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Medical Director's Office

Memorandum

Our ref:	RW/nt	Your ref:	
To:	Mr Aidan O'Brien		
c.c.	Dr Damian Scullion		
From:	Dr Richard Wright, Medical Director		
Date:	28 th December 2017		
Subject:	Appraisal Documentation		

Thank you for forwarding a copy of your 2016 Appraisal documentation.

This document has been stored electronically by the Revalidation Team and I return the original for your files.

Kind regards

Personal Information redacted by the USI

Dr Richard Wright
Medical Director

Enc.

**AIDAN O'BRIEN FRCSI
CONSULTANT UROLOGIST**

Personal Information redacted by the USI

11.12.17

DEAR GREGG,

PLEASE FIND ENCLOSED COMPLETED
APPRAISAL FORMS FOR 2016,

YOURS SINCERELY,

Personal Information redacted by the USI



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

AOB-22833

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)	☒
Have accounted for 100% Attendance / non-Attendance at all M&M / Patient Safety / Governance or equivalent Meetings throughout the year	☒
Have reflected on a Significant Event and included implications for own practice or have used the M&M SBAR Template with appropriate detail of involvement – click here	☒
Evidence of Regular Participation in Clinical Audit	☒
Remember to send the following:- <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 Appraiser	☒
FORM 2 – all parts completed by Appraiser to include <u>whole practice</u> i.e. Private / Medico Legal Work etc.	☒
FORM 3 – All four GMP Domains completed jointly by Appraiser 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 Appraiser & Appraiser	☒
FORM 7 – Completed in respect of where the appraiser 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 Appraiser & Appraiser	☒
APPENDIX 2 – NOT REQUIRED / COMPLETE AND 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@shsc.nhs.uk

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](#)



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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 – 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

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
- Director of CURE in 1995
- External Adviser to the Royal College of Surgeons in Ireland in 2012 for Specialist Registrar appointments in Republic of Ireland
- 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 in 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 clinical and operative management of acute urological admissions and referrals, in addition to the ongoing clinical management of all elective admissions, when urologist of the week, which pertains for one week in every six weeks. Otherwise, it includes the administrative, clinical and operative management of elective inpatient and day case surgery, flexible cystoscopy lists and urodynamic studies, new patient clinics, general and oncology review clinics.
2.2 List your main sub-specialist skills and commitments / special interests	Urological oncology. Lead Clinician of the Urology MDT. Chair of Urology MDM. Acute Urology. Lower urinary tract dysfunction. Paediatric Urology
2.3 Please give details of any emergency, on-call and out of hours responsibilities	Since the introduction of 'Urologist of the Week' in September 2014, one consultant is responsible for all acute urological management for the Southern Health and Social Care Trust population, and for that of County Fermanagh, in addition to all referrals from Daisy Hill and South West Acute Hospitals. As one of six consultants, I participate in this rota. In addition to acute urology, it also includes the ongoing clinical management of patients electively admitted. During 2016, I also continued to provide support to Mr. Suresh when he was 'urologist of the week' until he left our department in October 2016..
2.4 Please give details of out-patient work if applicable	On Mondays, I conduct review clinics, rotating through Armagh Community, South West Acute and Craigavon Area Hospitals. On Tuesdays, I conduct a New Patient clinic at Craigavon Area Hospital. On Fridays, I conduct an Oncology Review Clinic concurrent with Urodynamic Studies.
2.5 Details of any other clinical work	I triaged Red Flag referrals while 'urologist of the week'. I arranged inpatient and day case surgical admissions. I arranged flexible cystoscopy and urodynamic lists. I arranged oncology review clinics. I reviewed, and amended if necessary, all outcomes of the weekly urological MDM, ensuring all reviews of all consultants were conducted within required timeframes.
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 practising privileges in, any non-HSC hospitals or clinics I do conduct a private outpatient consultation practice at my home. I had 75 consultations during 2016. I have never had a complaint, adverse events or incidents arising out of private practice. I have continued to keep all private consultation records for a minimum period of three years, all correspondence has been filed in patients' hospital charts.

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 Coordinator and Tracker each week to ensure that the management of all urological cancer patients was progressed during the 31 and 62 day timelines. Having achieved 100% compliance during the year of Peer review in 2015, I ensured that remained the case during 2016. I held Urology MDM Business meetings in preparation for the Annual Report to the National Cancer Plan in September 2016.
2.7.2 List any non-clinical work that you undertake which relates to research	None
2.7.3 List any work you undertake for regional, national or international organisations.	Lead Clinician and Chair of the Northern Ireland Cancer Network Clinical Reference Group in Urology 2013 - 2016
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: -

Job Plan enclosed

ADDITIONAL INFORMATION

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

The only change in all of the factors which have impacted negatively upon the delivery of care to patients, particularly those most urgently in need, has been that they have worsened. My main concerns during 2016 were

- the suboptimal care delivered to acute admissions and referrals, due to lack of beds and lack of emergency operating capacity, the lack of elective operating
- the lack of elective operating capacity resulting in waiting lists becoming larger and longer
- the increasing number of patients waiting longer periods beyond expected review dates.

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	GMC Revalidation Details	28 April 2014
3	Certificate of Proof of Entry on GMC Register	18 December 2016
4	Annual GMC Retention Fee Confirmation	16 February 2017
5	Job Plan commencing 01 October 2016	01 October 2016
6	CLIP Report January 2016 to December 2016	2016
7	Elective Inpatient Operating 2016	2016
8	Clinics in 2016	2016
9	CLIP Structured Reflective Template	2016
10	Mandatory Training Passport	December 2016
11	Personal Development Plan 2016	December 2016
12	PDP Structured Reflective Template	November 2017
Discussion		
Mr O'Brien has continued to deliver an excellent service in urology. He was lead Clinician in urology until December 2016 and helped oversee improvements in urological Cancer service. His CPD has faltered due to issues beyond your control. His mandatory training is up to date. His job plan is very however.		
Actions Agreed		
① Focused CPD to keep up to date. ② Reflect on job plan with line manager and discuss issues.		

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

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	Record of attendance at Morbidity and Mortality Meetings 2016	2016
2	Incident Report	21 October 2016
3	Statement of General Practitioner	June 2016
4	Inoculation History	November 2008
5	Health and Probity Forms	November 2017
6	Certificate of Membership of Medical Protection Society	01 September 2017
7	Urology MDT Annual Report for January – December 2016	01 September 2017
8	Other Roles Structured Reflective Template	November 2017
9	Letter of Concerns	23 March 2016
10		

Discussion

Mr O'Brien chairs M&M meetings and is committed to health improvement. All aspects of his practice are audited. His attendance at M&M is 100% and includes request meeting which will bring up to recommended attendance guidelines letter of concern regarding administrative issues.

Actions Agreed

To continue his commitment to safety and quality.
To help the Trust address their concerns regarding his administration.

[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](#).

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	Signed probity declaration	
2	Signed health declaration	
3	Thank you cards for patients	
4	Reflective Template	
5		
6		
7		
8		
9		
10		

Mr O'Brien has signed his privacy and health declaration.
Mr O'Brien enjoys good health and was off for 2 months
for an [REDACTED]. His leave record is within
trust guidelines. He always treats patients with dignity
and respect and will always act with honesty and
integrity.

Mr. Olsen will continue to act with honesty and integrity.
He will give a commitment to seek help at the
earliest opportunity should any medical or other issues
arise.

Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.

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 address in a durable and effective manner my long waiting list, and in so doing, to reduce the inequity in waiting lists.	A Trust issue to be discussed and agreed	No. Even though I conducted additional operating sessions that were made available, there was no additional effort or strategy by Trust management to address the issue.
To address long waiting list for urological cancer reviews	A Trust issue to be discussed and agreed	No. As above
To reduce the numbers of new patient consultations	A Trust issue to be discussed and agreed	No. Politically unacceptable
Attend course in Urology	To attend Annual Meeting of Irish Society of Urology	Attended September 2016

Name: Aidan O'Brien

GMC Number: 13949111

Appraisal Period : Jan – Dec 2016 Page 10

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN <u>for the year ahead</u>		
Development needs	Actions agreed	Target dates
To continue to dictate letters following every outpatient consultation	Addressing letter of concern	December 2017
To continue to triage all referrals	Addressing letter of concern	December 2017
To discuss issues relating to a heavy workload	Discuss with line manager.	July 10/18
To attend an international meeting on urology	Attend meeting - ? EAU.	December 2017

[CLICK HERE](#) for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

Name: Aidan O'Brien

GMC Number: 13949111

Appraisal Period : Jan – Dec 2016 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.

Personal Information redacted by the USI

Signature: _____

Date: 30 November 2017

Name 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.

Personal Information redacted by the USI

Signature: _____

Date: 30 November 2017

Name in Capitals: Aidan O'Brien

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: _____

Personal Information redacted by the USI

Date: 30 November 2017

Name 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.

Signature: _____

Personal Information redacted by the USI

Date: 30 November 2017

Name in Capitals: Aidan O'Brien

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click [here](#)

Signature: _____

Personal Information redacted by the USI

Date: 30 November 2017

Name in Capitals: Aidan O'Brien

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.

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		Personal information redacted by the USI	
Quality improvement activity			
Significant events review			
Review of complaints and compliments			
Feedback from colleagues	Year undertaken OR Planned Year:		2014
Feedback from patients (where applicable)	Year undertaken OR Planned Year:		2014

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	Personal Information redacted by the USI
Ensure the previous year's Personal Development Plan has been reviewed.	
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:

APPRAISEE

Signature of Appraisee:

Date: 01.12.17

APPRAISER

Signature of Appraiser:

Date: 1/12/2017

GMC Number:

CO-APPRAISER (if applicable)

Signature of Co-Appraiser:

Name of Co-Appraiser:

GMC Number:

Organisation:

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraiser is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2015 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 2016 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: _____

Please ensure the section below is fully completed.

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years	2014	Personal Information redacted by the UST	1/12/17
Feedback from patients (where applicable) 1 in 5 years	2014		1/12/17
Significant Events Review	2016		1/12/17
Review of complaints and compliments	2016		1/12/17
Continuing Professional Development	2016		1/12/17
Quality Improvement Review	2016		1/12/17

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 (Every 3 years)	Elearning Blood Transfusion Module Click Here	Core	15/12/15
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff Contact Patricia Watt on Personal Information redacted by the USI	Core	16/04/14
Desist Notice	To obtain a desist notice, click here	Core	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development@hscni-trust.nhs.uk to book a place.	Core	07/12/15
2 Yearly Updates	Method	Core / Optional	Date Completed
Infection Prevention and Control	SHSCT E-Learning Module Click Here	Core	08/10/13
Resuscitation	Face to Face. CAH - Helen Cullen Personal Information redacted by the USI DHH - Bernie O'Connor Personal Information redacted by the USI Bleep: Personal Information redacted by the USI bernadette.ocorinor Personal Information redacted by the USI	Optional	
3 Yearly Updates	Method	Core / Optional	Date Completed
Safeguarding Children & Vulnerable Adults	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development@hscni-trust.nhs.uk to book a place.	Core	29/04/14
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module Click Here	Core	17/04/14
Moving and Handling	SHSCT E-Learning Module Click Here	Core	13/03/14
Health & Safety / Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module Click Here	Core	08/10/13
Discovering Diversity	HSC E-Learning Module Click Here	Optional	
Recruitment & Selection	HSC E-Learning Module Click Here	Optional	
Sickness & Absenteeism Training	Face to Face. Contact ELD on Personal Information redacted by the USI or email learning.development@hscni-trust.nhs.uk	Optional	
Hyponatraemia	BMJ E-Learning Module Click here	Optional	
Management of Actual or Potential Aggression	Face to Face. Contact ELD on Personal Information redacted by the USI or email learning.development@hscni-trust.nhs.uk	Optional	
Fraud Awareness	HSC E-Learning Module Click here	Optional	
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module Click here	Optional	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning Click here	Optional	
Obstetrics Early Warning System	Online Module Click here	Optional	
Paediatrics Early Warning System	Face to Face. Contact CAH Dr S Shah shilpa.shah Personal Information redacted by the USI Contact DHH Dr B Aljarad bassam.aljarad Personal Information redacted by the USI	Optional	
Consent	In House E-Learning Module Click here	Optional	
Blood Culture	In House E-Learning Module Click here	Optional	
Peripheral Line	In House E-Learning Module Click here	Optional	
Oral Anticoagulants	MHRA Module Click here Once on the site choose the Anticoagulant Module. On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration.	Optional	
Naso Gastric Tube Placement	In House E-Learning module Click here	Optional	
Protocol following death of patient	In House E-Learning module Click here	Optional	
Guide to Prescribing in SHSCT	In House E-Learning module Click here	Optional	
Research and Development - Good Clinical Practice Training	Elearning Module Click here	Optional	
VTE	King's Thrombosis Centre E-learning Click here	Optional	
Safe Sedation [Module 1, 2 & 3]	In House Elearning Modules Click here (Part 1) Click here (Part 2) Click here (Part 3)	Optional	
Gastrointestinal endoscopy	Face to Face Contact Dr A Murdock Personal Information redacted by the USI	Optional	
Chest Drain Insertion	Face to Face Contact Dr A Ferguson Personal Information redacted by the USI	Optional	
Blood Gas Instrument	Face to Face Contact Derek McKillop Personal Information redacted by the USI Personal Information redacted by the USI Face to face	Optional	
Appraiser Training	Face to face Dates available here	Optional	
Appraisee Training	Face to face Dates available here	Optional	
Insertion and Management of Indwelling Urinary Catheters	Online Module Click here	Optional	
Coroner's Investigations and Inquests Programme	Online Module Click here	Optional	
HIV Awareness Training	Face to Face Contact Lyndsey Hasson Tel: Personal Information redacted by the USI	Optional	
Patients enrolled in Clinical Trials	In House E-Learning module Click here	Optional	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Waste Management	SHSCT E-Learning Module Click Here	Optional	
Modules proposed for E-Learning	Method	Core / Optional	Date Completed
Better Communication/Complaint Handling	Face to face	Optional	
Incident Reporting	Face to face	Optional	
Clinical Negligence	Not currently available	Optional	

Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@hscni.net Personal Information redacted by the USI

Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.

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:

Name of Appraisee:

GMC Number:

Date:

APPRAISER

Signature of Appraiser:

Name of Appraiser:

GMC Number:

Date:

Mandatory Training Passport

Aidan O'Brien, Urology, Date Record Created 28/12/2017

Print as PDF

CORE MODULES			ADDITIONAL MODULES				
Module	Date	Date Renewal	Module	Date	Date Renewal	Module	Date
FIRE	24/10/2017	24/10/2018	FRAUD AWARENESS			NEWS	
INFECTION CONTROL	08/10/2013	08/10/2015	MAPA			OEWS	
SAFEGUARDING	24/10/2017	23/10/2020	EQUALITY	13/03/2014	12/03/2017	PEWS	
INFORMATION GOVERNANCE	17/04/2014	16/04/2017	RECRUITMENT SELECTION			CONSENT	06/07/2010
H&S COSHH	08/10/2013	07/10/2016	SICKNESS ABSENTEEISM			BLOOD CULTURE	
BACKCARE	13/03/2014	12/03/2017	HYPONATRAEMIA			PERIPHERAL LINE	
RPRB DESIST?			ENTER CPR COURSE NAME, COMPLETED DATE AND RENEWAL DATE BELOW			USE OF ANTICOAGs	
RPRB THEORY	15/12/2015	14/12/2018				NG TUBE	
RPRB COMPETENCY	20/12/2017	19/12/2020	Complaints / Incidents	08/10/2013		ACTIONS FOLLOWING DEATH	
			Coroners Cases			PM CONSENT	
						APPRAISER	
						APPRAISSEE	08/03/2016
						NEGLIGENCE	

COURSES FOR RECOGNISED TRAINERS	Activity	Activity date	Activity date expires

Paying Patients Declaration 2015

Any professional service that a Consultant carries out for a third party and which are not part of their contractual services must be declared to the Trust. Therefore in order to comply with financial governance controls all consultants as part of their contractual obligations must inform the Trust of any paying patient work that they are undertaking.

Please
tick to
accept

I do not treat / intend to treat paying patients either inside or outside the Trust

☐

I am treating / intend to treat paying patients:-

Inside the Trust

☐

Outside the Trust

☒

Inside and Outside the Trust

☐

I confirm that I have read and understood the Trust Guide to Paying Patients & accept the responsibilities outlined in the Guide – click [here](#)

☒

I understand that any work carried out by medical secretaries to assist my paying patient work must be completed outside NHS working time

☒

I understand that any paying patient work must be included in my job plan

☒

I agree to submit a quarterly declaration and payment to the Paying Patients Team for the use of Trust facilities for outpatient / medico-legal work – click [here](#) for forms

☐

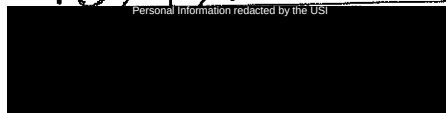
Consultant Name (PRINT):

AIDAN O'BRIEN

GMC Number:

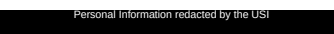
1394911

Signed:



Date:

27 NOVEMBER 2015

Please return this declaration via email to [katie.shields](#)  or via internal mail to Katie Shields, Medical Directorate, Clanrye House, Daisy Hill Hospital.

18/12/2016

**General
Medical
Council****A. O'Brien Esq., FRCS**

Personal information redacted by the USI

3 Hardman Street
Manchester M3 3AWEmail: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201**Certificate of proof of entry on the register**

Name: O'Brien, Aidan

GMC reference number: 1394911

Gender: Man

Primary medical qualification: MB BCh 1978 Queens University of Belfast

Registration and licensing history:

Status	From	To
Full with specialist registration with a licence to practise	07/08/2013	
Full registration with a licence to practise	16/11/2009	07/08/2013
Full registration	27/02/1980	16/11/2009
Provisional registration	28/12/1978	27/02/1980

Specialist Register entry:

Specialty	Sub-specialty	Date of entry
Urology	None	07/08/2013

Annual retention fee due date: 27/02/2017

Certificate of proof of entry on the register

Name: O'Brien, Aidan

GMC reference number: 1394911

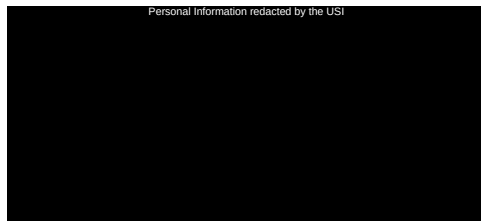
This certificate

All doctors who want to practise medicine in the UK must hold both registration and a licence to practise.

If the doctor's current status includes a reference to APS, this means their practice in the UK is subject to the requirements of our approved practice settings (APS) scheme. You can find more information about APS at www.gmc-uk.org/aps/.

This certificate does not guarantee that this doctor's status on the register has not changed. You can check this doctor's status on the register, and find up to date details of their eligibility to practise medicine in the UK, at www.gmc-uk.org/lrmp or by calling us.

For information on what the details of this certificate mean, go to www.gmc-uk.org/certificates/.



Charlie Massey
Registrar

**General
Medical
Council**

16/02/2017

Your GMC reference number: 1394911

A. O'Brien Esq., FRCS

Personal information redacted by the USI

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201

Dear Mr O'Brien

Annual retention fee confirmation for registration year starting 27/02/2017

I confirm that you have paid the appropriate fees required by the General Medical Council Registration Fees Regulations, either in full or by way of a Direct Debit arrangement.

This confirmation is not proof that you are currently registered, nor proof of identity. You or your employer can check your current status on our online register, the List of Registered Medical Practitioners, on our website. You can also call us on 0161 923 6602 (+44 161 923 6602 from outside the UK) with your GMC reference number and select option one.

This is not a receipt. Receipts for payments made in the last six years can be printed from your GMC online account.

Yours sincerely

Personal information redacted by the USI

**Steven Downs CPFA
Assistant Director - Finance and Procurement
Resources Directorate**

[Skip to content](#)[Working with doctors](#) [Working for patients](#)**Logged in as Mr O'Brien GMC Ref: 1394911**[My Details](#)

Revalidation details

[My Account](#)

The date you last revalidated was 28/04/2014.

[My Registration](#)

All fully registered doctors with a licence to practise need to revalidate to show more about [revalidation](#).

[My Revalidation](#)

Please check the designated body information below. If you're happy it's correct, If it's not correct please click 'Change designated body'.

[My Appointments](#)

If you don't know your designated body you can use our [online tool](#) to help you

[My Surveys](#)

If you are sure you don't have a designated body please click 'I don't have a designated body'

[My Tests](#)

Designated body	Southern Health and Social Care Trust
Responsible officer	Robert Wright
Designated body email address	medical.revalidation@shsc.nhs.uk
Next submission date	27/04/2019
Designated body last updated by	General Medical Council
Designated body last updated on	16/04/2012

[Contact Us](#)[Good Practice](#)[Confirm designated body](#)[Change designated body](#)[I don't have a designated body](#)[Browsealoud](#)

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CHKS Consultant Level Indicator Programme

The Southern Trust

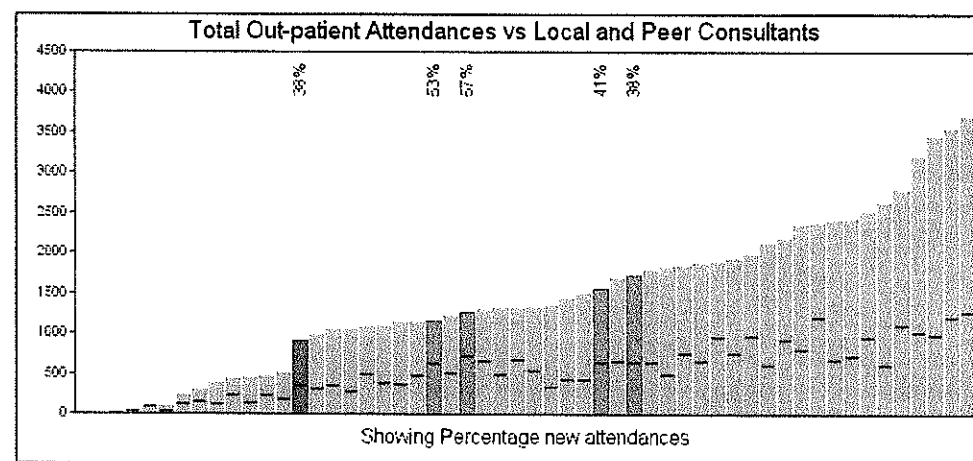
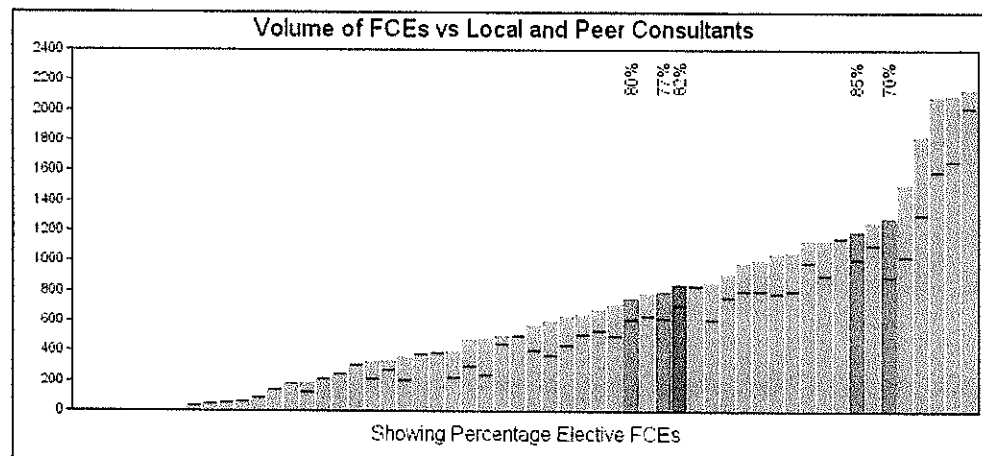
January 2016 to December 2016

Personal information
redacted by the USI

: Mr Aidan O'Brien

Urology

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Personal Information
 redacted by the USI


Workload Volumes	Consultant		Local	
Total Number of FCEs	849			
Elective FCEs	698	82.2%	77.6%	79.6%
In-Patients	202	28.9%	15.4%	21.6%
Day Cases	496	71.1%	84.6%	78.4%
Emergency FCEs	121	14.3%	19.9%	19.7%
Other FCEs	30	3.5%	2.6%	0.7%
* Regular Attendances			6.7%	2.4%

* 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	526	62.0%	62.3%	68.9%
FCEs - Female	323	38.0	37.7	31.1
FCEs - Child (0-18)	27	3.2%	2.6%	5.1%
FCEs - Adult (19-74)	576	67.8%	72.6%	65.4%
FCEs - Elderly (75+)	246	29.0%	24.7%	29.5%

Outpatient workload	Consultant		Local	
Total Attendances	920		1440	1481
New Attendances	347	37.7%	46.0%	36.0%
Follow-up Attendances	573	62.3%	54.0%	64.0%
Attendances with Procedure	89	9.7%	2.4%	32.7%

Consultant Total FCEs : 849 31,658 : Peer FCEs

Performance Indicators

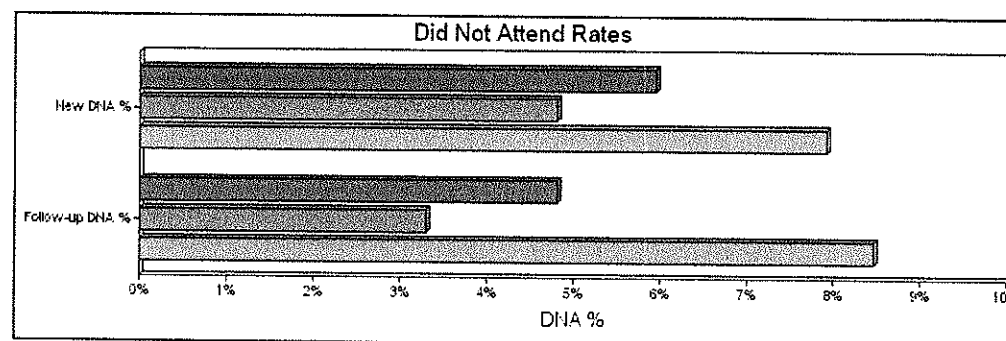
	Consultant	Local	Peer
FCE Inpatient ALoS (DC trimmed)		4.0	3.3
Average Length of Stay (Zero trimmed)		4.7	3.8
Elective		3.7	2.6
Non-Elective		5.8	4.4
Risk Adjusted Length of Stay *		104.3	117.9
Day Case Rate	496	71.1%	84.6%
Day Case Overstays	27	5.2%	5.2%
Average Elective Pre-Operative LoS		0.2	0.1
Elective IP Spells with no Procedure	3	3.0	0.6
Elective Inpatient spells - procedure not carried out			1.6%
Patient Cause			
Other Reason			1.6%

High Volume Procedures

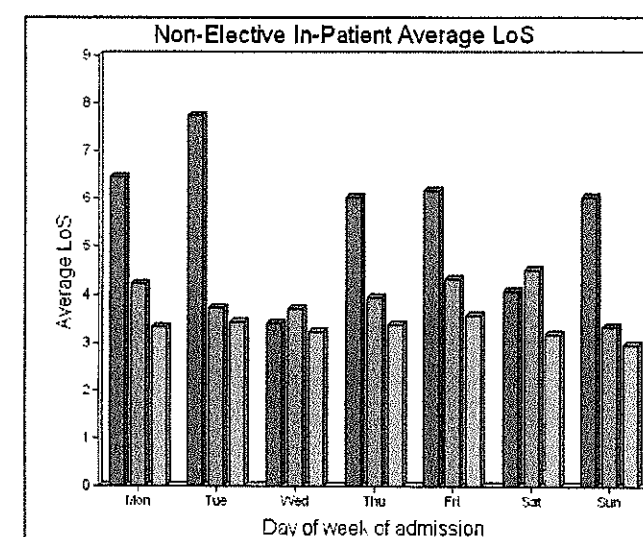
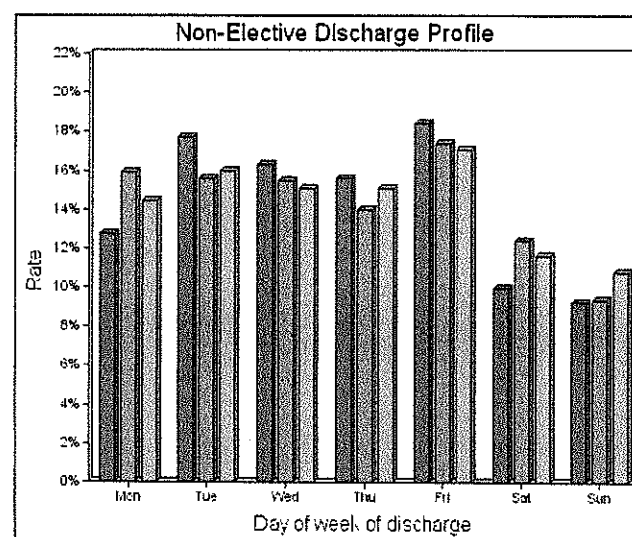
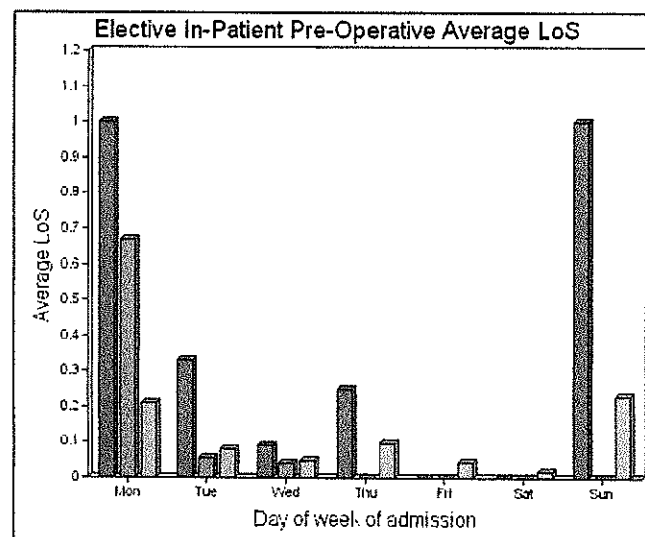
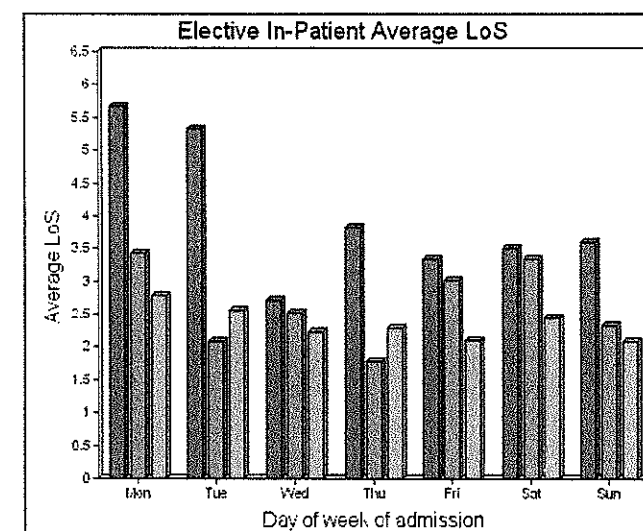
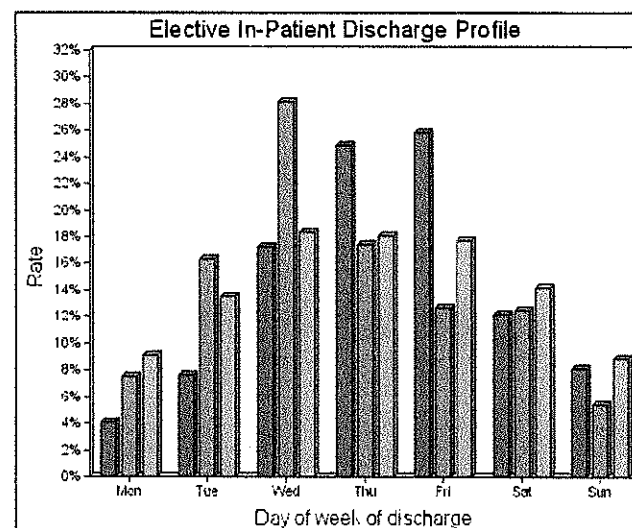
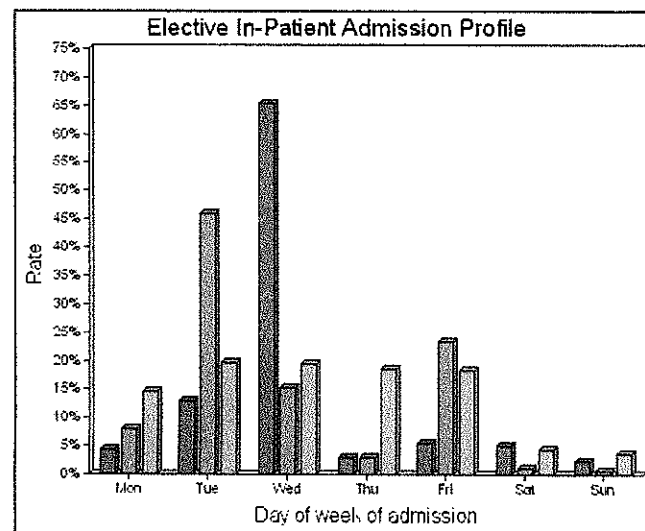
Day Case Procedures	Actual Day Cases						Day Case Overstays					
	Number			Rate of All Elective FCEs			Number			Average LoS		
	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer	Consultant	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	186	278.0	163.8	95.9%	98.2%	96.5%	2	2.0	5.2	2.5	1.5	1.4
M49 - Other operations on bladder	146	72.0	108.8	99.3%	99.7%	99.5%	1		1.3	1.0		1.4
M43 - Endoscopic operations to increase capacity of bladder	36	11.0	13.8	87.8%	91.7%	91.9%	1	1.0	2.5	1.0	1.0	1.5
N30 - Operations on prepuce	8	18.8	24.2	61.5%	81.5%	92.8%		3.0	2.0		1.0	1.3
N11 - Operations on hydrocele sac	7	5.0	5.8	87.5%	88.2%	88.6%	1	1.0	1.7	2.0	1.0	1.1
M29 - Other therapeutic endoscopic operations on ureter	6	15.7	15.0	37.5%	71.2%	66.5%	2	2.3	4.8	2.0	1.0	1.5
U26 - Diagnostic testing of genitourinary system	4	1.0	34.0	100.0%	100.0%	100.0%						
M47 - Urethral catheterisation of bladder	3	3.0	25.3	100.0%	80.0%	96.4%			1.7			1.8
N06 - Other excision of testis	3	1.0	2.7	75.0%	33.3%	69.9%			1.4			1.2
M16 - Other operations on kidney	2	8.0	0.4	25.0%	69.6%	16.2%	1	1.0	1.0	2.0	1.0	3.0

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	36	11.0	21.9	0.8	0.1	0.1	4.3	3.0	2.6
M27 - Therapeutic ureteroscopic operations on ureter	20	15.0	7.2	1.0	0.5	0.3	2.5	3.0	1.5
M29 - Other therapeutic endoscopic operations on ureter	20	12.0	10.2	0.7	0.5	0.5	3.8	3.8	2.3
U21 - Diagnostic imaging procedures	18	24.6	12.3	2.0	6.9	3.0	6.5	3.4	2.3
M42 - Endoscopic extirpation of lesion of bladder	18	15.8	22.5	1.4	0.7	0.2	6.2	3.0	1.9
M45 - Diagnostic endoscopic examination of bladder	12	9.2	6.1	0.0	0.0	0.4	2.8	2.4	1.2
M16 - Other operations on kidney	8	2.0	1.3	1.2	1.0	0.6	4.4	12.2	3.7
M02 - Total excision of kidney	6	3.2	7.2	0.2	0.0	0.3	10.5	4.5	4.4
M76 - Therapeutic endoscopic operations on urethra	6	3.2	3.4	0.0	0.0	0.2	0.8	0.8	1.2
M79 - Other operations on urethra	6	0.5	0.3	0.0	0.0	0.1	0.7	1.5	0.6

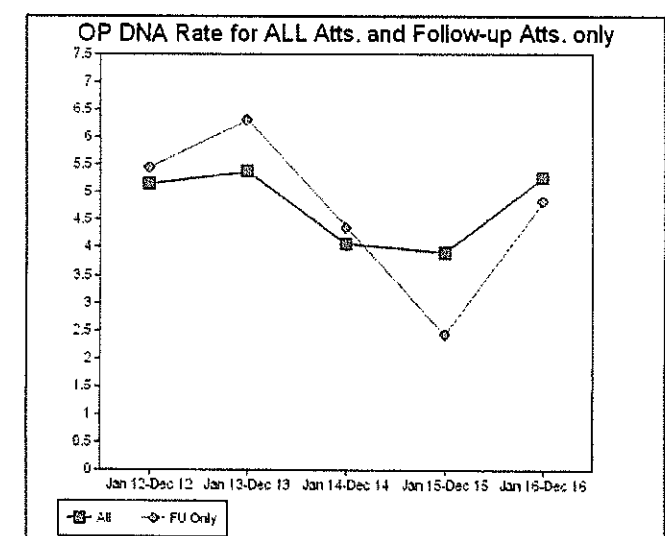
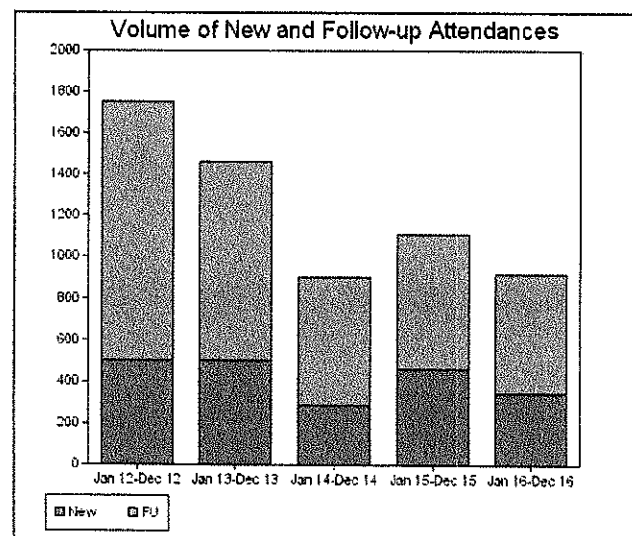
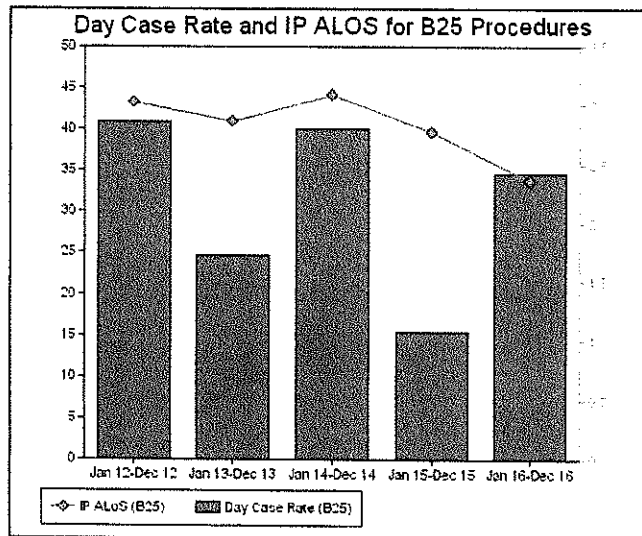
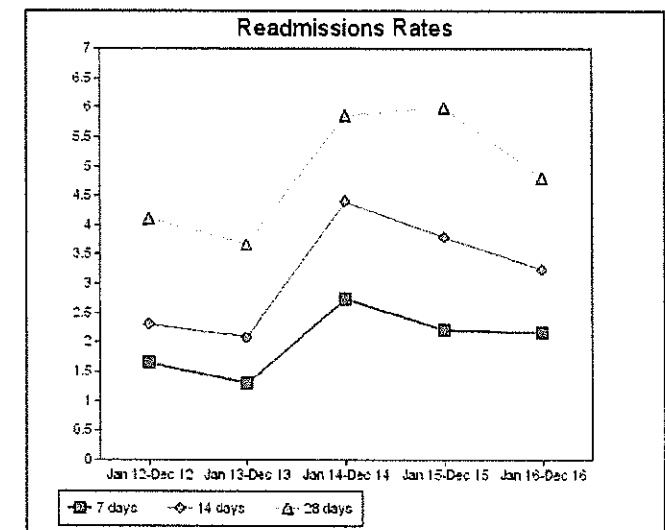
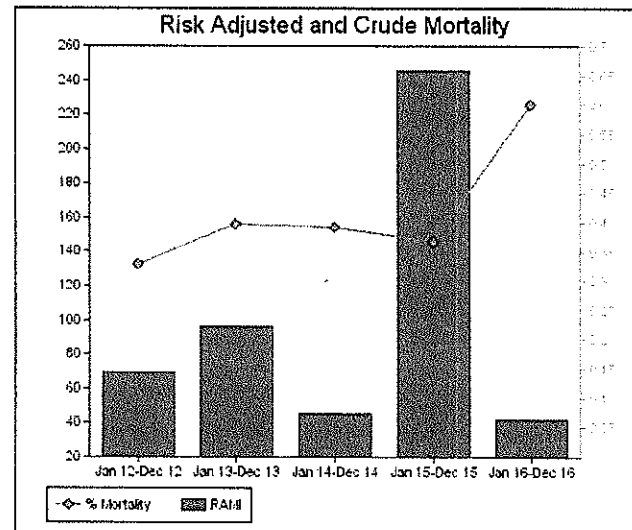
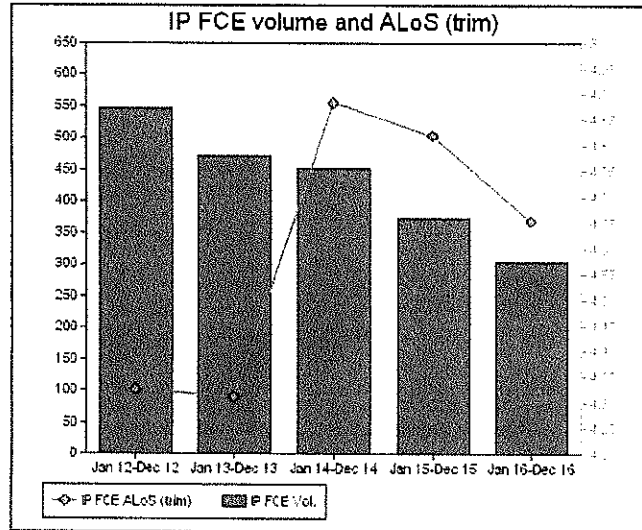
	Consultant		Local Peer		Selected Peer	
	Volume	Percentage / Rate	Average / Cons	Percentage / Rate	Average / Cons	Percentage / Rate
Total Attendances	920		1440		1481	
New Attendances	347	37.7%	663	46.0%	533	36.0%
Referred by General Practitioner	181	52.2%	478	72.1%	408	71.9%
With Procedures Recorded	80	23.1%	31	4.6%	165	29.2%
Average Procedure per coded attendance		1.1		1.0		1.1
Did Not Attend	22	6.0%	34	4.8%	49	7.9%
Follow-Up Attendances	573	62.3%	777	54.0%	949	64.0%
With Procedures Recorded	9	1.6%	4	0.5%	330	34.7%
Average Procedure per coded attendance		1.1		1.0		1.1
Did Not Attend	29	4.8%	26	3.3%	88	8.5%
New : Follow-Up Ratio	573	1 : 1.7	777	1 : 1.2	1010	1 : 1.8



Top ten Procedures Reported (Volume)	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	89	29	8
M70 - Other operations on outlet of male bladder	0	6	13
M45 - Diagnostic endoscopic examination of bladder	0	0	119
U26 - Diagnostic testing of genitourinary system	0	0	4
X36 - Blood withdrawal	0	0	1
Q55 - Other examination of female genital tract	0	0	1
X38 - Subcutaneous injection	0	0	1
X62 - Assessment			274
U32 - Diagnostic blood tests			92
H62 - Other operations on bowel			7

Personal Information
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Personal information
redacted by the USI



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

Clinics in 2016 (excluding SWAH clinics)

2016 was a 30.5 week year (until commencement of sick leave on 16 Nov 2016)

Armagh:	Job Plan:	One clinic per calendar month 7 clinics	
	Actual:	4 clinics	
Craigavon New Clinic:	Job Plan:	One clinic per week 30.5 clinics	
	Actual:	21 clinics	
Craigavon Review Clinic:	Job Plan:	One clinic per week (when not in Armagh or SWAH) 20.5 clinics	
	Actual:	12 clinics	
Specialty Clinics:	Job Plan:	One clinic per week 30.5 clinics	
	Actual:	Oncology:	8 clinics
		Urodynamics	9 clinics
		Urodyns & Oncology:	33 clinics

		Total Spec. Clinics	50 clinics
Total Job Planned Clinics:	88.5 clinics		
Actual Clinics:	87 clinics		
Total additional clinics in 2016:	- 1.85 clinics		
Total additional clinic session time in 2016:	- 7.4 hours		
Mean additional administrative time per clinic:	1 hour		
Total additional time allocated to clinics;	- 9.25 hours		
Mean Additional time allocated to clinics per week:	- 0.3 hours		

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

Requirement: One annually

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of report: January 2016 to December 2016	
What issues can I identify from the report? For several years, I have had doubts regarding the reliability and utility of the data contained within CLIP reports. On this occasion, I have had reason to have a detailed knowledge of all of the sessions of clinical activity conducted during the first ten months of 2016 (prior to sick leave). I conducted 83.25 elective inpatient operating sessions during that time, in contrast to the 58 sessions in my job plan. However, that additional operative work had only a minimal, negative effect on outpatient clinic activity (1.5 sessions). Moreover, the CLIP report takes no account of sick leave or other circumstances impacting upon performance. The report has detailed that I performed 36 prostatic resections in 2016. I actually performed 46. I have written to CHKS seeking an explanation. I have not received a reply. What actions will I undertake? At best, none. I will be even more circumspect than before regarding the merit of CLIP reports, if there is any. Final outcome after discussion at appraisal: (Complete at appraisal)	

Competencies

Mandatory Training Passport

Aidan O'Brien, Urology, Date Record Created: 15/12/2015

Print as PDF

CORE MODULES

Module	Date	Date Renewal
FIRE	07/12/2015	06/12/2016
INFECTION CONTROL	08/10/2013	08/10/2015
SAFEGUARDING	29/04/2014	28/04/2017
INFORMATION GOVERNANCE	17/04/2014	16/04/2017
H&S COSHH	08/10/2013	07/10/2016
BACKCARE	13/03/2014	12/03/2017
RPRB DESIST?		
RPRB THEORY	16/04/2014	16/10/2015
RPRB COMPETENCY	16/04/2014	15/04/2017

ADDITIONAL MODULES

Module	Date	Date Renewal	Module	Date	Date Renewal	Module	Date	Module	Date
FRAUD AWARENESS			MAPA			NEWS		PRESCRIBING	
RECRUITMENT SELECTION			EQUALITY	13/03/2014	12/03/2017	OEWS		CLINICAL TRIALS	
SICKNESS ABSENTEEISM			HYPONATRAEMIA			PEWS		VTE	
ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW						CONSENT	06/07/2010	SAFE SEDATION	
						BLOOD CULTURE		GASTRO ENDOSCOPY	
						PERIPHERAL LINE		CHEST DRAIN	
						USE OF ANTICOAGs		BLOOD GAS	
						NG TUBE		APPRAISER	
						ACTIONS FOLLOWING DEATH PM CONSENT		APPRAISSEE	23/01/2014
								NEGLIGENCE	

COURSES FOR
RECOGNISED
TRAINERS

Activity	Activity date	Activity date expires

Mandatory Training Passport

AOB-22868

Aidan O'Brien, Urology, Date Received: 16/12/2017

Print as PDF

CORE MODULES

Module	Date	Date Renewal
FIRE	07/12/2015	06/12/2016
INFECTION CONTROL	08/10/2013	08/10/2015
SAFEGUARDING	29/04/2014	28/04/2017
INFORMATION GOVERNANCE	17/04/2014	16/04/2017
H&S COSHH	08/10/2013	07/10/2016
BACKCARE	13/03/2014	12/03/2017
RPRB DESIST?		
RPRB THEORY	15/12/2015	14/12/2018
RPRB COMPETENCY	16/04/2014	15/04/2017

ADDITIONAL MODULES

Module	Date	Date Renewal	Module	Date	Date Renewal	Module	Date	Module	Date
FRAUD AWARENESS			MAPA			NEWS		PRESCRIBING	
EQUALITY	13/03/2014	12/03/2017	RECRUITMENT SELECTION			OEWS		CLINICAL TRIALS	
SICKNESS ABSENTEEISM			CONSENT	06/07/2010		PEWS		VTE	
HYPONATRAEMIA			BLOOD CULTURE					SAFE SEDATION	
ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW			PERIPHERAL LINE					GASTRO ENDOSCOPY	
			USE OF ANTICOAGs					CHEST DRAIN	
			NG TUBE					BLOOD GAS	
								APPRAISER	
Complaints / Incidents	08/10/2013		ACTIONS FOLLOWING DEATH					APPRAISSEE	08/03/2016
Coroners Cases			PM					NEGLIGENCE	
			CONSENT						

COURSES FOR RECOGNISED TRAINERS

Activity	Activity date	Activity date expires

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN <u>for the year ahead</u>		
Development needs	Actions agreed	Target dates
To address in a durable and effective manner my long inpatient waiting list, and in so doing, to reduce inequity in waiting lists.	} These are Trust issues to be discussed and agreed.	2017
To address long waiting list for urological cancer reviews.		2017
To reduce the numbers of new patient consultations.		2017
Attend Course - urology	Enjoy ~~S~~ Irish Society meeting.	2016.

