410	753
Western Health and Social Care Trust	389	635
Grand Total	2902	4063

>= 10% increase have been highlighted in red
% Change 2013 to 2014
28%
25%
27%
84%
63%
40%



**NICaN Urology Network Site Specific Group meeting
Tuesday 25th March 2014 at 2.30pm – 4.30pm
Seminar room 1, Belfast Cancer Centre**

In attendance:

Mr Aidan O'Brien – Clinical Lead
Ms Edel Aughey (BHSCT)
Ms Mary Jo Thompson (PHA/NICaN)
Ms Mary Haughey (NICaN)
Dr Suneil Jain (BHSCT)
Ms Wendy McPhee (BHSCT)
Ms Moyra Mills (NHSCT)

Ms Caroline Lynas (SEHSCT)
Mr Hugh O'Kane (BHSCT)
Ms Davinia Lee (BHSCT)
Ms Lisa McWilliams (NICaN)
Mr Martin Eatock (NICaN)
Mr Sam Gray (SEHSCT)
Mr Pat Shiels (BHSCT)

Videoconference:

Ms Fiona Reddick (SHSCT)
Dr Gareth McClean (SHSCT)
Ms Kate O'Neill (SHSCT)
Ms Annie Treanor (SHSCT)
Dr Gerry Millar (Macmillan GP Facilitator)

Apologies:

Prof Joe O'Sullivan (BHSCT)
Mr Robin Gray (PPI rep)
Ms Teresa Majury (PPI rep)
Mr John McKnight
Mr Chris Hagan (BHSCT)
Ms Martha Magee (WHSCT)

Ms Thamra Ayton (BHSCT)
Ms Elizabeth England (WHSCT)
Ms Pat McClelland (NHSCT)
Ms Wilma Boyd Carson (SEHSCT)

Summary of key points / outcomes/ action	Identified Party
Welcome & Introductions Mr O'Brien welcomed everyone to the meeting and apologies were noted as above. 1. Minutes of last meeting: read and agreed by members All matters arising will be covered on the agenda. 2. Transforming Cancer Follow Up Prostate Sub Group Audit on Holistic Needs Assessment – Wendy McPhee Mr O'Brien invited Ms McPhee, Macmillan Uro-oncology Project Nurse, to present the findings from an audit carried out with prostate cancer patients to explore individual needs and concerns following treatment using a modified Holistic Needs Assessment (HNA) tool. Ms McPhee advised that a questionnaire, based on EPIC (a validated tool) and the Macmillan concerns checklist was distributed to 50 patients undergoing radiotherapy treatment. The HNA questionnaire was given to patients to complete before their first review appointment at 6 weeks and at the 4-6 month follow up appointment. The questionnaire comprised of two sections; section 1 relating to the patients symptoms and section 2 to their holistic needs. It was noted that there was more improvement by the second assessment in urinary function, while the majority stayed the same for bowel function, sexual function and hormonal function. With regard overall level of concern, majority of patients had no concerns at second assessment. There were 20 referrals on to other health professionals / services. Ms McPhee advised that a recommendation from the audit would be that with the provision of a Uro-Oncology CNS, this tool or a version of it, could be used with all patients to ensure a holistic needs assessment is completed post radiotherapy or brachytherapy treatment. Mr O'Brien thanked Ms McPhee for the presentation. There was some group discussion on the findings from the audit. It was noted that the most common side effect for patients undergoing radical radiotherapy is fatigue. It was also noted that patients have financial concerns and that signposting to relevant agencies can help to address these worries / concerns. There was discussion on when the HNA is completed and it was agreed that it can be completed at key points in a patient's journey in line with the recovery package and NICE Quality Standards. Ms Thompson advised that the summary of the Prostate TCFU Programme evaluation will present some interesting baseline findings from the 250 patients surveyed. These patients were diagnosed in 2008 and were tracked over a 5 year period to ascertain the number of surgical and oncology appointments each patient had. The survey found that most patients (82.3%) had received the medical support that they needed, but were less well supported to manage the physical (47.6%), emotional	

(34.0%), financial (17.6%) and practical (29.9%) impacts of cancer. Only 32.6% of patients agreed that they were supported to make lifestyle changes to maximise their health and wellbeing. Ms Thompson advised that the report is currently being reviewed by the Evaluation Advisory Group following which it will be disseminated to the NICA Urology network group. With regard completion of the holistic needs assessments, it was noted that this has been adopted in WHSCT and SET (who complete a concerns check list with patients at 3 months); NHSCT is implementing a post-radiotherapy telephone review clinic which incorporates a holistic needs assessment. Dr Gerry Millar, Macmillan GP Facilitator for SHSCT, highlighted a project which is currently on-going regard measuring depression in cancer patients. He advised that 30% of patients within the project had clinical depression, and fatigue was a key factor for these patients; simple interventions like physical activity and medication can help people to overcome this. Dr Millar also highlighted the issue of financial worry, particularly in light of the Disability Living Allowance (DLA) guidelines, as cancer patients fall outside the criteria and therefore don't qualify for financial support. He asked Mr O'Brien, as Clinical Lead of the Urology NSSG, to write to the DLA Advisory Board, with regard the need to support patients who suffer fatigue as a result of cancer. Action1: Mr O'Brien to write to the DLA Advisory Board on behalf of the Urology Network Site Specific Group	Mr O'Brien
There was discussion on rolling the HNA Tool out to the other Trust sites and it was noted that it would be useful to have baseline data for each area before implementing. Action 2: A copy of the tool used by Ms McPhee to be forwarded to TCFU Project team for roll out to other sites.	TCFU Project team
Regional hormone therapy pathway – Mr O'Brien suggested that it would be useful for oncology and surgical to work together to develop an agreed regional hormone therapy pathway which would include adjuvant / neo-adjuvant treatment. It was discussed that geography & distance are big issues for patients undergoing hormone treatment and better chemical evidence is needed to ensure that this is the best treatment course for some patients. Dr Suneil Jain agreed and advised that he is involved with an oncology clinical trial targeting at patients with advanced castration resistant prostate cancer. Action 3: Mr O'Brien and Dr Jain to further discuss a regional hormone therapy pathway CNS Modelling exercise – feedback from Trusts: Ms Thompson referred to the comprehensive modelling exercise undertaken by NICA in collaboration with Trust personnel to ascertain the additional / reconfiguration CNS nursing requirements to support the nurse led pathways per Trust area. It was indicated this had been previously	Mr O'Brien & Dr Jain

circulated to all members and cancer managers / urology service managers.

Update per Trust area as follows:

SET: Ms Lynas circulated a brief report detailing the release of clinic appointments due to nurse led follow up across four pathways which equated to 37 appointments per week and therefore potentially freeing up 2.5 consultant sessions per annum.

Ms Thompson advised that the holistic needs assessment is built into the CNS appointments and while initially these are face-to-face, telephone / remote assessments can be utilised if clinically appropriate.

BHSCT: Mr O'Kane advised that they have two CNSs; one focused on cancer follow-up and the other CNS works in the clinic with himself and another consultant through which implementation of active surveillance, watchful wait and post radical prostatectomy nurse led follow-up is underway.

Dr Jain noted that there is no dedicated CNS in oncology. It was however noted there was benefit when CNSs work across the entire patient pathway.

SHSCT: Mr O'Brien advised that though SHSCT do not have a dedicated Oncology CNS currently he did not think there should be a demarcation between an Oncology CNS and a Urology CNS as this should be provided across all pathways. He advised there is merit though in separating the cancer and non-cancer patient clinics. SHSCT have had a meeting in order to get an overview of all CNS activity across the Trust.

There was a query as to why only 20% of radical radiotherapy patients are suitable for CNS follow up as it was thought that this figure underestimated the number of potential suitable patients – Ms Thompson advised that this figure was suggested as a starting point by Dr McAleese but would be accumulative over time. It was also thought that it would be better to start with a small number so as to allow time for nurses to build up their skill and expertise. It was acknowledged that WHSCT are the leaders regard CNS follow up and have been doing this for a longer period of time compared to other areas.

NHSCT: Dr Mills advised that Northern Trust hope to secure Macmillan funding for an Uro-oncology Nurse for an interim period to support nurse-led follow up as there is currently no capacity with general Urology Nurses. This will help to build a skill base locally though it was acknowledged that there is a risk regarding securing an exit strategy for these posts.

Dr Eatock advised that a funding proposal for 30 CNSs across the tumour sites is being considered by the Department of Health through the Cancer Service Framework process.

It was noted that the Transforming Cancer Follow Up Project Managers posts are finishing in December 2014 and the TCFU Steering Group is focused on looking at an exit strategy of the project and ensuring that the work is sustained and further developed across all Trusts.

DRE Training

The implication for CNSs delivering the pathways was discussed in reference to the need to undertake digital rectal examination (DRE) for those who are not already proficient. Ms Thompson reiterated that Clinical education Centre can provide the theoretical training which would be supported by mentoring at Trust level.

Patient Group Directives

Mr O'Brien advised that the use of patient group directives would support independent nurse led follow-up as a mechanism to prescribe a limited number of agreed drugs to patients as part of nurse-led follow up. It was agreed that this would need to be discussed further within the TCFU Project team regard taking forward within individual Trusts as practices differ across Trusts.

Wave two evaluation

Ms Thompson advised that a Wave two evaluation report has been developed and when signed off by the TCFU Project Steering Group, will be disseminated for information.

RISOH Update

Ms Thompson advised that PSA Tracking is being built within the RISOH system and this will be available at a further roll-out point.

Ms McWilliams advised that the oncology system will be rolled out in June to BHSCT and the combined haematology and oncology systems will be rolled out to SEHSCT in September, with roll-out to other Trusts sequentially.

3. Urology Clinical Management Guidelines

Mr O'Brien referenced the Guidelines for surgical treatment and management of urological cancer – the network group in 2011 had agreed to adopt the surgical components of the European Association of Urology as they reflected practice in NI (this was for prostate cancer, bladder cancer, non-muscle bladder, penile cancer, renal cell carcinoma and testicular cancer).

The regional group had also developed guidelines for the 'Imaging of Urological Cancers' in 2011 and these have been sent to original authors to review.

It was agreed that it would be timely to review all the guidelines, particularly in light of the updated NICE Prostate Cancer clinical guideline 175 that was recently issued. Mr O'Brien noted that it would be useful for a subgroup to review the updated NICE guideline, note implications for future service delivery and feedback to the network group.

Action 4: Sub group/virtual group to be convened to review the newly published NICE Prostate guidelines to inform commissioners of implications.

It was noted that the guidelines should include the referral process as well as the clinical management component.

It was agreed to contact the original sub group members in first instance in

**Sub group
to be
convened**

order to progress. Action 5: Ms Haughey to email original sub group members to seek agreement to review the Urology CMGs. 4. Targeted Service Improvement Activity Urological cancer care issues Mr O'Brien advised that the network provides a forum for members to discuss and identify the key issues across Trusts which may compromise cancer care outcomes. It is also an opportunity to further develop work with the NI Cancer Registry in relation to identifying areas for audit in order to get a better understanding of the key issues. This is particularly important in relation to gathering data for Peer review. Dr Eatock advised that the Urology review will take place in April 2015 and that this round of peer review will review the MDTs and clinical indicators based on the England model. The national standards were designed for England but work is on-going locally to review the standards to ensure they are fit for purpose in Northern Ireland. Dr Eatock advised that the majority of measures are applicable and the only deviations from the national standards will be in relation to an area that cannot comply due to commissioning status. The measures are currently being reviewed and will be available next month. Ms McWilliams advised that the peer review teams will be a mix of English and local reviewers including lay reviewers and work is on-going to seek reviewers across all Trusts for the first round of peer review this year. The national Peer Review team will provide training to all the nominated reviewers and this will be an opportunity to develop local knowledge and expertise. Update on Regional Urology Review Mr O'Brien advised that as Clinical Lead he has been invited to participate in a review stocktake meeting within the next week. He advised members to email him if they had any particular issues / concerns and he would be happy to raise at the meeting.	Ms Haughey
Action 6: Members to email Mr O'Brien with issues / comments in relation to the regional Urology review Cancer Referral Analysis Ms Haughey referred members to the Regional Cancer Referral Analysis spread-sheets which had been emailed earlier long with a summary of the regional analysis for Urology referrals. Ms McWilliams advised that the analysis was done from a performance perspective to quantify the number of referrals, look at trends and to measure the impact on services. The information provides early analysis of referrals and from a network perspective it will help with service improvement as there is a renewed focus on cancer waiting times and a new mechanism is being put in place to monitor cancer waits on a monthly basis. There was some discussion regard the need to monitor recurrences. Ms Davinia Lee highlighted that the Department of Health does not currently	All members

provide funding to track and monitor recurrences, though this is tracked in England. Members highlighted that it is important to track this particularly in terms of equity of service provision. Action 7: Ms McWilliams advised that she would raise this issue at the next Performance meeting in April and at the next NICAN Board meeting.	Ms McWilliams
5. Audit Mr O'Brien advised that he would welcome discussion with members on possible areas for audit and that it could be an opportunity to involve junior doctors in audit exercises. Mr O'Brien suggested a possible area could be Erectile & lower urinary tract dysfunction following radical prostatectomy as there is little information regarding this. Mr O'Kane advised that Ms Thompson is conducting an audit of his patients, from before and after treatment, and agreed to speak to Mr Hagan regard a retrospective audit of his patients. Mr O'Kane advised that he would send information to Mr O'Brien when completed. Action 8: Mr O'Kane to contact Mr Hagan regards completing a retrospective audit.	Mr O'Kane
Ms Haughey advised that she had circulated the Bladder Cancer Audit 2010 from the NI Cancer Registry before the meeting. Mr O'Brien asked members to look at the audit and added that it will provide useful information regard service pressures and bottlenecks in patient pathways. It was agreed to discuss further at the next meeting. Action point 9: Members to review the Bladder Cancer Audit and to discuss audit areas for consideration at the next network meeting.	All members
Ms Haughey circulated a list of open trials from the NI Cancer Trials Centre for information. Dr Jain provided an overview of the trials and advised that he would send an updated list to members. Action point 10: Dr Jain to forward updated list of open Urology trials to Ms Haughey for circulation.	Dr Jain
6. Peer Review This had been discussed earlier on the agenda. It was agreed that when the revised measures are issued, a sub group from the network group will be set up to look at the measures and highlight any derivations for NI. Action point 11: Ms Haughey will circulate the updated measures to all members when finalised.	Ms Haughey
7. Emerging Issues There were no emerging issues. Mr O'Brien finished the meeting and thanked members for their contribution.	
Date of next meeting: <u>Wednesday 11th June 2014 at 2.30pm, Seminar room 1,</u> <u>Belfast Cancer Centre</u>	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients

Attribute:4.2 Treat patients and colleagues fairly and without discrimination

Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	GMC Colleague Feedback Report	February 2014
2	Multi-source Feedback Structured Reflective Template	February 2014
3	Patient Feedback Questionnaire Report	2014
4	Patient or Client Survey Structured Reflective Template	2014
5	Discovering Diversity Programme	12 March 2014
6	Folder of Thank You Cards	2014
7		
8		
9		
10		

Discussion

Whilst I believe that I treat patients and colleagues with fairness and respect, that judgment best rests with them. I do believe that the patient and colleague feedbacks were a reasonable verdict of my behavior towards others.

Actions Agreed

To continue to act in compliance with GMC Good Practice Guidelines.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 Page 9

In Attendance	Aidan O'Brien, Mary Jo Thompson, Mary Haughey, Robin Gray, Jonathan McAleese, Anna Gavin, Thamra Ayton, Moyra Mills, Ruth Johnston, Darren Mitchell, Jean Simpson, Samantha Thompson, Karen Johnston, Kate White, Patricia Thompson, Annie Treanor, Davinia Lee, Edel Aughey, Richard Fiala (via telelink)
Apologies	Hugh O'Kane, Suneil Jain, Ali Thwaini, Teresa Majury, Chris Hagan, Joanne Cullen, Gareth McClean, Colin Mulholland, Wilma Boyd Carson, Kerry Chambers, Kate O'Neill, Martha Magee, Jenny McMahon, Elizabeth England, Fiona Reddick, Lisa McWilliams, Martin Eatock

	Item	Responsibility / Date
1.	Welcome & Introductions Mr Aidan O'Brien welcomed everyone to the meeting and apologies were recorded as above.	-
2.	Minutes of last meeting Members approved minutes of the last meeting. Matters arising: • <u>AP1 Physiotherapy input to HNA</u>: Ms Haughey advised that Ms Thamra Ayton forwarded the contact details of all Trust Physiotherapy leads and these were circulated to Trust Cancer Managers and TCFU Project Managers for onward distribution to the CNS's. • <u>AP2 Letter to DLA Advisory Board</u>: Mr O'Brien advised that he had received the contact name and address of person to write to and suggested that a meeting is also set up to discuss the issue of fatigue for people receiving cancer treatment. It was agreed that it would be useful to involve an <u>Oncologist</u> in the meeting. • <u>AP3 Regional hormone therapy subgroup</u>: Mr O'Brien advised that he had discussed with Mr Ali Thwaini and it was agreed that they would develop a draft pathway based on EAU and BAUS guidelines for consideration at the next regional meeting. It was also	AP1:Mr O'Brien by Nov'14 AP2:Mr O'Brien and Mr Thwaini by Nov'14

-

	suggested to review the SET Hormone therapy pathway.	
3.	Review of Work Programme 2014/15 The draft work programme was circulated to all members for review, no further comments were received. It was agreed to review the work programme again at the next regional meeting.	
4.	Urology Clinical Management Guidelines Ms Haughey advised that Ali Thwaini is currently reviewing the surgical guidelines, Stephen Vallely is meeting with Arthur Grey and Eoin Napier to review the imaging guidelines, Gareth Mc Clean is meeting with Declan O'Rourke to review the pathology guidelines. Mr Jonathan McAleese advised that regional Systemic Therapy Cancer Treatment (SACT) guidelines have already been agreed under auspice of RISOH programme (Prostate, Bladder & Renal) – these can be referenced or included in the network Urology guidelines.	AP3: Lead authors to provide updates at next network meeting (Nov'14)
5.	Targeted Service Improvement Activity A regional urology stocktake and review has been undertaken, meetings have taken place with clinical teams regard issues highlighted, feedback on possible solutions and priorities for the next six months. Mr O'Brien highlighted practice in SHSCT which helped to reduce the target time for patients to be reviewed by consultant within 2 weeks from MDM discussion. Mr O'Brien advised that he spoke to Mr Colin Mulholland regard future management of the MDM between the Northern and Western Trusts. Mr Mulholland is arranging a meeting with senior management to take forward. There was discussion on management of different urological cancers at MDMs. It was noted that it is important for oncology to be involved in renal cell management as a medical oncologist input is required due to the complexity of treatment decisions. It was noted that there are approximately 250 patients with renal cell carcinoma per annum, approximately 6-8 per week. There was discussion on the need to discuss these patients at the regional MDM given oncology is an important treatment modality for these patients. This may require a reconfiguration of existing MDTs as each MDT would require a link person who could feed into a Regional Renal Cell MDT. It was noted that BHSCT are working toward taking this forward with the proposal for SET to hold their own Urology MDM. Mr Darren Mitchell commented that a separate Renal MDT would allow more time for discussion of other cases at the regional MDM; currently separate sites are presented e.g. renal, bladder, testicular. Mr Mitchell will review current pathways with Mr Joe O'Sullivan and agreed to speak to Bode Oladipo and Seamus McAleer regarding process to discuss patients' with testicular tumour via video link.	- RCC TESTICULAR
6.	Audit Dr Anna Gavin, NI Cancer Registry, presented findings from an All-Ireland population-based study of past and current physical and psychological side-effects following prostate cancer treatments (2010-2014). The findings were from 3348 patients, of all ages, 2-15 years post diagnosis (1010 men were from NI). Some conclusions from the study indicated: Adverse physical effects from prostate cancer are common and often multiple	

Mary Haughey 101014

	• If extrapolated to population this represents a significant number who require on-going care • This information should advise decisions about investigation and treatment of prostate cancer and survivor expectation of symptom recovery • Recognition and treatment of adverse physical effects needs to be prioritised for the patient Dr Gavin advised that a major 3 year project across England, Wales, Northern Ireland and Scotland commenced in March 2014 to survey men with prostate cancer 1-3 years after diagnosis to better understand what affects men's outcomes. Results will be made public in 2017 and the study is being supported by the Movember Campaign and Prostate Cancer UK. Mr O'Brien thanked Dr Gavin for her informative presentation. Dr Gavin advised that she would be willing to present findings to other staff groups and members can contact her directly to arrange. Ms Haughey to email Dr Gavin's presentation to all members. Ms Thamra Ayton advised that the BHSCT Physiotherapy department has been successful in securing funding from Prostate Cancer UK to develop an 18 month programme on looking at reducing the impact of continence problems and erectile dysfunction associated with prostate cancer and its treatment. The programme is still in planning stage and work is on-going to meet with the MDT and CNS's. It is hoped to commence the programme before end of January 2015. Ms Ayton will provide update at next meeting. Ms Thompson also reported that following the regional workshop earlier in the year, it is proposed to establish a task and finish group to assess the current pathway for patients with gastro-intestinal consequences following pelvic radiotherapy treatment. The group will have wide representation across disciplines / specialities to establish a baseline and to bring forward recommendations to improve the pathway and patients' experience.	
7.	Peer review Sub group members to review measures and all members to discuss further at the next regional meeting.	AP4: Aidan O'Brien, Pat McClelland, Richard Fiala and Hugh O'Kane to review measures by Nov'14
8.	TCFU Prostate Sub Group TCFU Trust representatives provided updates on the roll out of holistic needs assessments and implementation of the new pathways across Trusts. Holistic needs assessment together with varying degrees of implementation has been achieved in 4/5 Trusts. SHSCT have not implemented pathway at present although a new review clinic has been set up and is hoped to start early October. It was noted that there is a NICE consultation currently on-going regard the Bladder Cancer clinical guideline and the holistic needs assessment is recognised as an integral part of implementation.	

? COXONOSCOPY
FOLLOWING EBRT ?

Mary Haughey 101014

	Mr O'Brien suggested that it would be useful to have a written report of implementation across all Trusts for the next network meeting. Ms Thompson advised that written updates are provided for the TCFU steering group and that these can be circulated to network members for information. Ms Thompson advised that the Wave 3 evaluation is currently on-going for the TCFU programme. As individual Trust focus groups were carried out in Wave two, it was suggested a regional focus group be arranged to ease the burden of the evaluation in Wave three and ensure effective time usage. The group were requested to consider the proposal of utilising an hour of the next network meeting for a focus group discussion for the evaluation report, which would be conducted by PwC - all members agreed. It was requested that representation from all Trusts was required.	AP5: Ms Thompson by next meeting <i>OUTCOME OF FOCUS GROUP ON AGENCIES</i> AP6: Focus group discussion to be held at next meeting
9.	Updates Clinical trials – summary paper of open trials was circulated to all members. Prostate Cancer UK programme update – information on services commissioned was circulated to all members for information. Prostate cancer evening 1st October – information on meeting regard 'recent developments in advanced prostate cancer' was circulated from Dr Suneil Jain.	
10.	Date of Next Meeting <u>Friday 30th January 2015 from 2.30pm-4.30pm, location Belfast, venue to be confirmed</u> **Please note, a separate meeting has been arranged for the focus group discussion as part of the TCFU Wave 3 evaluation and will NOT be part of the next Network meeting**	

Health and Social Care
in Northern Ireland

GMC Colleague Feedback Report

Participant: Dr Aidan OBrien**Survey Initiated: 25/02/2014**

Please find enclosed your report outlining your feedback from the recent GMC colleague feedback survey. The results are illustrated in the graphs and tables that follow.

You nominated **28 colleagues** in total. **24 people** responded. **4 respondents** opted out or did not respond within the timeframe.

Respondents

The following report is based on the 24 colleagues who completed feedback.

12 - Medical Colleagues

7 - Clinical Colleagues

5 - Support/Other Colleagues

Rating Scale

Your colleagues were asked to rate your behaviours in response to a range of questions recommended by the General Medical Council (GMC), the following rating scale was used.

Questions 1-15		Questions 16-18	
1	Poor		Strongly Disagree
2	Less than Satisfactory		Disagree
3	Satisfactory		Neutral
4	Good		Agree
5	Very good		Strongly Agree

Colleagues were also asked to provide free text comments. All comments are presented as written by colleagues, without any editing.

Section 1: Overall Summary

This section of the report provides a summary of your overall ratings as viewed by you and your colleagues. The number below each column displays the number of colleagues who rated you in that area. Colleagues who answered 'Don't Know' are not included in the average. Use your mouse to roll-over each number for further information.

	Poor	Less than Satisfactory	Satisfactory	Good	Very Good	Don't Know	Self	Colleague Average
1. Clinical Knowledge	0	0	0	2	22	0	5	4.92
2. Diagnosis	0	0	0	3	20	1	4	4.87
3. Clinical Decision Making	0	0	1	2	20	1	4	4.83
4. Treatment (including practical procedures)	0	0	0	1	19	4	5	4.95
5. Prescribing	0	0	0	2	15	7	4	4.88
6. Medical record keeping	0	0	2	3	18	1	4	4.70
7. Recognising and working within limitations	0	0	0	4	19	1	4	4.83
8. Keeping knowledge and skills up to date	0	0	1	5	15	3	4	4.67
9. Reviewing and reflecting on own performance	0	0	2	2	16	4	3	4.70
10. Teaching (students, trainees, others)	0	0	0	3	15	6	3	4.83
11. Supervising colleagues	0	0	0	4	15	5	3	4.79
12. Commitment to care and wellbeing of patients	0	0	1	1	22	0	5	4.88
13. Communication with patients and relatives	0	0	0	1	21	2	5	4.95
14. Working effectively with colleagues	0	0	1	2	21	0	4	4.83
15. Effective time management	0	2	5	5	11	1	3	4.09

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know	Self	Colleague Average	
16.	I am confident that this doctor respects patient confidentiality	0	0	1	4	19	0	4	4.75	
17.	I am confident that this doctor is honest and trustworthy	0	0	0	3	21	0	5	4.88	
18.	I am confident that this doctor's performance is not impaired by ill health	0	0	0	4	20	0	5	4.83	
							No	Yes	Don't Know	Self
19.	I am confident that this doctor is fit to practice medicine.					0	24	0	Yes	

Section 2: Written Comments

Colleagues were given the opportunity to add comments. Comments are presented as submitted, with no editing.

20.

Self Comments

I do believe that I am a good doctor. I committed my life to caring for the sick. I have used 35 years to be a good diagnostician. I read the literature of my specialty each day to enhance my knowledge, and I have used the years of experience in that specialty to improve my operative abilities. I believe that I have communicated well with patients and their relatives. I am aware that my main shortcoming has been time management, but that has conflicted with and been compromised by all of the above.

a great colleague

Exceptionally caring doctor

Mr O'Brien is a pleasure to work with. He cares deeply about the welfare of his patients. He is meticulous in all aspects of his work.

I think that this doctor works excessive hours and he should consider reducing towards 40/week

An excellent clinician who I have known for more than 10 years. During this time he has never been anything other than considerate, helpful and highly professional. Always willing to provide advice and/or assistance. Excellent way with patients and staff alike.

Dedicated meticulous surgeon who I would trust to operate on me or any of my family. A privilege to work with and an excellent colleague.

The patient is at the centre of every decision/discussion in which Mr O'Brien is involved. Patients and relatives/carers are highly complementary of both Mr O'Brien's approach to care and explanation of care.

Colleagues

Mr O'Brien always treats his patients and colleagues with the utmost of respect. He knows each patient individually and is truly committed to their care and well being. I also have the utmost respect for him and in the professional manner to which everything he does is carried out to the highest standard possible.

Aidan has excellent communication and interpersonal skills and his attention to patients in his care is outstanding. He always makes time to speak with concerned patients and their families. He is very pragmatic in his approach to healthcare delivery and is a pleasure to work with.

Mr O'Brien is a very respected and valued member of our Theatre team.

Highly knowledgeable professional.

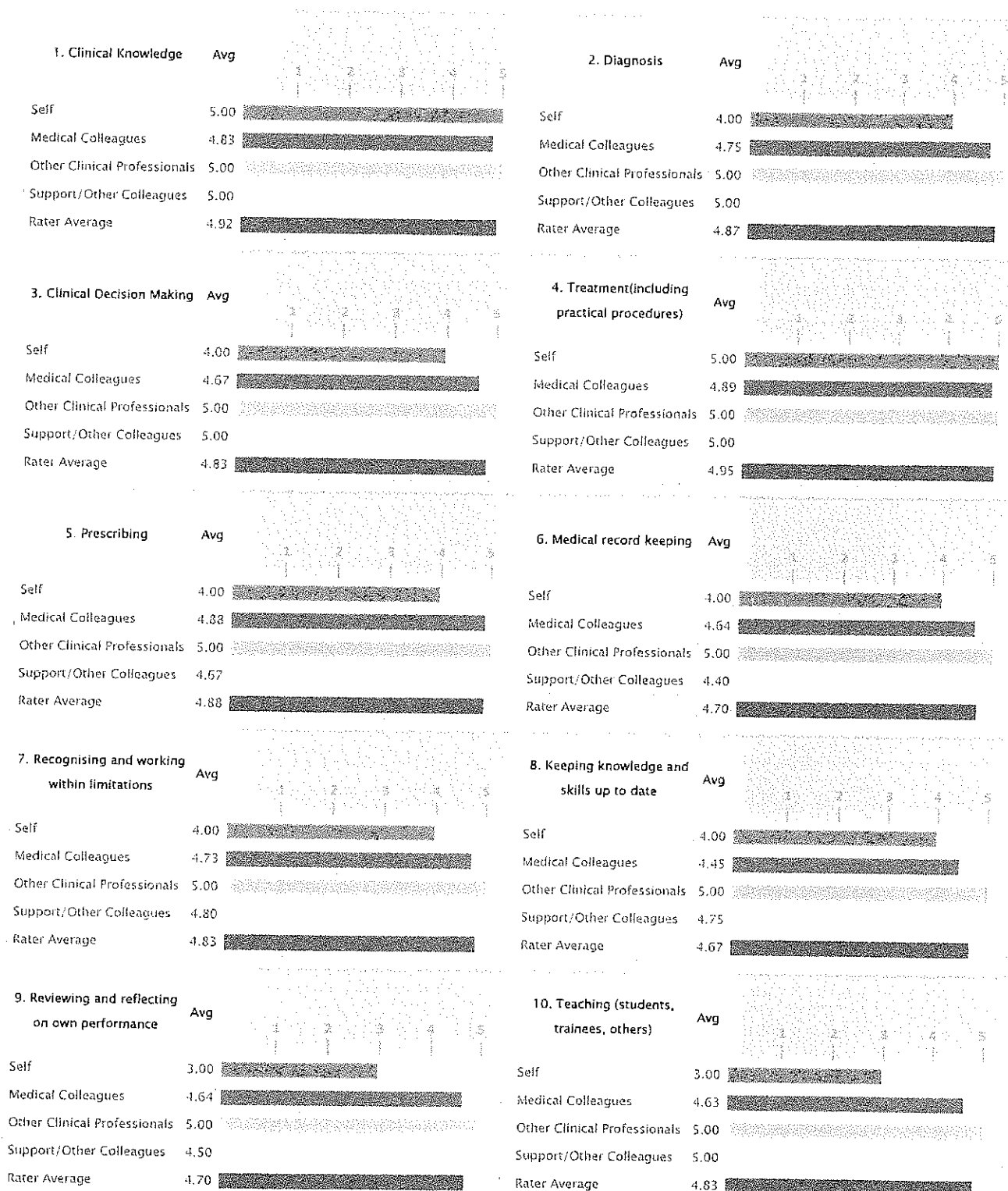
Mr O'Brien is extremely committed towards his patients in giving them the best care he can and they are his top priority.

Mr O'Brien is an excellent committed Consultant and very patient-focused. Any patient under his care is treated with the utmost confidentiality, care and attention to detail. Patients respect him and value his care and opinion

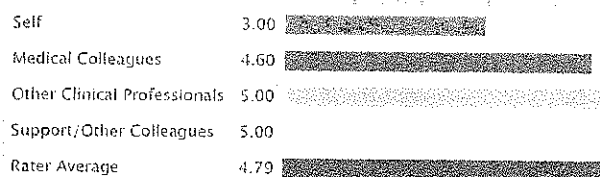
I have been Mr O'Brien's secretary for the the past 12 years and cannot compliment his manner and skills highly enough. His bedside manner is wonderful. He is a highly skilled surgeon. He is a perfectionist in every thing that he does. He is approachable at all times. It is a privilege to be his secretary.

Section 3: Summary Graphs by Question

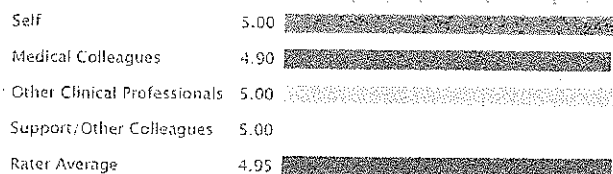
The following graphs show responses by colleague category. In order to protect the anonymity of colleagues if any category contains less than 3, these will be included in the Support/Other Colleagues category.



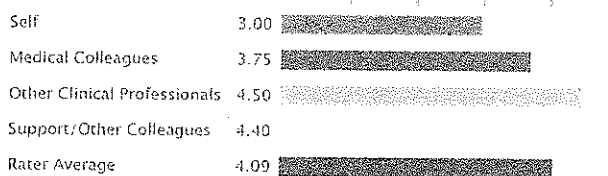
11. Supervising Colleagues Avg



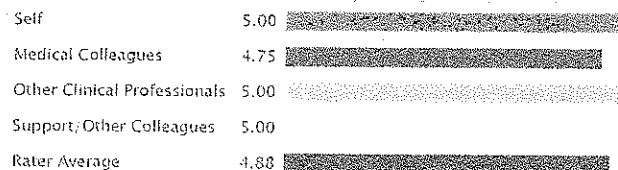
13. Communication with patients and relatives Avg



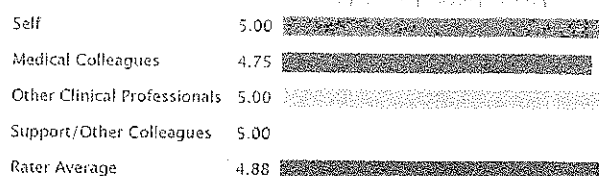
15. Effective time management Avg



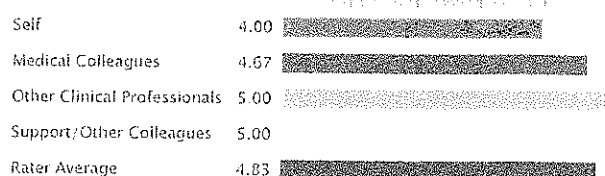
17. I am confident that this doctor is honest and trustworthy Avg



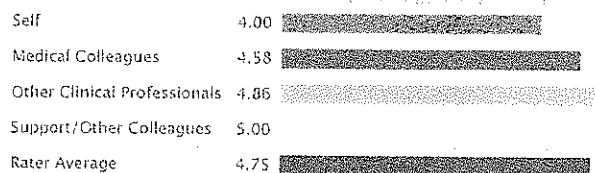
12. Commitment to care and wellbeing of patients Avg



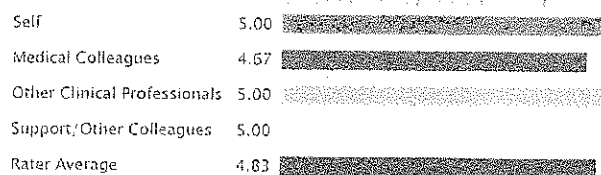
14. Working effectively with colleagues Avg



16. I am confident that this doctor respects patient confidentiality Avg



18. I am confident that this doctor's performance is not impaired by ill health Avg





Southern Health
and Social Care Trust

Quality Care - for you, with you

Multi-source feedback structured reflective template

Requirement: One every five years.

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of exercise: 22 February 2014	
Feedback scheme used (specify if self- or locally-designed): GMC Colleague Feedback Report	
Number of colleagues giving feedback: 24	
Name of person who collated and gave feedback: Beeches	
Designation of person giving feedback: (e.g. Clinical Director, Professional Partner, Appraiser, Professional Facilitator) Beeches	
Main outcomes of feedback Hints: Look at your positive outcomes, as well as learning needs: The Colleague Feedback was on the whole very satisfactory. The only domain in which some colleagues considered that I was less than satisfactory was that of effective time management.	
What learning might I undertake? Hint: It may help to separate learning from changing your behaviour. So, rather than "I will show more respect to nursing colleagues", it might be more productive to undertake learning which develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser. It may help if I could learn how to delegate administrative duties rather than tending to micromanage, even though I believe that there is an inverse relationship between clinical care and effective time management.	
Final outcome after discussion at appraisal: (Complete at appraisal, considering how your outcome will improve patient care) To explore possible behavioural learning or changing opportunities to enhance effective time management.	



Health and Social Care
in Northern Ireland

PATIENT FEEDBACK QUESTIONNAIRE REPORT

Doctor: Mr A O'Brien

Trust Name: SHSCT

Number of Responses: 45

Patient Respondent Profile

This section of the report displays the demographic profile of your respondents and gives the reasons for their visits.

The number below each heading displays the number of patients who responded to that category. Please note that not all patients responded to all questions.

Respondents were asked to indicate who the questionnaire was completed for.

Yourself	Your child	Your spouse or partner	Another friend or relative	No reply
39	1	2	3	0

Respondents were asked to state the reason(s) for visiting you.

To ask for advice	For treatment (including prescriptions)	For a routine check	Because of an on-going problem	Because of a one-off problem	For Tests	Other	No Reply
2	5	10	28	1	3	1	2

Respondents were asked about the importance placed on health and well being as a reason for visiting you.

Not very important

Very Important

1	2	3	4	5	No Reply
0	0	0	5	39	1

Gender Breakdown

Female	Male	Not Reported
10	33	2

Age Breakdown

Under 15	15-20	21-40
1	0	5
41 - 60	Over 60	Not reported
9	27	3

Ethnicity Breakdown

White	Chinese	Indian	Filipino	Black African	Irish Traveller
43	0	0	0	0	0
Black Caribbean	Black Other	Bangladeshi	Pakistani	Mixed Ethnic Group	Other
0	0	0	0	0	0
Not Reported					
2					

Question ratings and scores (Q5)

This section of the report provides a summary of your overall ratings as viewed by your patients.

The number below each heading displays the number of patients who rated you in that category.

The self column for Q5 displays how you rated yourself.

The scoring for the self and average columns for Q5 is as follows:
 Poor=1, Less than satisfactory=2, Satisfactory=3, Good=4, Very good=5

*Your mean score has been calculated for questions 5 and 6.
 Your mean score has also been compared to other doctors who have completed the questionnaire. You will find benchmark data and details of how your score was calculated in Appendix 1.

Respondents were asked to rate you at each of the following:

	Poor	Less than satisfactory	Satisfactory	Good	Very good	Does not apply	Blank (missing)	Average	Self	Mean score %*
Q5a Being polite	0	0	0	2	43	0	0	4.96	4	99
Q5b Making you feel at ease	0	0	0	3	42	0	0	4.93	4	98
Q5c Listening to you	0	0	0	2	43	0	0	4.96	4	99
Q5d Assessing your medical condition	0	0	0	3	41	1	0	4.93	4	98
Q5e Explaining your condition and treatment	0	0	0	3	42	0	0	4.93	4	98
Q5f Involving you in decisions about your treatment	0	0	1	2	40	1	1	4.91	4	98
Q5g Providing or arranging treatment for you	0	0	0	1	43	1	0	4.98	4	99

Question ratings and scores (Q6)

Respondents were asked to agree or disagree with the following statements about you.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Blank (missing)	Mean score %*
Q6a This doctor will keep information about me confidential	0	0	1	11	32	1	93
Q6b This doctor is honest and trustworthy	0	0	0	11	32	2	94

Question ratings and scores (Q7)

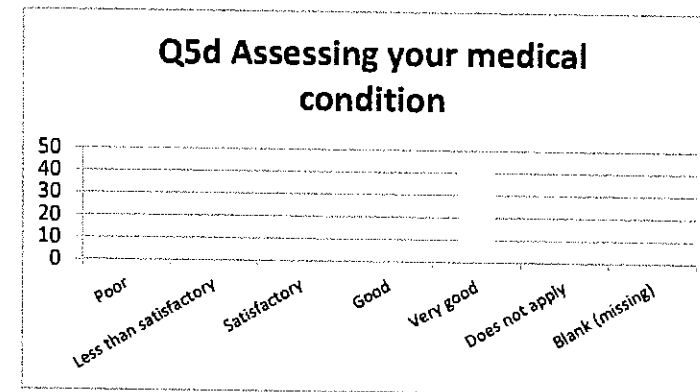
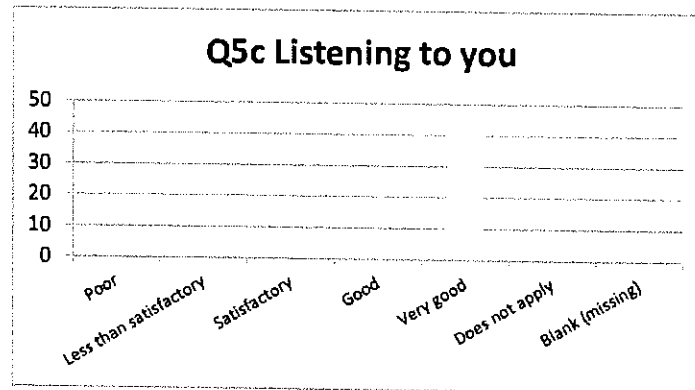
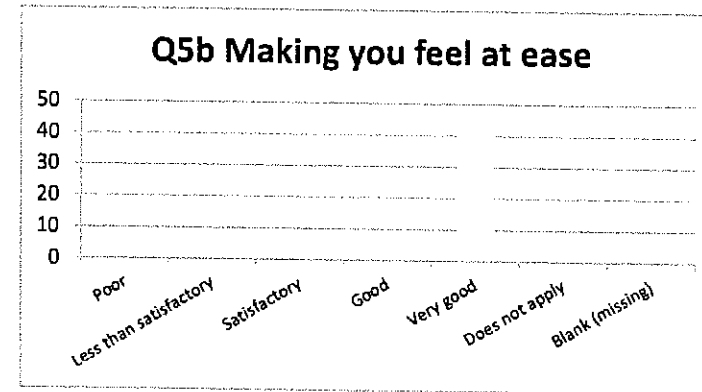
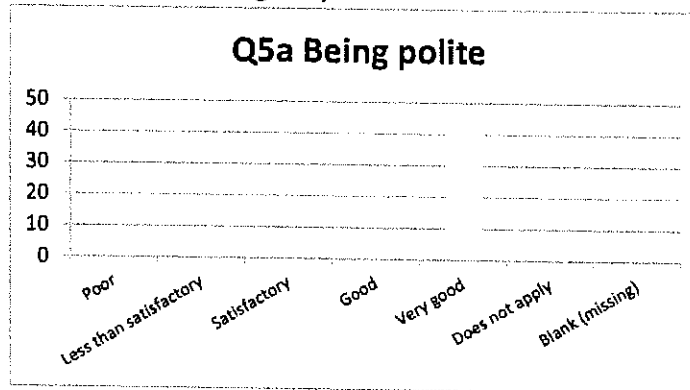
Respondents were asked to reply yes or no to the following statements about you.