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 14

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:

During 2016, I focussed on the areas which I believed were most clinically pressing, performing 25 additional, inpatient operating sessions, and 20 additional oncology review sessions, in the ten months available to me. I have no doubt that doing so significantly reduced the poor clinical outcomes and suffering of significant numbers of patients. I also have no doubt that doing so contributed to the issues since subject to formal investigation. My appraiser recorded that these were Trust issues to be discussed and agreed in 2017. They have yet to be so!

Date of reflection: 30 November 2017

Final outcome after discussion at appraisal:

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



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Record of Attendance Morbidity and Mortality Meetings 2016

Craigavon Area Hospital

UROLOGY

MR AIDAN O'BRIEN

4 out of 8 = 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.

Incidents
Consultant Appraisal 1 January 2016 to 31 December 2016
Mr Aidan O'Brien

ID	Record name	Incident date	Description	Action taken
Personal information redacted by the USI		21/10/2016	Male child scheduled for circumcision on emergency list. Not consented as consultant working alone, no reg/sho cover.	Discussed with Sr Johnston, agreed to child been consented in department due to above circumstances & to minimize distress to child.



23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road,
Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal information redacted by the USI

APPENDIX 1:



Southern Health
and Social Care Trust

10 April 2012.

Dear Mr. O'Brien,

Re: Clinical Lead for the Urology Multidisciplinary Team

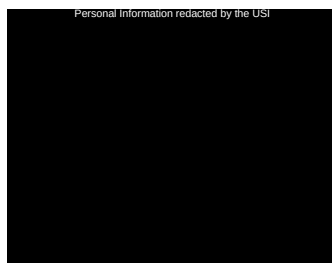
I understand that the Urology Cancer Multidisciplinary Team have nominated you as the Lead Clinician for the service.

I would like to confirm your position as Clinical Lead for the Urology Cancer Service from the 1st April 2012. This term of office will be for an initial 3 years, after which time it will be reviewed.

The role and responsibilities for the Lead Clinician are detailed in the Operational Policy for the service.

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

Yours sincerely,



Dr. Rory Convery,
Clinical Director of Cancer Services,
Southern Health and Social Care Trust.

Urology MDT Business Meetings 2016

Objectives

The purpose of the Business Meetings of 2016 will be to review the progress of the Urology Multidisciplinary Team in its functionality and efficacy in meeting the criteria established and agreed by the National Cancer Plan, to address and resolve inadequacies and deficiencies, and to collate all required data (MDM attendances, quoracy, compliance with cancer timelines etc.,) in preparation for the provision and uploading of the required annual report in September of each year.

Business Meetings will be held at 12.30 pm on each of the following dates:

- Thursday 10 March 2016
- Thursday 19 May 2016
- Thursday 02 June 2016
- Thursday 01 September 2016

It is hoped that all MDT members will be able to attend on these dates,

Aidan O'Brien

Lead Clinician of MDT

28 February 2016.



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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 Lead Clinician of Urology MDT, I have no doubt that I have contributed significantly to the improved management of urological cancers in the Southern Trust. In particular, I ensured continued 100% compliance with the 31 day timeline for new cancer referrals.	
They also brought the following drawbacks to my main clinical role: The role required and consumed considerable time, further exacerbated by the failure and refusal of clinicians to provide clinical summaries on each patient for discussion at MDM	
I could consider the following actions, to maximise the benefits and minimise the drawbacks: I stepped down from the role in December 2016	
Date of reflection: 30 November 2017	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)	

APPRAISAL 2017

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Appraisal 2017



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AOB-22880

MEDICAL APPRAISAL DOCUMENTS & CHECKLIST
PLEASE USE THESE FORMS FOR ALL SOUTHERN
TRUST MEDICAL APPRAISALS

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)	☒
Have accounted for 100% Attendance / non-Attendance at all M&M / Patient Safety / Governance or equivalent Meetings throughout the year	☒
Have reflected on a Significant Event and included implications for own practice or have used the M&M SBAR Template with appropriate detail of involvement – click here	☒
Evidence of Regular Participation in Clinical Audit	☒
Remember to send the following:- <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. NB: There is an updated requirement to include a signed Paying / Private Patient Declaration if the appraisee undertakes any work of this nature inside or outside the Trust. There is also another new requirement to explain at what <u>stage</u> the appraisee's job plan is in the approval process	☒
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, and one of the options for both the Health Declaration and the Probity Declarations ticked	☒
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 / COMPLETE AND 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@shsc.nhs.uk

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 Team, Beechfield House, CAH or Revalidation Team, Clanrye House, DHH

For further guidance and FAQ's – click [here](#)

APPRAISAL DOCUMENTS

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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 (for doctor's own use)

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 & 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: 11 June 1992
1.10	For any specialist registration / qualification outside UK, please give date and specialty	Fellow of the 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 Urologist, Craigavon Area Hospital Lead Clinician, Northern Ireland Cancer Network Clinical Reference Group in Urology

ANY ADDITIONAL INFORMATION

- Fellow of the Ulster Medical Society 1984
- Fellow of the Royal Society of Medicine in Ireland 1986
- Fellow of the Irish Society of Urology 1992
- Member of the Bristol Urological Institute 1992
- Founding Director of CURE 1995
- External Adviser to the Royal College of Surgeons in Ireland for Specialist Registrar appointments 2012 - 2014
- Lead Clinician of Southern Health and Social Care Trust Urological Cancer Multidisciplinary Team 2012 - 2016
- Lead Clinician & Chair of the Northern Ireland Cancer Network Clinical reference Group in Urology 2013 – 2015
- Peer reviewer for the National cancer Plan in February 2015

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 • Clinical and operative management of acute urological admissions and referrals when urologist of the week • Clinical management of all elective admissions when urologist of the week • Elective inpatient & day case surgery • New and review outpatient clinics • Urological cancer outpatient clinics • Charing Urological Cancer MDM • Urodynamic Studies & Flexible Cystoscopies
2.2 List your main sub-specialist skills and commitments / special interests	• Acute Urology • Urological Oncology • Urinary Tract Stone Disease • Lower Urinary Tract Dysfunction
2.3 Please give details of any emergency, on-call and out of hours responsibilities	I participate in the Urologist of the Week rota for a period of one week every six weeks. The primary commitment is the provision of clinical and operative management of all patients acutely admitted to Craigavon Area Hospital, in addition to advising on the management of patients acutely admitted to Daisy Hill and South West Acute Hospital, taking over their management if necessary following patient transfer.
2.4 Please give details of out-patient work if applicable	• General urology review clinics in Craigavon Area, Armagh Community and South West Acute Hospitals on Mondays • New patient clinics on Tuesdays • Urological Cancer review clinics on Fridays • Urodynamic clinics on Fridays
2.5 Details of any other clinical work	• Triage of referrals, including review by telephone, requesting investigations, initiating treatment, etc. • Administrative scheduling of elective admissions, flexible cystoscopy and urodynamic studies, and oncology reviews • Previewing and charing Urology MDM
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? (Include Paying / Private Declaration if relevant). 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 admitting or practicing rights in any non-HSC facilities. I have not had any tests or investigations performed privately at any HCS facility I do conduct a private outpatient practice at my home. I had 89 patients attend during 2017. I have never had a complaint from a patient who attended privately. A formal investigation has been conducted by the Southern Health and Social Care Trust during 2017 and 2018, following a reported allegation that I had arranged for patients who had attended privately, to be admitted for prostatic resection after a significantly shorter period of time than those who had not attended privately

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	None
2.7.2 List any non-clinical work that you undertake which relates to research	Director of Craigavon Urological Research & Education
2.7.3 List any work you undertake for regional, national or international organisations.	None
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 not, please explain below at which stage of the approval process your job plan is currently:-

My Current Job Plan is almost ready for Sign Off, just awaiting clarification of the amount of predictable time to be allocated for week-end ward rounds when urologist of the week.

ADDITIONAL INFORMATION

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

**AIDAN O'BRIEN FRCSI
CONSULTANT UROLOGIST**

Personal Information redacted by the USI

Declaration Concerning Private Practice

Having had a new home constructed in 2004, I had the opportunity of having an outpatient consultation facility designed and incorporated into the structure. The facility had to meet with all of the planning and building control regulations relating to disabled access, health and safety measures, etc.

Consultations arise usually as a consequence of referral from general practitioners, less frequently from other consultants and following self-referral. I also use the facility for review of professional colleagues, out of courtesy and in respect of their privacy, and without charge. I also use the facility for medicolegal consultations.

I use the facility for the above purposes, only on some Saturdays, when not on call or committed to any other HSC activity, such as waiting list initiatives. I do not conduct any private practice in any other place or at any other time.

I am cognisant of the requirements arising from the GMC's Good Medical Practice guidelines and with the Southern Trust's Guidelines for Management of Private Patients. I do believe that I comply with both.

Personal Information redacted by the USI

Aidan O'Brien

Consultant Urological Surgeon



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Paying Patients Declaration 2015

Any professional service that a Consultant carries out for a third party and which are not part of their contractual services must be declared to the Trust. Therefore in order to comply with financial governance controls all consultants as part of their contractual obligations must inform the Trust of any paying patient work that they are undertaking.

Please
tick to
accept

I do not treat / intend to treat paying patients either inside or outside the Trust

☐

I am treating / intend to treat paying patients:-

Inside the Trust

☐

Outside the Trust

☒

Inside and Outside the Trust

☐

I confirm that I have read and understood the Trust Guide to Paying Patients & accept the responsibilities outlined in the Guide – click [here](#)

☒

I understand that any work carried out by medical secretaries to assist my paying patient work must be completed outside NHS working time

☒

I understand that any paying patient work must be included in my job plan

☒

I agree to submit a quarterly declaration and payment to the Paying Patients Team for the use of Trust facilities for outpatient / medico-legal work – click [here](#) for forms

☒

Consultant Name (PRINT):

AIDAN O'BRIEN

GMC Number:

1394911

Signed:

[Redacted Signature]

Date:

30 NOVEMBER '17

Please return this declaration via email to [katie.shields](#) or via internal mail to Katie Shields, Medical Directorate, Clanyre House, Daisy Hill Hospital.

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	Certificate of Continued Specialist Registration	03 December 2018
3	Confirmation of payment of Annual retention Fee for 2017	16 February 2017
4	GMC Account Summary	03 December 2018
5	GMC Revalidation details	03 December 2018
6	Job Plan commencing 01 October 2016	01 October 2016
7	Job Plan commencing 01 April 2018	01 April 2018
8	CLIP report 2017	14 February 2018
9	CLIP Structured Reflective Template	03 December 2018
10	Mandatory Training Passport	03 December 2018

Discussion

My Job Plan does not adequately reflect the amount of work that I undertake each week, and the work which I do each week is inadequate relative to the need. The more patients one attends to, the more work it generates, and the inadequacy increases. Nevertheless, I do read the urological literature on a weekly basis. I do believe that I am up to date with regard to knowledge. Since my regional leadership of the Clinical Reference Group in Urological Oncology, I am entirely aware of all relevant guidelines. I believe that I do apply that knowledge and resulting competence in practice for the benefit of patients, usually with multidisciplinary consensus and scrutiny. I do believe that I have always recorded my work clearly, accurately and legibly.

Mr O'Brien has been absent for 3 weeks at beginning of year and has not had opportunity to fulfill CPD requirements

Actions Agreed

Mr O'Brien will D/W Line Manager his Job Plan and plans to reduce workload by 1 clinic per week. He will focus on his CPD and attend a national meeting. He will continue his mandatory training as per trust guidelines

[CLICK HERE](#) for further guidance about completing Form 3 and [HERE](#) for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

07/08/2013

Your GMC reference number: 1394911

A. O'Brien Esq., FRCS

Personal Information redacted by the USI

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_L1224656_UK2LETT-380A

Dear Mr O'Brien

Welcome to the Specialist Register

This letter confirms your name has been entered on the Specialist Register. I have enclosed details of your entry on the register which reflects this important change in your registration status.

Your entry on the register on our website has been updated to show the date of your entry onto the Specialist Register and details of the specialty which entitled you to be included. If we have been notified by our specialist and GP certification team that you have qualified in a sub-specialty, this will also be shown.

We endeavour to provide an excellent service to all those registered with the GMC. If you do have any questions, please call my colleagues in our contact centre who will be pleased to assist you.

I wish you continued success in your career.

Yours sincerely

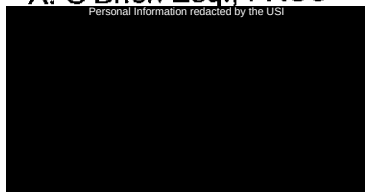
Personal Information redacted by the USI

Clare Barton
Assistant Director, Registration and Revalidation

03/12/2018

**General
Medical
Council****A. O'Brien Esq., FRCS**

Personal Information redacted by the USI

3 Hardman Street
Manchester M3 3AWEmail: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201**Certificate of proof of entry on the register**

Name: O'Brien, Aidan

GMC reference number: 1394911

Gender: Man

Primary medical qualification: MB BCh 1978 Queens University of Belfast

Registration and licensing history:

Status	From	To
Full with specialist registration with a licence to practise	07/08/2013	
Full registration with a licence to practise	16/11/2009	07/08/2013
Full registration	27/02/1980	16/11/2009
Provisional registration	28/12/1978	27/02/1980

Specialist Register entry:

Specialty	Sub-specialty	Date of entry
Urology	None	07/08/2013

Annual retention fee due date: 27/02/2019

Working with doctors Working for patients

Page 1 of 2

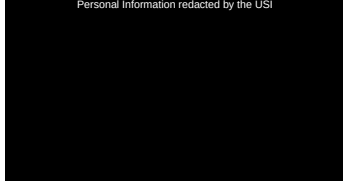
The GMC is a charity registered in
England and Wales (1089278)
and Scotland (SC037750)

16/02/2017

Your GMC reference number: 1394911

A. O'Brien Esq., FRCS

Personal Information redacted by the USI



3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201

Dear Mr O'Brien

Annual retention fee confirmation for registration year starting 27/02/2017

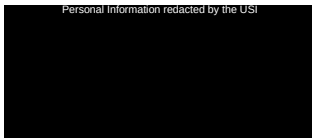
I confirm that you have paid the appropriate fees required by the General Medical Council Registration Fees Regulations, either in full or by way of a Direct Debit arrangement.

This confirmation is not proof that you are currently registered, nor proof of identity. You or your employer can check your current status on our online register, the List of Registered Medical Practitioners, on our website. You can also call us on 0161 923 6602 (+44 161 923 6602 from outside the UK) with your GMC reference number and select option one.

This is not a receipt. Receipts for payments made in the last six years can be printed from your GMC online account.

Yours sincerely

Personal Information redacted by the USI



**Steven Downs CPFA
Assistant Director - Finance and Procurement
Resources Directorate**

Working with doctors Working for patients

The GMC is a charity registered in
England and Wales (1089278)
and Scotland (SC037750)

Logged in as Mr O'Brien GMC Ref: 1394911[My Details](#)[Account summary](#)[My Account](#)**Summary**[Account
summary](#)

Annual retention fee due date	27/02/2019
Current account balance	£ 0
Direct Debit	Yes
Payment frequency	Annual
Next payment due date	No Payment E
e-billing	Yes

[Payment history](#)[Documents](#)[Income discount](#)[My Registration](#)[My Revalidation](#)[My Appointments](#)[My Surveys](#)[My Tests](#)[Contact Us](#)[Good Practice](#)

Logged in as Mr O'Brien GMC Ref: 1394911

My Details

Revalidation details

My Account

The date you last revalidated was 28/04/2014.

My Registration

All fully registered doctors with a licence to practise need to revalidate to show they are up to date. For more information, please see [more about revalidation](#).

My Revalidation

Please check the designated body information below. If you're happy it's correct please click 'I am happy with this information'. If it's not correct please click 'Change designated body'.

My Appointments

If you don't know your designated body you can use our [online tool](#) to help you find it or visit [our website](#).

My Surveys

If you are sure you don't have a designated body please click 'I don't have a connection'.

My Tests

Contact Us

Good Practice

Designated body	Southern Health and Social Care Trust
Responsible officer	Ahmed Faraz Khan
Designated body email address	medical.revalidation@shscaretrust.nhs.uk Personal Information redacted by the USI
Next submission date	27/04/2019
Designated body last updated by	General Medical Council
Designated body last updated on	16/04/2012

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
				Total:	1.000	
Predictable	n/a	n/a		DCC	0.000	
Unpredictable	n/a	n/a		DCC	1.000	
The total PAs arising from your on-call work is:		1.000				
Your availability supplement is:		5% (based on the highest supplement from all your rotas)				

On-call rota details

On-call Rota (PA entry)

General information

What is your on-call activity? On-call Rota
 Where does your on-call rota take place in? Craigavon Area Hospital
 What is your on-call classification? A
 Weekday work
 What is the frequency of your weekday on-call work? 1 in 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
Surgeon of the week 09:00 - 17:00 Week 1 (6 week cycle)	Surgeon of the week 09:00 - 17:00 Week 1 (6 week cycle)	Surgeon of the week 09:00 - 17:00 Week 1 (6 week cycle)	Surgeon of the week 09:00 - 17:00 Week 1 (6 week cycle)	Surgeon 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 10:00 - 17:00 Travelling time between hospitals 17:00 - 18:00	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	Sub Specialty clinic 09:00 - 13:00 Continuous professional development. 13:00 - 17:00		

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										
	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
	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
	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
	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
	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
	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

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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
	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

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

Southern Health and Social Care Trust.

This job plan started 01 April 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 12 weeks
Start Week	1
Report date	21 Oct 2018
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		24 Apr 2018	Mr Zircadian Support
In 'Discussion' stage - awaiting doctor agreement		24 Sep 2018	Mr Colin Weir

PA Breakdown

	Main Employer PAs	Total PAs	Core hours	ATC hours	Total hours
Direct Clinical Care (DCC)	10.249	10.249	40:57	0:00	40:57
Supporting Professional Activities (SPA)	1.462	1.462	5:51	0:00	5:51
Total	11.711	11.711	46:48	0:00	46:48

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000
Type	Normal	Premium	Cat.	PA		
Predictable	n/a	n/a	DCC	0.000		
Unpredictable	n/a	n/a	DCC	1.000		
			Total:	1.000		

The total PAs arising from your on-call work is: 1.000
 Your availability supplement is: 5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information

What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A

Weekday work

What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	0.000 1.000

Weekend work

(A weekend is classed as Saturday to Sunday for this rota)

What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	0.000 0.000

Other information

Which objective does this on-call work relate to?

Comments

Sign off

Role: Clinical Manager

Name: Mr Weir, Colin

Signed:

Date:

Role: Board Member

Name: Mr Carroll, Ronan

Signed:

Date:

Role: Clinical Director

Name: Mr Haynes, Mark Dean

Signed:

Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle) Surgeon of the week 09:00 - 12:00 Week 6,12 (12 week cycle)	Surgeon of the week 09:00 - 17:30 Week 1,7 (12 week cycle)		

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:45 - 13:00	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
New patient Clinic 13:00 - 16:45	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 13:30 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Core SPA 13:30 - 17:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		
	New patient Clinic 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Surgery MDT 13:15 - 17:15		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 13:30 - 17:00	Day surgery 08:30 - 13:00	Pre-op ward round 08:30 - 09:00	Core SPA 09:00 - 12:00	Sub Specialty clinic 09:00 - 13:00		

New patient Clinic	Planned in-patient operating sessions	Surgery MDT	Core SPA
13:30 - 17:00	09:00 - 18:00	14:00 - 17:00	13:30 - 17:00
	Post-op ward round		
	18:00 - 19:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic	Core SPA	Pre-op ward round	Surgery MDT	Sub Specialty clinic		
08:45 - 13:00	09:00 - 13:00	08:30 - 09:00	14:00 - 17:00	09:00 - 13:00		
New patient Clinic	Core SPA	Planned in-patient operating sessions		Sub Specialty clinic		
13:00 - 18:45	13:30 - 17:00	09:00 - 18:00		13:30 - 17:00		
		Post-op ward round				
		18:00 - 19:00				

Week 7

There are no activities this week

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic	Core SPA	Pre-op ward round	Core SPA	Sub Specialty clinic		
08:30 - 13:00	09:00 - 13:00	08:30 - 09:00	09:00 - 12:00	09:00 - 13:00		
Patient related admin (reports, results etc)	Core SPA	Planned in-patient operating sessions	Surgery MDT	Surgery MDT		
13:30 - 17:00	13:30 - 17:00	09:00 - 18:00	14:00 - 17:00	13:15 - 17:15		
		Post-op ward round				
		18:00 - 19:00				

Week 9

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc)	Day surgery	Pre-op ward round	Core SPA	Sub Specialty clinic		
09:00 - 17:00	08:30 - 13:00	08:30 - 09:00	09:00 - 12:00	09:00 - 13:00		
	New patient Clinic	Planned in-patient operating sessions	Surgery MDT	Core SPA		
	13:30 - 17:00	09:00 - 18:00	14:00 - 17:00	13:30 - 17:00		
		Post-op ward round				
		18:00 - 19:00				

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc)	Day surgery	Pre-op ward round	Core SPA	Sub Specialty clinic		
09:00 - 17:00	08:30 - 13:00	08:30 - 09:00	09:00 - 12:00	09:00 - 13:00		
	New patient Clinic	Planned in-patient operating sessions	Surgery MDT	Sub Specialty clinic		
	13:30 - 17:00	09:00 - 18:00	14:00 - 17:00	13:30 - 17:00		
		Post-op ward round				
		18:00 - 19:00				

Week 11

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc)	Day surgery	Pre-op ward round	Core SPA	Sub Specialty clinic		
09:00 - 17:00	08:30 - 13:00	08:30 - 09:00	09:00 - 12:00	09:00 - 13:00		
	New patient Clinic	Planned in-patient operating sessions	Surgery MDT	Core SPA		
	13:30 - 17:00	09:00 - 18:00	14:00 - 17:00	13:30 - 17:00		
		Post-op ward round				
		18:00 - 19:00				

Week 12

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:45 - 13:00	Core SPA 09:00 - 13:00	Pre-op ward round 08:30 - 09:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00		
New patient Clinic 13:00 - 18:45	Core SPA 13:30 - 17:00	Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00		Surgery MDT 13:15 - 17:15		

Activities

A Additional To Contract

H Hot Activity

U Unaffected by hot activity

S Shrunken by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	Mon	08:30 - 13:00	wks 3, 8	New patient Clinic 30 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	7	0.188	0:45
	Mon	08:45 - 13:00	wks 2, 6, 12	New patient Clinic 75 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	10.5	0.266	1:04
S	Mon	09:00 - 17:00	wks 4, 9-11	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	13.33	0.635	2:32
H	Mon	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Mon	13:00 - 18:45	wks 2, 6, 12	New patient Clinic 75 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	10	0.342	1:22
S	Mon	13:30 - 17:00	wks 3, 5, 8	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	10	0.208	0:50
S	Tue	08:30 - 13:00	wks 4-5, 9-11	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.446	1:47
S	Tue	09:00 - 13:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.397	1:35
H	Tue	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Tue	13:30 - 17:00	wks 4-5, 9-11	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.347	1:23
S	Tue	13:30 - 17:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.347	1:23
	Wed	08:30 - 09:00	wks 2-6, 8-12	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
H	Wed	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Wed	09:00 - 18:00	wks 2-6, 8-12	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	1.786	7:09
	Wed	18:00 - 19:00	wks 2-6, 8-12	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
H	Thu	09:00 - 12:00	wks 6, 12 12 wk cycle	Surgeon of the week Comments: Handover to oncoming Urologist of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.155	0:37
S	Thu	09:00 - 12:00	wks 2-5, 8-11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	24.67	0.440	1:46
H	Thu	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Thu	14:00 - 17:00	wks 2-6, 8-12	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.595	2:23
S	Fri	09:00 - 13:00	wks 2-6, 8-12	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10
H	Fri	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Fri	13:15 - 17:15	wks 4, 8, 12	Surgery MDT Comments: Reconstruction MDM Lagan Valley Hospital 45 minutes travel from Craigavon Area Hospital. 45 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Royal Victoria Hospital, Belfast	DCC	10	0.238	0:57

S	Fri	13:30 - 17:00	wks 2, 6, 10	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	10	0.208	0:50
S	Fri	13:30 - 17:00	wks 3, 5, 9, 11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	13.33	0.278	1:07
Total:									Core	10.175 40:40
									ATC	0:00

No specified day

"()" Refers to an activity that replaces or runs concurrently

A Additional To Contract

H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	2:00	0:00	Surgery MDT Comments: MDT Chair preparation	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.155	0:37
	8:00	0:00	Triaging of new patients referrals	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	8	0.381	1:31
							Core	0.536	6:08
Total:							Replaced	(0.000)	(0:00)
							ATC		0:00

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made



Consultant Level Indicator Programme

Consultant: Mr Aiden O'Brien

Personal Information redacted by the USI

10100 - Urology

Southern Health and Social Care Trust

Generated 14th February 2018

Attribution Discharge

Confidential and contains commercially sensitive information. Where HES data has been used, it is with the permission of The Health and Care Information Centre.

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About CHKS

CHKS is a provider of healthcare intelligence and quality improvement services. Over the last 29 years our team of NHS data experts, clinicians and quality managers have worked with more than 400 healthcare organisations around the world to improve population health.

We enable providers and commissioners to make better decisions at patient, service, organisation and population level and deliver sustainable improvements in care quality, patient outcomes and service efficiency along the entire patient pathway.

Our services include:

- Healthcare benchmarking and analytics - we identify what to improve and model the impact of change at patient, organisation and population level
- Clinical coding, data quality and costing services - we ensure data used for payment and decision making accurately reflects the care delivered
- Care quality, assurance and accreditation - we work to the latest international standards of best practice within a proven framework of continuous improvement

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1. Report Overview

This report has been produced based on information extracted from the organisation's patient administration system. The individual consultant and the data period are both detailed on the front cover of the report.

You have been assigned to a specialty based on a combination of the specialty your organisation assigned you to and the clinical information about the patients you treated. For example, you may have been assigned to trauma and orthopaedics by your organisation but based on the clinical information recorded about the patients you treated CHKS have subdivided this specialty further to hand, hip, knee, etc. The same criteria are then applied to both the local and selected peer ensuring that comparisons are as appropriate as possible.

The analysis included in this report frequently refers to consultant, local peer and selected peer which are explained below:

- Consultant - displays the consultant value, shown as an index, percentage/rate or ratio depending on each indicator's calculation. Where applicable the actual value (numerator) is shown.
- Local Peer - displays the local peer value which consists of consultant colleagues' average value within the same organisation and same specialism.
- Selected Peer - displays the external peer value which consists of a selection of consultants' average value within the same specialism but from external organisations.

The scorecard view also contains a Peer Range which displays a comparison with the selected peer group ONLY and is shown graphically within a RAG spectrum. The linear spectrum shows the consultants value plotted between the 10th to 90th percentile values of the selected peer. If the consultant's value is outside this range then it is displayed as a diamond.

Rating	Interpretation
	Consultant value falls within the top 75% percentile of the peer
	Consultant value falls between the 75% and 25% percentiles of the peer
	Consultant value falls within the bottom 25% percentile of the peer
	Consultant has no data
	Insufficient peer data available to make a meaningful comparison

* Data suppressed due to small number rules.

Indicator definitions are either included in your report, are available locally or can be obtained by emailing info@chks.co.uk, including the name of the organisation you work for along with your GMC number and name.

Peer Sites		
Isle of Wight NHS Trust	Barts Health NHS Trust	The London North West Healthcare NHS Trust
Royal Surrey County Hospital NHS Foundation Trust	Weston Area Health NHS Trust	Yeovil District Hospital NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust	Torbay And South Devon NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust
Southend University Hospital NHS Foundation Trust	Royal Free London NHS Foundation Trust	North Middlesex University Hospital NHS Trust
The Hillingdon Hospitals NHS Foundation Trust	Kingston Hospital NHS Foundation Trust	Taunton And Somerset NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust	Walsall Healthcare NHS Trust	Wirral University Teaching Hospital NHS Foundation Trust
St Helens And Knowsley Hospitals NHS Trust	Mid Cheshire Hospitals NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Bedford Hospital NHS Trust	Luton and Dunstable University Hospital NHS Foundation Trust	York Teaching Hospital NHS Foundation Trust
Harrogate And District NHS Foundation Trust	Airedale NHS Foundation Trust	The Queen Elizabeth Hospital King's Lynn NHSFT
Royal United Hospital Bath NHS Trust	Poole Hospital NHS Foundation Trust	Milton Keynes Hospital NHS Foundation Trust
Basildon And Thurrock University Hospitals NHSFT	Colchester Hospital University NHS Foundation Trust	Frimley Park Hospital NHS Foundation Trust
The Royal Bournemouth And Christchurch Hospitals NHSFT	South Tyneside NHS Foundation Trust	Royal Cornwall Hospitals NHS Trust
Aintree University Hospital NHS Foundation Trust	Barking Havering And Redbridge University Hospitals NHST	Barnsley Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust	Chesterfield Royal Hospital NHS Foundation Trust	Peterborough And Stamford Hospitals NHS Foundation Trust
James Paget University Hospitals NHS Foundation Trust	Ipswich Hospital NHS Trust	West Suffolk NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust	Royal Devon And Exeter NHS Foundation Trust	University Hospital Southampton NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust	Portsmouth Hospitals NHS Trust	Royal Berkshire NHS Foundation Trust
Guy's And St Thomas' NHS Foundation Trust	Lewisham and Greenwich NHS Trust	Croydon Health Services NHS Trust
St George's Healthcare NHS Trust	South Warwickshire NHS Foundation Trust	University Hospital Of North Midlands NHS Trust

Burton Hospitals NHS Foundation Trust	Northern Lincolnshire And Goole Hospitals NHS Foundation Trust	East Cheshire NHS Trust
Countess Of Chester Hospital NHS Foundation Trust	King's College Hospital NHS Foundation Trust	Sherwood Forest Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust	University Hospitals Coventry And Warwickshire NHS Trust	The Whittington Hospital NHS Trust
The Royal Wolverhampton Hospitals NHS Trust	City Hospitals Sunderland NHS Foundation Trust	Wye Valley NHS Trust
George Eliot Hospital NHS Trust	Norfolk And Norwich University Hospitals NHSFT	University Hospital Of South Manchester NHS Foundation Trust
Salford Royal NHS Foundation Trust	Bolton NHS Foundation Trust	Tameside Hospital NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust	Hampshire Hospitals NHS Foundation Trust	Dartford And Gravesham NHS Trust
The Dudley Group NHS Foundation Trust	North Cumbria University Hospitals NHS Trust	Kettering General Hospital NHS Foundation Trust
Northampton General Hospital NHS Trust	Salisbury NHS Foundation Trust	Doncaster And Bassetlaw Hospitals NHS Foundation Trust
Medway NHS Foundation Trust	Royal Liverpool And Broadgreen University Hospitals NHSFT	Mid Essex Hospital Services NHS Trust
Chelsea And Westminster Hospital NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust	Homerton University Hospital NHS Foundation Trust
Heart Of England NHS Foundation Trust	Gateshead Health NHS Foundation Trust	Leeds Teaching Hospitals NHS Trust
Wrightington Wigan And Leigh NHS Foundation Trust	University Hospitals Birmingham NHS Foundation Trust	University College London Hospitals NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust
Derby Hospitals NHS Foundation Trust	Oxford University Hospitals NHS Trust	Ashford And St Peter's Hospitals NHS Foundation Trust
Surrey And Sussex Healthcare NHS Trust	South Tees Hospitals NHS Foundation Trust	University Hospitals Of Morecambe Bay NHS Foundation Trust
North Bristol NHS Trust	Epsom And St Helier University Hospitals NHS Trust	East Kent Hospitals University NHS Foundation Trust
North Tees And Hartlepool NHS Foundation Trust	Southport And Ormskirk Hospital NHS Trust	Central Manchester University Hospitals NHS Foundation Trust
Pennine Acute Hospitals NHS Trust	Hull And East Yorkshire Hospitals NHS Trust	United Lincolnshire Hospitals NHS Trust
University Hospitals Of Leicester NHS Trust	Maidstone And Tunbridge Wells NHS Trust	West Hertfordshire Hospitals NHS Trust
East And North Hertfordshire NHS Trust	Stockport NHS Foundation Trust	Worcestershire Acute Hospitals NHS Trust

Warrington And Halton Hospitals NHS
Foundation Trust

Calderdale And Huddersfield NHS
Foundation Trust

Nottingham University Hospitals NHS
Trust

East Sussex Healthcare NHS Trust

Mid Yorkshire Hospitals NHS Trust

Brighton And Sussex University Hospitals
NHS Trust

Sandwell And West Birmingham Hospitals
NHS Trust

Blackpool Teaching Hospitals NHS
Foundation Trust

Lancashire Teaching Hospitals NHS
Foundation Trust

County Durham And Darlington NHS
Foundation Trust

Buckinghamshire Healthcare NHS Trust

East Lancashire Hospitals NHS Trust

Shrewsbury And Telford Hospital NHS
Trust

Imperial College Healthcare NHS Trust

Western Sussex Hospitals NHS Foundation
Trust

2. Scorecard

The scorecard below is a collection of performance and efficiency indicators at consultant level. For each indicator consultant, local peer and selected peer values are displayed along with a peer range based on a RAG spectrum. See overview for explanation of values.

Indicator		Consultant	Local	Peer	Peer Range
Average Length of Stay (FCE - zero trimmed)	1275	4.55	4.44	3.27	
Elective Average Length of Stay (FCE - zero trimmed)	411	3.31	2.87	2.40	
Non-elective Average Length of Stay (FCE - zero trimmed)	864	5.54	5.55	4.10	
Elective Average Pre-Op Length of Stay (Spell - zero trimmed)	2	0.03	0.03	0.10	
Day Case Rate	573	78.28%	84.11%	70.71%	
Day Case Overstays	30	4.98%	4.36%	8.42%	
Elective IP - procedure not carried out	0	0%	0.41%	0.75%	
Elective IP - procedure not carried out - patient reason	0	0%	0%	0.03%	
Elective IP - procedure not carried out - other than patient reason	0	0%	0.41%	0.72%	
Elective IP - no procedure	3	4.69%	1.23%	0.92%	
Mortality Rate	3	0.33%	0.14%	0.26%	
Mortality Rate - Elective	0	0%	0.02%	0.03%	
Mortality Rate - Non-elective	3	0.33%	0.12%	0.23%	
Readmissions within 28 days	34	3.76%	3.29%	6.94%	
Complication rate - attributed	9	0.99%	0.46%	1.33%	
Misadventure rate	1	0.11%	0.04%	0.19%	
Outpatient New to follow-up ratio	509	1 : 1.18	1 : 1.37	1 : 1.84	
Outpatient DNA Rate	27	2.80%	3.81%	7.06%	
Outpatient DNA Rate - New Attendances	16	3.59%	4.24%	6.29%	
Outpatient DNA Rate - Follow-up Attendances	11	2.12%	3.49%	7.47%	

3. Activity

The activity tables display a collection of activity based indicators split by inpatient and outpatient workload.

Admitted Workload

Indicator	Consultant	Local	Peer	
Total FCEs	928	-	719.43	409.30
% Elective FCEs	758	81.68%	84.11%	73.55%
% Elective FCEs - Inpatients	167	22.03%	14.94%	29.80%
% Elective FCEs - Day Cases	585	77.18%	75.78%	68.84%
% Regular Attenders	7	0.92%	9.30%	1.72%
% Emergency FCEs	129	13.90%	12.73%	24.28%
% Other FCEs	41	4.42%	3.16%	2.17%

Outpatient Workload

Indicator	Consultant		Local	Peer
Total Attendances (OP)	939	-	1086.86	2491.37
Total New OP Attendances	430	-	458.43	877.50
Total Follow-up OP Attendances	509	-	628.43	1613.76
Outpatient Attendances with a Procedure	70	7.45%	3.43%	36.32%
New Outpatient Attendance with a Procedure	67	15.58%	5.67%	43.42%
Follow-up Attendances with a Procedure	3	0.59%	1.80%	32.46%
New Outpatient Attendance - referred by GP	273	63.49%	66.10%	53.79%
Total DNA's	27	-	43	189.21
% of DNA's New Attendances	16	59.26%	47.18%	31.13%
% of DNA's Follow-up Attendances	11	40.74%	52.82%	68.87%

4. Focus

Focus displays the top 10 procedures / diagnoses at consultant level split by day cases, inpatient procedures and the top 5 outpatient procedures. In medical specialties the inpatient profile will be the top diagnoses while for surgical specialities it will be procedures. The day case procedure profile includes the volume, day case rate and day case overstay rate; the inpatient profile includes the volume and average length of stay and the outpatient profile shows volume of procedures.

Please note that if your organisation or your selected peer does not clinically code, or only partially clinically code outpatient activity these values may not reflect activity. Your local clinical coding department will be able to advise you.

Day Case Top 10 Procedures by Volume

Procedure	Actual Day Cases						Day Case Overstays					
	Number			Rate			Number			Average LoS		
	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer
M45 - Diagnostic endoscopic examination of bladder	216	166.29	42.02	95.15 %	97.65 %	88.24 %	3	2	*	1.33	2.07	1.41
M49 - Other operations on bladder	142	53	26.97	99.30 %	99.46 %	94.96 %	0	0	*	0	0	1.93
M43 - Endoscopic operations to increase capacity of bladder	25	6.71	*	78.12 %	95.92 %	87.11 %	5	0.14	*	5.20	2	1.42
M29 - Other therapeutic endoscopic operations on ureter	11	9.14	6.27	55%	68.82 %	64.22 %	2	1.86	*	1.50	1.69	1.96
M76 - Therapeutic endoscopic operations on urethra	5	2.71	*	55.56 %	73.08 %	65.98 %	1	0.29	*	2	1.50	1.63
N30 - Operations on prepuce	5	6.57	11.72	83.33 %	90.20 %	91.65 %	1	0.29	*	15	1	1.23
M42 - Endoscopic extirpation of lesion of bladder	3	2.71	6.02	14.29 %	18.45 %	29.52 %	3	2.71	*	1	2.32	1.70
N11 - Operations on hydrocele sac	3	2.29	*	100%	80%	81.83 %	0	0.29	*	0	1	1.28
M47 - Urethral catheterisation of bladder	2	1.71	17.17	100%	85.71 %	92.18 %	0	0	*	0	0	2.42
M77 - Diagnostic endoscopic examination of urethra	1	0.71	*	100%	100%	88.88 %	0	0	*	0	0	1.41

Inpatient Top 10 Procedures by Volume

Procedure	Number			Pre-op Average LoS			IP Average LoS		
	Cons	Local	Peer	Cons	Local	Peer	Cons	Local	Peer
M65 - Endoscopic resection of outlet of male bladder	23	9.14	11.49	0	0.02	-2.99	2.26	2.88	2.28
M42 - Endoscopic extirpation of lesion of bladder	23	12.71	15.41	0	0	-0.76	2.74	3.01	2.10
M29 - Other therapeutic endoscopic operations on ureter	17	10.71	7.60	0	0.07	-5.17	3.53	3.13	2.47
M45 - Diagnostic endoscopic examination of bladder	15	7.43	6.95	-	0	-7.42	1.40	3.73	1.63
U21 - Diagnostic imaging procedures	13	9.57	11.95	0	-	14.29	3.69	5.30	2.62
M27 - Therapeutic ureteroscopic operations on ureter	12	11	6.25	0	0.06	-2.45	1.83	2.75	1.93
M47 - Urethral catheterisation of bladder	8	6.57	17.71	0	0	0.25	4.12	5.28	2.73
M43 - Endoscopic operations to increase capacity of bladder	7	0.29	*	0	0	-11.87	3.86	2	1.29
M44 - Other therapeutic endoscopic operations on bladder	6	1.14	*	0	0	0.19	1.67	2.88	2.19
M16 - Other operations on kidney	5	2.14	*	0.20	0.12	0.42	1.80	5.07	3.55

Outpatient Top 5 Procedures by Volume

Procedure	Consultant	Local	Peer
M47 - Urethral catheterisation of bladder	67	23.71	21.20
M45 - Diagnostic endoscopic examination of bladder	3	1.57	128.58

5. Trend

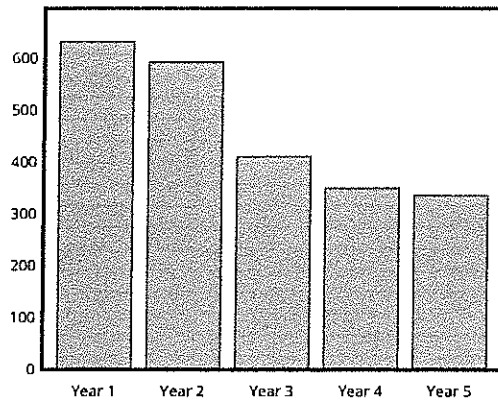
This analysis displays a collection of performance and efficiency indicators for the target consultant comparing performance year on year data for the selected time period. Up to a maximum of five years can be displayed depending on the availability of data.

Data may be missing if your organisation has not submitted historical data to CHKS or if you became a consultant at the organisation within the last five years.

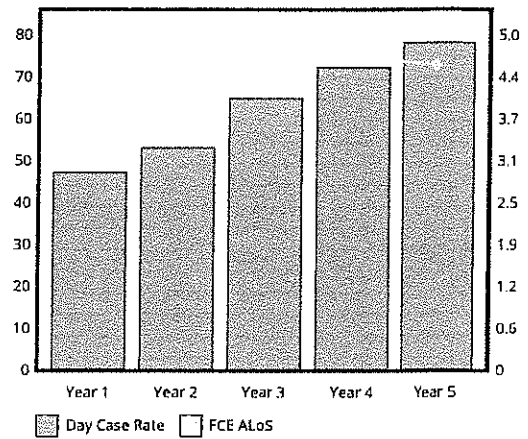
If a period of less than 12 months is selected then this is also the period that will be reported for the previous years. For example, if the selected period is January - June 2016 then the previous four years will be the January - June period in each year.

Indicator	Jan 13 - Dec 13	Jan 14 - Dec 14	Jan 15 - Dec 15	Jan 16 - Dec 16	Jan 17 - Dec 17
Total FCEs (Exclusions: Standard and Day-cases)	634	594	412	351	337
Average Length of Stay (FCE - zero trimmed)	4.31	4.88	4.83	4.67	4.55
Day Case Rate	47.40%	53.17%	64.98%	72.35%	78.28%
Mortality Rate	0.40%	0.39%	0.37%	0.60%	0.33%
Readmissions within 7 days	1.30%	2.92%	2.20%	2.16%	0.99%
Readmissions within 14 days	2.10%	4.63%	3.79%	3.24%	2.43%
Readmissions within 28 days	3.70%	6.14%	6.11%	4.68%	3.76%
Total New OP Attendances	499	285	462	347	430
Total Follow-up OP Attendances	966	614	647	573	509
Outpatient DNA Rate	5.36%	4.06%	3.90%	5.25%	2.80%
Outpatient DNA Rate - Follow-up Attendances	6.30%	4.36%	2.41%	4.82%	2.12%

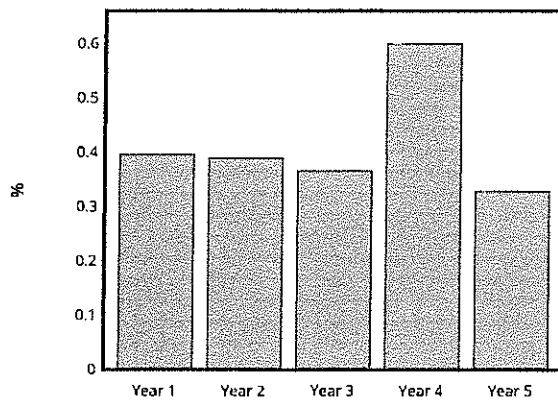
Total FCEs



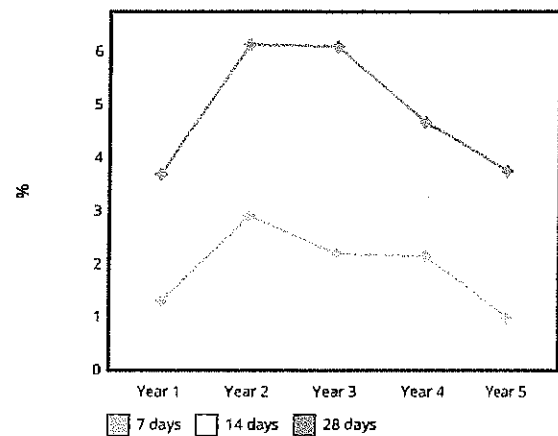
Day Case Rate & FCE ALoS



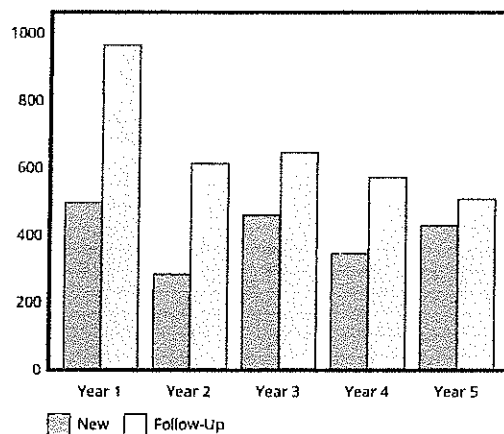
Mortality Rate



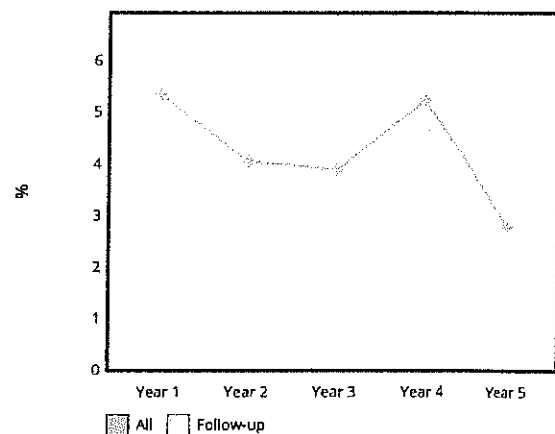
Readmission Rate



Outpatient Attendances



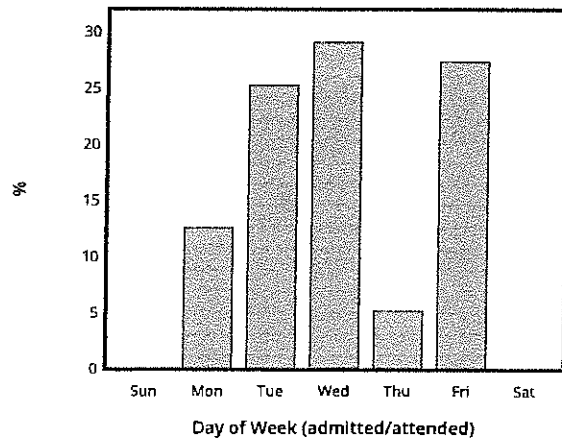
Outpatient DNA Rate



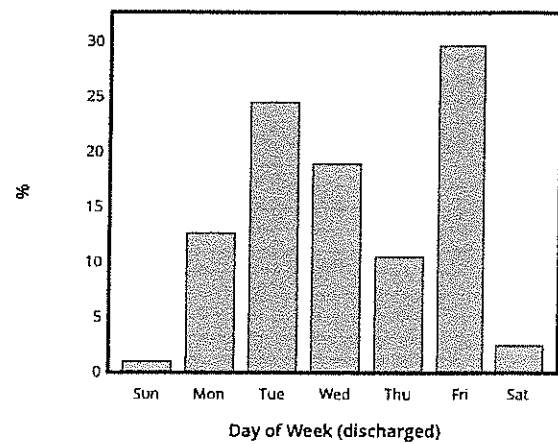
6. Schedule

This section displays the consultant profile for a selection of indicators by the day of the week of admission and discharge.