	No	Yes	Blank (missing)
Q7a I am confident about this doctor's ability to provide care	0	45	0
Q7b I would be completely happy to see this doctor again	0	45	0
Q7c Was this visit with your usual doctor	11	33	1

Graphical analysis (Q5)

The following graphs display your patients' responses to Q5

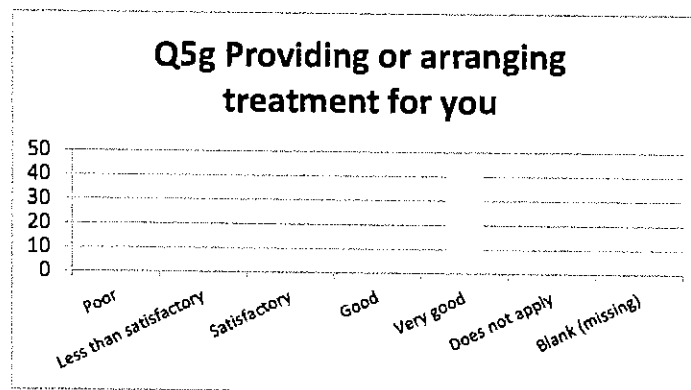
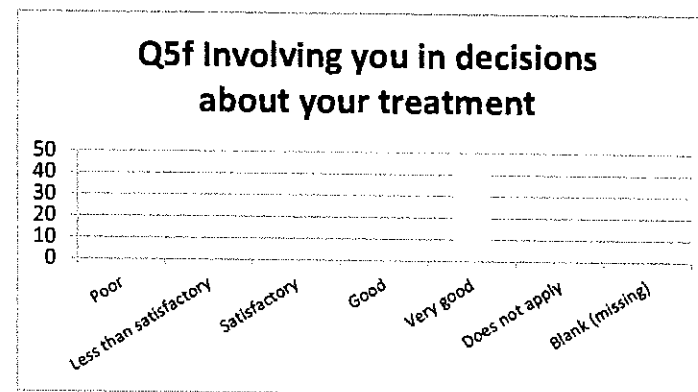
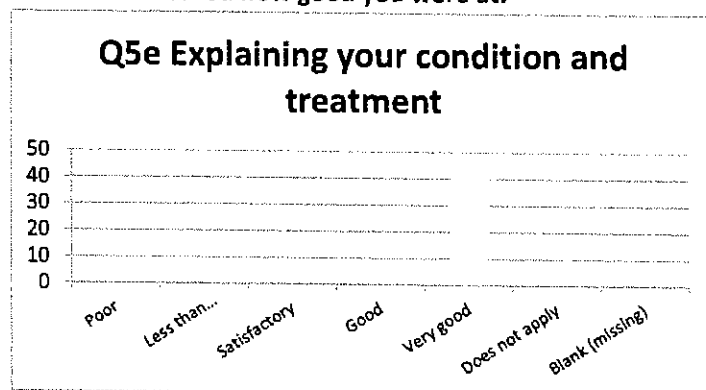
Patients were asked how good you were at:



Graphical analysis (Q5) continued

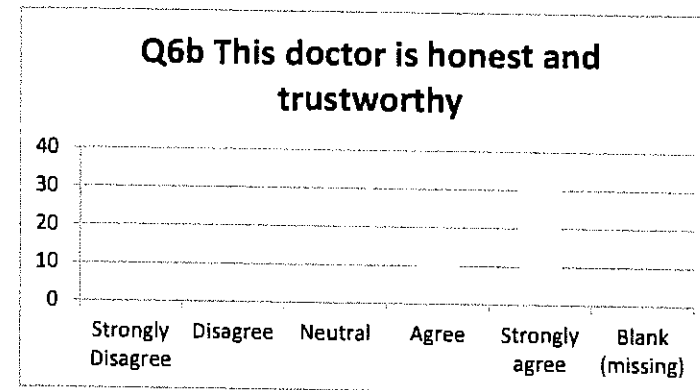
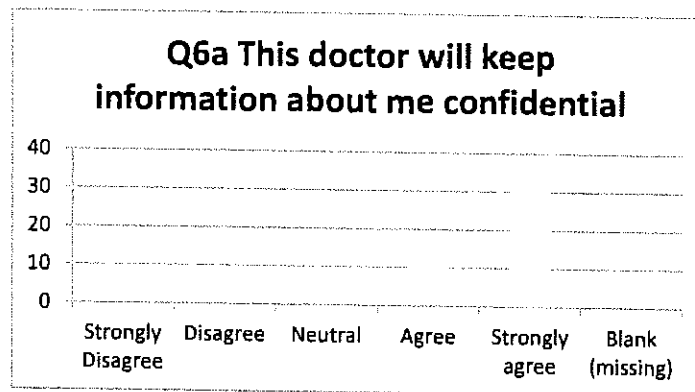
The following graphs display your patients' responses to Q5

Patients were asked how good you were at:



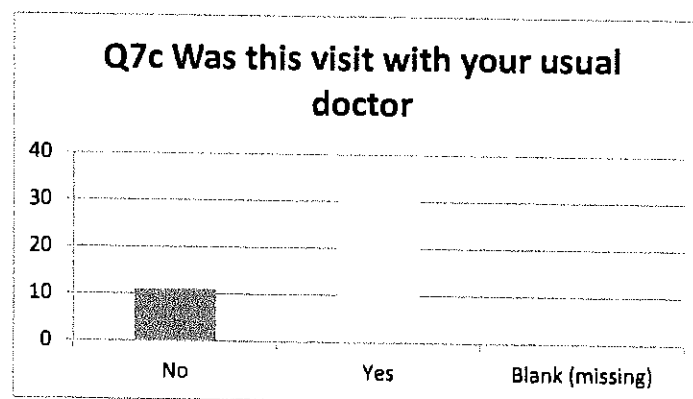
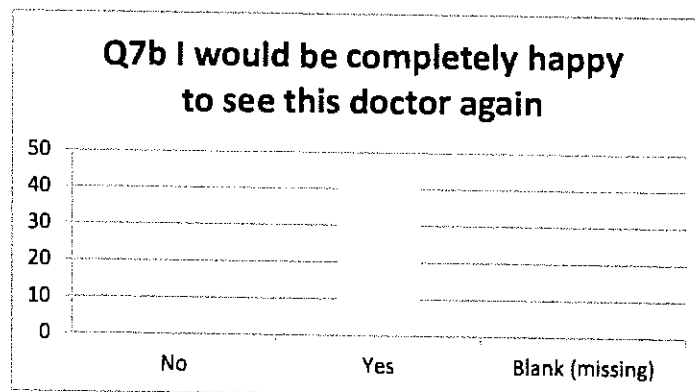
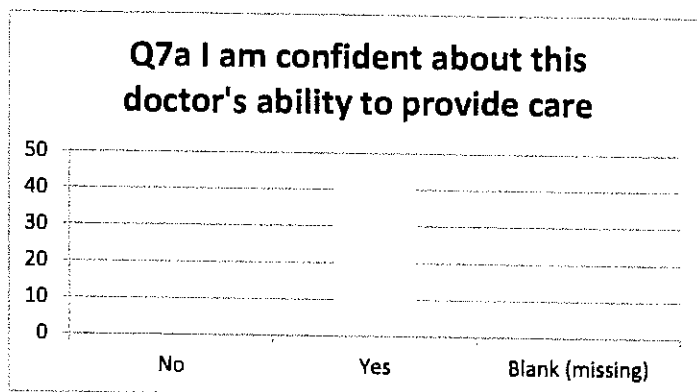
Graphical analysis (Q6)

The following graphs display your patients' responses to Question 6



Graphical analysis (Q7)

The following graphs display your patients' responses to Question 7



Patient comments

Respondents were given the opportunity to add comments. Comments are presented as submitted, with no editing.

Very pleased with assessment of my condition and speed at which it was dealt with.

Very pleased with consultation.

Mr O'Brien has been nothing more than a gentleman on each visit going beyond his line of duty to make me feel at ease and keeping me well informed of my illness I own my like to him.

Mr O'Brien is a v.clear communicator, has a v.personal touch, is thoughtful, sensitive, knowledgeable and experienced. I trust him implicitly and feel privileged to have such high quality professional expertise interested in me.

The Doctor is very good at his job and has looked after my health for many years I could trust him because he knows what he is doing. He is a god send.

The Doctor was very helpful and explained all the treatment in great detail. The doctor made me feel at ease and was very friendly.

Mr O'Brien is a consultant & the best in his field, could not ask for any better. Has approved to see me at regular periods due to ongoing problem which requires an operation, diagnosed before it cause me pain/anxiety etc.

Mr O'Brien has an excellent way of putting a patient at ease and is very exact in his approach to patient care.

Excellent manner in dealing with all queries. Excellent consultant.

Very polite - took time to explain medical facts & aspects of case - made me feel completely at ease.

Mr O'Brien is very courteous and kind.

Lovely doctor very kind manners and very caring.

Lovely man. Very easy to talk to.

Have always received first class treatment from this doctor and look forward to his continuation with my problems.

A very professional consultant who has great experience in his field of expertise. Should it be needed I would highly recommend this consultant to provide their care.

This Dr has provided me with excellent care over a number of years, always fully explaining symptoms and effects at each stage. His whole demeanour inspires confidence.

Mr O'Brien has been extremely good to me explaining my different issues of health & complete gentleman. Wish we had more like him.

An excellent doctor, who takes time with his patients accessing, investigating and treating his patients. Excellent at communication, also an excellent surgeon. I have been under his care for over 20 years and would not change. Mr O'Brien phones patients personally, re-tests, surgery for admission to hospital. He is always the same.

Very good at explaining my condition.

Was very professional and caring in all he did in fact would say was fantastic and very informative.

Mr O'Brien made me feel totally at ease. He did not rush or haste me and his advice was concise and to the point.

Mr O'Brien has always been very understanding and helpful in every way towards me. An excellent doctor.

APPENDIX 1

Benchmark % (Q5-A6)

The benchmark data shown below is based on all data available for the doctors who participated in the Peninsula Medical School GMC Patient Feedback survey in July 2009.

These benchmarks are provided to give you a sense of how you are performing in relation to other doctors who have completed the GMC surveys. They are not intended to imply any 'minimum standard' that doctors are expected to achieve for the purposes of revalidation. This is particularly important due to the fact that these benchmarks are based on a volunteer sample of doctors and as such the benchmarks may be higher than might be expected if all doctors had contributed data.

	Your mean score %*	Benchmark data %				
		Min	Lower quartile	Median	Upper quartile	Max
Q5a Being polite	99	70	96	98	99	100
Q5b Making you feel at ease	98	69	94	97	98	100
Q5c Listening to you	99	61	94	97	98	100
Q5d Assessing your medical condition	98	68	93	96	98	100
Q5e Explaining your condition and treatment	98	65	93	95	98	100
Q5f Involving you in decisions about your treatment	98	67	92	95	97	100
Q5g Providing or arranging treatment for you	99	68	93	96	98	100
Q6a This doctor will keep information about me confidential	93	59	90	93	95	100
Q6b This doctor is honest and trustworthy	94	65	91	94	96	100

*Each individual score for the evaluation questions is expressed as a mean (average) for all patients who completed the question. These scores are expressed as a percentage of the maximum possible score, which is 100%. Non rated responses (don't know, blank missing etc.) are not used in the score.

APPENDIX 1 continued...

Mean score calculation example

All five point rating scale questions are scored from 0 - 100% as shown below:

	Poor	Less than satisfactory	Satisfactory	Good	Very Good	Non rated response
Your mean score (%)	0	25	50	75	100	

The following example uses data from question Q5a from the patient questionnaire based on a return of 24 questionnaires

Questions	Poor	Less than satisfactory	Satisfactory	Good	Very Good	Non rated response
Q5a Being polite	0	0	0	3	20	1

$$\frac{(0 \times 0) + (0 \times 25) + (0 \times 50) + (3 \times 75) + (20 \times 100)}{24 - 1} = 97\% \text{ mean percentage score}$$



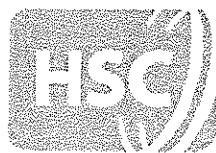
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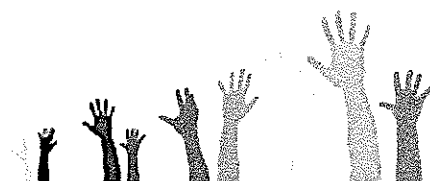
Patient or client survey structured reflective template

Requirement: One every five years.

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of survey:	
March and April 2014	
Type of survey:	
Patient Satisfaction Survey	
What issues can I identify from the exercise? Hints: Look at your positive findings just as carefully as the most negative. Discuss and seek advice from colleagues both peer and senior, if possible. If you have difficulty identifying learning needs from the survey, be frank about this. Skills in interpreting such information can then be considered as your first learning need in this regard. I found that the findings of the survey were very satisfactory, with no significant, negative issues What actions will I undertake? Hints: These might include: improving communication techniques, restructuring ward rounds to maximise dignity and privacy, negotiating changes to the consulting environment, developing skills with respect to specific cohorts of patients, learning more about how to learn from patient surveys (as above). I believe that there were two inadequacies in the survey. All patients requested to participate were outpatients. It would be more challenging perhaps to have inpatients involved. Secondly, and I believe more importantly, a minimum proportion should be first encounters with the patient, as, by definition, those patients of long standing are probably satisfied with the clinician's conduct. Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care) To spread the type of patient encounter when next conducting survey.	



Discovering
Diversity
Health & Social Care in Northern Ireland



Certificate of Completion

This is to certify that on 12 March 2014

Aidan O'Brien

From

Southern Health and Social Care Trust

Completed the
Discovering Diversity
programme



HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 5- HEALTH AND PROBITY STATEMENTS**HEALTH DECLARATION****Professional Obligations**

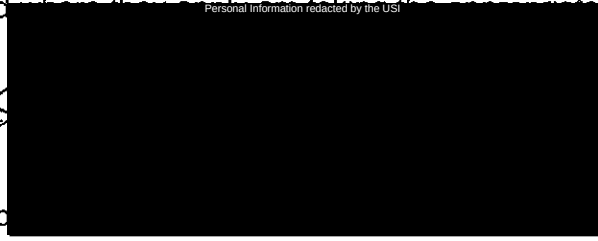
The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

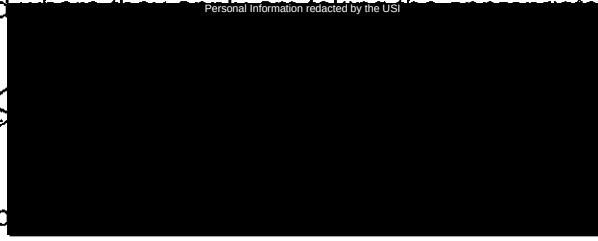
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and undertake to take appropriate action.

Signature: 

Date: 16.12.15

Name in capital letters: 

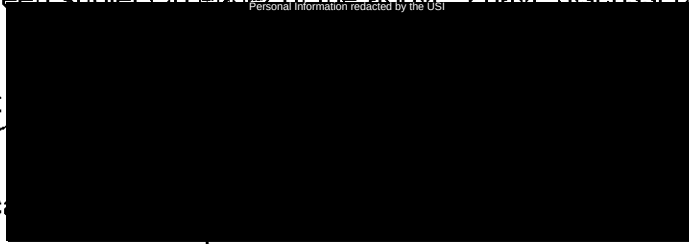
Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I have not, in the UK or outside:

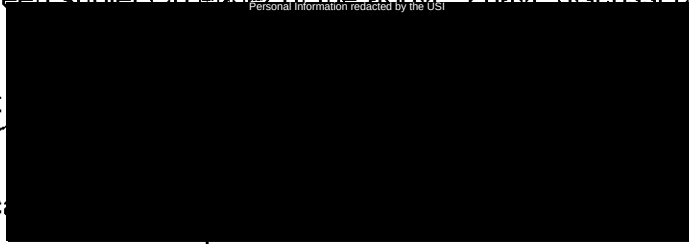
- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

If I have been subject to either of the above I have discussed these with my appraiser.

Signature: 

Date: 16.12.15

Name in capital letters: 

Name:

GMC Number:

Appraisal Period :

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PROBITY DECLARATION

Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006)*.

Signature:

Date: 16.12.15

Name in c.....

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I have not, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

If I have been subject to any of the above, I have discussed this with my appraiser.

Signature:

Date: 16.12.15

Name in c.....

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 7- REVALIDATION PROGRESS

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____	Name of Appraiser: _____
GMC Number: _____	Date: _____

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: _____ Name of Appraiser: _____
 GMC Number: _____ Date: _____

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Name: Aidan O'Brien

GMC Number: 1394911

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Appendix 1 Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (18 month refresher required)	Learn Blood Transfusion Module	Core Module	
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff	Core Module	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face – Trust Mandatory Training Day	Core Module	
2 Yearly Updates	Method	Core / Optional	Date Completed
Infection Prevention and Control	Face to Face – Trust Mandatory Training Day	Core Module	
Resuscitation	Face to Face		
Safeguarding Children & Vulnerable Adults	Face to Face – Trust Mandatory Training Day	Core Module	
3 Yearly Updates	Method	Core / Optional	Date Completed
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module	Core Module	
Moving and Handling	SHSCT E-Learning Module	Core Module	
Health & Safety / Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module	Core Module	
Discovering Diversity	HSC E-Learning Module		
Recruitment & Selection	HSC E-Learning Module		
Hyponatraemia	BMJ E-Learning Module		
Management of Actual or Potential Aggression	Face to Face		
Fraud Awareness	HSC E-Learning Module		
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module		
Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning		
Obstetrics Early Warning System	OEWS e-learning		
Paediatrics Early Warning System	PEWS e-learning		
Consent	In House E-Learning module		
Blood Culture	In House E-Learning module		
Peripheral Line	In House E-Learning module		
Anticoag (Starting and Maintaining)	BMJ E-Learning Module		
Naso Gastric Tube Placement	Merck & In House E-Learning module		
Protocol following death of patient	In House E-Learning module		

Name:

GMC Number:

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Guide to Prescribing in SHSCT	In House E-Learning module		
Patients enrolled in Clinical Trials	In House E-Learning module		
VTE	E-learning for Health		
Safe Sedation [Module 1,2 & 3]	In House E-Learning module		
Gastrointestinal endoscopy	Face to face		
Chest Drain Insertion	Face to face		
Blood Gas Instrument	Face to face		
Appraiser Training	Face to face		
Appraisee Training	Face to face		
Fraud Awareness	HSC Module		
Modules proposed for E-Learning	Method	Core / Optional	Date Completed
Better Communication/Complaint Handling	Face to face		
Incident Reporting	Face to face		
Clinical Negligence	Not currently available		
Infection Prevention and Control	Face to face		
Waste Management	Not currently available		

Links to the various e-learning modules and information regarding face-to-face training can be found [here](#). Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@southerntrust.hscni.net

TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

APPRAISEE

Signature of Appraisee: _____ Date: _____

GMC Number: _____

APPRAISER

Signature of Appraiser: _____ Date: _____

PRINT NAME OF APPRAISER: _____

Name:

GMC Number:

Appraisal Period : Jan – Dec 2014 Page 17

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

APPRAISER FEEDBACK FORM

Appraiser:

Appraisee:

Date of Appraisal:

Before the Appraisal

1. How challenging did you find it to review the paperwork for this appraisal?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Very Difficult Difficult Neither Difficult / Easy Easy Quite Simple

2. How much time did you spend preparing for this appraisal?

- Over 5 hours ☐ Between 2 and 5 hours ☐ Between 1 and 2 hours ☐ Less than 1 hour ☐

3. Overall, how would you say you were feeling towards this impending appraisal?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Very Negative Negative Neither Negative / Positive Positive Very Positive

During the Appraisal

4. Did you begin the appraisal feeling clear about what was going to be discussed?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Not at all A Little Unclear Fairly Clear Very Clear We agreed this at the beginning

5. Did you feel that the confidentiality of the process was understood?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Not at all A Little Fairly Understood Well Understood Completely Understood

6. Did you feel at ease during this appraisal?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
I felt ill at ease throughout I felt a little uneasy I felt neither easy / uneasy I felt fairly at ease I felt completely at ease from the start

7. Did you feel that the appraisee was familiar with the paperwork?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
They did not appear to have read it May have read it briefly Was fairly familiar Was very familiar Had clearly taken time to read and think about it

8. Did you feel that the appraisal addressed all the issues that needed to be addressed?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Not at all A Little Could have been addressed better Almost Completely

9. Did you feel that the feedback you gave was constructive?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Not at all A Little Unconstructive and Unfair A Little Constructive and Fair Fairly Constructive and Fair Very constructive and fair

10. To what extent did this appraisal help reflect on and identify development needs?

- 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014

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11. To what extent are you confident that enough evidence was gathered for revalidation as a doctor in HSC?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not at all	A little	Moderately Confident	Fairly Confident	Very Confident

12a. Did you discuss other roles in addition to the clinical role?

Yes ☐ No ☐ Role discussed: _____

12b. If yes, to what extent are you confident that enough revalidation evidence was gathered for this other role?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not at all	A little	Moderately Confident	Fairly Confident	Very Confident

13. Did you feel that a fair and appropriate personal development plan was identified by the end of the interview?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not at all	A little	Could have been better	More or Less	Very Much So

14. Overall, how did you feel by the end of appraisal interview?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Very negative	Negative	Neither Positive/ Negative	Positive	Very Positive

After the Appraisal

15. How long did the appraisal interview last?

Over 2 hours ☐ Between 1.5 and 2 hours ☐ Between 1 and 1.5 hours ☐ Less than 1 hour ☐

16. Did it feel the right length?

Too long ☐ Too short ☐ Just about right ☐

17. Please rate the venue of the appraisal in terms of convenience to get to, comfort and freedom from interruption:

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Very Unsuitable	Unsuitable	Neither Unsuitable / Suitable	Suitable	Very Suitable

18. How soon after the meeting did you complete the paperwork?

Not yet complete ☐ within 2 weeks ☐ within 1 week ☐ We completed it together straight after the interview ☐

19. How many hours did it take to complete the paperwork?

4 hours or more ☐ Between 2 – 3 hours ☐ Between 1 – 2 hours ☐ Less than 1 hour ☐

20. Did you feel the completed paperwork reflected a fair and accurate account of your discussion?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not at all	A Little	Reasonably Fair & Accurate	Very Fair & Accurate	Completely Fair & Accurate

Name: Aidan O'Brien

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



Southern Health
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Quality Care - for you, with you

Appendix 3

APPRAISEE FEEDBACK FORM

1 Very poor / Strongly disagree	2 Poor / Disagree	3 Average / Neutral	4 Good / Agree	5 Very good / Strongly agree				
				1	2	3	4	5
The organisation's approach to appraisal								
1. The organisation's appraisal system								

My appraiser's skills								
2. The appraiser's preparation for the appraisal								
3. The appraiser's skill in conducting my appraisal								
4. The appraiser's ability to listen to me								
5. The appraiser was supportive								
6. The appraiser's feedback was constructive and helpful								
7. The appraiser helped me think about new areas for development								
8. Overall rating of my appraiser in their role as an appraiser								

The appraisal discussion								
9. The appraiser reviewed progress against last year's development plan								
10. How challenging was the appraisal in making me think about my practice								
11. How useful was the appraisal in my professional development								
12. The PDP reflects my main priorities for development								
13. How useful was the appraisal in preparation for revalidation								
14. I have confidence in the confidentiality of the appraisal discussion								

The administration of appraisal								
15. I had access to forms and materials for appraisal								
16. I was given adequate notice of the date of my appraisal								
17. I had access to the necessary supporting information								
18. I was satisfied with the process for appraiser allocation								
19. Overall rating of the administration supporting appraisal in the Trust								

How long did the appraisal meeting take? _____ minutes.

How could the Appraisal Meeting have been improved?

Comments to help appraisers improve their skills:

Name: Aidan O'Brien

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APPENDIX 4

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

Medical Staff Appraisal

Aide Memoire and Quality Assurance Audit Tool

(Revised February 2015)

(PLEASE RETAIN FOR OWN RECORDS)

Doctor's Name: _____

Specialty: _____

Appraisal Year: _____

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Form 1 – Background Details	Yes	No	Partial	Comments (attached document or written statement)
Details of registration/licence to practice				
Brief details of employment in the previous year				
Supplementary Information e.g. membership of medical and specialist societies				

Form 2 – Current Medical Activities	Yes	No	Partial	Comments (attached document or written statement)
Job Plan				
Summary of Clinical Activities inc. Private Practice				
Evidence of MPS / MDU Membership if carrying out private practice				
Information on non-clinical work – such as teaching or management responsibilities				
Location of all current practices				

NB: Evidence must be held in your folder against all of these domains

Form 3 – Supporting Information and Summary of Appraisal Discussion	Yes	No	Partial	Comments (attached document or written statement)
DOMAIN 1: Knowledge, Skills and Performance				
Job Plan				
Workload Records				
Evidence of how educational activity may have affected service delivery outcomes				
Information on Teaching and Training Activities				
Evidence of Reflective Practice				
Evidence of Audit Activity				
Evidence of Research Activity				
Evidence that CPD follows the recognised best practice in your field or specialty as set out by the Colleges.				
Evidence of Published Articles and/or Presentations to Peers				
Record of Funding Arrangements				

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GMC Number: 1394911

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Relevant Process and Outcome Data (i.e. where a change in processes has resulted in better outcomes/way of working)				
Previous and Current Personal Development Plan				
Additional information on formal management commitments				
HPSS regional or national management involvement				
DOMAIN 2: Safety and Quality	Yes	No	Partial	Comments (attached document or written statement)
Evidence of any resource shortfalls which may have compromised outcomes				
Up to date audit data including information on audit methodology and a record of how results of audit have resulted in changes to practice (if applicable)				
Reflection on significant events/critical incidents/near misses				
Records of how relevant medical guidelines have been reviewed by you and your team and how these have changed practice				
Evidence of attendance at, and participation in, governance activity relevant to practice				
Evidence of risk management to include near misses and action taken to addresses/reduce risks				
Analysis of, and reflection on, current practice				
Records of training related to enhancing safety and quality of patient care				
Statement of satisfactory research practice				
Evidence of registration with a GP, Statement of Health, vaccination records				
DOMAIN 3: Communication, Partnership and Teamwork	Yes	No	Partial	Comments (attached document or written statement)
Evidence of any team development activity				
Description of the team you work within (medical and/or multidisciplinary)				
Description of all activities in which you interact with other healthcare workers e.g. multidisciplinary meetings, working groups and committee work.				
Analysis of trainee/medical student survey (where appropriate)				
Evidence of participation in multi-professional team meetings				
Evidence of Patient Feedback				
Evidence of Colleague Feedback				

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HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

DOMAIN 4: Maintaining Trust	Yes	No	Partial	Comments (attached document or written statement)
Signed Statement of Probity and Health				
Complaints				
Compliments				
Evidence of Patient and Colleague Feedback				
Summary of Form 3	Yes	No	Partial	Comments (attached document or written statement)
Knowledge, Skills and Performance – commentary				
Action Agreed				
Safety and Quality – commentary				
Action Agreed				
Communication, Partnership and Teamwork – commentary				
Action Agreed				
Maintaining Trust – commentary				
Action Agreed				
Any Other Points – commentary				
Action Agreed				
Summary of development action				

FORM 4 - Personal Development Plan				
Fully Completed				
Evidence of Updating and Ongoing Effort to Achieve Plan				
Evidence of Two Years Current and Past PDPs.				
Evidence of, for example:- ▪ Patient / Safety Project ▪ CME / Course Plan ▪ Research or Audit ▪ Service Development				

Name: Aidan O'Brien

GMC Number: 1394911

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23. Agenda of Urology MDT Business Meeting dated 12 March 2015	66 – 67
24. Minute of Urology MDT Business Meeting dated 02 April 2015	68 – 71
25. Urology MDT, Annual Report for 2014/15 dated April 2015	72 – 81
26. Urology MDT, Work Plan for 2015/16 dated April 2015	82 - 84
27. Peer Review Visit Report dated 16 June 2015	85 – 92
28. Letter to Ms Clarke from Mr McMahon dated 01 July 2015	93 – 94
29. Notification of Immediate Risk and Serious Concerns dated 16 June 2015	95 - 96
30. Other Roles Structured Reflective Template (undated)	97 – 98
31. NI Peer Review Programme, Reviewers Briefing Pack dated 2014 – 2016	99 - 121
32. NICaN Minutes of Urology Network Site Specific Group Meeting dated 30 January 2015	122 – 127
33. NICaN Minute of Urology Network Site Specific Group Meeting dated 17 April 2015	128 – 132
34. NICaN Minute of Urology Network Site Specific Group Meeting dated 18 September 2015	133 – 136
35. Email correspondence between Mr O’Brien, Ms Haughey and others dated 03 May 2015	137 – 140
36. Email correspondence between Mr O’Brien, Ms Haughey and Mr Thwaini dated 17 May 2015	141 - 142
37. Email correspondence between Ms Haughey and Mr O’Brien dated 19 May 2015	143 - 144
38. Email correspondence between Mr Williams, Ms McVeigh and others dated 28 May 2015	145 – 146
39. Review of Clinical Management Guidelines (undated)	147 – 149
40. Urological Nursing in the Management of Urological Cancer, A Statement of Roles and Responsibilities dated 2015	150 – 153
41. NICaN Urology Care Pathways, revised dated 2015	154 -162
42. Prostate Cancer: Hormone Therapy Alone Pathway (for Men with locally advanced prostate cancer) Guidelines (undated)	163 - 174
43. Domain 4 – Maintaining Trust	175
44. Form 4 – Personal Development Plan	176
45. Form 5 – Health and Probity Statements dated 18 December 2016	177 – 178
46. Form 6 – Sign off dated 23 December 2016	179

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MEDICAL APPRAISAL DOCUMENTS & CHECKLIST

PLEASE USE THESE FORMS FOR CALENDAR YEAR
JANUARY TO DECEMBER 2015 ONWARDS

Remember to include:- <i>[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]</i>	
Your name, GMC No, and the appraisal period covered in the footer of the forms. Simply double-click on the relevant section at the bottom of the document.	☐
Evidence of Reflection on Practice and use of Structured Reflective Templates – click here	☐
Evidence of Research Activity (if applicable)	☐
Evidence of at Least 66% Attendance at M&M Meetings (or equivalent)	☐
Use of M&M SBAR Template with Appropriate Detail of Involvement – click here <i>See D 2.</i>	☒
Evidence of Regular Participation in Clinical Audit	☐
Remember to send:- <i>[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]</i>	
FRONT PAGE CHECKLIST – with <u>all</u> boxes ticked	☐
FORM 1 – all parts completed by Appraisee	☐
FORM 2 – all parts completed by Appraisee to include <u>whole practice</u> i.e. Private / Medico Legal Work etc.	☐
FORM 3 – All four GMP Domains completed jointly by Appraisee and Appraiser to include list of supporting information and evidence of the discussion that took place during the appraisal meeting – click here	☐
FORM 3 – Inclusion of agreed actions against <u>all four</u> GMP domains – click here	☐
FORM 4 – Review of Last Year's PDP	☐
FORM 4 – PDP for the Year Ahead Developed from the Discussions Around the Four GMP Domains – click here	☐
FORM 5 – all parts completed with FIVE signatures, one for each section	☐
FORM 6 – completed, signed and dated by both Appraisee & Appraiser	☐
FORM 7 – Completed in respect of where the appraisee is in their forthcoming Revalidation Cycle i.e. Year 1, 2, 3 etc. Please ensure last section also completed in relation to whether the Revalidation Requirements have been met or when they are proposed to be met.	☐
APPENDIX 1 – all parts completed, signed and dated by Appraisee & Appraiser	☐
APPENDIX 2 – NOT REQUIRED / KEEP FOR YOUR OWN RECORDS	☐

PLEASE DO NOT SUBMIT THESE FORMS UNLESS ALL OF THE ABOVE BOXES HAVE BEEN TICKED AS THEY WILL NOT BE ACCEPTED FOR PROCESSING.

You can submit the documentation by scanning and emailing the original signed copies to:-

medical.revalidation@hscni.net

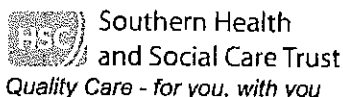
Personal Information redacted by the USI

Or send the signed originals by internal mail to the Revalidation Support Team at the address below where they will be scanned in, saved and returned to you:- (Copies will not be accepted).

Revalidation Support Team, Medical Directorate, Clanrye House, DHH.

For further guidance and FAQ's – click [here](#)

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION



APPRAISAL DOCUMENTS

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Form 1	Background Details
Form 2	Current Medical Activities
Form 3	Supporting Information for Appraisal & Summary of Appraisal Discussion
Form 4	Personal Development Plan
Form 5	Health & Probity Statements
Form 6	Sign Off -
Form 7	Revalidation Progress
Appendix 1	Education and Training Competencies Available for Medical Staff
Appendix 2	Aide Memoire and Quality Assurance Audit Tool

FORM 1 - BACKGROUND DETAILS

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.
- The form includes an optional section for any additional information – click [here](#) to navigate to the relevant guidance in Appendix 4 of these forms.

1.1 Full name	Aidan O'Brien
1.2 GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3 Main employer	Southern Health and Social Care Trust
1.4 Main place of work	Craigavon Area Hospital, Craigavon.
1.5 Other employers/ places of work	Armagh Community Hospital, Armagh South West Acute Hospital, Enniskillen
1.6 Date of primary medical qualification	December 1978
1.7 GMC registration number and type	1394911 Full with Specialist Registration
1.8 Start date of first substantive appointment in HSC as a trained doctor	06 July 1992
1.8 GMC Registration date and specialties	07 August 2013 Urology
1.9 Title of current post and date appointed	Consultant Urological Surgeon on 11 June 1992
1.10 For any specialist registration / qualification outside UK, please give date and specialty	Fellow of Royal College of Surgeons in Ireland November 1983
1.11 Please list any other specialties or sub-specialties in which you are registered	None
1.12 Is your registration currently in question?	No
1.13 Date of last revalidation (if applicable)	28 April 2014
1.14 Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Consultant Urological Surgeon, Craigavon Area Hospital

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 2

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION**ANY ADDITIONAL INFORMATION**

I became a

- Fellow of the Ulster Medical Society in 1984
- Fellow of the Royal Society of Medicine in Ireland in 1986
- Fellow of the Irish Society of Urology in 1992
- Member of the Bristol Urological Institute in 1992
- Founding Director of CURE in 1995
- External Adviser to Royal College of Surgeons in Ireland in Specialist Registrar appointments in the Republic of Ireland in 2012
- Lead Clinician of Urological Cancer Multidisciplinary Team of the Southern Health and Social Care Trust in April 2012
- Lead Clinician and Chair of the Northern Ireland Cancer Network Clinical Reference Group for Urology in January 2013
- Peer Reviewer for the National Cancer Plan in February 2015

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 2 - CURRENT MEDICAL ACTIVITIES

- This form should be completed by the appraisee in advance of the appraisal.
- The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.
- Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.
- You may wish to comment in addition on factors which affect the provision of good health care.

Click [here](#) to navigate to the relevant guidance in Appendix 2.

2.1 Please give a short description of your work, including the different types of activity you undertake	My work includes the management of acute urological admissions and the ongoing clinical management of elective admissions when urologist of the week. It includes the administrative arrangement, clinical and operative management of elective inpatients and day cases. It includes conducting outpatient clinics for new patients as well as clinics for general and oncological patients. It includes arranging and participating in urodynamic and flexible cystoscopy clinics. It includes chairing or attending urological cancer multidisciplinary meetings and reconstructive urology multidisciplinary meetings. It has included chairing the Northern Ireland Cancer Network Clinical Reference Group for Urology.
2.2 List your main sub-specialist skills and commitments / special interests	Urological Cancer. Paediatric Urology. Lower Urinary Tract Functional and Reconstructive Urology.
2.3 Please give details of any emergency, on-call and out of hours responsibilities	Since the introduction of the 'Urologist of the Week' system for the provision of emergency urological care in September 2014, one consultant urologist is responsible for the clinical and operative management of all acute admissions during that week, in addition to the ongoing management of all other patients previously admitted acutely and those admitted electively. As one of six consultant urologists, I participated in that rota, so that I would have been on call continuously for the period of one week.
2.4 Please give details of out-patient work if applicable	I am scheduled to conduct general urological review clinics in Armagh Community Hospital once monthly, in South West Acute Hospital once monthly and in Craigavon Area Hospital once or twice monthly. I am scheduled to conduct a clinic for new patient referrals once weekly. I conduct a clinic for the investigation of lower tract dysfunction by urodynamic studies and flexible cystoscopy once weekly, and an oncology review clinic once weekly.
2.5 Details of any other clinical work	I triage red flag referrals when urologist of the week. I arrange inpatient and day case surgical admissions. I have reviewed, and amended, all outcomes of the weekly urological cancer multidisciplinary meetings. I answer and address queries from patients, their general practitioners, their relatives and other representatives daily.
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	I do not have admission rights to or practicing privileges in any non-HSC hospitals or clinics. I do conduct a private outpatient consultation practice at my home, on Saturdays only, typically twice monthly, and when not on call or providing any other HSC service. I do not conduct any private practice or provide any fee-paying service within any HSC premises. I have never had a complaint arising from private practice. There have been no adverse events or incidents arising from private practice. In addition to keeping private clinical records for a minimum period of three years, all clinical correspondence is duplicated to a Craigavon Area Hospital or Daisy Hill Hospital chart, in addition to being included on the Northern Ireland Electronic Care Record.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 4

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

2.7 List any non-clinical work that you undertake which relates to teaching	Clinical Supervisor of Specialist Registrars in Urology
2.7.1 List any non-clinical work that you undertake which relates to management	As Lead Clinician of the Urological Cancer MDT, I liaised with the Cancer Coordinators and with the Heads of Service each week to ensure that the management of cancer patients was progressed within the 31 and 62 day time lines. Having achieved 100% compliance by January 2015, that complete compliance was maintained throughout 2015. I led the Southern Trust Urological Cancer submission for Peer Review in June 2016. I was a member of the Peer Review Panel of the Western Trust Urological Cancer MDT in June 2015.
2.7.2 List any non-clinical work that you undertake which relates to research	Participant in 'Living with and Beyond Prostate Cancer: a study of the Impact on Men of Increased and Variable Investigation and Treatment of Prostate Cancer in Ireland'.
2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of the Northern Ireland Cancer Network's Clinical Reference Group in Urology
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	Provision of expert medicolegal reports.

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

Current Job Plan enclosed.

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

The issues which have impacted upon the delivery of optimal patient care have remained unchanged from those recorded in previous appraisals. I have a waiting list of over 280 patients waiting up to almost three years for admission for surgery. More patients are added to that waiting list each week than can be removed from it. Within the totality, there are patients with clinical urgencies waiting so long that their clinical conditions are worsened by doing so. My waiting list has been up to ten times greater than those of some of my colleagues. A similar situation pertains to outpatient reviews, and particularly those of cancer patients. Yet the situation has not been addressed in a durable and effective manner, whilst there persists an expectation that I will continue to accommodate new referrals.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 1 - Knowledge, Skills and Performance		
Attribute: 1.1 Maintain your professional performance		
Attribute: 1.2 Apply knowledge and experience to practice		
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.		
	List of Supporting Information	Applicable Date
1	Entry on the Specialist Register of the General Medical Council	07 August 2013
2	Confirmation of GMC Online account activation	16 March 2014
3	Annual Retention Fee Confirmation for registration year starting 27/02/2015	16 February 2015
4	Certificate of Proof of Entry on the General Medical Council Register	18 December 2016
5	Job Plan commencing 01 January 2015	01 January 2015
6	CLIP Report January 2015 to December 2015	2015
7	CLIP Report Structured Reflective Template	11 December 2016
8	Structured Reflective Template regarding role as Clinical Supervisor	13 December 2016
9	Structured Reflective Template regarding role as Facilitator of All Ireland Study of Side Effects following Prostate Cancer Treatments 2014/5	14 December 2016
10	Structure Reflective Template regarding Northern Ireland Cancer Patient Experience Survey 2015	14 December 2016
11	Structured Reflective Template regarding role in the UK Life after Prostate Cancer Diagnosis 2015	14 December 2016
12	Previous Personal Development Plan 2014	2014
13	PDP Structured Reflective Template	14 December 2016
14	Mandatory Training Passport	15 December 2015
Discussion = Job plan up to date and adjusted after meeting @ C.D. - still needs signed. = Mandatory training document is up to date bar two areas - These have now been completed. = CLIP report - Confirms. New to review ratios are very good as is length of stay & DSN rates. Aidan has enclosed several structured Reflective Template documents. He has clearly reflected Actions Agreed on his & others role an input into Urological oncology in Northern Ireland, including holistic care. Action - should find a way to collect his internal C.P.D record = Plan to attend Urology external meetings		

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) for the Structured Reflective Templates

**General
Medical
Council**

16/03/2014

Your GMC reference number: 1394911

A. O'Brien Esq., FRCS

Personal information redacted by the UST

3 Hardman Street
Manchester M3 3AW

Telephone: +44 (0) 161 923 6602
Facsimile: +44 (0) 161 923 6201
Email: registrationhelp@gmc-uk.org
www.gmc-uk.org

-GMC_L1257623_UK2LETT-518

Dear Mr O'Brien

Confirmation of GMC Online account activation

Thank you for activating your GMC Online account.

You can now, among other things, update your details, make payments and complete surveys online.

If you did not activate your GMC Online account please contact us immediately.

Yours sincerely

Personal information redacted by the UST

Jane Durkin
Head of Registration Enquiries and Support
Registration Directorate

Southern Health and Social Care Trust.

This job plan started 01 January 2015.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 12 weeks
Start Week	1
Report date	16 Apr 2015
Expected number of weeks in attendance	42 weeks
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New
Private practice	Yes

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		16 Apr 2015	Mr Malcolm Clegg

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	10.458	10.458	41:25
Supporting Professional Activities (SPA)	1.583	1.583	6:20
Total	12.042	12.042	47:45

On-call availability

Works on-call?	Yes
General Settings:	
What is your on-call frequency?	1 in 6
Weekend on-call work:	
Other Information:	
Where does your on-call work take place?	Craigavon Area Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.000
The number of PAs arising from your unpredictable on-call work is:	1.000
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Director	Role: Clinical Manager	Role: Board Member
Name: Mr Hall, Samuel	Name: Mr Mackie, Edward	Name: Mrs Trouton, Heather
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Travelling time between hospitals	Pre-op ward round	Patient related admin (reports, results etc)	Uroradiology meeting	Sub Specialty clinic		
09:00 - 10:00	08:30 - 09:00	09:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
New patient Clinic	Day surgery	Pre-op ward round	Grand Round	Continuous professional development.		
10:00 - 16:00	09:00 - 13:00	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
Travelling time between hospitals	New patient Clinic	Emergency operating sessions	Departmental meeting			
16:00 - 17:00	13:30 - 17:30	12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Continuous professional development.	Patient related admin (reports, results etc)	Patient related admin (reports, results etc)	Uroradiology meeting	Sub Specialty clinic		
09:00 - 13:00	09:00 - 13:30	09:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
Review Outpatients clinic	New patient Clinic	Pre-op ward round	Grand Round	Continuous professional development.		
13:30 - 17:30	13:30 - 17:30	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
		Emergency operating sessions	Departmental meeting			
		12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic	Pre-op ward round	Surgery MDT	Uroradiology meeting	Sub Specialty clinic		
09:00 - 13:00	08:30 - 09:00	08:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
Review Outpatients clinic	Day surgery	Pre-op ward round	Grand Round	Continuous professional development.		
13:30 - 17:30	09:00 - 13:00	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
	New patient Clinic	Emergency operating sessions	Departmental meeting			
	13:30 - 17:30	12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Travelling time between hospitals 09:00 - 10:00	Patient related admin (reports, results etc) 09:00 - 13:30	Patient related admin (reports, results etc) 09:00 - 11:00	Uroradiology meeting 08:30 - 10:00	Sub Specialty clinic 09:00 - 13:00		
New patient Clinic 10:00 - 16:00	New patient Clinic 13:30 - 17:30	Pre-op ward round 11:00 - 12:00	Grand Round 10:00 - 12:00	Continuous professional development. 13:00 - 17:00		
Travelling time between hospitals 16:00 - 17:00		Emergency operating sessions 12:00 - 20:00	Departmental meeting 12:00 - 14:00			
		Post-op ward round 20:00 - 20:30	Surgery MDT 14:00 - 17:30			

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Continuous professional development. 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Patient related admin (reports, results etc) 09:00 - 11:00	Uroradiology meeting 08:30 - 10:00	Sub Specialty clinic 09:00 - 13:00		
Review Outpatients clinic 13:30 - 17:30	Day surgery 09:00 - 13:00	Pre-op ward round 11:00 - 12:00	Grand Round 10:00 - 12:00	Continuous professional development. 13:00 - 17:00		
	New patient Clinic 13:30 - 17:30	Emergency operating sessions 12:00 - 20:00	Departmental meeting 12:00 - 14:00			
		Post-op ward round 20:00 - 20:30	Surgery MDT 14:00 - 17:30			

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00		

Week 7

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Surgery MDT 08:00 - 11:00	Uroradiology meeting 08:30 - 10:00	Sub Specialty clinic 09:00 - 13:00		
Review Outpatients clinic 13:30 - 17:30	Day surgery 09:00 - 13:00	Pre-op ward round 11:00 - 12:00	Grand Round 10:00 - 12:00	Continuous professional development. 13:00 - 17:00		
	New patient Clinic 13:30 - 17:30	Emergency operating sessions 12:00 - 20:00	Departmental meeting 12:00 - 14:00			
		Post-op ward round 20:00 - 20:30	Surgery MDT 14:00 - 17:30			

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Travelling time between hospitals 09:00 - 10:00	Patient related admin (reports, results etc) 09:00 - 13:30	Patient related admin (reports, results etc) 09:00 - 11:00	Uroradiology meeting 08:30 - 10:00	Sub Specialty clinic 09:00 - 13:00		
New patient Clinic 10:00 - 16:00	New patient Clinic 13:30 - 17:30	Pre-op ward round 11:00 - 12:00	Grand Round 10:00 - 12:00	Continuous professional development. 13:00 - 17:00		
			Departmental meeting			

Travelling time between hospitals	Emergency operating sessions	12:00 - 14:00
16:00 - 17:00	12:00 - 20:00	Surgery MDT
	Post-op ward round	14:00 - 17:30
	20:00 - 20:30	

Week 9

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Continuous professional development.	Pre-op ward round	Patient related admin (reports, results etc)	Uroradiology meeting	Sub Specialty clinic		
09:00 - 13:00	08:30 - 09:00	09:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
Review Outpatients clinic	Day surgery	Pre-op ward round	Grand Round	Continuous professional development.		
13:30 - 17:30	09:00 - 13:00	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
	New patient Clinic	Emergency operating sessions	Departmental meeting			
	13:30 - 17:30	12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Continuous professional development.	Patient related admin (reports, results etc)	Patient related admin (reports, results etc)	Uroradiology meeting	Sub Specialty clinic		
09:00 - 13:00	09:00 - 13:30	09:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
	New patient Clinic	Pre-op ward round	Grand Round	Continuous professional development.		
	13:30 - 17:30	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
		Emergency operating sessions	Departmental meeting			
		12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 11

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic	Pre-op ward round	Surgery MDT	Uroradiology meeting	Sub Specialty clinic		
09:00 - 13:00	08:30 - 09:00	08:00 - 11:00	08:30 - 10:00	09:00 - 13:00		
	Day surgery	Pre-op ward round	Grand Round	Continuous professional development.		
	09:00 - 13:00	11:00 - 12:00	10:00 - 12:00	13:00 - 17:00		
	New patient Clinic	Emergency operating sessions	Departmental meeting			
	13:30 - 17:30	12:00 - 20:00	12:00 - 14:00			
		Post-op ward round	Surgery MDT			
		20:00 - 20:30	14:00 - 17:30			

Week 12

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant of the week	Consultant of the week	Consultant of the week	Consultant of the week	Consultant of the week		
09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00	09:00 - 17:00		

Activities

Job plan report

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Mon	09:00 - 10:00	1, 4, 8	Travelling time between hospitals	Southern He..	Erne Hospit..	DCC	10.5	0.063	0:15
Mon	09:00 - 13:00	3, 7, 11	Review Outpatients clinic Comments: Clinic is dropped when Consultant of the week	Southern He..	Armagh Comm..	DCC	10.5	0.250	1:00
Mon	09:00 - 13:00	2, 5, 9-10	Continuous professional development.	Southern He..	Craigavon A..	SPA	14	0.383	1:20
Mon	09:00 - 17:00	6, 12	Consultant of the week	Southern He..	Craigavon A..	DCC	7	0.333	1:20
Mon	10:00 - 16:00	1, 4, 8	New patient Clinic	Southern He..	Erne Hospit..	DCC	10.5	0.375	1:30
Mon	13:30 - 17:30	2-3, 5, 7, 9	Review Outpatients clinic	Southern He..	Craigavon A..	DCC	17.5	0.417	1:40
Mon	16:00 - 17:00	1, 4, 8	Travelling time between hospitals	Southern He..	Erne Hospit..	DCC	10.5	0.063	0:15
Tue	08:30 - 09:00	1, 3, 5, 7, 9, 11	Pre-op ward round	Southern He..	Craigavon A..	DCC	21	0.063	0:15
Tue	09:00 - 13:00	1, 3, 5, 7, 9, 11	Day surgery	Southern He..	Craigavon A..	DCC	21	0.500	2:00
Tue	09:00 - 13:30	2, 4, 8, 10	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	14	0.375	1:30
Tue	09:00 - 17:00	6, 12	Consultant of the week	Southern He..	Craigavon A..	DCC	7	0.333	1:20
Tue	13:30 - 17:30	1-5, 7-11	New patient Clinic	Southern He..	Craigavon A..	DCC	35	0.833	3:20
Wed	08:00 - 11:00	3, 7, 11	Surgery MDT Comments: MDT preparation	Southern He..	Craigavon A..	DCC	10.5	0.186	0:45
Wed	09:00 - 11:00	1-2, 4-5, 8-10	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	24.5	0.292	1:10
Wed	09:00 - 17:00	6, 12	Consultant of the week	Southern He..	Craigavon A..	DCC	7	0.333	1:20
Wed	11:00 - 12:00	1-5, 7-11	Pre-op ward round	Southern He..	Craigavon A..	DCC	35	0.208	0:50
Wed	12:00 - 20:00	1-5, 7-11	Emergency operating sessions	Southern He..	Craigavon A..	DCC	35	1.736	6:40
Wed	20:00 - 20:30	1-5, 7-11	Post-op ward round	Southern He..	Craigavon A..	DCC	35	0.139	0:25
Thu	08:30 - 10:00	1-5, 7-11	Uroradiology meeting	Southern He..	Craigavon A..	DCC	35	0.313	1:15
Thu	09:00 - 17:00	6, 12	Consultant of the week	Southern He..	Craigavon A..	DCC	7	0.333	1:20
Thu	10:00 - 12:00	1-5, 7-11	Grand Round	Southern He..	Craigavon A..	DCC	35	0.417	1:40
Thu	12:00 - 14:00	1-5, 7-11	Departmental meeting	Southern He..	Craigavon A..	SPA	35	0.417	1:40
Thu	14:00 - 17:30	1-5, 7-11	Surgery MDT	Southern He..	Craigavon A..	DCC	35	0.729	2:55
Fri	09:00 - 13:00	1-5, 7-11	Sub Specialty clinic Comments: Uro-oncology and urodynamics	Southern He..	Craigavon A..	DCC	35	0.833	3:20
Fri	09:00 - 17:00	6, 12	Consultant of the week	Southern He..	Craigavon A..	DCC	7	0.333	1:20
Fri	13:00 - 17:00	1-5, 7-11	Continuous professional development.	Southern He..	Craigavon A..	SPA	35	0.833	3:20
Total:								11.042	43:45

No specified day

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.								

On-call

Type	Normal	Premium	Cat.	PA
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.000
Total:				1.000

Resources

Staff

Equipment

Clinical Space

Other

Southern Health and Social Care Trust.

This job plan started 01 October 2016.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 6 weeks
Start Week	1
Report date	12 Dec 2016
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	Yes

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		16 Apr 2015	Mr Malcolm Clegg
In 'Discussion' stage - awaiting doctor agreement		10 Oct 2016	Mr Colin Weir
In 'Discussion' stage - request cancelled		10 Oct 2016	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		7 Nov 2016	Mr Colin Weir

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	10.635	10.635	42:16
Supporting Professional Activities (SPA)	1.508	1.508	6:01
Total	12.143	12.143	48:17

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	6	6	A	5%	1.000
Type	Normal	Premium		Cat.		PA
Predictable	n/a	n/a		Total:		1.000
Unpredictable	n/a	n/a		DCC		0.000
				DCC		1.000
The total PAs arising from your on-call work is:		1.000				
Your availability supplement is:		5% (based on the highest supplement from all your rotas)				

On-call rota details

On-call Rota (PA entry)

General information

What is your on-call activity? On-call Rota
 Where does your on-call rota take place in? Craigavon Area Hospital
 What is your on-call classification? A

Weekday work

What is the frequency of your weekday on-call work? 1 in 6.00
 Predictable Unpredictable
 How many PAs arise from your weekday on-call work? 0.000 1.000

Weekend work

(A weekend is classed as Saturday to Sunday for this rota)

What is the frequency of your weekend on-call work? 1 in 6.00
 Predictable Unpredictable
 How many PAs arise from your weekend on-call work? 0.000 0.000

Other information

Which objective does this on-call work relate to?

Comments

Sign off

Role: Clinical Manager

Name: Mr Weir, Colin

Signed:

Date:

Role: Board Member

Name: Mr Carroll, Ronan

Signed:

Date:

Role: Clinical Director

Name: Mrs Gishkori, Esther

Signed:

Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Supervision of the week 09:00 - 17:00 Week 1-6 week cycle	Supervision of the week 09:00 - 17:00 Week 1-6 week cycle	Supervision of the week 09:00 - 17:00 Week 1-6 week cycle	Supervision of the week 09:00 - 17:00 Week 1-6 week cycle	Supervision of the week 09:00 - 17:00 Week 1-6 week cycle		

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Travelling time between hospitals 09:00 - 10:00 New patient Clinic	Continuous professional development. 09:00 - 13:00 New patient Clinic		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00	Sub Specialty clinic 09:00 - 13:00 Continuous professional development.		

10:00 - 17:00 13:30 - 17:30
Travelling time
between hospitals
17:00 - 18:00

Departmental
meeting
12:00 - 14:00
Surgery MDT
14:00 - 17:30

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Review Outpatients clinic 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Continuous professional development. 09:00 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00 Review Outpatients clinic 13:30 - 17:30	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:30		Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:30	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

Activities

Hot Activity
Unaffected by hot activity
Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Total: 10.840 43:04										
100%	Mon	09:00 - 10:00	wk 3	Travelling time between hospitals	Southern Health and Social Care Tru..	Erne Hospital	DCC	6.67	0.040	0:10
100%	Mon	09:00 - 13:00	wk 5	Review Outpatients clinic	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	6.67	0.159	0:38
100%	Mon	09:00 - 13:00	wks 2, 4, 6	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	20	0.476	1:54
100%	Mon	09:00 - 17:00	wk 1 6 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.413	1:39
100%	Mon	10:00 - 17:00	wk 3	New patient Clinic	Southern Health and Social Care Tru..	Erne Hospital	DCC	6.67	0.278	1:07

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
1591	Mon	13:30 - 17:30	wks 2, 4-6	Review Outpatients clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	26.67	0.635	2:32
	Mon	17:00 - 18:00	wk 3	Travelling time between hospitals	Southern Health and Social Care Tru..	Erne Hospital	DCC	7	0.042	0:10
1592	Tue	08:30 - 13:00	wks 2, 4, 6	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	20	0.536	2:09
1593	Tue	09:00 - 13:00	wks 3, 5	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	13.33	0.317	1:16
1594	Tue	09:00 - 17:00	wk 1 6 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.413	1:39
1595	Tue	13:30 - 17:30	wks 2-6	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10
	Wed	08:00 - 09:00		Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	17	0.101	0:24
1597	Wed	09:00 - 17:00	wk 1 6 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.413	1:39
1598	Wed	09:00 - 20:00		Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	15.32	1.033	4:01
1599	Wed	11:00 - 12:00		Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.099	0:24
1600	Wed	12:00 - 20:00		Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	18.02	0.894	3:26
1601	Thu	08:30 - 10:00	wks 2-6	Uroradiology meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.298	1:11
1602	Thu	09:00 - 17:00	wk 1 6 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.413	1:39
1603	Thu	10:00 - 12:00	wks 2-6	Grand Round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.397	1:35
1604	Thu	12:00 - 14:00	wks 2-6	Departmental meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	33.33	0.397	1:35
1605	Thu	14:00 - 17:30	wks 2-6	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.694	2:47
1606	Fri	09:00 - 13:00	wks 2-6	Sub Specialty clinic Comments: Uro-oncology and urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10
1607	Fri	09:00 - 17:00	wk 1 6 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.413	1:39
1608	Fri	13:00 - 17:00	wks 2-6	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	33.33	0.794	3:10

No specified day

"()" Refers to an activity that replaces or runs concurrently

 Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
									Total: 0.304 1:13
3:00	0:00		Surgery MDT Comments: 3 hours preparation for MDT outside normal working time 17 activities shared between 2 others	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	17	0.304	1:13

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made



CHKS Consultant Level Indicator Programme

Southern Trust Northern Ireland

January 2015 to December 2015

Personal Information
redacted by the USI

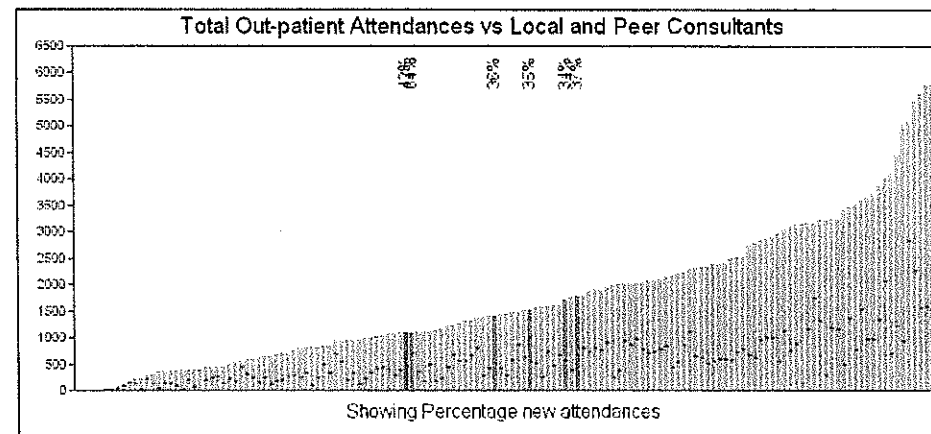
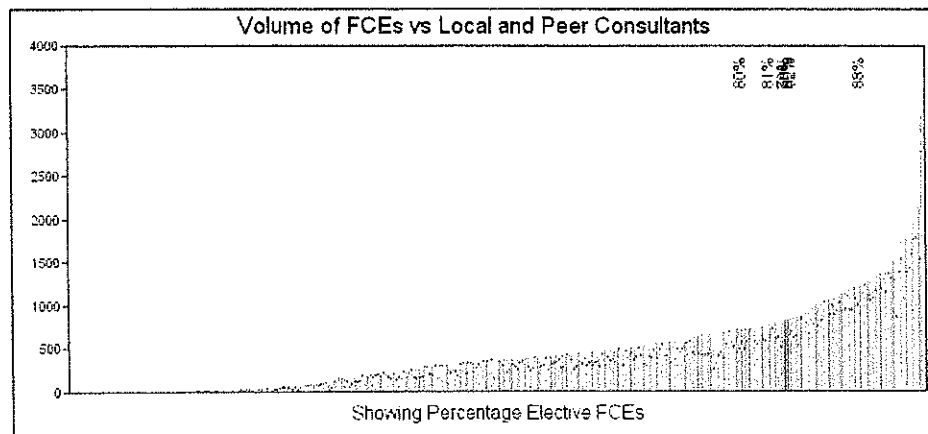
: Mr A O'Brien

Urology

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Southern Trust Northern Ireland
 Personal information redacted by the USI : Mr A O'Brien - Urology
 January 2015 to December 2015



Workload Volumes	Consultant	Local	
Total Number of FCEs	830		
Elective FCEs	655	78.9%	82.6%
In-Patients	237	36.2%	21.5%
Day Cases	418	63.8%	78.5%
Emergency FCEs	140	16.9%	14.6%
Other FCEs	35	4.2%	2.8%
* Regular Attendances			6.2%

* Regular Attendances are counted only in this report line

They are expressed as a percentage of Elective FCEs (above) + Regular Attendances

They are NOT aggregated into any other data line or chart

In-Patient Details	Consultant	Local	
FCEs - Male	504	60.7%	67.3%
FCEs - Female	326	39.3	32.7
FCEs - Child (0-18)	18	2.2%	1.6%
FCEs - Adult (19-74)	570	68.7%	74.4%
FCEs - Elderly (75+)	242	29.2%	23.9%

Outpatient workload	Consultant	Local	
Total Attendances	1109		1515
New Attendances	462	41.7%	39.6%
Follow-up Attendances	647	58.3%	60.4%
Attendances with Procedure	81	7.3%	3.8%

Consultant Total FCEs : 830 150,892 : Peer FCEs

Performance Indicators

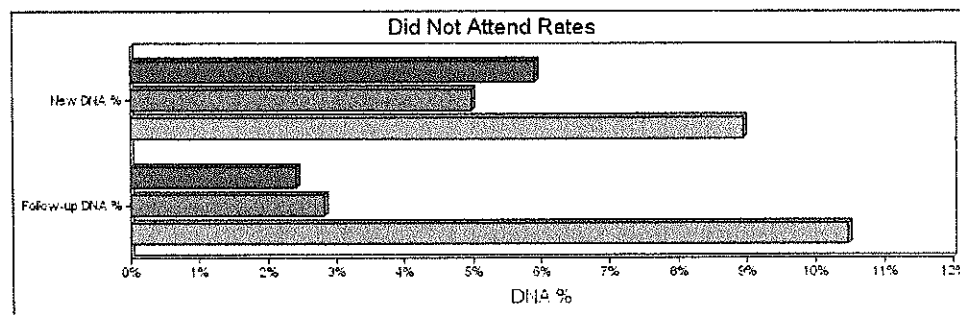
		Consultant	Local	Peer
FCE Inpatient ALoS (DC trimmed)		4.4	3.6	2.4
Average Length of Stay (Zero trimmed)		4.8	4.1	3.2
Elective		3.7	3.2	2.6
Non-Elective		6.2	4.9	4.0
Risk Adjusted Length of Stay *		121.6	121.1	89.1
Day Case Rate	418	63.8%	78.5%	68.2%
Day Case Overstays	40	8.7%	6.2%	7.1%
Average Elective Pre-Operative LoS		0.2	0.1	0.1
Elective IP Spells with no Procedure	3	2.3	1.8	0.7
Elective Inpatient spells - procedure not carried out	2	1.5%	1.5%	0.8%
Patient Cause			0.2%	0.1%
Other Reason	2	1.5%	1.2%	0.8%

High Volume Procedures

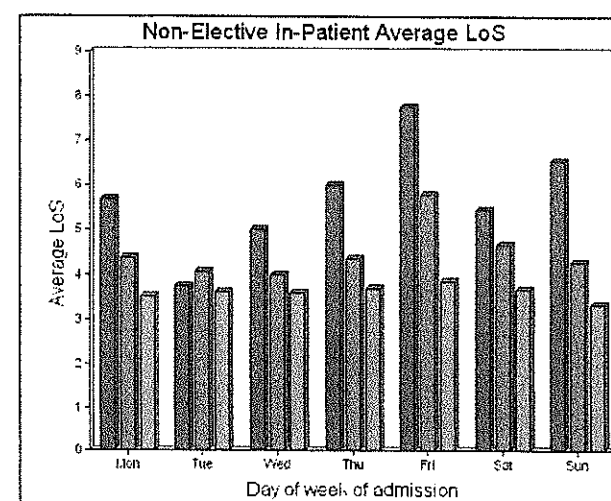
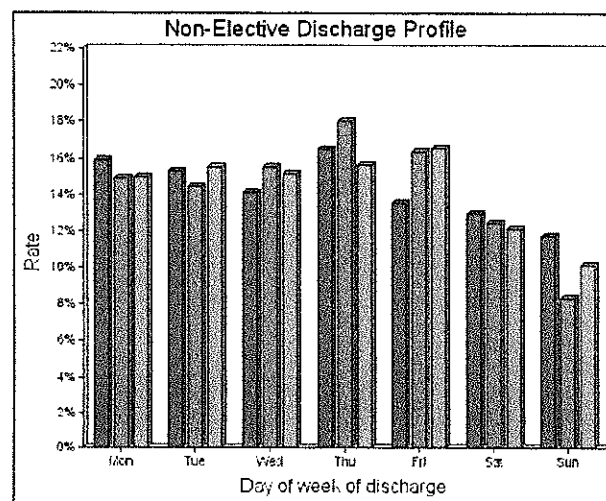
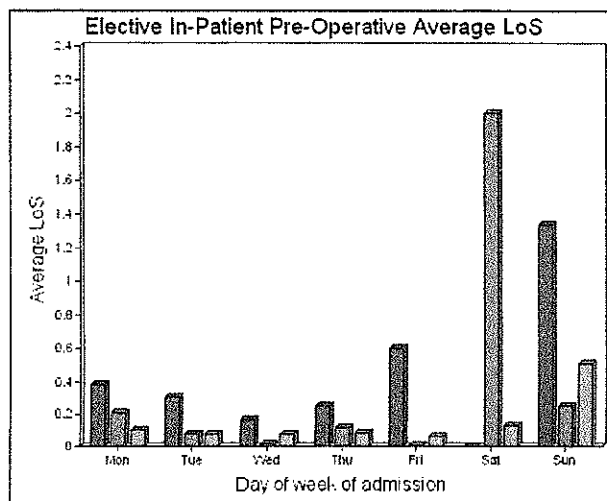
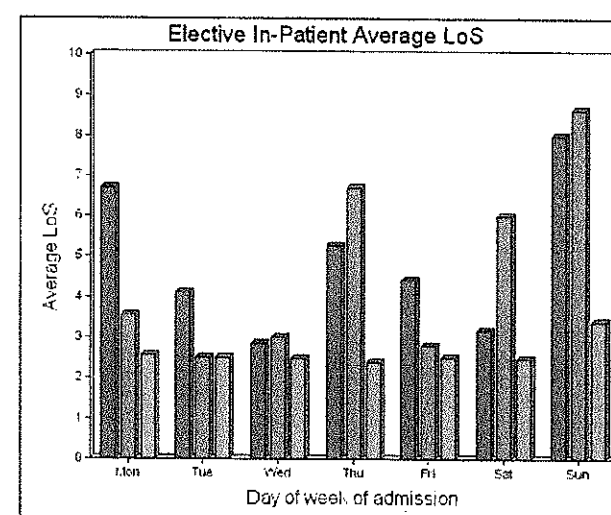
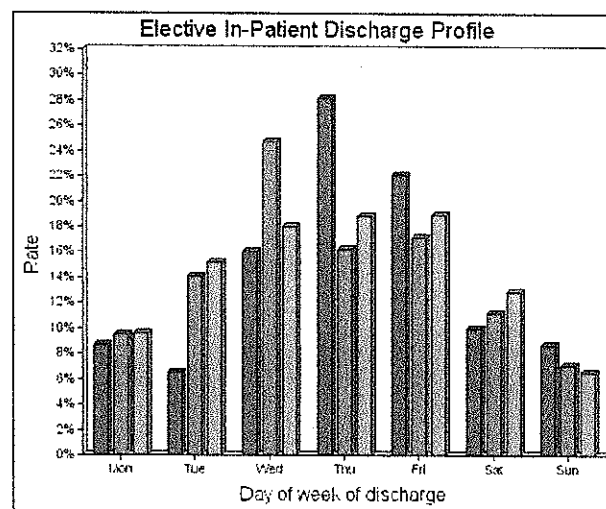
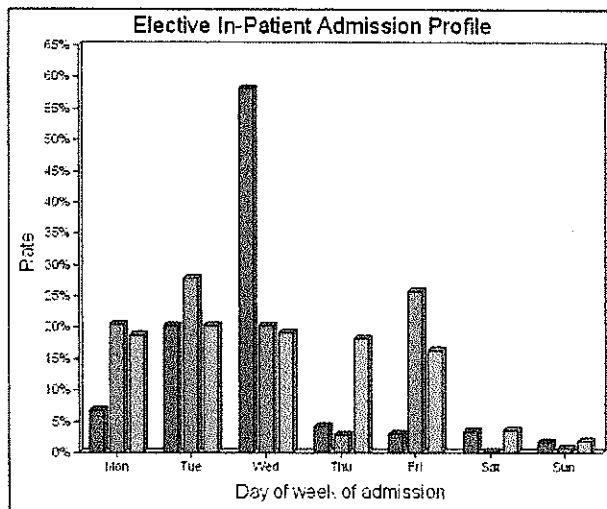
Day Case Procedures	Actual Day Cases						Day Case Overstays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	140	254.6	100.7	95.2%	96.3%	91.4%	1	3.8	3.6	1.0	1.9	1.7
M49 - Other operations on bladder	97	43.6	42.7	97.0%	99.5%	94.6%	1		1.7	1.0		1.8
M43 - Endoscopic operations to increase capacity of bladder	38	11.2	9.3	82.6%	87.5%	81.8%	5	1.0	2.3	1.8	1.0	1.3
N30 - Operations on prepuce	7	13.6	19.8	70.0%	90.7%	90.2%		2.0	1.6		1.0	1.2
M29 - Other therapeutic endoscopic operations on ureter	6	12.8	10.8	75.0%	80.0%	62.4%	2	1.8	2.8	4.0	1.4	2.3
M79 - Other operations on urethra	5	3.0	5.9	55.6%	88.2%	74.8%	2	1.0	1.9	1.5	1.0	1.2
N17 - Excision of vas deferens	4	6.8	7.5	100.0%	100.0%	95.8%			1.1			1.1
N11 - Operations on hydrocele sac	3	3.2	4.4	50.0%	84.2%	80.6%	1	1.0	1.5	2.0	1.0	1.7
N15 - Operations on epididymis	3	2.5	3.2	75.0%	100.0%	87.0%			1.2			1.7
N28 - Plastic operations on penis	3	1.2	3.3	100.0%	83.3%	64.2%			1.2			1.3

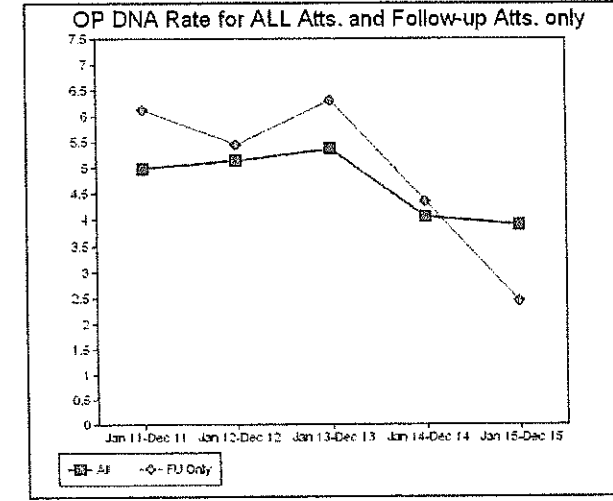
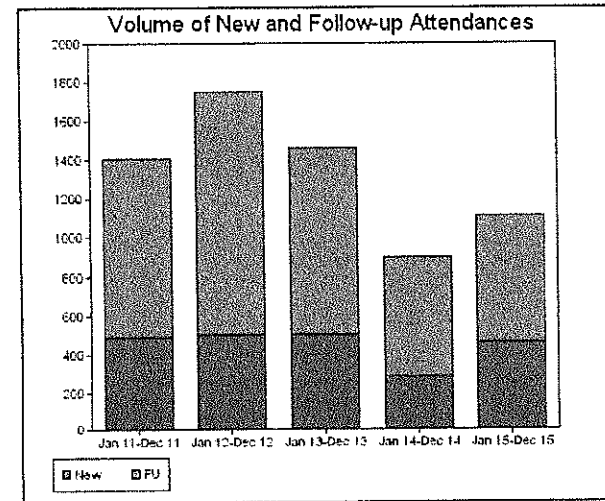
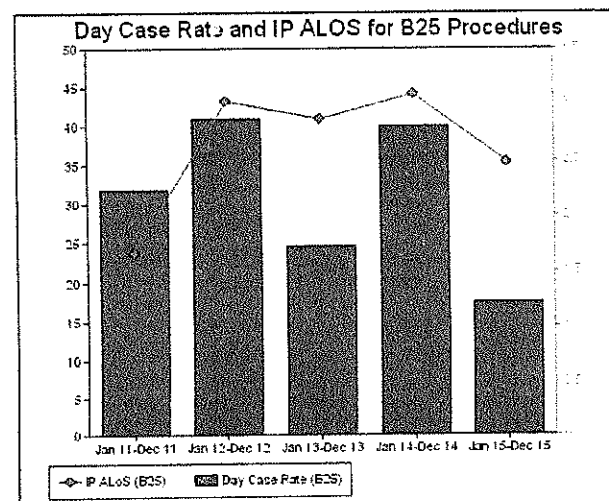
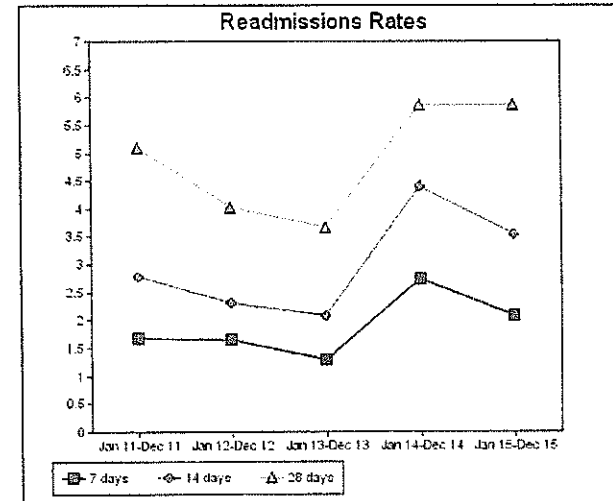
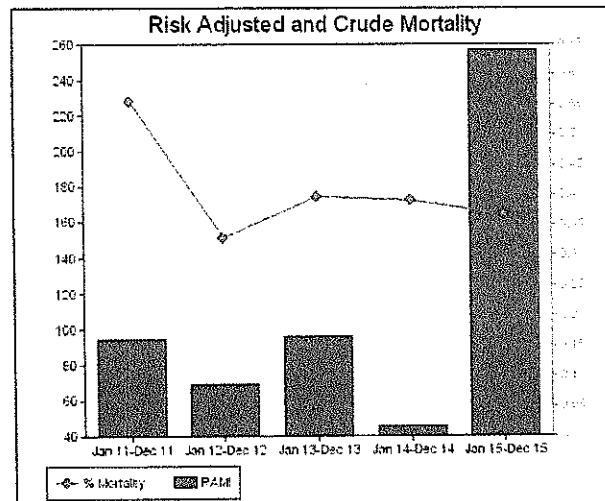
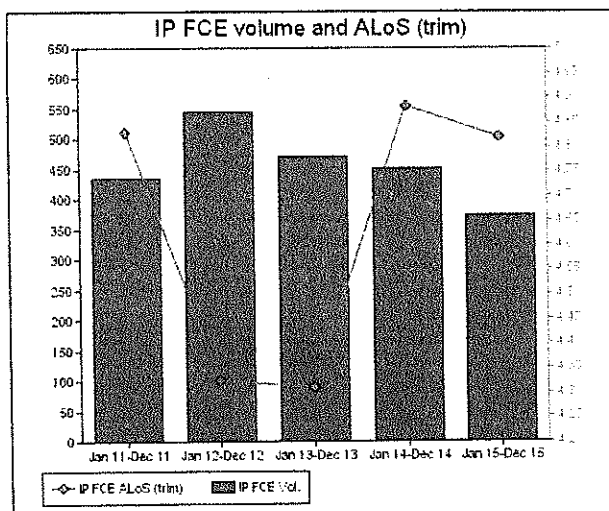
In-Patient Procedures	Number			Pre-Op Average LoS			IP Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M65 - Endoscopic resection of outlet of male bladder	54	27.6	15.9	0.3	0.1	0.1	3.9	3.5	2.6
M27 - Therapeutic ureteroscopic operations on ureter	51	47.4	7.6	0.6	0.3	0.3	3.1	3.1	1.8
M42 - Endoscopic extirpation of lesion of bladder	38	22.0	19.5	1.2	0.1	0.2	4.2	2.6	2.1
U21 - Diagnostic imaging procedures	28	19.2	12.5	1.0	4.0	2.9	7.4	4.4	2.6
M43 - Endoscopic operations to increase capacity of bladder	11	1.6	1.0	0.7	0.0	0.3	2.1	1.2	1.6
M45 - Diagnostic endoscopic examination of bladder	10	14.2	8.7	4.0	0.0	0.7	3.3	3.9	1.5
M76 - Therapeutic endoscopic operations on urethra	10	4.0	3.5	0.0	0.0	0.2	1.9	2.1	1.4
M47 - Urethral catheterisation of bladder	6	7.6	21.2		1.0	5.3	3.2	3.4	2.3
M03 - Partial excision of kidney	6	2.8	1.5	0.3	0.5	0.2	5.3	5.9	4.7
N30 - Operations on prepuce	5	2.2	2.2	0.4	0.3	0.1	1.0	1.1	1.1

	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	1109		1515		1782	
New Attendances	462	41.7%	601	39.6%	571	32.0%
Referred by General Practitioner	270	58.4%	416	69.3%	381	66.7%
With Procedures Recorded	77	16.7%	28	4.6%	145	25.4%
Average Procedure per coded attendance		1.2		1.0		1.3
Did Not Attend	29	5.9%	32	5.0%	56	9.0%
Follow-Up Attendances	647	58.3%	915	60.4%	1211	67.9%
With Procedures Recorded	4	0.6%	29	3.2%	262	21.0%
Average Procedure per coded attendance		1.0		1.0		1.2
Did Not Attend	16	2.4%	27	2.8%	144	10.5%
New : Follow-Up Ratio	647	1 : 1.4	915	1 : 1.5	1211	1 : 2.1



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	76	22	21
M45 - Diagnostic endoscopic examination of bladder	3	0	158
M70 - Other operations on outlet of male bladder	2	35	15
M29 - Other therapeutic endoscopic operations on ureter	0	0	2
M49 - Other operations on bladder	0	0	8
U26 - Diagnostic testing of genitourinary system	0	0	50
U08 - Diagnostic imaging of abdomen	0	0	13
U09 - Diagnostic imaging of pelvis	0	0	2
H62 - Other operations on bowel	0	0	2
X36 - Blood withdrawal	0	0	1





CHKS CLIP Programme :- Indicator definitions
Report Indicator Definitions (Surgical)
Workload Volumes
Total FCEs

Numerator: Count of FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

FCEs (incl. day cases) per inpatient DCC

Numerator: Count of FCEs / 52 (weeks in year)

Denominator: Number of inpatient direct clinical care (DCC) sessions

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective FCEs

Numerator: Count of elective FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Elective IP FCEs

Numerator: Count of elective inpatient FCEs minus elective daycases

Denominator: Count of elective FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Day Case Rate

Numerator: Count of elective day case FCEs

Denominator: Count of elective FCEs

Exclusions: Well babies and regular attenders

Emergency FCEs

Numerator: Count of emergency FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Other FCEs

Numerator: Count of OTHER (not elective or emergency) FCEs

Denominator: Total FCEs

Exclusions: Well babies, regular attenders and renal dialysis patients

Regular attendances

Numerator: Count of regular attenders

Denominator: Total elective FCEs including regular attenders

Exclusions: Well babies



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

CLIP (Consultant Led Indicator Programme) Report structured
reflective template
Requirement: One annually

Name of doctor: Aidan O'Brien	GMC No: Personal Information redacted by the USI
Date of report:	
January 2015 to December 2015	
What issues can I identify from the report? There was an apparent decrease in the total number of finished consultant episodes from 1003 in 2014 to 830 in 2015. There was an increase in the total number of outpatient attendances from 899 in 2014 to 1109 in 2015. Most of this increase was due to an increased number of new patient attendances from 285 in 2014 to 462 in 2015. The number of patients attending as outpatients and having a procedure as doubled, from 39 in 2014 to 81 in 2015. The new / review ratio has decreased from 2.2 in 2014 to 1.4 in 2015 What actions will I undertake? I would like to significantly reduce the numbers of new patients attending as outpatients as a proportion are added to waiting lists for admission as inpatients, only to languish there for periods so long as would be considered untenable in other parts of the UK. The situation is so bad that many patients have diminishing prospects of ever being admitted. I also believe that it is inappropriate for me to spend time seeing new patients when urological cancer patients are waiting years beyond their review dates for review. Final outcome after discussion at appraisal: (Complete at appraisal) <i>Notes the changes in 'Numbers' and sets out the Trusts objectives.</i> <i>Concerned that Trust is not providing facilities to deal with issue. This is outside his control!</i> <i>Regards the balance of provision as wrong.</i> <i>Issues to be discussed at Trust level.</i>	



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

Other roles structured reflective template

Name of doctor: Aidan O'Brien	GMC No: 1394911
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role: As a Clinical Supervisor, I have enjoyed making a contribution to the ongoing clinical and operative learning and career development of trainees working in our department. I have endeavoured to maximize the number of Procedure Based Discussions completed for each trainee.	
They also brought the following drawbacks to my main clinical role: Executing the role and responsibilities of Clinical Supervision can particularly slow down operating and add to totality of the working day.	
I could consider the following actions, to maximise the benefits and minimise the drawbacks: I believe that the training of trainees is an essential component of our Department's activities even it slow down operating time. Discussion of operative procedures and case management is conducted outside of formal scheduled time to minimize the risk of negative impacts.	
Date of reflection: 18 December 2016	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care) AOB. is an active Participant. Notes implications but very willing to continue in this Role, as long as Trust aware of effect on output.	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
To develop Operational Policy for Urological Cancer MDT	To collaborate with Head of Cancer Services to develop Operational Policy	Yes
To consolidate conduct of Urological Cancer MDM	To preview cases so that patient management is optimized and communicated with family doctors in a timely manner	Yes

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014

Page 10

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	Actions agreed	Target dates
To have Annual MDT Report for 2014 prepared		March 2015
To have Annual MDT Meeting in April 2015		April 2015
Completion of MDT Operational Policy		April 2015
To complete agreed Work Plan for 2015		April 2015

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2014 Page 11

Personal Development Plan structured reflective template
Requirement: annual

Name of doctor: Aidan O'Brien

Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year:

Having completed a four year tenure as Lead Clinician and Chair of the NICaN Clinical Reference Group in Urology, during which time I believe I made a significant contribution to rendering NICaN Urology fit for Peer Review, in addition to ensuring that the Southern Trust was prepared for Peer Review, I considered it reasonable to step down from the role earlier in 2016.