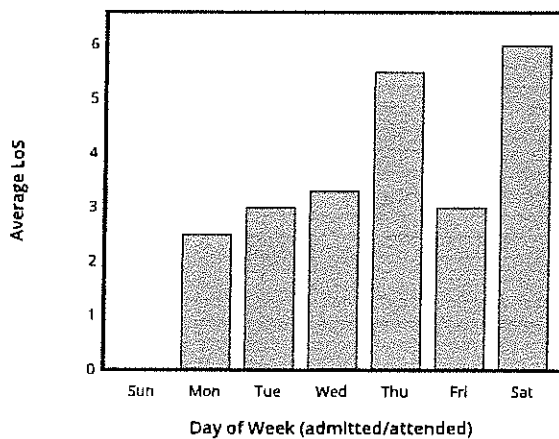
Elective Inpatient Admission Profile



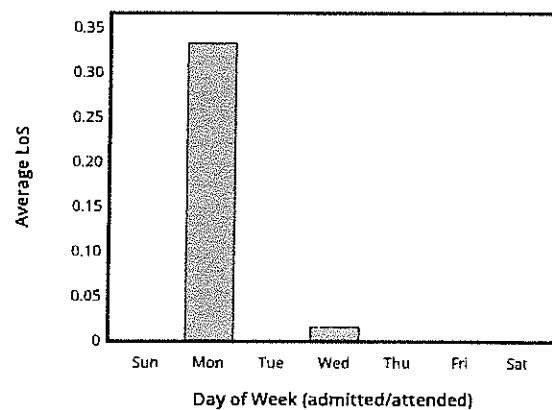
Elective Inpatient Discharge Profile



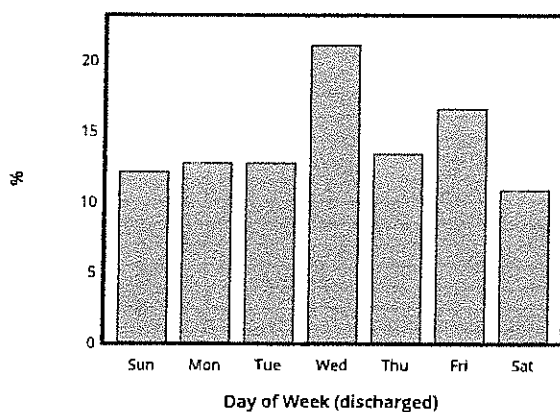
Elective Inpatient ALoS Profile



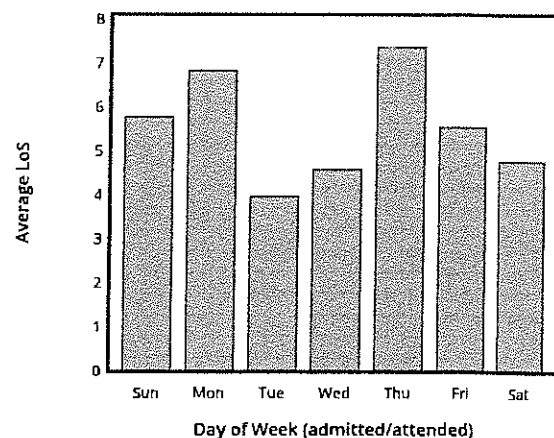
Elective Inpatient Pre-op ALoS Profile



Non-Elective Inpatient Discharge Profile



Non-Elective Inpatient ALoS Profile



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

Requirement: One annually

Name of doctor: Aidan O'Brien	GMC No: 1394911
Date of report: 14 february 2018	
What issues can I identify from the report? Average length of stay for patients is a meaningless indicator of clinical outcomes. My average length of stay is higher than the peer group. Perhaps the only indicator of related quality of clinical outcomes is that my complication rate and readmission rates are lower than the peer group, possibly as a consequence of a one day longer length of stay. Regarding outpatient clinics, my new:review ratio of 1:1.18 is lower than the peer group, as is my DNA rate. Total inpatient and day case admissions were negatively affected by my being not working during the first three months of 2017, as were outpatient attendances. Total outpatient attendances do not include virtual clinic episodes. In all, the CLIP report does not have any measure of quality of clinical outcomes. It is disappointing that it continues to use indicators of performance instead. What actions will I undertake? I will continue to offer the best management which I am capable of providing to those in most need of it. That apart, the total numbers will have increased during 2018 due to a full working year. Final outcome after discussion at appraisal: (Complete at appraisal)	

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	Mandatory Training Passport	03 December 2018
2	Right Patient, Right Blood: Certification of Clinical Competency	20 December 2017
3	'Core of Knowledge' Laser Safety training Course	16 November 2018
4	Statement of Completion of Information Governance Awareness course	21 November 2018
5	Statement of Completion of Manual Handling Awareness course	22 November 2018
6	Infection Prevention & Control course	22 November 2018
7	COSHH and Waste Management course	22 November 2018
8	Certificates of Membership of Medical protection Society	Sept 17 – Aug 2019
9	Record of Attendance Morbidity & Mortality Meetings 2017	April – Dec 2017
10	Serious Adverse Incident Review: Comments upon Draft Report	25 January 2017
11	Root Cause Analysis report on the review of a Serious Adverse Incident	15 March 2017
12	SEA Structured Reflective Template	04 December 2018
13	Complaints 2017	2017
14	Complaints Structured Reflective Template	04 December 2018
Discussion Mr O'Brien is committed to Safety and quality and has fulfilled all related requirements in his mandatory training. He has attended 66% of his M&M meetings and has participated in a Serious Adverse Incident. His audit looked at reasons for delay in Reduced Capabilities in Abdominal Invasive Bladder Cancer.		
Actions Agreed Mr O'Brien is committed to patient safety and quality. He will continue to engage in the M&M process and audit actively. He will ensure he is up to date in all patient safety related requirements in his mandatory training.		

[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](#).

Mandatory Training Passport

AOB-22920

Print as PDF

CORE MODULES

ADDITIONAL MODULES

Module	Date	Date Renewal	Module	Date	Date Renewal	Module	Date	Module	Date
FIRE	24/10/2017	24/10/2018	FRAUD AWARENESS			NEWS		PRESCRIBING	
INFECTION CONTROL	22/11/2018	21/11/2020	MAPA			OEWS		CLINICAL TRIALS	
SAFEGUARDING	24/10/2017	23/10/2020	EQUALITY	22/11/2018	21/11/2021	PEWS		VTE	
INFORMATION GOVERNANCE	21/11/2018	20/11/2021	RECRUITMENT SELECTION			CONSENT	06/07/2010	SAFE SEDATION	
H&S COSHH	22/11/2018	21/11/2021	SICKNESS ABSENTEEISM			BLOOD CULTURE		GASTRO ENDOSCOPY	
BACKCARE	22/11/2018	21/11/2021	HYPONATRAEMIA			PERIPHERAL LINE		CHEST DRAIN	
RPRB DESIST?			ENTER CPR COURSE NAME, COMPLETED DATE AND RENEWAL DATE BELOW			USE OF ANTICOAGs		BLOOD GAS	
RPRB THEORY	15/12/2015	14/12/2018				NG TUBE		APPRAISER	
RPRB COMPETENCY	20/12/2017	19/12/2020	Complaints / Incidents	08/10/2013		ACTIONS FOLLOWING DEATH		APPRAISSEE	08/03/2016
			Coroners Cases			PM CONSENT		NEGLIGENCE	

COURSES FOR
RECOGNISED
TRAINERS

Activity	Activity date	Activity date expires



Southern Health
and Social Care Trust

Quality Care - for you. with you

Right Patient, Right Blood

Northern Ireland Certification of Clinical Competency Assessment

Staff Name:
(Print name)

MR AIDAN O'BRIEN

Professional / Staff Number:

Completed Clinical Competency Assessment(s) for:-

Clinical Competency	Yes	Not Applicable
Competency 1 Obtaining a Venous Sample for Pre-Transfusion Testing	✓	
Competency 2 Organising a Request for a Blood Component for Transfusion	✓	
Competency 3 Collecting a Blood Component for Transfusion		NIA
Competency 4 Preparing and Administering a Transfusion of a Blood Component	✓	

Date: 20th December 2017

(Valid for three years)

Personal information redacted by the USI

Signature of Staff Member:

Name of Assessor:
(Print name)

Signature of Assessor:

Date of Transfusion Knowledge
Training:

Therapy Dec 2017 - due 2018

You are now certified to undertake the above procedures in the Blood Transfusion Process.



**Belfast Health and
Social Care Trust**
caring supporting improving together

**Northern Ireland Regional
Medical Physics Service**

This is to certify that

Aidan O'Brien

Has attended a

‘Core of Knowledge’

laser safety training course for
Medical and Nursing Staff

on 16th November 2018

Personal Information redacted by the USI

Philip Loan
RPA 2000 Certificated
Laser Protection Adviser
(Certificate number L00124)

biAexLGFaE

STATEMENT of COMPLETION

This is to certify that

Aidan O'Brien

has completed the course

Information Governance Awareness

November 21, 2018



LHzbl8PtpU

STATEMENT of COMPLETION

This is to certify that

Aidan O'Brien

has completed the course

SHSCT_Manual Handling Awareness (Regional)

November 22, 2018

IPC Medical including Quiz

Aidan O'Brien

Date / Time	Student Score	Passing Score	Result
November 22, 2018 8:47 pm	80	80	Pass

IPC Medical including Quiz

#	Question	Correct Answer	Student Answer	Result	Points Awarded
1	Alcohol hand rubs are inactivated by	Spore forming organisms such as c difficile, Organic matter	Spore forming organisms such as c difficile, Organic matter	Correct	10
2	Hand hygiene has 5 steps True or False?	False	False	Correct	10
3	Respiratory masks should be changed in which of the following scenarios?	If the mask is not maintaining the proper fit, If the mask is damaged, If breathing becomes difficult, Immediately after use	If the mask is not maintaining the proper fit, If the mask is damaged, If breathing becomes difficult, Immediately after use	Correct	10
4	What is Moment 3?	After potential exposure to body fluids	After potential exposure to body fluids	Correct	10
5	What is Moment 5?	After touching a patients surroundings	After touching a patients surroundings	Correct	10
6	Which of the following is/are considered good practice?	Safe management of equipment, Preventing exposure to blood and body fluids, Appropriate use of PPE, Effective hand washing	Safe management of equipment, Preventing exposure to blood and body fluids, Appropriate use of PPE, Effective hand washing	Correct	10
7	Which statement or statements are true about glove use?	Wear gloves only when	Wear gloves only when	Correct	10

		indicted, otherwise they can be a major risk for transmission of organisms	indicted, otherwise they can be a major risk for transmission of organisms		
8	Removing and disposing of PPE correctly is important to minimise the risk of cross-contamination. What one of the following orders is correct?	Gloves-apron-mask	Mask-apron-gloves	Incorrect	0
9	Contact transmission occurs when micro-organisms come into contact with which of the following?	Sterilization, Disinfection, Frequent effective cleaning, Hand hygiene	Hand hygiene	Incorrect	0
10	Hands should only be decontaminated with soap and water True or False?	False	False	Correct	10

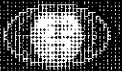
COSHH and Waste Management**Aidan O'Brien**

Date / Time	Student Score	Passing Score	Result
November 22, 2018 10:13 pm	90.32	80	Pass

COSHH and Waste Management

#	Question	Correct Answer	Student Answer	Result	Points Awarded
1	Where can you dispose of sharps?	Purple lidded sharps box , Orange lidded sharps box	Purple lidded sharps box	Incorrect	0
2	When should sharps boxes be disposed of?	When it reaches the fill line	When it reaches the fill line	Correct	10
3	What actions should be taken before disposing of a sharps box ?	Leave the box in the designated storage area , Ensure a tag is attached to the box, Ensure the box is signed off, Ensure the box is sealed correctly	Leave the box in the designated storage area , Ensure a tag is attached to the box, Ensure the box is signed off, Ensure the box is sealed correctly	Correct	10
4	What is the average monthly spend for the transport, disposal and treatment of clinical waste in the Southern Trust?	£55,000	£55,000	Correct	10
5	What waste type would a Duty of Care Waste transfer note be used for?	Confidential Waste	Clinical Waste	Incorrect	0
6	What waste type would a Hazardous waste consignment note be used for?	Clinical waste	Clinical waste	Correct	10
7	What should be disposed of in a yellow rigid container with an orange lid?	Chest drains	Chest drains	Correct	10
8	What should be disposed of in an orange lidded sharps box?	Non-cytotoxic waste, IV giving sets (sharps)	IV giving sets (sharps)	Incorrect	0
9	When should waste bags be removed from bins?	When the bin $\frac{3}{4}$ full	When the bin $\frac{3}{4}$ full	Correct	10
10	What should be disposed of in a purple lidded burn box?	Cytotoxic Waste, Pharmaceutical Waste	Cytotoxic Waste, Pharmaceutical Waste	Correct	10
11	The material safety data sheet is the only source to check information concerning the precautions necessary for the chemicals you use.	False	False	Correct	10

12	Ingestion is the most common route of entry.	False	False	Correct	10
13	You can be exposed to hazardous substances either through short term contact or long term repeated use.	True	True	Correct	10
14	Hazardous substances can affect your skin.	True	True	Correct	10
15	As an employee you need to report any defects immediately to your manager.	True	True	Correct	10
16	Micro-organisms (e.g. blood borne viruses) are not covered by COSHH Regulations.	False	False	Correct	10
17	As an employee you have a responsibility to report any accidental releases of a hazardous substance to your manager.	True	True	Correct	10
18	This symbol indicates that the material is toxic or very toxic? (European symbols are being phased out and are being replaced by new international symbols but you may see either for an interim period).	False	False	Correct	10
19	Hazardous substances can be disposed of down the sink.	False	False	Correct	10
20	If you've been wearing protective gloves it's not necessary to wash your hands before eating, drinking or smoking.	False	False	Correct	10
21	Personal protective equipment (PPE) should be worn for the whole time you are exposed to a hazardous substance.	True	True	Correct	10
22	Hazardous substances should be decanted prior to disposal.	False	False	Correct	10
23	A substance is not considered hazardous to your health if doesn't enter your body.	False	False	Correct	10
24	A hazardous substance is a mixture of chemicals.	False	False	Correct	10
25	Splashes from cleaning materials will not cause harm to the eyes.	False	False	Correct	10
26	You are required to participate in health surveillance.	True	True	Correct	10
27	Employers are required to control risks from exposure to hazardous substances.	True	True	Correct	10
28	Only hazardous substances brought directly into the workplace have the potential to cause harm.	False	False	Correct	10
29	Environmental/air monitoring is undertaken to ensure that Workplace Exposure Limits are not exceeded.	True	True	Correct	10
30	Local exhaust ventilation prevents the dispersion into the air of dusts, fumes, mists, vapours and gases.	True	True	Correct	10
31	Using some hazardous substances can trigger an allergic reaction.	True	True	Correct	10

CERTIFICATE OF
MEDICAL MEMBERSHIP

Mr A O'Brien

DAC117

Personal Information redacted by the USI

Name:

Mr Aidan O'Brien

Membership Number:

Personal Information redacted
by the USI

Period of Membership:

01/09/17-31/08/18

Subscription:

Personal Information redacted
by the USI

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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Abstract

11. The following table shows the number of people who attended the 2008 Summer Olympics in Beijing, China, and the 2012 Summer Olympics in London, England. The number of people who attended the 2008 Summer Olympics in Beijing, China, was 1.1 million more than the number of people who attended the 2012 Summer Olympics in London, England. How many people attended the 2008 Summer Olympics in Beijing, China?

॥ गणेशाय नमः ॥ श्रीगणेशाय नमः ॥ श्रीगणेशाय नमः ॥

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CERTIFICATE OF MEDICAL MEMBERSHIP

AOB-22931
Medical Protection

Mr. Aidan O'Brien

Personal information redacted by the USI

MEDICAL PROTECTION CERTIFICATE

| | |
|-------------------------|---|
| Name: | Mr. Aidan O'Brien |
| Membership Number: | Personal information redacted by the USI |
| Period of membership: | 01/09/2018 – 31/08/2019 |
| Country of practice: | United Kingdom |
| Region: | England & Wales |
| 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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Issue date 02 August 2018

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Quality Care - for you, with you

Record of Attendance Morbidity and Mortality Meetings 2017

CRAIGAVON AREA HOSPITAL

Urology

Mr Aidan O'Brien

6 out of 9= 67% 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.



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

Organisation's Unique Case Identifier:

Personal Information redacted by the USI

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier:

Personal Information redacted by the USI

Service User Details:

D.O.B:

Personal Information redacted by the USI

Gender: F

Age: 66 yrs

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off: 15 March 2017

Date submitted to HSCB: 16 March 2017



1.0 EXECUTIVE SUMMARY

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

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

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

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

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

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

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



**Southern Health
and Social Care Trust**

2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

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

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



4.0 REVIEW METHODOLOGY

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

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

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

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

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

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

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

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

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

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

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

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



Southern Health
and Social Care Trust

5.0 DESCRIPTION OF INCIDENT/CASE

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

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

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

6.0 FINDINGS

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

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

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

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



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6.0 FINDINGS

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

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

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

7.0 CONCLUSIONS

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

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

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

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

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



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8.0 LESSONS LEARNED

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

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

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

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



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10.0 DISTRIBUTION LIST

Patient 10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

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

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

Chair of Surgical Morbidity and Mortality

Checklist for Engagement / Communication with Service User¹ / Family / Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report
for all levels of SAI reviews)

| | | | |
|---|---|-------------------------|---|
| Reporting Organisation
SAI Ref Number: | <small>Personal Information
redacted by the USI</small> | HSCB Ref Number: | <small>Personal Information
redacted by the USI</small> |
|---|---|-------------------------|---|

SECTION 1

| INFORMING THE SERVICE USER ¹ / FAMILY / CARER | | | | |
|--|----------------------------|-----------|--------------------------------|--|
| 1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates <u>only</u> to a HSC Child Death notification (SAI criterion 4.2.2)
Please select as appropriate (✓) | Single Service User | x | Multiple Service Users* | HSC Child Death Notification only |
| Comment:

<i>*If multiple service users involved please indicate the number involved</i> | | | | |
| 2) Was the Service User¹ / Family / Carer informed the incident was being investigated as a SAI?

Please select as appropriate (✓) | YES | x | NO | |
| If YES, insert date informed : 6 January 2016 | | | | |
| If NO, please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being investigated as a SAI | | | | |
| a) No contact or Next of Kin details or Unable to contact | | | | |
| b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| d) Case involved suspected or actual abuse by family | | | | |
| e) Case identified as a result of review exercise | | | | |
| f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| g) Other rationale | | | | |
| If you selected c), d), e), f) or g) above please provide further details: | | | | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | | | |
| Content with rationale? | YES | NO | | |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER ¹ / FAMILY / CARER
(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI) | | | | |
|---|------------|----------|-----------|----------|
| 3) Has the Final Review report been shared with the Service User¹ / Family / Carer?

Please select as appropriate (✓) | YES | x | NO | x |
| If YES, insert date informed : | | | | |
| If NO, please select only one rationale from below, for NOT SHARING the SAI Review Report with Service User / Family / Carer | | | | |
| a) Draft review report has been shared and further engagement planned to share final report | | | | |
| b) Plan to share final review report at a later date and further engagement planned | | | | |
| c) Report not shared but contents discussed (if you select this option please also complete 'f' below) | | | | |
| d) No contact or Next of Kin or Unable to contact | | | | |
| e) No response to correspondence | | | | |
| f) Withdrew fully from the SAI process | | | | |

Continued overleaf

| SHARING THE REVIEW REPORT WITH THE SERVICE USER / FAMILY / CARER
(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI) | | | | |
|--|---|--|----|--|
| | g) Participated in SAI process but declined review report | | | |
| | (if you select any of the options below please also complete 'i' below) | | | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user ¹ family/ carer | | | |
| | i) case involved suspected or actual abuse by family | | | |
| | j) identified as a result of review exercise | | | |
| | k) other rationale | | | |
| | l) If you have selected c), h), i), j), or k) above please provide further details: | | | |
| For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)) | | | | |
| Content with rationale? | YES | | NO | |

SECTION 2

| INFORMING THE CORONER'S OFFICE
(under section 7 of the Coroners Act (Northern Ireland) 1959)
(complete this section for all death related SAIs) | | | | |
|---|------------------------------------|--|----|---|
| 1) Was there a Statutory Duty to notify the Coroner at the time of death?
Please select as appropriate (✓) | YES | | NO | x |
| | If YES, insert date informed: | | | |
| | If NO, please provide details: | | | |
| 2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner?
Please select as appropriate (✓) | YES | | NO | x |
| | If YES, insert date informed: | | | |
| | If NO, please provide details: | | | |
| 3) If you have selected 'YES' to any of the above '1' or '2' has the review report been shared with the Coroner?
Please select as appropriate (✓) | YES | | NO | x |
| | If YES, insert date report shared: | | | |
| | If NO, please provide details: | | | |

| | |
|--------------------------|---------------|
| DATE CHECKLIST COMPLETED | 15 March 2017 |
|--------------------------|---------------|

Southern Health and Social Care Trust

Acute Services Directorate

Patient 10

Meeting Room 2, Admin Floor
Craigavon Area Hospital

PRESENT:

Mr A [REDACTED] G [REDACTED], Consultant Urologist, Chair
Mrs C [REDACTED] C [REDACTED], Lead Nurse Acute Governance
Mrs R [REDACTED] F [REDACTED], Acute Governance administrator
[REDACTED] Patient 10 patient
[REDACTED] Patient 10's Husband Husband of patient.

Mrs C [REDACTED] welcomed [REDACTED] Patient 10, Patient 10's Husband to the meeting. She introduced the staff and outlined the process and format of the meeting. She confirmed with [REDACTED] Patient 10, Patient 10's Husband they had received a copy of the report.

[REDACTED] Patient 10's Husband said they had read and understood the report.

Mr [REDACTED] asked if there were any specific issues.

[REDACTED] Patient 10 advised she had an understanding of the report and what happened was quite clear.

[REDACTED] Patient 10's Husband report there were 4 x-ray's/ scans /MRI reported. The first was requested by Mr [REDACTED]. After the scan [REDACTED] Patient 10 received a letter reporting the scan was ok but had shown a couple of cysts which he believed to be water filled, Mr [REDACTED] requested a further scan to confirm his suspicion. This is where [REDACTED] Patient 10's Husband feels the mistake was made as there was no mention of the third cyst. [REDACTED] Patient 10 had another scan along with her routine mammogram which was reported as clear.

[REDACTED] Patient 10's Husband questioned if the same radiologist reported on all scans?

Mrs C [REDACTED] replied no. [REDACTED] Patient 10 asked was this reason there was more than one doctor named on the report. Mrs Connolly confirmed that was the reason.

Mr G [REDACTED] stated the key element identified in the SAI report was some scan/x-ray/MRI reports were not as comprehensive as they should have been. He added there were errors and omissions from radiology.

[REDACTED] Patient 10's Husband acknowledged the SAI report was comprehensive and the report had highlighted 3 mistakes. Mr G [REDACTED] agreed there were 3 issues identified by the report.

[REDACTED] Patient 10's Husband asked if there were any other scans showing cancer other than the ones reported. Mr G [REDACTED] advised as far as he was aware all were reported correctly. He advised when the imaging was reviewed retrospectively there was a small cyst on one kidney; this was on some reports but not on the report that was requested. He believed the cyst was there for quite some time before surgery but was not reported on.

[REDACTED] Patient 10 advised it came as a shock when she attended Mr [REDACTED] to be told she had cancer as she was feeling well and considered cancelling the appointment. She said over

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital

Tel: [REDACTED] by the USI
E-mail: AcutePatient.ClientLiaison@ [REDACTED] Personal Information redacted by the USI

this last year she has had horrendous year with a roller coaster of emotions. She has thought several times of what if but feels if she dwelled "it would only eat you up". Mrs [Patient 10] had to focus on her breast surgery and treatment before she could focus on her other cancer. She added that during her illness she fractured her spine which delayed her recuperation and had her chemotherapy delayed. She added the surgery was very traumatic.

[Patient 10] added she had received excellent treatment and care from all medical and nursing staff during the past while.

She spoke of the mixed emotions she had when she received the report as she felt very very confused as there was 3 mistakes made which has since made her scared of something else happening and she dreads getting results of her tests. She advised she has an appointment on 11.4.17 and was dreading getting those results.

Mrs C [Patient 10] empathised with [Patient 10] and advised her emotions were normal considering what she went through.

[Patient 10] advised she was surprised to receive the report in the format she did. She was aware Mr [Patient 10] was reporting the incident but the family thought no more of it until she received a letter advising the report was complete.

Mrs C [Patient 10, Patient 10's Husband] advised [Patient 10] then review team were aware [Patient 10] was going through treatment and that was the reason they decided to delay sending the report to them. [Patient 10] appreciated the delay in sending the report. She added whilst it was not a good report from a medical point of view she hoped the report would highlight the issues raised and try to prevent similar happening again.

Mr G [Patient 10, Patient 10's Husband] advised [Patient 10, Patient 10's Husband] there was a long establish process in place a multi-disciplinary meeting takes place to highlight issues raised, this works well when brought to the attention of those at the meeting but fails when not brought to the meeting.

[Patient 10] expressed her hopes the report would help someone else and [Patient 10's Husband] added his hope was it would benefit the hospital in general. Mr G [Patient 10] informed [Patient 10, Patient 10's Husband] the recommendations were put in place.

[Patient 10's Husband] advised his wife has a scan tomorrow and wants to make absolutely sure and have the confidence that the report will be accurate. [Patient 10] advised the scan has been organised by Mr [Patient 10] for CT of upper abdomen and pelvic area. She added she has four different cancers and is being prioritised due to this.

Mr G [Patient 10] offered with the permission of [Patient 10] he would speak to Mr [Patient 10] regarding the scan.

[Patient 10's Husband] added a great system needs good staff to operate the system and hoped the system would be improved and work better.

Mrs C [Patient 10] added the report was not to name and shame or to upset the family it is to identify failings and put a process in place to improve the service.

[Patient 10] concluded by saying she hoped the report and the issues identified would help other families. [Patient 10's Husband] finished by expressing his appreciation of the detail within the report.

Significant event audit (SEA) structured reflective template
Requirement: one annually

| | |
|--|------------------------|
| Name of doctor: Aidan O'Brien | GMC No: 1394911 |
| SEA Title: | |
| Delayed Diagnosis of Renal Cell Carcinoma | |
| Date of incident: | |
| 06 January 2016 | |
| Description of events: | |
| <p>A 59 year old lady had sigmoid colonic carcinoma managed by sigmoid colectomy and adjuvant chemotherapy in 2010. On CT scanning in 2010, she was reported to have a 'simple renal cyst particular in right. No solid renal mass.' There were in fact three right renal cysts considered at that time to be simple. On retrospective review of the images of the third annual CT scan in 2012, it was evident that some regional enhancement of one of the three cysts had developed. However, the report referred only to simple 'cyst present right kidney'. The patient then had right breast carcinoma diagnosed and managed by surgery, radiotherapy and hormonal therapy in 2013.</p> <p>When CT scanning was requested by her GI surgeon and repeated in July 2014, it was reported that multiple, bilateral simple renal cysts were present, and that one of the right renal cysts 'demonstrated subtle layering with high density in its medial aspect which was probably present previously'. Ultrasound scanning was recommended. The GI surgeon wrote to the patient to reassure her of the benign nature of the cyst, while requesting the ultrasound scan which was performed later in July 2014 when it was reported this cyst contained 'echogenic, well-defined material posteriorly, possibly solid'. MRI scanning was recommended and performed in September 2014. The report did not include any reference to the cyst of concern, it only confirming that the largest right renal cyst was definitely simple.</p> <p>The patient's oncologist also requested a CT scan in September 2014 to investigate recent right chest wall pain. This CT scan was performed in October 2014 and reported in November 2014, detailing the presence of both a large simple cyst and a smaller complex cyst containing solid and cystic components. The oncologist wrote to the patient in November 2014 to reassure her that the CT scan had reported no worrying abnormality.</p> | |



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The patient's GP referred her to Urology in October 2014 on foot of the report of the MRI scan, relating that she had a history of bowel and breast cancer, had right renal angle pain and had been found to have a large right renal cyst, requesting assessment and advice. The referral was delivered to me for triage. As I did not have time to triage the referral, and would have retained its referral status as routine if I had had the time to do so, she did not have a urological outpatient consultation until 06 January 2016 when the potential significance of the smaller complex cystic lesion was appreciated.

On restaging by further CT scanning in January 2016, the complex cystic lesion remained unchanged, she was found to have partially healed fractures of her right sixth and seventh ribs (the cause of her pain), and was found to have left axillary lymphadenopathy. Biopsy confirmed metastatic breast carcinoma managed by lymphadenectomy, systemic chemotherapy and radiotherapy. The complex, right renal cystic lesion was resected in October 2016. It proved to be a papillary renal cell carcinoma. She has remained free of evidence of recurrence of all three carcinomata since.

The case became the subject of a SAI, though I am uncertain of the date of its initiation. I was not advised of the existence of any SAI until December 2016. I was provided with a draft report in January 2017. I was invited to return any comments (enclosed). The Root Cause Analysis was signed off in March 2017 (enclosed).

What went well?

The one feature of this case which went well was the decision of the urologist who met the patient when she attended on 06 January 2016 to arrange a CT scan of her chest, abdomen and pelvis, and which led to the diagnosis of metastatic breast carcinoma, and its management.

What could have been done better?

The change in the index, complex, right renal lesion was evident on CT scanning in December 2012, and could have been appreciated by the reporting radiologist. This change was reported on CT scanning in June 2014 and was reported to have probably been present previously. If it had been appreciated and reported in January 2013, its assessment and management could have proceeded then.

The potentially significant features of the lesion on CT and ultrasound scanning in 2014 could have been brought to the attention of the urological service by reporting radiologists, informally or via MDM. This did not occur.

Even though the patient's clinicians were advised in 2014 to request further imaging to further assess the complexity of the renal lesion, none considered referral of the patient to the urological service.



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Instead, the report of the definitive MRI scan inexplicably included no reference to the right renal lesion of concern, even though the scan was reported by the radiologist who had advised that MRI scanning be performed to further assess the lesion. Instead, the report described the entirely benign features of the larger, simple, right renal cyst. As a consequence, her GP referred her routinely for assessment of the possibility that the large, simple cyst was the cause of her pain.

The letter of referral was delivered to me on Thursday 30 October 2014. In addition to providing management of all urological inpatients and acute referrals from Daisy Hill and South West Acute Hospitals, I had spent several hours previewing all cases to be discussed at MDM which I chaired on that date, as well as reviewing ten cancer cases on 31 October 2014. I had advised that I had found it impossible to triage all referrals as well.

This routine referral could only have been upgraded to Red Flag status as a consequence of a review of all the previous radiological reports on NIECR, as a minimum, if not a review of imaging on NIPACS. Such a review would require a minimum of 10 – 15 minutes for each referral, some additional 20 hours for the approximate 120 referrals received each week at that time. No predictable time was allocated in job plans to triage.

The Trust stated in January 2017 that it had an agreed Policy and Procedure on Triage. The Trust confirmed in October 2018 that it did not have one. In January 2017, I requested that Management discuss with clinicians to agree such a Policy, and particularly in the context of the waiting times for urgent and routine outpatient consultations, now 97 and 149 weeks, respectively. It has not yet done so. As a consequence, consultant urologists do not know what kind of triage is expected by the Trust, or when it should be done, so as not to compromise patient care or clinical outcomes.

What changes have been agreed?

Personally:

As I have continued to find it impossible to triage all referrals (approx. 180) received while urologist of the week, I take a day of annual leave after completion of my urologist of the week, and I spend that day and the following weekend to complete triage, in my own time.

For the team:

All consultants will receive an allocation of eight hours in their new Job Plans as predictable time for triage. The allocation would only be adequate if triage is conducted entirely on the information provided in the referral, and without any regard to waiting times.



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Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

CONSULTANT APPRAISAL
Complaints: 1.1.17 - 31.12.17

Mr A O'Brien

| ID | First received | Record name | Description | Outcome |
|--|----------------|--|---|--|
| Personal Information redacted by the USI | 11/12/2017 | Personal Information redacted by the USI | Complainant believes that her brother should not have been discharged from hospital as early as he was. | Advised that patient had informed nursing staff that he had no pain or concerns and would be happy to go home. Patient did not require medication from Pharmacy as he stated he had an ample supply at home. |



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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: | |
| 11 December 2017 | |
| Nature of complaint: | |
| <p>This 73 year old man had an elective endoscopic resection of his prostate gland performed under my care on 04 October 2017. He was apparently able to pass urine satisfactorily following urethral catheter removal on 06 October 2017 when he was keen to go home, and had arranged for a friend to collect him. However, he then had difficulty in passing urine following his discharge, having to attend the Emergency Department at South West Acute Hospital during the early hours of 07 October 2018.</p> <p>His sister lodged a complaint on his behalf, alleging that he had been discharged prematurely, and requesting that the Southern Trust reimburse the expenditure on taxi fares bringing him to and from South West Acute Hospital. The Southern Trust has asserted that he had not been discharged prematurely, and has declined to reimburse expenses as he is a resident of the Western Trust. His sister has appealed that decision to the Ombudsman.</p> | |
| Status of complaint: On-going / resolved | |
| On-going | |
| Involvement of other bodies: Responsible organisation / GMC / Other | |
| Ombudsman | |
| If resolved, what were the findings? | |
| How will my practice change? | |
| <p>The care of all inpatients, whether acutely or electively admitted, is the responsibility of the urologist of the week, who was not involved in his discharge. My practice will not change as I was not responsible for his discharge.</p> | |



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Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome 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 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 | Description of Department of Urology and its teams | 2017 |
| 2 | Formal Investigation and Exclusion | 2017 |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Discussion
<p>Mr O'Brien is a member of the Urology MOM which meets every Thursday afternoon - radiologist, pathologist, oncologist, palliative care nurses and link in with Belfast.</p> <p>2017 was very difficult for Mr O'Brien as he was excluded as he was the subject of a formal investigation. The issues around him are still ongoing.</p> | | |
| Actions Agreed
<p>Mr O'Brien will continue to participate in and chair urology MOMs on a weekly basis. The ongoing investigation is having a detrimental effect on his health and well being. It remains a difficult concern for Mr O'Brien.</p> | | |

[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](#).

Department of Urology

The Department of urology at Craigavon Area Hospital has grown significantly since I was appointed as a single-handed consultant, assisted by half a Registrar, and with an allocation of four inpatient beds, in July 1992. I provided an unbroken, acute urological service until the appointment of a second consultant in 1996. The Department has had a compliment of six consultant urologists since 2013.

During the 25 years since 1992, there have been a number of developments which have expanded the complexity of the service provided, and the multidisciplinary team which provides the service. CURE (Craigavon Urological Research and Education) was founded in 1994, enabling the funding of research fellowships leading to higher degrees, the appointment of a lecturer in urological nursing at Ulster University, the establishment of academically accredited modules in urological nursing and the launch of the International Journal of Urological Nursing. I remain a Director of CURE.

Northern Ireland's only on-site ESWL (extracorporeal shock wave lithotripsy) service was launched at Craigavon Area Hospital in 1998. The Department established its own purpose built, one-stop, outpatient diagnostic service, the Thorndale Unit, in 2007. The Southern Trust Urological MDT was launched in April 2010. I was appointed its Lead Clinician in April 2012, and I remain a chair of the Urology MDM. Our Department was allocated responsibility for the provision of urological services to the population of County Fermanagh since January 2013.

The Department contains several teams, of consultant urologists as well as consultants in other specialties, particularly anaesthesia, radiology and oncology. I work with all of these in the furtherance of patient management. A team of clinical nurse specialists largely work in the Thorndale Unit, but supplemented by nurse specialists in palliative care and in the community. I work with the teams of junior doctors and nurses caring for inpatients at ward level, and particularly the Elective Admissions Ward and Ward 3 South. I work with the teams of anaesthetists, nurses, radiographers and orderlies to provide optimal operative care in theatre, and postoperatively in Recovery Ward, and in the High Dependency and Intensive Care Units when required.

I conduct a monthly clinic at Armagh Community Hospital, and similarly at South West Acute Hospital in Enniskillen. I particularly enjoy the latter, as it is particularly gratifying to be able to bring an outpatient consultation service to that part of Northern Ireland most distant from urological access, and where that distance is such a significant factor that some patients would not be able to access such a service otherwise.

Aidan O'Brien

Formal Investigation & Exclusion

In my last appraisal for the year 2016, I included the letter of the 23 March 2016 that had been given to me by Mr. Eamon Mackle, Associate Medical Director, and accompanied by Mrs. Martina Corrigan, Head of Service for ENT and Urology, who represented Mrs. Heather Trouton, Assistant Director, detailing their concerns regarding referrals which had not been triaged, outpatient review backlog, an allegation that there had been no record of consultations in patients' notes or on Patient Centre, and my having patients' notes at home. The letter requested that I respond with a commitment and immediately plan to address the concerns. I immediately asked what I should do. I was answered with a shrug of the shoulders.

I left that brief meeting wholly despondent, knowing that I would receive no support or assistance in addressing the concerns. I still remained Lead Clinician of Urology MDT, having responsibility for endeavouring to ensure that urological cancer diagnostic and therapeutic services were delivered to patients within the required timelines. In addition, I was daily conscious of the morbidity suffered by so many patients on our waiting lists, morbidity which was often acute and life threatening, requiring acute readmission to hospital with urosepsis as a consequence of the delay in elective admission for definitive surgical management. For that reason, I used every available operating session, undertaking 22 additional operating sessions during 2016 to endeavour to mitigate the risk to patients. I similarly conducted an additional 10 oncology review clinics for similar reasons.

During all of this time, I

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

in order to provide continued support to one of my consultant colleagues while he was urologist of the week. When he advised me that he had taken up an appointment in England, commencing in November 2016, I

Personal Information redacted by the USI

I had also received the agreement of Mrs. Corrigan, Head of Service, to use my time of recovery at home to process and have patients' charts returned from my home. I did so by contacting all patients by telephone to update their clinical status, dictating letters to GPs and to the patients themselves. In doing so, I had scheduled all inpatient and day case operating for January 2017, and had my secretary schedule review appointments for the more clinically significant patients at clinics in January and February 2017. In doing so, I had processed two thirds of all the remaining patients.

I then received a call on 28 December 2016 to advise that the Medical Director wished to meet with me on Tuesday 03 January 2017. I advised that I would be unable to do so at the stipulated time as I would be operating. I offered to speak with him by telephone. However, I was advised that he required to meet me in person. I enquired whether he appreciated that I was still on sick leave. I was advised that he did. I offered to meet with

him on Friday 30 December 2016 instead. That offer was accepted. As I then wondered what the meeting could be about, I requested an agenda. On receipt of the agenda, and which included the advice that I could be accompanied for support, I became greatly concerned.

I attended the meeting, accompanied by my wife, on 30 December 2016 when I was advised that an Oversight Committee had decided that a formal investigation of my administrative practices be held, and that I was to be immediately excluded from the workplace for a period of time, and up to a maximum of four weeks. As I was subsequently to learn from the record of this Oversight Committee, and made available to me only in October 2018 after requests had been ignored since July 2017, this has been just one of the untruths perpetuated during the past two years, as the Oversight Committee had determined on 22 December 2016 that I should be formally excluded for the duration of a formal investigation, which took 18 months to complete, breaching the Trust's own guidelines in doing so.

The month of January 2017 was the most traumatic month for me in my lifetime. In pointing out that the Trust had breached its own Guidelines, a Case Conference was held on 26 January 2017 when it was determined that there was no need for continued exclusion, and that I could return to work, under the terms to be advised by Occupational Health. Whilst I was so pleased to be able to return to work, not least out of concern for patients, I was a difficult process.

Since then, any residuum of confidence which I had in the integrity of a number of senior personnel in the Trust has been completely demolished. Most importantly, any belief that I had in their claim that their conduct, actions and inactions had been guided by concern for the welfare of patients, has been completely eliminated.

This domain of Good Medical Practice has been one in which I have been widely acknowledged to excel in. Not a clinic ends without my having been thanked by patients and relatives for my explanation of their condition, their options of management and the manner in which it has been communicated. I do believe that I have always endeavoured to work collaboratively and respectfully with my colleagues whose support I have enjoyed throughout my career. I have had continuity of patient care a first priority, maintaining with them a partnership in their ongoing care, indefinitely. Most importantly, I have done so with honesty and transparency.

To then be subjected to an investigative process which has been lacking in honesty and transparency, and which has included fabrication, misinformation and prejudice, has been the most traumatic, disillusioning and demoralising experience of my 40 year career in medicine.

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, Respect and Integrity | 2017 |
| 2 | Statement of Completion of Course in Equality, Good Relations and Human Rights: Making a Difference (Regional) | 22 November 2018 |
| 3 | Collection of Compliments and Gratitude received from patients | 2017 |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| | | |
| | | |
| | | |
| | | |

Discussion

Mr O'Brien is committed to treating patients and staff with dignity and respect. He has a large number of thank you cards and 1 complaint which he has reflected on. He has signed his health, probity and integrity declaration.

Actions Agreed

Mr O'Brien will continue to meet his high standards relating to maintain Trust. If any issue arise relating to Trust, he will seek advice and/or help at the earliest possible opportunity.

[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](#).

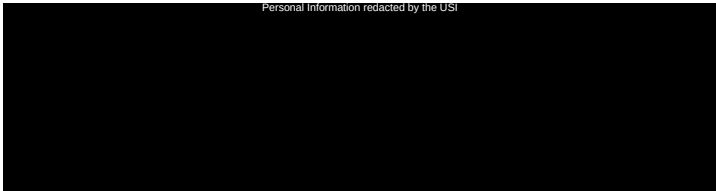
Statement of Probity, Respect and Integrity

I was a child of eight years old when I first visited a hospital, not knowing what a hospital was on entry, and having decided that it was in a hospital that I would wish to spend my life caring for the sick patients I found that day. As the years progressed, it was to be as a doctor, then a surgeon, then a urological surgeon.

Irrespective of the specialisation, it is still caring for the sick as a doctor to which I dedicated my life. Doing so to perfection every day is not only challenging, but impossible. The main constraints imposed upon our endeavours to do so are infrastructural. At present, and for the foreseeable future, we do not have adequate operating theatre capacity to honour the commitments we agree with our patients. Even if we did, we do not have the bed capacity to accommodate them.

Nevertheless, it is our duty to treat our patients, their relatives, their advocates and all of our colleagues with respect and integrity, with honesty and humility. I have found the General Medical Council's Good Medical Practice in Action (GMPiA) very instructive and helpful. It is to be recommended. I endeavour to follow its principles. I do hope my patients and colleagues agree.

Personal information redacted by the USI



Aidan O'Brien

YxfaUY9BhY

STATEMENT of COMPLETION

This is to certify that

Aidan O'Brien

has completed the course

SHSCT_Equality, Good Relations and Human Rights: Making a Difference (Regional)

November 22, 2018



Southern Health
and Social Care Trust

Part 1 - All Staff

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? |
|--|--|--|
| Resolution of the concerns raised in the letter of 23 March 2016 | To cooperate with the Investigation of the concerns raised | I participated fully in the Investigation. |
| Continued Professional Development | To attend a Urological Conference | I attended the Annual Meeting of the British Association of Urological Surgeons in Liverpool in June 2018. |
| | | |
| | | |
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| | | |
| | | |

[CLICK HERE](#) for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2017 Page 11

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

PERSONAL DEVELOPMENT PLAN for the year ahead

| Development needs | Actions agreed | Target dates |
|---|---|---------------|
| To have a written expectation from the Trust of its expectations of me when urologist of the week | Memorandum of understanding of what is expected from the Trust. | December 2018 |
| To have an clear, written understanding of the expectation of the Trust of the type of triage to be conducted, and when it should be conducted. | Memorandum, to adhere to Trust Policy | December 2018 |
| Continued Professional Development | To attend EAU in Barcelona in March 2019 | December 2018 |
| Use college template to record CPD | Use college Template | |
| | | |
| | | |
| | | |
| | | |

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2017 Page 12

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| PERSONAL DEVELOPMENT PLAN for the year ahead | | |
|--|------------------------------|---------------|
| Development needs | Actions agreed | Target dates |
| To continue to dictate letters following every outpatient consultation | Addressing letter of concern | December 2017 |
| To continue to triage all referrals | Addressing letter of concern | December 2017 |
| To discuss issues relating to a heavy rota plan. | Discuss with line manager. | July 10/18 |
| To attend an international meeting on urology | Attend meeting - ? EAU. | December 2017 |
| | | |
| | | |
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| | | |

[CLICK HERE](#) for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click [here](#).

Name: Aidan O'Brien

GMC Number: 13949111

Appraisal Period : Jan – Dec 2016 Page 12

ISSUES OF CONCERN FOR DISCUSSION**At****DEPARTMENTAL MEETING****On****24 SEPTEMBER 2018**

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

UROLOGIST OF THE WEEK

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

TRIAGE

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation. I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, 90 year old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on 17 October for TURP, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

SUMMARY

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.



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 <i>Maintaining Good Medical Practice</i> (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year:

I would like to attend the European Association of Urology in Barcelona in March 2019 |
| Date of reflection: 05 December 2018 |
| 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

FORM 5- HEALTH AND PROBITY STATEMENTS**HEALTH DECLARATION**

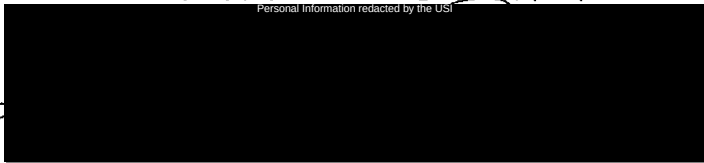
To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click [here](#).

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: 

Date: 07 December 2018

Name 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]

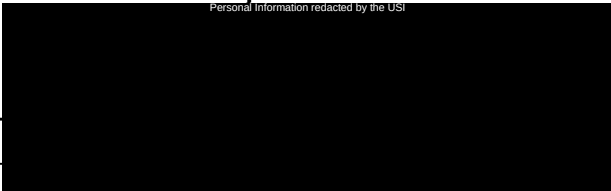
Since my last appraisal/revalidation I have not, in the UK or outside:

- 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: 

Date: 07 December 2018

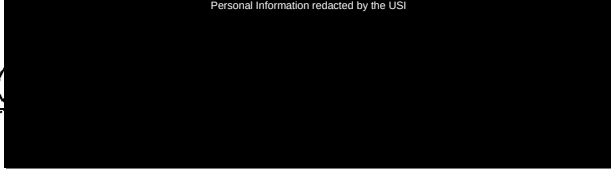
Name in Capitals: Aidan O'Brien

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: 07 December 2018

Name in Capitals: Aidan O'Brien

Convictions, findings against you and disciplinary action [Please check relevant box by clicking on it and then sign below]



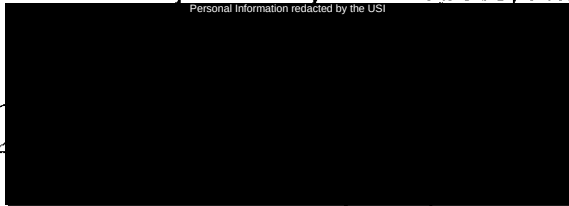
Since my last appraisal/revalidation I have not, in the UK or outside:

- 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.

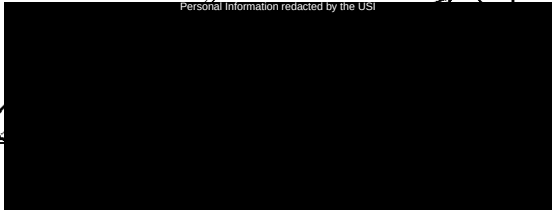
Signature: 

Date: 07 December 2018

Name in Capitals: Aidan O'Brien

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click [here](#)

Signature: 

Date: 07 December 2018

Name in Capitals: Aidan o'Brien

Personal information redacted by the USI

MBE, MB, BCh, BAO, D

MRCGP(dist), FRSPH

MB, BCh, BAO, DGM, DRCOG, FRCGP, DFFP

Personal information redacted by the USI

To whom it may concern,

I can confirm that Aidan O'Brien has been a patient in my practice since 1992 and will continue to be so.

The only health issue that he has had over the years is

Personal information redacted by the USI

Personal information redacted by the USI

Sick Leave

The periods of sick leave which I have had during my employment as a consultant urologist have been:

One week in October 2006

Personal Information redacted by the USI

From 16 November 2016 to 20 February 2017

Personal Information redacted by the USI

Personal Information redacted by the USI

Aidan O'Brien

05 April 2019

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.

| CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS | APPRAISER SIGNATURE | DATE |
|--|--|------------|
| NIL | Personal Information redacted by the USI | 11/12/2018 |
| | | |
| | | |

When you have completed the appraisal, the appraiser should check and sign the following:

| GMC REQUIRED INFORMATION | | | PRESENT |
|---|-------------------------------------|------|--|
| Continuing professional development | | | Personal Information redacted by the USI |
| Quality improvement activity | | | |
| Significant events review | | | |
| Review of complaints and compliments | | | |
| Feedback from colleagues | Year undertaken
OR Planned Year: | 2018 | |
| Feedback from patients (where applicable) | Year undertaken
OR Planned Year: | 2018 | |

| APPRAISAL CHECKLIST | COMPLETED |
|--|--|
| Check that all sections of the documentation have been completed. | Personal Information redacted by the USI |
| Ensure the previous year's Personal Development Plan has been reviewed. | |
| 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:

| | |
|--|--|
| APPRAISEE
Signature of Appraisee: _____ Date: 11.12.18 | |
| APPRAISER
Signature of Appraiser: _____ Date: 11/12/2018 | |
| GMC Number: 3574522 | |
| CO-APPRAISER (if applicable)
Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____
GMC Number: _____ Organisation: _____ | |

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraiser is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2015 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 2016 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 2017 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: _____

Please ensure the section below is fully completed.

| GMC Supporting Information Requirements | Year Completed | Reviewed by | Date |
|--|----------------|--|---------|
| Feedback from colleagues 1 in 5 years | 2014 | Personal Information redacted by the USI | 1/12/17 |
| Feedback from patients (where applicable) 1 in 5 years | 2014 | | 1/12/17 |
| Significant Events Review | 2016 | | 1/12/17 |
| Review of complaints and compliments | 2016 | | 1/12/17 |
| Continuing Professional Development | 2016 | | 1/12/17 |
| Quality Improvement Review | 2016 | | 1/12/17 |

Name: Aidan O'Brien

GMC Number: 1394911

Appraisal Period : Jan – Dec 2015 Page 22

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 (Every 3 years) | Elearning Blood Transfusion Module Click Here | Core | 15/12/15 |
| Competency 1,2 & 4 (Every 3 Years) | Face to face – Trust Haemovigilance Staff Contact Patricia Watt on
<small>Personal Information redacted by the USI</small> | Core | 20/12/17 |
| Desist Notice | To obtain a desist notice, click here | Core | |

| Annual Updates | Method | Core / Optional | Date Completed |
|---|--|------------------------|-----------------------|
| Fire Safety | Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development <small>Personal Information redacted by the USI</small> to <small>Personal Information redacted by the USI</small> to book a place. | Core | 24/10/17 |
| 2 Yearly Updates | Method | Core / Optional | Date Completed |
| Infection Prevention and Control | SHSCT E-Learning Module Click Here | Core | 22/11/18 |
| Resuscitation | Face to Face.
CAH - Helen Cullen <small>Personal Information redacted by the USI</small>
<small>Personal Information redacted by the USI</small>
DHH - Bernie O'Connor <small>Personal Information redacted by the USI</small>
<small>Personal Information redacted by the USI</small> | Optional | |
| 3 Yearly Updates | Method | Core / Optional | Date Completed |
| Safeguarding Children & Vulnerable Adults | Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development <small>Personal Information redacted by the USI</small> to <small>Personal Information redacted by the USI</small> to book a place. | Core | 24/10/17 |
| Information Governance/Data Protection/IT Security | SHSCT E-Learning Module Click Here | Core | 21/11/18 |
| Moving and Handling | SHSCT E-Learning Module Click Here | Core | 22/11/18 |
| Health & Safety / Control of Substances Hazardous to Health (COSHH) | SHSCT E-Learning Module Click Here | Core | 22/11/18 |
| Discovering Diversity | HSC E-Learning Module Click Here | Optional | |
| Recruitment & Selection | HSC E-Learning Module Click Here | Optional | |
| Sickness & Absenteeism Training | Face to Face. Contact ELD on <small>Personal Information redacted by the USI</small> or email learning.development <small>Personal Information redacted by the USI</small> | Optional | |
| Hyponatraemia | BMJ E-Learning Module Click here | Optional | |
| Management of Actual or Potential Aggression | Face to Face. Contact ELD on <small>Personal Information redacted by the USI</small> or email learning.development <small>Personal Information redacted by the USI</small> | Optional | |
| Fraud Awareness | HSC E-Learning Module Click here | Optional | |
| Seeking and Obtaining Consent for Hospital Post Mortem Examination | SHSCT E-Learning Module Click here | Optional | |

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| Once off Training | Method | Core / Optional | Date Completed |
|--|--|-----------------|----------------|
| National Early Warning System | National NEWS e-learning Click here | Optional | |
| Obstetrics Early Warning System | Online Module Click here | Optional | |
| Paediatrics Early Warning System | Face to Face. Contact CAH Dr S Shah
shilpa.shah
Contact DHH Dr B Aliarad
Personal Information redacted by the USI | Optional | |
| Consent | In House E-Learning Module Click here | Optional | |
| Blood Culture | In House E-Learning Module Click here | Optional | |
| Peripheral Line | In House E-Learning Module Click here | Optional | |
| Oral Anticoagulants | MHRA Module Click here
Once on the site choose the Anticoagulant Module.
On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration. | Optional | |
| Naso Gastric Tube Placement | In House E-Learning module Click here | Optional | |
| Protocol following death of patient | In House E-Learning module Click here | Optional | |
| Guide to Prescribing in SHSCT | In House E-Learning module Click here | Optional | |
| Research and Development - Good Clinical Practice Training | Elearning Module Click here | Optional | |
| VTE | King's Thrombosis Centre E-learning Click here | Optional | |
| Safe Sedation [Module 1,2 & 3] | In House Elearning Modules
Click here (Part 1)
Click here (Part 2)
Click here (Part 3) | Optional | |
| Gastrointestinal endoscopy | Face to Face Contact Dr A Murdock
Personal Information redacted by the USI | Optional | |
| Chest Drain Insertion | Face to Face
Contact Dr A Ferguson
Personal Information redacted by the USI | Optional | |
| Blood Gas Instrument | Face to Face
Contact Derek McKillop
Personal Information redacted by the USI
Face to face | Optional | |
| Appraiser Training | Face to face
Dates available here | Optional | |
| Appraisee Training | Face to face
Dates available here | Optional | |
| Insertion and Management of Indwelling Urinary Catheters | Online Module Click here | Optional | |
| Coroner's Investigations and Inquests Programme | Online Module Click here | Optional | |
| HIV Awareness Training | Face to Face
Contact Lyndsey Hasson
Tel: Personal Information redacted by the USI | Optional | |
| Patients enrolled in Clinical Trials | In House E-Learning module Click here | Optional | |

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

| Waste Management | SHSCT E-Learning Module Click Here | Optional | |
|---|--|-----------------|----------------|
| Modules proposed for E-Learning | Method | Core / Optional | Date Completed |
| Better Communication/Complaint Handling | Face to face | Optional | |
| Incident Reporting | Face to face | Optional | |
| Clinical Negligence | Not currently available | Optional | |

Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@hscni.net Personal Information redacted by the USI

Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.

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:

Name of Appraisee: Aidan O'BrienGMC Number: 1394911Date: 07 December 2018

APPRAISER

Signature of Appraiser:

Name of Appraiser: Dariusz SzwedGMC Number: 257222Date: 11/12/2018

Revalidation 2019

29/12/2018

Your GMC reference number: 1394911

**General
Medical
Council**

09002_1621699050<535>_S264-PK264/1L C

A. O'Brien Esq., FRCS

Personal information redacted by the USJ

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: +44(0)161 923 6602
Fax: +44(0)161 923 6201

Dear Mr O'Brien

Notice of your GMC revalidation submission date

This is your formal notice that we need to receive a recommendation about you from your Responsible Officer for your revalidation.

We need to receive a recommendation from your Responsible Officer by 27/04/2019.

Your designated body

Our records show that your designated body is Southern Health and Social Care Trust.

If this is correct then there is nothing further you need to do at this stage.

If your designated body is wrong or you no longer have a connection to one you need to:

- Log in to your GMC Online account (or set one up) at www.gmc-uk.org/gmconline/.
- Click 'My Revalidation' on the left hand menu.
- Add your correct designated body if you have one OR select the option that you don't have a designated body.

Our revalidation guidance

It is important you understand what our requirements are for revalidation so you can maintain your licence to practise. You should read our *Guide for doctors: Revalidation and maintaining your licence* at www.gmc-uk.org/revalmaintain, which explains what you need to do to meet these requirements.

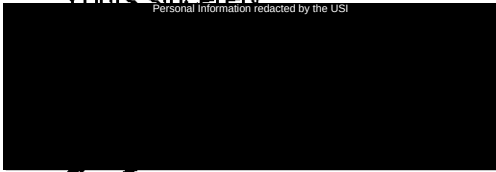
You can also find information about revalidation on our website at www.gmc-uk.org/revalidation/.

If you have any questions about your revalidation submission date or your appraisal, please contact your Responsible Officer at Southern Health and Social Care Trust.

If you have any other questions, please contact us. We will do our best to help.

Yours sincerely,

Personal information redacted by the USI



Clare Barton
Assistant Director
Revalidation



**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 |
| <p>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:</p> <p>I was Lead Clinician and Chair of the NICaN Clinical Reference Group in Urology from January 2013 until January 2016. During that time, I prepared all of the work for and chaired all of the Group's meetings. In preparation for the first National Peer Review of Northern Ireland's Urological Cancer Services, I constructed all of the referral pathways for patients suspected of having a cancer. I commissioned, supervised, revised and gained multidisciplinary agreement for the Northern Ireland's first Urological Cancer Clinical Guidelines. I brought the five Trusts towards Peer Review in June 2015 with robust Guidelines and Operational Policies. As a trained Peer reviewer, I assisted Team North West in meeting Peer Review.</p> <p>In addition, I was the Southern Trust's Lead Clinician of its Urology MDT and Chair of its MDM from April 2012 until December 2016. I developed its Operational Policy through repeated business meetings, in preparation for Peer Review. In the Annual Reports of 2014 – 2016, there was a progressive increase in Red Flag referrals, of cancer diagnoses and of MDM case discussions. By the time of Peer Review in June 2015, I had succeeded in having the Southern Trust not having one case in breach of a cancer timeline. I had done so by ensuring that all patients were processed within those timelines, either by their named consultants, or by myself, when colleagues took holidays etc.</p> | |
| <p>They also brought the following drawbacks to my main clinical role:</p> <p>I did all of the above without any assistance from my employing Trust: no time allocation, remunerated or otherwise. The significant time spent in executing the above roles had a significantly negative impact in fulfilling all aspects of my clinical responsibilities.</p> | |
| <p>I could consider the following actions, to maximise the benefits and minimise the drawbacks:</p> <p>Too late, except never do the same again, as it is at least thankless, if not punishable!</p> <p>Date of reflection: 04 April 2019</p> | |



**Southern Health
and Social Care Trust**

Quality Care - for you, with you

Final outcome after discussion at appraisal:

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



NICaN Urology Cancer Clinical Guidelines

March 2015



| | |
|------------------|---|
| Document Title | Guidelines for the Referral, Diagnosis, Treatment and Management of Urological Cancer |
| Document Date | March 2015 – version 1.1 |
| Document Purpose | <p>This guidance has been produced to support the diagnosis, treatment and management of urological cancer.</p> <p>Treatment decisions for individual patients require the weighing of a multiplicity of factors, which cannot all be accounted for in a CMG. The CMG provides a description of the range of treatment options available for a clinical scenario. To maximise the benefit of multi-professional working management strategies for the individual are best discussed with a multidisciplinary meeting (MDM).</p> |
| Authors | <p>Surgical: New NI guidelines have been developed by Ali Thwaini, Consultant Urologist, BHSCT, for Bladder, Prostate, Penile, Renal Cell, Testicular & Upper Urinary Tract Urothelial Cell Carcinomas</p> <p>Imaging: Yorkshire Cancer Network Imaging Guidelines (These guidelines have been adopted by the Network group as they reflect NI Practice)</p> <p>Pathology: Royal College of Pathologists Standards and Minimum Datasets for reporting Cancers (These guidelines have been adopted by the Network group as they reflect NI Practice)</p> <p>Systemic Anti-cancer Therapy Protocols: Reference to separate guidance developed on behalf of the NI Cancer Network and the HSCB</p> <p>Radiotherapy Protocols: These guidelines have been adopted by the Network group as they reflect NI Practice)</p> <p>Urological Nursing Sections: Kate O'Neill (SHSCT), Kerry Chambers (WHSCT), Patricia Thompson (SEHSCT), Hazel Kerr (SEHSCT)</p> |

| | |
|--|---|
| | Follow up section: Transforming Cancer Follow Up Project team |
|--|---|

| | |
|-------------|--|
| Version 1 | Original Draft |
| Version 1.1 | Reformatted with inclusion of new Surgical guidelines, Imaging, Pathology, Clinical Nurse Specialist, Follow Up and Specialist Radiographer Sections |

| | |
|---------------------|---|
| Regional Agreements | To be agreed at the Regional Urology Network Group Meeting on 17 th April 2015 |
| Agreed: | |
| Review: | April 2017 |

Contents
(To be finalised)**Page No**

Introduction

Network Configuration of the Urology cancer service

Referral Guidelines

- Primary Care Referral
- Referral following surgical emergency
- Secondary to tertiary care

Clinical Responsibilities across the Patient Pathway

Imaging protocol

Pathology

Surgery for Urological Cancers

- Management of Surgical Emergencies

Chemotherapy

Radiotherapy

Site Specific Guidelines: Kidney cancer, Bladder cancer, Prostate cancer, Testicular cancer

Palliative Treatments

Follow Up

Urology Nursing

Specialist Palliative Care & Supportive Care

Psychological Support

Appendices:

1. Patient pathways for Kidney cancer, Bladder cancer, Prostate cancer, Testicular cancer, Penile Cancer

1.0 Introduction

Urological cancers include a range of tumours with different presentations including:

- Prostate cancer
- Bladder cancer
- Kidney cancer
- Testicular cancer
- Penile cancer

Prostate cancer is a form of cancer that develops in the prostate. Advanced prostate cancer can spread to other parts of the body. It accounts for 24% of all new cancers in UK males, and in 20-30% of cases, prostate cancer spreads to other locations in the body. In Northern Ireland, the average number of cases per year between 2009-2013 was 1,039 per year (figures provided by NI Cancer Registry).

Bladder cancer is any of several types of malignant growths of the urinary bladder and is the 4th most common male tumour. The most common type of bladder cancer begins in cells lining the inside of the bladder and is called transitional cell carcinoma. Incidence of bladder cancer is higher in males than in females, with over 6,400 cases in 2009 in males compared to under 2,400 in females. In Northern Ireland, the average number of cases per year between 2009-2013 was 211 per year, with a breakdown of 150 males and 61 females (figures provided by NI Cancer Registry).

Kidney cancer is a form of cancer that develops in the kidneys. Kidney cancer is often asymptomatic until an advanced stage. In approximately one third of cases, the tumour is detected incidentally during imaging carried out for other reasons. The two most common types of kidney cancer, reflecting their location within the kidney, are renal cell carcinoma (RCC) and urothelial cell carcinoma (UCC) of the renal pelvis.

In Northern Ireland, the average number of cases per year between 2009-2013 was 288 per year, with a breakdown of 173 males and 115 females (figures provided by NI Cancer Registry).

Testicular cancer or cancer of the testicles is one of the less common cancers. It usually affects younger men between the ages of 15 and 49. Testicular cancer is relatively uncommon, accounting for just 1% of all cancers that occur in men. The most common type of testicular cancer is known as 'germ cell testicular cancer', which accounts for around 95% of all cases. In Northern Ireland, the average number of cases per year between 2009-2013 was 65 per year (figures provided by NI Cancer Registry).

Penile cancer is a rare type of cancer that occurs on the skin of the penis or within the penis. In the UK, around 550 men are diagnosed with cancer of the penis each year. It most commonly affects men over 60 years of age. Over the last 30 years, the number of penile cancer cases has increased by more than 20%, possibly due to changes in sexual practices.

2.0 Network Configuration of the Urology cancer services

Northern Ireland Cancer Network has three cancer MDTs which diagnose and treat urological cancers. These are held at the following locations:

Craigavon Area Hospital – Southern HSS Trust

Belfast City Hospital – combined team for Belfast HSS Trust and South Eastern HSS Trust

Altnagelvin Hospital – combined team for Western HSS Trust & Northern HSS Trust

The catchment populations of these MDTs are shown below:

| Urology MDT | Catchment¹ |
|---|------------------------------|
| Craigavon Area Hospital | 348,657 |
| Combined for:
Belfast City Hospital &
Ulster Hospital | 334,528
341,085 |
| Combined for:
Altnagelvin Hospital &
Antrim Area Hospital | 296,909
453,824 |
| Total | 1,775,003 |

Each MDT meets on a weekly basis. All MDTs have named surgeons who deal with urological cancers.

¹ Catchment populations based on NISRA projected population figures by electoral ward for 2008.

3.0 Referral Guidelines for Urology Cancer

Patients can be referred to their local hospital as 'red flags' (i.e. suspect cancer) by their GPs under the following NICE guidance:

Red Flag referral (Prostate), patients:

- With a hard, irregular prostate typical of a prostate carcinoma. Prostate-specific antigen (PSA) should be measured and the result should accompany the referral. (An urgent referral is not needed if the prostate is simply enlarged and the PSA is in the age-specific reference range.)
- With a normal prostate, but rising/raised age-specific PSA, with or without lower urinary tract symptoms. (In patients compromised by other comorbidities, a discussion with the patient or carers and/or a specialist may be more appropriate.)
- With symptoms and high PSA levels.

Red Flag referral (Bladder and Renal), patients:

- Of any age with painless macroscopic haematuria
- Aged 40 years and older who present with recurrent or persistent urinary tract infection associated with haematuria
- Aged 50 years and older who are found to have unexplained microscopic haematuria
- With an abdominal mass identified clinically or on imaging that is thought to arise from the urinary tract.

Red Flag referral (Testicular), patients:

- With a swelling or mass in the body of the testis.

Red Flag referral (Penile), patients:

- With symptoms or signs of penile cancer. These include progressive ulceration or a mass in the glans or prepuce particularly, but can involve the skin of the penile shaft. (Lumps within the corpora cavernosa can indicate Peyronie's disease, which does not require urgent referral.)

Non-urgent referral:

- Patients under 50 years of age with microscopic haematuria.
- Patients with proteinuria or raised serum creatinine should be referred to a renal physician. If there is no proteinuria and serum creatinine is normal, a non-urgent referral to a urologist should be made.

3.1 Haematuria Referral Guideline – please see Appendix 1

4.0 Urology Care Pathways

Cancer Care Pathways outline the steps and stages in the patient journey from referral 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.

Please see **appendix 2** for the care pathways for:

Prostate

Renal Tumour

Testicular Cancer Pathway

Transitional Cell Carcinoma

Castration Resistant Prostate Cancer

Penile Cancer Pathway



5.0 REGIONAL UROLOGICAL CANCER GROUP

| | |
|-------------------------|---|
| Document Title | Guidelines for the Imaging of Urological Cancers |
| Document Date | March 2015 – Version 2 |
| Document Purpose | <p>This guidance has been produced to support the diagnosis, treatment and management of urological cancer</p> <p>Treatment decisions for individual patients require the weighing of a multiplicity of factors, which cannot all be accounted for in a CMG. The CMG provides a description of the range of treatment options available for a clinical scenario. To maximise the benefit of multi-professional working management strategies for the individual are best discussed with a multidisciplinary meeting (MDM).</p> |
| Authors | <p>Dr Arthur Grey – Consultant Radiologist</p> <p>Dr Stephen Vallely – Consultant Radiologist</p> <p>Dr Eoin Napier – Consultant Radiologist</p> |
| Version Changes | <p>Version 1 – issued to Regional Group 7/4/11</p> <p>Version 1.1 – the updated Yorkshire Cancer Network Imaging Guidelines for the Investigation and Treatment of Urological Cancers were reviewed by the authors in September 2014 and they agreed to adopt the updated guidelines as they reflected NI Practice. The guidelines were circulated to the Urology Network Group for sign off on 17 April 2015. Copies of the Yorkshire Cancer Network Imaging Guidelines are available at http://www.ycn.nhs.uk/</p> |



6.0 REGIONAL UROLOGICAL CANCER GROUP

| | |
|-------------------------|--|
| Document Title | Regional Pathology Guidelines for Urological Cancers |
| Document Date | Version 1 23rd March 1015 |
| Document Purpose | The guidance has been produced to support the pathological diagnosis and staging of Urological Malignancies |
| Author | Dr Gareth McClean |
| Evidence | <p>Royal College of Pathologists Standards and Minimum Datasets for reporting Cancers;</p> <p>Dataset Adult Renal Parenchymal Cancer Histopathology Reports Nov 2006</p> <p>http://www.rcpath.org/publications-media/publications/datasets/adult-renal.htm</p> <p>Dataset for penile cancer histopathology reports Nov 2006</p> <p>http://www.rcpath.org/publications-media/publications/datasets/penile.htm</p> <p>Dataset for histopathology reports for prostatic carcinoma (2nd edition) October 2009</p> <p>http://www.rcpath.org/publications-media/publications/datasets/prostate.htm</p> <p>Dataset for the histological reporting of testicular neoplasms May 2014</p> <p>http://www.rcpath.org/publications-media/publications/datasets/testicular-cancer.htm</p> <p>Dataset for tumours of the urinary collecting system (renal pelvis, ureter, urinary bladder and urethra) (2nd edition) April 2013</p> |

| | |
|--|---|
| | http://www.rcpath.org/publications-media/publications/datasets/urinary-collecting-system.htm |
|--|---|

Statement:

Via Consultation with Pathologists at all Trusts it has been confirmed that all Pathologists in Northern Ireland are reporting to the standards laid down by the Royal College of Pathologists in the following College Publications and that there is no additionality of practice.

Dr Gareth McClean



7.0 REGIONAL UROLOGICAL CANCER GROUP

| | |
|-------------------------|--|
| Document Title | Systemic Anti-cancer Therapy Protocols |
| Document Date | 2015 |
| Document Purpose | Please refer to separate NICaN guidance documents for the Systemic Anti-cancer Therapy Protocols for Bladder, Penile, Testicular Germ Cell tumours, Prostate and Renal Cell. These documents are available on the NICaN website www.cancerni.net . |



8.0 REGIONAL UROLOGICAL CANCER GROUP

| | |
|-------------------------|---|
| Document Title | Radiotherapy Protocols |
| Document Date | 2015 |
| Document Purpose | <p>Radiotherapy is delivered in the Northern Ireland Cancer Centre at the Belfast City Hospital with a second department due to open in Altnagelvin in 2016. The Cancer Centre is equipped with 10 Linear Accelerators and a full range of conventional and CT simulation equipment. The Radiotherapy Department employs approximately 90 radiographers. The department is accredited by ISO9000 and Charter mark standards. There is a modern treatment planning system with 10 planning terminals. A comprehensive radiology service is available within the Cancer Centre and in the main City Hospital.</p> <p>IMRT is routinely delivered for radically treating prostate cancer, radiotherapy may also be used palliatively for all urological cancers. Further details of treatment regimens and fractionations are contained within treatment protocols are located in the radiotherapy department.</p> <p>For further information please contact Joanne McCarthy Clinic Coordinator <small>Personal Information redacted by the USI</small> or <small>Personal Information redacted by the USI</small></p> |



REGIONAL UROLOGY GROUP

9.0 Site Specific Guidelines

| | |
|-------------------------|--|
| Document Title | Guidelines for the Surgical Treatment and Management of Urological Cancer |
| Document Date | March 2011 – Final Version |
| Document Purpose | <p>This guidance has been produced to support the diagnosis, treatment and management of urological cancer</p> <p>Treatment decisions for individual patients require the weighing of a multiplicity of factors, which cannot all be accounted for in a CMG. The CMG provides a description of the range of treatment options available for a clinical scenario. To maximise the benefit of multi-professional working management strategies for the individual are best discussed with a multidisciplinary meeting (MDM)</p> |
| Authors | Ali Thwaini, BHSC |
| Version Changes | <p>It was agreed at the Urology Network Meeting on 11th June 2014 to review the Surgical components of the EAU guidelines for urological cancers. Mr Ali Thwaini has developed new Urological surgical guidelines to reflect practice within NI.</p> <p>It was agreed at the Urology Network Meeting on 17th April 2015 that the EAU guidelines for Kidney would continue to be adopted by the Network group until the guideline has been reviewed by the relevant core members to highlight exceptions in practice in NI.</p> |

9.1 Bladder Cancer Surgical Guidelines (2014)

Bladder Cancer

Epidemiology:

Bladder cancer is the ninth most commonly diagnosed cancer worldwide, with more than 380,000 new cases each year and more than 150,000 deaths per year, and an estimated male-female ratio of 3.8:1. At any one time, 2.7 million people have a history of urinary bladder cancer. Recently, overall and stage-specific age-adjusted incidence rates of bladder cancer have been analysed in the U.S. (5 year survival and mortality rates between 1973 and 2009). Although the analysis of the Surveillance, Epidemiology and End Results (SEER) database implies some limitations it is worrying to note that in the last 30 years the mortality rate associated with bladder cancer has not changed substantially, highlighting gaps in diagnosis, monitoring and management of these patients (3). At the initial diagnosis of bladder cancer, 70% of cases are diagnosed as non-muscle-invasive bladder cancer (NMIBC) and approximately 30% as muscle-invasive bladder cancer (MIBC). Among patients treated with radical cystectomy because of MIBC, 57% had muscle invasion at presentation, while 43% were initially 8 MUSCLE-INVASIVE AND METASTATIC BLADDER CANCER - LIMITED UPDATE APRIL 2014 diagnosed with NMIBC that progressed despite organ-preserving treatment (4). Approximately one-third of patients diagnosed with MIBC have undetected metastases at the time of treatment for the primary tumour (5), while 25% of patients who undergo radical cystectomy present with lymph node involvement at the time of surgery.

Risk factors:

Tobacco smoking

- is the most well-established risk factor for bladder cancer, causing 50-65% of male cases and 20-30% of female cases
- the incidence of bladder cancer is directly related to the duration of smoking and the number of cigarettes smoked per day
- the risk of bladder cancer is also higher in those who start smoking at a young age or who are exposed to environmental tobacco smoke during childhood
- the reduction of bladder cancer was about 40% within 1-4 years of quitting smoking and 60% after 25 years of cessation.

Occupational exposure

- is the second most important risk factor for bladder cancer. Work-related cases have accounted for 20-25% of all bladder cancer cases in several series.
- substances involved in chemical exposure include benzene derivatives and aryl amines (2-naphthylamine, 4-ABP, 4,4'-methylenedianiline, and o-toluidine), and it is likely to occur in occupations in which dyes, rubbers, textiles, paints, leathers, and chemicals are used.
- risk of bladder cancer due to occupational exposure to carcinogenic aromatic amines is significantly greater after 10 years or more of exposure; the mean latency period usually exceeds 30 years.
- carcinogens can be inactivated by a metabolic acetylation pathway. The presence of an NAT2 slowacetylation genotype has been associated with a higher risk of bladder cancer (16), suggesting that patients who are slow acetylators may be more susceptible to bladder cancer than rapid acetylators. Other risk factors include phenacetin, which the International Agency for Research on Cancer (IARC) included in 1987 among proven human carcinogens. Some studies have suggested that the risk of bladder cancer due to phenacetin is dose-dependent; however, the data concerning its metabolite acetaminophen are controversial.

Radiotherapy Increased rates of secondary bladder malignancies have been reported after external-beam radiotherapy (EBRT) for gynaecological malignancies, with relative risks of 2-4

Dietary factors have been considered to be related to bladder cancer; however, the links remain controversial. Currently, there is limited evidence of a causal relationship between bladder cancer and dietary factors.

Bladder schistosomiasis (bilharzia) is the second most common parasitic infection after malaria, with about 600 million people exposed to infection in Africa, Asia, South America, and the Caribbean.

Chronic urinary tract infection: bladder cancer, particularly invasive squamous cell carcinoma, has been linked to the presence of chronic urinary tract infection (UTI) distinct from schistosomiasis. A direct association between bladder cancer and UTIs has been observed in several case-control studies, which have reported a two-fold increased risk of bladder cancer in patients with recurrent UTIs in some series.

Chemotherapy: The use of cyclophosphamide, an alkylating agent used to treat lymphoproliferative diseases and other nonneoplastic diseases, has been correlated with subsequent development of MIBC, with a latency period of 6-13 years. Acrolein is a metabolite of cyclophosphamide and is responsible for the increase in the incidence of bladder cancer. This effect occurs independently of the association of haemorrhagic cystitis with the same treatment and was counteracted with concomitant application of mercaptoethanesulfonate (MESNA).

Synchronous and metachronous upper urinary tract tumours: In some cases, there is an association between upper tract urothelial carcinoma (UTUC) and bladder cancer.

- The incidence of UTUC after a diagnosis of NMIBC has been reported to be between 1.7% and 26%. Although synchronous UTUC and NMIBC are uncommon, 46% of UTUCs are invasive. In a retrospective review of 1,529 patients with primary non-muscle-invasive bladder carcinoma who underwent initial examination of the upper urinary tract with excretory urography, those with a tumour in the bladder trigone were almost six times more likely to develop a synchronous tumour in the upper urinary tract. Examination of the upper urinary tract alone in patients with a tumour in the trigone or with multiple bladder tumours was capable of diagnosing 41% or 69% of UTUCs, respectively.
- In multiple and high-risk tumours, there is an increased risk of tumour recurrence in the upper urinary tract.
- Carcinoma in situ (CIS) in the bladder is an important risk factor for subsequent upper urinary tract recurrence. It has been shown in various studies that tumour involvement of the distal ureter at RC is an independent risk factor for metachronous upper urinary tract (mUUT) recurrence, with an approximate 2.6-fold increase in the relative risk.
- The overall incidence of bladder cancer developing after treatment for UTUC has been reported in the literature as 15-50%.

Gender:

- women were more likely to be diagnosed with primary muscle-invasive disease than men (85% vs. 51%).
- women are more likely to be older than men when diagnosed, with a direct effect on their survival. In addition, delayed diagnosis is more likely in women after haematuria is observed, as the differential diagnosis in women includes diseases that are more prevalent than bladder cancer.
- Differences in the gender prevalence of bladder cancer may be due to other factors besides tobacco and chemical exposure. In a large prospective cohort study,

postmenopausal status was associated with an increase in bladder cancer risk, even after adjustment for smoking status.

Ethnic and socioeconomic status: There are limited data on this topic, but a study based on 13,234 cases diagnosed in the SEER database in the period 1979-2003 showed that the survival time from diagnosis was significantly lower among cancer cases in patients with low socioeconomic status (SES) compared with those with higher SES. Hazard ratios for all causes and cancer-specific mortality among blacks in comparison with whites for eight of the most common types of cancer combined lost statistical significance after adjustment for SES factors and treatments. However, blacks still had unfavourable prognoses in comparison with whites even after adjustment for SES and treatment for tumours such as breast, colorectal, and urinary bladder cancer (44).

Genetic factors: There is growing evidence that genetic susceptibility factors and family associations may influence the incidence of bladder cancer. The relationship between family history of cancer and risk of bladder cancer was examined in the Spanish Bladder Cancer Study. It was found that family history of cancer in first-degree relatives was associated with an increased risk of bladder cancer; the association being stronger among younger patients. Shared environmental exposure was recognised as a potentially confounding factor.

TNM classification of urinary bladder cancer (2009)

| T - Primary Tumour | |
|---------------------------------|---|
| Tx | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| Ta | Non-invasive papillary carcinoma |
| Tis | Carcinoma in situ: "flat tumour" |
| T1 | Tumour invades subepithelial connective tissue |
| T2 | Tumour invades muscle |
| T2a | Tumour invades superficial muscle (inner half) |
| T2b | Tumour invades deep muscle (outer half) |
| T3 | Tumour invades perivesical tissue: |
| T3a | Microscopically |
| T3b | Macroscopically (extravesical mass) |
| T4 | Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall |
| T4a | Tumour invades prostate stroma, seminal vesicles, uterus, or vagina |
| T4b | Tumour invades pelvic wall or abdominal wall |
| N - Regional Lymph Nodes | |
| Nx | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph-node metastasis |
| N1 | Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac, or presacral) |
| N2 | Metastasis in multiple lymph nodes in the true pelvis (hypogastric, obturator, external iliac, or presacral) |
| N3 | Metastasis in common iliac lymph node(s) |

M - Distant Metastasis

M0 No distant metastasis

M1 Distant metastasis

World Health Organization grading for bladder cancer

1973 WHO grading

Urothelial papilloma

Grade 1: well differentiated

Grade 2: moderately differentiated

Grade 3: poorly differentiated

2004 WHO grading

Flat lesions Hyperplasia (flat lesion without atypia or papillary aspects)

Reactive atypia (flat lesion with atypia)

Atypia of unknown significance

Urothelial dysplasia

Urothelial CIS is always high-grade

Papillary lesions

Urothelial papilloma (completely benign lesion)

Papillary urothelial neoplasm of low malignant potential (PUNLMP)

Low-grade papillary urothelial carcinoma

High-grade papillary urothelial carcinoma

Non-muscle-invasive (Ta, T1 and CIS) Bladder Cancer

Diagnosis and Initial Treatment Steps

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
- Microscopic haematuria in adults over 50 years.
- Swellings in the body of the testis.
- Palpable renal masses.
- Solid renal masses found on imaging.
- Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
- A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.

- Any suspected penile cancer.

Papillary (Ta, T1) tumours

The diagnosis of papillary BC ultimately depends on cystoscopic examination of the bladder and histological evaluation of the resected tissue.

The standard initial therapy for Ta and T1 papillary bladder tumours is complete macroscopic transurethral resection (TURB), including a part of the underlying muscle. TURB should be performed systematically in individual steps, which Non-muscle invasive (Ta, T1, CIS) Bladder Cancer 11 are described in the full version of the guidelines. Small tumours (< 1 cm) can be resected en bloc, including a part of the underlying muscle. Larger tumours should be resected separately in fractions, which include the exophytic part of the tumour, the underlying bladder wall with the detrusor muscle and the edges of the resection area. The specimens from different fractions must be referred to the pathologist in separate containers.

A second TURB 2-6 weeks after initial resection is recommended in the following situations:

- After incomplete initial TURB, if there was no muscle in the specimen after initial resection (with exception of Ta low grade (G1) tumours);
- In all T1 tumours and in all high grade (G3) tumours (except primary CIS).

CIS

CIS is diagnosed by a combination of cystoscopy, urine cytology, and histological evaluation of multiple bladder biopsies.

Biopsies are taken from suspect areas. In patients with positive urine cytology and no papillary tumour, multiple biopsies from normal looking mucosa including prostatic urethra (random

biopsies) are recommended. If equipment is available, photodynamic diagnosis (PDD) is a useful tool to target the biopsy in these patients. Urine cytology is useful in the diagnosis and follow-up of CIS. CIS cannot be eradicated by TURB and further treatment is mandatory.

| Guidelines for primary assessment of NMIBC | GR |
|---|----|
| Patient history should be taken and recorded regarding all important information with a possible association with bladder cancer, including risk factors and suspicious symptoms. | A |
| Renal and bladder US may be used during the initial work-up in patients with haematuria. | C |
| At the time of the initial diagnosis of bladder cancer, CT urography (or IVU) should be performed only in selected cases (e.g., tumours located in the trigone). | B |
| Cystoscopy is recommended in all patients with symptoms suggestive of bladder cancer. It cannot be replaced by cytology or by any other non-invasive test. | A |
| Cystoscopy should describe all macroscopic features of the tumour (site, size, number and appearance) and mucosal abnormalities. A bladder diagram is recommended. | C |
| Voided urine cytology is advocated to predict high grade tumour before TURB. | C |
| Cytology should be performed on fresh urine with adequate fixation. Morning urine is not suitable because of the frequent presence of cytolysis. | C |

| | |
|---|-----------|
| TURBT | GR |
| <p>TURB should be performed systematically in individual steps:</p> <ul style="list-style-type: none"> • bimanual palpation under anaesthesia; • insertion of the resectoscope, under visual control with inspection of the whole urethra; • inspection of the whole urothelial lining of the bladder; • biopsy from prostatic urethra (if indicated); • cold-cup bladder biopsies (if indicated); • resection of the tumour; • bimanual palpation after resection; • protocol formulation; • formulation of order form for pathological evaluation. | C |
| Perform resection in one piece for small papillary tumours (< 1 cm), including part from the underlying bladder wall. | B |
| Perform resection in fractions (including muscle tissue) for tumours > 1 cm in diameter. | B |
| Biopsies should be taken from abnormal-looking urothelium. Biopsies from normal-looking mucosa (trigone, bladder dome, and right, left, anterior and posterior bladder walls) are recommended only when cytology is positive or when exophytic tumour has a non-papillary appearance. | C |
| Biopsy of the prostatic urethra is recommended for cases of bladder neck tumour, when bladder CIS is present or suspected, when there is positive cytology without evidence of tumour in the bladder, or when abnormalities of the prostatic urethra are visible. If biopsy is not performed during the initial procedure, it should be completed at the time of the second resection. | C |
| Biopsy of the prostatic urethra should be taken from abnormal areas and from the precollicular area (between 5 and 7 o'clock position) using a resection loop. In primary non-muscle-invasive tumours when stromal invasion is not suspected, the cold-cup biopsy with forceps can be used. | C |
| If equipment is available, fluorescence-guided (PDD) biopsy should be performed instead of random biopsies when bladder CIS or high-grade tumour is suspected (e.g., positive cytology, recurrent tumour with previous history of a high-grade lesion) | B |
| The specimens from different biopsies and resection fractions must be referred to the pathologist in separate containers and labelled separately. | C |
| TURB protocol must describe all steps of the procedure, as well as the extent and completeness of resection. | C |
| <p>A second TURB is recommended in the following situations:</p> <ul style="list-style-type: none"> • after incomplete initial TURB; • if there is no muscle in the specimen after initial resection, with exception of Ta G1 tumours and primary CIS; • in all T1 tumours; • in all G3 tumours, except primary CIS. | A |
| When done, a second TURB should be performed within 2-6 weeks after initial resection. | C |
| Classification and pathological report | GR |
| Depth of tumour invasion is classified according to the TNM system. | A |
| For histological classification, 1973 and 2004 WHO grading systems are used. Until the WHO 2004 is validated by more prospective trials and incorporated into prognostic models, both classifications should be used. | A |
| Whenever the terminology NMIBC is used in individual cases, the tumour stage and | A |

| | |
|--|---|
| grade should be mentioned. | |
| The pathological report should specify tumour location, tumour grade, depth of tumour invasion, presence of CIS, and whether the detrusor muscle is present in the specimen. | A |
| The pathological report should specify the presence of LVI or unusual histology | C |

CIS = carcinoma in situ; CT = computed tomography; IVU =

intravenous urography; LVI = lymphovascular invasion;

PDD = photodynamic diagnosis; US = ultrasound; TURB =

transurethral resection of the bladder

Prognostic Factors and Adjuvant Treatment

It is recommended to stratify patients according to prognostic factors into three risk groups that will facilitate treatment recommendations. Their definition, which takes into account the EORTC risk tables probabilities of recurrence and especially progression, can be found in Table 3. For individual prediction of the risk of tumour recurrence and progression at different intervals after TURB, application of EORTC risk tables and calculator (<http://www.eortc.be/tools/bladdercalculator/>) is strongly recommended

Table 3: Treatment recommendations in Ta, T1 tumours and CIS according to risk stratification

| Risk Category | Definition | Treatment recommendation |
|----------------------------------|--|---|
| Low-risk Tumours | Primary, solitary, Ta, LG/ G1, < 3 cm, no CIS | One immediate instillation of chemotherapy |
| Intermediate risk tumours | All cases between categories of low and high risk | One immediate instillation of Chemotherapy followed by further instillations, either chemotherapy for a maximum of 1 year or 1-year full dose BCG |
| High-risk Tumours | Any of the following:
• T1 tumours;
• HG/G3 tumours;
• CIS;
• Multiple and recurrent and large (> 3 cm) Ta G1G2 tumours (all these conditions must be presented) | Intravesical full dose BCG instillations for 1-3 years or cystectomy (in highest-risk tumours) |
| Subgroup of highest-risk tumours | T1G3 associated with concurrent bladder CIS, multiple and/or large T1G3 and/or recurrent T1G3, T1G3 with CIS in prostatic urethra, micropapillary variant of urothelial carcinoma, LVI | Radical cystectomy should be considered |

| | | |
|--|--------------|-----------------------------------|
| | BCG failures | Radical cystectomy is recommended |
|--|--------------|-----------------------------------|

CIS = carcinoma in situ; HG = high-grade; LG = low-grade;

LVI = lymphovascular invasion

Since there is considerable risk for recurrence and/or progression of tumours after TURB, adjuvant intravesical therapy is recommended for all stages (Ta, T1, and CIS). Immediate postoperative

instillation of chemotherapy within 6 hours after TURB is recommended in tumours presumed to be at low or intermediate risk, except in cases of bladder perforation or severe bleeding. The choice of drug (mitomycin C, epirubicin, or doxorubicine) is optional. Intravesical chemotherapy reduces the risk of recurrence but not progression and is associated with minor side-effects. Intravesical immunotherapy with Bacillus Calmette-Guérin (BCG) (induction and maintenance) is superior to intravesical chemotherapy in reducing recurrences and in preventing or delaying progression to muscle-invasive bladder cancer. However, intravesical BCG is more toxic. The individual choice

of further intravesical adjuvant therapy depends on the patient's risk (Table 3). In patients at highest risk of progression (Table 3), radical cystectomy should be considered in patients with BCG failure

since they are unlikely to respond to further BCG therapy; radical cystectomy is therefore the preferred option.

| | |
|---|----|
| Recommendations for adjuvant therapy in Ta, T1 tumours and for therapy of CIS | GR |
| Smokers with confirmed NMIBC should be counselled to stop smoking. | B |
| The type of intravesical therapy should be based on risk groups. | A |
| One immediate chemotherapy instillation is recommended in tumours presumed to be at low or intermediate risk. | A |
| In patients with low-risk tumours, one immediate instillation of chemotherapy is recommended as the complete adjuvant treatment. | A |
| In patients with intermediate-risk Ta tumours, one immediate instillation of chemotherapy should be followed by 1-year full-dose BCG treatment, or by further instillation of chemotherapy for a maximum of 1 year. | A |
| In patients with high-risk tumours, full-dose intravesical BCG for 1-3 years is indicated. | A |
| In patients with CIS in the epithelial lining of the prostatic urethra, TUR of the prostate followed by intravesical instillation of BCG can be offered. | C |
| In patients at highest risk of tumour progression (Table 3), immediate radical cystectomy should be considered. | C |
| In patients with BCG failure, radical cystectomy is indicated. | B |
| In patients with BCG failure ineligible for radical cystectomy, gemcitabine or MMC in combination with hyperthermia are options. | C |
| Intravesical chemotherapy | GR |
| One immediate instillation should be administered within 24 hours after TURB. | C |
| One immediate instillation of chemotherapy should be omitted in any case of overt or suspected intra- or extra-peritoneal perforation (after extensive TURB, or bleeding requiring bladder irrigation). | C |
| The optimal schedule of further intravesical chemotherapy instillation and its duration is not defined and should not exceed 1 year. | C |
| If intravesical chemotherapy is given, it is advised to use the drug at its optimal pH and to maintain the concentration of the drug during instillation by reducing fluid intake. | B |

| | |
|---|----|
| The length of individual instillation should be 1-2 hours. | C |
| BCG intravesical immunotherapy | GR |
| Absolute contraindications of BCG intravesical instillation are:
<ul style="list-style-type: none"> • during the first 2 weeks after TURB; • in patients with macroscopic haematuria; • after traumatic catheterization; • in patients with symptomatic urinary tract infection. | C |
| The management of side effects after BCG intravesical instillation should reflect their type and grade | C |

BCG = bacillus Calmette-Guérin; CIS = carcinoma in situ;

MMC = mitomycin C; TUR = transurethral resection; TURB = transurethral resection of the bladder

Follow-up for Non-Muscle Invasive Bladder Tumours

As a result of the risk of recurrence and progression, patients with Ta, T1 bladder tumours and with CIS need to be followed up. However, the frequency and duration of cystoscopy and imaging should reflect the individual patient's degree of risk.

When planning the follow-up schedule and methods, the following aspects should be considered:

- The prompt detection of muscle-invasive and HG/G3 nonmuscle-invasive recurrence is crucial because a delay in diagnosis and therapy can be life-threatening.
- Tumour recurrence in the low-risk group is nearly always low stage and LG/G1.

Small, non-invasive (Ta), LG/G1 papillary recurrence does not present an immediate danger to the patient, and early detection is not essential for successful therapy (LE: 2b).

Fulguration of small papillary recurrences on an outpatient basis could be a safe option that reduces the therapeutic burden.

- The first cystoscopy after TURB at 3 months is a very important prognostic indicator for recurrence and progression. The first cystoscopy should thus always be performed

3 months after TURB in all patients with Ta, T1 tumours and CIS.

- In tumours at low risk, the risk of recurrence after 5 recurrence-free years is low.
- Discontinuation of cystoscopy or its replacement with less invasive methods can be considered.
- In tumours originally intermediate- or high-risk, recurrences after 10 years tumour-free are not unusual. Therefore, lifelong follow-up is recommended.
- The risk of upper urinary tract recurrence increases in patients with multiple and high-risk tumours.
- Positive urine test results have a positive impact on the quality of performed follow-up cystoscopy). It supports the adjunctive role of urine tests during follow-up.

The following recommendations are only based on retrospective experience.

| Recommendations for follow-up | GR |
|---|----|
| The follow-up of Ta, T1 tumours and CIS is based on regular cystoscopy. | A |
| Patients with low-risk tumours should undergo cystoscopy at 3 months. If negative, subsequent cystoscopy is advised 9 months later, and then yearly for 5 years. | C |
| Patients with high-risk tumours should undergo cystoscopy and urinary cytology at 3 months. If negative, subsequent cystoscopy and cytology should be repeated every 3 months for a period of 2 years, and every 6 months thereafter until 5 years, and then yearly | C |
| Patients with intermediate-risk Ta tumours should have an in-between follow-up scheme using cystoscopy and cytology, which is adapted according to personal and subjective factors. | C |
| Regular (yearly) upper tract imaging (CT-IVU or IVU) is recommended for high-risk tumours. | C |
| Endoscopy under anaesthesia and bladder biopsies should be performed when office cystoscopy shows suspicious findings or if urinary cytology is positive | B |
| During follow-up in patients with positive cytology and no visible tumour in the bladder, R-biopsies or biopsies with PDD (if equipment is available) and investigation of extravesical locations (CT urography, prostatic urethra biopsy) are recommended. | B |

CIS = carcinoma in situ; CT-IVU = computed tomography intravenous

urography; IVU = intravenous urography; PDD = photodynamic

diagnosis; R-biopsies = random biopsies.

Bladder Cancer – Muscle invasive and metastatic

DIAGNOSIS AND STAGING

Primary diagnosis

Symptoms: Painless haematuria is the most common presenting complaint. Others include urgency, dysuria, increased frequency, and in more advanced tumours, pelvic pain and symptoms related to urinary tract obstruction.

Physical examination: including rectal and vaginal bimanual palpation. A palpable pelvic mass can be found in patients with locally advanced tumours. In addition, bimanual examination under anaesthesia should be carried out before and after TURB, to assess whether there is a palpable mass or if the tumour is fixed to the pelvic wall. However, considering the discrepancy between bimanual examination and pT stage after cystectomy (11% clinical overstaging and 31% clinical understaging), some caution is suggested with the interpretation of bimanual examination.

Endoscopic bladder imaging: Ultimately, the diagnosis of bladder cancer is made by cystoscopy and histological evaluation of resected tissue. In general, cystoscopy is initially performed in the office using flexible instruments. If a bladder tumour has been visualised unequivocally in earlier imaging studies, such as computed tomography (CT), magnetic resonance imaging (MRI), or ultrasound (US), diagnostic cystoscopy may be omitted and the patient can proceed directly to TURB for histological diagnosis. A careful description of the cystoscopic findings is necessary. This should include documentation of the site, size,

number, and appearance (papillary or solid) of the tumours, as well as a description of mucosal abnormalities. Use of a bladder diagram is recommended. The use of photodynamic diagnosis could be considered, especially if a T1 high-grade tumour is present, to find associated CIS. The additional presence of CIS may lead to a modified treatment plan. Photodynamic diagnosis is highly sensitive for the detection of CIS; with experience, the rate of false-positive results may be similar to that with regular white-light cystoscopy.

Urinary cytology and urinary markers: Examination of voided urine or bladder washings for exfoliated cancer cells has high sensitivity in high-grade tumours (LE: 3) and is a useful indicator in cases of high-grade malignancy or CIS. Positive urinary cytology may originate from a urothelial tumour located anywhere in the urinary tract. Evaluation of cytology specimens can be hampered by low cellular yield, UTIs, stones or intravesical instillations, but for experienced readers, specificity exceeds 90% (LE: 2b). However, negative cytology does not exclude tumour. Cytology should be performed on fresh urine with adequate fixation. Early morning urine is not suitable as cytolysis may often be present. There is no known urinary marker specific for the diagnosis of invasive bladder cancer.

Random bladder and prostatic urethral biopsy: Bladder tumours are often multifocal and can be accompanied by CIS or dysplasia. These lesions may present themselves as velvet-like, reddish areas, indistinguishable from inflammation, or may not be visible at all. The biopsies from normal-looking mucosa in patients with invasive bladder tumours, so-called random biopsies (R-biopsies) show a low yield. Fluorescence cystoscopy is performed using filtered blue light after intravesical instillation of a photosensitiser, such as 5-aminolevulinic acid (5-ALA), and more recently, hexaminolaevulinate (HAL), following approval by the European Medicines Agency. It has been confirmed that fluorescence-guided biopsy and resection are more sensitive than conventional procedures in detecting malignant tumours, particularly CIS (9-12) (LE: 2a). However, false-positive results may be induced by inflammation, or recent TURB or intravesical instillation therapy. A recent multicentre, prospective, international trial showed that, in experienced hands, the rate of false-positive results is no higher than that seen for regular, white-light cystoscopy (7). Material obtained by random or directed biopsies must be sent for pathological assessment in separate containers. The involvement of the prostatic urethra and ducts in men with bladder tumours has been reported. The exact risk is not known, but it seems to be higher if the tumour is located on the trigone or bladder neck, in the presence of bladder CIS, and in multiple tumours (LE: 3). Involvement of the prostatic urethra can be determined either at the time of primary TURB or by frozen section during the cystoprostatectomy procedure. A frozen section has a higher negative predictive value and is more accurate.

Second resection: In the case of high-grade non-muscle-infiltrative tumour, residual disease is observed in 33-53% of patients (18-24). In order to reduce the risk of understaging, a second TURB resection is often required to determine the future treatment strategy. In consultation with the patient, orthotopic neobladder should be considered in case reconstructive surgery does not expose the patient to excessive risk (as determined by comorbidity and age). Age greater than 80 years is often considered to be the threshold after which neobladder reconstruction is not recommended, however, there is no exact age for strict contraindication. In most large series coming from experienced centres, the rate of orthotopic bladder substitution after cystectomy for bladder tumour is up to 80% for men and 50% for women. Nevertheless, no randomized controlled studies comparing conduit diversion with neobladder or continent cutaneous diversion have been performed. Diagnosis of urethral tumour before cystectomy or positive urethral frozen section leads to uretrectomy and therefore excludes neobladder reconstruction. If indicated, in males urethral frozen section has to be performed on the cysto-prostatectomy specimen just under the verumontanum and on the inferior limits of the bladder neck for females. When there are positive lymph nodes, orthotopic neobladder can nevertheless be considered in case of N1

involvement (metastasis in a single node in the true pelvis) but not for N2 or N3 tumours. Oncological results after orthotopic neobladder substitution or conduit diversion are similar in terms of local or distant metastasis recurrence, but secondary urethral tumours seem less common in patients with neobladder compared with those with conduits or continent cutaneous diversions.