I also did so as the role required a significant work load, requiring much time, without any facilitation of any kind by the Southern Trust.

Date of reflection: 16 December 2016

Final outcome after discussion at appraisal:

(To complete at appraisal considering how your approach will improve patient care)

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 2 - Safety and Quality		
Attribute: 2.1 Contribute to and comply with systems to protect patients		
Attribute: 2.2 Respond to risks to safety		
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health		
	List of Supporting Information	Applicable Date
1	Impact of Audit Studies in 2015	2015
2	Suspect Cancer: Recognition and Referral (NG12)	July 2015
3	Record of Attendance at Morbidity and Mortality Meetings 2015	2015
4	Incident Report	07 October 2015
5	Complaint	03 November 2015
6	Complaint Structured Reflective Template	18 December 2016
7	Evidence of Registration with a General Practitioner	2015
8	Inoculation History	2015
9	Certificate of Attendance at the National Peer Review Reviewer Training Programme	16 April 2015
10	Certificates of MPS Membership	01/09/2014 to 31/08/2017

Discussion

~ Has reflected on Audits performed and their outcomes.
 ~ Suspect Cancer study - major quality improvement
 ~ All is satisfactory
 ~ No significant events
 ~ Incident - Minor
 ~ Complaint - There appears to have been a lot of patient external factors addressed & resolved.

Actions Agreed

~ Past played in National Peer Review programme discussed
 ~ Although no SBAR cases for discussion we spent time on the document and the current governance weekly provision noting how excellent it was.

Action: To include Regional Audit meeting.
 & enclose local Audits performed in Trust

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

Suspected Cancer: Recognition and Referral (NG12)

In July 2015, NICE published revised guidelines for the referral and further investigation of all symptoms, signs or investigative findings associated with a probability of an associated cancer greater than 3%.

With regard to prostate cancer, a new guideline was that a serum PSA and a rectal examination should be considered for any man with visible haematuria. While this new guideline may seem rather sensible, men with visible haematuria have often received an investigative focus, without either a serum PSA or rectal examination having been considered.

The second new guideline was that any man with a PSA level above the age – specific reference range be referred for further assessment as a suspect prostate cancer.

The investigative implications of visible haematuria were somewhat simplified in the new guidelines, indicating that unexplained visible haematuria in anyone aged over 45 years be investigated as a suspect cancer, whilst anyone aged over 60 years with recurrent or persistent non-visible haematuria should be similarly investigated. Patients aged over 60 years with recurrent or persistent urinary infection should be considered for non-urgent investigation for a suspect cancer.

These new guidelines were considered at NICaN and at the Southern Trust MDM, agreed and implemented.



Southern Health
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Record of Attendance Morbidity and Mortality Meetings 2015

CRAIGAVON AREA HOSPITAL

UROLOGY

DR AIDAN O'BRIEN

7 out of 11 = 64% meetings attended

The following rates are based on the signed attendance sheet at M&M. These do not take account of a Consultant's attendance at Regional Specialty Audit meetings or Consultants who work on a part time basis. The attendance rates have been adjusted on a pro rata basis for those Consultants who commenced / left mid-year.

MM Certificate 2015

INCIDENTS
Appraisals 1 January 2015 to 31 December 2015
Mr Aiden O'Brien

ID	Record name	Incident date	Description	Action taken
Personal Information redacted by the USI		07/10/2015	Patient booked on emergency list on 7/10/15 at 12:45 for bilateral inguinal exploration. Patient sent for at 17:37 however when porter arrived on the ward to collect patient he was told there was no staff available to take the patient to theatre as they were all on tea break. Porter returned to the theatre department and reported same to theatre sister. I tried to contact the ward however no answer.	Mr O'Brien informed who then collected the patient from the ward, patient arrived at 18:09, approximately 30 mins after being sent for.

COMPLAINANTS
Appraisals 1 January 2015 to 31 December 2015
Mr Aiden O'Brien

ID	First received	Record name	Description	Outcome
Personal Information redacted by the	03/11/2015	Personal Information redacted by the USI	Complainant unhappy with the length of time it took for him to be assessed after him presenting with chest pain. Also concerned with the manner in which he was spoken to by a nurse when he queried the treatment that he was receiving.	Complainant advised HOS spoke with consultant, consultant refutes allegations made against him. Consultant advised it was the complainant approached him in a shopping centre and he didn't wish to appear rude and did talk on this occasion but felt uncomfortable speaking in a public area regarding complainants health issues. Complainant advised he was offered two appointments, both were cancelled and inline with the Department of Health guidelines was discharged back to GP. Complainant has now been placed onto another consultant waiting list and has been upgraded to urgent. Complainant should receive an appointment mid March.



Southern Health
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Complaint report structured reflective template
Requirement: one for each complaint you have received.

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of complaint: 03 November 2015	
Nature of complaint: Complainant alleged that he had had a second appointment for hydrostatic dilatation of his bladder cancelled even though he advised me in a local shopping sister that he had had a MRI scan of his brain requested. Nevertheless, he did not attend even though I advised him that there was no need for him to cancel the appointment because he was awaiting an MRI scan. In his letter of complaint, he also alleged that I had been rude to him and his wife during an earlier outpatient consultation.	
Status of complaint: On-going / resolved Addressed and resolved by having him placed on another consultant's waiting list.	
Involvement of other bodies: Responsible organisation / GMC / Other None	
If resolved, what were the findings? I do not know, as I declined to involve myself in any response to it.	
How will my practice change? It will not.	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)	
Case discussed - Patient issues	

Personal information redacted
by the ULSI

CERTIFICATE OF ATTENDANCE

I certify that

Aidan O'Brien

attended

The National Peer Review Reviewer Training Programme

Thursday 16th April 2015

at

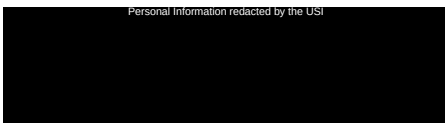
Antrim Civic Centre

The training programme covered the following:

- Principles of the redesigned National Peer Review Programme
- Stages of the Peer Review visit programme
- Role and responsibilities of reviewers and the relationship with other team members including the local review unit
- Practising the skills needed when reviewing
- Report writing
- Training on the CQuINS web based database

**This course has been approved by The Royal College of Pathologists
and has been awarded 8 CPD Credits.**

Signed:

Personal Information redacted by the USI


**Richard McMahon
Quality Director,
North Region
National Peer Review Programme**



National Peer Review Programme 2015

NICaN Reviewer Training Programme

Thursday 16 April 2015

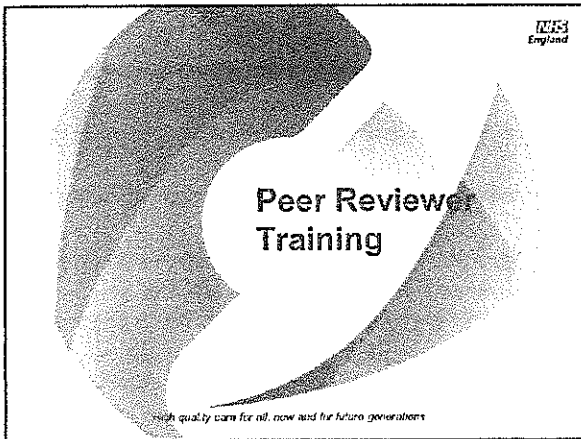
The Steeple Suite, Antrim Civic Centre, Antrim

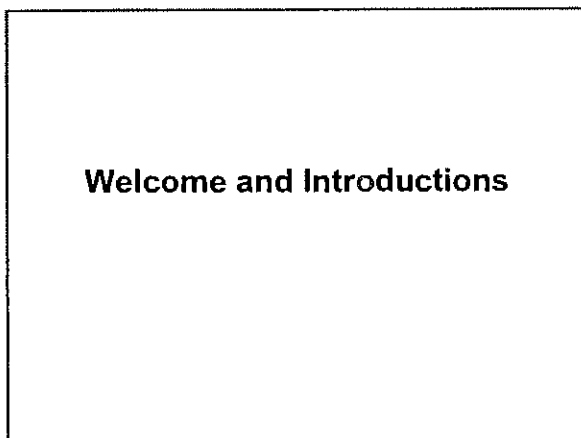
Timings

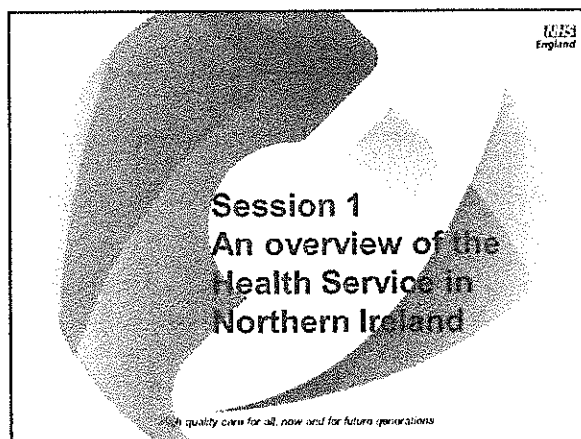
11.30	Registration
11.45	Welcome and Introductions
	Session 1: Overview of Cancer in Northern Ireland
	Session 2: Aims of the Training Day and Delegate Expectations
12.00	Session 3: The National Peer Review Programme
12.15	Session 4: Peer Review Visit
12.30	Session 5: Review of Evidence
13.00	Refreshments
13.30	Group Work 1 – Introduction to Compliance Matrix
14.00	Session 6: Meeting with the Team
14.15	Session 7: Raising Concerns
	Group Work 2 - Concerns
14.45	Session 8 - Report Writing
	Group Work 3 - Report Writing
15.15	Evaluation and Close

Improving health outcomes across England by providing improvement and health expertise

02/04/2015







Key players

DHSSPS (Department of Health, Social Services & Public Safety)

- 1 of 11 departments created in 1999 as part of the NI Executive with a mission statement: To improve the health & social wellbeing of the people of Northern Ireland
- Leads a major programme of cross-governmental action to improve health & wellbeing of the population and reduce inequalities
- 3 main responsibilities:
Health & Social Care
Public Health
Public Safety

The key players

Health and Social Care Board for NI – the Commissioners

- Responsibility to plan, secure and buy health services, including cancer services, for NI population
- Commissions health services from 5 Health & Social Care Trusts as well as voluntary organisations & charities

Strategic context of cancer services

NHS 'Cancer Services; investing for the future'. (The Campbell Report 1996). outlined 6 key principles:

- Cancer services should be patient centred
- All patients should have access to same high quality of care
- As far as possible, clinicians should specialise in a particular area in the management of cancer
- Different healthcare professionals should work closely together in teams (multidisciplinary teams or MDTs)
- Cancer services should be based on research evidence to determine best treatments
- Regular audits should take place to ensure that the quality of the service is maintained

Cancer Policy & Targets in NI

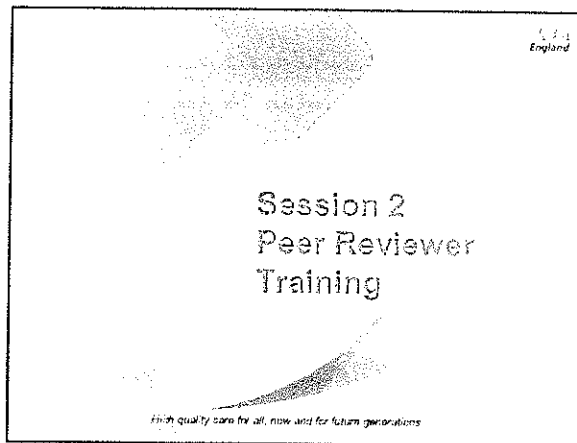
- Shape the delivery of cancer care
- Cancer Control Programme (2008), DHSSPS
- Sets out 55 recommendations for quality of cancer care over next 10 years
- Service Framework for Cancer Prevention, Treatment & Care
- Sets out standards in relation to prevention, diagnosis, treatment, ongoing care, rehabilitation and palliative/end of life care

Cancer Policy & Targets in NI

- Priorities for Action (PfA)
- Minister for Health sets out his priorities in a document called Priorities for Action
- There are a number of targets which relate directly or will impact on cancer services
- Include screening targets as well as cancer access targets (31 and 62 day pathways)

Why peer review?

- Provides important information about the quality of clinical teams
- Provides a national benchmark of cancer services for NI against the UK
- Provides a key part in the monitoring & delivery of cancer services



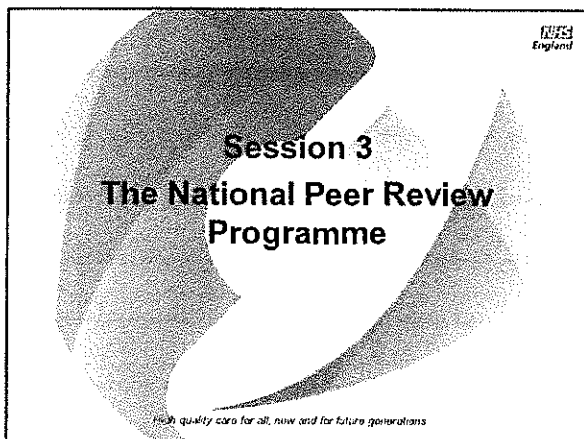
Aims of Peer Reviewer Training

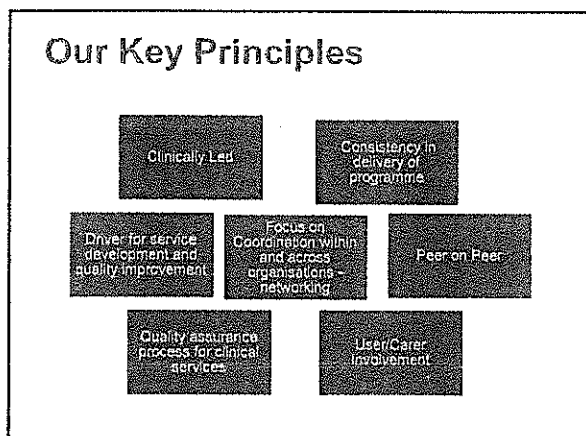
- To promote understanding of the purpose and implementation of the National Peer Review Programme
- To provide peer reviewers with the information to enable them to fully contribute and participate as equal team members in the National Peer Review Programme

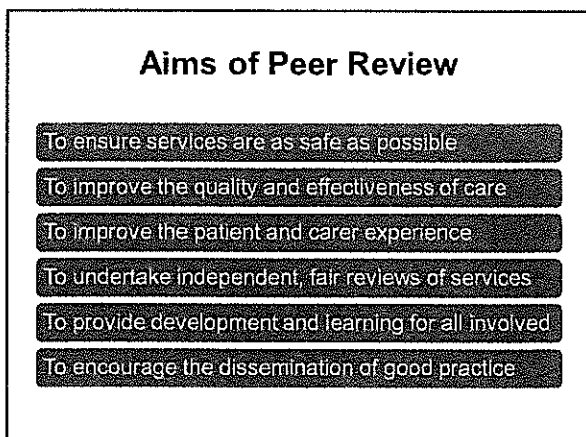
Learning Outcomes

By the end of the day you will:

- Understand the principles of the National Peer Review Programme and your responsibilities as a reviewer
- Understand your role and relationship with other team members and the peer review team
- Understand what you need to do at each stage of the peer review visit
- Have practiced some of the skills you will need when reviewing
- Be introduced to the VIMS electronic communications system







02/04/2015

The Peer Review Programme

Peer Review Visits

Spring 2015 to 2016
 2015/16

External Verification of Self Assessments

2015/16 to 2016/17

Validated Self Assessment

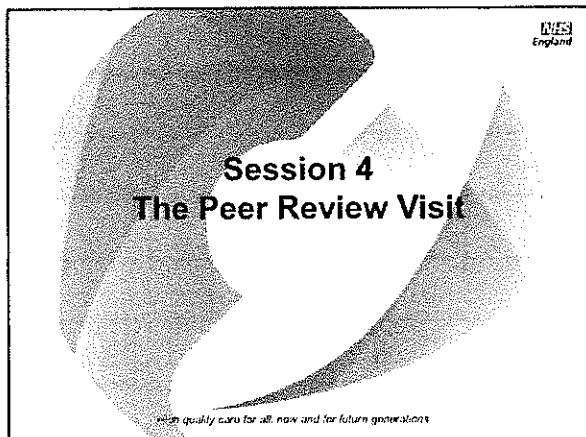
All teams/services

The Measures

- Evidence based using national guidance such as Improving Outcomes Guidance, NICE quality standards and service specifications, agreed best practice based on national consensus
- Development of measures for each topic is undertaken by an expert group
- Consultation on new measures

Development of Clinical Indicators

- Clinical Indicators developed in consultation with national clinical groups
- Using national data collated by NCIN where available
- Service profiles will be used where appropriate
- In the meantime teams should be undertaking local audit and understand their own performance and results

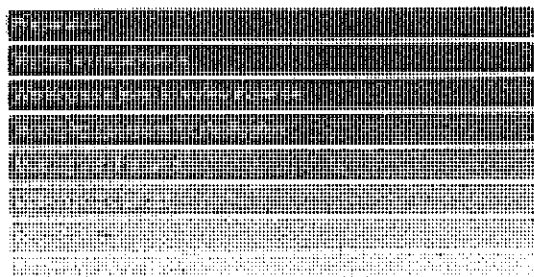


What is a Peer Review Visit?

Purpose:

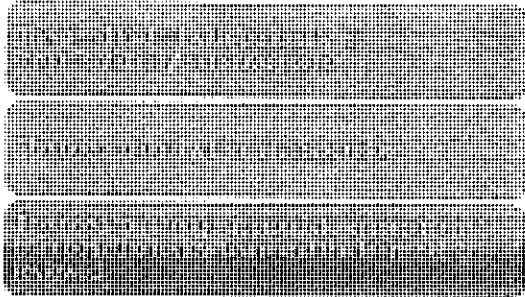
- Provide an opportunity to meet with members of a service to determine compliance with the quality measures
- Identify any broader issues relating to the delivery of a quality and safe service including a review of clinical indicators
- Provide a further external check on internal quality assurance processes

What does a Peer Review Visit entail for Reviewers?

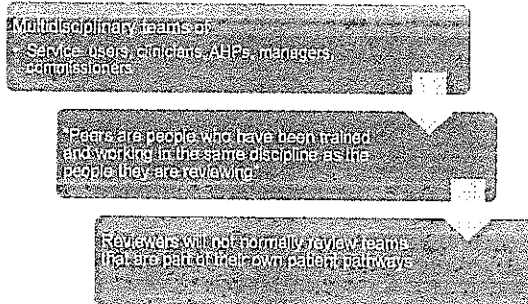


02/04/2015

Possible Challenges



Who are Reviewers?



Information for the Review Team

- Practical arrangements including hotel bookings where agreed
- Emergency contact details
- Membership of visiting team
- Timetable
- Measures
- Access to key evidence documents
- Compliance against the measures
- Previous reports
- Contextual information
- Clinical indicators
- Expenses claim form

02/04/2015

The Visit Day

1.5 Hours
Peer Review Team Preparation

1.5 Hours
Peer Review Meeting with team being reviewed

2 Hours
Peer Review Team Report Writing



Session 5
Review of Evidence

High quality care for all, now and for future generations

VIMS

02/04/2015

VIMS (Visit Information Management System)

This system is used for online storage of

- key evidence
- peer review measures for reference
- visit schedule
- logistical arrangements
- contextual information
- travel expense

VIMS

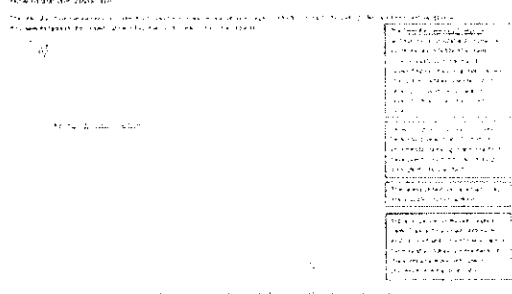
Prior to review you will be sent an email containing:

- a web link
- a user ID
- a user password

These have to be typed in

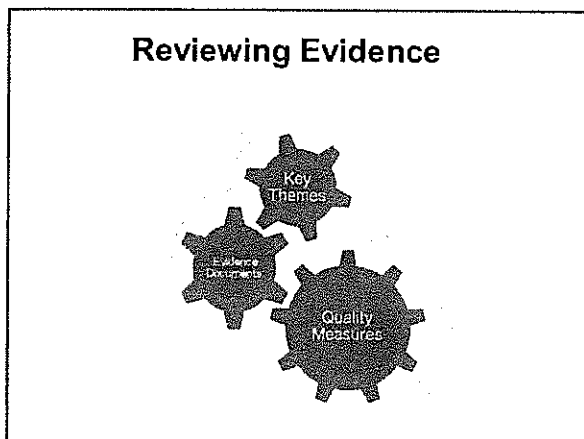
VIMS – Work page view

How to use the VIMS site



02/04/2015

5



- Evidence Documents**
- Operational policy
 - Annual report
 - Work programme
 - Appendices
 - Self assessment report

- Key Themes**
- Structure and Function
 - Co-ordination of Care/Pathways
 - Patient experience
 - Clinical Outcomes/Indicators

CNS, HNA, Key Worker

CLINICAL TRIAL RECRUITMENT

Relationship of Measures to Key Documents

- When reviewing the evidence you will need to refer to the actual measures, not abbreviated versions or what you think the measure is!
- Decisions against the measures are made in discussion as a team
- **Yes / No / N/A – at the time of the visit**
 - All aspects of the measure have to be met
- **Comments**
 - No and ...
 - No but ...
 - Yes and ...
 - Yes but ...

Visit Day preparation

- Welcome and introductions
- Review of evidence documents to
 - Establish a 'feel' for the service
 - Initial consensus on compliance
 - Review patient case notes if applicable – **NHS professionals only**
 - Identify and formulate questions
- Agree structure and process for the meeting

Group Work 1

A Fictional MDT- Preparing to Meet the Team

- You are reviewing the evidence for an MDT and need to make an initial assessment. Using the spreadsheet, review the evidence for those measures highlighted
- Consider whether you have sufficient information for initial compliance and identify any questions you want to ask the team
- Complete compliance spread sheet

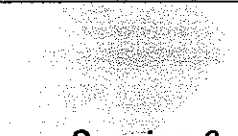
Key Points from Group Work

- What conclusions did you reach after looking at the evidence?
- What questions do you have that you need to ask the team?

Discussion Topics

- Recent improvements/service development
- Tracking the patient pathway
- General team issues,
- Relationship with networking groups / referring teams
- Current clinical issues
- Clinical indicators

02/04/2015



Session 6

Meeting with the Team



High quality care for all now and for future generations

Question Types

Open	Encourage people to talk	What, where, when, why, how?
Closed	Checking facts	How many? do you?
Hypothetical	Test contingencies	What if?
Probing	Greater depth	In what way? Tell me more..
Leading	Pacifying Use with care	You do, don't you?
Multiple	Avoid	Who sends it, what do you do and how?

Listening

Listen before deciding response

- Their story not yours!
- Be active
 - summarise regularly
 - ask confirmatory questions
- Encourage contributions from everyone
- What if they won't stop talking?

02/04/2015

Body Language

- Look for reaction and adjust style to suit
- Watch for defensive behaviour
 - sudden arm-crossing
 - agitation
 - face touching
 - avoidance of eye-contact
- Use empathy wisely

Approach

- Open, fair, consistent and comparable
- Encourage development and learning
- All members of the team have a valuable contribution to make
- Try to understand and follow the patient's journey
- Seek clarity where required

Meeting the Team

- Start on time and keep to time
- Make sure everyone is introduced
- Put at ease – and get comfortable
- Develop rapport
- Explain purpose and structure
- Note-taking
- Open questions to start

02/04/2015

Closing the Meeting

- Give the opportunity for further comment:
 - “Is there anything we’ve missed?”
 - “Is there anything else you’d like to tell us about?”
 - “Which aspect of the service are you most proud of?”
- Thanks

Session 7 Raising Concerns

It is the quality care for all, now and for future generations

UCL
England

Categorising Review Findings

Good Practice/ Significant Achievement	• Related to the service and can be either innovative or common practice undertaken very well
Immediate Risk	• An issue that is likely to result in harm and requires immediate action. Patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action
Serious Concern	• An issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care and therefore requires urgent action to resolve
Concern	• An issue that affects the delivery or quality of the service

Group Work 2

- Exercise in your groups
- Identify which category each of the issues identified would fall into

Feedback on Concerns

**Session 8
Report Writing**

NHS
England

With quality care for all, now and for future generations

Drawing Conclusions (1)

- **Work together as team to produce an accurate, objective report**
 - All team members have a responsibility to contribute
 - Consensus view
 - Use the 4 key themes to support report writing
- **Check each measure:**
 - Yes / No / N/A
 - If no: Give reason why
 - If very good: Say so!
- **Agree issues:**
 - Always include MDT membership, attendance, cover
 - Quantify issues if possible
 - Write sentences or as near as possible
- **Progress from last visit**

Group Work 3

- From the information you have gathered work together to categorise issues and document in the report

Feedback from Group Work

What happens next?

- Feedback
- Draft report circulated to review team
- Then circulated to organisations for comment on factual accuracy
- Final report sent to review team for confirmation
- Final report published on CQuINS within 8 weeks

Session 9 Evaluation and Close

NHS
England

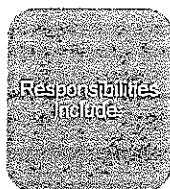
With quality care for all, now and for future generations

Learning Outcomes

- Understand the principles of the National Peer Review Programme and your responsibilities as a reviewer
- Understand your role and relationship with other team members and the peer review team
- Understand what you need to do at each stage of the peer review visit
- Have practiced some of the skills you will need when reviewing
- Be introduced to the ViMs electronic communications system

02/04/2015

Reviewer Responsibilities



- Working on behalf of the health community
- Preparation before the visit – information pack and VIMS
- Reviewing the evidence and ascertaining compliance
- Identifying issues relating to the measures and to the quality of service for patients
- Allocating questions for each reviewer
- Keeping to timetable
- Confidentiality...sensitivity
- Obtaining consensus re compliance/report content
- Writing & checking the report at several stages
- Clarification on any issues following review

Reviewer responsibilities 2



- Notifying the peer review team as early as possible of the need to cancel participation in a review
- Checking whether a hotel booking prior to the review is required
- Completing travel expense forms and returning them as soon as possible

Resources Available

www.cqu.edu.au/hsa/vi

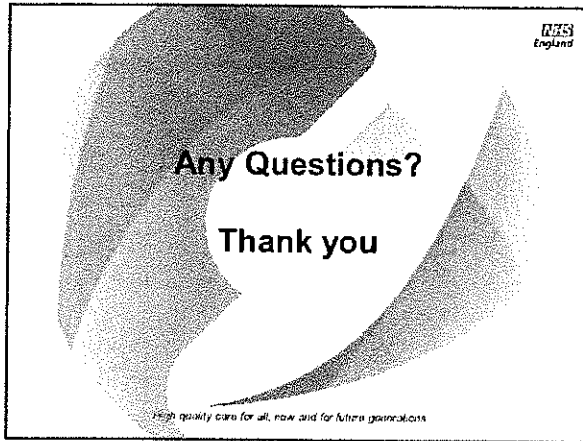
NPR Handbook

Slides and packs from today

VIMS

Quality Manager and NICAN office are able to offer support

02/04/2015



Certificate of MPS membership

AOB-22709

MPS



Putting members **first**

Mr A O'Brien

Personal information redacted by the USI

Name: Mr Aidan O'Brien

Membership number:

Personal information redacted by the USI

Period of membership: 01/09/14-31/08/15

Subscription:

Personal information redacted by the USI

Country of practice: United Kingdom

Region:

Grade: CA2

Grade description: Consultant/private specialist - group 2

Additional information: Your rate is determined according to your special
the amount you earn from specialist unindemnified
(gross income less legitimate practice expenses)

MEDICAL PROTECTION SOCIETY

Your MPS membership

MEDICAL PROTECTION SOCIETYVictoria House, 2 Victoria Place,
Leeds LS11 5AE, UK.Service Centre helpline (UK) 0845 718 7187
(IRL) 1800 509 441International code +44 (0)113 243 6436
Facsimile +44 (0) 113 241 0500www.mps.org.ukwww.medicalprotection.orgmemberhelp@mps.org.uk**Professional support and expert advice**

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world. We are a mutual, not-for-profit organisation offering more than 270,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal-accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm. MPS is not an insurance company. The benefits of membership are discretionary – this allows us the flexibility to provide help and support even in unusual circumstances.

You are eligible to apply for the benefits of membership subject to the Memorandum and Articles of MPS and upon payment of the appropriate subscription.

If you are practising in the United Kingdom

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IAOK1

Mr A O'Brien

Personal Information redacted by the USI

28 July 2015

Member Number:

Personal Information redacted by the USI

Dear Mr O'Brien

Practice and Income Audit

Thank you for completing the Practice and Income Declaration form and returning it to us.

We have reviewed your declaration form and are pleased to inform you that based on the information provided, your recorded details of membership are in order and your subscription payments seem sufficient for the membership periods audited. Please note we may request copies of your SA302 form or audited accounts in due course.

We would like to remind you that it is your responsibility to inform us immediately if any of your details change in the future. In particular, please contact us as soon as possible if your income is likely to exceed estimated amounts and/or your deductible expenses are lower than expected, as failure to do so may adversely affect your entitlement to the benefits of membership.

I would like to take this opportunity to thank you again for your co-operation with the Practice and Income Audit to date.

Yours sincerely

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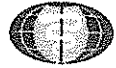
Idris Khan

Member Operations Team Leader - Payments

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Medical
Protection



member.help@medicalprotection.org
medicalprotection.org

DAC116

3 August 2016

Mr A O'Brien

Personal Information redacted by the USI



Member reference:

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440 / 305 / 51
02701MVEH / UK22

Dear Mr O'Brien

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We value your membership and look forward to supporting you for many years to come.

Yours sincerely

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Dan Bown

Executive Director, Operations

IMPORTANT!

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- ii) You may cancel your membership at the end of any subscription period by giving us prior notice.
- iii) Please see Important Information About Direct Debit Payments on the back of the form.

Name: Mr Aidan O'Brien

Membership reference:

Personal Information
redacted by the USI

Country of practice: United Kingdom

Status: Consultant

Specialty: Urology

Grade / Grade description: CB4 / Consultant/private specialist - group 4

Renewal date: 01/09/2016

Amount due:

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- **Please note:** We require you to tell us about any current or previous claims, complaints, criminal convictions, disciplinary or similar issues, which have not been previously notified to MPS.
- **ANY** changes to your professional practice may affect the subscription you need to pay. Please advise us of **ANY** changes including maternity or sabbatical leave
- MPS requires doctors undertaking specialist private practice to be in the GMC Specialist register in the specialty in which indemnity is required OR if undertaking primary care services to be on the GMC GP register. **(See guidance)**.
- It is your responsibility to provide accurate information about your professional practice and relevant income.
- Please ensure you have read the Important – Your Personal Information and Data section on the back of the form.
- If you need to advise us of any change of personal details you can update your information via our website medicalprotection.org/change-details, or you can contact Member Services on 0800 561 9000, our lines are open Monday to Friday, 8.00am to 6.30pm.
- In order to provide you with the best possible service we would like to inform you of other products and services offered by us that we believe may be of interest to you. If you do not wish to receive such information, either via post or email, please tick here. ☐
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Medical
Protection



Mr A O'Brien

DAC116

Personal information redacted by the USI

Name:

Mr Aidan O'Brien

Membership Number:

Personal information redacted by the USI

Period of Membership:

01/09/16-31/08/17

Subscription:

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Country of Practice:

United Kingdom

Region:

Grade:

CB4

Grade description:

Consultant/private specialist - group 4

Additional information:

Your rate is determined according to your specialty and the amount you earn from specialist unindemnified practice (gross income less legitimate practice expenses)

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Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively

Attribute: 3.2 Work constructively with colleagues and delegate effectively

Attribute: 3.3 Establish and maintain partnerships with patients

List of Supporting Information		Applicable Date
1	Letter of Appointment as Clinical Lead for the Urology MDT	10 April 2012
2	Agenda for Urology MDT Business Meeting	12 March 2015
3	Agenda for Urology MDT Business Meeting	02 April 2015
4	Operational Policy Urology Cancer Service	April 2015
5	Urology MDT Annual Report for 2014/5	April 2015
6	Urology MDT Work Plan for 2015/6	April 2015
7	Self-Assessment and Peer Review Matrix	June 2015
8	Peer Review Visit Report	18 June 2015
9	Peer Review Notification Of Serious Concerns	01 July 2015
10	Structured Reflective Template on Lead Clinicianship of MDT	18 December 2016
11	Structured Reflective Template on role of Peer Reviewer 18 June 2015	18 December 2016
12	Record of NICaUrology Meeting 30 January 2015	30 January 2015
13	Record of NICaUrology Meeting 17 April 2015	17 April 2015
14	Record of NICaUrology Meeting 18 September 2015	18 September 2015

Discussion

In addition to the above, I commissioned the Draft Clinical Management Guidelines for Urological Cancer in Northern Ireland, first submitted in March 2015 (enclosed), proposed and had agreed amendments to the Guidelines (enclosed). I commissioned and amended 'Urological Nursing in the Management of Urological Cancer' for inclusion in the Draft Guidelines for Peer Review in Northern Ireland (enclosed). I revised and had agreed the Urology Care Pathways for Northern Ireland, and designed the Hormone Treatment Only Pathway for Prostate Cancer Patients in Northern Ireland (enclosed), and amended the Regional Hormone Therapy Guideline to accommodate its inclusion (enclosed).

AOB clearly involved in Regional discussion for Northern Ireland urological cancer provision having chaired Committee for last four years. It has taken the process through Peer Review - the first time performed for N.I. Urology. Documents to cover this whole period are enclosed.

Actions Agreed

- = Highlighted short comings in local service noted.
- = Reflective comments on same
- = Views on MDT compliance: now 'fit for purpose' & impacting very positively now on pt pathways
- = Part of N.I. reconstructive Urology Network not recorded above but discussed
- ACTION = maintain involvement in both

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

UROLOGY MDT BUSINESS MEETING

THURSDAY 12 MARCH 2015

AGENDA

Triage of Red Flag Referrals

To discuss merits or otherwise of advanced triage, which would include

- Contacting patient (by phone or letter) to advise of
- Investigation(s) requested in advance of consultation or admission or discharge
- Consultation or admission or discharge scheduled to occur following investigation(s)
- Office of Cancer Services advised of plan and schedule
- Need for operative capacity to facilitate management within 62 day timeline

Membership of MDT and Attendance at MDM

To discuss

- Extending membership of MDT to all consultant urologists
- Implications for attendance at MDM
- Core vs. Extended membership
- Attendance of Registrars at MDM
- Attendance of Consultant Radiologists at MDM

MDM Format

To discuss

- Role of the Cancer Tracker
- Provision of Clinical Summaries
- Format of Clinical Summaries which are
 - Compiled to inform MDT to facilitate further management decisions or advice
 - Permanent record of patient investigation and management
 - Communicated following each MDM to GP or other Clinician
- Renewal of Clinical Summaries after a period of time
- Possibility of Provision of Summaries to MDT members in Chairperson's format

MDT Role in Expedition of 'Secondary' Cancer Patient Management

To discuss the possibility of MDT /MDM being used to

- Address Backlog of 'Secondary' Cancer-related Operative Management such as
 - TURBT for Recurrent Bladder Tumour
 - TURP for Bladder Outlet Obstruction prior to Radical Radiotherapy

Key Worker(s)

To discuss

- Need for all current and future cancer patients to have a key worker
- Introduction of all patients to an allocated key worker
- Human resource implications
- Establishment of stand-alone key worker / CNS clinics (virtual and real)
- Administrative support

UROLOGY MDT BUSINESS MEETING**THURSDAY 02 APRIL 2015****12 NOON****AGENDA****WITH TOPICS OF DISCUSSION FOR AGREEMENT FROM 12 MARCH 2015****TRIAGE OF RED FLAG REFERRALS**

The principal agreement reached on 12 March 2015 was that advanced triage of Red Flag referrals would not necessarily be conducted. The main reasons for this conclusion were that:

- It has been found that it was too time consuming
- The other duties when urologist on call did not leave adequate time to undertake it
- An appropriate assessment of the need for advanced investigations often required, or was best made in, consultation with the patient
- The delay in consultation following advanced triage may jeopardise the patient's further management within the 62 day period.

A number of other issues relating to the triage of Red Flag Referrals were discussed and which may require definitive clarification. These were:

- If a Red Flag referral is downgraded from Red Flag status upon triage, that downgrading will be clearly made and the referral returned to the Office of Cancer Services. The Office will advise the Cancer Tracker of the downgrading?
- If another course of action is taken, such as a plan to have the patient attend a clinic of the triaging consultant (such as hot clinic or oncology review clinic) or a plan to have the patient admitted, then that plan should be communicated clearly to the Office of Cancer Services. How should this communication be conveyed? For example, should the letter of referral be returned to the Office even in the case of intended admission of the patient? Does the Office have an email address? The Office will advise the Cancer Tracker of the planned course of action?

In both of the above scenarios, it requires to be clarified whether the receptacle is the Office of Cancer Services, and the communicative relationship between the Office and the Cancer Tracker.

On the other hand, when a Red Flag Referral has been triaged in the normal manner to attend a New Clinic at which it is concluded that the patient is no longer suspected of having a cancer, thereby no longer remaining on a Red Flag pathway, that conclusion requires to be made to the Cancer Tracker, as the responsibility of the Office of Cancer Services ends with the triaging of the referral. It would be optimal if it could be agreed how that conclusion is communicated to the Cancer Tracker.

MEMBERSHIP OF MDT AND ATTENDANCE AT MDM

It was acknowledged that there was a desire to extend membership of MDT to all six consultant urologists and to facilitate their attendance at MDM.

It was acknowledged that there could be some flexibility with regard to the attendance of one or more consultants by having one or more regarded as extended members rather than core members.

Mr. Young, Lead Clinician in Urology, may be able to provide an update with regard to the possibility of a greater number of consultants being able to be members and attend MDM.

It was agreed that Registrars should be able to attend MDM rather than having a service commitment, because of its educational value and because it would enhance their compliance with the requirements of MDM.

The difficulties regarding the attendance of a Uroradiologist at every MDM have been noted. Dr. Hall has agreed to attend MDM on 02 April 2015 to address this issue.

MDM FORMAT

It was acknowledged and agreed that it is not the role of the Cancer Tracker to provide a Clinical Summary or Update for any patient, nor is it the role of the Cancer Tracker to extract a Clinical Summary or Update from dictated letters, clinical or operative records.

It was acknowledged and agreed that it is the responsibility of the clinician to provide the Clinical Summary or Update, by whatever means, bearing in mind that:

- Its purpose is to enable a MDT to decide or advise upon further assessment and management
- It remains as a permanent record of assessment and management
- It will be sent in the submitted form to the GP
- It will be sent in the submitted form to other clinicians at the time of direct referral

It would be helpful if it could be agreed that a new Clinical Summary be compiled after a significant period of time (such as one year) has elapsed from an initial or previous Summary.