Imaging for staging MIBC: The treatment and prognosis for MIBC is determined by tumour stage and grade. In clinical practice, CT and MRI are the imaging techniques used. The purpose of using imaging for staging MIBC is to determine prognosis and provide information to assist treatment selection. Tumour staging must be accurate to ensure the correct choice of treatment is made. Imaging parameters required for staging MIBC are:

- extent of local tumour invasion;
- tumour spread to lymph nodes;
- tumour spread to the upper urinary tract and other distant organs (e.g., liver, lungs, bones, peritoneum, pleura, and adrenal glands).

CT imaging for local staging of MIBC: The advantages of CT include high spatial resolution, shorter acquisition time, wider coverage in a single breath hold, and lower susceptibility to variable patient factors. Computed tomography is unable to differentiate between stages Ta and T3a tumours, but it is useful for detecting invasion into the perivesical fat (T3b) and adjacent organs. The accuracy of CT in determining extravesical tumour extension varies from 55% to 92% and increases with more advanced disease.

MRI for local staging of invasive bladder cancer: Magnetic resonance imaging has superior soft tissue contrast resolution compared with CT, but poorer spatial resolution. In studies performed before the availability of multidetector CT, MRI was reported as more accurate in local assessment. The accuracy of MRI for primary tumour staging varies from 73% to 96% (mean 85%). These values were 10-33% (mean 19%) higher than those obtained with CT. Dynamic contrast-enhanced (DCE) MRI may help to differentiate bladder tumour from surrounding tissues or post-biopsy reaction, because enhancement of the tumour occurs earlier than that of the normal bladder wall, due to neovascularisation. In 2006, a link was established between the use of gadolinium-based contrast agents and nephrogenic systemic fibrosis (NSF), which may result in fatal or severely debilitating systemic fibrosis. Patients with impaired renal function are at risk of developing NSF and the non-ionic linear gadolinium-based contrast agents should be avoided (gadodiamide, gadopentetate dimeglumine and gadoversetamide). A stable macrocyclic contrast agent should be used (gadobutrol, gadoterate meglumine or gadoteridol). Alternatively, contrast-enhanced CT could be performed using iodinated contrast media (LE: 4).

TREATMENT

Recommendations for treatment failure of non-muscle-invasive bladder cancer

| Recommendations | GR |
|---|----|
| In all T1 tumours at high risk of progression (i.e., high grade, multifocality, CIS, and tumour size, as outlined in the EAU guidelines for non-muscle-invasive bladder cancer [7]), immediate radical treatment is an option | C |
| In all T1 patients failing intravesical therapy, radical treatment should be offered. | B |

CIS = carcinoma in situ

NEOADJUVANT CHEMOTHERAPY

Advantages and disadvantages:

- Chemotherapy is delivered at the earliest time-point, when the burden of micrometastatic disease is expected to be low.
- Potential reflection of in vivo chemosensitivity.
- Tolerability of chemotherapy and patient compliance are expected to be better before rather than after cystectomy.
- Patients might respond to neoadjuvant therapy and reveal a favourable pathological status, determined mainly by achieving pT0, a negative lymph node status, and negative surgical margins.
- Delayed cystectomy might compromise the outcome in patients not sensitive to chemotherapy (8,9), although published studies on the negative effect of delayed cystectomy only entail series of chemonaïve patients. There are no trials or large patient series indicating that delayed surgery, due to neoadjuvant chemotherapy, has a negative impact on survival.

| Conclusions | LE |
|---|----|
| Neoadjuvant cisplatin-containing combination chemotherapy improves overall survival (5-8% at 5 years). | 1a |
| Neoadjuvant treatment of responders and especially patients who show complete response (pT0 N0) has a major impact on OS. | 2 |
| Currently, no tools are available to select patients who have a higher probability to benefit from neoadjuvant chemotherapy. In the future, genetic markers, in a personalised medicine setting, might facilitate the selection of patients for neoadjuvant chemotherapy and to differentiate responders from non-responders. | |

| Recommendations | GR |
|--|----|
| Neoadjuvant chemotherapy is recommended for T2-T4a, cN0M0 bladder cancer and should always be cisplatin-based combination therapy. | A |
| Neoadjuvant chemotherapy is not recommended in patients who are ineligible for cisplatin-based combination chemotherapy. | A |

RADICAL SURGERY AND URINARY DIVERSION

Radical cystectomy is the standard treatment for localised MIBC in most western countries. Recent interest in patients' quality of life (QoL) has increased the trend toward bladder preservation treatment modalities, such as radio- and/or chemotherapy. Performance status (PS) and age influence the choice of primary therapy, as well as the type of urinary diversion, with cystectomy being reserved for younger patients without concomitant disease and with a better PS. The value of assessing overall health before recommending and proceeding with surgery was emphasised in a multivariate analysis. The analysis found an association between comorbidity and adverse pathological and survival outcome following radical cystectomy. PS and comorbidity have a different impact on treatment outcome and

must be evaluated independently. Controversy remains about age, radical cystectomy and the type of urinary diversion. Cystectomy is associated with the greatest risk reduction in disease-related and non-disease-related death in patients aged > 80 years. The largest, retrospective, single-institution study on cystectomy to date found that patients aged > 80 years had increased postoperative morbidity but not increased mortality. Although some patients successfully underwent a neobladder procedure, most patients were treated with an ileal conduit diversion. It is particularly important to evaluate the function and QoL of elderly patients using a standardised geriatric assessment, as well as carrying out a standard medical evaluation.

Each network should agree clear guidelines on treatment and follow up of bladder cancer which ensure that cystectomy is considered for patients with muscle-invasive or high-risk recurrent disease. Cystectomy is a complex operation which should be undertaken only by specialist surgeons working in cancer centres. Ideally, all radical cystectomies undertaken in each network should be carried out by a single team. Teams providing this form of surgery should carry out a cumulative total of at least 50 radical operations (cystectomies or radical prostatectomies) for bladder or prostate cancer per year.

Timing and delay of cystectomy: patients treated > 90 days after the primary diagnosis showed a significant increase in extravesical disease (81 vs 52%). Delay in cystectomy affects treatment outcome and the type of urinary diversion. In organ-confined urothelial cancer of the bladder, the average time from primary diagnosis to cystectomy was 12.2 months in patients who received a neobladder and 19.1 months in those who received an ileal conduit. This was even more noticeable with organ-confined invasive cancer; the average time to surgery was 3.1 months with a neobladder and 15.1 months with an ileal conduit (8). Similar results have been observed in a series of 247 patients: recurrence-free survival and OS were significantly better in patients treated before 90 days compared to others treated after 90 days.

LN removal at the time of cystectomy:

The extent of LND has not been established to date. Standard lymphadenectomy in bladder cancer patients involves removal of nodal tissue cranially up to the common iliac bifurcation, with the ureter being the medial border, and including the internal iliac, presacral, obturator fossa and external iliac nodes (10). Extended lymphadenectomy includes all lymph nodes in the region of the aortic bifurcation, and presacral and common iliac vessels medial to the crossing ureters. The lateral borders are the genitofemoral nerves, caudally the circumflex iliac vein, the lacunar ligament and the lymph node of Cloquet, as well as the area described for standard lymphadenectomy. A super-extended lymphadenectomy extends cranially to the level of the inferior mesenteric artery.

Morbidity and mortality from cystectomy:

The perioperative mortality was reported as 1.2-3% at 30 days and 2.3-5.7% at 90 days. In a large single-centre series, early complications (within 3 months of surgery) were seen in 58% of patients. Late morbidity is usually due to the type of urinary diversion. Early morbidity associated with radical cystectomy for NMIBC (at high risk for disease progression) is similar and no less than that associated with muscle-invasive tumours. In general, lower morbidity and (perioperative) mortality have been observed by surgeons and in hospitals with a higher caseload and therefore more experience.

Survival:

According to a multi-institutional database of 888 consecutive patients undergoing radical cystectomy for bladder cancer, the 5-year recurrence-free survival was 58% and the cancer-specific survival was 66%. Recent external validation of postoperative nomograms for bladder-cancer-specific mortality showed similar results, with 5-year OS of 45% and cancer-specific survival of 62%. Recurrence-free survival and OS in a large single-centre study of 1,054 patients was 68% and 66% at 5 years and 60% and 43%, at 10 years, respectively. The 5-year recurrence-free survival in node-positive patients who underwent cystectomy was considerably less at 34-43%. However, in patients with a low level of lymph node metastasis, the survival is better. In a surgery only study, the 5-year recurrence-free survival was 76% in patients with pT1 tumours, 74% for pT2, 52% for pT3, and 36% for pT4. Another study reported 10-year disease-specific survival and OS rates of 72.9% versus 49.1% for organ-confined disease (defined as pT < 3a), and 33.3% versus 22.8% for non-organconfined disease. A trend analysis according to the 5-year survival and mortality rates of bladder cancer in the United States, between 1973 and 2009 with a total of 148,315 bladder cancer patients, revealed an increased stage-specific 5-year survival rate for all stages, except for metastatic disease. However, no changes in mortality were recorded among localized and regional stage. In patients with visceral metastases an increase in mortality rates was observed, but differences were minor, and hardly of any clinical importance.

Recommendations:

| Recommendations | GR |
|---|----|
| Radical cystectomy is recommended in T2-T4a, N0 M0, and high-risk non-MIBC (as outlined above). | A |
| Do not delay cystectomy for > 3 months because it increases the risk of progression and cancerspecific mortality. | B |
| Preoperative radiotherapy is not recommended in subsequent cystectomy with urinary diversion. | A |
| Lymph node dissection should be an integral part of cystectomy. Extended LND is recommended. | B |
| The urethra can be preserved if margins are negative. If no bladder substitution is attached, the urethra must be checked regularly. | B |
| Laparoscopic cystectomy and robot-assisted laparoscopic cystectomy are both management options. However, current data have not sufficiently proven the advantages or disadvantages for oncological and functional outcomes. | C |
| Before cystectomy, the patient should be fully informed about the benefits and potential risks of all possible alternatives, and the final decision should be based on a balanced discussion between patient and surgeon. | B |
| Pre-operative bowel preparation is not mandatory. "Fast track" measurements may reduce the time of bowel recovery. | C |
| An orthotopic bladder substitute should be offered to male and female patients lacking any contraindications and who have no tumour in the urethra or at the level of urethral dissection. | B |

NON-RESECTABLE TUMOURS

| Recommendations | LE | GR |
|---|----|----|
| In patients with inoperable locally advanced tumours (T4b), primary radical cystectomy is a palliative option and cannot be offered as curative treatment. | | B |
| In patients with symptoms palliative cystectomy may be offered. Prior to any further interventions, surgery-related morbidity and quality of life should be fully discussed with the patient. | 3 | B |

BLADDER-SPARING TREATMENTS FOR LOCALIZED DISEASE**Transurethral resection of bladder tumour (TURBT)**

| Recommendation | LE | GR |
|---|-----------|-----------|
| Transurethral resection of bladder tumour (TURB) alone is not a curative treatment option in most patients. | 2a | B |

External beam radiotherapy (EBRT)

Based on available trials, a Cochrane analysis has demonstrated that radical cystectomy has an overall survival benefit compared to radiotherapy. However, external radiotherapy is an alternative treatment in patients unfit for radical surgery. The target dose for curative radiotherapy for bladder cancer is 60-66 Gy, with a subsequent boost using external radiotherapy or interstitial brachytherapy. The daily dose is usually 1.8-2 Gy and the course of radiotherapy should not extend beyond 6-7 weeks to minimize the repopulation of cancer cells. The use of modern standard radiotherapy techniques results in major, related, late morbidity of the urinary bladder or bowel in less than 5% of tumour-free patients. Overall, 5-year survival rates in patients with MIBC range between 30% and 60%, depending on whether they show a complete response (CR) following radiotherapy. Cancer-specific survival rates are between 20% and 50%.

Conclusions:

| Conclusions | LE |
|--|-----------|
| External beam radiotherapy alone should only be considered as a therapeutic option when the patient is unfit for cystectomy or a multimodality bladder-preserving approach. | 3 |
| Radiotherapy can also be used to stop bleeding from the tumour when local control cannot be achieved by transurethral manipulation because of extensive local tumour growth. | 3 |

Recommendation:

| Recommendation | GR |
|---|-----------|
| Surgical intervention or multimodality treatment are the preferred curative therapeutic approaches because they are more effective than radiotherapy alone. | B |

Chemotherapy

Chemotherapy alone rarely produces durable CRs. In general, a clinical CR rate of up to 56%, as reported in some series, must be weighed against a staging error of > 60%. Response to chemotherapy is a prognostic factor for treatment outcome and eventual survival, though it may be confounded by patient selection. For very selected patients, a

bladder-conserving strategy with TURB and systemic cisplatin-based chemotherapy, preferably with MVAC, may allow long-term survival with intact bladder. However, this approach cannot be recommended for routine use.

Conclusion:

| Conclusion | LE |
|---|----|
| With cisplatin-based chemotherapy as primary therapy for locally advanced tumours in highly selected patients, complete and partial local responses have been reported. | 2b |
| Recommendation | GR |
| Chemotherapy alone is not recommended as primary therapy for localized bladder cancer. | A |

Multimodality bladder-preserving treatment

Recent organ-preservation strategies combine TURB, chemotherapy and radiation (1,2). The rationale for performing TURB and radiation is to achieve local tumour control. Application of systemic chemotherapy, most commonly as methotrexate, cisplatin and vinblastine (MCV), aims at the eradication of micrometastasis. Many protocols use cisplatin and/or 5-FU and, recently, gemcitabine with radiation, because of their established role as radiosensitizers. Cisplatin-based chemotherapy in combination with radiotherapy, following TURB, results in a CR of 60-80%.

Conclusions:

| Conclusions | LE |
|---|----|
| In a highly selected patient population, long-term survival rates of multimodality treatment are comparable to those of early cystectomy. | 3 |
| Delay in surgical therapy can compromise survival rates. | 2b |

| Recommendations | GR |
|--|----|
| Transurethral resection of bladder tumour alone cannot be offered as a standard curative treatment option in most patients. | B |
| Radiotherapy alone is less effective than surgery and is only recommended as a therapeutic option when the patient is unfit for cystectomy or a multimodality bladder-preserving approach. | B |
| Chemotherapy alone is not recommended as primary therapy for MIBC. | A |
| Surgical intervention or multimodality treatments are the preferred curative therapeutic approaches as they are more effective than radiotherapy alone. | B |
| Multimodality treatment could be offered as an alternative in selected, well-informed, well-selected and compliant patients, especially for whom cystectomy is not an option. | B |

ADJUVANT CHEMOTHERAPY

Adjuvant chemotherapy after radical cystectomy for patients with pT3/4 and/or lymph node positive (N+) disease without clinically detectable metastases (M0) is under debate and still infrequently used.

The general benefits of adjuvant chemotherapy include:

- Chemotherapy is administered after accurate pathological staging, therefore treatment in patients at low risk for micrometastases is avoided.
- No delay in definitive surgical treatment.

The drawbacks of adjuvant chemotherapy are:

- Assessment of in vivo chemosensitivity of the tumour is not possible and overtreatment is an unavoidable problem.
- Delay or intolerability of chemotherapy, due to postoperative morbidity.

Conclusions:

| Conclusion | LE |
|--|----|
| Neither randomised trials nor two meta-analyses have provided sufficient data to support the routine use of adjuvant chemotherapy. | 1a |
| Recommendations | GR |
| Adjuvant chemotherapy should only be given within clinical trials, whenever possible. | A |
| Adjuvant cisplatin based combination chemotherapy may be offered to patients with pN+ disease if no neoadjuvant chemotherapy has been given. | C |

METASTATIC DISEASE

| Conclusions | LE |
|--|----|
| In a first-line setting, PS and the presence or absence of visceral metastases are independent prognostic factors for survival. | 1b |
| In a second-line setting, negative prognostic factors are: liver metastasis, PS > 1 and low haemoglobin (< 10 g/dL) 1b Cisplatin-containing combination chemotherapy can achieve median survival of up to 14 months, with long-term disease-free survival reported in ~15% of patients with nodal disease and good PS. | 1b |
| Single-agent chemotherapy provides low response rates of usually short duration. | 2a |
| Carboplatin combination chemotherapy is less effective than cisplatin-based chemotherapy in terms of complete response and survival. | 2a |
| Non-platinum combination chemotherapy produces substantial responses in first- and second-line settings, but has not been tested against standard chemotherapy in patients who are fit or unfit for cisplatin combination chemotherapy. | 2a |
| There is no defined standard chemotherapy for unfit patients with advanced or metastatic urothelial cancer. | 2b |
| Vinflunine reaches the highest level of evidence ever reported for second-line use. | 1b |
| Post-chemotherapy surgery after partial or complete response may contribute to long-term disease-free survival. | 3 |
| Zoledronic acid and denosumab have been approved for all cancer types including urothelial cancer, because they reduce and delay skeletal related events in metastatic bone disease. | 1b |

| Recommendations | GR |
|--|----|
| First-line treatment for fit patients: Use cisplatin-containing combination chemotherapy with GC, PCG, MVAC, preferably with G-CSF, or HD-MVAC with G-CSF. | A |

| | |
|---|---|
| Carboplatin and non-platinum combination chemotherapy is not recommended. | B |
| First-line treatment in patients ineligible (unfit) for cisplatin: Use carboplatin combination chemotherapy or single agents. | C |
| For cisplatin-ineligible (unfit) patients, with PS2 or impaired renal function, as well as those with 0 or 1 poor Bajorin prognostic factors and impaired renal function, treatment with carboplatin-containing combination chemotherapy, preferably with gemcitabine/carboplatin is indicated. | A |
| Second-line treatment: In patients progressing after platinum-based combination chemotherapy for metastatic disease, vinflunine should be offered. Alternatively, treatment within a clinical trial setting may be offered. | A |
| Zoledronic acid or denosumab is recommended for treatment of bone metastases. | B |

9.2 Prostate cancer

Epidemiology

Prostate cancer is the most common cancer in elderly males in Europe. It is a major health concern, especially in developed countries with their greater proportion of elderly men in the general population. The incidence is highest in Northern and Western Europe (> 200 per 100,000), while rates in Eastern and Southern Europe have showed a continuous increase. There is still a survival difference between men diagnosed in Eastern Europe and those in the rest of Europe. Overall, during the last decade, the 5-year relative survival percentages for prostate cancer steadily increased from 73.4% in 1999-2001 to 83.4% in 2005-2007.

There are three well-established risk factors for PCa:

- increasing age;
- ethnic origin;
- heredity

Genetics:

- If one first-line relative has PCa, the risk is at least doubled. If two or more first-line relatives are affected, the risk increases by 5-11-fold.
- A small subpopulation of individuals with PCa (about 9%) have true hereditary PCa. This is defined as three or more affected relatives, or at least two relatives who have developed early onset disease, i.e. before age 55.
- Patients with hereditary PCa usually have an onset six to seven years earlier than spontaneous cases, but do not differ in other ways.

Geography:

- The frequency of autopsy-detected cancers is roughly the same in different parts of the world.
- This finding is in sharp contrast to the incidence of clinical PCa, which differs widely between different geographical areas, being high in the USA and northern Europe and low in South-East Asia.
- However, if Japanese men move from Japan to Hawaii, their risk of PCa increases. If they move to California their risk increases even more, approaching that of American men.

Metabolic syndrome and prostate cancer:

- Metabolic syndrome is weakly and non-significantly associated with the risk of PCa, but associations vary with geography.
- Among single components of the syndrome (body mass index, dysglycaemia or dyslipidaemia, high triglycerides, low HDL cholesterol) only hypertension and waist

circumference >102 cm were associated with a significantly greater risk of PCa, increasing it by 15% ($p = 0.035$) and 56% ($p = 0.007$), respectively.

Chemoprevention in prostate cancer:

- Currently, there are no data to suggest that medical intervention would effectively reduce progression of PCa.
- Several 5-alpha-reductase inhibitors (5-ARIs) have been studied to assess their effect on reducing risk of developing PCa. Although it seems that 5-ARIs have a potential benefit in preventing or delaying the development of PCa (~25%, only of Gleason 6 cancer), this must be weighed against treatment-related sideeffects as well as the potential increased risk of high-grade PCa. None of the available 5-ARIs have been approved for this indication.

SCREENING FOR PROSTATE CANCER:

Prostate cancer screening is one of the most controversial topics in urological literature. The main summary of findings from literature published on PCa screening is the Cochrane review published in 2013. Its findings are as follows:

- Screening was associated with an increased diagnosis of PCa (RR: 1.3; 95% CI: 1.02-1.65).
- Screening was associated with more localized disease (RR: 1.79; 95% CI: 1.19-2.70) and less advanced PCa (T3-4, N1, M1) (RR: 0.80; 95% CI: 0.73-0.87).
- From the results of five RCTs, representing more than 341,000 randomized men, no PCa-specific survival benefit was observed (RR: 1.00; 95% CI: 0.86-1.17). This was the main objective of all the large trials.
- From the results of four available RCTs, no overall survival benefit was observed (RR: 1.00; 95% CI: 0.96-1.03).

ERSPC: at 11 years of median follow-up, there was a 21% reduction in PCa-specific mortality and a 29% reduction after adjustment for non-compliance. However, there is still no overall survival benefit.

Thus, an individualized risk-adapted strategy for early detection might be offered to a well-informed man with a least 10-15 years of individual life expectancy. Men who have less than a 15-year life expectancy are unlikely to benefit based on the PIVOT and the ERSPC trials. Screening is associated with minor and major harms such as overdiagnosis and overtreatment.

Recommendations:

| | LE | GR |
|--|----|----|
| An individualized risk-adapted strategy for early detection might be offered to a well-informed man with a good performance status and at least 10-15 years of life expectancy. | 3 | B |
| Early PSA testing in men at elevated risk of having PCa: • men over 50 years of age • men over 45 years of age and a family history of PCa • African-Americans • men with a PSA level of > 1 ng/mL at 40 years of age • men with a PSA level of > 2 ng/mL at 60 years of age | 2b | A |
| A risk-adapted strategy might be considered (based on initial PSA level), which may be every 2 years for those initially at risk, or postponed up to 8 years in those not at risk. 3 C The age at which early diagnosis of PCa should be | 3 | A |

| | | |
|--|--|--|
| stopped is influenced by life expectancy and performance status; men who have < 15-year life expectancy are unlikely to benefit based on the PIVOT and the ERSPC trials. | | |
|--|--|--|

DIAGNOSIS:

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
- Microscopic haematuria in adults over 50 years.
- Swellings in the body of the testis.
- Palpable renal masses.
- Solid renal masses found on imaging.
- Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
- A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.
- Any suspected penile cancer.

Digital rectal examination:

- Most prostate cancers are located in the peripheral zone of the prostate and may be detected by DRE when the volume is about 0.2 mL or larger.
- In about 18% of all patients, PCa is detected by a suspect DRE alone, irrespective of the PSA level.
- A suspect DRE in patients with a PSA level up to 2 ng/mL has a positive predictive value of 5-30%.
- An abnormal DRE is associated with an increased risk of a higher Gleason score and should therefore be considered an indication for prostate biopsy.

Prostate-specific antigen (PSA):

PSA is a kallikrein-like serine protease produced almost exclusively by the epithelial cells of the prostate, which is organ- but not cancer specific. Thus, serum levels may be elevated in the presence of benign prostatic hypertrophy (BPH), prostatitis and other non-malignant conditions. The level of PSA as an independent variable is a better predictor of cancer than suspicious findings on DRE or transrectal ultrasound (TRUS).

PSA and the risk of prostate cancer:

| PSA level (ng/mL) | Risk of PCa (%) | Risk of Gleason > 7 PCa (%) |
|-------------------|-----------------|-----------------------------|
| 0.0-0.5 | 6.6 | 0.8 |
| 0.6-1.0 | 10.1 | 1.0 |
| 1.1-2.0 | 17.0 | 2.0 |
| 2.1-3.0 | 23.9 | 4.6 |
| 3.1-4.0 | 26.9 | 6.7 |

Practical modifications of serum PSA value that may improve the specificity of PSA in the early detection of PCa have been described. They include:

- PSA density;
- PSA velocity; defined as the absolute annual increase in serum PSA (ng/mL/year).
- PSA doubling time: the exponential increase in serum PSA over time, reflecting a relative change.
- age-specific reference ranges;
- The free/total PSA ratio: between 4 ng/mL and 10 ng/mL and a negative DRE, PCa was found on biopsy in 56% of men with f/t PSA < 0.10, but in only 8% of men with f/t PSA > 0.25.

PCA3: is an increasingly studied new biomarker that is detectable in urine sediments obtained after three strokes of prostatic massage during DRE. The costly ProgenSA urine test for PCA3 is now commercially available. The amount of the prostate-specific non-coding mRNA marker PCA3 normalized against PSA mRNA (urine sediment) gives a PCA3 score. This is superior to total PSA and percent-free PSA in the detection of PCa in men with elevated PSA levels as it shows slight but significant increases in the area under the receiveroperator characteristics curve (AUC) for positive biopsies. The main current indication for the PCA3 urine test may be to determine whether a man needs a repeat biopsy after an initially negative biopsy outcome, but its cost-effectiveness remains to be shown.

Prostate biopsy:

- Indications: PSA level and/or a suspicious DRE.
- The first elevated PSA level should not prompt an immediate biopsy.
- The PSA level should be verified after a few weeks by the same assay under standardized conditions (i.e. no ejaculation, no manipulations such as catheterisation, cystoscopy or transurethral resection, and no urinary tract infections) in the same diagnostic laboratory, using the same methods.
- It is now considered the standard of care to perform prostate biopsies guided by ultrasound.

Types of prostatic biopsy:

- Transrectal approach is used for most prostate biopsies, with ultrasound-guided periprostatic block as state-of-the-art. The British Prostate Testing for Cancer and Treatment (PROTECT) Study recommended 10 core biopsies, with > 12 cores being not significantly more conclusive.
- Transperineal approach is another alternative used by some urologists, with less incidence of biopsy related sepsis, but requires sedation or general anaesthetic (GA). There are two types:
 - Template biopsy requiring 24-30 cores using the brachytherapy grid and is performed under GA, with higher tumour detection rate (38%), but with a higher incidence of acute urinary retention (AUR) (up to 10%).
 - Targeted biopsy, which requires less cores and is more tolerated and less incidence of AUR.
- Diagnostic transurethral resection of the prostate: is a poor tool for cancer detection.

- Transition zone sampling during baseline biopsies gives a very low detection rate and should therefore be confined to repeat biopsies
- Indications for a repeat biopsy are:
 - rising and/or persistently elevated PSA;
 - suspicious DRE, 5-30% risk of cancer;
 - atypical small acinar proliferation (ASAP), 40% risk of cancer;
 - extensive (multiple biopsy sites) prostatic intra-epithelial neoplasia (PIN), 20-30% risk of cancer.
 - **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.**
 - **Do not offer another biopsy if the multiparametric MRI (using T2- and diffusion-weighted imaging) is negative, unless any of the risk factors above is present.**
- An isolated high-grade PIN as finding is no longer considered an indication for repeat biopsy.
- Antibiotics prior to biopsy: Oral or intravenous antibiotics are state-of-the-art treatment. Optimal dosing and treatment time vary. Quinolones are the drugs of choice, with ciprofloxacin being superior to ofloxacin, but increased resistance to quinolones associated with a rise in severe infectious complications after biopsy has been reported in the past few years.
- Percentage of complications per biopsy session, irrespective of the number of cores:

| Complications | Percentage of biopsies affected |
|--|---------------------------------|
| Haematospermia | 37.4 |
| Haematuria > 1 day | 14.5 |
| Rectal bleeding < 2 days | 2.2 |
| Prostatitis | 1.0 |
| Fever > 38.5°C (101.3°F) | 0.8 |
| Epididymitis | 0.7 |
| Rectal bleeding > 2 days ± requiring surgical intervention | 0.7 |
| Urinary retention | 0.2 |
| Other complications requiring hospitalisation | 0.3 |

The role of imaging

- **TRUS:** Grey-scale TRUS is not adequately reliable at detecting areas of PCa. It is therefore used as a guide to direct systematic biopsies of the prostate gland.
- **Multiparametric MRI:**
 - has excellent sensitivity for detecting aggressive Gleason > 7 cancers
 - mMRI is particularly good at accurately detecting anterior tumours that are usually missed by systematic biopsy and therefore trigger a (targeted) repeat biopsy.
 - cost-effectiveness of mMRI as a triage test before the first biopsy has not been assessed.
 - Inter-reader variability is also a current concern, especially outside reference centres.

Recommendations for the diagnosis of prostate cancer:

| | LE | GR |
|---|----|----|
| Prostate cancer should be graded according to the ISUP 2005 modified Gleason grading system. 2a A The decision to biopsy should be based on PSA testing and DRE. | 2b | A |
| For initial diagnosis, a core biopsy of 10-12 systematic transrectal or transperineal peripheral zone biopsies should be performed under ultrasound imaging guidance. | 2a | B |
| Transrectal prostate needle biopsies should be taken under antibiotic protection. | 1b | A |
| Local anaesthetic by periprostatic infiltration is recommended for prostate needle biopsies. | 1a | A |
| Prostate core biopsies from different prostatic sites should be submitted separately for processing and pathology reporting. | 3 | A |
| Processing and reporting of prostatectomy specimens by pathology should follow the guidelines provided by the 2010 ISUP consensus meeting. | 3 | A |

STAGING FOR PROSTATE CANCER

| | |
|---------------------------------|---|
| T - Primary tumour | |
| TX | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| T1 | Clinically inapparent tumour not palpable or visible by imaging |
| T1a | Tumour incidental histological finding in 5% or less of tissue resected |
| T1b | Tumour incidental histological finding in more than 5% of tissue resected |
| T1c | Tumour identified by needle biopsy (e.g. because of elevated PSA level) |
| T2 | Tumour confined within the prostate |
| T2a | Tumour involves one half of one lobe or less |
| T2b | Tumour involves more than half of one lobe, but not both lobes |
| T2c | Tumour involves both lobes |
| T3 | Tumour extends through the prostatic capsule |
| T3a | Extracapsular extension (unilateral or bilateral) including microscopic bladder neck involvement |
| T3b | Tumour invades seminal vesicle(s) |
| T4 | Tumour is fixed or invades adjacent structures other than seminal vesicles: external sphincter, rectum, levator muscles, and/or pelvic wall |
| N - Regional lymph nodes | |
| NX | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph node metastasis |
| N1 | Regional lymph node metastasis |
| M - Distant metastasis | |
| MX | Distant metastasis cannot be assessed |
| M0 | No distant metastasis |
| M1 | Distant metastasis |
| M1a | Non-regional lymph node(s) |
| M1b | Bone(s) |
| M1c | Other site(s) |

- Provisional treatment intent should be determined (radical or non-radical) before decisions on imaging are made.

- Imaging should not be routinely offered to men who are not candidates for curative intent.
- Isotope bone scans should be offered when hormonal therapy is being deferred through watchful waiting to asymptomatic men who are at high risk of developing bone complications.
- Multiparametric MRI (or CT if MRI is contraindicated) should be offered for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management.
- Urological cancer MDTs should assign a risk category (below) to all newly diagnosed men with localised prostate cancer.

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.

- CT of the pelvis should not be offered to men with low- or intermediate-risk localised prostate cancer (see table 1).
- Isotope bone scans should not be routinely offered to men with low-risk localised prostate cancer.
- Positron emission tomography imaging should not be offered for prostate cancer in routine clinical practice.

TREATMENT:**LOCALIZED PROSTATE CANCER (stage T1-T2c, Nx-N0, M0):****DEFERRED TREATMENT (ACTIVE SURVEILLANCE/ WATCHFUL WAITING):****Definitions:**

Active surveillance is active monitoring, aiming at the proper timing of curative treatment; an active decision not to treat the patient immediately.

- The patient remains under close surveillance, and treatment is prompted by predefined thresholds indicative of the presence of a potentially life-threatening disease, while taking the patient's life-expectancy into consideration.
- The treatment options are intended to be *curative*.
- Aim is to reduce overtreatment in patients with clinically confined very low-risk PCa, without giving up the option of curative treatment.

Patients selected for active surveillance:

The various series have applied several eligibility criteria for enrolment in active surveillance programmes (D'Amico, Epstein, PRIAS, etc.):

- clinically confined PCa (T1-T2);
- Gleason score < 7 for most studies;
- PSA < 10-15 ng/mL;
- prostate cancer volume criteria on biopsies, e.g. number of positive biopsies, maximum cancer involvement of biopsy.

Protocol for active surveillance

There are several studies with variable protocols for the active surveillance patients. However, NICE recommends the following:

| Timing | Tests ¹ |
|-------------------------------------|---|
| At enrolment in active surveillance | Multiparametric MRI if not previously performed |
| Year 1 of active surveillance | Every 3–4 months: measure PSA ²
Throughout active surveillance: monitor PSA kinetics ³
Every 6–12 months: DRE ⁴
At 12 months: prostate rebiopsy |

| | |
|---|--|
| Years 2–4 of active surveillance | Every 3–6 months: measure PSA ²
Throughout active surveillance: monitor PSA kinetics ³
Every 6–12 months: DRE ⁴ |
| Year 5 and every year thereafter until active surveillance ends | Every 6 months: measure PSA ²
Throughout active surveillance: monitor PSA kinetics ³
Every 12 months: DRE ⁴ |
| <p>¹ If there is concern about clinical or PSA changes at any time during active surveillance, reassess with multiparametric MRI and/or rebiopsy.</p> <p>² May be carried out in primary care if there are agreed shared-care protocols and recall systems.</p> <p>³ May include PSA doubling time and velocity.</p> <p>⁴ Should be performed by a healthcare professional with expertise and confidence in performing DRE.</p> | |

Triggers for active treatment:

- A PSA doubling time (PSADT) with a cut-off value ranging between < 2 and < 4 years.
- Gleason score progression to > 7 during systematic follow-up biopsies, at intervals ranging from one to four years.
- Patients' requests for treatment are based mainly on anxiety.
- Radiological progression, supported with an updated biopsy.

Recommendations:

| Recommendations - active surveillance | LE | GR |
|--|----|----|
| Active surveillance is an option in patients with the lowest risk of cancer progression: over 10 years of life-expectancy, cT1-2, PSA < 10 ng/mL, biopsy Gleason score < 6 (at least 10 scores), < 2 positive biopsies, minimal biopsy core involvement (< 50% cancer per biopsy). | 2a | A |
| Follow-up should be based on DRE, PSA and repeated biopsies. The optimal timing for follow-up is still unclear. | 2a | A |
| Patients with biopsy progressions should be recommended to undergo active treatment. | 2a | A |

Watchful waiting is the delayed application of palliative treatment options. The rationale behind watchful waiting is the observation that PCa often progresses slowly, and is predominantly diagnosed in older men in whom there is a high incidence of co-morbidity and related high competitive mortality. Watchful waiting can be considered as an option for

treating patients with localized PCa and a limited life-expectancy, or for older patients with less aggressive cancers.

Recommendations:

| Recommendations - watchful waiting | LE | GR |
|---|----|----|
| Watchful waiting may be offered to all patients not willing to accept the side-effects of active treatment, particularly patients with a short life-expectancy. | 1b | A |
| When on watchful waiting, the decision to start any non-curative treatment should be based on symptoms and disease progression. | 1a | B |

RADICAL PROSTATECTOMY

- Radical prostatectomy can be offered to men with intermediate-risk localised prostate cancer.
- Radical prostatectomy can be offered to men with high-risk localised prostate cancer when there is a realistic prospect of long-term disease control.
- Patients for radical prostatectomy should be referred to urological cancer team that has a specialist interest in urological cancer and all team members must attend a majority of meetings. The team should carry out a cumulative total of at least 50 radical operations for prostate or bladder cancer per year.
- Commissioners of urology services should consider providing robotic surgery to treat localised prostate cancer.
- 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.

Low risk prostate cancer (cT1-T2a, Gleason score < 6 and PSA < 10 ng/mL):

- Patients should be informed about the results of two randomized trials comparing retropubic RP versus watchful waiting (WW) in localized PCa.
- In the SPCG-4 study, the survival benefit associated with RP was similar before and after 9 years of follow-up and was also observed in men with low-risk PCa, and was confined to men < 65 years of age.
- In the PIVOT trial, a preplanned subgroup analysis of men with low-risk tumours showed that RP did not significantly reduce all-cause mortality.
- The decision to offer RP in cases of incidental cancer should be based upon the estimated probability of clinical progression compared to the relative risk of therapy and potential benefit to survival.
- In stage T2a patients with a 10-year life expectancy, RP is one of the recommended standard treatments, as 35-55% of these patients will show disease progression after 5 years if not treated.
- Extended pelvic lymph node dissection (eLND) is not necessary in low-risk PCa because the risk for positive lymph nodes does not exceed 5%.

Intermediate-risk, localized prostate cancer (cT2b-T2c or Gleason score = 7 and/or PSA 10-20 ng/mL):

- Radical prostatectomy is one of the recommended standard treatments for patients with intermediate-risk PCa and a life expectancy of > 10 years.
- The prognosis is excellent when the tumour is confined to the prostate, based on pathological examination

- Although active monitoring could be proposed for some selected patients with intermediate-risk localized tumours, however, when the tumour is palpable or visible on imaging and clinically confined to the prostate, disease progression can be expected in most long term survivors.
- An eLND should be performed in intermediate-risk PCa if the estimated risk for positive lymph nodes exceeds 5%.
- Limited LND should no longer be performed because this misses at least half of the nodes involved.

High-risk localized and locally advanced prostate cancer (Gleason score 8-10 and/or PSA > 20 ng/mL):

- RP is a reasonable treatment option in selected patients.
- RP is offered after all treatments have been discussed at the multidisciplinary team, with the pros and cons of each therapy has been considered by the patients with regard to their own individual circumstances.
- If RP is performed, pelvic eLND must be performed, because the estimated risk for positive lymph nodes is 15-40%.
- The patient must be informed about the likelihood of a multimodal approach.
- Neoadjuvant androgen deprivation therapy before RP does not provide a significant DSF or OS advantage over prostatectomy alone

Complications and functional outcome in RP and RALP:

| Complication, mean % | Retropubic RP | RALP |
|------------------------------------|---------------|--------|
| Continence* | 80-97 | 89-100 |
| Potency* | 51-81 | 26-63 |
| Peri-operative death | 0.1 | 0.04 |
| Readmission | 3.0 | 3.5 |
| Reoperation | 2.3 | 0.9 |
| Vessel injury | 0.04 | 0.08 |
| Nerve injury | 0.4 | 0.4 |
| Ureteral injury | 1.5 | 0.1 |
| Bladder injury | 0.05 | 0.07 |
| Rectal injury | 0.5 | 0.3 |
| Bowel injury | 0 | 0.09 |
| Ileus | 0.8 | 0.8 |
| Deep vein thrombosis | 1.0 | 0.3 |
| Pulmonary embolism | 0.5 | 0.3 |
| Pneumonia | 0.5 | 0.05 |
| Myocardial infarction | 0.2 | 0.2 |
| Haematoma | 1.6 | 0.7 |
| Lymphocele | 3.2 | 0.8 |
| Anastomotic leakage | 10.0 | 3.5 |
| Fistula | 0.07 | 0.03 |
| Bladder neck/anastomotic stricture | 2.2 | 0.9 |
| Sepsis | 0.2 | 0.1 |
| Wound infection | 2.8 | 0.7 |

RALP = robot-assisted laparoscopic prostatectomy; RP = radical prostatectomy

* The major limitations of the included studies were the frequent retrospective study design and the use of different assessment tools preventing a proper comparison between techniques and series.

RADIOTHERAPY

Radical Radiotherapy:

- There have been no randomized studies comparing radical prostatectomy (RP) with either external-beam radiotherapy (EBRT) or brachytherapy for localized prostate cancer (PCa).
- The National Institutes of Health (NIH) consensus statement in 1988 stated that external irradiation offers the same long-term survival results as surgery.
- EBRT provides a QoL at least as good as that following surgery. A recent systematic review has provided a more sophisticated overview of outcomes from trials that meet the criteria for stratifying patients by risk group, standard outcome measures, numbers of patients, and minimum median follow-up period.
- Radiotherapy continues to be an important and valid alternative to surgery alone for curative therapy.
- Intensity-modulated radiotherapy (IMRT), with or without image-guided radiotherapy (IGRT), is the gold standard for EBRT.
- All centres that do not yet offer IMRT should plan to introduce it as a routine method for the definitive treatment of PCa.
- Radiotherapy can be offered to men with intermediate-risk localised prostate cancer.
- Radiotherapy can be offered to men with high-risk localised prostate cancer when there is a realistic prospect of long-term disease control.
- Radiotherapy should be offered for localised prostate cancer a minimum dose of 74 Gy to the prostate at no more than 2 Gy per fraction.
- Men with intermediate- and high-risk localised prostate cancer should be offered a combination of radical radiotherapy and androgen deprivation therapy, rather than radical radiotherapy or androgen deprivation therapy alone.
- Men with intermediate- and high-risk localised prostate cancer should be offered 6 months of androgen deprivation therapy before, during or after radical external beam radiotherapy.
- Androgen deprivation therapy can be continued for up to 3 years for men with high-risk localised prostate cancer and the benefits and risks of this option should be discussed with them.
- Incidence of late toxicity and outcome by Radiation Therapy Oncology Group (RTOG) grade (from EORTC trial 22863):

| Toxicity | Grade 2
% | Grade 3
% | Grade 4
% | Any significant toxicity (> grade 2)% |
|-------------------|--------------|--------------|--------------|---------------------------------------|
| Cystitis | 4.7 | 0.5 | 0 | 5.3 |
| Haematuria | 4.7 | 0 | 0 | 4.7 |
| Urinary stricture | 4.7 | 1.3 | 1 | 7.1 |

| | | | | |
|-------------------------|------|-----|----|------|
| Urinary incontinence | 4.7 | 0.5 | 0 | 5.3 |
| Overall GU toxicity | 12.4 | 2.3 | 1† | 15.9 |
| Proctitis | 8.2 | 0 | 0 | 8.2 |
| Chronic diarrhoea | 3.7 | 0 | 0 | 3.7 |
| Small bowel obstruction | 0.2 | 0.2 | 0 | 0.5 |
| Overall GI toxicity | 9.5 | 0.2 | 0 | 9.8 |
| Leg oedema | 1.5 | 0 | 0 | 1.5 |
| Overall toxicity* | 19.0 | 2.7 | 1 | 22.8 |
| Potency after 1 year | -- | -- | -- | 55 |
| Secondary malignancy | -- | -- | -- | 0.16 |

- Men with signs or symptoms of radiation-induced enteropathy should be offered care from a team of professionals with expertise in radiation-induced enteropathy.
- The nature and treatment of radiation-induced enteropathy should be included in the training programmes for oncologists and gastroenterologists.
- Full investigations should be carried out, 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.
- Caution should be used when performing anterior wall rectal biopsy after brachytherapy because of the risk of fistulation.

Immediate (adjuvant) post-operative external irradiation after RP:

There's currently conflicting evidence with biochemical free and overall survival advantages of adjuvant versus salvage radiotherapy in the following post RP patients:

- Patients classified as pT3 pN0.
- Positive margins (highest impact)
- Capsule rupture, and/or invasion of the seminal vesicles
- with a PSA level of < 0.1 ng/mL.

RADICALS trial outcome is awaited. However, currently two options can be offered in the framework of informed consent. These are:

- Immediate adjuvant radiotherapy to the surgical bed (79,81-83,86) after recovery of urinary function; or
- Clinical and biological monitoring followed by salvage radiotherapy (SRT) before the PSA exceeds 0.5 ng/mL.
- Immediate post-operative radiotherapy after radical prostatectomy, even to men with margin-positive disease, other than in the context of a clinical trial.

Post radiotherapy biochemical failure:

- After primary RT, with or without short-term hormonal manipulation, the RTOG-ASTRO Phoenix Consensus Conference definition of PSA failure (with an accuracy of > 80%) is

any PSA increase > 2 ng/mL higher than the PSA nadir value, regardless of the serum concentration of the nadir.

- In patients with BCF who are candidates for local salvage therapy, prostate multiparametric MRI can guide biopsy.
- Selected patients with localized PCa at primary treatment and histologically proven recurrence without evidence of metastatic disease should be treated with salvage RP (SRP).
- Due to the increased rate of treatment-related complications and side effects, SRP and salvage brachytherapy should only be performed in experienced centres.
- Permanent seed implantation, high-intensity focused ultrasound (HIFU) and cryosurgical ablation are treatment options in carefully selected patients without evidence of metastasis and with histologically proven local recurrence.

Experimental therapeutic options to treat clinically localized PCa:

- High frequency focused ultrasound (HIFU) has been shown to have a therapeutic effect in low-stage PCa, but prospective randomized comparison studies are not available to support its routine use.
- Cryotherapy for PCa compares unfavourably with external-beam radiation for the preservation of sexual function. Similarly this modality should be used in the context of clinical trials.
- Focal therapy of any sort is investigational, and the follow-up and retreatment criteria are unclear.
- In patients who are unfit for surgery or radiotherapy, cryotherapy can be an alternative treatment for PCa but cannot be recommended as a therapeutic alternative outside clinical trials.
- If HIFU is offered, the lack of long-term comparative outcome data (> 10 y) should be discussed with the patient.

LOCALLY ADVANCED PROSTATE CANCER (stage T3-T4, Nx-N0, M0):

DEFERRED TREATMENT

- Only indicated in selected patients with non-poorly differentiated T3 tumours and a life expectancy of less than 10 years.
- Significant risk factors associated with a worse outcome hence indications of active treatment are:
 - patients with a baseline PSA > 50 ng/mL.
 - in patients with a baseline PSA < 50 ng/mL, a PSADT of < 12 months carries the risk of PCa related death (approximately 7.5-fold).

RADICAL RADIOTHERAPY

- In patients with locally advanced PCa T3-4 N0 M0, concomitant and adjuvant hormonal therapy for a total duration of 3 years, with external-beam irradiation for patients with WHO 0-2 performance status, is recommended, as it improves the overall survival.
- In a subset of patients with T2c-T3 N0-X and a Gleason score of 2-6, short-term androgen deprivation therapy ADT before and during radiotherapy can be recommended, as it may favourably influence the overall survival.

ADT monotherapy:

- ADT monotherapy can be offered to patients with locally advanced disease who are unwilling or unable to receive any form of associated local treatment.
- Immediate castration should be considered in the most aggressive situations (PSA > 50 ng/mL, PSADT < 12 months).
- Otherwise a wait-and-see policy with deferred treatment at clinical progression is a reasonable option.

RADICAL PROSTATECTOMY

- RP is optional in highly selected patients with cT3b-4 N0 or any cT N1 PCa in the context of a multimodality approach.
- When nodal involvement is detected after surgery:
 - Adjuvant ADT is recommended when > 2 nodes are involved;
 - Expectant management is optional when the patient has undergone eLND and < 2 nodes show microscopic involvement.

Focal therapeutic options:

High-intensity focused ultrasound and cryotherapy should not be offered to men with locally advanced prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions.

METASTATIC PCa (stage M1):

ANDROGEN DEPREVATION THERAPY (ADT):

- In patients with symptomatic metastatic prostate cancer, ADT is recommended to palliate symptoms and to reduce the risk for potentially catastrophic sequelae of advanced disease (spinal cord compression, pathological fractures, ureteral obstruction, extraskelatal metastasis).
- In patients who are asymptomatic from their metastatic disease:
 - Immediate ADT can be used to defer progression to a symptomatic stage and prevent serious disease progression-related complications.
 - An active clinical surveillance protocol is an acceptable option in clearly informed patients if survival is the main objective.
- Anti-androgens are initially used to reduce the risk of the 'flare-up' phenomenon in patients with advanced metastatic disease who are to receive an LHRH agonist.
- It may be sufficient to give an anti-androgen for some weeks of concomitant use, starting treatment on the same day as an LHRH analogue is started, or for up to 7 days before the first LHRH analogue injection.
- Anti-androgens as monotherapy can be considered as an option in highly selected and motivated patients with a low PSA.
- Intermittent ADT:
 - When this method is used, it should reproduce what has been used in clinical trials; treatment is usually stopped when the PSA level is < 4 ng/mL (M1) and < 0.5-4 ng/mL (relapsing). Treatment is usually re-started when the PSA is > 4-10 (relapsing) and > 10-20 ng/mL (M1).
 - This can be used in patients with asymptomatic metastatic disease and are very motivated, with a major PSA response after the induction period.
 - Other cohort includes patients relapsing after radiotherapy; patients with a clear response after the induction period.

Contraindications of ADT

| Therapy | Contraindications | LE | GR |
|---------------------------|--|----|----|
| Bilateral orchiectomy | Psychological reluctance to undergo surgical castration. | 3 | A |
| Oestrogens | Known cardiovascular disease. | 2b | B |
| LHRH agonists monotherapy | Patients with metastatic disease at high risk for clinical 'flare-up' phenomenon. | 2b | A |
| ADT, anti-androgen | Localized PCa as primary monotherapy (except in some high-risk localized situations in patients unwilling or unable to receive any form of local treatment). | 1b | A |

DEFERRED TREATMENT:

- Only indicated in asymptomatic patients with a strong wish to avoid treatment-related side-effects
- If a deferred treatment policy is chosen for a patient with advanced PCa, close follow-up must be possible.

RADICAL RADIOTHERAPY

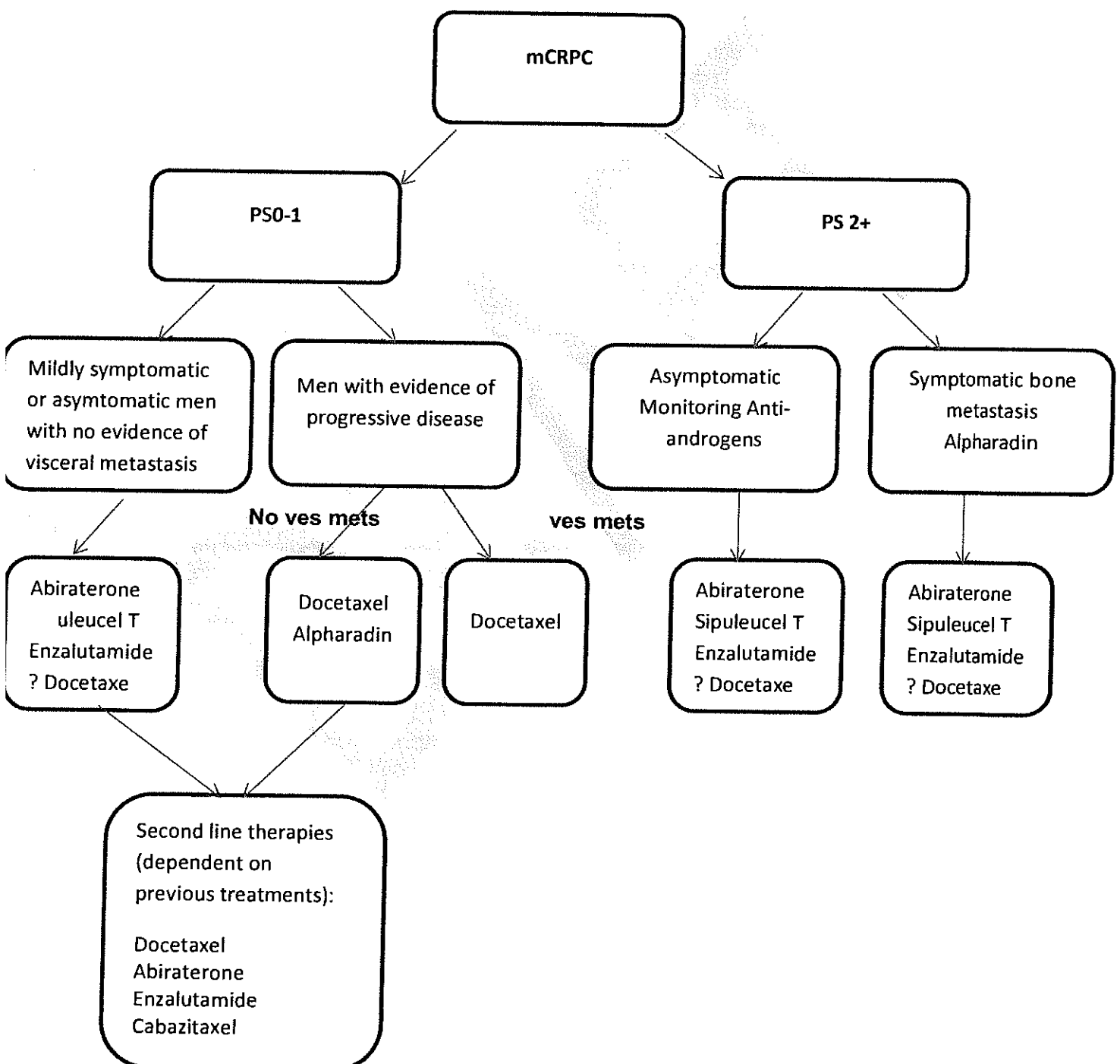
- In patients with very high-risk PCa c-pN1 M0, with no severe comorbidity, pelvic external irradiation and immediate long-term adjuvant hormonal treatment is recommended, as it may improve the overall survival, disease-specific failure rate, metastatic failure rate, and biochemical control.

CASTRATION-RESISTANT PCa (CRPC)

Defined as:

- Castrate serum testosterone < 50 ng/dL or 1.7 nmol/L plus either:
 - Biochemical progression: Three consecutive rises of PSA, 1 week apart, resulting in two 50% increases over the nadir, with PSA > 2 ng/mL. or
 - Radiological progression: The appearance of two or more bone lesions on bone scan or enlargement of a soft tissue lesion using RECIST (Response Evaluation Criteria in solid tumours).

Flowchart of the potential therapeutic options after PSA progression following initial hormonal therapy:



- Patients with mCRPC should be counselled, managed and treated by a multidisciplinary team.

FOLLOW UP**Guidelines for follow-up of prostate cancer patients with curative intent/watchful waiting:**

- Men should be clearly advised with prostate cancer about potential longer-term adverse effects of treatment and when and how to report them.
- 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.
- PSA levels for all men with prostate cancer who are having radical treatment should be checked 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.
- DRE is not routinely offered to men with localised prostate cancer while the PSA remains at baseline levels [NICE].
- After radical prostatectomy, a serum PSA level of more than 0.2 ng/mL can be associated with residual or recurrent disease.
- After radiation therapy, a rising PSA level over 2 ng/mL above the nadir PSA, rather than a specific threshold value, is the most reliable sign of recurrent disease.
- Both a palpable nodule and a rising serum PSA level can be signs of local disease recurrence.
- Detection of local recurrence by imaging studies is only recommended if it will affect the treatment plan. In most cases, a biopsy is not necessary before second-line therapy.
- Routine bone scans and other imaging studies are not recommended in asymptomatic patients with no signs of biochemical relapse. If a patient has bone pain or other symptoms of disease progression, re-staging should be considered irrespective of the serum PSA level.
- In asymptomatic patients, a disease-specific history and a serum PSA measurement supplemented by DRE are the recommended tests for routine follow-up. These should be performed at 3, 6 and 12 months after treatment, then every 6 months until 3 years, and then annually [EAU].
- After at least 2 years, follow-up can be performed 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.

Guidelines for follow-up of prostate cancer patients on ADT:

- Patients should be evaluated at 3 and 6 months after the initiation of treatment.
- As a minimum, tests should include serum PSA measurement, DRE, serum testosterone, and careful evaluation of symptoms in order to assess the treatment response and side effects.
- In patients undergoing intermittent androgen deprivation, PSA and testosterone should be monitored at set intervals during the treatment pause (one or three months).
- Follow-up should be tailored for the individual patient, according to symptoms, prognostic factors and the treatment given.
- In patients with stage M0 disease with a good treatment response, follow-up is scheduled every 6 months, and as a minimum should include a disease-specific history, DRE and serum PSA determination.
- In patients with stage M1 disease with a good treatment response, follow-up is scheduled for every 3 to 6 months. As a minimum, this should include a disease-specific history, DRE and serum PSA determination, and is frequently supplemented with haemoglobin, serum creatinine and alkaline phosphatase measurements. The testosterone level should be checked, especially during the first year.
- Patients (especially with M1b status) should be advised about the clinical signs that could suggest spinal cord compression.
- When disease progression occurs, or if the patient does not respond to the treatment given, follow-up needs to be individualized.
- In patients with suspected progression, the testosterone level must be checked. By definition, CRPC is based on the assumption that the patient has a testosterone level of at least < 50 ng/mL.
- Routine imaging of stable patients is not recommended.

9.3 PENILE CANCER

Penile carcinoma is mostly a squamous cell carcinoma (SCC) but other types of carcinoma exist as well. It usually originates from the epithelium of the inner prepuce or the glans. Also, penile SCC occurs in several histological subtypes. Penile SCC shares similar pathology with SCC of the oropharynx, the female genitalia (cervix, vagina and vulva) and the anus and it is therefore assumed that it also shares to some extent the natural history.

EPIDEMIOLOGY

- In Western countries, primary penile cancer is uncommon, with an incidence of less than 1.00 per 100,000 males in Europe and the United States.
- Incidence is also affected by race and ethnicity in North America, with the highest incidence of penile cancer found in white Hispanics (1.01 per 100,000), followed by a lower incidence in Alaskan, Native American Indians (0.77 per 100,000), blacks (0.62 per 100,000) and white non-Hispanics (0.51 per 100,000), respectively.
- In contrast, in some other parts of the world such as South America, South East Asia and parts of Africa the incidence of penile cancer is much higher and can represent 1-2% of malignant diseases in men.

- Penile cancer is common in regions with a high prevalence of human papilloma virus (HPV). The annual age-adjusted incidence is 0.7-3.0 per 100,000 men in India, 8.3 per 100,000 men in Brazil and even higher in Uganda, where it is the most commonly diagnosed cancer in men.
- There are no data linking penile cancer to HIV or AIDS.
- In European countries, the overall incidence has been stable from the 1980s until today. Recently, an increased incidence has been reported from Denmark and the UK.
- A longitudinal study from the UK has confirmed a 21% increase in incidence over the period 1979-2009.
- The incidence of penile cancer increases with age, with an age peak during the sixth decade of life. However, the disease does occur in younger men.

RISK FACTORS AND PREVENTION

| Risk factors | Relevance |
|--|--|
| • Phimosis | OR 11-16 versus no phimosis |
| • chronic penile inflammation (balanoposthitis related to phimosis) | Risk |
| • balanitis xerotica obliterans (lichen sclerosis) | |
| • sporadic and UV-A phototherapy for various dermatologic conditions such as psoriasis | Incidence rate ratio 9.51 with > 250 treatments |
| • smoking | 5-fold increased risk (95% CI: 2.0-10.1) versus nonsmokers |
| • HPV infection condylomata acuminata | 22.4% in verrucous SCC and 36-66.3% in basaloid-warty |
| • Rural areas, low socio-economic status, unmarried | Risk |
| • multiple sexual partners early age of first intercourse | 3-5-fold increased risk of penile cancer |

- Neonatal circumcision reduces the incidence of penile cancer in countries and cultures where this is routinely practiced.
- The lowest incidence of penile cancer is reported from Israel amongst Jews (0.3/100,000/ year).
- Medical circumcision in adult life does not influence the incidence of penile cancer.

- The controversial discussion about any preventive value of neonatal circumcision must take into consideration that circumcision removes about 50% of the tissue that can develop penile cancer.
- The protective effect of neonatal circumcision against invasive penile cancer (OR 0.41) - which does apparently not apply to CIS (OR 1.0) - is much weaker when the analysis is restricted to men without a history of phimosis (OR 0.79, 95% CI 0.29-2).

TNM clinical and pathological classification of penile cancer (2009)

| | |
|--|--|
| T - Primary Tumour | |
| Tx | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| Ta | Non-invasive carcinoma |
| Tis | Carcinoma in situ |
| T1 | Tumour invades subepithelial connective tissue |
| T1a | Tumour invades subepithelial connective tissue without lymphovascular invasion and is not poorly differentiated or undifferentiated (T1G1-2) |
| T1b | Tumour invades subepithelial connective tissue with lymphovascular invasion or is poorly differentiated or undifferentiated (T1G3-4) |
| T2 | Tumour invades corpus spongiosum and/or corpora cavernosa |
| T3 | Tumour invades urethra |
| T4 | Tumour invades adjacent structures |
| N - Regional Lymph Nodes | |
| Nx | Regional lymph nodes cannot be assessed |
| N0 | No palpable or clinically visible inguinal lymph-node |
| N1 | Palpable mobile unilateral inguinal lymph node |
| N2 | Palpable mobile multiple unilateral or bilateral inguinal lymph nodes |
| N3 | Fixed inguinal nodal mass or pelvic lymphadenopathy, unilateral or bilateral |
| M - Distant Metastasis | |
| M0 | No distant metastasis |
| M1 | Distant metastasis |
| Pathological classification | |
| The pT categories correspond to the clinical T categories. The pN categories are based upon biopsy or surgical excision. | |
| pN - Regional Lymph Nodes | |
| pNX | Regional lymph nodes cannot be assessed |
| pN0 | No regional lymph node metastasis |
| pN1 | Intranodal metastasis in a single inguinal lymph node |
| pN2 | Metastasis in multiple or bilateral inguinal lymph nodes |
| pN3 | Metastasis in pelvic lymph node(s), unilateral or bilateral or extranodal extension of any regional lymph node metastasis |
| pM - Distant Metastasis | |
| pM0 | No distant metastasis |
| pM1 | Distant metastasis |
| G - Histopathological Grading | |
| GX | Grade of differentiation cannot be assessed |
| G1 | Well differentiated |
| G2 | Moderately differentiated |
| G3-4 | Poorly differentiated/undifferentiated |

Premalignant penile lesions (precursor lesions)

Lesions sporadically associated with SCC of the penis

- Cutaneous horn of the penis
- Bowenoid papulosis of the penis
- Lichen sclerosus (balanitis xerotica obliterans)

Premalignant lesions (up to one-third transform to invasive SCC)

- Intraepithelial neoplasia grade III
- Giant condylomata (Buschke-Löwenstein)
- Erythroplasia of Queyrat or Bowen's disease
- Paget's disease (intradermal ADK)

Histological subtypes of penile carcinomas, their frequency and outcome

| Subtype | frequency
(% of cases) | prognosis |
|------------------------------|---------------------------|--|
| common SCC | 48-65 | depends on location, stage and grade |
| basaloid carcinoma | 4-10 | poor prognosis, frequently early inguinal nodal metastasis |
| warty carcinoma | 7-10 | good prognosis, metastasis rare |
| verrucous carcinoma | 3-8 | good prognosis, no metastasis |
| papillary carcinoma | 5-15 | good prognosis, metastasis rare |
| sarcomatoid carcinoma | 1-3 | very poor prognosis, early vascular metastasis |
| mixed carcinoma | 9-10 | heterogeneous group |
| pseudohyperplastic carcinoma | < 1 | foreskin, related to lichen sclerosus, good prognosis, metastasis not reported |
| carcinoma cuniculatum | < 1 | variant of verrucous carcinoma, good prognosis, metastasis not reported |
| pseudoglandular carcinoma | < 1 | high grade carcinoma, early metastasis, poor prognosis |
| warty-basaloid carcinoma | 9-14 | poor prognosis, high metastatic potential (12) |

| | | |
|--|-----|--|
| | | (higher than in warty, lower than in basaloid SCC) |
| adenosquamous carcinoma | < 1 | central and peri-meatal glans, high grade carcinoma, high metastatic potential but low mortality |
| mucoepidermoid carcinoma | < 1 | highly aggressive, poor prognosis |
| clear cell variant of penile carcinoma | 1-2 | exceedingly rare, associated with HPV, aggressive, early metastasis, poor prognosis, outcome lesion dependent, frequent lymphatic metastasis |

DIAGNOSIS AND STAGING

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
- Microscopic haematuria in adults over 50 years.
- Swellings in the body of the testis.
- Palpable renal masses.
- Solid renal masses found on imaging.
- Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
- A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.
- Any suspected penile cancer:

GPs should refer men with suspicious penile lesions such as growths, swelling at or near the glans, painless ulcers which do not appear to be due to infection, or other unexplained abnormalities such as plaques on the skin or foreskin of the penis, to a local urological cancer team.

Recommendations for the diagnosis and staging of penile cancer

| | |
|--|-----------|
| | GR |
| Primary tumour: <ul style="list-style-type: none"> • Physical examination, recording morphology, extent and invasion of penile structures. • MRI with artificial erection in selected cases with intended organ preserving surgery. | C |
| Inguinal lymph nodes: | C |

| | |
|---|---|
| <ul style="list-style-type: none"> Physical examination of groins, recording number, laterality and characteristics of inguinal nodes. If nodes are not palpable, invasive lymph node staging in high-risk patients. If nodes are palpable, a pelvic CT may be indicated, PET/CT is an option. | |
| <p>Distant metastases:</p> <ul style="list-style-type: none"> In N+ patients, abdomino-pelvic CT scan and chest X-ray are required for systemic staging. PET/CT scan is an option. In patients with systemic disease or with relevant symptoms, a bone scan may be indicated. | C |

TREATMENT

Patients with penile cancer should be managed by specialist penile cancer teams working at the supra-network level. Such teams should serve up to four networks, with a combined population base of at least four million for penile cancer and expect to manage a minimum of 25 new patients each year. The team should include members of the specialist urological cancer team who work in the cancer centre within which it is based, and it should also have access to expertise in plastic surgery.

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

Local care is classed as:

i) The diagnostic process only.

Local care should be carried out by local teams for their catchment. It should also be carried out by specialist teams and supranetwork teams for the local catchment of their host locality.

Specialist care is classed as:

(i) Resection (except in cases needing penile reconstruction or lymph node resection). All resections should be carried out in the host hospital of the team.

(ii) Radiotherapy and chemotherapy. The site(s) where this is carried out should be agreed in the network guidelines.

Specialist care may be delivered by:

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

guidelines.

- The supranetwork team for the local catchment of their host locality.

Supranetwork care is classed as:

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

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

- The aims of the treatment of the primary penile cancer lesion are complete tumour removal with as much organ preservation as possible while radicality of the treatment should not be compromised.
- A local recurrence in itself has little influence on long-term survival so that organ preservation strategies are justified.
- There are no randomised controlled trials for any of the surgical management options of localised penile cancer, neither are there any observational studies comparing different surgical approaches or studies comparing surgical and non-surgical treatment modalities.
- The available studies all have one or more form of bias such as bias of selection, performance, detection, attrition, selective reporting or publication. Thus, the overall quality of the existing evidence must be regarded as low.
- Penile preservation appears to be superior in functional and cosmetic outcomes and should be offered as the primary treatment modality to men with localised penile cancer.
- Histological diagnosis with local staging must be obtained in all cases, especially if non-surgical treatment modalities are considered
- The treatment of the primary tumour and that of the regional nodes can be done as staged procedures.
- In both cases, it is essential to remove all malignant tissue with negative surgical margins.
- Patients must be counselled about all relevant treatment modalities.
- There are a variety of local treatment modalities for small and localized penile cancer including
 - excisional surgery,
 - external beam radiotherapy,
 - brachytherapy and laser ablation which are used to treat localized invasive disease.

Treatment of superficial non-invasive disease (CIS)

- For penile CIS, topical chemotherapy with imiquimod or 5-FU is an effective first-line treatment.
- Toxicity and adverse events of these topical treatments are relatively low but the efficacy is limited.
- Complete responses have been reported in up to 57% of cases of CIS.
- For the reason of a high rate of persistence and/or recurrence, close and long-term surveillance of such patients is required.
- If topical treatment fails it should not be repeated. Laser treatment can be used for CIS.
- Photodynamic control may be used in conjunction with CO2 laser treatment.
- Alternatively, total or partial glans resurfacing can be offered as a primary treatment modality for CIS and as a secondary treatment in case of treatment failure with topical chemotherapy or laser therapy.
- Glans resurfacing is a surgical technique which consists of complete abrasion of the glandular epithelium with covering by a split skin graft.
- With glans resurfacing for presumed non-invasive disease, up to 20% of patients are found to have superficial invasive disease.

Treatment of invasive disease confined to the glans (category Ta/T1a)

- Penis-preserving strategy is recommended.
- Prior to conservative treatment modalities, it is mandatory to obtain histopathological diagnosis by biopsy.
- All patients must be circumcised before considering conservative non-surgical treatment modalities.
- For tumours confined to the prepuce, radical circumcision alone may be curative, if negative surgical margins are confirmed by definitive histology.
- For all surgical treatment options, the intra-operative assessment of surgical margins by frozen section is recommended as tumour-positive margins lead to local recurrence.
- Total removal of the glans (glansectomy) and prepuce does have the lowest recurrence rate among the treatment modalities for small penile lesions (2%).
- Negative surgical margins are imperative when using penile-conserving treatments and a margin of 5 mm is considered oncologically safe.
- Treatment choice should depend on tumour size, histology including stage and grade, localization especially relative to the meatus, as well as patient preference as there are no documented differences in the long term local recurrence rates between surgery, laser and radiation therapy.

Summary of reported complications and oncological outcomes of local treatments

| treatment | complications | local recurrence | nodal recurrence | cancer-specific deaths |
|----------------------------|--|------------------|------------------|------------------------|
| Nd:YAG laser | none reported | 10-48% | 21% | 2-9% |
| CO2-laser | bleeding, meatal stenosis(both < 1%) | 14-23% | 2-4% | none reported |
| Lasers (unspecified) | bleeding (8%), local infection 2% | 11-26% | 2% | 2-3% |
| Moh's micrographic surgery | local infection 3%, meatal stenosis 6% | 32% | 8% | 3-4% |

| | | | | |
|-------------------|---|--------------|--------------|---------------|
| Glans resurfacing | none reported | 4-6% | not reported | not reported |
| Glansectomy | none reported | 8% | 9% | none reported |
| Partial penectomy | not reported | 4-13% | 14-19% | 11-27% |
| Brachytherapy | meatal stenosis > 40% | 10-30% | not reported | not reported |
| Radiotherapy | urethral stenosis 20-35%, glans necrosis 10-20% | not reported | not reported | not reported |

Recommendations for stage-dependent local treatment of penile carcinoma

| Primary tumour | Organ-preserving treatment is to be considered whenever possible | LE | GR |
|---|---|----|----|
| Tis | <ul style="list-style-type: none"> Topical treatment with 5-fluorouracil or imiquimod for superficial lesions with or without photodynamic control. Laser ablation with CO2 or Nd:YAG laser. Glans resurfacing. | 3 | C |
| Ta, T1a (G1, G2) | <ul style="list-style-type: none"> Wide local excision with circumcision CO2 or Nd:YAG laser surgery with circumcision. Laser ablation with CO2 or Nd:YAG laser. Glans resurfacing. Glansectomy with reconstructive surgery, with or without skin grafting. Radiotherapy by external beam or as brachytherapy for lesions < 4 cm. | 3 | C |
| T1b (G3) and T2 confined to the glans | <ul style="list-style-type: none"> Wide local excision plus reconstructive surgery, with or without skin grafting. Laser ablation with circumcision. Glansectomy with circumcision, with reconstruction. Radiotherapy by external beam or brachytherapy for lesions < 4 cm in diameter. | 3 | C |
| T2 with invasion of the corpora cavernosa | <ul style="list-style-type: none"> Partial amputation and reconstruction. Radiotherapy by external beam or brachytherapy for lesions < 4 cm in diameter. | 3 | C |
| T3 with invasion of the urethra | <ul style="list-style-type: none"> Partial penectomy or total penectomy with perineal urethrostomy. | 3 | C |
| T4 with invasion of other adjacent structures | <ul style="list-style-type: none"> Neoadjuvant chemotherapy followed by surgery in responders. Alternative: palliative external beam radiation. Local recurrence after conservative treatment Salvage surgery with penis-sparing treatment in small recurrences or partial amputation. Large or high stage recurrence: partial or total amputation | 3 | C |

Management of regional lymph nodes

- The development of lymphatic metastases in penile cancer follows some anatomic rules.
- The inguinal and the pelvic lymph nodes are the regional drainage system of the penis.

- The superficial and deep inguinal lymph nodes are thereby the first regional nodal group reached by lymphatic metastatic spread.
- Spread to the inguinal lymph nodes can be uni- or bilateral from any primary penile cancer.
- The second regional lymph node groups are the ipsilateral pelvic lymph nodes.
- Pelvic nodal disease does not seem to occur without ipsilateral inguinal lymph node metastasis and cross-over metastatic spread from one inguinal side to the other pelvic side has never been reported in penile cancer.
- Further metastatic lymph node spread from the pelvic nodes to paraaortic and paracaval nodes is outside the regional lymph node drainage system of the penis and is therefore classified as systemic metastatic disease.
- The management of regional lymph nodes is decisive for long-term patient survival.
- Cure can be achieved in metastatic disease confined to the regional lymph nodes.
- Lymphadenectomy is the treatment of choice for patients with inguinal lymph node metastases but multimodal treatment combining surgery and polychemotherapy is often indicated.
- Management of the regional lymph nodes should be stage-dependent. In clinically node-negative patients (cN0), there is a definite risk of micro-metastatic lymph node involvement in about 25% of cases which is related to local tumour stage and grade.
- In clinically positive lymph nodes (cN1/cN2), metastatic disease is highly likely and no time should be wasted on antibiotic treatment before surgical treatment.
- With enlarged fixed inguinal lymph nodes (cN3), multimodal treatment by chemotherapy and surgery is indicated. Capsular penetration and extranodal extension in lymph node metastasis even if present in only one node carries a high risk of progression and is classified as pN3 which also requires multimodal treatment.

Recommendations for treatment strategies for nodal metastases

| Regional lymph nodes | Management of regional lymph nodes is fundamental in the treatment of penile cancer | LE | GR |
|-----------------------------------|--|-----------|-----------|
| No palpable inguinal nodes (cN0) | <ul style="list-style-type: none"> • Tis, Ta G1, T1G1: surveillance. • > T1G2: invasive lymph node staging by bilateral modified inguinal lymphadenectomy or DSNB. | 2a | B |
| Palpable inguinal nodes (cN1/cN2) | Radical inguinal lymphadenectomy. | | |
| Fixed inguinal lymph nodes (cN3) | <ul style="list-style-type: none"> • Neoadjuvant chemotherapy followed by radical inguinal lymphadenectomy in responders. • Pelvic lymphadenectomy Ipsilateral pelvic lymphadenectomy is indicated if two or more inguinal nodes are involved on one side (pN2) and in extracapsular nodal metastasis (pN3). | 2a | B |
| Adjuvant chemotherapy | <ul style="list-style-type: none"> • Indicated in pN2/pN3 patients after radical lymphadenectomy • Radiotherapy Radiotherapy is not indicated for the treatment of nodal disease in penile cancer. | 2b | B |

Chemotherapy

- Multimodal treatment can improve patient outcome in many tumour entities.

- The value of adjuvant chemotherapy after radical inguinal lymphadenectomy in node-positive penile cancer has a long-term disease-free survival (DFS) as opposed those without chemotherapy of (84% vs 39% respectively).
- There is limited evidence to support the use of neoadjuvant chemotherapy for patients with fixed, unresectable nodal disease, particularly with a triple combination including cisplatin and a taxane, whenever feasible.

Recommendations for chemotherapy in penile cancer patients

| | LE | GR |
|--|----|----|
| Adjuvant chemotherapy (3-4 cycles of TPF) is an option for patients with pN2-3 tumours. | 2b | C |
| Neoadjuvant chemotherapy (4 cycles of a cisplatin and taxane-based regimen) followed by radical surgery is recommended in patients with non-resectable or recurrent lymph node metastases. | 2a | B |
| Chemotherapy for systemic disease is an option in patients with limited metastatic load. | 3 | C |

FOLLOW UP

Recommendations for follow-up in penile cancer

| | Interval of follow-up
Years 1-2 | Interval follow-up
Years 3-5 | Examinations examination and investigations | Minimum duration of follow-up | GR |
|---|------------------------------------|---------------------------------|--|-------------------------------|----|
| Primary tumour:
penile preserving treatment | 3 months | 6 months | Regular physician or self examination
Repeat biopsy after topical or laser treatment for CIS. | 5 years | C |
| Amputation | 3 months | 1 year | Regular physician or self examination | 5 years | C |
| Recommendations for follow-up of the inguinal lymph nodes:
Surveillance | 3 months | 6 months | Regular physician or selfexamination | 5 years | C |
| pN0 at initial treatment | 3 months | 1 year | <ul style="list-style-type: none"> • Regular physician or self examination. • Ultrasound with FNAB optional. | 5 years | C |

| | | | | | | |
|------------------|---------|----------|----------|--|---------|---|
| pN+ at treatment | initial | 3 months | 6 months | <ul style="list-style-type: none"> • Regular physician or selfexamination • Ultrasound with FNAC optional, • CT/MRI optional. | 5 years | C |
|------------------|---------|----------|----------|--|---------|---|

9.4 Renal Cell Carcinoma

Epidemiology:

- Renal cell carcinoma (RCC) represents 2-3% of all cancers.
- In 2012, there were approximately 84,400 new cases of RCC and 34,700 kidney cancer-related deaths in the European Union.
- In Europe, overall mortality rates for RCC increased up to the early 1990s, and stabilised or declined thereafter. Mortality has decreased since the 1980s in Scandinavian countries and since the early 1990s in France, Germany, Austria, the Netherlands, and Italy. However, in some European countries (Croatia, Estonia, Greece, Ireland, Slovakia), mortality rates still show an upward trend.
- Different RCC types have specific histopathological and genetic characteristics.
- There is a 1.5:1 male predominance, with peak incidence between 60 and 70 years.
- Having a first-degree relative with kidney cancer also increases the risk of RCC.
- Literature results are inconclusive regarding the association of specific dietary habits and occupational exposure to RCC.
- Moderate alcohol consumption appears to have a protective effect for unknown reasons.
- Effective prophylaxis includes avoidance of cigarette smoking and obesity.

Aetiology:

- Smoking:
 - The RR of RCC for ever-smokers is 1.38 times higher than that for non-smokers
 - A strong dose-response relationship between number of cigarettes smoked and increased risk of RCC has been established; Smokers with a history of ≥ 20 pack-years have an increased risk of RCC 1.35 times that of never-smokers
- Obesity:

- Increasing body weight and body mass index (BMI) incrementally increases the risk of developing RCC
- Being overweight (BMI 25–29.9 kg/m²) increases the risk of RCC by 1.35 times versus BMI
- Hypertension and antihypertensive therapy:
 - The presence of hypertension is estimated to increase the RR of RCC by 1.4–1.9 times compared with normotensive individuals
 - Systolic blood pressure ≥ 160 mmHg increases the RR of RCC by 2.5 times versus < 120 mmHg.
 - Diastolic blood pressure ≥ 100 mmHg increases the RR of RCC by 2.3 times versus < 80 mmHg.
 - Treatment with diuretics also increases the risk of RCC (OR 1.43), but this is only significant in women
- End-stage renal disease:
 - Patients undergoing dialysis for end-stage renal disease are estimated to have a 3.6 times higher RR of developing renal cancer than healthy individuals.
- Renal cancer syndromes:

| Disease | Renal and other tumours | Gene mutation |
|-----------------------------------|--|--------------------|
| Von Hippel–Lindau disease | Clear cell RCC: Clear cell renal cysts
Retinal and central nervous system haemangioblastomas, phaeochromocytoma, pancreatic cyst and endocrine tumour, endolymphatic sac tumour, epididymal and broad ligament cystadenomas | VHL |
| Birt-Hogg-Dubé syndrome | Hybrid oncocytic RCC, chromophobe RCC, oncocytoma, clear cell RCC
multiple and bilateral Cutaneous lesions (fibrofolliculoma +++, trichodiscoma, acrochordon), lung cysts, spontaneous pneumothorax, colonic polyps or cancer | Folliculin (FLCN) |
| Hereditary papillary RCC | Type 1 papillary RCC: multiple and bilateral | MET |
| Hereditary leiomyomatosis and RCC | Type 2 papillary RCC: solitary and aggressive
Uterine leiomyoma and leiomyosarcoma, cutaneous leiomyoma and leiomyosarcoma | Fumarate hydratase |
| Tuberous sclerosis complex | Angiomyolipoma, clear cell RCC, cyst, oncocytoma: bilateral and multiple Facial | TSC-1 TSC-2 |

| | | |
|-------------------------|--|---------|
| | angiofibroma, subungual fibroma, hypopigmentation and café au lait spots, cardiac rhabdomyoma, seizure, mental retardation, CNS tubers, lymphangioleiomyomatosis | |
| Familial clear cell RCC | Clear cell RCC | Unknown |

Diagnosis:

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
 - Microscopic haematuria in adults over 50 years.
 - Swellings in the body of the testis.
 - Palpable renal masses.
 - Solid renal masses found on imaging.
 - Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
 - A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.
 - Any suspected penile cancer.
-
- Many renal masses remain asymptomatic until the late stages of the disease.
 - More than 50% of renal cell carcinomas (RCCs) are detected incidentally when noninvasive imaging is used to investigate a variety of nonspecific symptoms and other abdominal diseases.
 - The classic triad of flank pain, gross haematuria and palpable abdominal mass is now rare (<10%).
 - Other clinical symptoms include new onset varicocele or bilateral lower extremity oedema; these symptoms should initiate radiological examinations.
 - Renal Cell Carcinoma Paraneoplastic syndromes are found in approximately 30% of patients with symptomatic RCCs.
 - A few symptomatic patients present with symptoms caused by metastatic disease, such as bone pain or persistent cough.

Investigations:

- Radiological and other investigations of RCC Radiological investigations of RCC include CT imaging, before and after intravenous contrast to verify the diagnosis and provide information on:
 - function and morphology of the contralateral kidney
 - assess tumour extension
 - extrarenal spread
 - venous involvement
 - enlargement of lymph nodes and adrenals.
- Abdominal US and magnetic resonance (MR) imaging are supplements to CT.
- Contrast enhanced US can be helpful in specific cases (e.g., chronic renal failure with a relative contraindication for iodinated or gadolinium contrast media, complex cystic masses, and differential diagnosis of peripheral vascular disorders such as infarction and cortical necrosis).
- Magnetic resonance imaging can be used in patients with possible venous involvement, or allergy to intravenous contrast.
- Chest CT is the most accurate chest staging; a routine chest X-ray should be done as a minimum only.
- Indications of renal biopsy:
 - for histological diagnosis of radiologically indeterminate renal masses
 - to select patients with small renal masses for surveillance approaches
 - to obtain histology before ablative treatments
 - to select the most suitable form of targeted pharmacologic therapy in the setting of metastatic disease.
- Total renal function should always be evaluated.
- In patients with any sign of impaired renal function, a renal scan and total renal function evaluation should be undertaken to optimise the treatment decision.

Staging system:

The current UICC 2009 TNM (Tumour Node Metastasis) classification is recommended for the staging of RCC.

| T - Primary tumour | |
|---------------------------|---|
| TX | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| T1 | Tumour ≤ 7 cm in greatest dimension, limited to the kidney |
| T1a | Tumour ≤ 4 cm in greatest dimension, limited to the kidney |
| T1b | Tumour > 4 cm but ≤ 7 cm in greatest dimension |
| T2 | Tumour > 7 cm in greatest dimension, limited to the kidney |

| | |
|---------------------------------|--|
| T2a | Tumour > 7 cm in greatest dimension but ≤ 10 cm |
| T2b | Tumour > 10 cm limited to the kidney |
| T3 | Tumour extends into major veins or perinephric tissues, but not into the ipsilateral adrenal gland and not beyond Gerota's fascia |
| T3a | Tumour grossly extends into the renal vein or its segmental (muscle-containing) branches, or tumour invades perirenal and/or renal sinus (peripelvic) fat but not beyond Gerota's fascia |
| T3b | Tumour grossly extends into the vena cava below diaphragm |
| T3c | Tumour grossly extends into vena cava or its wall above the diaphragm or invades the wall of the vena cava |
| T4 | Tumour invades beyond Gerota's fascia (including contiguous extension into the ipsilateral adrenal gland) |
| N - Regional lymph nodes | |
| NX | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph node metastasis |
| N1 | Metastasis in a single regional lymph node |
| N2 | Metastasis in more than one regional lymph node |
| M - Distant metastasis | |
| M0 | No distant metastasis |
| M1 | Distant metastasis |

Histopathological classification:

Fuhrman nuclear grade is the most commonly used grading system. The most aggressive pattern observed defines the Fuhrman grade. The most common histological subtypes of rCC are below:

| Histological subtype | Frequency (%) |
|---------------------------|---------------|
| clear cell RCC | 80-90%), |
| papillary RCC | 10-15%), |
| chromophobe RCC | 4-5% |
| collecting duct carcinoma | 1% |

- Generally, the RCC types have different clinical courses and responses to therapy.

Recommendations for diagnosis and staging of RCC:

| | |
|--|----|
| Recommendations for the diagnosis and staging of RCC | GR |
| The Fuhrman grading system and classification of RCC subtype should be used | B |
| In a patient with one or more suspicious laboratory or physical findings, the possible presence of RCC should be suspected | B |
| Contrast-enhanced abdominal CT and MRI are recommended for the work-up of patients with RCC. These are the most appropriate imaging modalities for renal tumour staging prior to surgery | A |
| A chest CT is most sensitive for assessment of the lung, but at least a plain chest radiograph should be taken for clinical staging | A |
| In patients at risk for bone metastases (raised alkaline phosphatase level or bone pain), further evaluation with a bone scan is needed | A |
| Evaluation of renal function is recommended before treatment decision in any patient in whom renal impairment is suspected | B |
| Percutaneous biopsy is recommended in active surveillance strategies in order to stratify the follow-up according to tumour histology | B |
| Percutaneous biopsy is always required before ablative therapy and systemic therapy without previous pathology | A |
| When biopsy is indicated, good-quality needle cores should be obtained with a coaxial technique in order to increase the safety of the procedure and maximize its diagnostic yield | B |

Recommendations for "other renal tumours":

| Recommendations for "Other renal tumours" | LE | GR |
|---|----|----|
| Except for angiomyolipomas, most of these less common renal tumours cannot be differentiated from RCC on the basis of radiology and should therefore be treated in the same way as RCC. | 3 | C |
| Bosniak cysts $\geq$ type III should be treated surgically. When possible, a nephron-sparing procedure should be performed in Bosniak type III. | 3 | C |
| In oncocytomas verified on biopsy, follow-up is an option. | 3 | C |
| In angiomyolipomas, treatment (surgery, thermal ablation, and selective arterial embolisation) can be considered in only very well selected cases. A nephron-sparing procedure is preferred | 3 | C |
| In advanced uncommon types of renal tumours, a standardised oncological treatment approach does not exist. | 4 | C |

Bosniak classification of renal cysts:

| Bosniak category | Features | Work-up |
|------------------|---|--|
| I | Simple benign cyst with a hairline-thin wall without septa, calcification, or solid components. Same density as water and does not enhance with contrast medium. | Benign |
| II | Benign cyst that may contain a few hairline-thin septa. Fine calcification may be present in the wall or septa. Uniformly high-attenuation lesions < 3 cm in size, with sharp margins without enhancement. | Benign |
| IIF | These may contain more hairline-thin septa. Minimal enhancement of a hairline-thin septum or wall. Minimal thickening of the septa or wall. The cyst may contain calcification, which may be nodular and thick, with no contrast enhancement. No enhancing soft-tissue elements. This category also includes totally intrarenal, non-enhancing, high attenuation renal lesions > 3 cm. Generally well-margined. | Follow-up. Some are malignant. |
| III | These are indeterminate cystic masses with thickened irregular walls or septa with enhancement. | Surgery or active surveillance
Over 50% are malignant |
| IV | Clearly malignant containing enhancing soft-tissue components. | Surgery. Most are malignant |

Guidelines for primary treatment for RCC:

- Based on the available oncological and QoL outcomes, the current evidence suggests that localised renal cancers are best managed by nephron-sparing surgery (partial nephrectomy) rather than by radical nephrectomy, irrespective of the surgical approach.
- Radical nephrectomy with complete removal of the tumour-bearing kidney with perirenal fat and Gerota's fascia is currently recommended only for patients with localised RCC, who are not suitable for nephron-sparing surgery due to locally advanced tumour growth, when partial resection is technically not feasible due to an unfavourable localisation of the tumour or local growth.
- Complete resection of the primary RCC either by open or laparoscopic surgery offers a reasonable chance for cure.

- If pre-operative imaging is normal, routine adrenalectomy is not indicated.
- Lymphadenectomy should be restricted to staging because extended lymphadenectomy does not improve survival.
- In patients who have RCCs with tumour thrombus and no metastatic spread, prognosis is improved after nephrectomy and complete thrombectomy.
- Embolisation of the primary tumour is indicated in patients with gross haematuria or local symptoms (e.g. pain), in patients unfit for surgical intervention, and before surgical resection of large skeletal metastases. No benefit is associated with tumour embolisation before routine radical nephrectomy.

Nephron sparing surgery (NSS):

- Absolute indications for partial nephrectomy are
 - anatomical or functional solitary kidney or
 - bilateral RCC.
- Relative indications are
 - a functioning opposite kidney affected by a condition that might impair renal function and
 - hereditary forms of RCC with a high risk of developing a tumour in the contralateral kidney.
- Elective indications also localised unilateral RCC with a healthy contralateral kidney, which is the recommended approach, when technically feasible, since recurrence-free and long-term survival rates are similar to those for radical nephrectomy.
- Even in selected patients with a tumour diameter of up to 7 cm, nephron-sparing surgery has achieved results equivalent to those of a radical approach.
- If the tumour is completely resected, the thickness of the surgical margin (> 1 mm) does not correlate with the likelihood of local recurrence.
- If RCCs of larger size are treated with nephron-sparing surgery, follow-up should be intensified, as there is an increased risk of intrarenal recurrences.
- These procedures should only be delivered under the care of members of the specialist urology team and this is not subject to change by the network's own guidelines (National Cancer Action Team- Manual of Cancer Services 2011).

Laparoscopic radical and partial nephrectomy:

- Laparoscopic radical and partial nephrectomy Laparoscopic radical nephrectomy has a lower morbidity compared with open surgery.
- It has become an established surgical procedure for RCC.

- Whether done retro- or transperitoneally, the laparoscopic approach must duplicate established, open surgical, oncological principles.
- Long-term outcome data indicate equivalent cancer-free survival rates versus open radical nephrectomy.
- Thus, laparoscopic radical nephrectomy is now considered the standard of care for patients with T1 and T2 RCCs, who are not treatable by nephron-sparing surgery.
- Laparoscopic radical nephrectomy should not be performed in patients with T1 tumours for whom partial resection is indicated. Laparoscopic and robot assisted nephron-sparing surgery has become available treatment options in experienced hands.
- Laparoscopic partial resection has a risk for longer intraoperative ischaemia time than open partial nephrectomy and therefore carries a higher risk for reduced long-term renal function.
- The oncological outcome seems comparable in available series.
- Robotic-assisted partial nephrectomy requires further evaluation and more mature data before any conclusive technical recommendations can be made.
- Conclusion: Radical nephrectomy, preferably laparoscopic, is recommended for patients with localised RCC, who are not suitable for nephron-sparing surgery. Nephron-sparing surgery is the standard of care despite the surgical approach.

Minimally invasive alternative treatment:

- Minimally invasive techniques, such as ablation with percutaneous radio-frequency, cryotherapy, microwave, and high-intensity focused US (HIFU), are suggested alternatives to surgery.
- Microwave therapy should only be used within the context of research.
- Potential advantages of these techniques include reduced morbidity, outpatient therapy, and the ability to treat high-risk patients not fit for conventional surgery.
- These experimental treatments might be recommended for selected patients with small, incidentally found, renal cortical lesions, elderly patients, patients with a genetic predisposition to multiple tumours, patients with a solitary kidney, or patients with bilateral tumours.
- The oncological efficacy remains to be determined for both cryotherapy and RFA, which are the most often used minimally invasive techniques.
- Current data suggest that cryoablation, when performed laparoscopically, results in fewer re-treatments and improved local tumour control compared with RFA.
- Current evidence on the safety and efficacy of percutaneous radiofrequency ablation (RFA) for renal cancer in the short and medium term appears adequate to support the use of this procedure provided that normal arrangements are in place for clinical

governance, consent and audit, and provided that patients are followed up in the long term.

- For both treatments, tumour recurrence rates are higher compared with nephron-sparing surgery.
- Further research is needed to determine the oncological success rate and complications associated with these procedures.
- NICE encourages collection and publication of data on the long-term outcomes of these procedures.

Adjuvant therapy:

- Adjuvant tumour vaccination may improve the duration of the progression-free survival (PFS), which is especially important in patients at high risk of metastases, e.g. T3 RCC. Cytokine therapy does not improve survival after nephrectomy.
- Although there is no current data supporting adjuvant therapy with targeting agents, three worldwide phase III randomised trials are ongoing.
- Outside controlled clinical trials, there is no indication for adjuvant therapy following surgery.

Surgical treatment for metastatic RCC (mRCC):

- Nephrectomy of the primary tumour is curative only if surgery can excise all tumour deposits.
- For most patients with mRCC, nephrectomy is palliative.
- In a meta-analysis of two randomised studies, comparing nephrectomy + immunotherapy versus immunotherapy alone, increased long term survival was found in patients who underwent prior nephrectomy.
- For targeting agents, there is no current knowledge whether cytoreductive surgery is advocated before or after successful medical therapy. The CARMENA and SURTIME trials comparing cytoreductive nephrectomy with neoadjuvant/adjuvant (respectively) targeted therapy versus control arms of nephrectomy alone are awaited.
- However, in the absence of available evidence data, cytoreductive nephrectomy is recommended when possible.
- Complete removal of metastases contributes to improved clinical prognosis.
- Metastasectomy should be carried out in patients with resectable disease and a good PS.
- It should also be considered in patients with residual and respectable metastatic lesions, who have previously responded to systemic therapy.

Radiotherapy for metastasis:

For selected patients with non-resectable brain or osseous lesions, radiotherapy can induce significant symptom relief.

Systemic chemotherapy for mRCC:

Chemotherapy as monotherapy should not be considered effective in patients with mRCC.

Immunotherapy for mRCC:

- Interferon-alpha monotherapy is no longer recommended as first-line therapy for mRCC.
- Interferon alpha monotherapy still has a role only in selected cases (good performance status, clear cell type, lung metastases only).
- Interleukin-2 has more side effects than INF- α .
- High-dose IL-2 is associated with durable complete responses in a limited number of patients.
- Interleukin-2 can be considered as monotherapy in selected patients with a good prognosis profile.
- A combination of bevacizumab and IFN- α is more effective than IFN α in treatment-naïve, low-risk and intermediate-risk tumours.
- Vaccination therapy with tumour antigen 5T4 showed no survival benefit over the first-line standard of care.

Recommendations:

| Recommendations for immunotherapy | GR |
|---|-----------|
| Monotherapy with IFN- α or high-dose bolus IL-2 can only be recommended as a first-line treatment for mRCC in selected patients with clear cell histology and good prognostic factors. | A |
| Bevacizumab + IFN- α is recommended as first-line therapy in low-risk and intermediate-risk patients. | B |
| Cytokine combinations, with or without additional chemotherapy, do not improve the overall survival in comparison with monotherapy. | A |

Drugs targeting VEGF or mammalian target of rapamycin (mTOR):

- Recent advances in molecular biology have led to the development of several novel agents for the treatment of mRCC.

- In sporadic clear cell RCC, HIF accumulation due to von Hippel-Lindau (VHL) inactivation results in overexpression of VEGF and PDGF, both of which promote neoangiogenesis and contributes to the development and progression of RCC.
- At present, several targeting drugs have been approved both in the USA and in Europe for the treatment of mRCC:
- Their general inability to produce durable CRs necessitates chronic treatment in most patients
- The benefits must therefore be weighed against the overall burden of treatment, including acute and chronic toxicity, time and cost.

Recommendations:

| Recommendations | GR |
|---|-----------|
| Sunitinib is recommended as first-line therapy in favorable-risk and intermediate-risk patients. | A |
| Bevacizumab + IFN- α is recommended as first-line therapy in favourable-risk and intermediate-risk patients. | A |
| Sorafenib is recommended as a second-line treatment for mRCC after cytokine failure. | A |
| Pazopanib is recommended as first-line or after cytokine failure in favourable-risk and intermediate-risk patients. | A |
| Temsirolimus is recommended as first-line treatment in poor-risk patients. | A |
| Everolimus is recommended as second-line treatment after failure of tyrosine kinase inhibitors. | A |
| Axitinib is recommended as second-line treatment after failure of cytokines or tyrosine kinase inhibitors. | A |

EAU recommendations for first and second line systemic therapy in mRCC:

| Treatment | Risk or prior treatment | Recommended agent |
|------------------|--------------------------------|---|
| First-line | Low- or intermediate-risk mRCC | Sunitinib Bevacizumab + IFN- α Pazopanib |
| | High-risk mRCC | Temsirolimus |
| Second-line | Prior cytokine therapy | Sorafenib Pazopanib |
| | Prior VEGFR therapy | Everolimus |
| | Prior mTOR inhibitor therapy | Clinical trials |

Surveillance following surgery for RCC:

- The aim of surveillance is to detect either local recurrence or metastatic disease while the patient is still surgically curable.
- There is no evidence for whether early versus later diagnosis of recurrence improves survival.
- Depending on the availability of new effective treatments, more strict follow-up schedules may be required, particularly as there is a higher local recurrence rate after cryotherapy and RFA.
- At present there is no evidence-based standard for the follow-up of patients with RCC as well as the optimal duration of follow-up.
- It is therefore a need for a surveillance algorithm that monitors patients after treatment for RCC that recognises not only the patient's risk profile but also treatment efficacy.

Algorithm for surveillance following treatment for RCC taking into account patient risk profile and treatment efficacy

| Risk profile | Treatment | Surveillance | | | | | | |
|--------------|----------------|--------------|--------|---------|---------|---------|---------|----------------------|
| | | 6 months | 1 year | 2 years | 3 years | 4 years | 5 years | After 5 years |
| Low | RN/PN only | US | CT | US | CT | US | CT | Discharge |
| Intermediate | RN/PN/cryo/RFA | CT | US | CT | US | CT | CT | CT alternate 2 years |
| High | RN/PN/cryo/RFA | CT | CT | CT | CT | CT | CT | CT alternate years |

Recommendations:

| Recommendations | LE | GR |
|---|----|----|
| Surveillance after treatment for RCC should be based on a patient's risk factors and the type of treatment delivered. | | C |
| For low-risk disease, CT/MRI can be used infrequently. | 4 | C |
| In the intermediate-risk group, intensified follow-up should be performed, including CT/MRI scans at regular intervals in accordance with a risk-stratified nomogram. | 4 | C |
| In high-risk patients, the follow-up examinations should include routine CT/MRI scans. | 4 | C |

| | | |
|--|--|---|
| There is an increased risk of intrarenal recurrences in larger-size (> 7 cm) tumours treated with nephron-sparing surgery, or when there is a positive margin. Follow-up should be intensified in these patients | | C |
|--|--|---|

9.5 Testicular Cancer

Testicular cancer

Background:

- Testicular cancer represents between 1% and 1.5% of male neoplasms and 5% of urological tumours in general, with 3-10 new cases occurring per 100,000 males/per year.
- Data from the Surveillance Epidemiology and End Results (SEER) Program during the years 1973 to 1998 show a continuing increased risk among Caucasian men in the USA only for seminoma.
- Only 1-2% of cases are bilateral at diagnosis.
- There is a clear predominance (90-95%) of germ cell tumours
- Peak incidence is in the third decade of life for non-seminoma, and in the fourth decade for pure seminoma.
- Familial clustering has been observed, particularly among siblings
- Epidemiological risk factors for the development of testicular tumours are:
 - history of cryptorchidism or undescended testis (testicular dysgenesis syndrome)
 - Klinefelter's syndrome
 - familial history of testicular tumours among first-grade relatives (father/brothers)
 - the presence of a contralateral tumour or TIN
 - infertility.