MDT ROLE IN EXPEDITION OF 'SECONDARY' CANCER PATIENT MANAGEMENT

There was inadequate time on 12 March 2015 to discuss the role of MDT and MDM in expediting the 'secondary' operative management of cancer patients when that management is of significance in progressing their global cancer management. Examples are:

- TURBT for recurrent bladder tumour
- TURP for Bladder Outlet Obstruction prior to Radical Radiotherapy

It would be most desirable to ensure that this topic be discussed and some plan of action agreed for the following reasons:

- This cohort of patients should be regarded as a priority in the context of the request to agree a plan of action for all Urgent cases
- This cohort of patients should be the core of the Annual Action Plan for MDT for the year 2015/2016

KEY WORKER PRACTICE

There was inadequate time to discuss the implications of the need for all current and future cancer patients to have, and be introduced to, a key worker.

It would be useful to have an update on the PAS structure for the provision of templated, coded, key worker clinics.

The development of separate clinics conducted by key workers requires to be included in the Action Plan for 2015/2016.

OTHER ITEMS

It is intended that the Operational Policy for the Urology Cancer Service will be circulated to all members for their perusal upon their return from Easter leave on Monday 13 April 2015.

It is essential that updated, agreed Job Plans of all MDT members are provided as they must be included prior to signing off at MDT AGM.

It is essential that the Job Plans include specified provision of all that is required to enable each member to carry out the responsibilities of membership.

This includes operating sessional schedules and outpatient clinic sessions.

Outpatient clinic sessions, and their templates, for the purpose of review of patients remaining on Red Flag pathways, require to be available for inclusion in the Operational Policy.

AGM

To agree a time for the AGM during week commencing Monday 20 April 2015, and preferably on Thursday 23 April 2015.



**Southern Health
and Social Care Trust**

Quality Care - for you, with you

Urology MDT

Annual Report for 2014/5

Aidan O'Brien

MDT Lead Clinician

April 2015

Introduction

The Southern Health and Social Care Trust established a Urology Local MDT in April 2010 under the Clinical Leadership of Mr. Mehmood Akhtar, Consultant Urological Surgeon. On his departure from the Trust in April 2012, Mr. Aidan O'Brien was appointed to the position of Lead Clinician, and has remained in that role since.

This report relates the changes and developments, challenges and achievements of the fifth year of the Urology MDT, from April 2014 to March 2015.

Appointment of Consultant Urologists

Whilst the previous year of 2013/14 had begun with 5 Consultant Urologists in post, two subsequently left during that year, the resulting vacancies partially mitigated by the appointment of Mr. Suresh in late 2013. The resultant reduction in service capacity had impacted negatively on the ability of the MDT to meet demand and deliver cancer services within agreed target times.

That negative impact has been eliminated by the appointments of Mr. Haynes and Mr. O'Donoghue during 2014, bringing the consultant compliment to six by August 2014.

Red Flag Referrals

There has been a 40% increase in the number of Red Flag referrals throughout Northern Ireland during the past year, up from 2902 in 2013 to 4063 in 2014. The greatest increase has been to the Southern Trust, with an increase of 84% from 410 in 2013 to 753 in 2014.

This has occurred in the context of the Southern Trust having the greatest percentage increase in all urological referrals, with an 18% increase from 3987 in 2013 to 4695 in 2014.

Performance

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

This has been reflected in the most recent Cancer Performance data. The average wait for cancer patients in the care of the Southern Trust was 23 days on 30 July 2014 and had decreased to 18 days by 26 March 2015.

The longest wait in the Southern Trust was 138 days in April 2014, with 20 patients waiting more than 62 days. The longest wait in March 2015 was 59 days. The Southern Trust has been the only Trust with no patients waiting more than 62 days in February 2015 and in March 2015.

The increased activity has been reflected in an increased number of case discussions by the MDT at MDMs. There has been a 17% increase in cases discussed, up from 1555 in 2013/14 to 1776 in 2014/15.

The diagnostic and operative activity has been reflected in a 13% increase in the numbers of specimens received by the Cellular Pathology Laboratory at Craigavon Area Hospital, Tissue specimens increased from 874 in 2013/14 to 993 in 2014/15.

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

SPECIMENS	2011/12	2012/13	2013/14	2014/15
Prostate Biopsies	345	225	248	340
TURP	158	141	163	176
Bladder Biopsies	182	253	224	205
TURBT	78	70	115	120
Testis Biopsies	-	-	4	8
Testis	28	37	36	38
Renal Biopsies	-	-	24	14
Kidney	28	33	46	76
Penile Biopsies	6	9	13	13
Penis	4	3	1	3

It is notable that there has been a significant increase in the numbers of bladder resections over the past four years, and that there was a marked increase in the numbers of nephrectomies during the past year.

New Clinics

The introduction of the New Patient Clinics in October 2014 has contributed significantly to the ability of MDT to absorb the increased Red Flag referrals and meet the target times in all cases by early 2015. It has also been the perception of MDT members that they have been a qualitative success. It will be learned during 2015/16 whether patients share that perception, when the results of surveys are available.

Operative Capacity

The main limiting factor in providing a complete cancer service is operating theatre capacity and operator time. Though the MDT has provided for the increased demand on Red Flag pathways, it has been

at the expense of patients having, or suspected of having, recurrent bladder tumours, and those awaiting prostatic resection to facilitate their progress to radical radiotherapy for prostatic carcinoma having to wait increasingly longer periods of time for surgery, in addition to all those with non-cancerous pathology. This is a common and concerning experience across Northern Ireland, and will remain an increasing challenge until operative capacity is increased.

Conduct of MDM

The quality of the conduct of MDM has been a singular achievement these past five years. The quality of participation has been enhanced by increasing the number of persons chairing, and by having time allocated for preview. It is intended to increase the core membership in the near future to include all consultant urologists.

However, challenges and failures persist. The main inadequacies have remained the absence of a consultant urological radiologist at too many meetings. The MDT is cognisant of the current problems regarding the provision of experienced radiological cover and will encourage the Trust to address this issue.

Whilst the presence of clinical and medical oncologists has improved significantly in recent years, it is still not complete.

Both of these inadequacies have resulted in a MDM quoracy of 23% for 2014, as evidenced by the MDT Attendance Spreadsheet.

Lastly, it has been a collective failure of MDT and the Trust to see developed the functions of Key Workers. This will certainly be a priority issue for the MDT during 2015/16.

Conclusion

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

Urology Statistics Southern Trust

Urology

Conversion Rates	Suspect Urology Referrals Received					Suspect Urology Referrals Received that have been closed as a Confirmed Urology Cancer					Urology Cancer Conversion Rate				
Referral Type	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE
Consultant Upgrade	193	165	255	128	256	37	14	37	20	40	19%	8%	15%	16%	16%
Red Flag (GP)	488	700	994	469	938	93	135	173	81	162	19%	19%	17%	17%	17%
Subtotal	681	865	1249	597	1194	130	149	210	101	202	19%	17%	17%	17%	17%
Other Referral Routes	532	551	484	258	516	267	227	164	91	182	50%	41%	34%	35%	35%
Total	1213	1416	1733	855	1710	397	376	374	192	384	33%	27%	22%	22%	22%

Detection Rates	Urology Confirmed Referrals					Urology Detection Rates				
Referral Type	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE
Consultant Upgrade	37	14	37	20	40	9%	4%	10%	10%	10%
Red Flag (GP)	96	136	175	81	162	24%	36%	46%	42%	42%
Other Referral Routes	271	229	169	91	182	67%	60%	44%	47%	47%
Total	404	379	381	192	384	100%	100%	100%	100%	100%

Urology Average Suspect Red Flag Referrals

Referral Type	2011/12	2012/13	2013/14	2014/15 (Apr-Sep)	2014/15 FYE
Consultant Upgrade	16	14	21	21	21
Red Flag (GP)	41	58	83	78	78
Total	57	72	104	100	100

Urology Pattern of Red Flag and Consultant (combined) Suspect Referrals by months of referral

Month	11-Dec	Dec-13	13/14	14/15 (Apr-Sep)
Apr	54	60	80	86
May	68	72	86	87
Jun	41	38	80	95
Jul	50	59	108	117
Aug	48	61	87	101
Sep	52	61	69	111
Oct	76	66	102	
Nov	55	91	138	
Dec	53	60	118	
Jan	54	97	137	
Feb	58	101	137	
Mar	72	99	107	
TOTAL	681	865	1249	597

Urology Pattern of Red Flag and Consultant (combined) Suspect Referrals by day of referral

Day	11-Dec	Dec-13	13/14	14/15 (Apr-Sep)	14/15 (FYE)
Monday	125	171	240	114	228
Tuesday	151	166	251	122	244
Wednesday	121	171	243	122	244
Thursday	157	180	269	114	228
Friday	123	177	243	123	246
Saturday	2	0	1	1	2
Sunday	2	0	2	1	2
TOTAL	681	865	1249	597	1194

MDM attendance

			Con. Urologist	Con. Urologist	Con. Urologist	Con. Urologist		Cons. Pathologist	Cons. Pathologist	Cons. Pathologist		Cons. Radiologist	Cons. Radiologist	Cons. Radiologist		Cons. Clinical Oncologist		Cons. Medical Oncologist	Urology Nurse Specialist	Urology Nurse Specialist		Palliative Nurse Specialist	Co-ordinator	Co-ordinator	Co-ordinator	Co-ordinator		Quorate
MDM Date	MDM Location	Tumour site	Mr O'Brien	Mr Glackin	Mr Haynes	Mr Suresh	Con. Urologist x1	Dr McClean	Dr Dedic	Dr Shah	Cons. Pathologist x1	Dr Williams	Dr McClure	Dr Hamill	Con. Radiologist x1	Dr Houghton	Cons. Clinical Oncologist x1	Dr Carner	K O'Neill	J McMahon	Urology Nurse Rep x1	S Reid	V Graham	W Kelly	A Turkington	M Dabbous	MDT Co-ordinator x1	
02/01/2014	CAH	Uro I	1	0	0	1	1	1	0	0	1	1	0	0	1	0	0	0	1	0	1	1	1	0	0	0	1	No
09/01/2014	CAH	Uro I	0	1	0	1	1	1	0	0	1	0	0	1	1	0	0	0	1	0	1	1	1	0	0	0	1	No
16/01/2014	CAH	Uro I	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	
23/01/2014	CAH	Uro I	0	1	0	1	1	1	0	0	1	1	1	1	1	0	0	1	1	0	1	1	1	0	0	0	1	No
30/01/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	1	1	1	1	0	0	1	0	1	1	1	1	0	0	0	1	No
06/02/2014	CAH	Uro I	1	1	0	0	1	1	0	0	1	0	1	0	1	0	0	1	1	0	1	1	0	0	1	0	1	No
13/02/2014	CAH	Uro I	1	1	0	0	1	1	0	0	1	1	1	0	1	0	0	1	1	0	1	1	1	0	0	0	1	No
20/02/2014	CAH	Uro I	1	0	0	1	1	0	0	1	1	1	0	1	1	0	0	1	1	0	1	0	1	0	0	0	1	No
27/02/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	0	0	1	1	0	0	0	1	0	1	1	1	0	0	0	1	No
06/03/2014	CAH	Uro I	1	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	1	1	1	1	1	0	0	0	1	No
13/03/2014	CAH	Uro I	0	1	0	1	1	1	0	0	1	1	0	0	1	0	0	1	1	0	1	1	0	1	0	0	1	No
20/03/2014	CAH	Uro I	1	1	0	0	1	1	0	0	1	0	1	0	1	1	1	0	0	1	1	0	1	0	0	0	1	Ye

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27/03/2014	CAH	Uro I	1	1	0	1	1	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0	1	No
03/04/2014	CAH	Uro I	1	1	0	0	1	1	0	0	1	0	0	1	1	0	0	0	1	0	1	0	1	0	0	0	1	No
10/04/2014	CAH	Uro I	1	0	0	1	1	1	0	0	1	0	0	0	0	1	1	1	0	1	1	1	1	0	0	0	1	Yes
17/04/2014	CAH	Uro I	0	1	0	1	1	0	0	0	1	1	0	1	1	0	0	1	1	0	1	0	1	0	0	0	1	No
24/04/2014	CAH	Uro I	1	0	0	1	1	1	0	0	1	1	0	0	1	0	0	1	1	0	1	0	1	0	0	0	1	No
01/05/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	0	1	0	1	0	0	0	0	1	1	0	1	0	0	0	1	No
08/05/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	1	0	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
15/05/2014	CAH	Uro I	1	1	0	1	1	0	1	0	1	1	1	1	1	1	1	0	1	0	1	1	1	0	0	0	1	Yes
22/05/2014	CAH	Uro I	1	0	1	1	1	1	0	0	1	0	0	0	0	0	0	0	1	0	1	1	1	0	0	0	1	No
29/05/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	1	0	0	1	0	0	0	0	1	1	1	1	0	0	0	1	No
05/06/2014	CAH	Uro I	1	1	1	0	1	0	0	1	1	0	0	1	1	0	0	1	1	0	1	1	1	0	0	0	1	No
12/06/2014	CAH	Uro I	1	0	1	0	1	1	0	0	1	0	0	0	0	0	0	1	1	0	1	1	1	0	0	0	1	No
19/06/2014	CAH	Uro I	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M		
26/06/2014	CAH	Uro I	0	1	1	1	1	1	0	0	1	1	0	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
03/07/2014	CAH	Uro I	1	1	0	1	1	0	1	0	1	1	0	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
10/07/2014	CAH	Uro I	1	0	1	1	1	0	1	0	1	1	0	0	1	1	1	0	0	1	1	0	1	0	0	0	1	Yes
17/07/2014	CAH	Uro I	0	1	1	0	1	1	0	0	1	1	1	0	1	0	0	0	1	0	1	0	1	0	0	0	1	No
24/07/2014	CAH	Uro I	1	1	1	0	1	1	0	0	1	0	1	0	1	0	0	0	1	0	1	0	1	0	0	0	1	No
31/07/2014	CAH	Uro I	1	0	1	0	1	1	0	0	1	1	1	0	1	0	0	0	1	0	1	1	1	0	0	0	1	No
07/08/2014	CAH	Uro I	1	0	1	0	1	1	0	0	1	0	1	0	1	0	0	1	1	0	1	1	1	0	0	0	1	No
14/08/2014	CAH	Uro I	0	1	0	1	1	0	1	0	1	0	1	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
21/08/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	1	0	1	1	1	1	1	1	0	1	1	0	0	1	0	1	Yes

28/08/2014	CAH	Uro I	0	1	1	1	1	1	0	0	1	1	0	0	1	0	0	1	1	0	1	1	0	1	0	0	1	No
04/09/2014	CAH	Uro I	1	0	1	1	1	1	0	0	1	0	1	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
11/09/2014	CAH	Uro I	0	1	1	1	1	1	1	0	1	0	1	0	1	1	1	1	1	0	1	1	1	0	0	0	1	Yes
18/09/2014	CAH	Uro I	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	
25/09/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	0	0	0	0	1	1	1	1	0	1	1	1	0	0	0	1	No
02/10/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	0	1	0	1	0	0	1	1	0	1	1	1	0	0	0	1	No
09/10/2014	CAH	Uro I	1	1	0	1	1	1	0	0	1	0	1	0	1	0	0	0	1	0	1	1	1	0	0	0	1	No
16/10/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	1	0	1	1	0	0	0	0	1	1	0	1	0	0	0	1	No
23/10/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	1	0	0	1	0	0	0	1	1	1	1	0	0	0	1	1	No
30/10/2014	CAH	Uro I	1	1	0	0	1	1	0	1	1	0	0	1	1	0	0	0	0	1	1	1	0	0	0	1	1	No
06/11/2014	CAH	Uro I	0	1	1	0	1	0	1	1	1	0	0	1	1	0	0	1	1	0	1	1	0	0	0	1	1	No
13/11/2014	CAH	Uro I	0	1	1	0	1	1	0	0	1	1	0	1	1	0	0	1	1	0	1	1	0	0	0	1	1	No
20/11/2014	CAH	Uro I	0	0	1	1	1	1	0	0	1	0	0	0	0	1	1	1	0	1	1	0	0	0	0	1	1	No
27/11/2014	CAH	Uro I	1	1	1	1	1	1	0	1	1	0	0	1	1	1	1	0	1	0	1	0	0	0	0	1	1	No
04/12/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	0	0	1	1	1	1	1	1	0	1	1	0	0	0	1	1	No
11/12/2014	CAH	Uro I	1	1	1	1	1	1	0	0	1	1	0	1	1	0	0	1	1	0	1	0	0	0	0	1	1	No
18/12/2014	CAH	Uro I	1	1	0	1	1	1	0	1	1	0	0	1	1	0	0	1	1	0	1	0	0	0	0	1	1	No
25/12/2014	CAH	Uro I	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	NO MD M	
Weeks attended			36	36	23	34	48	39	6	7	48	22	16	18	41	15	15	28	39	11	48	33	35	2	2	9	48	
52 weeks year			75 %	75 %	48 %	71 %	100 %	81 %	12 %	15 %	100 %	46 %	33 %	37 %	85 %	31 %	31 %	58 %	81 %	23 %	100 %	69 %	73 %	4%	4%	19 %	100 %	

Southern Health and Social Care Trust

Urology MDT

Work Plan for 2015/16

Aidan O'Brien

MDT Lead Clinician

April 2015

In updating the Operational Policy for the Urology MDT, in having conducted MDT Business Meetings, in completing the Annual MDT Report and in preparing for Peer Review, it is both evident that much has been achieved since the establishment of the MDT five years ago and that there is much more yet to be done.

In constructing a Work Plan for 2015/16, I believe that it would be best to focus on the inadequacies which blight some of the achievements made, and on those issues which can be developed and hopefully achieved. In doing so, the comments and contributions of all MDT members will be welcomed and important. They are:

1. To complete the extension of core membership of MDT to all consultant urologists.
2. To ensure that specialist registrars attend MDM
3. To address with the Trust the inadequacy of Radiologist membership of MDT and presence at MDM
4. To ensure that one oncologist is present at each MDM
5. To train and increase the numbers of Key Workers
6. To have every cancer patient have a Key Worker
7. To have every patient offered a Record of their diagnosis and management plans
8. To complete surveys of patient experience of their cancer management experience
9. To hold regular MDT Business meetings to agree the prioritisation of these issues and others which may emerge.

Code	Measure	Compliant?			Evidence					Internal Comments	Zonal Team Comments	
		SA	EV	PR	OP	AR	WP	APP	-		Self-Assessment	Peer Review
N14-2G-101	Core Membership	Y	-	Y								
										The attendance at each individual scheduled treatment planning meeting did not constitute a quorum for 95% or more of the meetings.		
N14-2G-102	MDT Quorum	N	-	N								Only 25% quorate
N14-2G-103	MDT Review	Y	-	Y								
										Some core members did not achieve 66% attendance		
N14-2G-104	Core Members Attendance	N	-	N								Clinical oncologist only 31%, medical oncologist 58%
N14-2G-105	Extended Membership of MDT	Y	-	N								No stoma nurse named
N14-2G-106	Clinical Guidelines	Y	-	N								Network guidelines not yet agreed
N14-2G-107	Regular Prostate Clinic	Y	-	Y								
N14-2G-108	Regular Haematuria Clinic	Y	-	Y								
	Agreed Policy for Patient Access to MDT to											
N14-2G-109	Discuss Treatment Options	Y	-	N								No joint or parallel clinics in place
N14-2G-110	Patient Pathways	Y	-	N								Not agreed across the region
N14-2G-111	Treatment Planning	Y	-	N								HNA not documented
N14-2G-112	Attendance at the Network Group	Y	-	Y								
N14-2G-113	Key Worker	Y	-	N								Not implemented for all patients as yet
N14-2G-114	Patient Information	Y	-	N								No local MDT leaflet
N14-2G-115	Permanent Record of Consultation	N	-	N								Not being offered at present
N14-2G-116	Patient Feedback	Y	-	Y								
N14-2G-117	Clinical Indicators Review / Audit	N	-	N								Local audit undertaken but not discussed at NSSG
N14-2G-118	Discussion of Clinical Trials	Y	-	Y								
	Policy for Communication of Diagnosis to											
N14-2G-119	GP	N	-	N								Not being achieved for all patients
N14-2G-120	Attendance at National Advanced Communication Skills Training Programme	N	-	N								5 out of 8 core members attended
	% Compliant	70.0	0.0	35.0								



PEER REVIEW VISIT REPORT (MULTI-DISCIPLINARY TEAM)

Network	NICaNI
Organisation	Southern
Team	Craigavon Area Hospital Urology Local MDT Measures (M14-2G-1) - 2015
Peer Review Visit Date	16th June 2015

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

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

Structure and function of the service

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

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

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



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

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

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

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

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

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

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

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

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



pathways into the MDT are coordinated and appropriate information is readily available to ease

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

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

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

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

Coordination of care/patient pathways

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

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

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

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

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



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

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

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

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

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

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

Patient experience

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

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

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

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

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

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



Clinical outcomes/indicators

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

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

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

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

No activity data per surgeon was provided.

Communication

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

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

Good Practice/Significant Achievements

The implementation of the Single Visit Clinic.

Appointment of two additional consultant surgeons.

Well-structured MDT meeting with rotating chair.

Proactive 62 day pathway management and no breaches since January 2015

Secured slots in clinic following MDT meeting for patient discussion.

Protected preview time to allow preparation for the MDT meeting.



Immediate Risks Identified?

Not Identified

Immediate Risks

Immediate Risks Resolved?

Not Applicable

Immediate Risks Resolution

Serious Concerns Identified?

Identified

Serious Concerns

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

Trust response:

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

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

Trust response:

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



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

Trust response:

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

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

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

Trust response:

The guidelines remain to be agreed by NICA and HSCB, and it is intended that they will be by January 2016.

Serious Concerns Resolved?

Not Resolved

Serious Concerns Resolution

Concerns

Lack of implemented keyworker policy.

Lack of HNA and documentation.

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

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

Lack of agreed clinical guidelines.

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



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

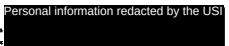
Timeliness in communicating to GPs as reliant on postal service.

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



National Office:
Quality Surveillance Team
6th Floor, Skipton House
80 London Road
Elephant and Castle
London
SE1 6LH

Personal information redacted by the USI

Tel: 

1 July 2015

Ms Paula Clarke
Interim Chief Executive
Southern Health and Social Care Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Dear Paula,

RE: Peer Review: Notification of Serious Concerns

Once again NICA has commissioned cancer peer review visits from the NHS England National Peer Review Programme, which is now known as the Quality Surveillance Team. I am writing to you in my capacity as the person in the team with oversight of the Northern Ireland visits.

Firstly, I would like to thank you and your staff for the warm welcome and hospitality shown to the team during the recent review visit and for the hard work undertaken in preparation for it. Whilst I am unable to attend every visit I am notified of the outcomes of all external reviews undertaken.

As discussed at the feedback meeting to the Trust I am writing to formally notify you of the significant findings made by the peer review team during the visit. The Trust will have the opportunity to review the report for factual accuracy in the coming weeks, and the final report will normally be published no later than eight weeks following the last review visit being undertaken locally. However in the meantime I am writing to bring to your attention the serious concerns identified by the reviewers and to set out the requirement on the Trust to respond.

As described to the team at feedback a "serious concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve.

Please find attached to this letter a table setting out the serious concerns raised by the reviewers at this visit. It is recommended that immediate risks and serious concerns identified at peer review are entered on the Trust's risk register and that the Board is made aware of these findings.

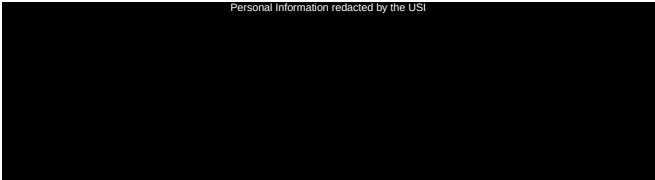
I would be grateful if you would formally respond to me with the Trust's plan and actions to address the serious concerns by **29 July 2015**.

Please note that in order to make best use of resources this letter has been emailed to you and no paper copy has been sent. If you require a signed copy please let me know and I will provide this for you. In order to ensure timely receipt I would be grateful if you would arrange for your reply to be sent to me electronically to the email address above.

I look forward to hearing from you in due course.

Yours sincerely,

Personal Information redacted by the USI



Richard McMahon PhD
Deputy Head of Quality Surveillance Team
(Operations & Service Reviews)
NHS England.

CC: Dr Miriam McCarthy – Consultant in Public Health Medicine, Public Health Agency
Sara Long – Assistant Director of Performance Management in the Health and Social Care Board
Lisa McWilliams – Network Manager
Fiona Reddick Trust Cancer Manager
Sally Edwards, Head of the Quality Surveillance Team, NHS England.
Clare Langslow, Quality Manager (Northern Ireland), Quality Surveillance Team

Notification of Immediate Risks and Serious Concerns

Trust:	Southern HSC Trust
Date of Visit:	16 th June 2015
Service:	Local Urology MDT
Immediate Risks:	None
Serious Concerns:	1. There is now a single handed radiologist supporting the Urology MDT with no cover arrangements in place. Attendance at the MDT during 2015 is not consistent due to clinical commitments in order to deliver timely waits for patients. This could adversely affect the treatment planning decisions for patients. Trust Response The Trust can confirm that the reduction of Radiology provision to the Urology MDT was entirely unpredictable. The Trust has taken appropriate measures and has advertised replacement radiologists with Urology interest/expertise.
	2. Due to low clinical oncology and radiology attendance at the MDT meetings in the reported period only 25% of meetings were quorate. This means that a large proportion of patients are not benefitting from the knowledge and expertise of a full multidisciplinary team when decisions are being made about their diagnosis and care. As a result this could lead to delays in the decision making processes and treatment. Trust Response The attendance from Clinical Oncology at MDT has significantly improved over the past year, however, this improvement must continue and to this end HSCB are working with the Regional Oncology Centre to ensure adequate Oncology cover at all MDTs
	3. The reviewers were informed by a member of the cancer management team that routine referrals can wait up to 52 weeks for their initial clinic appointment. Patients who have a diagnosis of urological cancer following routine referral have a significant delay in diagnosis and this could impact on the treatment pathways and significantly affect outcomes for patients.

High quality care for all, now and for future generations

	All referrals to the Trust are triaged by consultants, affording the opportunity for routine referrals to be processed more expeditiously, whether by upgrading to Red Flag status or Urgent, thereby minimising the risk to patients. With specific regard to the waiting times, HSCB are about to undertake a review of outpatient services with view to reform where appropriate and relevant.
	4. Nephron sparing surgery is being undertaken locally and this should all be undertaken by the specialist MDT as indicated in the NICA agreed clinical guidelines. Trust Response The Guidelines remain to be agreed by NICA and HSCB, and that it is the intent that they will be by January 2016.



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

Other roles structured reflective template

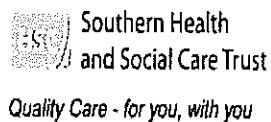
Name of doctor: Aidan O'Brien	GMC No: 1394911
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role: Bringing the Urology MDT to and through Peer Review on 16 June 2015 was the culmination of much work since being appointed Lead Clinician in April 2012. By the end of 2014, I had established an effective, robust structure to weekly MDM, preparing for and chairing each meeting following by amending reports, so that the quality of reportage was optimal. However, much work needed to be done for Peer Review. The greatest piece of work was to write and have agreed an Operational Policy which met with National Cancer Plan measures, in addition to conducting business meetings, formulating and improving annual reports and work plans. We succeeded in Peer Review with four serious concerns largely beyond our control. I contributed significantly to the Peer Review Report and to the Trust's replies to the serious concerns raised.	
They also brought the following drawbacks to my main clinical role: Such work consumes a significant quantum of time and effort, which did impact negatively upon my main clinical role. No allowance was made by the Trust.	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)	



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

Other roles structured reflective template

Name of doctor: Aidan O'Brien	GMC No: 1394911
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role: Having been certified as a trained Peer Reviewer in April 2015, I was appointed to the Peer Review Panel for the North Western Urology MDT on 18 June 2016. The Panel included Dr. Paul Mansour of Southport & Ormskirk Hospital NHS Trust and Ms. Claire Langslow of NHS England. I subsequently advised on amendments to the Peer Review Report.	
They also brought the following drawbacks to my main clinical role: None	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care) Continued involvement as required.	
Personal Information redacted by the USI	



NI PEER REVIEW PROGRAMME 2014-2016: Reviewers briefing pack

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Health & Social Care Structures in N. Ireland

Northern Ireland has an integrated health and social care service which serves a population of 1.8million. The key health and social care organisations are as follows:

1. Department of Health Social Services & Public Safety (DSHH&PS)

The Department leads on policy development on behalf of the region.

2. Health and Social Care Board for Northern Ireland (HSCB)

The HSCB will focus on commissioning, resource management and performance management and improvement. It will identify and meet the needs of the local population through its five Local Commissioning Groups that will cover the same geographical area as the HSC Trusts.

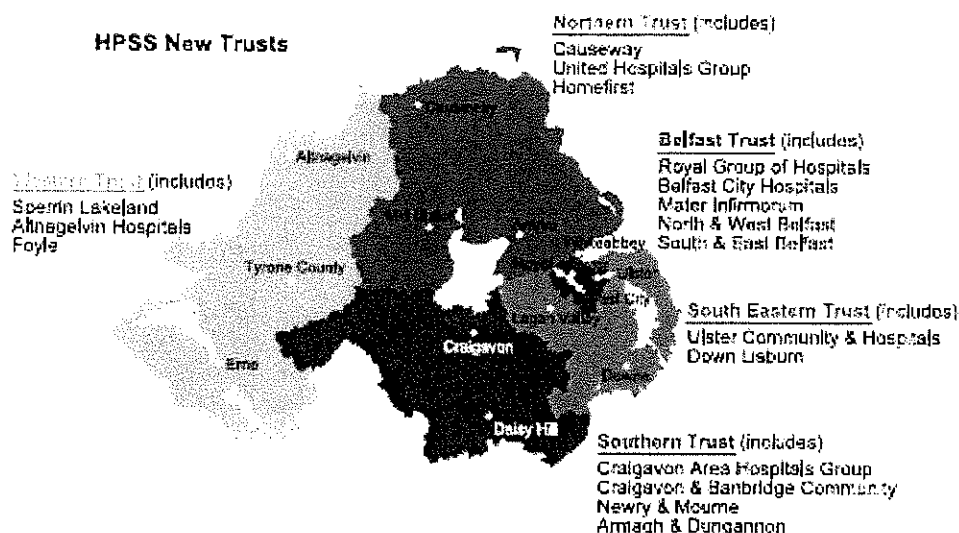
3. Public Health Agency (PHA)

The PHA will have much responsibility for health protection and screening and health improvement and development to improve overall public health and address existing health inequalities.

4. Local Health & Social Care Trusts

Following the review of Public Administration the number of trusts in Northern Ireland has been reduced from 18 to five: Belfast; Northern; Southern; South Eastern; and Western. All of the trusts are integrated, providing both acute and community services. Detailed information about each trust is included in Section 7.

New Trust Configuration



5. Regional Business Services Organisation

The RBSO provides a range of support functions for the whole of the health and social care system (e.g. procurement, human resources, finance).

6. Patient and Client Council

The PCC has five local offices operating in the same geographical areas as the existing Trusts, and provides a strong voice for patients, clients and carers.

7. Regulation and Quality Improvement Authority (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. RQIA is represented on the peer review reference group which is coordinating the planning and implementation of peer review on behalf of the Network.

Cancer: The Strategic Context

Campbell

Following the Campbell Report "Cancer Services – Investing for the Future" (DHSS&PS, 2003) Northern Ireland's cancer services were reconfigured around a cancer unit and centre model. There is one cancer centre based in the Belfast Trust and units in each of the four remaining Trusts:

- Western Trust – Altnagelvin Hospital
- South Eastern Trust – The Ulster Hospital
- Northern trust – Antrim Area Hospital
- Southern Trust – Craigavon Area Hospital

The Cancer Centre opened at Belfast City hospital in 2006 and also functions as a cancer unit for its own resident population.

The units care locally for patients with breast, bowel, lung and some prostate cancers which require systemic Anti Cancer Therapy (SACT) and which can be delivered on a day case basis. They also undertake surgery for breast and bowel cancer.

A new Radiotherapy Centre is currently planned to open in WHSCT on the Altnagelvin Hospital site to service the west of Northern Ireland and the border population of the Republic of Ireland.

The Cancer Control Programme

The Cancer Control Programme for Northern Ireland (DHSS&PS, 2006) represented the first element of an overarching regional framework for cancer services and set out 55 recommendations which span every aspect of cancer care and aims to improve the quality of cancer care in Northern Ireland over the next ten years.

Service Framework for Cancer Prevention, Treatment & Care

The Service Framework for Cancer Prevention, Treatment and Care was selected as the third Service Framework for development as cancer continues to be one of the significant causes of ill health and disability in Northern Ireland. Launched in March 2011, the Cancer Service Framework sets a range of standards in relation to the prevention, diagnosis, treatment and ongoing care, rehabilitation and palliative/ end of life care for those who have cancer and those who have a higher risk of developing cancer.

These standards have been developed in partnership with a wide range of stakeholders with representation from all aspects of health and social care as well as service users and carers. They are aimed at improving areas such as health promotion, preventative services and the quality of cancer care. They also set out the standards of care and treatment that patients can expect to receive.

Standard 20 relates to MDTs stating that “all patients who have high clinical suspicion or have a diagnosis of cancer should have their care managed by an appropriately constituted and effective MDT which meets weekly or fortnightly (in accordance with the manual of Cancer Services Standards).

The Framework is currently being reviewed in 2015.

Priorities for Action

Each year the Minister for Health sets out the priorities for health in a document called Priorities for Action (PfA). There are currently a number of PfA targets which relate directly to or which will impact on cancer services. These include screening targets as well as cancer access targets (31 and 61 day pathways).

Transforming Your Care (TYC)

Transforming Your Care (TYC) is the name given to the programme of work aimed at changing Northern Ireland’s health and social care system so that it meets our needs now and well into the future.

Transforming Your Care is focused on improving the care provided for individuals and families across Northern Ireland. This means more care at home and less care in hospitals. It means supporting people to live as independently and healthily as possible, for as long as possible. In essence, it is about getting better at preventing ill health in the first place but making it simpler for patients and clients to access health and social care should they need it.

HSCNI have now started to see real, meaningful and positive change through the implementation of the reform plans.

The Northern Ireland Cancer Network

The Northern Ireland Cancer Network (NICaN) is NI's first regional managed clinical network. It was established in 2004 to work towards the continuous improvement in cancer care and survival for the people of Northern Ireland.

The Cancer Network:

- supports its members in the delivery of services that are evidence based
- ensures equity of access and uniform quality of services for the population of Northern Ireland, and
- Works across organisational boundaries following the patient pathway.

Network Structure

NICaN has a Board, which helps to steer the work of the Network.

NICaN Board has representation from the HSCB, PHA, Trusts and Cancer Charities Alliance to include both clinical and managerial input. It also has two patient representatives.

The Network sits under the Commissioning Directorate of the Health and Social Care Board and a key function is to provide resolved advice to the Commissioners.

Network Clinical Reference Groups

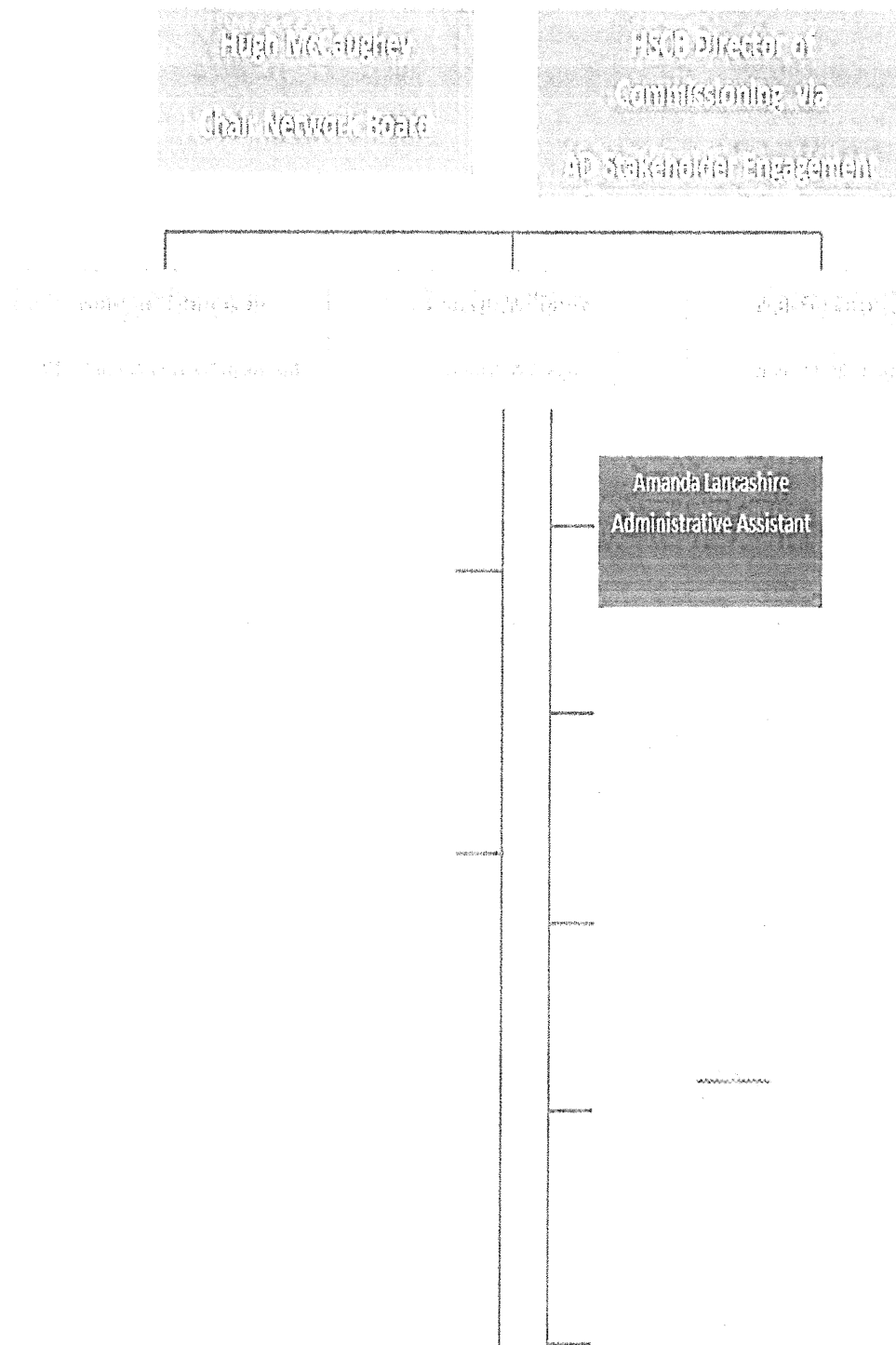
The Clinical Reference Groups are groups made up of individuals who meet to address;

- i) a particular type of cancer e.g. Breast, Lung
- ii) work evolving across specific areas of care

The groups are the nucleus of the Cancer Network and are responsible for the development of work within the Cancer Network. They provide the opportunity for health care professionals and individuals affected by cancer to meet, discuss and plan both current and future developments which will affect the care of patients.

There are 12 Clinical Reference Groups (Haematology, Lung, Upper GI, Thyroid, Head and Neck, Brain and CNS, Skin, Sarcoma, Urology, Breast, Colorectal and Gynae)

NISCAN Organisational Chart 2014 - November 2014



RISOH (Regional Information System for Oncology and Haematology)

RISOH; is the Regional Information System for Oncology and Haematology. This system is a regional wide system that will record the patients journey with the Oncology and/or Haematology service. The system include a full electronic patient record and electronic prescribing, the electronic prescribing will be based on the regionally agreed CMG's and protocols. System will interface with existing PAS and Labs systems as well as providing information to NIECR to ensure other services involved in the patients care can see up to date information from Oncology and Haematology. System will be rolled out during 2015 regional wide.

Teenager and Young Adult Project

The teenage and young adults with cancer work stream, is a 2 year fixed term project focussed on developing a regional cancer service for this cohort of patients in Northern Ireland. After an initial scoping exercise of current services, five themes have emerged as central to developing a regional cancer service.

The themes will form the basis for the key areas of work moving forward, and include; strategic direction of travel for TYA cancer services in NI, TYA service developments and support needed to develop a TYA service, facilities to support TYA cancer care in NI and education for staff and patient information needs.

All service developments in NI will be in line with best available evidence to include;

- NICE Improving Outcomes in Children and Young People with Cancer;
- NICE Quality Standard 55 for Children and Young People with Cancer;
- National Cancer Peer Review Programme: Manual for Cancer Services: Teenage and Young Adults Measures; and
- DHSSPS Departmental Framework for Cancer Services 2015.

Acute Oncology

In late 2014 HSCB/PHA approved a service model for delivery of Acute Oncology Services across Northern Ireland. SHSCT have had an Acute Oncologist and Acute Oncology Nurse in place for several years and this additional funding will allow for rollout across the rest of the Province. Macmillan Cancer Support has provided the initial funding for 7 Acute Oncology Nurses. Recruitment for Acute Oncologists and Acute Oncology Nurses began in spring 2015. It is hoped the first post holders will be appointed during the summer. It is proposed that there will be a formal launch of the service in January 2015. NiCaN are developing Regional Clinical Guidelines, a Network Induction Policy and marketing/educational material for Trust Acute Oncology Teams. It is anticipated that a Network Clinical Reference Group will be established when post holders are appointed.