PATHOLOGICAL CLASSIFICATION

The recommended pathological classification (modified from the 2004 version of the World Health Organization [WHO] guidance) is shown below:

- **Germ cell tumours**
 - Intratubular germ cell neoplasia, unclassified type (IGCNU)
 - Seminoma (including cases with syncytiotrophoblastic cells)
 - Spermatocytic seminoma (mention if there is sarcomatous component)
 - Embryonal carcinoma
 - Yolk sac tumour
 - Choriocarcinoma
 - Teratoma (mature, immature, with malignant component)
 - Tumours with more than one histological type (specify percentage of individual components)
- **Sex cord/gonadal stromal tumours**
 - Leydig cell tumour
 - Malignant Leydig cell tumour
 - Sertoli cell tumour - lipid-rich variant - sclerosing - large cell calcifying
 - Malignant Sertoli cell tumour
 - Granulosa cell tumour - adult type - juvenile type

- Thecoma/fibroma group of tumours
- Other sex cord/gonadal stromal tumours
 - incompletely differentiated
 - mixed
- Tumours containing germ cell and sex cord/gonadal stromal (gonadoblastoma)
- **Miscellaneous non-specific stromal tumours**
 - Ovarian epithelial tumours
 - Tumours of the collecting ducts and rete testis
 - Tumours (benign and malignant) of non-specific stroma.

DIAGNOSIS:

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
- Microscopic haematuria in adults over 50 years.
- **Swellings in the body of the testis.**
- Palpable renal masses.
- Solid renal masses found on imaging.
- Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
- A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.
- Any suspected penile cancer.

- **Clinical examination.**

- **Testicular imaging:**

- US serves to confirm the presence of a testicular mass and to explore the contralateral testis.
- Its sensitivity in detecting a testicular tumour is almost 100%, and it has an important role in determining whether a mass is intra- or extratesticular
- Ultrasound of the testis has to be performed in young men without a palpable testicular mass who have retroperitoneal or visceral masses or elevated serum human chorionic gonadotrophin (hCG) or AFP or in men consulting for fertility problems
- Ultrasound may be recommended in the follow-up of patients at risk, when other risk factors than microlithiasis are present (e.g. size < 12 ml or atrophy, inhomogeneous parenchyma). Solely, the presence of microlithiasis is not an indication for a regular scrotal US
- MRI of the scrotum offers a sensitivity of 100% and a specificity of 95-100%, but its high cost does not justify its use for diagnosis.

- **Serum tumour markers at diagnosis**

- AFP (produced by yolk sac cells)
- hCG (expression of trophoblasts)
- LDH (lactate dehydrogenase).

- **Inguinal exploration and orchidectomy**

- **Organ-sparing surgery:** indicated in:

- In synchronous bilateral testicular tumours
- metachronous contralateral tumours
- in a tumour in a solitary testis with normal pre-operative testosterone levels
- organ preserving surgery can be performed when the tumour volume is less than 30% of the testicular volume and surgical rules are respected
- the rate of associated TIN is high (at least up to 82%)
- all patients must be treated with adjuvant radiotherapy (16-20 Gy) at some point.

STAGING

Serum tumour markers:

- The mean serum half-life of AFP and hCG is 5-7 days and 2-3 days, respectively.
- Tumour markers have to be re-evaluated after orchidectomy to determine half-life kinetics.
- Marker decline in patients with clinical stage I disease should be assessed until normalisation has occurred.
- Markers before start of chemotherapy are important to classify the patient according to the International Germ Cell Cancer Collaborative Group (IGCCCG) risk classification.
- The persistence of elevated serum tumour markers after orchidectomy might indicate the presence of metastatic disease (macro- or microscopically), while the normalisation of marker levels after orchidectomy does not rule out the presence of tumour metastases.
- During chemotherapy, the markers should decline; persistence has an adverse prognostic value

Radiological staging:

- Abdominopelvic CT offers a sensitivity of 70-80% in determining the state of the retroperitoneal nodes.
- Magnetic resonance imaging (MRI) produces similar results to CT in the detection of retroperitoneal nodal enlargement.
- MRI can be helpful when abdominopelvic CT or US are inconclusive, when CT is contraindicated because of allergy to contrast media, or when the physician or the patient are concerned about radiation dose.
- There is no evidence to support the use of the fluorodeoxyglucose (FDG)-PET in the staging of testis cancer.
- It is recommended in the follow-up of patients with seminoma with any residual mass at least 6 weeks after chemotherapy in order to decide on watchful waiting or active treatment.
- The use of FDGPET is not recommended in the re-staging of patients with non-seminomatous tumours after chemotherapy.

Recommended tests for staging at diagnosis

| Test | Recommendation | GR |
|-----------------------|---|----|
| Serum tumour markers | AFP hCG LDH | A |
| Abdominopelvic CT | All patients | A |
| Chest CT | All patients | A |
| Testis US (bilateral) | All patients | A |
| Bone scan | In case of symptoms | |
| Brain scan (CT/MRI) | In case of symptoms and patients with metastatic disease with multiple lung metastases and high beta-hCG values | |

Further investigations

| | |
|--|---|
| Fertility investigations:
Total testosterone
LH
FSH
Semen analysis | B |
| Sperm banking should be offered | A |

TNM classification for testicular cancer (UICC, 2009):

| | |
|-----------|---|
| pT | Primary tumour |
| pTX | Primary tumour cannot be assessed |
| pT0 | No evidence of primary tumour (e.g. histological scar in testis) |
| pTis | Intratubular germ cell neoplasia (testicular intraepithelial neoplasia) |
| pT1 | Tumour limited to testis and epididymis without vascular/lymphatic invasion: tumour may invade tunica albuginea but not tunica vaginalis |
| pT2 | Tumour limited to testis and epididymis with vascular/lymphatic invasion, or tumour extending through tunica albuginea with involvement of tunica vaginalis |
| pT3 | Tumour invades spermatic cord with or without vascular/lymphatic invasion |
| pT4 | Tumour invades scrotum with or without vascular/lymphatic invasion |
| N | Regional lymph nodes clinical |
| NX | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph node metastasis |
| N1 | Metastasis with a lymph node mass 2 cm or less in greatest dimension or multiple lymph nodes, none more than 2 cm in greatest dimension |

| | | | | | |
|-------------------------------|--|-----|--------------|-----|--------------|
| N2 | Metastasis with a lymph node mass more than 2 cm but not more than 5 cm in greatest dimension, or multiple lymph nodes, any one mass more than 2 cm but not more than 5 cm in greatest dimension | | | | |
| N3 | Metastasis with a lymph node mass more than 5 cm in greatest dimension | | | | |
| pN Pathological | | | | | |
| pNX | Regional lymph nodes cannot be assessed | | | | |
| pN0 | No regional lymph node metastasis | | | | |
| pN1 | Metastasis with a lymph node mass 2 cm or less in greatest dimension and 5 or fewer positive nodes, none more than 2 cm in greatest dimension | | | | |
| pN2 | Metastasis with a lymph node mass more than 2 cm but not more than 5 cm in greatest dimension; or more than 5 nodes positive, none more than 5 cm; or evidence of extranodal extension of tumour | | | | |
| pN3 | Metastasis with a lymph node mass more than 5 cm in greatest dimension | | | | |
| M Distant metastasis | | | | | |
| MX | Distant metastasis cannot be assessed | | | | |
| M0 | No distant metastasis | | | | |
| M1 | Distant metastasis | | | | |
| M1a | Non-regional lymph node(s) or lung | | | | |
| M1b | Other sites | | | | |
| S Serum tumour markers | | | | | |
| Sx | Serum marker studies not available or not performed | | | | |
| S0 | Serum marker study levels within normal limits | | | | |
| | LDH (U/l) | | hCG (mIU/mL) | | AFP (ng/mL) |
| S1 | < 1.5 x N | and | < 5,000 | and | < 1,000 |
| S2 | 1.5-10 x N | or | 5,000-50,000 | or | 1,000-10,000 |
| S3 | > 10 x N | or | > 50,000 | or | > 10,000 |

Prognostic-based staging system for metastatic germ cell cancer (International Germ Cell Cancer Collaborative Group (IGCCCG):

| | |
|---|---|
| <p>Good-prognosis group</p> <p>Non-seminoma (56% of cases)</p> <p>5-year PFS 89%</p> <p>primary</p> <p>5-year survival 92%</p> <p>metastases</p> | <p>All of the following criteria:</p> <ul style="list-style-type: none"> • Testis/retroperitoneal • No non-pulmonary visceral • AFP < 1,000 ng/mL • hCG < 5,000 IU/L (1,000 |
|---|---|

| | |
|---|---|
| ng/mL) | • LDH < 1.5 x ULN |
| <p>Seminoma (90% of cases)</p> <p>5-year PFS 82%</p> <p>5-year survival 86%</p> <p>metastases</p> | <p>All of the following criteria:</p> <ul style="list-style-type: none"> • Any primary site • No non-pulmonary visceral • Normal AFP • Any hCG • Any LDH |
| <p>Intermediate prognosis group</p> <p>Non-seminoma (28% of cases)</p> <p>primary</p> <p>5-year PFS 67%</p> <p>ng/mL or</p> <p>5-year survival 72%</p> <p>metastases</p> | <ul style="list-style-type: none"> • Testis/retroperitoneal • AFP 1,000 - 10,000 • No non-pulmonary visceral • hCG 5,000 - 50,000 IU/L or • LDH 1.5 - 10 x ULN |
| <p>Seminoma (10% of cases)</p> <p>5 years PFS 75%</p> <p>5-year survival 80%</p> <p>metastases</p> | <p>All of the following criteria:</p> <ul style="list-style-type: none"> • Any primary site • Non-pulmonary visceral • Normal AFP • Any hCG • Any LDH |
| <p>Poor prognosis group</p> <p>Non-seminoma (16% of cases)</p> <p>5-year PFS 41%</p> <p>5-year survival 48%</p> <p>metastases</p> | <p>Any of the following criteria:</p> <ul style="list-style-type: none"> • Mediastinal primary • Non-pulmonary visceral • AFP > 10,000 ng/mL or • hCG > 50,000 IU/L |
| (10,000 ng/mL) or • LDH > 10 x ULN | |
| Seminoma prognosis | No patients classified as poor |

Prognostic factors for occult metastatic disease in testicular cancer

| | For seminoma | For non-seminoma |
|--|-------------------------------|----------------------------|
| Pathological (for stage I) | | |
| Histopathological type | • Tumour size (> 4 cm) | • vascular/lymphatic |
| invasion of the | | primary tumour |
| | • Invasion of the rete testis | • Proliferation rate > 70% |
| embryonal | | • Percentage of |
| | | carcinoma > 50% |
| Clinical (for metastatic disease) | | |
| <ul style="list-style-type: none"> • Primary location • Elevation of tumour marker levels • Presence of non-pulmonary visceral metastasis | | |

TREATMENT: STAGE I GERM CELL TUMOURS

Supranetwork Testicular Team

- The minimum catchment population for the specialist treatment of testicular cancer is two million.
- Supranetwork teams for testicular cancer deliver supranetwork care for their referring catchment.
- The minimum catchment population of two million means that currently no cancer network in England should host more than one such team on the basis of their own network population and some networks will not be able to host a team, needing to refer such patients to a team in a neighbouring network.
- In order that supranetwork teams for testicular cancer experience the full range of practice for the disease, they are required to deliver all of the care including local care to at least part of their network, usually the local catchment of their host locality. For testicular teams to add their full potential value to patient care, some surgical procedures and their immediate post-op care are required to be restricted to certain named hospitals.

Stage I seminoma

- After modern staging procedures, about 15-20% of stage I seminoma patients have subclinical metastatic disease, usually in the retroperitoneum, and will relapse after orchidectomy alone.

Surveillance

- The actuarial relapse rate is in the order of 15-20% at 5 years, and most of the relapses are first detected in infra-diaphragmatic lymph nodes.
- In patients with low risk the recurrence under surveillance is as low as 6%.
- Chemotherapy, according to the IGCCCG classification, is a possible treatment for seminoma relapse under surveillance.
- The overall cancer-specific survival rate reported under surveillance performed by experienced centres is 97-100% for seminoma stage I.
- The main drawback of surveillance is the need for more intensive follow-up, especially with repeated imaging examinations of the retroperitoneal lymph nodes, for at least 5 years after orchidectomy.
- There is a small but clinically significant risk of relapse more than 5 years after orchidectomy for stage I seminoma, which supports the need for long term surveillance.

Adjuvant chemotherapy

- Compared with adjuvant radiotherapy, studies did not show a significant difference with regard to recurrence rate, time to recurrence and survival after a median follow-up of 4 years.
- Adjuvant carboplatin therapy using a dosage of one course AUC 7 is an alternative to radiotherapy or surveillance in stage I seminoma.

Adjuvant radiotherapy

- Seminoma cells are extremely radiosensitive.
- Adjuvant radiotherapy to a para-aortic (PA) field or to a hockeystick field (para-aortic and ipsilateral iliac nodes), with moderate doses (total 20-24 Gy), will reduce the relapse rate to 1-3%.
- After modern radiotherapy, nearly all relapses will first occur outside the irradiated field (supradiaphragmatic lymph nodes or in the lungs).
- Adjuvant irradiation of supradiaphragmatic lymph nodes is not indicated in seminoma stage I. With regard to the irradiation dose, the MRC recently finished a large randomised trial of 20 Gy versus 30 Gy PA radiation in stage I seminoma that showed equivalence for both doses in terms of recurrence rates.

- The rate of severe radiation-induced long-term toxicity is < 2%. Moderate chronic gastrointestinal (GI) side-effects are seen in ~5% of patients, and moderate acute GI toxicity in ~60%.

Retroperitoneal lymph node dissection (RPLND)

- Post RPLND incidence of retroperitoneal relapses is high (9.5%).
- This policy should not be recommended in stage I seminoma.

Risk-adapted treatment

- Using tumour size > 4 cm and rete testis invasion, patients with seminoma stage I may be subdivided into a low-and high-risk group of occult metastatic disease.
- Patients with and without both risk factors have a risk of occult disease of 32% and 12%, respectively.
- These risk factors were introduced by an analysis of retrospective trials (29). A prospective trial based on these risk factors (no risk factors: surveillance; both risk factors: two courses of carboplatin AUC 7) showed the feasibility of a risk-adapted approach.
- Early data with limited follow-up indicate that patients without either risk factor have a 6.0% risk of relapse at 5 years.
- Patients in the high risk group treated with carboplatin experienced a 1.4% relapse rate at mean follow-up of 34 months.
- However, given the fact that cure is achieved in ~100% in patients with stage I seminoma whatever therapy used (adjuvant radiotherapy, adjuvant chemotherapy, or surveillance) and that the relapse rate in large surveillance series not using risk factors is ~15-20%, indicates a risk of over-treatment. Therefore, the therapeutic decision should be shared with an informed patient.

Guidelines for the treatment of seminoma stage I

| | GR |
|--|-----------|
| Surveillance is the recommended management option (if facilities available and patient compliant). | A |
| Carboplatin-based chemotherapy (one course at AUC 7) is recommended. | B |
| Adjuvant treatment is not recommended for patients at very low risk. | A |
| Radiotherapy is not recommended as adjuvant treatment. | A |

NSGCT stage I

- Up to 30% of NSGCT patients with clinical stage I (CS1) disease have subclinical metastases and will relapse if surveillance alone is applied after orchidectomy

Surveillance

- The largest reports of the surveillance strategy indicate a cumulative relapse rate of ~30%, with 80% of relapses occurring during the first 12 months of follow-up, 12% during the second year and 6% during the third year, decreasing to 1% during the fourth and fifth years, and occasionally even later.
- About 35% of relapsing patients have normal levels of serum tumour markers at relapse.
- About 60% of relapses are in the retroperitoneum. Despite very close follow-up, 11% of relapsing patients presented with large-volume recurrent disease.
- Based on the overall cancer-specific survival data, surveillance within an experienced surveillance programme may be offered to patients with non-risk stratified clinical stage I non-seminoma as long as they are compliant and informed about the expected recurrence rate as well as the salvage treatment.

Primary chemotherapy

- Two courses of chemotherapy with cisplatin, etoposide and bleomycin (PEB) as primary treatment for high-risk patients (having ~50% risk of relapse) are recommended, with a relapse rate of only 2.7% was reported, with very little long-term toxicity.
- Adjuvant chemotherapy do not seem to adversely affect fertility or sexual activity.
- Long term (> 20 years) side effects of adjuvant chemotherapy in this setting are currently unknown.
- It is important to be aware of slow-growing retroperitoneal teratomas after primary chemotherapy.

Risk-adapted treatment

- It is based on the risk factor vascular invasion.
- Risk-adapted treatment is an equally effective alternative treatment of choice in CS1 NSGCT.
- If applied, patients with vascular invasion are recommended to undergo adjuvant chemotherapy with two cycles of PEB, and patients without vascular invasion are recommended to undergo surveillance.
- The Swedish-Norwegian Testicular Cancer Project (SWENOTECA) recently showed that in a large population-based study with a risk-adapted approach within a management

programme and a median follow-up of 4.7 years, the relapse rate was 3.2% for patients with vascular invasion treated with only one adjuvant PEB.

- Taken together, ~300 patients with high-risk CS I have been adjuvantly treated with 1 x PEB with a follow-up of > 5 yrs. As long as 1 x PEB has not been proven superior or at least equivalent to 2 courses PEB, this adjuvant treatment cannot be recommended outside of a clinical trial or a prospective registry.

Retroperitoneal lymph node dissection

- If performed, ~30% of patients are found to have retroperitoneal lymph node metastases, which corresponds to pathological stage II (PS2).
- 10% of the PS1 patients relapse at distant sites.
- The main predictor of relapse in CS1 NSGCT is histopathological evidence of vascular invasion by tumour cells in, or near, the primary tumour in the testis.
- For CS1, patients without vascular invasion have only a 15-20% risk of relapse on surveillance, compared with a 50% relapse rate in patients with vascular invasion.
- The risk of relapse for PS1 patients is < 10% for those without vascular invasion and ~30% for those with vascular invasion.
- If two (or more) courses of cisplatin-based chemotherapy are given adjuvant to RPLND in PS2 cases, the relapse rate is reduced to < 2%, including teratoma relapse).
- The risk of retroperitoneal relapse after a properly performed nerve-sparing RPLND is very low (< 2%), as is the risk of ejaculatory disturbance or other significant side-effects.
- If there is a rare indication to perform a staging RPLND, a laparoscopic or robot-assisted RPLND is feasible in expert hands. This minimal-invasive approach cannot be recommended as a standard approach outside of a specialised laparoscopic centre.
- In a randomised comparison of RPLND with one course of PEB chemotherapy, adjuvant chemotherapy significantly increased the 2-year recurrence-free survival to 99.41% (confidence interval [CI] 95.87%, 99.92%) as opposed to surgery, which had a 2-year recurrence-free survival of 92.37% (CI 87.21%, 95.50%).
- Therefore, one course of adjuvant PEB is superior to RPLND with regard to recurrence rates in patients unstratified for risk factors. In the SWENOTECA data mentioned in section 7.3.3 it was also found that one adjuvant PEB reduced the number of recurrences to 3.2% in the high-risk and to 1.4% in the low-risk patients.

CS1S with (persistently) elevated serum tumour markers

- If the marker level increases after orchidectomy, the patient has residual disease. If RPLND is performed, up to 87% of these patients have pathologically documented nodes in the retroperitoneum (165). An

- US examination of the contralateral testicle must be performed, if this was not done initially.
- The treatment of true CS1S patients is still controversial. They may be treated with three courses of primary PEB chemotherapy and with follow-up as for CS1B patients after primary chemotherapy, or by RPLND. The presence of vascular invasion may strengthen the indication for primary chemotherapy as most CS1S with vascular invasion will need chemotherapy sooner or later anyway.

Guidelines for the treatment of NSGCT stage I

| NSGCT stage 1 | GR |
|--|-----------|
| CS1 risk-adapted treatments based on vascular invasion or surveillance without using risk factors are recommended treatment options. | A |
| Risk-adapted treatments for CS1 based on vascular invasion | |
| CS1A (pT1, no vascular invasion): low risk | |
| If the patient is willing and able to comply with a surveillance policy, long-term (at least 5 years) close follow-up should be recommended. | A |
| In low-risk patients not willing (or suitable) to undergo surveillance, adjuvant chemotherapy or nerve-sparing RPLND are treatment options. If RPLND reveals PN+ (nodal involvement) disease, chemotherapy with two courses of PEB should be considered. | A |
| CS1B (pT2-pT4): high risk | |
| Primary chemotherapy with two courses of PEB should be recommended (one course of PEB within a clinical trial or registry). | A |
| Surveillance or nerve-sparing RPLND in high-risk patients remains an option for those not willing to undergo adjuvant chemotherapy. If pathological stage II is revealed at RPLND, further chemotherapy should be considered. | A |

TREATMENT: METASTATIC GERM CELL TUMOURS

The treatment of metastatic germ cell tumours depends on:

- the histology of the primary tumour;
- prognostic groups as defined by the IGCCCG.

Low-volume metastatic disease (stage IIA/B)**Seminoma:**

- The standard treatment for stage IIA/B seminoma has been radiotherapy.
- The radiation dose delivered in stage IIA and IIB is approximately 30 Gy and 36 Gy, respectively.
- The standard radiation field compared with stage I will be extended from the PA region to the ipsilateral iliac field (the hockey-stick field).
- Overall survival is almost 100%. Conversely, dose reduction to 27 Gy has been associated with 11% of relapses.

Non-seminoma

- Initial chemotherapy is recommended in all advanced cases of NSGCT (except for stage II NSGCT disease without elevated tumour markers, which alternatively can be managed by primary RPLND or surveillance to clarify stage).
- If surveillance is chosen, one follow-up after 6 weeks is indicated to document whether the lesion is growing, remaining stable or shrinking.
 - A shrinking lesion is likely to be of non-malignant origin and should be observed further.
 - A stable or growing lesion indicates either teratoma or an undifferentiated malignant tumour.
 - If the lesion is growing without a corresponding increase in the tumour markers AFP or beta-hCG, RPLND should be performed by an experienced surgeon because of suspected teratoma.
 - Patients with a growing lesion and a concomitant increase in the tumour markers AFP or beta-hCG should not undergo surgery; they require chemotherapy with PEB according to the treatment algorithm for patients with metastatic disease and IGCCCG recommendations.
- An alternative to the surveillance strategy in marker-negative II A/B non-seminoma with suspicion of an undifferentiated malignant tumour is a (CT-guided) biopsy, if technically possible.
- There is insufficient published data on PET scans in this situation.

- Patients not willing to undergo primary chemotherapy have the option of primary nerve-sparing RPLND with adjuvant chemotherapy (two cycles of PEB) in case of metastatic disease.
- Primary chemotherapy and primary RPLND are comparable options in terms of outcome but side-effects and toxicity are different, allowing for involvement of the patient in selecting the treatment of choice. The cure rate with either approach will be close to 98%.

Advanced metastatic disease

- The primary treatment of choice for advanced disease is three or four cycles of PEB combination chemotherapy, depending on the IGCCCG risk classification. This regimen has proven superiority to cisplatin, vinblastine and bleomycin (PVB) in patients with advanced disease.
- Good prognosis group (IGCCCG Classification):
 - standard treatment consists of three cycles of PEB
 - in very selected cases where bleomycin is contraindicated, four cycles of EP.
- Intermediate prognosis group (5-year survival rate of ~80%):
 - four cycles of PEB as standard treatment.
- Poor prognosis group (5-year progression-free survival is 45-50%):
 - standard treatment consists of four cycles of PEB, or etoposide and ifosfamide (PEI) with similar effect but more toxicity.
 - poor-prognosis patients should be transferred to a reference centre because a better outcome was reported for intermediate and poor prognosis patients who had been treated within a clinical trial in a high volume centre.
 - There are no general recommendations for treatment modifications for patients with a poor general condition (Karnofsky < 50%) or extended liver infiltration (> 50%).
 - Patients with extended pulmonary infiltration are at risk for acute respiratory distress syndrome: adapting the doses of the PEB regimen in the first cycle of chemotherapy (only 3 days of EP without bleomycin) was suggested to reduce the risk of early death in this setting.

Residual tumour resection

- A residual mass of seminoma should not be primarily resected, irrespective of the size, but controlled by imaging investigations and tumour markers.
- FDG-PET has a high negative predictive value in patients with residual masses after treatment of seminoma but false positive results can be a problem and scans should not be performed < 2 months after chemotherapy.

- In patients with residuals of > 3 cm, FDG-PET should be performed in order to gain more information on the viability of these residuals.
- In patients with residuals of < 3 cm, the use of FDG-PET is optional.
- On progression, salvage therapy is indicated (chemotherapy, salvage surgery, radiotherapy) .
- In patients with concurrent hCG elevation, progressing seminoma after first-line chemotherapy should be treated by salvage chemotherapy (or radiotherapy if only small volume recurrence is present).
- Progressing patients without hCG progression should undergo histological verification (e. g. by biopsy or open surgery) before salvage chemotherapy is given. In the case of non-seminoma and complete remission after chemotherapy (no tumour visible), residual tumour resection is not indicated.
- The long-term relapse rate in this patient group is 6-9%, however, one third of the late relapsing patients will not survive.
- In the case of any visible residual mass and marker normalisation, surgical resection is indicated. In patients with lesions < 1 cm, there still is an increased risk of residual cancer or teratoma although the role of surgery in this setting is debated.
- In persistent larger volume retroperitoneal disease, all areas of primary metastatic sites must be completely resected within 4-6 weeks of completion of chemotherapy.
- If technically feasible, a nerve-sparing procedure should be performed.
- Overall, following PEB induction chemotherapy, only 10% of residual masses contain viable cancer, 50% contain mature teratoma, and 40% contain necrotic-fibrotic tissue.
- As yet, no imaging investigations, including PET or a prognosis model, are able to predict histological differentiation of the non-seminomatous residual tumour. Thus, residual tumour resection is mandatory in all patients with residual disease > 1 cm.
- The extent of surgery should be based on the risk of relapse of an individual patient and quality of life issues. If possible, all the masses should be resected, because a complete resection, in the setting of viable malignant cells, is more critical than recourse to post-operative chemotherapy.
- There is growing evidence that “template” resections in selected patients yield equivalent long-term results compared to bilateral systematic resections in all patients.
- Mere resection of the residual tumour (so called “lumpectomy”) should not be performed.
- The histology may diverge in different organ sites. Resection of contralateral pulmonary lesions is not mandatory in case pathologic examination of the lesions from the first lung shows complete necrosis.

Consolidation chemotherapy after secondary surgery

- After resection of necrosis or mature/immature teratoma, no further treatment is required.

- In the case of incomplete resection of other germ cell tumour pathologies, two adjuvant cycles of conventionally dosed cisplatin-based chemotherapy may be given in certain subgroups (e.g. 'poor prognosis' patients).
- After complete resection of 'vital' tumour < 10% of the total volume, especially in patients with an initially good prognosis group according to IGCCCG, the relapse rate is very low and adjuvant chemotherapy is not beneficial for preventing further relapse.
- The prognosis will definitely deteriorate if vital malignant neoplasm is found in resection specimens after second- and third-line chemotherapy. In this latter situation, post-operative chemotherapy is not indicated and is unable to improve the prognosis.

Systemic salvage treatment for relapse or refractory disease

- Cisplatin-based combination salvage chemotherapy will result in long-term remissions for about 50% of the patients who relapse after first-line chemotherapy (255). The.
- Regimens of choice are four cycles of PEI/VIP (etoposide, ifosfamide, cisplatin), four cycles of TIP (paclitaxel, ifosfamide, cisplatin) or four cycles of VeIP (vinblastine, ifosfamide, cisplatin)
- Due to the lack of evidence, it is therefore of the utmost importance that these rare patients are treated within clinical trials and at experienced centres.

Treatment of brain metastases

- Brain metastases occur in the frame of a systemic relapse and rarely as an isolated relapse.
- The longterm survival of patients presenting with brain metastases at initial diagnosis is poor (30-40%)
- 5-year survival-rate for brain metastasis as a recurrent disease is even poorer (2-5%)
- Chemotherapy is the initial treatment in this case, and some data support the use of consolidation radiotherapy, even in the case of a total response after chemotherapy.
- Surgery can be considered in the case of a persistent solitary metastasis, depending on the systemic state, the histology of the primary tumour and the location of the metastasis.

FOLLOW-UP AFTER CURATIVE THERAPY

Recommended follow-up schedule in a surveillance policy: stage I non-seminoma

| Procedure | Year | Year | Year | Year |
|-----------|------|------|------|------|
|-----------|------|------|------|------|

| | 1 | 2 | 3-5 | 6-10 |
|--------------------------------|----------------------------|----------|------------|-------------|
| Physical examination | 4 times | 4 times | Once/year | Once/year |
| Tumour markers | 4 times | 4 times | Once/year | Once/year |
| Plain radiography chest | Twice | Twice | | |
| Abdominopelvic CT | Twice (at 3 and 12 months) | | | |

Recommended follow-up schedule after retroperitoneal lymphadenectomy or adjuvant chemotherapy: stage I non-seminoma

| Procedure | Year | Year | Year | Year |
|--------------------------------|-------------|-------------|-------------|-------------|
| | 1 | 2 | 3-5 | 6-10 |
| Physical examination | 4 times | 4 times | Once/year | Once/year |
| Tumour markers | 4 times | 4 times | Once/year | Once/year |
| Plain radiography chest | Twice | Twice | | |
| Abdominopelvic CT | Once | Once | | |

Recommended follow-up schedule for post-orchidectomy surveillance, radiotherapy or chemotherapy: stage I seminoma

| Procedure | Year | Year | Year | Year |
|--------------------------------|-------------|-------------|-------------|-------------|
| | 1 | 2 | 3-5 | 6-10 |
| Physical examination | 4 times | 4 times | Once/year | Once/year |
| Tumour markers | 4 times | 4 times | Once/year | Once/year |
| Plain radiography chest | Twice | Twice | | |
| Abdominopelvic CT | Once | Once | | |

Recommended minimum follow-up schedule in advanced NSGCT and seminoma

| Procedure | Year | Year | Year | Year |
|-----------------------------|-------------|-------------|-------------|-------------------|
| | 1 | 2 | 3-5 | Thereafter |
| Physical examination | 4 times | 4 times | Twice/year | Once/year |
| Tumour markers | 4 times | 4 times | Twice/year | Once/year |
| Plain radiography | Twice | Twice | Twice/year | Once/year |

| | | | | |
|-------------------|--------------|--------------|--------------|--------------|
| chest | | | | |
| Abdominopelvic CT | Twice | Twice | As indicated | As indicated |
| Chest CT | As indicated | As indicated | As indicated | As indicated |
| Brain CT | As indicated | As indicated | As indicated | As indicated |

9.6 Upper Urinary Tract Urothelial Cell Carcinomas

Epidemiology:

- Upper urinary tract urothelial cell carcinomas (UUT-UCCs) are uncommon and account for only 5-10% of urothelial carcinomas
- The estimated annual incidence of UUT-UCCs in Western countries is about one or two new cases per 100,000 inhabitants.
- Pyelocaliceal tumours are about twice as common as ureteral tumours.
- In 8-13% of cases, concurrent bladder cancer is present.
- Recurrence of disease in the bladder occurs in 30-51% of UUT-UCC patients
- Recurrences in the contralateral upper tract are observed in 2-6%.
- 60% of UUT-UCCs are invasive at diagnosis.
- Upper urinary tract urothelial cell carcinomas have a peak incidence in people in their 70s and 80s, and UUT-UCC is three times more prevalent in men than in women.
- There are familial/hereditary cases of UUT-UCCs linked to hereditary nonpolyposis colorectal carcinoma (HNPCC)

Risk factors:

- Tobacco and occupational exposure remain the principal exogenous risk factors for developing these tumours. Exposure to tobacco increases the relative risk of developing a UUT-UCC from 2.5 to 7
- UUT-UCC "amino tumours" are related to occupational exposure to certain aromatic amines. These aromatic hydrocarbons are used in many industries (e.g., dyes, textiles, rubber, chemicals, petrochemicals, and coal). They are responsible for the carcinogenicity of certain chemicals, including benzidine and β -naphthalene. The estimated risk (odds ratio) of developing UCC after exposure to aromatic amines is 8.3.
- Upper urinary tract tumours resulting from phenacetin consumption almost disappeared after the product was banned in the 1970s.
- Although the incidence of Balkan endemic nephropathy is also on the decline, roles have been proposed for aristolochic acid and the consumption of Chinese herbs in the physiopathology and induction, respectively, of this nephropathy.
- One polymorphism specific to UUT-UCC has been reported so far. A variant allele, SULT1A1*2, which reduces sulfotransferase activity, enhances the risk of developing UUT-UCC.

- Epidermoid carcinoma of the UUT is associated with chronic inflammatory and infectious disease arising from stones in the UUT.

TNM classification of UUT-UCC (2009)

| | |
|---------------------------------|--|
| T - Primary Tumour | |
| Tx | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| Ta | Non-invasive papillary carcinoma |
| Tis | Carcinoma in situ |
| T1 | Tumour invades subepithelial connective tissue |
| T2 | Tumour invades muscle |
| T3 | (Renal pelvis) Tumour invades beyond muscularis into peripelvic fat or renal parenchyma
(Ureter) Tumour invades beyond muscularis into periureteric fat |
| T4 | Tumour invades adjacent organs or through the kidney into perinephric fat |
| N - Regional Lymph Nodes | |
| Nx | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph-node metastasis |
| N1 | Metastasis in a single lymph node 2 cm or less in the greatest dimension |
| N2 | Metastasis in a single lymph node more than 2 cm but not more than 5 cm in the greatest dimension or multiple lymph nodes, none more than 5 cm in greatest dimension |
| N3 | Metastasis in a lymph node more than 5 cm in greatest dimension |
| M - Distant Metastasis | |
| M0 | No distant metastasis |
| M1 | Distant metastasis |

World Health Organization grading for bladder cancer

| |
|------------------------------------|
| 1973 WHO grading |
| <i>Urothelial papilloma</i> |
| Grade 1: well differentiated |
| Grade 2: moderately differentiated |
| Grade 3: poorly differentiated |

Diagnosis:

The following guidelines for urgent referral (within two weeks) have been published by the Department of Health:

- Macroscopic haematuria in adults.
- Microscopic haematuria in adults over 50 years.
- Swellings in the body of the testis.
- Palpable renal masses.
- Solid renal masses found on imaging.

- Elevated age-specific prostate specific antigen (PSA) in men with a 10 year life expectancy.
- A high PSA (>20ng/ml) in men with a clinically malignant prostate or bone pain.
- Any suspected penile cancer.

Imaging:

CT Urogram (CTU)

- CTU is the gold standard for exploration of the upper urinary tract and has replaced intravenous excretory urography.
- It must be conducted under optimal conditions, particularly with acquisition of an excretory phase.
- The detection rate of UUT-UCC is satisfactory for this type of imaging: 96% sensitivity and 99% specificity for polypoid lesions between 5 and 10 mm.
- Sensitivity drops to 89% for polypoid lesions < 5 mm and 40% for polypoid lesions < 3 mm.

Magnetic resonance imaging (MRI):

- MRI urography is indicated in patients who cannot be subjected to a CTU.
- The detection rate of MRI is 75% after contrast injection for tumours < 2 cm.
- MRI urography with contrast injection, however, remains contraindicated in selected patients with severe renal impairment (< 30 ml/min creatinine clearance) due to the risk of nephrogenic systemic fibrosis.
- Magnetic resonance urography without contrast is less helpful compared with CTU in diagnosing UUT-UCCs.

Cystoscopy and urinary cytology

- Positive urine cytology is highly suggestive of UUT-UCC when bladder cystoscopy is normal and if CIS of the bladder or prostatic urethra has been excluded.
- Cytology is less sensitive for UUT-UCC than for bladder tumours, even for high-grade lesions, and it should ideally be performed in situ (i.e. in the renal cavities).
- A positive cytology may be valuable in staging because it has been associated with muscle-invasive and nonorgan-confined disease.

Diagnostic ureteroscopy

- Ureteroscopy is a better approach to diagnose UUT-UCCs.
- Flexible ureteroscopy is especially useful when there is diagnostic uncertainty, when conservative treatment is being considered, or in patients with a solitary kidney.
- The possible advantages of ureteroscopy should be discussed in the preoperative assessment of any UUT-UCC patient. Combining ureteroscopic biopsy grade, ipsilateral hydronephrosis, and urinary cytology may help decision making on radical nephroureterectomy (RNU) versus endoscopic treatment

Guidelines for the diagnosis of UUT-UCC

| | |
|---|----|
| Recommendations | GR |
| Urinary cytology | A |
| Cystoscopy to rule out a concomitant bladder tumour | A |
| CTU | A |

Prognostic factors:

- Upper urinary tract urothelial cell carcinomas that invade the muscle wall usually have a very poor prognosis.
- The 5-yr specific survival is < 50% for pT2/pT3 and < 10% for pT4.
- Tumour stage and grade: the primary recognised prognostic factors.
- Age: poor prognosis with advanced age at diagnosis.
- Gender: no relation.
- Tumour location: no relation.
- Lymphovascular invasion: is present in approximately 20% of UUT-UCCs and an independent predictor of survival.
- Extensive tumour necrosis: is an independent predictor of clinical outcomes in patients who undergo RNU.
- The tumour architecture (e.g., papillary vs. sessile) of UUT-UCCs appears to be associated with prognosis after RNU. A sessile growth pattern is associated with worse outcomes (LE: 3) (8,63,69).
- The presence of concomitant CIS in patients with organ-confined UUT-UCC is associated with a higher risk of recurrent disease and cancer-specific .

Treatment**Localised disease:**

- Radical nephroureterectomy (RNU) with excision of the bladder cuff is the gold standard treatment for UUT-UCCs, regardless of the location of the tumour in the upper urinary tract
- The RNU procedure must comply with oncologic principles, which consist of preventing tumour seeding by avoiding entry into the urinary tract during tumour resection.
- Resection of the distal ureter and its orifice is performed because it is a part of the urinary tract with considerable risk of recurrence.
- After removal of the proximal part, it is almost impossible to image or approach it by endoscopy during follow-up.
- Plucking/endoscopic resection of the distal ureter (apart from ureteral stripping) are non-inferior to excision of the bladder cuff.
- A delay > 45 d between diagnosis and resection of the tumour constitutes a risk for disease progression.
- Lymph node dissection associated with RNU is of therapeutic interest and allows for optimal staging of the disease.
- Lymphadenectomy in pN+ allows for reduction of the tumour mass to guide patients towards adjuvant treatments.
- Anatomic sites of lymphadenectomy have not yet been clearly defined.
- The number of lymph nodes to be removed depends on the tumour location.

- Lymphadenectomy appears to be unnecessary in cases of TaT1 UUT-UCCs.
- The safety of laparoscopic RNU has not yet achieved final proof. In early experience, there were reports of retroperitoneal metastatic dissemination and dissemination along the trocar pathway when large tumours were manipulated in a pneumoperitoneal environment.
- Recent data, however, show a tendency towards equivalent oncologic results between laparoscopic RNU and open surgery.
- In addition, the laparoscopic approach appears to be superior to open surgery only with regard to functional outcomes.
- When considering laparoscopic RNU the following precautions must be considered:
 - Entering the urinary tract should be avoided.
 - Direct contact of the instruments with the tumour should be avoided.
 - Laparoscopic RNU must take place in a closed system.
 - Morcellation of the tumour should be avoided, and an endobag is necessary to extract the tumour.
 - The kidney and ureter must be removed en bloc with the bladder cuff.
 - Invasive, large (T3/T4 and/or N+/M+), or multifocal tumours are contraindications for laparoscopic RNU, until proven otherwise.

Guidelines for radical management of UUT-UCC: radical nephroureterectomy

| | |
|--|----|
| Indications for RNU for UUT-UCC | GR |
| Suspicion of infiltrating UUT-UCC on imaging | B |
| High-grade tumour (urinary cytology) | B |
| Multifocality (with two functional kidneys) | B |
| Techniques for RNU in UUT-UCC Open and laparoscopic access are equivalent in terms of efficacy | B |
| Bladder cuff removal is imperative | A |
| Several techniques for bladder cuff excision are acceptable except stripping | C |
| Lymphadenectomy is recommended in case of invasive UUT-UCC | C |

Conservative surgery

- Conservative surgery for low-risk UUT-UCCs allows for preservation of the upper urinary renal unit while sparing the patient the morbidity associated with open radical surgery
- Conservative management of UUT-UCCs can be considered in imperative cases (renal insufficiency, solitary functional kidney) or in elective cases (i.e. when the contralateral kidney is functional) for low-grade, low-stage tumours.
- The choice of technique depends on technical constraints, the anatomic location of the tumour, and the experience of the surgeon.
 - Ureteroscopy: Endoscopic ablation can be considered in highly selected cases (96,97,98) and in these situations:
 - A flexible rather than a rigid ureteroscope, laser generator, and pliers (pluck) for biopsies are available.
 - The patient is informed of the need for closer, more stringent surveillance.
 - A complete resection is advocated.
 - Segmental resection:
 - It provides adequate pathologic specimens for definitive staging and grade analysis while also preserving the ipsilateral kidney.
 - Segmental resection is possible for the treatment of low- and high-risk tumours of the distal ureter .
 - It is necessary, however, to ensure that the area of tissue around the tumour is not invaded.

- Segmental resection of the iliac and lumbar ureter is associated with a failure rate greater than that for the distal pelvic ureter.
- Open resection of tumours of the renal pelvis or calices has almost disappeared.
- Resection of pyelocaliceal tumours is technically difficult, and the recurrence rate is higher than for tumours of the ureter.
- Percutaneous access:
 - It is considered for low-grade or non-invasive UUT-UCCs in the renal cavities.
 - This treatment option may be offered to patients with low-grade tumours in the lower caliceal system that are inaccessible or difficult to manage by ureteroscopy.
 - A theoretical risk of seeding exists in the puncture tract and in perforations that may occur during the procedure.
 - This approach, however, is being progressively abandoned due to enhanced materials and advances in distal-tip deflection of recent ureteroscopes.
- Adjuvant topical agents:
 - BCG or mitomycin C in the urinary tract by percutaneous nephrostomy via a three-valve system open at 20 cm (after complete eradication of the tumour), or even through a ureteric stent is technically feasible after conservative treatment of UUT-UCCs or for the treatment of CIS.
 - The medium-term results are similar to those observed for the treatment of bladder tumours but have not been confirmed in long-term studies.

Guidelines for conservative management of UUT-UCC

| Indications for conservative management of UUT-UCC | GR |
|--|----|
| Unifocal tumour | B |
| Small tumour | B |
| Low-grade tumour (cytology or biopsies) | B |
| No evidence of an infiltrative lesion on MDCTU | B |
| Understanding of close follow-up | B |
| Techniques used in conservative management of UUT-UCC | |
| Laser should be used in case of endoscopic treatment | C |
| Flexible ureteroscopy is preferable over rigid ureteroscopy | C |
| Open partial resection is an option for pelvic ureteral tumours | C |
| A percutaneous approach remains an option in small low-grade caliceal tumours unsuitable for ureteroscopic treatment | C |

Advanced disease:

- There are no benefits of RNU in metastatic (M+) disease, although it can be considered a palliative option.
- Because UUT-UCCs are urothelial tumours, platinum-based chemotherapy is expected to produce similar results to those seen in bladder cancer.
- Limited evidence to support the use of neoadjuvant chemotherapy in RNU.
- Adjuvant chemotherapy (depending on patient fitness and renal function) achieves a recurrence-free rate of up to 50% but has minimal impact on survival.
- Adjuvant radiotherapy may improve local control of the disease.
- When given in combination with cisplatin, it may result in a longer disease-free survival and longer overall survival.
- Radiation therapy appears to be scarcely relevant nowadays both as a unique therapy and associated with chemotherapy as a tumour adjuvant.

Follow-up

- Strict follow-up of UUT-UCC patients after surgical treatment is mandatory to detect metachronous bladder tumours.
- Bladder recurrence after treatment of a primary UUT-UCC varies considerably from 15% to 50%. Thus the bladder should be observed in all cases.
- A prior history of bladder cancer and upper tract tumour multifocality are the risk factors most often reported for bladder tumours following UUT-UCCs.
- The surveillance regimen is based on cystoscopy and urinary cytology for at least 5 yr.
- When conservative treatment is performed, the ipsilateral upper urinary tract requires careful follow-up due to the high risk of recurrence.

Guidelines for follow-up of UUT-UCC patients after initial treatment

| After RNU, over at least 5 yr | GR |
|---|-----------|
| Noninvasive tumour Cystoscopy/urinary cytology at 3 mo and then yearly | C |
| MDCTU every year | C |
| Invasive tumour Cystoscopy/urinary cytology at 3 mo and then yearly | C |
| MDCTU every 6 mo over 2 yr and then yearly | C |
| After conservative management, over at least 5 yr | |
| Urinary cytology and MDCTU at 3 mo, 6 mo, and then yearly | C |
| Cystoscopy, ureteroscopy and cytology in situ at 3 mo, 6 mo, and then every 6 mo over 2 yr, and then yearly | C |

10.0 Follow Up

11.0 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).

11.1 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.

12.0 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:

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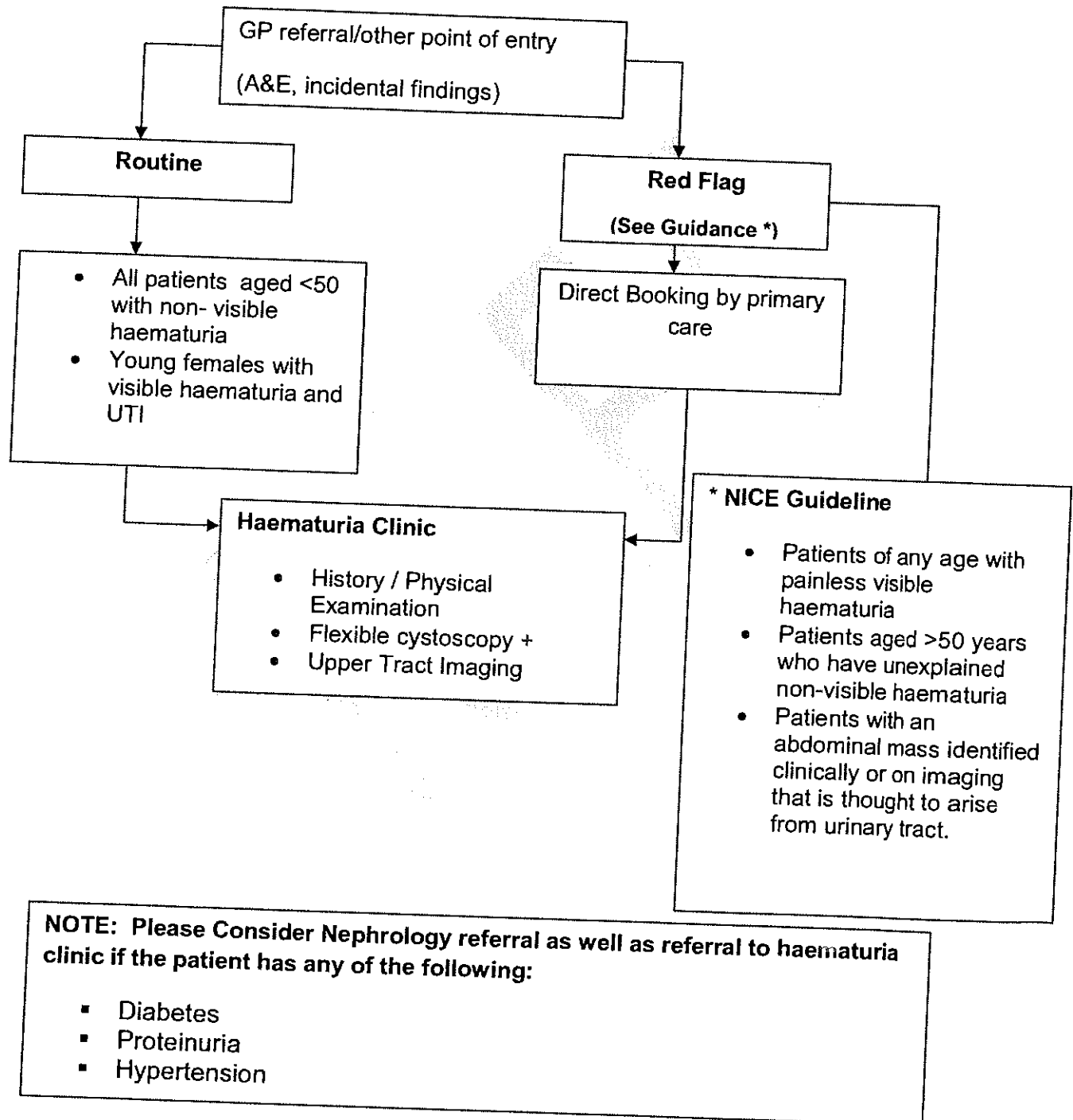
World Health Organisation (2014) <http://www.who.int/cancer/palliative/definition/en/>

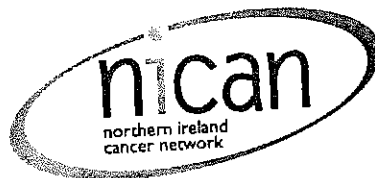
APPENDICES:

- 1. Haematuria Referral Guideline**
- 2. Urology Care Pathways:**
 - Prostate,**
 - Renal Tumour**
 - Testicular Cancer Pathway**
 - Transitional Cell Carcinoma**
 - Castration Resistant Prostate Cancer**
 - Penile Cancer Pathway**
- 3. Guidelines for nurse led follow up prostate cancer pathways**



1. Haematuria Referral Guideline





2. 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.