Cancer Patient Experience Survey

The Cancer Patient Experience Survey was issued for the first time in Northern Ireland in 2015. The survey was sent to 5,388 patients who were having treatment for their cancer in hospitals over a defined six month period. The purpose of the survey is to get the views of patients on the care they received and how they can be improved. The survey is being carried out by researchers from Quality health for the Public Health Agency (PHA) and Macmillan Cancer Support. Public reports will be produced that will include the anonymous survey findings and these will be benchmarked against similar surveys carried out in England and Wales.

The response rate was 62%.

Transforming Cancer Follow-Up Programme

"After care is an after-thought" was a key message heard at a regional workshop for people affected by cancer. This provided the impetus to organise a multi-professional workshop, raising awareness of survivorship needs. A partnership between Macmillan, DHSSPS, HSCB, PHA and NiCaN was formed and the Transforming Cancer Follow-Up (TCFU) initiative launched November 2010.

The TCFU Project team had regional and local project managers working closely with clinical teams to progress the change programme.

The programme's aims for breast and prostate cancer follow-up were to:

- Improve the patient experience and promote health & well-being
- Enhance communication and coordination of care
- Maximise use of resources.

Utilising different methodological approaches enabled the development of a framework for action. These include service improvement, practice development methodology, co-production principles, lean processes, project management and realistic evaluation. Methods include stakeholder engagement workshops, lean project plans, process mapping events, plan-do-study-act cycles and target setting.

Improved patients' experience and enhanced coordination of care:

- 90% reported their mammogram appointments took place on time
- Regionally prostate patients are moving onto new pathways aided by Clinical Nurse Specialists
- Health and wellbeing events have shown 33% increase in patients being made aware of the importance of lifestyle changes and 26% increase in support to manage physical impacts of cancer

Significant improvements in resource utilisation:

- 58% of new breast cancer patients are allocated to a self-directed aftercare pathway
- 2,952 appointments reduced in waiting lists across breast services.
- 39% reduction in dual specialty follow-up
- No additional oncology review waiting lists clinics required (63 required in 2010/2011)
- A NICA Survivorship website was established

Significant learning has been harnessed with extensive pathway redesign taking place in some other regional tumour groups. The learning from this project is easily transferable to other non-cancer areas, and interest in the approach adopted is increasing.

Oncology Provision

Oncology treatment is provided at the Cancer Centre on the Belfast City Hospital site of the Belfast Trust, and at four units at the Antrim, Craigavon, Altnagelvin and the Ulster Hospitals. All Consultant Oncologists hold contracts with the Belfast Trust. Each of the units have oncology provision from visiting medical and clinical oncologists to ensure local provision of chemotherapy treatment for patients across Northern Ireland.

Oncology at the Units

The Consultant Oncologists contracted to the Belfast Trust attend Lung/GU, GI and Breast clinics at each of the four cancer units. While work is ongoing with commissioners to ensure that all clinics have at least two Consultants attending, there remain a number of single handed clinics, with obvious vulnerabilities.

Cancer Services by HSC Trust

Belfast Health & Social Care Trust

With an annual budget of approximately £1.2bn and a workforce of around 20,000 staff, Belfast Trust is one of the largest Trusts in the United Kingdom. It has approximately 2000 beds and provides cancer services across four hospital sites: Belfast City hospital, Royal Victoria Hospital, Mater Hospital and Musgrave Park Hospital. The Trust is commissioned by the Health and Social Care Board and Public Health Agency.

Belfast Trust delivers local cancer care to approximately 340,000 citizens in Belfast and part of the Borough of Castlereagh. The Trust has a large area of social deprivation in North and West Belfast and pockets of deprivation in South and East which impact on cancer incidence in these areas. Belfast Trust also serves as a tertiary cancer centre for the population of Northern Ireland (1.8 million). It provides inpatient and outpatient services for a wide range of specialties and acts as a regional provider for rare cancers and complex treatments including bone marrow transplantation, radiotherapy and complex surgery.

Specialist palliative care is provided by the Trust in both hospital and community settings. The Trust has a support and information centre on two sites, Belfast City Hospital and the Royal Victoria Hospital, offering information, wig services, classes, counselling, CAB, complementary therapies and psychology services.

The regional oncology service is hosted by Belfast Trust, delivered from the Cancer Centre, employing over 35 wte Consultant Oncologists. This team provide an oncology service to the local Belfast population, oncology SACT services for the core tumour sites (breast, lung, GU and colorectal) at the four other Health Trusts on a hub and spoke model, and provide regional/specialist services for patients across NI.

Radiotherapy is delivered solely at the Cancer Centre. There are 10 linear accelerators, 3 simulator / CT's and a gynae and prostate brachytherapy service. Intensity Modulated Radiotherapy (IMRT), including Volumetric Arc Therapy (VMAT or 'Rapidarc') is well established. Image-Guided Radiotherapy (IGRT) has been further progressed with 4DCT planning and availability of Cone Beam CT (CBCT). Plans are in place to develop a cranial stereotactic service, and there is a fledgling service for lung stereotactic ablative body radiotherapy (SABR). A second radiotherapy service is planned to open in the Western HSC Trust in 2016.

Cancer clinical trials are co-ordinated by the Northern Ireland Cancer Trials Centre (NICTC), which is based in the Belfast Trust. The NICTC works in active partnership with Queen's University Belfast, the Research and Development Division of the Public Health Agency, Cancer Research UK and Friends of the Cancer Centre to deliver this service.

The Trust currently has 16 Multidisciplinary meetings, 9 of which act as specialist MDTs for the region. The majority of which are supported by an MDT coordinator. The Trust continuously strives to improve patient pathways and the effectiveness of the Cancer MDTs with its clinical teams and in conjunction with the Northern Ireland Cancer Network (NICaN).

While the Trust did not meet the cancer access targets in 2013/14 improvements have been made in this area. The Trust continues to seek ways of improving capacity and service provision but as a tertiary referral centre for the region late referrals have a big impact on the Trust's performance.

Northern Health & Social Care Trust

The Northern Health and Social Care Trust became operational on 1 April 2007 and cover 10 local council areas – Antrim, Ballymena, Ballymoney, Carrickfergus, Coleraine, Cookstown, Larne, Magherafelt, Moyle and Newtownabbey. It provides services for a population of approximately 459,000, the largest resident population in Northern Ireland. It also provides services to the only inhabited island in Northern Ireland, Rathlin. The Northern Coast is also popular with older people as a retirement and holiday venue, additionally the older population is growing significantly with a 24.4% increase in age 65 years or more.

The Northern Trust provides a range of services across 9 different hospitals.

Acute Hospital Services

Acute and emergency hospital services are based on two main sites, at Antrim Area Hospital and at Causeway Hospital in Coleraine.

Antrim site

Number of Beds = 393 inpatient and 27 Day beds

Number of Endoscopy Rooms = 2

Causeway site

Number of Beds = 210 in-patient beds and 22 day beds

Number of Endoscopy Rooms = 1

Sub-acute services in the Northern Trust are provided at:

Mid Ulster Hospital, Magherafelt and Whiteabbey Hospital

Minor injuries units are located in Mid Ulster and Whiteabbey.

Our Minor Injuries leaflet explains the treatment which is provided at each.

Community hospital services are provided at:

Braid Valley Hospital, Ballymena

Dalriada Hospital, Ballycastle

Moyle Hospital, Larne

Robinson Hospital, Ballymoney

The Trust provides histopathology and radiology services. Both acute hospitals in Antrim and Coleraine have all facilities required for an Acute Hospital - emergency care outpatients, theatre, day procedure unit, endoscopy, In-patient acute care including medical, surgical, Gynae, CCU, intensive care services etc. MRI services are provided from Antrim Hospital. There is a 12 bedded Macmillan Palliative Care unit based at the Antrim site.

An outreach oncology service is provided to the Northern Trust patients at the Antrim site by the Oncology service from the Belfast Trust, with outpatient and treatment clinics on Monday, Tuesday and Wednesday.

There has been good progress across all MDMs since Peer review in 2010.

South Eastern Health & Social Care Trust

The South Eastern Health & Social Care Trust is an integrated community and acute hospital Trust which provides integrated health and social care services. It provides general hospital services at the Ulster and Lagan Valley Hospitals and a comprehensive range of health, social and primary care services at one enhanced local Hospital in Downpatrick (Downe Hospital), one Mental Health Hospital in Downpatrick (Downshire) and two community Hospitals located at Bangor and Newtownards. Community bases are located in many local towns and villages from Moira in the West to Portaferry in the East and from Bangor in the North to Newcastle in the South.

The Trust covers the local government districts of North Down, Ards, Down and Lisburn incorporating an area of approximately 425 square miles stretching from Lough Neagh to Newcastle with a total population of 346,911 residents (NI Census). Although covering a relatively small geographical area in comparison to other Trusts across Northern Ireland, SET delivers services to 19 per cent of the total population of Northern Ireland.

However, the Ulster Hospital provides general acute services not only to the population of the four District Council areas (North Down, Ards, Down and Lisburn) but to a wider population of approximately 440,000, including a proportion of the East Belfast population.

In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, embracing areas of relative wealth and prosperity as well as pockets of considerable deprivation and need.

Overall the trust provides a total of 1101 beds with 943 inpatient beds with an additional 158 beds used during the day.

Patients are referred to the Trust with all of the main cancers for diagnostic and surgical treatment; this includes breast, colorectal, gynaecology, urology, lung and upper GI. Some cancers operate a shared arrangement and proceed to the Cancer Centre for surgery such as lung and gynaecology. Paediatric and orthopaedic related primary cancers are directly referred to the cancer centre. In addition chemotherapy services are available for all common cancers.

The chemotherapy unit provides day unit facilities for administration of parenteral chemotherapy, supportive therapies, blood product support, infusion of immunoglobulin, venesection and procedures such as bone marrow biopsy. Chemotherapy is dispensed by a team of specialist Pharmacists in the Aseptic suite at pharmacy and is administered by a

specialist nursing team in the day unit. A Helpline is provided for patients attending for chemotherapy treatment on a 24 hour basis with a triage assessment mechanism.

The Oncology Service is delivered on an outreach basis by the Belfast Trust with visiting oncologists providing outpatient clinics enabling onsite chemotherapy with access to radiotherapy in the Belfast Trust. A total of 11 sessions per week are provided.

There are four Consultant Haematologists in post supported by three specialty doctors, one SHO and one Haematology Clinical Nurse Specialist. The haematology inpatient ward has 12 beds and access to the day unit facilities. The Haematology Service is part of the Medical Specialties Directorate which also includes Emergency Medicine, Cardiology, Renal services and General Medicine and Elderly Care.

The palliative care team has 2.5 WTE Consultants in Palliative Medicine and provides both inpatient and outpatient services including advice concerning symptom control. There is access to counselling provided by Cancer Focus NI and clinical psychology provided by Dr Maggie Moore.

Range of diagnostic imaging examinations available:

CT Imaging Systems	2 CT systems at Ulster (40 & 64 slice configurations) 1 CT system at Downe (64 slice configuration) 1 CT system at Lagan Valley (64 slice configuration)
Magnetic Resonance Imaging (MRI)	2 MR Imaging systems at Ulster
Ultrasound Imaging Systems	6 Ultrasound systems, Ulster 2 Ultrasound systems, LVH 2 Ultrasound systems, Downe
Mammography Imaging	1 imaging system, Ulster

Southern Health & Social Care Trust (SHSCT)

SHSCT was established on 1 April 2007. The Trust provides a wide range of hospital, community and primary care services primarily to the populations of Armagh, Banbridge, Craigavon, Dungannon, Newry & Mourne. The hospital services provided by the Trust are also used by people from many other areas in Northern Ireland.

The Trust:-

- Employs approximately 13,000 staff
- Covers a population of 362,711

There are 664 acute in patient hospital beds in the 2 main hospital sites:-

- Craigavon Area Hospital 452
- Daisy Hill Hospital 212

SHSCT provides all acute services including – emergency care, outpatients, theatres, day procedure unit, endoscopy, inpatient acute care including medical, surgical, gynae, intensive care services etc

Imaging and Testing

There are 17 consultant radiologists within SHSCT.

Imaging equipment includes CT Scanners, MRI scanners, Nuclear Scanner, US scanners, general X-ray equipment, mammography equipment.

Tests provided include ultrasounds, nuclear medicine scans, CT, MRI, plain film, fluoroscopy, mammography, ERCP, EUS

Endoscopy is undertaken on 3 hospital sites, Craigavon, South Tyrone and Daisy Hill Hospital. There are 3 endoscopy rooms which undertake colonoscopy, OGD, flexible sigmoidoscopy and cystoscopy

There are 6 Histopathologists for the SHSCT

There are Clinical Nurse Specialists for each of the following tumour sites; lung, colorectal, breast, gynae, acute oncology and palliative care. Further information on job plans and WTE is available within Trust and MDT documentation.

Western Health and Social Care Trust

The Western Health and Social Care Trust (Western Trust) was established on 1 April 2007 under the Review of Public Administration. The Trust brought together the delivery of Health and Social Care which previously had been provided by three separate Trusts, namely Altnagelvin, Foyle and Sperrin Lakelands Trusts. The Trust provides services across five council areas (Limavady, Derry, Strabane, Omagh and Fermanagh) and covers 4,842 square kilometres of landmass. Services are provided to approximately 300,000 people. The Trust employs almost 12,500 staff and invests approximately £422 million in the delivery of a comprehensive range of Health and Social Care Services. The vast majority of services are provided in Community based settings with access to specialist inpatient services available from a number of hospitals such as Altnagelvin, Gransha, Waterside, Lakeview, Erne, Tyrone County, Tyrone and Fermanagh.

WHSC Vision:

"To provide high quality patient and client-focused Health and Social Care Services through well trained staff with high morale"

Altnagelvin area Hospital is an acute hospital which offers a range of services, including a 24 hours accident and emergency department and is one of Northern Ireland's designated cancer units. The hospital has 481 inpatient beds and 48 day case beds.

The cancer unit is based on the Altnagelvin site and host seven multidisciplinary tumour teams:

- Lung – Linked to South Western Acute Hospital in Enniskillen (SWAH) and cancer centre Belfast
- Colorectal – Linked to SWAH
- Upper GI – Linked to SWAH and cancer centre Belfast
- Breast – Linked to SWAH
- Urology – Linked to Northern Trust and Cancer Centre Belfast
- Gynaecology – Linked to SWAH and Cancer Centre Belfast
- Haematology - Linked to Northern Trust

The Trust offers local cancer services, surgery medicine, chemotherapy and specialist palliative care, servicing a total population of approximately 300,000.

Cancer services facilities are situated in a purpose built faculty within the new South Wing on the Altnagelvin hospital site. The facilities consist of:

Inpatient ward combined Haematology and oncology with 14 beds operational 7 days a week 24 hours a day.

Chemotherapy suite with 17 chairs and 4 treatment rooms operational Monday to Friday. Outpatient clinic faculty with 9 consultation rooms operational Monday to Friday 0800 – 1700.

Western Trust continues to make progress on the Radiotherapy development project, now awaiting full approval prior to contract being awarded when construction work will then commence. It is anticipated that the department will be operational by mid-2016.

The second hospital is Tyrone County Hospital which is situated 40 miles from the Cancer Unit. The Trust has gone through the process of Review of Public Administration, for the WHSCT, this brought about a change to the level of care provided on the Tyrone County Site. The Hospital was remodelled from an Acute Hospital Site to a Community Hospital as from February 2009. The range of services provided on the Tyrone County Site, are predominately outpatient centred. The Tyrone County Site serves a population of 51,030 which is largely rural in nature with limited public transport facilities. This site is also undergoing a substantial redevelopment programme, which will see phase one of the development moving the Tyrone County Site into a local enhanced hospital complex. The complex will consist of a Health and Care centre and GP facilities.

The third hospital site is the new South West Acute Hospital (SWAH) which was opened on 21st June 2012 and serves a population of 60,570 again this location is predominately rural in nature with limited public transport infrastructure. The SWAH provides a range of acute services and has a bed compliment of 312 inpatient and day case beds.

The travel times and distance between the hospital sites are as described below:

Hospital Site	To Hospital Site	Miles	Time
Altnagelvin Hospital	Tyrone County Hospital, Omagh	36	1 Hour each way
Omagh Hospital	Erne Hospital	30	45 mins
Altnagelvin Hospital	Erne Hospital	59	1.30 mins

The population is dispersed across a mixed urban and rural environment. The road infrastructure and public transport support is poor.

Specialist Palliative Care Services: Workforce overview

Guidance from the National Council for Hospice and Specialist Palliative Care states that while the NICE guidelines give some indication about the minimum range of services to be provided for any given population, it does not offer guidance about the volume of services required. It therefore advises flexibility in the commissioning of services based on local need, demographics, mortality rates and user views. The majority of specialist staff are funded or have been pump primed by the voluntary hospice sector or the Cancer Charities.

There is now a dedicated specialist palliative care service, in every hospital in the region though the numbers and variety of disciplines involved varies. Several teams have a core membership of dedicated staff with an extended membership of colleagues who provide some sessions to palliative care as well as their generic caseload.

Further information on Specialist Palliative Care workforce is contained within each Trust/MDT's documentation.

Appendix 1: Cancer Epidemiology Information Northern Ireland

Table 1. % Patients Discussed at Multi-Disciplinary Team Meetings (MDT) IN 2013: Data source CaPPS*

Site	Number	%
Stomach	192/196	98%
Oesophagus	223/227	98%
Lung	1097/1110	99%
Colon	849/853	99%
Rectum	283/285	99%
Ovary	154/154	100%
Prostate	859/932	92%
Breast	1391/1403	99%
Pancreas	184/186	99%

* Cancer Patient Pathway System (CaPPS)

Table 2. % Patients with Cancer Staged 2012: Data source N. Ireland Cancer Registry

	Patients	%
Stomach	91/151	60%
Oesophagus	159/243	65%
Lung*	956/1103	87%
Colon	755/850	89%
Rectum	318/352	90%
Ovary	148/173	86%
Prostate	948/1025	93%
Breast	1221/1318	93%
Pancreas	154/245	63%
Cervix	90/93	97%

* Lucada 2012 data

Table 3: % Patients referred to oncology 2013: Data source CaPPS

Site	2013	%
Lung	771/1110	70%
Colorectal	417/853	49%
Prostate	177/285	62%
Uterus	89/154	58%
Breast	887/1403	63%



Urology Network Site Specific Group Meeting
Friday 30th January 2015
2.30pm-4.30pm, Conference room 2, Linenhall Street

Record of Discussion & Agreed Actions

In Attendance	Aidan O'Brien, Mary Haughey, Mary Jo Thompson, Edel Aughey, Robin Gray, Suneil Jain, Darren Mitchell, Teresa Majury, Pat Sheils, Alison Downey, Rae Browne, Patricia Thompson, Lin Shum, Rae Browne, Karen Parsons, Kate White,
Teleconference	Fiona Reddick, Kate O'Neill, Gareth McClean, Gerry Millar
Apologies	Elizabeth England, Moyra Mills, Kerry Chambers, Jackie Harney, Thamra Ayton, Harry Lockhart, Hugh O'Kane, Ali Thwaini, Karen Johnston, Wilma Boyd Carson, Davinia Lee

	Item	Responsibility / Date
1.	Welcome, Introductions & Apologies Mr Aidan O'Brien welcomed everyone to the meeting and invited members to introduce themselves. Edel Aughey advised of her role as Macmillan Service Improvement Lead for Patient information and the Recovery Package. Alison Downey, SHO, was there to present the outcomes of cystectomy for bladder cancer 2012-2014.	
2.	Minutes of Last Meeting Minutes of the last meeting were read and agreed. Matters Arising: AP1 Letter to DLA Advisory Board: Mr O'Brien advised that he has written a letter to the DLA Advisory Board highlighting the significance of fatigue for people with cancer and referenced the statistics from the information presented by Anna Gavin at the last network meeting. Mr O'Brien offered to meet with the DLA Advisory Board along with Dr Gerry Millar. To date, there has been no response. A task and finish group has been established to assess the current pathway for patients with gastro-intestinal consequences following	

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	pelvic radiotherapy treatment. Ms Edel Aughey will support the group in her new role. It was also noted that Dr Suneil Jain will be invited to be involved in the group from an oncology perspective. Further updates will be provided at future network meetings. All other matters will be covered on the agenda.	
3.	Urology guidelines & pathways Regional hormone therapy guideline & pathway: Mr O'Brien extended thanks to Dr Darren Mitchell and Dr Suneil Jain for their work in taking this forward. Dr Mitchell advised that the draft guideline has been circulated to oncology colleagues for comment and to pharmacy to advise regard licensing restrictions. It was proposed that the guideline and pathway would also be circulated to the Urology Network Group for consultation. A deadline date of end of February 2015 was agreed. Mr O'Brien queried if bone densitometry testing should be considered within the guidance. Dr Mitchell advised that he would review guidance regard this. AP1: All members to forward comments on the draft guideline and pathway by end of February 2015 Patient Care pathways: Mr O'Brien advised that he is currently reviewing and updating all pathways. Clinical management guidelines: Surgical: Mr Ali Thwaini is currently developing new surgical guidelines and will have them completed for the next Urology network meeting. Imaging: Ms Haughey advised that Dr Arthur Grey has proposed that the updated Yorkshire network imaging guidelines are adopted by the network group – this has been agreed by Dr Stephen Vallely and Dr Eoin Napier. It was agreed that the imaging guidelines would be circulated to all members for information. AP2: Ms Haughey to circulated Yorkshire imaging guidelines to all members. Pathology: Dr Gareth Mc Clean advised that he had reviewed the EAU guidelines which detailed some sections on pathology. He highlighted that the Royal College of Pathologists has produced datasets across all sites and it may be appropriate to reference these as opposed to providing a large amount of detail within the guidelines. Mr O'Brien concurred as long as there is assurance of compliance here to the datasets. Ms Haughey advised that reference to datasets was provided for some of the other tumour sites and agreed to forward an example to Dr McClean. AP3: Ms Haughey to forward an example of a pathology guideline from another tumour site to Dr McClean Radiotherapy protocol: Need to check about including this protocol within the guidelines Nursing section: Ms Kate O'Neill, Ms Patricia Thompson and Ms Kerry Chambers to work together on developing a nursing section within the guideline to include reference to the inclusion of the recovery package.	All members by end of Feb'15 Ms Haughey Ms Haughey

	AP4: Ms O'Neill, Ms Thompson and Ms Chambers to develop nursing section for inclusion in the guidelines before next network meeting. <u>Follow up section:</u> All TCFU pathways to be included. Mr O'Brien updated members on the outpatient model which is being followed in SHSCT. CT scans / tests are arranged for patients prior to attending their outpatient appointment. This ensures that the outpatient visit is definitive; the patient will either be discharged or placed on a waiting list for a therapeutic procedure. The key worker is also introduced to the patient at the first visit. The patient is usually seen within 2-3 weeks with most tests already completed. Dr Gerry Millar advised there is a need to improve information flow to patients and GPs as there is still uncertainty regard what is going to happen and when and this would help to manage patient's fears. Communicating with patients in a timely manner can be an issue as patients are reluctant to answer phone if it is a withheld number. It was suggested that it would be useful to do an audit of the new system against the previous system to see if it works. It was noted that the model only works if there is good tracking as this will help to identify dates for surgery within the 62 day timeline. <u>NICE consultations:</u> there are currently two consultations out regard bladder cancer and the draft prostate quality standards. Mr O'Brien noted the increasing reference of MRI scanning prior to first biopsy in the draft prostate guidance. It was observed that more MRI capacity is required to make this change and that this issue has been flagged with commissioners.	Ms O'Neill, Ms Thompson & Ms Chambers
4.	Targeted Service Improvement Activity Ms Mary Jo Thompson advised that Ms Lynne Charlton is currently leading the review of the regional urology service and has been linking with individual teams regard taking this forward. Ms Charlton had indicated there was an indicative 40% increase in red flag referrals and would be keen to understand what this is reflective off and queried if there were any changes to the microscopic haematuria pathway or any other reasons. Ms Thompson suggested that the Be Clear on Cancer "Blood in Pee" campaign may have impacted on an increase in referrals. Dr Millar highlighted the difficulty by GPs in accessing investigations e.g. ultrasounds, and there could be a reduction of referrals to secondary care if there was better and timely access to diagnostic testing.	
5.	Audit i) Audit of patient outcomes following radical cystectomy Mr O'Brien invited Alison Downey to present the audit of patient outcomes following radical cystectomy. Hard copies of the audit were circulated to all members for information. Data included source of referral, timing from TURBT to radical surgery, indications, peri-operative outcomes, incidental prostate cancer, complications, re-admissions and survival. 110 patients were identified in the timeframe from 04/01/2012 to 22/07/2014, gender breakdown of 95 male patients, 15 female patients and median age of 66 years.	

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	Following the presentation, Mr O'Brien thanked Ms Downey and asked for questions / comments from members: ➤ It was noted that there was no chart review of patients, data was retrieved from PAS, ECR, Link Labs, BAUS database and CaPPS ➤ Oldest patient was aged early 80's ➤ Average length of stay was 2.5 months and it was noted that there is more disease progression if stay is delayed beyond 3 months ➤ Mortality rates are consistent with national figures: 34% death rate, 66% survivor rate ➤ Greater number of lymph nodes retrieved – 20-30 lymph nodes, survival marginal benefit is equivalent to neo-adjuvant chemotherapy ➤ Dr Suneil Jain suggested looking at some standards in relation to the audit e.g. reported rates of neo-adjuvant chemotherapy ➤ There were a significant number unrecorded for pre-op neo-adjuvant chemotherapy and form of urinary diversion - though it was noted that there was no access to COHIS. This highlights the need for clinical teams to document information. ➤ Approximately one third of patients undergoing lymph node resection were node positive – members queried if this was higher than should be? ➤ Pre-op staging provides 5-10% increase of survival benefit ➤ A pathological based audit is required to look at the management of all patients with muscle invasive disease ➤ Radical radiotherapy for bladder – survival comparable for 50% of patients, should be re-run for neo-adjuvant patients ➤ CT scanning is difficult to use for staging bladder cancer, MRI should be considered ➤ For the data which was not on ECR, Mr O'Brien suggested contacting Mr Ali Thwaini to gain access to Lablinks which has a repository of histologies in BHSCT AP5: Ms Downey to send the database, without patient names, to Dr Darren Mitchell, and he will re-run audit for neo-adjuvant patients ii) Erectile & lower urinary tract dysfunction following radical prostatectomy audit AP6: Mr Hugh O'Kane will present audit findings at the next network meeting.	
6.	Peer review Ms Haughey advised that upload of documentation is the 18th May and the peer review visits are scheduled for the weeks of 15th and 22nd June across different trusts. Ms Haughey outlined the structure of the visit and timescale for resulting reports. Peer review training is taking place on Thursday 16th April 2015 and members should book a place through their Trust Cancer Manager.	
7.	TCFU Prostate Sub group Ms Thompson referenced the progress report on prostate follow-up implementation which was circulated prior to the meeting. This provided an update on prostate cancer patients moving onto shared care / nurse led pathways across all of the Trusts.	

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	It was noted that the follow-up pathways are being implemented at varying degrees and Prostate cancer follow-up has come a long way to moving patients to nurse led follow up. Ms Thompson also provided an update on the PSA IT Tracking feature within RISOH. The triggers are set at disease level though further work is required with the developers to ensure functionality. The tracking feature is allocated an identifier reflective of the PSA tracking category, including a prefix to indicate what trust. A search can also be initiated via the patient health and care number. Customised reports can be written to facilitate reporting requirements and letters can be set up for correspondence. It is envisaged that the RISOH system will go live from 20th April in BHSCT for oncology moving on to other trust sites over a five week period with a final go live on 15th June for haematology. Staff can start to utilise once go live. PAS virtual clinics to be developed within trusts to facilitate timely monitoring and training for staff will be rolled out. Stage 3 TCFU evaluation: – PWC has completed the evaluation. The draft report is currently out for comment and when finalised, it will be issued to stakeholders.	
8.	Updates Clinical Trials: Dr Suneil Jain advised that 8 trials are due to open in next year for local and metastatic prostate cancer and these will help to improve access to new therapies. Members highlighted the importance of dedicated staff within trusts to support recruitment of suitable patients for trials. Cancer Patient Experience Survey: Ms Haughey advised that the survey will be issued within the next week or two and will be sent to over 5,000 patients who received treatment for cancer over a defined six month period. It is hoped that interim trust reports will be available prior to peer review upload. It was also acknowledged that trusts are carrying out their own surveys to capture patient experience and feedback for peer review. Prostate Cancer UK research: Ms Haughey advised that PCUK carried out a nursing survey and a report will be published in March. Ms Haughey advised that PCUK researcher, Morven Masterson, has offered to present the finding of the study at a future network group meeting. PCUK BHSCT Physiotherapy pilot: Ms Thamra Ayton was unable to attend the meeting but has advised that her-self and Alison Robinson started the 18 month pilot on 19th January 2015. The next few months will involve background work: setting up the service, pathways, patient recruitment, assessment forms, outcome measures and meeting with nursing and medical colleagues. A further update will be provided at the next meeting.	

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9.	Emerging Issues Presentation of completed audits: It was agreed that it would be useful to present findings / recommendations from completed Trust audits at the next network meeting. Completed audits include the Brachytherapy audit, Patient history audit, the Docetaxel neutropenic sepsis audit, and possibly a Bladder chemo audit. AP7: Dr Darren Mitchell and Dr Lin Shum to contact relevant audit personnel regard summaries of completed audits for presentation at the next network meeting	Drs' Darren Mitchell & Lin Shum
10.	Date of Next Meeting Friday 17 April 2015 at 2.30pm – 4.30pm in Conference room 4, Linenhall Street, Belfast.	

2.30pm-4.30pm, Conference room 4, Linenhall Street, Belfast

In Attendance	Aidan O'Brien (SHSCT), Mary Haughey (NICaN), Suneil Jain (BHSCT), Darren Mitchell (BHSCT), Mary Jo Thompson (PHA/NICaN), Edel Aughey (NICaN), Chris Hagan (BHSCT), Ali Thwaini (BHSCT), Thamra Ayton (BHSCT), Hugh O'Kane (BHSCT), Pat Sheils (BHSCT), Jacque Warwick (BHSCT), Karen Parsons (BHSCT), Melanie Blackwood (BHSCT), Ruth Johnston (BHSCT)
Teleconference	Moyra Mills (NHSCT)
Videoconference	Gareth McClean (SHSCT), Kate O'Neill (SHSCT)
Apologies	Fiona Reddick (SHSCT), Davinia Lee (BHSCT), Patricia Thompson, Elizabeth England (WHSCT), Robin Gray (PPI rep), Teresa Majury (PPI Rep), Harry Lockhart (PPI Rep), Samantha Thompson (BHSCT)

	Item	Responsibility / Date
1.	Welcome & Introductions Aidan O'Brien welcomed everyone to the meeting and apologies were recorded as above.	
2.	Minutes of last meeting The minutes of the last meeting were Matters arising: i) <u>Letter to DLA Advisory Board:</u> Mr O'Brien advised that he had spoken to the ATOS Director and she welcomed an opportunity for the network group to make representation regard the lasting impacts of cancer with a particular focus on fatigue. The Director proposed a meeting is set up with herself and the medical assessor before the end of June to discuss further. Mr O'Brien suggested that an oncologist and a GP should also attend the meeting. Ms Edel Aughey highlighted the fatigue management programme and the need for further promotion to clinicians. Ms Thamra Ayton advised that she would speak to Jane Rankin regard AHP representation and to Janet Morrison, Macmillan Information Manager.	
	Action point 1: Mr O'Brien to arrange a meeting with ATOS before end of June and to invite key people to attend as highlighted	Aidan O'Brien

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	above. ii) <u>Regional Urology meeting</u>: Ms Mary Jo Thompson advised that Ms Lynne Charlton & Ms Sara Long are facilitating a Regional urology meeting on 30th April 2015 in Linenhall Street, chaired by Mr Dean Sullivan. Mr O'Brien advised that he would be attending in his capacity as SHSCT MDM Chair but it was agreed that it would be useful to have further representation on behalf of the Network Group. Action point 2: Ms Mary Jo Thompson to contact Lynne Charlton to seek Urology network group representation at the meeting iii) <u>Audit of patient outcomes following radical cystectomy</u>: This audit was presented by Ms Alison Downey at the last meeting. Mr Darren Mitchell advised that he had not received the database to re-run the audit for neo-adjuvant patients. Action point 3: Mr Hugh O'Kane agreed to follow this up. iv) <u>Audit on erectile & lower urinary tract dysfunction following radical prostatectomy</u>: Mr Hugh O'Kane advised that this audit is on-going and will be presented at the regional Urology audit meeting next month. He advised that a registrar could present at a future network meeting. Action point 4: Mr Hugh O'Kane to arrange for presentation of audit at next network meeting.	Mary Jo Thompson Hugh O'Kane Hugh O'Kane
3.	Urology guidelines & pathways Regional hormone therapy guideline & pathway: Following the last network meeting, the guideline and pathway were circulated to all network members for comment. Dr Darren Mitchell advised that he had received no comments to date. Mr O'Brien queried the term 'shared care' used in the pathway and thought that this may require clarification as it implies shared care with GPs. Action point 5: Ms Mary Jo Thompson agreed to review and define the term. Action point 6: Dr Mitchell advised that he will send the guideline to pharmacy colleagues to clarify licensing restrictions and following this, the document will be ready for final sign off. Clinical Management Guidelines: A draft version of the guidelines was circulated to members prior to the meeting. It was noted that Mr Ali Thwaini has done extensive work in reviewing and developing guidelines for Bladder, Prostate, Penile, Renal Cell, Testicular & Upper Urinary Tract Urothelial Cell Carcinomas, using the EAU guidelines as a template and including others from BAUS, NICE, NHS England and the Improvement of Outcomes Guidelines (IOG). Mr Thwaini advised that he would need to circulate the draft document to other colleagues for review and to ensure it is in accordance with other appropriate guidelines.	Mary Jo Thompson Darren Mitchell

Mary Haughey 300415

	Ms Mary Haughey advised that the updated Yorkshire Imaging guideline were adopted following review by the lead authors. Dr Gareth McClean advised that he had consulted with colleagues to adopt the Royal College of Pathologists datasets. Ms Haughey advised that the existing SACT and Radiotherapy guidelines / protocols have been referenced in the document. Ms Kate O'Neill in partnership with nursing colleagues has developed the nursing section and it was also noted that the TCFU Prostate follow up documents have been included in the document. It was noted that the network should consider follow up pathways for other groups of patients besides prostate patients. There was discussion on whether Mr Thwaini should remove the chemotherapy and radiotherapy sections from his sections as they are already referenced under the relevant sections. Ms Haughey advised that the network group needs to agree guidelines and pathways which are circulated to trust MDTs – this needs to happen before the peer review documentation upload on 18th May. As there will not be a network meeting before this, it was agreed that the most up to date version would be sent to trusts with a rider that the document was still under review. Action point 7: Mr Ali Thwaini to circulate guidelines to relevant colleagues for review and comment. Pathways: Mr O'Brien advised that there are referral pathways, patient pathways and follow-up pathways. He has reviewed all the Urology care pathways and is content that they do not require any further update at this time. Follow up: It was highlighted that follow up pathways should be considered for other groups of patients besides prostate patients. There was discussion on the need to review all national guidance in relation to a number of procedures that are not currently available in Northern Ireland. Mr Chris Hagan suggested that the Urology CMGs should consider the inclusion of unique solutions to problems of managing cancer in NI when there are smaller volumes. Reference was made to the fact that patients currently travel to England for robotic prostatectomy under current commissioning arrangements and that a proposal for robotic surgery is being developed by BHSCT.	Mr Ali Thwaini
4.	Clinical Trials Dr Suneil Jain referred to the annual report on urology cancer trial activity 2014 which was developed by Melanie Morris from the NI Cancer Trials Network and was circulated to members prior to the meeting. Dr Jain highlighted that during 2014, 1415 participants, (16.6%) of incidental cancers, were recruited into regional cancer clinical trials, 2.7% of participants (235) received interventional, systemic or radiotherapy treatment. There were 14 urological cancer trials open to recruitment during this time and a total of 495 participants were recruited into urology cancer studies, with 59 participants into interventional trials. There were ten prostate trials which recruited 144 participants, there were two open testicular trials and only one randomised controlled trial (STAR) available for renal cell cancer, which was halted due to limited staff and will re-open for recruitment in April 2015.	

Mary Haughey 300415

	Urological cancer clinical trial activity is increasing at the Cancer Units, not only in identifying patients but also supporting full trial activity for studies such as UKGPC and HaBio. Dr Jain advised that further information on all open urological trials in 2014 was detailed in the report.	
5.	Peer review update All trusts are preparing documentation for upload on the 18th May. Visits are scheduled for weeks of 15th and 22nd June 2015. Some members attended the peer review training on 16th April 2015 and feedback was that it was very informative. It was noted that there may be network actions after the peer review visits which may need discussion / action at the next network group meeting.	
6.	TCFU Prostate sub group Implementation of pathways: Ms Mary Jo Thompson advised that the TCFU project team finished in December 2014 and work is on-going within trusts to implement the prostate pathways though it was noted that the focus has been on surgical rather than oncology. Ms Thompson advised that Macmillan Service Improvement Leads posts for trusts are being recruited to support the transformation of cancer services. Ms Thompson also advised that the HSCB and PHA have been requested to develop a risk-based, prioritised, incremental development plan to address the gaps in the specialist cancer nursing workforce. This plan will be supported through charitable organisations using a pump prime model. A recent workshop in March has begun the discussion with key stakeholders on how this programme will be managed and prioritised across the region and across tumour sites. It was noted that there needs to be flexibility of how these nurse roles are utilised to ensure best use of time and cost effectiveness and consideration of skill mix. Chemotherapy prescribing nurses will be looked at through the chemotherapy review work stream. It was also highlighted that Friends of the Cancer Centre in partnership with Belfast trust have a CNS development programme currently underway. The TCFU evaluation report has been signed off and will be circulated to key stakeholders. Ms Edel Aughey advised that a Gastro-Intestinal (GI) Consequences of Pelvic Radiotherapy task and finish group has been set up following a workshop held last year, to assess the current pathway for patients with gastro-intestinal consequences following pelvic radiotherapy treatment and to bring forward recommendations to improve the pathway and patients' experience. The first meeting took place in February 2015, and the group is establishing a baseline of patients affected, identifying clinical champions in each trust, implementing a redesigned pathway to include patient information, raising awareness with GPs and introducing a treatment summary record. They are also going to explore the way forward for patients with complex cases. It was noted that a PSA tracking functionality has been developed for the RISOH system and currently this functionality is being tested.	

Mary Haughey 300415

7.	Updates Cancer Patient Experience Survey: There has been a 62% response rate to the survey which was issued in February 2015 and is closing today. Interim data reports will be available for those MDTs that are being reviewed this year by late April and the full CPES reports will be available by late May 2015. Prostate Cancer UK funded programmes: Dr Jain advised that Charis Integrated Cancer Care had delivered two successful pilot programmes of education and support to individuals affected by prostate cancer and their families from diagnosis onwards. Dr Maura O'Neill advised that the second session took place in Causeway Hospital and was well attended Physiotherapy programme Ms Thamra Ayton advised that the 18 month pilot started on 19th January 2015. Work has been on-going to set up the service, including developing pathways and assessment forms, recruiting patients and agreeing outcome measures. To date 30 patients were identified from the pre-op surgery clinic, 50% were post-op patients, 17% were historical patients. The aim of the programme is to ensure that patients are doing their pelvic floor exercises correctly. From the 10 patients from the pre-op clinic, 4 were doing it correctly, 5 were doing it wrong. Of the 14 post-op patients assessed, 7 could do reasonably well, 7 were doing the exercises wrong and 1 patient was over active, so in this case it is best that they don't do. Ms Ayton advised that referral rates have been good to date and patients are assessed by DRE.	
8.	Emerging Issues There were no emerging issues. Date of next meeting Friday 18th September 2015, 2.30pm-4.30pm, Conference room 4, Linenhall Street, Belfast.	



Urology Network Site Specific Group Meeting
Friday 18th September 2015
2.30pm-4.30pm, Conference room 4, Linenhall Street, Belfast

Record of Discussion & Agreed Actions

In Attendance	Aidan O'Brien (SHSCT), Darren Mitchell (BHSCT), Edel Aughey (NICaN), Ali Thwaini (BHSCT), Hugh O'Kane (BHSCT), Ruth Johnston (BHSCT), Colin Mulholland (WHSCT), Wilma Boyd Carson (SET), Robin Gray (PPI Rep), Mark Haines (SHSCT),
Videoconference	Gareth McClean (SHSCT), Kate O'Neill (SHSCT)
Apologies	Fiona Reddick (SHSCT), Davinia Lee (BHSCT), Elizabeth England (WHSCT), Teresa Majury (PPI Rep), Harry Lockhart (PPI Rep), Samantha Thompson (BHSCT), Mary Haughey (NICaN), Mary Jo Thompson (PHA/NICaN), Chris Hagan (BHSCT), Kerry Chambers (WHSCT), Declan O'Rourke (BHSCT), Thamra Ayton (BHSCT), Suneil Jain (BHSCT), Pat Sheils (BHSCT), Jacque Warwick (BHSCT)

	Item	Responsibility / Date
	Welcome & Introductions Aidan O'Brien welcomed everyone to the meeting and apologies were recorded as above.	
1.	Minutes of last meeting The minutes of the last meeting were agreed. Matters arising: i) <u>Meeting with DLA Advisory Board:</u> Mr O'Brien advised that the meeting with ATOS Director regard the lasting impacts of cancer with a particular focus on fatigue has not yet taken place but will be arranged and he will update the group at the next meeting. Action point 1: Mr O'Brien to arrange a meeting with ATOS and to invite key people to attend. ii) <u>Regional Urology meeting:</u> Mr O'Brien provided update. There have been a number of regional meetings but the local meetings have not taken place as yet. Mr O'Brien would be keen that the NICaN network group would take on one of the sub group roles particularly with regard reviewing and updating clinical management guidelines for suitability of these being implemented in Northern Ireland. Mr O'Brien is keen that the network group agrees local guidelines which	

Mary Haughey 230915

	can be reported back to the HSCB and the regional Urology group by the end of the year. Mr Ali Thwaini advised that local guidelines need to be manageable for NI but should also be in line with UK / National guidelines. Mr Mark Haines queried whether the role of the group is to offer advice to HSCB regard what is clinically appropriate or if HSCB advise the network group what should be done clinically?	
5.	Audits: It was agreed to move agenda item 5 up and Mr O'Brien invited Dr Anna Gavin, NI Cancer Registry, to present an update on the UK wide patient reported outcomes programme for prostate cancer patients. Dr Gavin advised that the programme aims to find out what effect prostate cancer has had on men's physical, emotional and social wellbeing, as well as exploring the impact on their families and will consist of a number of work-streams including dissemination of a UK wide survey, organisational performance and benchmarking, health economics & patient and public involvement. In Northern Ireland, approximately 4,000 men will be surveyed who have been diagnosed with prostate cancer between 18-24 months previously and registered by NI Cancer Registry between 1st July 2012 and 30th June 2014. The survey will cover urinary and bowel functioning, sexual functioning, psychological and social well-being, physical, social and financial concerns. To date, the survey has been developed and ethical approval will be sought after the methodology has been finalised for NI. The expected outcomes include population based patient reported outcomes from UK which will help to identify gaps, organisational performance measured with feedback, toolkit for comparators and to identify factors associated with poor outcomes. Information about the programme was circulated to all members. Mr O'Brien thanked Dr Gavin and queried if the local Research & Development offices should be contacted regarding the research as well as senior personnel within the trusts. There was also some discussion regard how best to correspond with patients living in the different trust areas and there was a suggestion that a cover letter could be issued through NICaN with HSC / Trust logos and the MDT Lead signatures. There was also discussion on the need to ensure death checks are completed through BSO before any correspondence is issued to patients. Action point 1: Ms Edel Aughey to liaise with Lisa McWilliams and Mary Jo Thompson regard using a headed cover letter from NICaN for dissemination of the patient surveys.	Ms Edel Aughey
2.	Peer review: feedback There was discussion around the issues outlined from peer review. The general consensus was that members should work on taking recommendations forward within each of the trust teams including response to immediate / serious concerns raised. In relation to peer review feedback there was a query if a meeting is required to discuss and decide what is feasible in NI and it was agreed that this may require further discussion with the commissioners.	

Mary Haughey 230915

3.	Urology guidelines & pathways Regional hormone therapy guideline & pathway: Following the last network meeting, the guideline and pathway were circulated to all network members for final comment. Dr Darren Mitchell advised that he had received no further comments. Members agreed to ratify the regional guideline and pathway. Clinical Management Guidelines: Reference was made to the updated NICE referral guidance which was issued in June 2015 and the need to ensure that the NICaN regional guidance is in line with the updated NICE guidance. There was discussion on: - the need to look at the pathway for muscle invasive bladder cancer in order to reduce delays for e.g. if patient is offered neo-adjuvant chemotherapy - delivering a partial nephrectomy surgery service Action point 2: Mr Darren Mitchell agreed to provide appropriate wording on the early use of Docetaxel concomitant with androgen deprivation for patients with prostate cancer. Action point 3: All members to review the issues highlighted by Mr O'Brien in relation to the clinical management guidelines and feedback any comments in relation to these.	Mr Darren Mitchell All members
4.	Clinical Trials Information on open urological trials from the NI Clinical Centre was circulated to all members for information.	
6.	TCFU Prostate sub group To be deferred to the next meeting.	
7.	Updates Cancer Service Framework: The urology site specific section for the new Cancer Services Framework was circulated to all members for review and comment back by 4th September 2015. Restructuring to Clinical Reference Groups: Dr Martin Eatock will be writing formally to all the Clinical Leads regard restructuring the existing network groups to Clinical Reference groups. It is proposed that the groups will have a stronger link to HSCB as they will take on the role as expert advisory groups to commissioners. Formal correspondence will be issued shortly.	

	Cancer Patient Experience Survey: The findings from the regional report will be formally launched on Friday 9th October. PCUK BHSCT Physiotherapy programme (written update from Ms Thamra Ayton) There have been 75 referrals to date; the majority of those are pre/post-op surgical patients. 30 men have completed their physiotherapy intervention. Evaluations on whole are good with most men stating they felt it had been beneficial to them to have someone seeing them regularly and guide them in their recovery. Particular emphasis on being examined pre-op in order to be reassured or retaught how to do their pelvic floor muscles correctly. The outcomes are currently being collated. 6 - 8 of these men have signed up for the new Pilates exercise programme in October (pilot being run in conjunction with MacMillan by Will Moore-exercise therapist) to work on combatting fatigue and improving core strength and exercise tolerance. Staff will also be presenting at the Prostate Cancer HWBE in November regard issue of continence. A reminder to all network members that we are happy to accept referrals for any men currently living with Prostate Cancer and having problems with bladder/bowel/pelvic pain.	
8.	Emerging Issues Mr Darren Mitchell raised the issue of oncology radiology cover at Belfast City Hospital which is under significant pressure. There is a real risk that oncology imaging will be out sourced and this would have a real impact on the MDT, overall service quality and would be a significant risk to the service. Davinia Lee has advised that the issue has been escalated to Jennifer Welsh. Date of next meeting Thursday 26th November 2015, 2.30pm-4.30pm, venue to be confirmed.	

Mary Haughey

From: O'Brien, Aidan [Personal Information redacted by the USI]
Sent: 03 May 2015 18:15
To: Mary Haughey; Thwaini, Ali; Darren Mitchell (niecr); Suneil Jain [Personal Information redacted by the USI]
Cc: Chris.hagan [Personal Information redacted by the USI]; Hugh kane (niecr); Colin.Mulholland [Personal Information redacted by the USI]
Subject: RE: Guidelines

Mary et al,

I am concerned with regard to the Clinical Management Guidelines and Peer Review. For too long, we have had our heads in the sand with regard to Clinical Management Guidelines. One good example has been our non-adherence to IOG with regard to the supranetwork aspect of the management of penile and carcinoma. Without prejudice to the views of others, I do suspect that this has been due to the perceived impracticality or inappropriateness of referring all patients with penile carcinoma to a supranetwork centre outside of Northern Ireland. It is unfortunate that we have not sought to have dealt with issues such as this before now, and before being effectively forced to do so by the advent of Peer Review. Yet, that is where we are, and this example is only one of several in the Draft Guidelines compiled by Ali which will require to be considered by NICA Urology in coming months.

As we discussed at our last meeting, I do hope that I have support of members in the intent to address all of the issues in the Guidelines where it may be our contention that we cannot adhere due to incapacities (intravesical chemotherapy, multiparametric MRI, key workshop), unfunded treatments (drugs, robot assisted radical prostatectomy) etc. As you know, I alluded to doing so when we met with Dean Sullivan and colleagues on Thursday 30 April 2015.

I do believe that it would be useful to draw up a draft list of issues or items in the Draft Guidelines that could be included in a preface to those Guidelines and which will relate will be addressed by NICA in coming months prior to discussion and resolution with the Commissioners as an integral part of the further process launched by Dean Sullivan last Thursday.

I do believe that it would be wrong to adopt Guidelines with which we have not been fully adherent and with which we may conclude should not be fully adherent.

Equally well, I believe it would be wrong to rush to decisions regarding these issues prior to a deadline imposed by Peer review.

I would prefer that we were honest with Peer Review, declaring that there are these issues which will be addressed and resolved one way or another with our own Department of Health with the intent of concluding agreed Clinical Management Guidelines for Northern Ireland.

I would welcome your comments, in agreement or otherwise,

Aidan.

From: Mary Haughey [Personal Information redacted by the USI]
Sent: 01 May 2015 09:41
To: Thwaini, Ali; Darren Mitchell (niecr); Suneil Jain [Personal Information redacted by the USI]
Cc: O'Brien, Aidan
Subject: RE: Guidelines

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

Many thanks Ali – I'll link with you toward the end of next week regard the latest version.
Best regards
Mary

From: Thwaini, Ali [Personal Information redacted by the USI]
Sent: 01 May 2015 09:36
To: Darren Mitchell (niecr); Mary Haughey; Suneil Jain [Personal Information redacted by the USI]
Subject: RE: Guidelines

That's brilliant Darren thank you very much for your input. You're right regarding the medications tailored to our local guidelines, and I totally agree that meds that aren't available (yet) should be removed, hence input from the oncology colleagues would be invaluable.

I've already emailed renal and testicular to Bode and Ali/Jane awaiting their update.

Mary

Personally and from the surgical side I would be happy for the guidelines to be uploaded, but it should be stated that they are only draft and are currently undergoing update and some of the treatment may not be available/applicable to the region.

Ali

From: Mitchell, Darren
Sent: 30 April 2015 17:44 [Personal Information redacted by the USI]
To: Mary Haughey; Thwaini, Ali; Suneil Jain [Personal Information redacted by the USI]
Subject: Guidelines

Ali – great work on this. I've a few suggestions – these largely are at the points where I think it would be useful to have a stock phrase (Please see the Systemic Anti-Cancer Therapy guidelines for this disease sub-site) or radiotherapy etc.

I see a few places where there are drug listed which have either never been NICE approved or have been removed from approval. I don't think we can have these listed in our guidelines but then not offer – could be open to challenge.

The Renal sections and testicular sections probably need Bode and ali/jane to comment – I think they'll same.

Might take a few edits to get it where I think it would be ready for signature.

DMM

Dr DM Mitchell FRCR
Consultant in Clinical Oncology
Northern Ireland Cancer Centre
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB



-



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Secretary -

[Personal Information redacted by the USI]

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Mary

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From: Mitchell, Darren
Sent: 30 April 2015 17:44
To: Mary Haughey; Thwaini, Ali; Suneil Jain
Subject: Guidelines

Personal Information redacted by the USI

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I see a few places where there are drug listed which have either never been NICE approved or have been removed from approval. I don't think we can have these listed in our guidelines but then not offer – could be open to challenge.

The Renal sections and testicular sections probably need Bode and ali/jane to comment – I think they'll same.

Might take a few edits to get it where I think it would be ready for signature.

DMM

Dr DM Mitchell FRCR
 Consultant in Clinical Oncology
 Northern Ireland Cancer Centre
 Belfast City Hospital
 Lisburn Road
 Belfast BT9 7AB



Secretary -

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Mary Haughey

From: O'Brien, Aidan [Personal Information redacted by the USI]
Sent: 17 May 2015 22:29
To: Thwaini, Ali; Mary Haughey
Cc: Darren Mitchell (niecr); Hagan, Chris
Subject: RE: Draft Urology Clinical Guidelines

Thank you, Ali.

I have to confess that I disagree with the elimination of any distinction between dipstick / biochemical Haematuria and microscopic haematuria implicate in these 2008 Guidelines.

I believe this is one reason for the increase in Red Flag referrals without any proportionate increase in cancer incidence.

Anyhow, perhaps this can be added to the list of issues for discussion at a later date,

Aidan.

From: Thwaini, Ali [Personal Information redacted by the USI]
Sent: 15 May 2015 17:58
To: 'Mary Haughey'
Cc: O'Brien, Aidan; Mitchell, Darren; Hagan, Chris
Subject: RE: Draft Urology Clinical Guidelines

Hi Mary

Sorry for the late response, but it occurred to me that the haematuria referral pathway is out of date.

Whilst my task (to my understanding) was to write the urology clinical guidelines and not the referral pathways, I thought it may be worthwhile replacing the haematuria pathway with the Renal Association/BAUS combined pathway below (last page of the document).

I hope all agree

<http://www.colchesterhospital.nhs.uk/urology/BAUS%20Haematuria%20Consensus%20Guidelines.pdf>

Best wishes

Ali

From: Mary Haughey [Personal Information redacted by the USI]
Sent: 11 May 2015 10:07
To: Aidan O'Brien; Thwaini, Ali; Clayton, Alison; Grey, Arthur; Brian Duggan; Hagan, Chris; colin.mulholland [Personal Information redacted by the USI]; Mitchell, Darren; ORourke, Declan; dianne.kirkpatrick [Personal Information redacted by the USI]; Houghton, Fionnuala; Gareth McClean; McCarthy, Gerry; Gerry Millar; Harry Lockhart; O'Kane, Hugh; Igbo Diegbe; Harney, Jacqui; Rankin, JaneP; Jenny McMahon; O'Sullivan, Joe; joe.osullivan [Personal Information redacted by the USI]; John McKinght (niecr); McAleese, Jonathan; Kate O'Neill; Kerry Chambers; Shum, Lin; Liz England; Lynn McLean; Michael Young; Mr Michael Reilly; Patricia Thompson; Keane, Patrick; Paul Downey; Peter.Ball setrust; Richard Fiala; Robin Gray; Johnston, RuthE; Moore, Ruth; Sam Gray; Thompson, Samanthae; Vallely, Stephen; Jain, Suneil; Suneil Jain (2); Teresa Majury; Ayton, Thamra; Tim Vits
Cc: Claire Cassells (niecr); Wightman, Debbie; Jean Simpson; Cullen, JoanneZ; McCarthy, Joanne; Johnston, Karen; Parsons, Karen; Lisa Ranaghan; Mills, Moyra; Shiels, Pat; Una Cardin; McPhee, Wendy
Subject: Draft Urology Clinical Guidelines

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

Dear all

Please find version 1.3 attached of the Urology Clinical Guidelines. These are the guidelines which have been agreed to date though further revision is required in the Surgical sections and this has been detailed in the version control table on page 14. This version of the guidelines will be sent to the trust cancer managers for circulation to the MDTs and to enable peer review documentation upload on the 18th May.

Kind regards

Mary

Mary Haughey, Clinical Network Coordinator, Northern Ireland Cancer Network (NICaN)
(post part funded by Macmillan Cancer Support)

1st Floor, IT Department, Back Entrance Knockbracken Clinic, Knockbracken Healthcare Park, Belfast BT88BH

Tel: [Personal Information redacted by the USI], Mobile: [Personal Information redacted by the USI] Email: [Personal Information redacted by the USI]

Web: <http://www.cancerni.net>

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Mary Haughey

From: Mary Haughey
Sent: 19 May 2015 08:41
To: O'Brien, Aidan
Subject: RE: Draft Urology Clinical Guidelines

Hi Aidan

Could we have a chat about this please as I am a bit confused? Ali referred to the referral pathway which we had included in our guidelines but the reference is to the initial investigation and referral of haematuria. The Manual for cancer services for Urology on page 19 states that the Urology Network Group should produce clinical guidelines for bladder cancer and these should include protocols for diagnosis and assessment, agreed with a network representative from primary care, for GP referral to the designated haematuria clinic.

Best regards

Mary

From: O'Brien, Aidan Personal Information redacted by the USI
Sent: 18 May 2015 14:36
To: Mary Haughey; Thwaini, Ali
Cc: Darren Mitchell (niecr); Hagan, Chris
Subject: RE: Draft Urology Clinical Guidelines

Mary,

I do not think that this matter be discussed at the next Network meeting. Instead, I think that it should be one of many issues to be discussed by all urologists providing cancer services, if not indeed all urologists.

I believe that we should leave that discussion to a separate meeting of all urologists, and which will be convened in September.

The problem with the network meetings is that few urologists attend or engage with them,

Aidan

From: Mary Haughey Personal Information redacted by the USI
Sent: 18 May 2015 07:18
To: O'Brien, Aidan; Thwaini, Ali
Cc: Darren Mitchell (niecr); Hagan, Chris
Subject: RE: Draft Urology Clinical Guidelines

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

Dear all

If you are in agreement, I will add to the agenda for discussion at the next network meeting?

Best regards

Mary

From: O'Brien, Aidan Personal Information redacted by the USI
Sent: 17 May 2015 22:29
To: Thwaini, Ali; Mary Haughey
Cc: Darren Mitchell (niecr); Hagan, Chris
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Aidan.

From: Thwaini, Ali [Personal Information redacted by the USI]
Sent: 15 May 2015 17:56
To: 'Mary Haughey'
Cc: O'Brien, Aidan; Mitchell, Darren; Hagan, Chris
Subject: RE: Draft Urology Clinical Guidelines

Hi Mary

Sorry for the late response, but it occurred to me that the haematuria referral pathway is out of date.

Whilst my task (to my understanding) was to write the urology clinical guidelines and not the referral pathways, I thought it may be worthwhile replacing the haematuria pathway with the Renal Association/BAUS combined pathway below (last page of the document).

I hope all agree

<http://www.colchesterhospital.nhs.uk/urology/BAUS%20Haematuria%20Consensus%20Guidelines.pdf>

Best wishes

Ali

From: Mary Haughey [Personal Information redacted by the USI]
Sent: 11 May 2015 10:07
To: Aidan O'Brien; Thwaini, Ali; Clayton, Alison; Grey, Arthur; Brian Duggan; Hagan, Chris; colin.mulholland [Personal Information redacted by the USI]; Mitchell, Darren; ORourke, Declan; dianne.kirkpatrick [Personal Information redacted by the USI]; Houghton, Fionnuala; Gareth McClean; McCarthy, Gerry; Gerry Millar; Harry Lockhart; O'Kane, Hugh; Igho Diegbe; Harney, Jacqui; Rankin, JaneP; Jenny McMahon; O'Sullivan, Joe; joe.osullivan [Personal Information redacted by the USI]; John McKinght (niecr); McAleese, Jonathan; Kate O'Neill; Kerry Chambers; Shum, Lin; Liz England; Lynn McLean; Michael Young; Mr Michael Reilly; Patricia Thompson; Keane, Patrick; Paul Downey; Peter.Ball setrust; Richard Fiala; Robin Gray; Johnston, RuthE; Moore, Ruth; Sam Gray; Thompson, Samanthae; Vallely, Stephen; Jain, Suneil; Suneil Jain (2); Teresa Majury; Ayton, Thamra; Tim Vits
Cc: Claire Cassells (niecr); Wightman, Debbie; Jean Simpson; Cullen, JoanneZ; McCarthy, Joanne; Johnston, Karen; Parsons, Karen; Lisa Ranaghan; Mills, Moyra; Shiels, Pat; Una Cardin; McPhee, Wendy
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Kind regards

Mary

Mary Haughey

From: Williams, Marc [Personal Information redacted by the USI]
Sent: 28 May 2015 12:46
To: McVeigh, Shauna; Brown, Robin; Campbell, Dolores; Carser, Judith; connolly, maureen; Cummings, Ursula; Dabbous, Marie; Davies, Caroline L; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Fionnuala Houghton; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Hazel.Cantley [Personal Information redacted by the USI] Keith Rooney (niecr); Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCreesh, Kate; McMahon, Jenny; Murphy, Linda; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; White, Deborah; Mary Haughey
Subject: RE: Urology Clinical Guidelines & Pathways

The prostate guidelines are odd and antiquated, even allowing for the date of publication. They suggest that a low risk patient does not need imaging (how can he be truly low risk on the basis of 10 random biopsies without any imaging? – or is the patient assumed to be low risk if he is still alive after 5 years with a static PSA?) How does a random 10 core biopsy risk stratify the patient? There is no mention of best practice – pre biopsy MRI (increased detection of significant tumour, less detection of irrelevant tumour and resultant overtreatment, fewer biopsies, reduced morbidity, more risk stratification etc – all evidence based and we also have numerous local anecdotal examples where patients have been upstaged from low to intermediate risk on the basis of imaging). Best practice needs an entirely different pathway. Are patients on this pathway properly informed about the alternatives before they undergo their random biopsy given the proven benefit of pre biopsy MRI? How does informed consent fit in here?

Marc Williams MB BChir (Cantab), BSc (hons), MRCS, FRCR.
 Consultant Radiologist.

From: McVeigh, Shauna
Sent: 28 May 2015 10:45
To: Brown, Robin; Campbell, Dolores; Carser, Judith; connolly, maureen; Cummings, Ursula; Dabbous, Marie; Davies, Caroline L; Dignam, Paulette; Dr Sai Jonnada; Elliott, Noleen; Fionnuala Houghton; Glackin, Anthony; Graham, Vicki; Hanvey, Leanne; Haynes, Mark; Hazel.Cantley [Personal Information redacted by the USI] Keith Rooney; Kelly, Wendy; Larkin, Bronagh; Loughran, Teresa; McCartney, Rachel; McClean, Gareth; McClure, Mark; McConville, Richard; McCreesh, Kate; McMahon, Jenny; McVeigh, Shauna; Murphy, Linda; O'Brien, Aidan; ODonoghue, JohnP; ONeill, Kate; Reid, Stephanie; Shah, Rajeev; Shannon, Hilda; Sheridan, Patrick; Suresh, Ram; Topping, Christina; Troughton, Elizabeth; Turkington, Ann E; White, Deborah; Williams, Marc
Subject: FW: Urology Clinical Guidelines & Pathways
Importance: High

Hi

Please see Urology Clinical guidelines and pathways.

Thanks

Shauna

From: Graham, Vicki
Sent: 28 May 2015 10:24
To: McVeigh, Shauna

Subject: FW: Urology Clinical Guidelines & Pathways
Importance: High

Shauna,

Could you please forward onto Urology Circulation list please?

Many thanks,

Vicki Graham
Cancer Services Co-ordinator
Mandeville Unit

Personal Information redacted by the USI

Email –

Personal Information redacted by the USI

From: Lee, Davinia [Personal Information redacted by the USI]

Sent: 12 May 2015 12:37

To: Alexander, Juliea; Burgess, Elizabeth; Cantley, Hazel; Claire Cassels; Clayton, Alison; Corcoran, Bernie; Crowther, Karen; Cunningham, Wendy; Eakin, Ruth; Elliott, Kelly; Gray, Moyra; Grey, Arthur; Hagan, Chris; Harney, Jacqui; Harvey, Barbara; Hegarty, Shauna; Hennell, Claire; Hetherington, Stacey; Houghton, Fionnuala; Hurwitz, Jane; Hynds, Sharon; Jain, Suneil; John McKnight; Johnston, Karen; Johnston, Margaret; Keane, Patrick; 'Laffan, Anna'; Lindsay, Richard; Lyons, CiaraA; McAleese, Jonathan; McCloskey, Paulam; McDonald, Colm; McEvoy, Teresa; McGuigan, Jim; McLaughlin, Michelle; Milligan, Gail; Mills, Karen; Mitchell, Darren; Morgan, Sharon; Morrow, Michelle; Mort, Paula; Napier, Hazel; 'Neville.dugan [Personal Information redacted by the USI]'; Norwood, Gillian; O'Donnell, Adrina; OKane, Hugh; ORourke, Declan; O'Sullivan, Joe; Parkinson, Melanie; Parsons, Karen; Hegarty, Shauna; Patricia Thompson; Peter Ball; Rooney, Keith; Shum, Lin; Smyth, Helen; Stephen Hamilton; Stewart, David; Thompson, Samantha; Thwaini, Ali; Totten, Grace; Vallely, Stephen; Venney, Cara; Graham, Vicki; Walker, Jennifer; Warren, Pamela; White, Kate; Wilson, Brian; Wlosinski, Marie

Subject: FW: Urology Clinical Guidelines & Pathways
Importance: High

Dear all,

Please see below email and find attached the current versions of the NiCaN clinical management guidelines for Urology.

Could I ask you all to review and formally acknowledge these at the MDT meeting this Thursday in advance of the peer review deadline which is next Monday 18th May.

Many Thanks
 Davinia

From: Mary Haughey [Personal Information redacted by the USI]

Sent: 11 May 2015 15:00

To: Lee, Davinia; Wilma Boyd Carson; Fiona Reddick; pat.mcclelland [Personal Information redacted by the USI]
 elizabeth.england [Personal Information redacted by the USI]

Cc: Aidan O'Brien [Personal Information redacted by the USI]

Lowry, Lynne [Personal Information redacted by the USI] Gallagher Lynn [Personal Information redacted by the USI]

Subject: Urology Clinical Guidelines & Pathways
Importance: High

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Dear Cancer Manager

REVIEW OF CLINICAL MANAGEMENT GUIDELINES

CATCHMENT POPULATIONS

- There is a need to update the catchment populations of each MDT. For example, the catchment population of Southern Trust MDT is now 427,000 rather than 348,000.

REFERRAL GUIDELINES FOR UROLOGICAL CANCER

- We need to review the revised NICE referral guidelines.
- Do we agree with all of the revisions

BLADDER CANCER

- Do all agree with and practise second resections as recommended?
- Should we formulate a view and goal regarding the use of photodynamic diagnosis?.
- Should not all cases of newly diagnosed bladder cancer have upper tract imaging?
- Should we have a policy regarding intravesical BCG and MMC as a consequence of availability and capacity issues?
- Should we formulate a view that radical cystectomy should be offered to higher risk, non-muscle invasive, bladder cancer, rather than having it considered?
- Should there be an increased role for MRI in the staging of muscle invasive bladder cancer?
- Should neo-adjuvant chemotherapy be offered except when contraindicated?
- What actions should be taken to reduce delay in cystectomy?
- Should there be a greater consideration of chemoradiation as an alternative to radical cystectomy?
- Should we formulate a policy regarding the offer of palliative cystectomy?
- Should we have a policy for systemic chemotherapy in metastatic disease?

PROSTATE CANCER

- Should we have a regional policy regarding the use of MRI
 - Prior to biopsies
 - Following positive biopsies
 - Following negative biopsies
- Criteria for Active Surveillance
 - Should have MRI to ensure T1-T2
 - Gleason 3+3 and 3+4?
 - PSA<10 or <15
 - Number of biopsies
 - Maximum core length
- Active Surveillance
 - Role of DRE
 - Role of MRI
 - Role of biopsies
- To formulate a view regarding the provision of Robotic surgery
- To review or update criteria for brachytherapy
- To formulate a policy regarding the early use of Docetaxel concomitant with androgen deprivation
 - Who to refer to Oncology
 - When to refer to Oncology

RENAL CELL CARCINOMA

- Nephron Sparing Surgery
 - Where it should be done
 - By whom
 - Open/laparoscopic

UPPER TRACT UROTHELIAL CARCINOMA

- Where and by whom should it be done

PENILE CARCINOMA

- Where and by whom should glansectomy, partial and total penectomy be done
- Where and by whom should lymphadenectomy be done

TESTICULAR CANCER

- Any issues??

PEER REVIEW FEEDBACK

Some Issues:

- That any urologist who electively provides a urological cancer service should be a full member of an MDT, and should therefore be bound by the rules of attendance at MDM
- (Do all oncologists electively participating in urological cancer service provision be full members of MDT and similarly bound to attend MDM?)
- That the management of patients be discussed at MDM following completion of diagnosis and staging of their cancer, and not just after diagnosis
- Whether all patients with advanced disease (for example, metastatic bladder cancer) be discussion at Regional MDM
- The focus on nephron-sparing surgery

Urological Nursing

In the

Management of Urological Cancer

A Statement of Roles and Responsibilities

For

Peer Review 2015

Urological Nursing

It is well-documented that the CNS plays an essential role within the cancer multidisciplinary team (MDT) in providing high-quality care from diagnosis throughout the patient journey (National Peer Review Programme, 2014). The National Institute for Clinical Excellence (NICE) (2002) called for major changes in improving outcomes for patients with Urological Cancers. In particular they recommended that the CNS should have specific knowledge and expertise and should be trained in advanced communication skills. More recently, NICE (2014) emphasised that the CNS can ensure that patients have information that is tailored to their individual needs, therefore enhancing shared decision making. The CNS is also in an excellent position to provide individualised care following treatment which promotes cancer survivorship (National Cancer Survivorship Initiative, 2011). A recent Macmillan census on specialist nurses workforce in Northern Ireland (2014) has highlighted that cancer care teams of the future will need to have more flexibility working with people who are living with cancer. This census emphasised that the role of the CNS must be optimised to support those living in the community with a diagnosis of cancer.

The combination of improved life expectancy, advancements in diagnostics and treatment, and increased use of PSA testing in primary Care have all contributed to a significant rise in Urological cancer diagnosis. In Northern Ireland the number of new cases of Urological cancers diagnosed annually has increased and the associated workload creating significant challenges for Urological cancer teams and further demands on Uro-Oncology Clinical Nurse Specialists (CNS).

Responsibilities of the Uro-oncology Specialist Nurses

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 physical, psychological, social, spiritual and financial support at key points of their journey. A structured pack has been provided for use by professionals to assist with this process (NCAT, 2010). This HNA approach and subsequent care planning is a process which would ensure that people's needs are

met in a timely and appropriate way and that resources are targeted to those who need them most. As a result of the HNA patients should be appropriately referred or signposted to any required support services.

Where cystectomy is considered, the involvement of the Stoma Therapist and/or Urology Clinical Nurse Specialist soon after diagnosis is essential. Patients should be offered the opportunity to meet a patient who has had a cystectomy and urinary diversion to help the decision making process. Patients who may have problems with urinary incontinence should be given information about local continence services.

Supportive and Palliative Care

Supportive care is available to people with cancer and their carers throughout the patient pathway, from pre-diagnosis onwards and is a term used to describe all services that may be required to support people with cancer and their carers(NICE,2004). It is identified by NICE (2004) that patients and carers may have a series of problems preceding diagnosis (when cancer is suspected) which may include physical and anxiety related symptoms which require appropriate management, and information should be available for patients at this stage if they require it. As recognised by NICE (2004) supportive care is the responsibility of all health and social care professionals involved in delivering care and effective communication within teams will enable a seamless transition from one service to another if and when required.

Patients with advanced urological cancer may benefit from supportive and palliative care. Palliative care is defined by the World Health Organization (WHO, 2014) as an approach that improves the quality of life of patients and their families, facing the problems associated with life threatening illness. Uncontrolled symptoms can adversely affect quality of life and a patient's ability to cope with their illness, therefore, early identification, thorough assessment and treatment of pain and other problems, physical, psychological and spiritual, is essential (WHO 2014). The overall goal of palliative care is to help manage the symptoms and difficulties that may arise with disease progression, through appropriate support and intervention.

Palliative Care is an integral part of the multidisciplinary team and patients may require palliative care at different stages of the patient pathway (NICE, 2004). Generalist palliative care is the level of care required by most people and is provided by non-palliative/ end of life care specialist's i.e. primary and secondary health care teams (Living Matters, Dying Matters, 2010). Specialist palliative care may be required for those patients with more demanding care needs, i.e. unresolved symptoms and complex psychosocial, end of life and bereavement issues (Living Matters, Dying Matters, 2010).Referral to Specialist Palliative Care may be made at any time in the course of the disease when the patient wishes and would benefit from it.

References:

Living Matters, Dying Matters (2010) A Palliative and End of Life Care Strategy for Adults in Northern Ireland www.dhsspsni.gov.uk

Macmillan (2014) Specialist adult cancer Nurses in Northern Ireland: A census of the specialist adult cancer nursing workforce in the UK, 2014. Macmillan Cancer Support.

National Cancer Action Team (2010) Holistic Needs Assessment for people with cancer: a practical guide for health care professionals. www.ncsi.org.uk

National Cancer Survivorship Initiative (2011) Consequences of Cancer Treatment. National Cancer Survivorship Initiative: London.

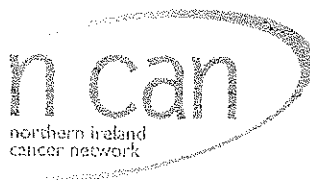
National Institute for Clinical Excellence (2002) Guidance on Cancer Services Improving Outcomes in Urological Cancers. NICE.

National Institute for Clinical Excellence (2004) Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer. London: NICE.

National Institute for Clinical Excellence (2014) Prostate Cancer: diagnosis and treatment. NICE: London.

National Peer Review Programme (2014) Manual for Cancer Services- Urology Measures.

World Health Organisation (2014) <http://www.who.int/cancer/palliative/definition/en/>



UROLOGY CARE PATHWAYS

REVISED 2015

AIDAN O'BRIEN

Lead Clinician

Clinical reference group in Urology

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Urology Care Pathways

Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that can be adapted for local use. The timelines on the pathway are intended to facilitate the proactive management of patients within the access standards and it is to be noted that for some urological tumours, the patient will move much quicker through the pathway (e.g. testicular cancer).

The pathways are in draft form and amendments have been made following discussion at the workshop of the NICaN Regional Urology group held on Thursday 2nd October, 2008.

Document History

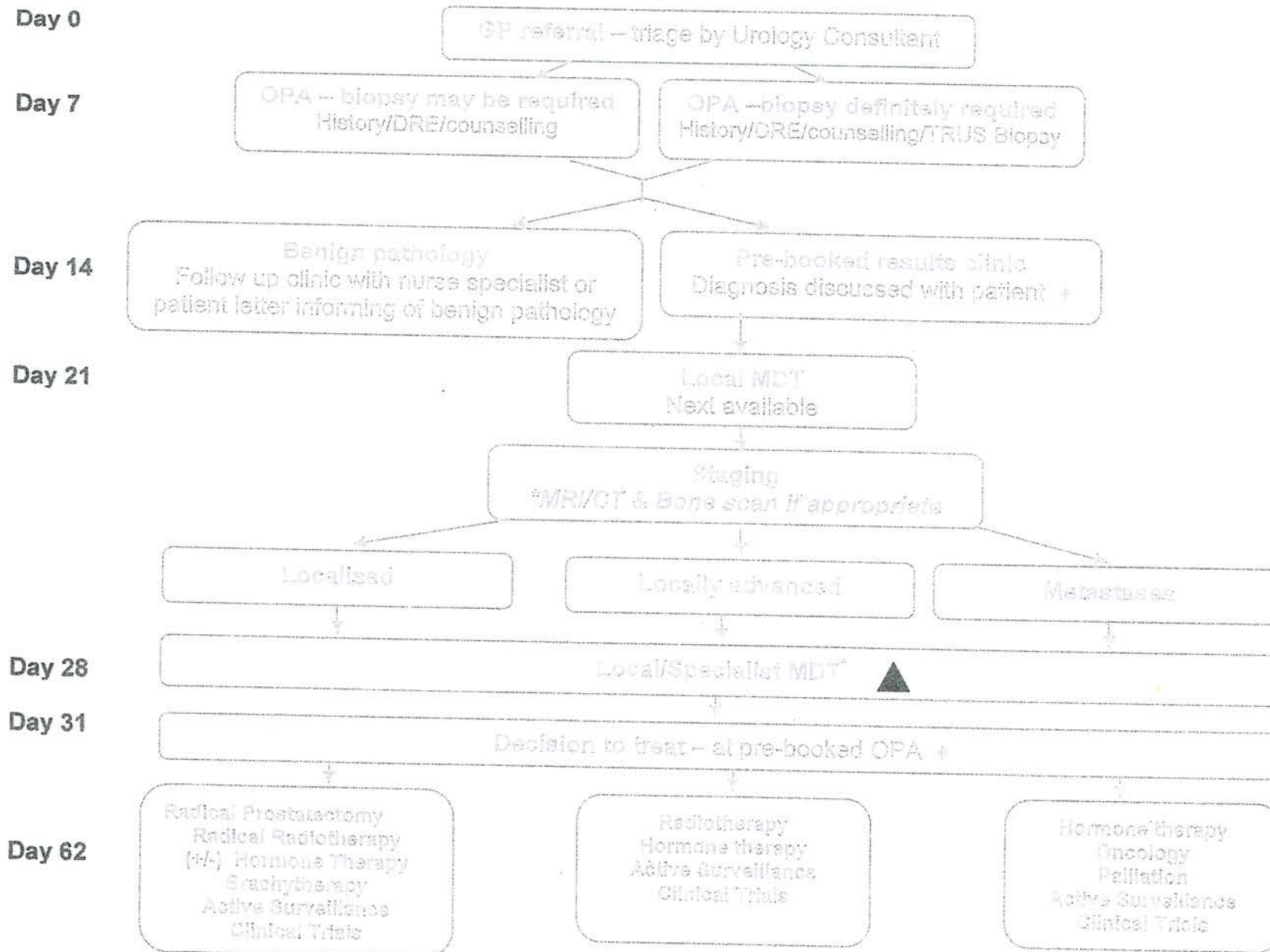
V1 Draft discussed at workshop 2/10/08

V2 Draft discussed 29/1/09 and amendments noted

Version 3 circulated for final comments 26/02/09

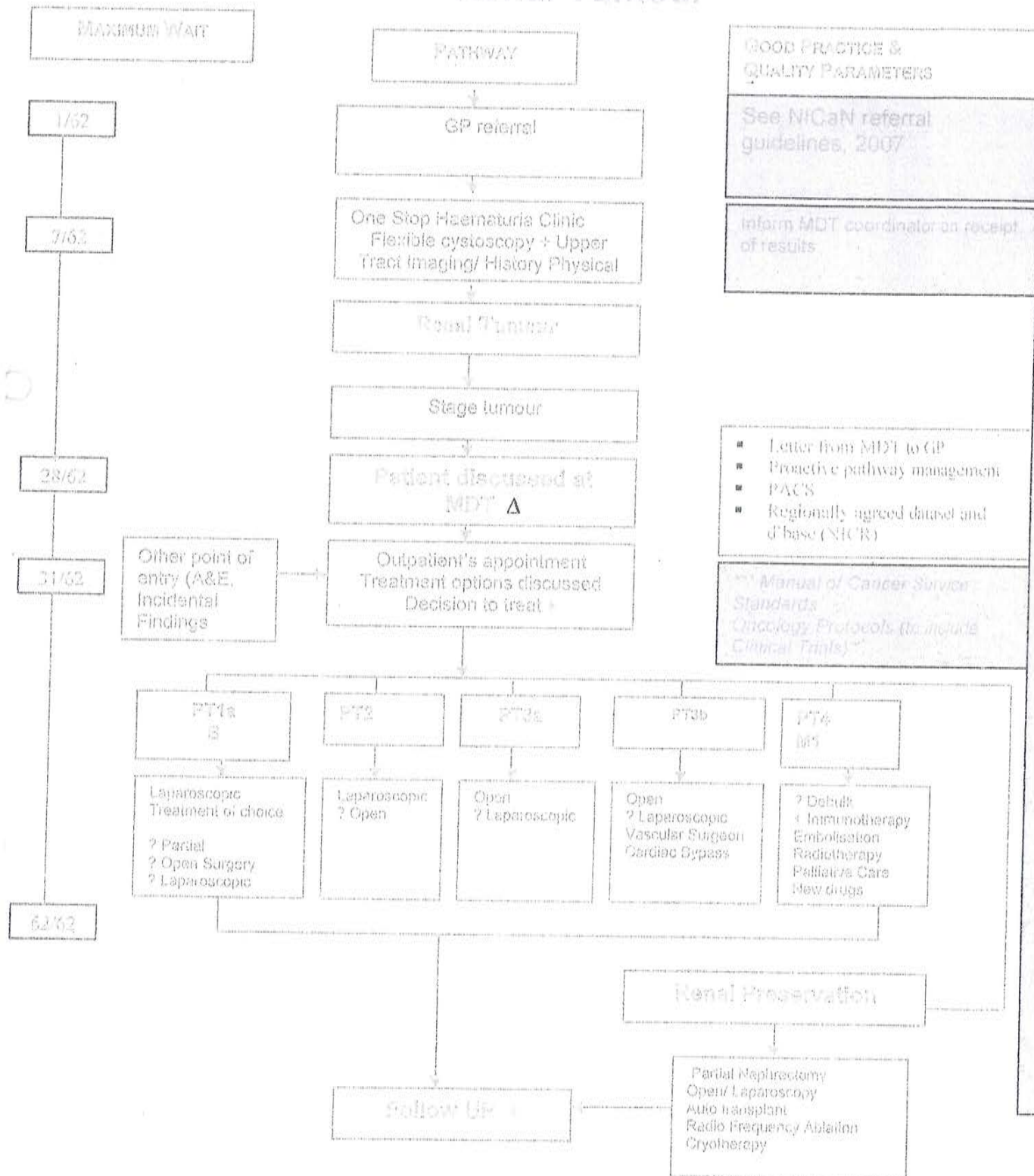
Pathways agreed at regional meeting 23/4/09

♦ Indicates point of holistic assessment △ Inter-Trust transfer by Day 28





Renal Tumour

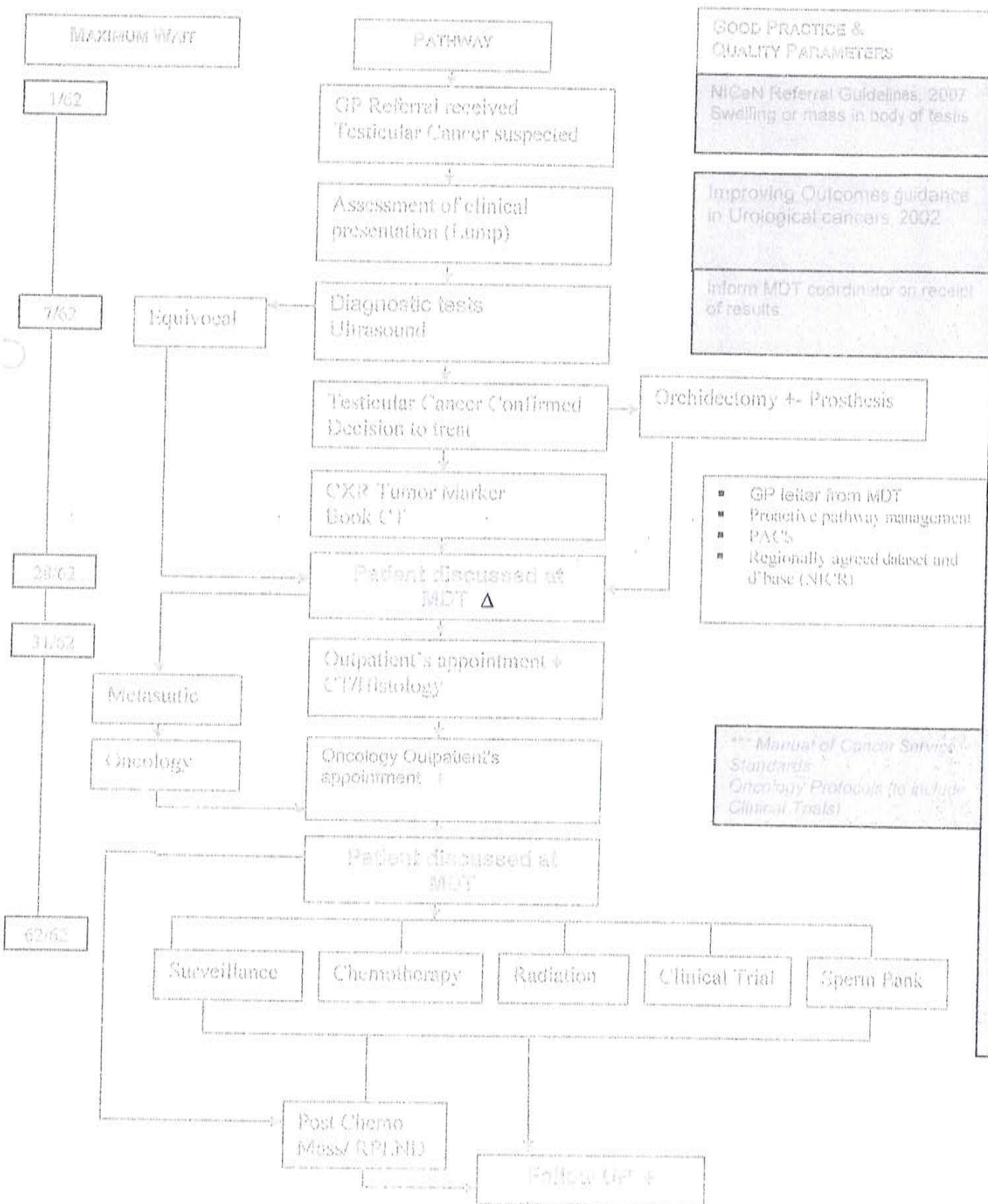


* Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28



Testicular Cancer Pathway

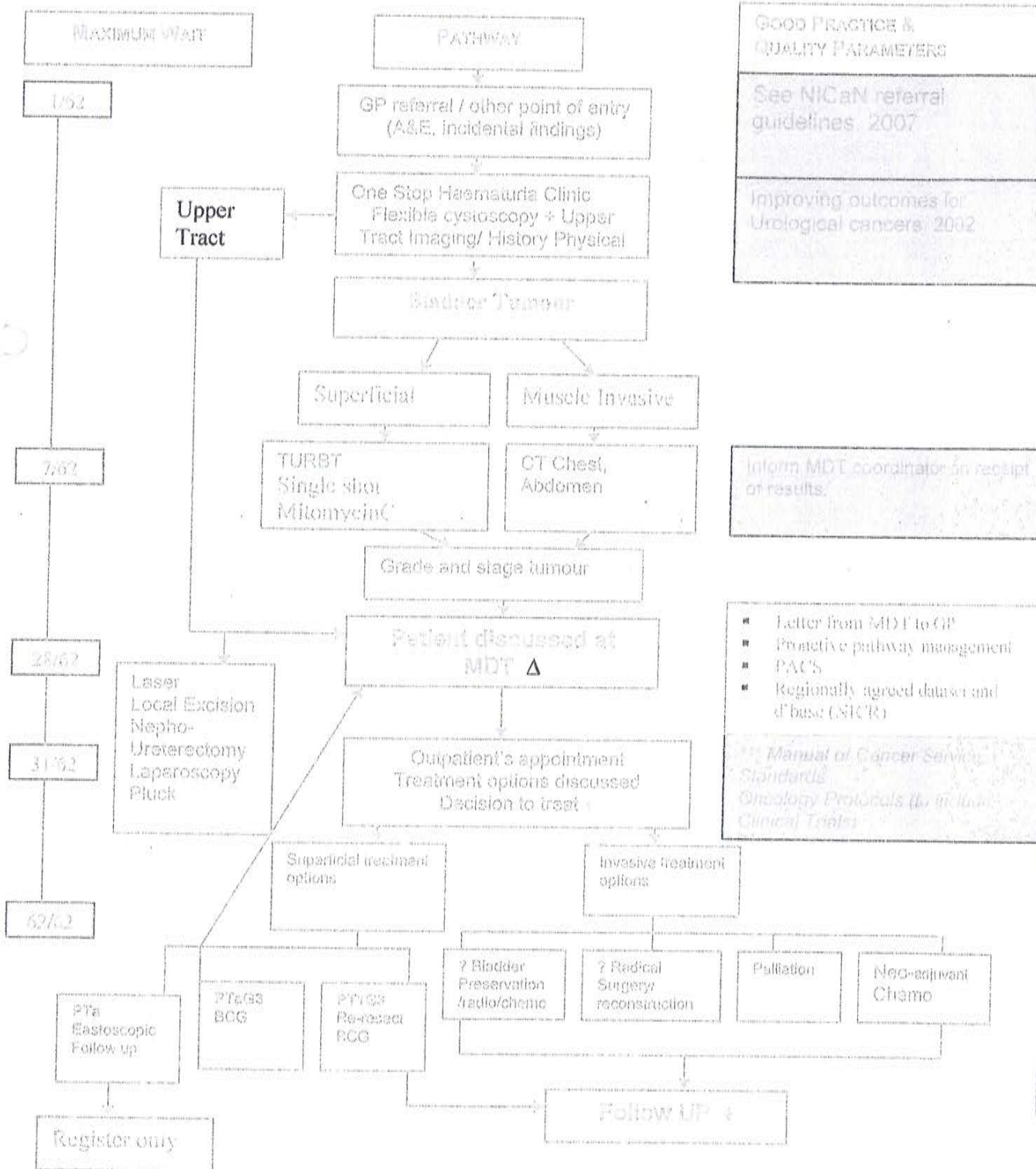
Patient support & information at all stages. Patient details recorded. Patient informed at appropriate points. *****NICE



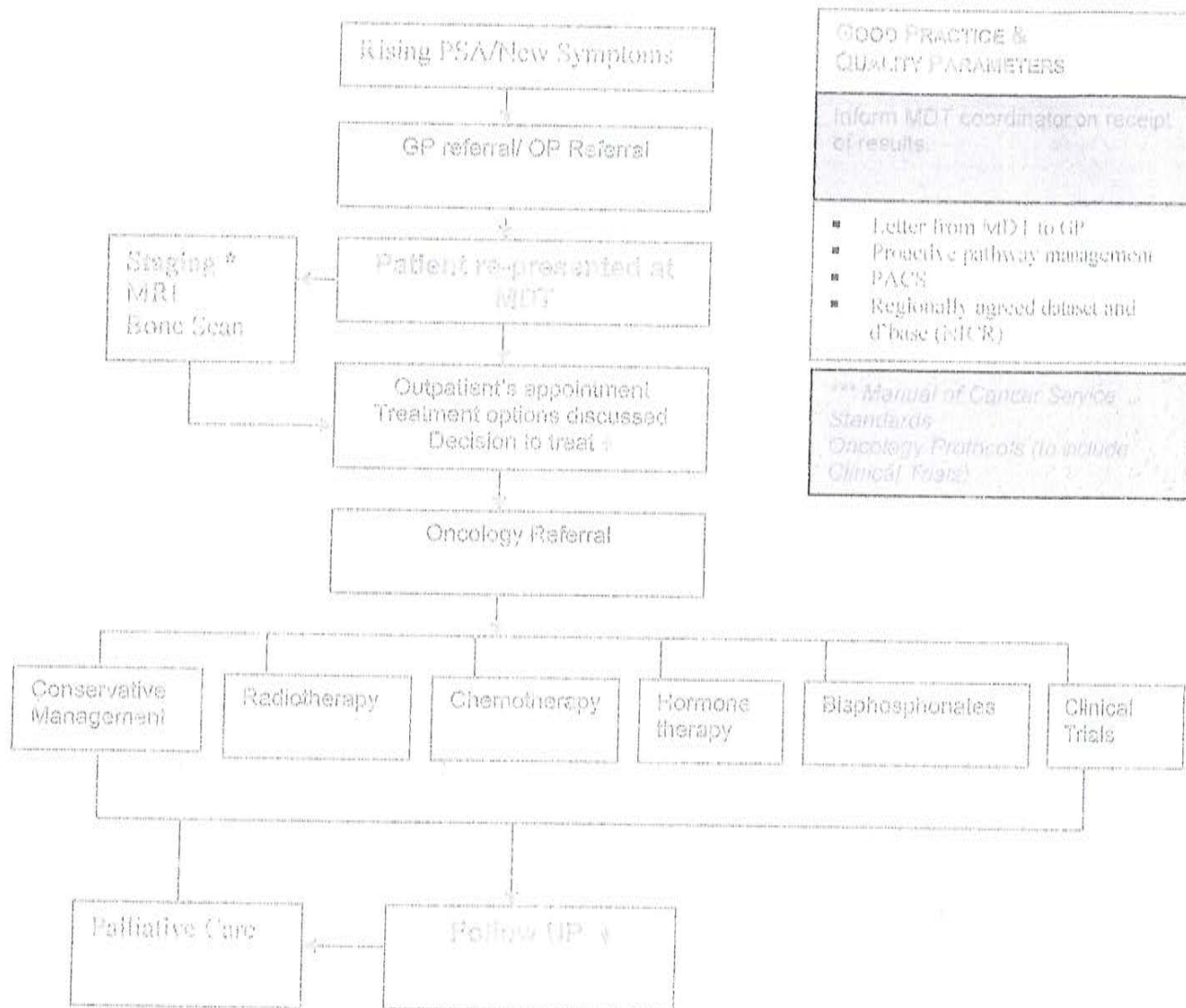
* Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28



Transitional Cell Carcinoma



Δ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28



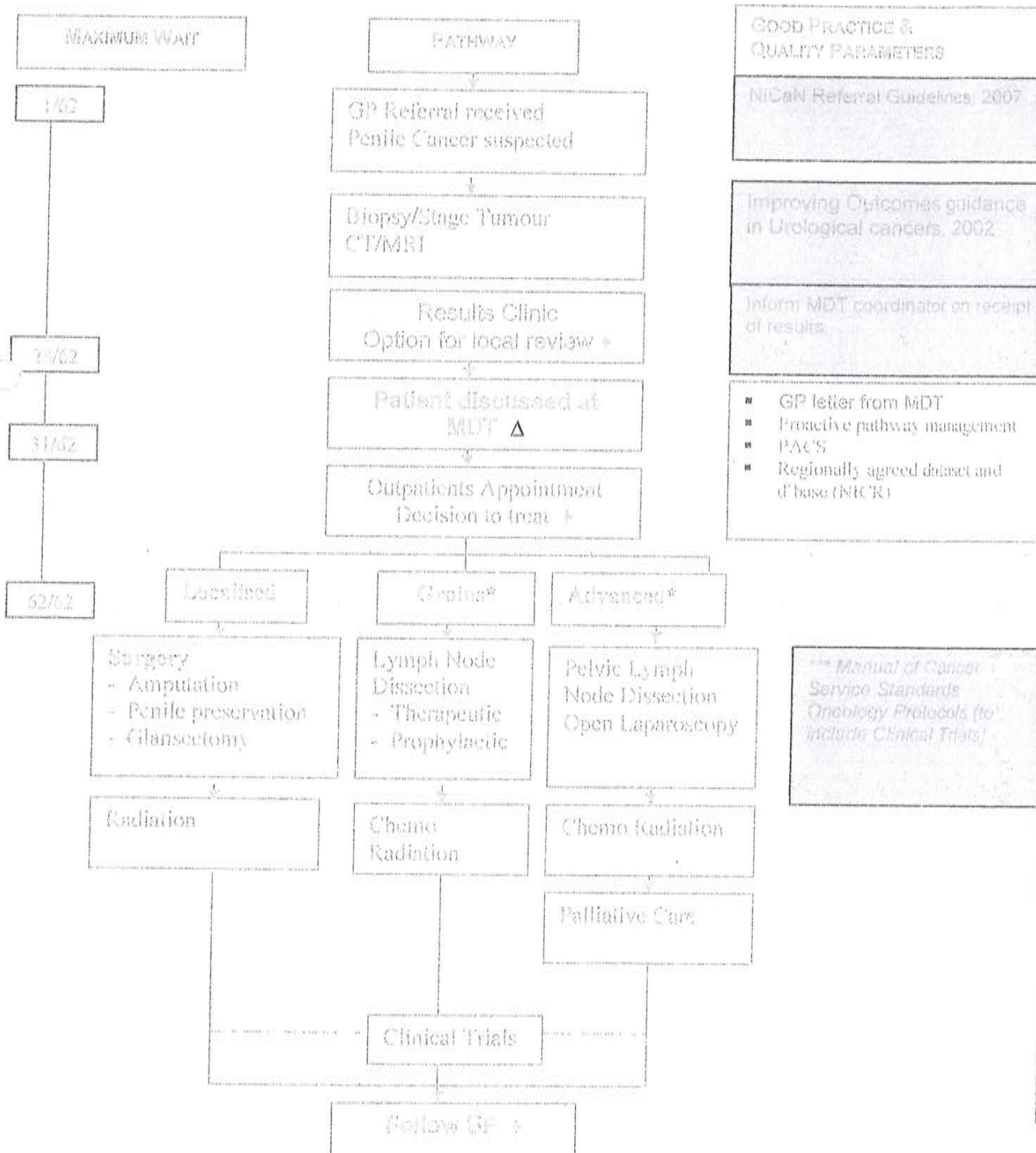
Patent support & information at all stages. Patient details recorded. Patient informed at appropriate points. NICE

* MRI/Bone Scan as clinically indicated

Δ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28



Penile Cancer Pathway



* Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10889>

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11924>

<http://www.baus.org.uk/>

<http://www.europeanurology.com/>

4 Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

Prostate Cancer: Hormone Therapy Alone Pathway (For men with locally advanced prostate cancer)

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MDT discussion
Hormone Therapy Alone agreed

Consultant review with Urologist / Oncologist - results given
Confirmed diagnosis discussed
Shared Care Pathway and Rapid Access to services explained
Symptoms to look out for discussed
Signposting to other services as appropriate
Refer to Macmillan Information and Support Manager
*Hormone therapy commenced
*PSA triggers agreed and documented
Consultant letter to GP requesting PSA to be checked in primary care
Copy of letter to CNS

*Refer to Supporting regional hormone therapy guideline

g.

HNA at 3 months (with clinician +/- CNS)
CNS secretary requests patient to get PSA checked by primary care one week before apptment
Confirmed diagnosis discussed
Shared care pathway and rapid access to services explained
Symptoms to look out for discussed
Signposting to other services as appropriate
Refer to Macmillan Information and Support Manager

PSA checked 3 monthly
(via telephone by CNS/Consultant)

PSA stable

CNS letter to consultant, patient and GP

CNS remote monitoring of PSA test
PSA to be checked 3 monthly

PSA breach or alert symptoms

Fast track to consultant for discussion within 2 working days
Consultant dictates letter regarding treatment decision to patient and GP with copy to CNS

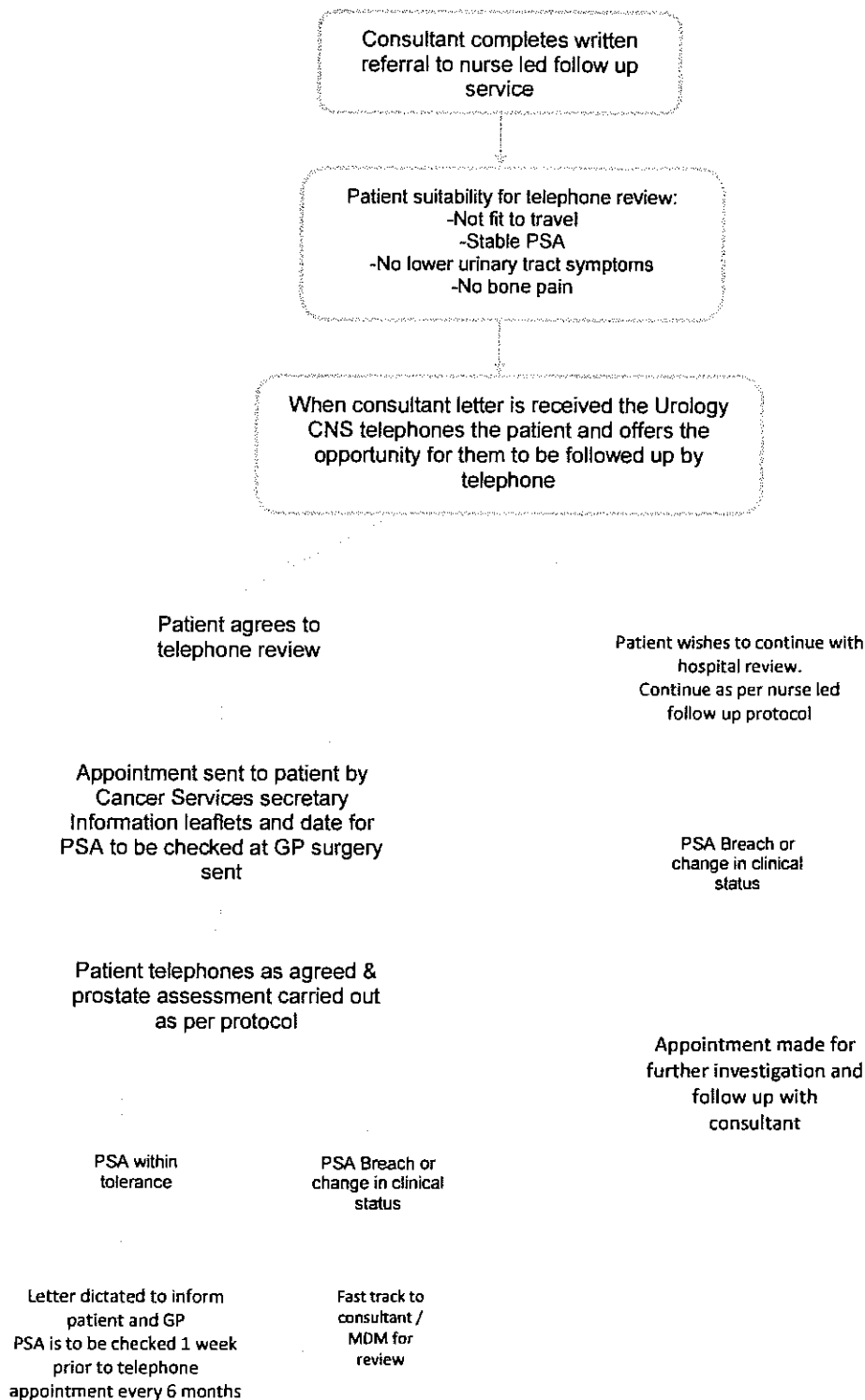
Education of patients regarding PSA monitoring, alert symptoms and access to services

Open Rapid Access if raised PSA or reported symptoms refer back to MDM for discussion
PSA checked in primary care every 3 months

Appendix 7

Survivorship- Signposting to
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Telephone Review Protocol



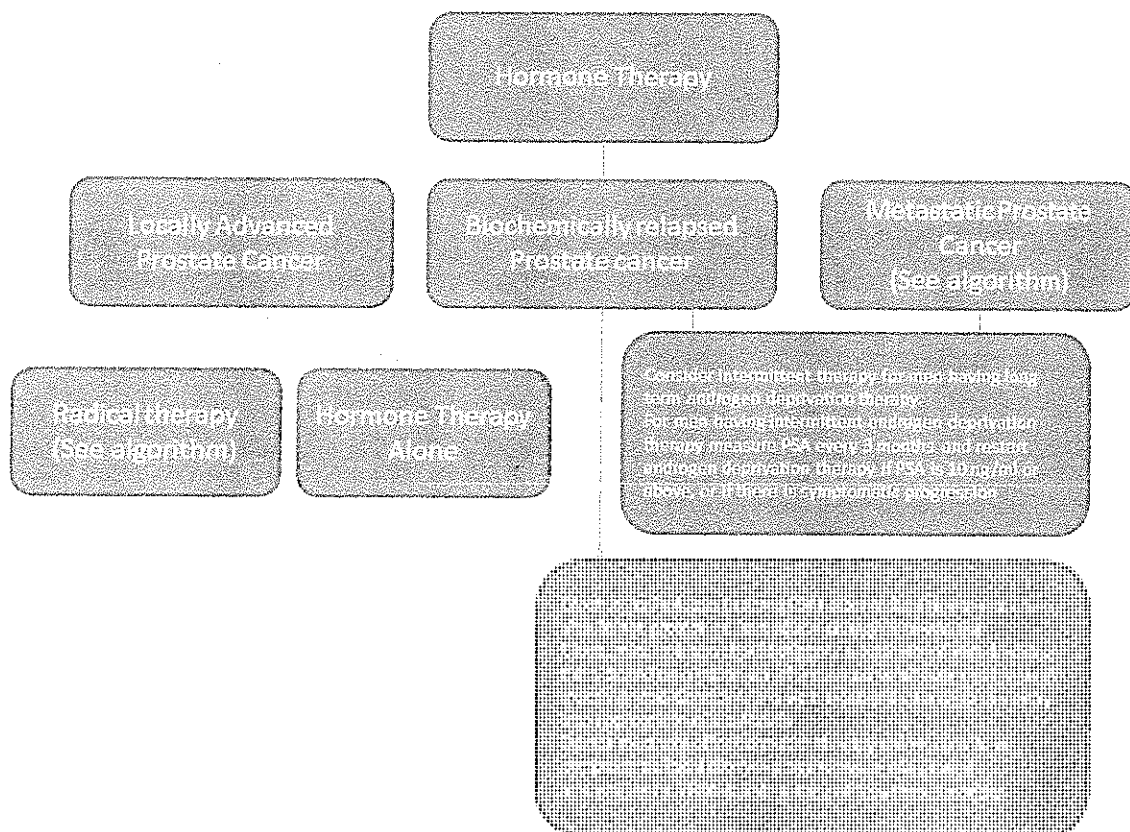
REGIONAL HORMONE THERAPY GUIDELINE

The regional guidelines on hormonal therapy for prostate cancer are drawn from the extensive research in this region and broadly adhere to the EAU guidelines (1) and NICE guidelines (2) on this topic.

The role of hormonal manipulation in men with prostate cancer is well established and fits within 3 broad groups.

- 1) Neo-adjuvant, concurrent and adjuvant hormone therapy with radical treatment.
- 2) Treatment of biochemical failure after radical treatment.
- 3) Treatment of metastatic disease.

Men within each group should be advised of the role of hormonal therapy in the management of their cancer and where appropriate PSA trigger points should be given. Men should be advised of alert signs and symptoms which should be reported to the supervising clinical team and rapid access arrangements explained.



NEO-ADJUVANT, CONCURRENT AND ADJUVANT HORMONE THERAPY WITH RADICAL TREATMENT.

There is clear randomised evidence supporting the addition of hormone therapy to radical radiotherapy in men with non-metastatic disease. The majority of this evidence is for hormone therapy in men with an increased risk of systemic disease and is based on pre-treatment clinical and pathological features.

Men with intermediate or high risk prostate cancer should be offered **neo-adjuvant** hormone therapy for at least 3 months before the commencement of radical radiotherapy.

For very large prostate glands or patients with high risk prostate cancer or pelvic node positive prostate cancer (3, 4), a longer period of neo-adjuvant hormone therapy may be required.

Cyto-reductive hormone therapy is also considered in men with large prostate's prior to their prostate brachytherapy volume study.

Men with intermediate or high risk prostate cancer should **continue** their hormone therapy through the course of radiotherapy.

Men with Intermediate risk prostate cancer should receive a total of 6 months of hormone therapy before, during and after their radiotherapy is complete (6-9)

Up to 3 years of **adjuvant** hormone therapy after radical radiotherapy should be considered for men with high risk prostate cancer. The benefits and risks of long term androgen deprivation therapy should be discussed. [NICE 2014] (5)

Hormone therapies options with radical radiotherapy include

LHRH agonists:-

Zoladex (goserelin) 3.6mg subcut every 4 weeks or

Prostap (leuporeline) 3.75 mg IM every 4 weeks or

Decapeptyl (triptorelin) 3mg IM every 4 weeks

Consider transferring to the 12weekly preparation of androgen deprivation therapy if the 4weekly preparation is tolerated and the intention is to proceed with longer term therapy.

In order to prevent testosterone flare, anti-androgen cover with Bicalutamide 50mg is given for 3 weeks in total with the first LHRHa given 1week after the start of the Bicalutamide.

The anti-androgen - Bicalutamide 150mg OD mono-therapy can be used as neo-adjuvant hormone therapy especially in men where preservation of physical capacity or sexual function is important or in those who may not tolerate hot flushes.

The cardiovascular and metabolic toxicities of LHRHa should be discussed and the patient advised to address cardiovascular risk factors with their GP.

The use of concurrent and adjuvant androgen deprivation with adjuvant and salvage radiotherapy post prostatectomy remains undefined. It is currently being assessed as part of the RADICALs study. Use is therefore at the discretion of the treating clinician.

Limited evidence suggested that the patients who may gain most benefit from the addition of hormone therapy to adjuvant radiotherapy have Gleason scores of ≥ 8 . (13)

The use of concurrent and adjuvant androgen deprivation therapy in this setting remains undefined.

A select group of men with positive nodes at the time of prostatectomy (pN1) may benefit from adjuvant LHRHa following surgery (14)

Locally Advanced Prostate Cancer

Consider androgen deprivation therapy (ADT) with or without docetaxel for men with locally advanced prostate cancer.

ADT with or without docetaxel is preferred for men with locally advanced prostate cancer who are not candidates for radical prostatectomy or radiation therapy.

ADT with or without docetaxel is preferred for men with locally advanced prostate cancer who are not candidates for radical prostatectomy or radiation therapy and who have not received ADT.

Consider androgen deprivation therapy (ADT) for up to 3 years for men with high-risk localized prostate cancer.

Consider ADT with or without docetaxel for men with locally advanced prostate cancer who are not candidates for radical prostatectomy or radiation therapy.

ADT with or without docetaxel is preferred for men with locally advanced prostate cancer who are not candidates for radical prostatectomy or radiation therapy.

Consider adjuvant hormone therapy or surgery in men found to have positive nodes at the time of radical prostatectomy.

BIOCHEMICAL RELAPSE AFTER RADICAL THERAPY

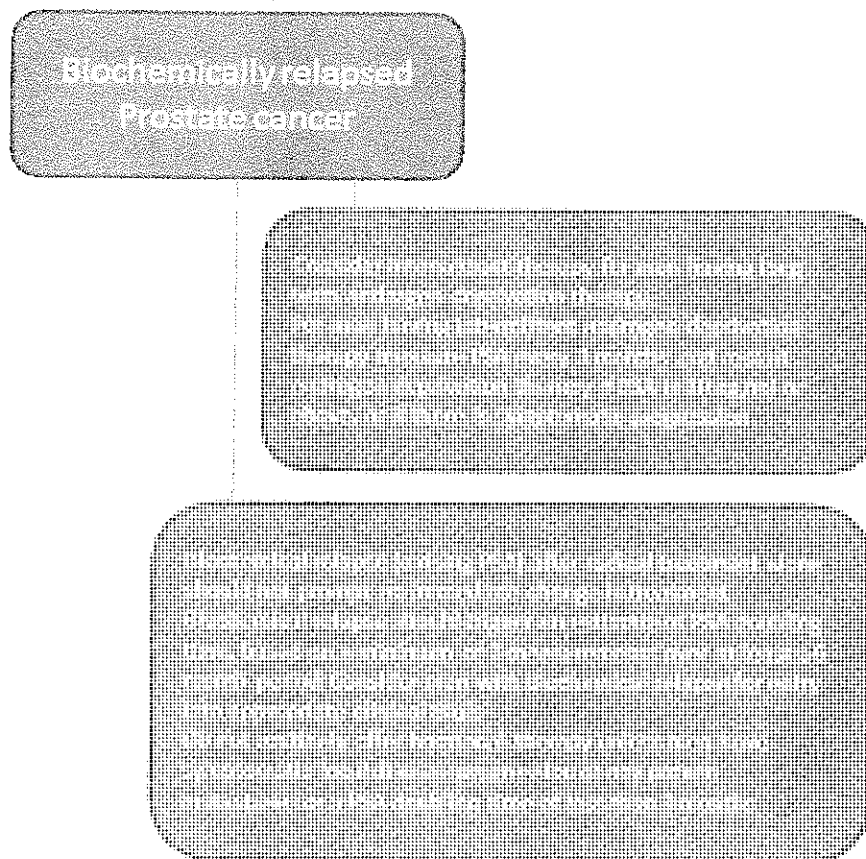
It is not known whether initiating hormone treatment at the time of biochemical relapse, rather than waiting until there are clinical signs of disease, will influence survival. Biochemical relapse after radical treatment, in many cases, does not lead to metastases or death from prostate cancer. Whether men with biochemical relapse should be treated depends in part on the timing and rate of rise of PSA as a predictor of clinical progression. Management options for men at the time of biochemical relapse can be divided into local salvage therapies and systemic therapy with hormones.

Local salvage options may be appropriate in highly selected cases, where the balance of achieving biochemical control and potential toxicity of the salvage therapy should be explained

For men who are considering systemic therapy the exact timing of intervention remains undefined.

NICE recommends that hormonal therapy should not routinely be offered to men with prostate cancer who have a biochemical relapse unless they have:

- symptomatic local disease progression, or
- any proven metastases, or
- a PSA doubling time of < 3 months.



TREATMENT OF METASTATIC DISEASE

Hormone therapy is a crucial component of the management of metastatic prostate cancer and may successfully control the disease for several years. LHRHa's provide equivalent benefit when compared with orchiectomy and have the advantage of allowing the consideration of using them intermittently.

LHRHa's may be used alone (after a short course of anti-androgens such as Bicalutamide 50mg OD for 3weeks to cover testosterone flare on initiation of LHRHa's, with the first LHRHa given 1 week after the start of the Bicalutamide) or in combination with anti-androgens (Known as combined androgen blockade – typically with Bicalutamide 50mg OD).

If LHRHa mono-therapy fails to control the disease then anti-androgen's may be added as second-line hormonal therapy.

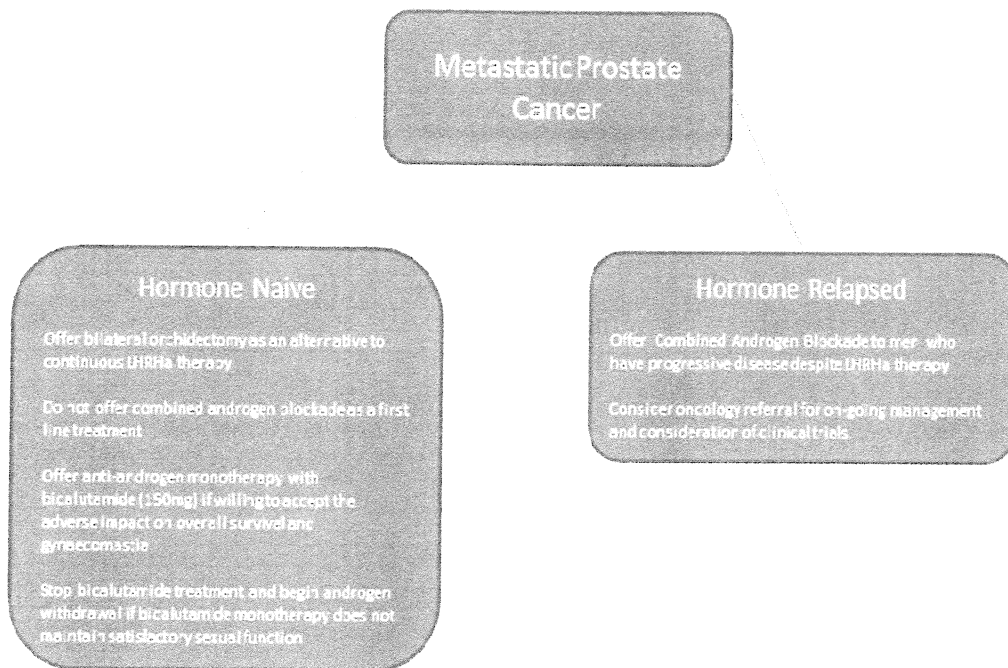
PSA monitoring is recommended every 3 months and men should be advised of the signs and symptoms which should be reported to the supervising clinical team and rapid access arrangements explained.

Anti-androgen mono-therapy

Research demonstrates inferior outcomes with Anti-androgen mono-therapy in the metastatic setting when compared to LHRHa therapy (12). For well-informed men with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and potential of gynaecomastia in the hope of maintaining sexual function then anti-androgen therapy with Bicalutamide 150mg OD can be offered (Off-licence prescribing). If sexual function is not maintained then androgen deprivation should be used instead.(2)

LHRH antagonists.

Immediate androgen suppression without risk of testosterone flare may be required in selected cases. Noting the limitation of the monthly administration formulation and risk of injection site reaction LHRH antagonist provide rapid testosterone suppression and should be considered in such cases.



Intermittent hormone therapy

Intermittent therapy for men having long-term androgen deprivation therapy in the metastatic or biochemical relapse after radical treatment setting can be considered as a potential method of reducing the side-effects of hormone therapy (10,11). There is limited evidence of an improvement in quality of life with intermittent hormone therapy when compared to continuous therapy.

NICE CG175 recommends that when it is offered there should be discussion with the man, and his partner, family or carers if he wishes, about:

- the rationale for intermittent therapy and
- the limited evidence for reduction in side effects from intermittent therapy and
- the effect of intermittent therapy on progression of prostate cancer.

For men who are having intermittent androgen deprivation therapy:

- Measure PSA every 3 months **and**
- Restart androgen deprivation therapy if PSA is 10 ng/ml or above, or if there is symptomatic progression.

EAU guidelines on intermittent blockade recommend:

The induction cycle must last between 6 to 9 months, otherwise testosterone recovery is unlikely.

The treatment is stopped only if patients have fulfilled all the following criteria:

- well-informed and compliant patient
- no clinical progression
- clear PSA response, empirically defined as a PSA < 4 ng/mL in metastatic disease
- Strict follow-up with clinical examination every 3-6 months. The more advanced the disease, the closer the follow-up.
- Treatment is resumed when the patient reaches either a clinical progression, or a PSA above a predetermined, empirically fixed, threshold: typically 10-20 ng/mL in metastatic cases (NICE recommends 10ng/ml)
- The same treatment is used for at least 3-6 months.
- Subsequent cycles of treatment are based on the same rules until there is evidence of castration resistant disease – i.e. a rising PSA despite testosterone suppression/rising PSA while on LHRHa.

The PSA response to the first cycle of hormone therapy appears to be the best indicator of a patient's suitability for intermittent hormone therapy.

- 1 Guidelines on prostate cancer, European Association of Urology 2014.
http://www.uroweb.org/gls/pdf/09%20Prostate%20Cancer_LRLV2.pdf
- 2 Prostate cancer: diagnosis and treatment. National Collaborating Centre for Cancer. Commissioned by the National Institute for Clinical Excellence.
<http://www.nice.org.uk/guidance/cg175/resources/cg175-prostate-cancer-full-guideline3>
- 3 Denham JW, Steigler A, Lamb DS et al. Short-term androgen deprivation and radiotherapy for locally advanced prostate cancer: results from the Trans-Tasman Radiation Oncology Group 96.01 randomised controlled trial. *Lancet Oncology* 2005; 6: 841-850
- 4 Abraham A, Crook J, Jones S et al. Is biochemical response more important than duration of neo-adjuvant hormone therapy before radiotherapy for clinically localized prostate cancer? An analysis of the 3- versus 8- month randomised trial. *Int J Rad oncol Biol Phys* 2010; 76: 23-30
- 5 Bolla M, Van Tienhoven G, Warde P, et al. External irradiation with or without long-term androgen suppression for prostate cancer with high metastatic risk: 10-year results of an EORTC randomised study. *Lancet Oncol* 2010 Nov;11(11):1066-73.
- 6 Jones CU, Hunt D, McGowan DG, et al. Radiotherapy and short-term androgen deprivation for localized prostate cancer. *N Engl J Med* 2011 Jul;365(2):107-18.
- 7 Pilepich MV, Winter K, Lawton CA, et al. Androgen suppression adjuvant to definitive radiotherapy in prostate carcinoma--long-term results of phase III RTOG 85-31. *Int J Radiat Oncol Biol Phys* 2005 Apr;61(5):1285-90.
- 8 Roach M, Bae K, Speight J, et al. Short-term neoadjuvant androgen deprivation therapy and externalbeam radiotherapy for locally advanced prostate cancer: long term results of RTOG 8610. *J Clin Oncol* 2008 Feb;26(4):585-91.
- 9 D'Amico A, Renshaw AA, Loffredo M, et al. Androgen suppression and radiation vs radiation alone for prostate cancer; a randomized controlled trial. *JAMA* 2008 Jan;299(3):289-95.
- 10 Crook JM, O'Callaghan CJ, Duncan G et al. Intermittent androgen suppression for rising PSA level after radiotherapy. *NEJM* 2012; 367: 895-903
- 11 Hussain M. Tangan CM. Berry DL. Et al Intermittent versus Continuous Androgen Deprivation in Prostate Cancer *NEJM* 2013; 368: 1314-1325
- 12 Tyrrell CJ, Kajsarv AV, Iversen P et al. A randomised comparison of 'Casodex' (bicalutamide) 150 mg monotherapy versus castration in the treatment of metastatic and locally advanced prostate cancer. *Eur Urol.* 1998; 33(5): 447-56

13 King CR, Presti JC , Jr, Gill H, et al. Radiotherapy after radical prostatectomy: does transient androgen suppression improve outcomes? Int J Radiat Oncol Biol Phys. 2004;59:341–347

14 Messing EM, Manola J, Sarosdy M, et al. Immediate hormonal therapy vs. observations in men with node positive prostate cancer following radical prostatectomy and pelvic lymphadenectomy: a randomized phase III Eastern Cooperative Oncology Group/Intergroup trial. N Engl J Med. 1999;341:1781–1788

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients

Attribute:4.2 Treat patients and colleagues fairly and without discrimination

Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
1	Statement of Probity, Honesty and Integrity	2015
2	Collection of Thank You messages	2015
3		
4		
5		
6		
7		
8		
9		
10		

Discussion

i Appreciative patients even though some complain about the service and wait times. often rmp patients to explain situation

Actions Agreed

Continue as above

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
To develop Operational Policy for Urological Cancer MDT	To collaborate with Head of Cancer Services to develop Operational Policy	Yes
To consolidate conduct of Urological Cancer MDM	To preview cases so that patient management is optimized and communicated with general practitioners in a timely manner	Yes

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 12

FORM 5- HEALTH AND PROBITY STATEMENTS**HEALTH DECLARATION**

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

Professional Obligations

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.
78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.
79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: _____

Personal Information redacted by the USI

Date: 18 December 2016Name in Capitals: Aidan O'Brien

NB: Additional Health and Probity forms are on the Southern Docs website – click [here](#)

Regulatory and Voluntary Proceedings [Please check relevant box by clicking on it and then sign below]

Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR



If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: _____

Personal Information redacted by the USI

Date: 18 December 2016Name in Capitals: Aidan O'Brien

Name:

GMC Number:

Appraisal Period :

Page 16

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PROBITY DECLARATION

Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006)*.

Personal Information redacted by the USI

Signature: _____

Date: 18 December 2016Name in Capitals: Aidan O'Brien

Convictions, findings against you and disciplinary action [Please check relevant box by clicking on it and then sign below]



Since my last appraisal/revalidation I **have not**, in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR



If I have been subject to any of the above, I have discussed this with my appraiser.

Personal Information redacted by the USI

Signature: _____

Date: 18 December 2016Name in Capitals: Aidan O'Brien

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click [here](#)

Personal Information redacted by the USI

Signature: _____

Date: 18 December 2016Name in Capitals: Aidan O'Brien

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 18

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraiser and Appraisee.

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			Yes.
Quality improvement activity			Yes.
Significant events review			Yes.
Review of complaints and compliments			Yes.
Feedback from colleagues	Year undertaken OR Planned Year:		/
Feedback from patients (where applicable)	Year undertaken OR Planned Year:		/

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	Yes.
Ensure the previous year's Personal Development Plan has been reviewed.	Yes.
Forward required Forms according to the organisation's appraisal policy.	

APPRAISAL COMPLETION	
We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:	
Personal Information redacted by the USI	
APPRAISEE	
Signature of Appraisee: _____	Date: 23.12.16
APPRAISER	
Signature of Appraiser: _____	Date: 23.12.16
GMC Number: 28463851 ✓	
CO-APPRAISER (if applicable)	
Signature of Co-Appraiser: _____	Name of Co-Appraiser: _____
GMC Number: _____	Organisation: _____