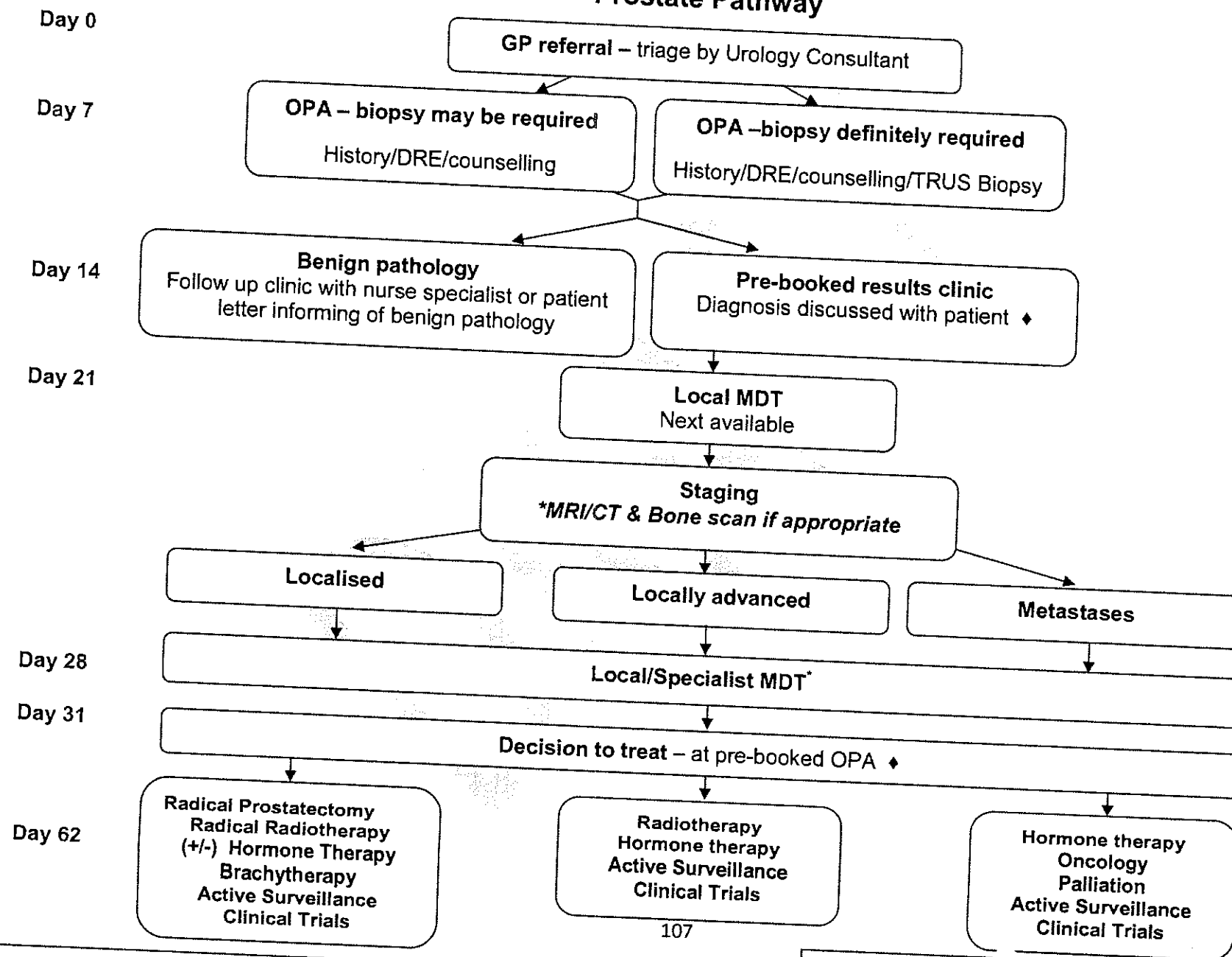
Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that 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

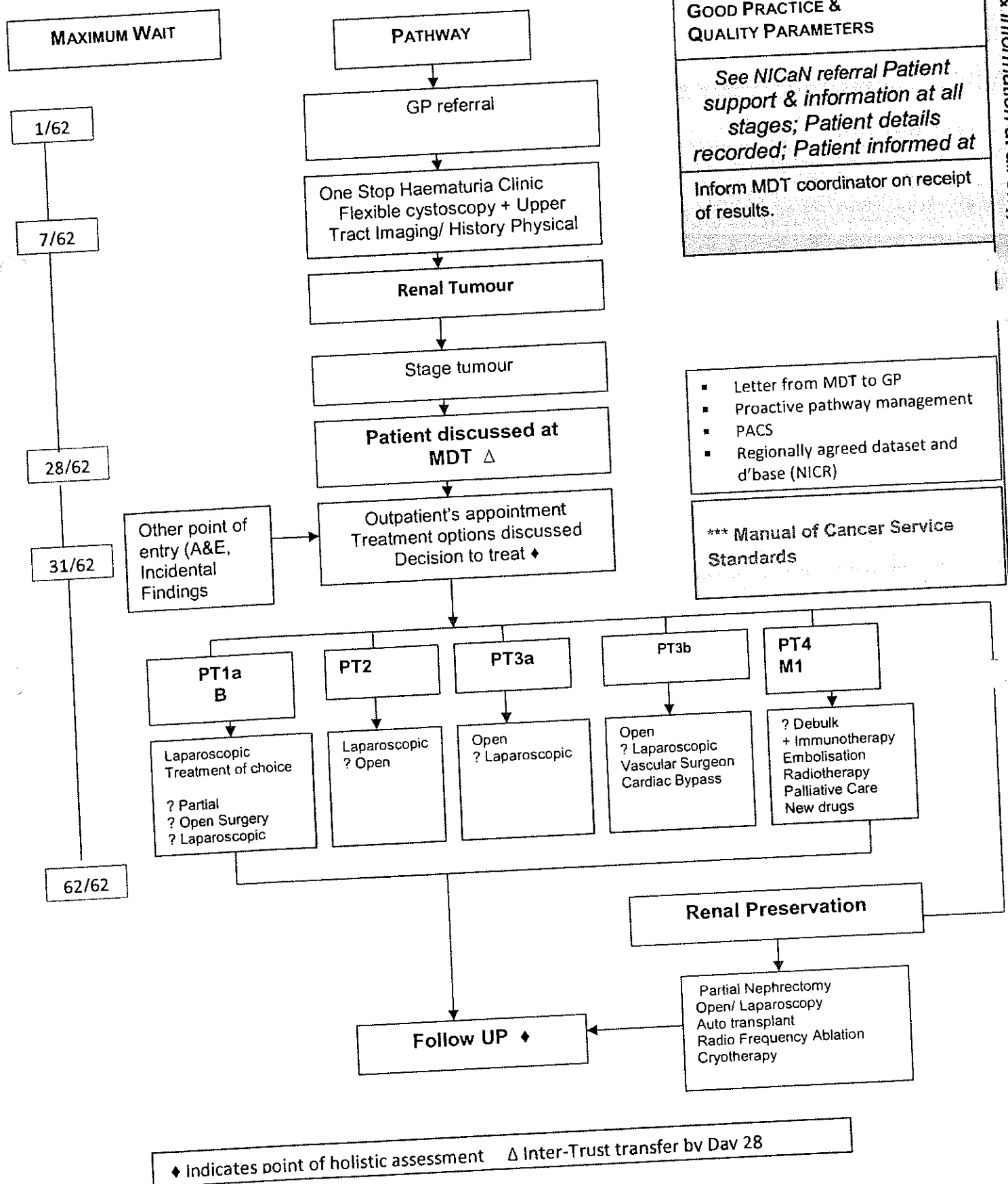
Prostate Pathway



♦ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

* CT necessary only when clinically indicated

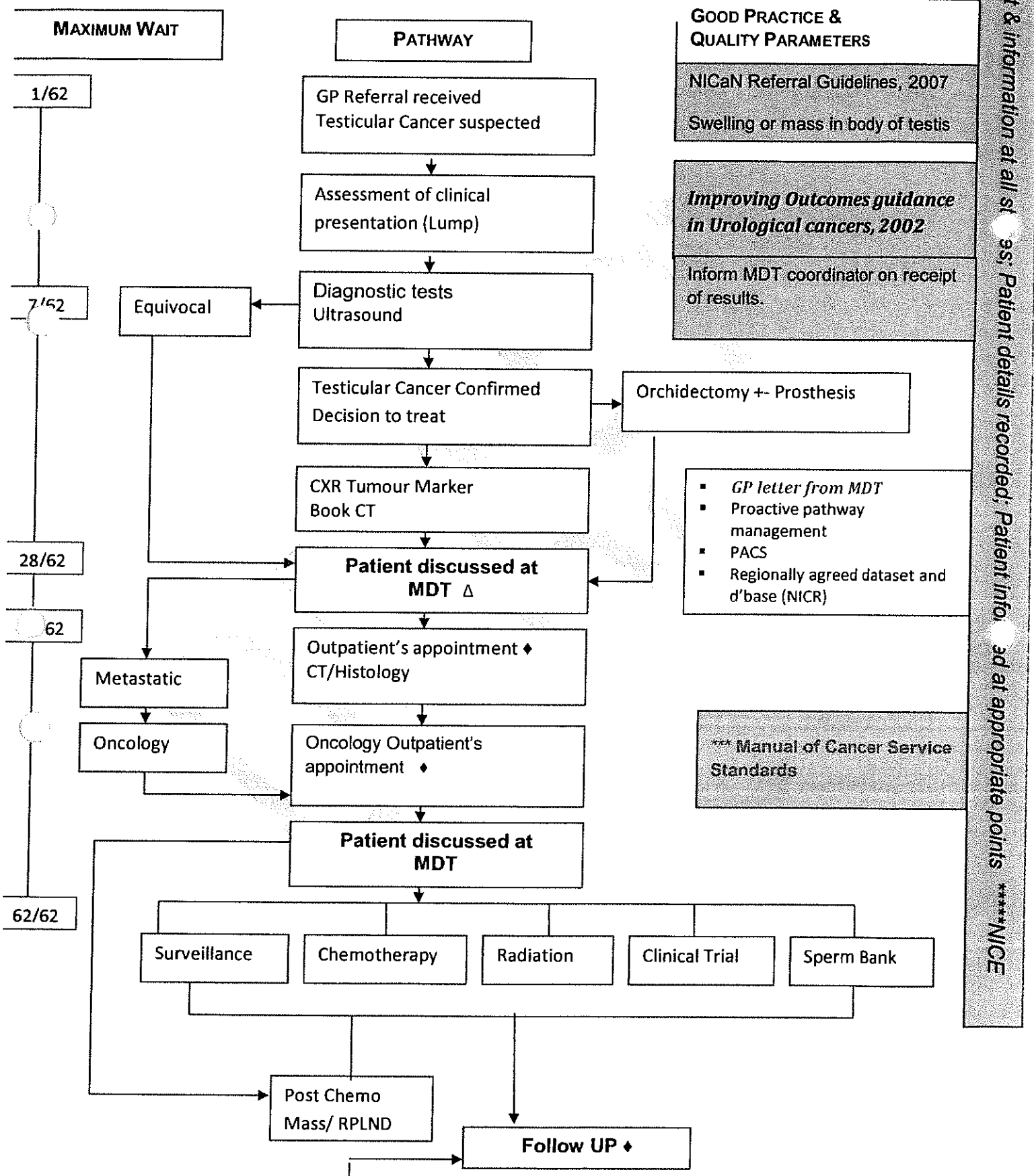
Renal Tumour



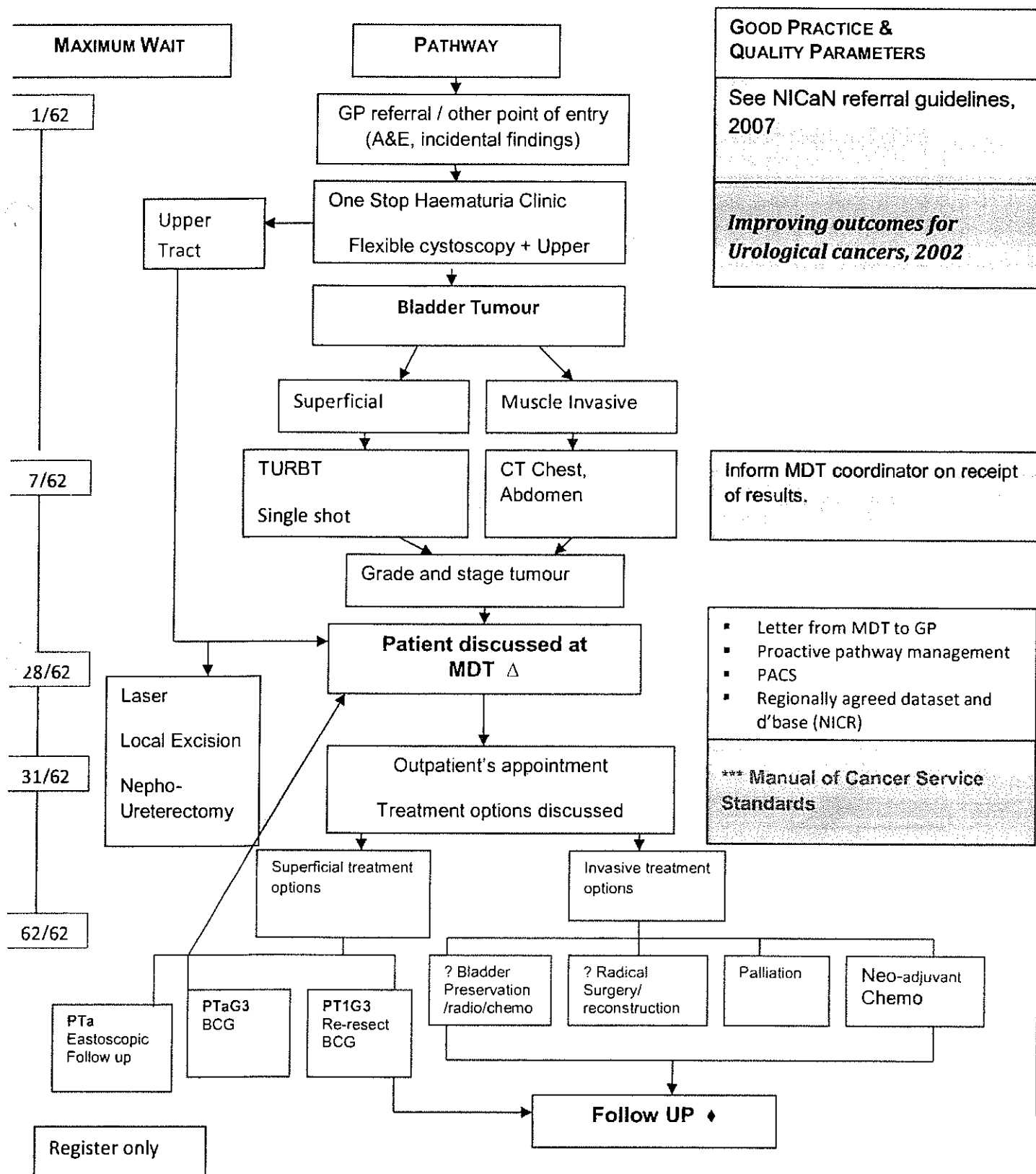
Patient support & information at all stages. Patient details recorded, Patient informed at



Testicular Cancer Pathway



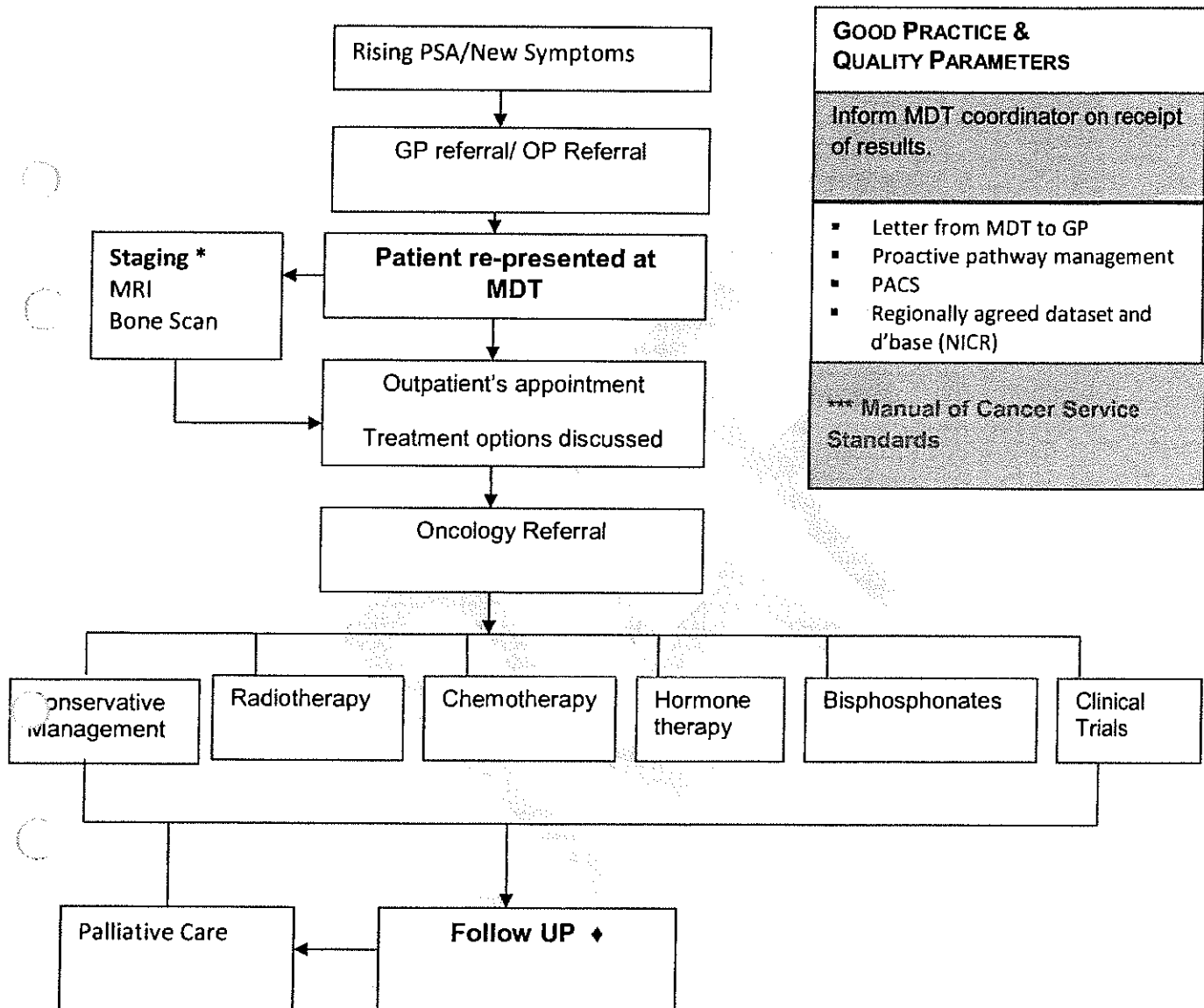
◆ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28



Patient support & information at all stages; Patient details recorded; Patient informed; Appropriate points ****NICE



Castration Resistant Prostate Cancer

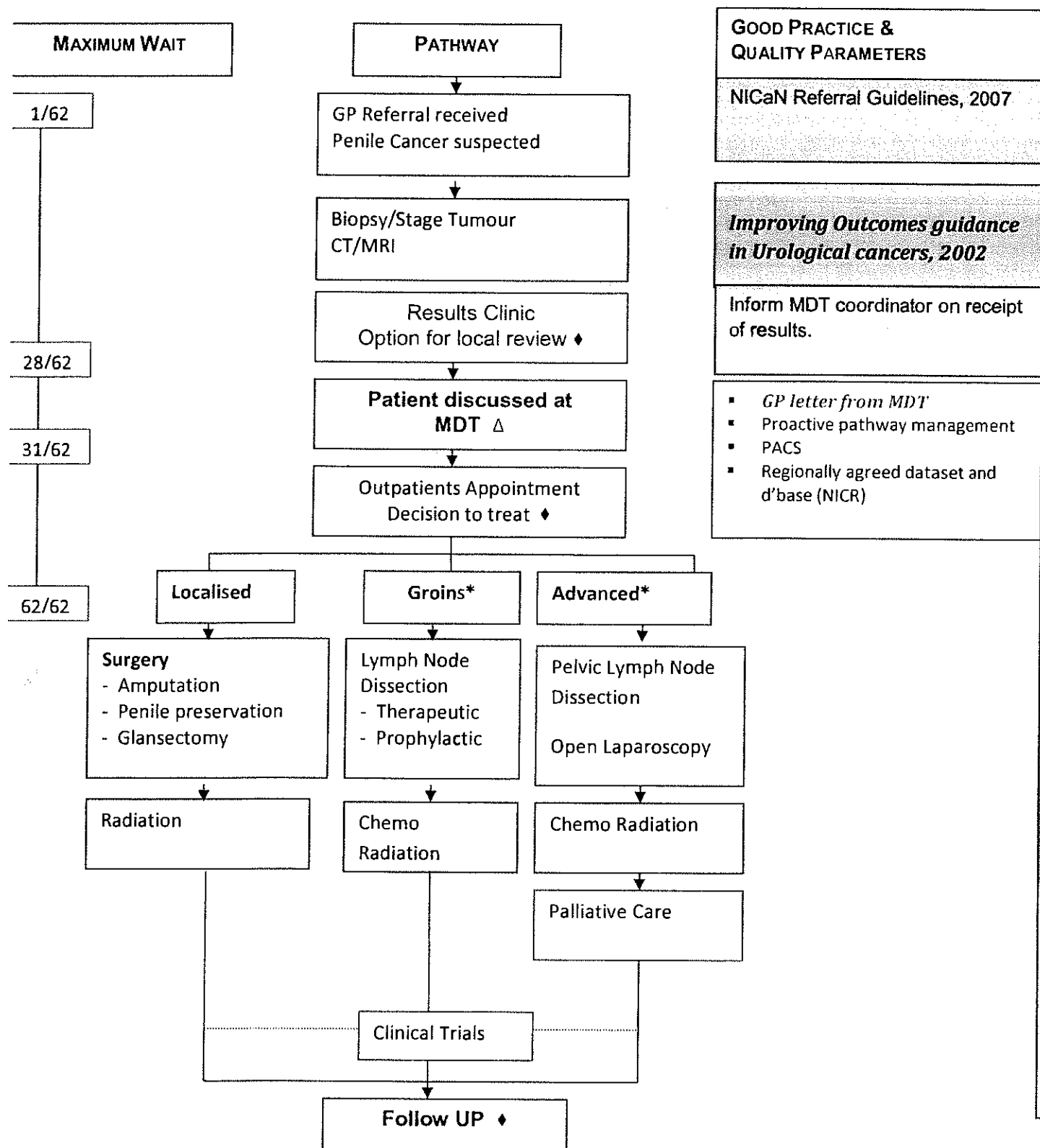


Patient support & information at all stages. Patient details recorded. Patient informed at appropriate points. NICE

* MRI/Bone Scan as clinically indicated



Penile Cancer Pathway



References

- NICE (2002) Improving Outcomes in Urological Cancer
<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10889>
- NICE (2008) Prostate Cancer: Diagnosis and Treatment
<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11924>
- British Association Of Urological Surgeons Guidelines
<http://www.baus.org.uk/>
- European Association Of Urology
<http://www.europeanurology.com/>

Trust Logo

Policy Code / Reference No:

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| | | | |
|--------------------------------|--|-----------------------|--------------------------------------|
| Title: | Guidelines for Nurse Led Assessment and Follow up of patients with stable Prostate Cancer | | |
| Author(s) | <i>Adapted from SET</i> | | |
| Ownership: | | | |
| Approval by: | NICaN Urology NSSG Group | Approval date: | 29th 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

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CSCIP (2005) Applying High Impact Changes in Cancer Care

http://www.cancerimprovement.nhs.uk/documents/CSC_High_Impact.pdf

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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

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

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

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

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

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

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<http://www.uroweb.org>

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

1993-2004 [http://www.qub.ac.uk/researchcentres/](http://www.qub.ac.uk/researchcentres/nicr/FileStore/PDF/Survival/Filetoupload,81422,en.pdf)

[nicr/FileStore/PDF/Survival/Filetoupload,81422,en.pdf](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).

| | |
|---------------|--------------|
| _____ | Date: |
| Name | |
| Title: | |
| _____ | Date: |
| Name | |
| Title: | |
| _____ | Date: |
| Name | |
| Title: | |
| _____ | Date: |
| Name | |
| Title: | |

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.....

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

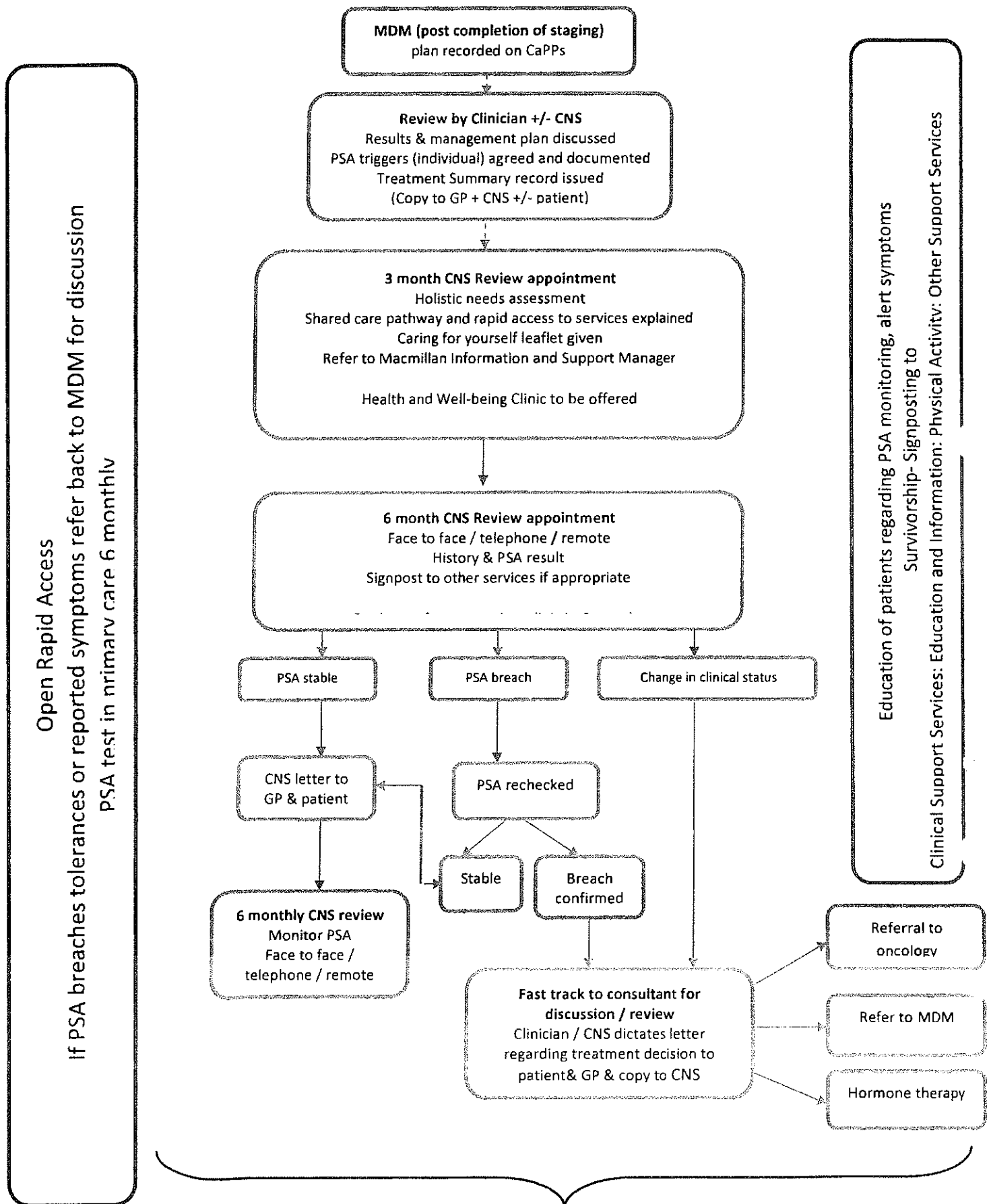
This plan will help to identify the appropriate actions when there is a change in the patients condition/needs during nurse led assessment and follow-up of patients with prostate cancer.

| 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

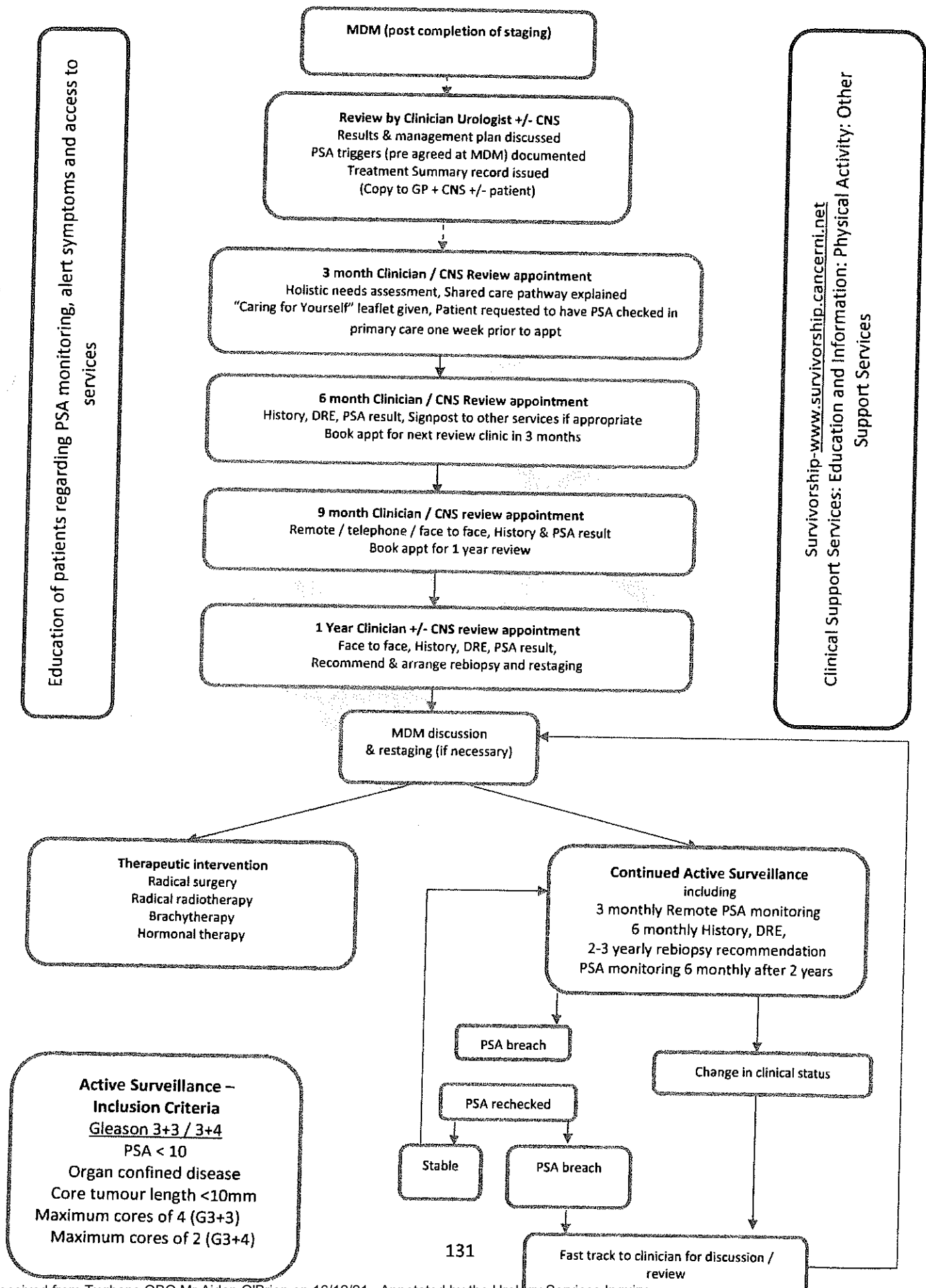


Watchful waiting – Adapted from NICE Guidance 2008

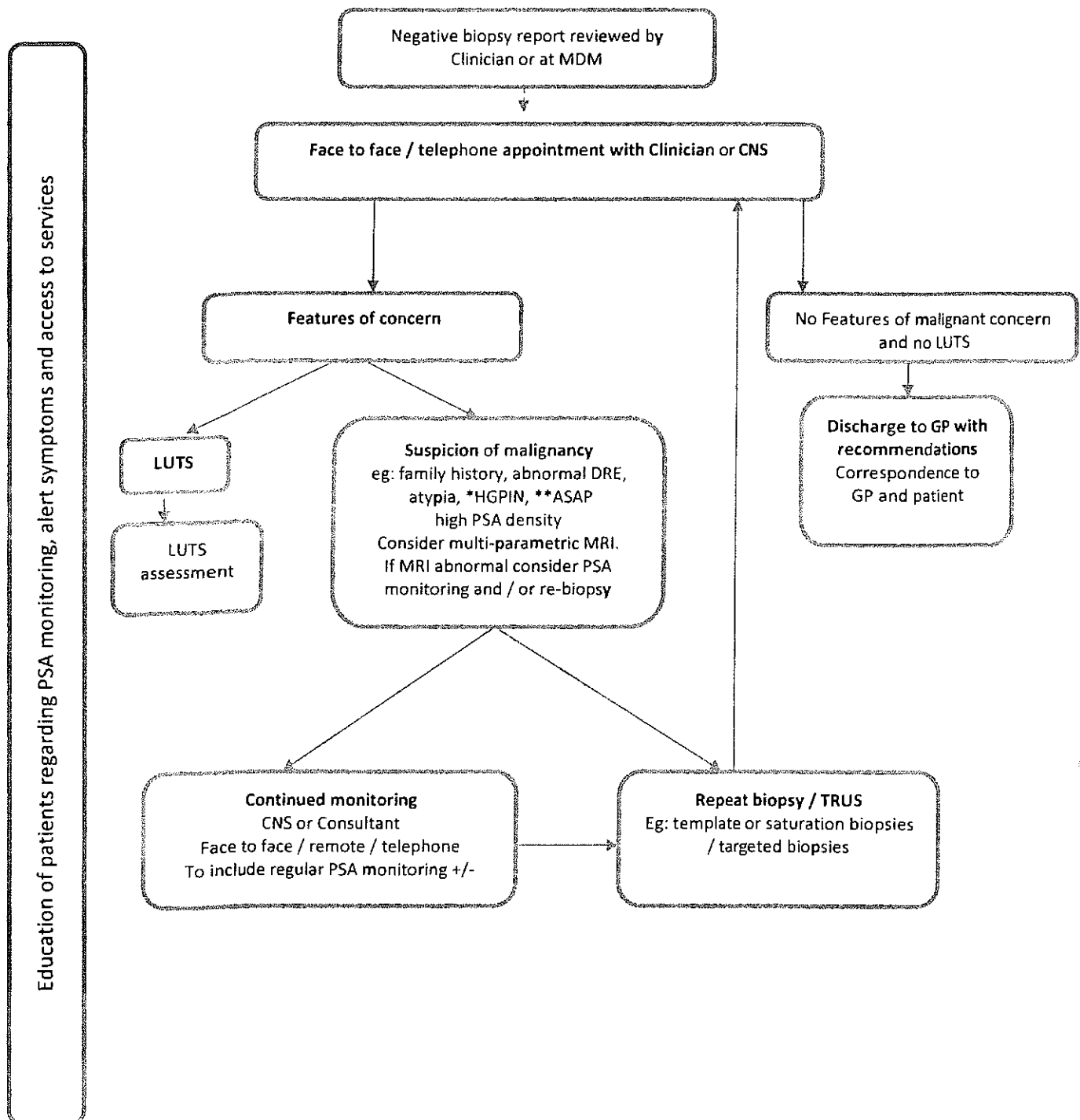
'Watchful Waiting is the form of continued review of Prostate Cancer patients for whom future therapeutic intervention with curative intent has been considered to be inappropriate'.

Pathway 2

Prostate Cancer: Active Surveillance



Pathway 3 Raised PSA & Negative Biopsy



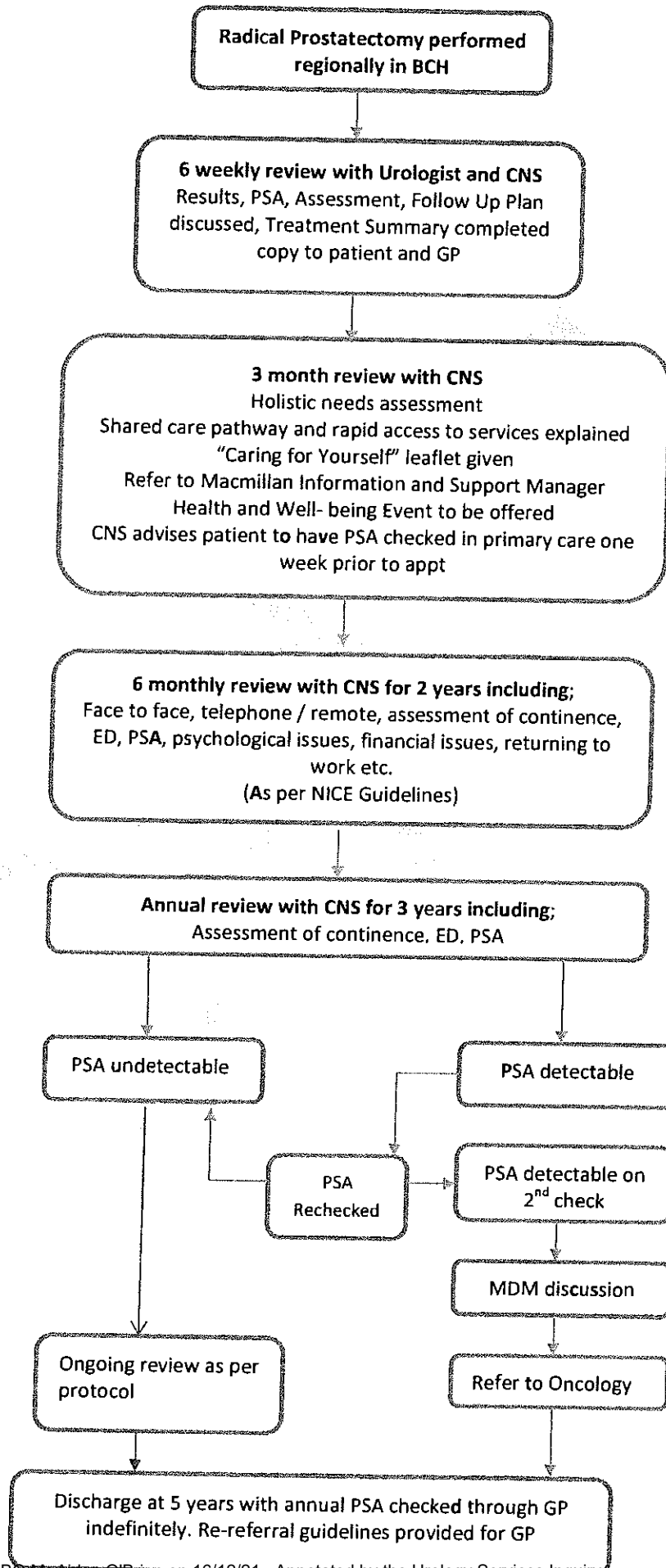
*HGPIN – High grade prostatic intra-epithelial neoplasia

**ASAP – Atypical small acinar proliferation

Pathway 4

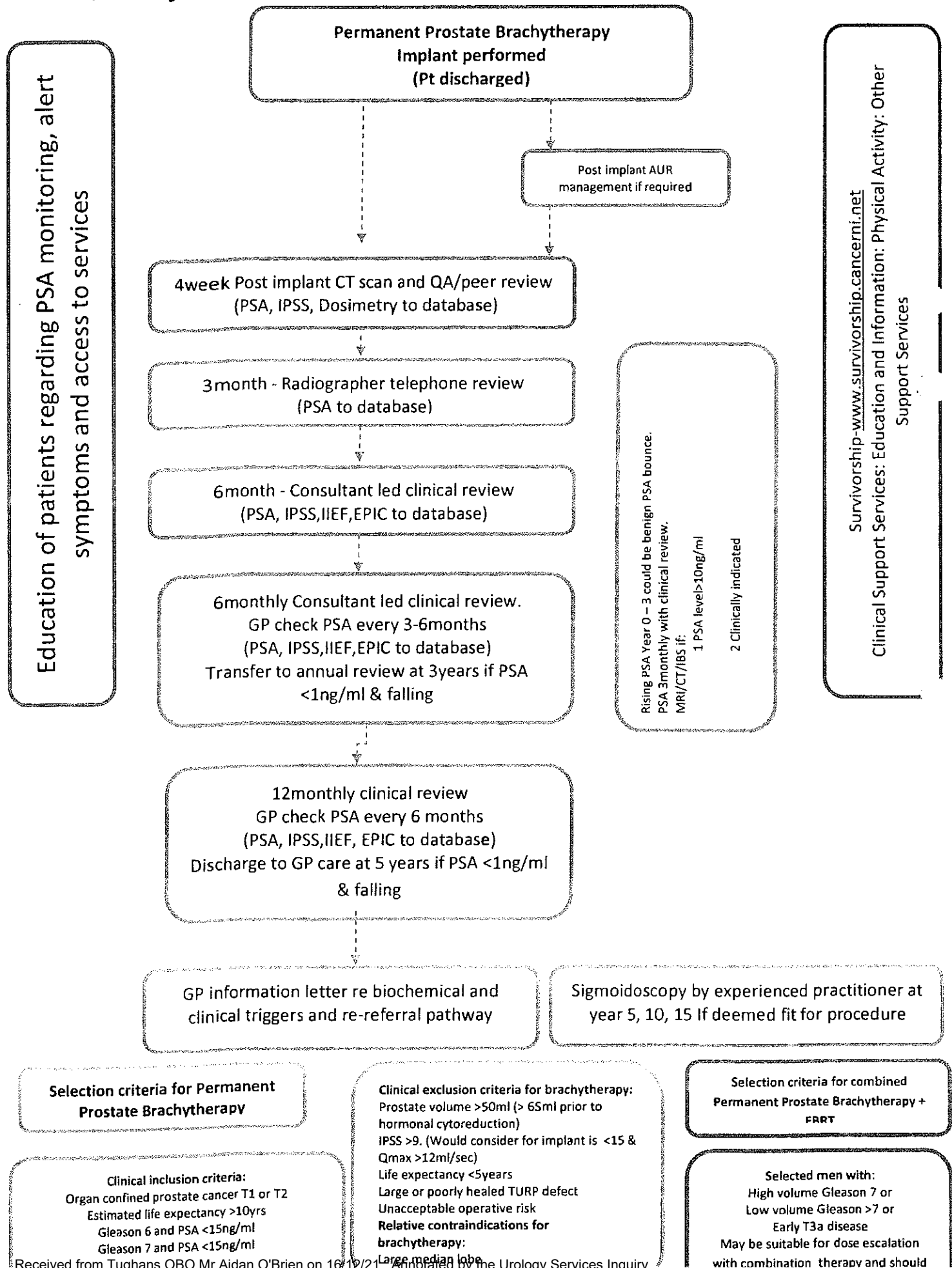
Prostate Cancer: Radical Surgery – Negative margins

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



Survivorship-www.survivorship.cancerni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)



Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)

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

Survivorship-www.survivorship.cancer.ni.net
Clinical Support Services: Education and Information: Physical Activity: Other Support Services

Radiotherapy delivered in NICC
PSA record card explained and issued.

Consultant Review
6 week post radiotherapy
PSA assessment, Assessment of side effects of XRT
Duration of hormone therapy discussed if relevant

Follow Up Plan discussed

Consultant Review
6 monthly review for 2 years with
Oncologist or CNS where available
PSA assessment
Assessment of side effects of XRT

Annual Review
Annual review for 2 years with
Oncologist or CNS where available
PSA assessment, Assessment of side effects of XRT
Duration of hormone therapy discussed if relevant
Follow Up Plan discussed

Annual review year 3-5 with Consultant or CNS where available
PSA assessment
Assessment of side effects of XRT
Signpost to other services if appropriate
Book appt for next review clinic

Annual review year 3-5 with Consultant or CNS where available
PSA assessment
Assessment of side effects of XRT
Signpost to other services if appropriate
Book appt for next review clinic

PSA Stable

Letter to GP and Patient

On-going review as per protocol

PSA Increase/trigger *

PSA rechecked

Stable

Confirmed increase/trigger *

Clinical concern re recurrence /progression

Fast track to consultant for discussion/review
Clinician/CNS dictates letter regarding treatment decision to patient and GP

Discharge to GP care at 5 years if PSA stable and testosterone within normal range.
Discharge letter and re-referral guidelines re biochemical* and clinical triggers

Sigmoidoscopy by experienced practitioner at year 5, 10, 15.
If deemed fit for procedure.

*Phoenix definition of Biochemical failure:
Absolute increase of 2.0ng/ml above the post treatment PSA
Received from Tughans OBO Mr Aidan O'Brien on 16/12/21. Annotated by the Urology Services Inquiry.



**Southern Health
and Social Care Trust**

Operational Policy Urology Cancer Service

MDT Clinical Lead

Mr. A. O'Brien

Clinical Director of Cancer Services

Dr. R. Convery

Trust Cancer Executive Lead

Mrs. D. Burns

April 2015

The following Operational Policy for the Southern Health and Social Care Trust (SHSCT) Urology Multidisciplinary Team (MDT) provides an overview of the service, how it is accessed by patients and coordinated through both the local and regional teams.

Two other documents have been developed, which should be read in conjunction with this operational policy. They are the Annual Work plan, which outlines the direction of the service in the incoming year and the Annual Report, which details the work completed in the past year, any achievements and areas of work outstanding which need to be rolled into the incoming year.

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Peer Review Measures

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| N14-2G-102 | MDT Quorum | |
| N14-2G-103 | MDT Review | |
| N14-2G-104 | Core Members Attendance | |
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| N14-2G-106 | Clinical Guidelines | |
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| N14-2G-117 | Clinical Indicators Review / Audit | |
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1. INTRODUCTION

The Southern Health and Social Care Trust (SHSCT) was formed on 1 April 2007 and is responsible for the services which were formerly delivered by four smaller Trusts: Armagh and Dungannon Trust, Craigavon and Banbridge Community Trust, Craigavon Area Hospital Group Trust and Newry and Mourne Trust.

In addition to primary and community services, SHSCT provides all the acute hospital services for its resident population, including emergency care, diagnostics, inpatient and day case operative procedures, endoscopy, and inpatient acute care with intensive care services available in Craigavon Hospital.

1.1 Southern Trust Urology Services

The Southern Health and Social Care Trust has provided a Urology service for patients living the southern area of Northern Ireland since 1992, when one consultant urologist was appointed. A second consultant urologist was appointed by Craigavon Area Hospital Group Trust in 1996. Since then, the service has increased incrementally in size and capacity, with a sixth consultant urologist appointed in 2014. Particular features of the service has been the provision of Extracorporeal Shock Wave Lithotripsy at the Stone Treatment Centre at Craigavon Area Hospital since 1998, and the provision of all outpatient services at a dedicated unit, the Thorndale Unit, since 2007. This unit moved to a new location within the hospital in 2013, with increased capacity, to enable all outpatient consultations to be conducted there, in addition to ultrasound scanning, prostatic biopsies, flexible cystoscopy and urodynamic studies. The Unit is staffed by Clinical Nurse Specialists, Staff Nurses and Health Care workers, in addition to visiting Radiographers and Radiologists.

A review of urological service provision in Northern Ireland was conducted in 2008/09, resulting in a reconfiguration of responsibilities for services to be provided to changed geographical areas and by three separate teams of urologists. Team South, based at Southern Health and Social Care Trust (SHSCT), took on responsibility for the provision of services to the population of County Fermanagh, with effect from 1st January 2013. County Fermanagh has a population of 61,175.

More recently, SHSCT has agreed to provide urological services to the population of and surrounding Cookstown, County Tyrone, bringing the entire catchment population to 427,000.

Since their commencement in 1992, urological services have been based in the Department of Urology at Craigavon Area Hospital. When the future configuration of all cancer services was advised in the Campbell Report of 1996, Craigavon Area Hospital was designated a Cancer Unit in 1997. In addition to all of the urological services provided at Craigavon Area Hospital, some core services have been provided at Daisy Hill Hospital in Newry since 1992 by a consultant general surgeon with an interest in urology. As the number of consultant urologists has increased in recent years, it has also been possible to provide endoscopic and day case surgery at South Tyrone Hospital in Dungannon, in addition to outpatient clinics at Banbridge Polyclinic, Armagh Community Hospital and South West Acute Hospital in Enniskillen, County Fermanagh.

Urology Services by Site

| Hospital | Outpatients | Endoscopy | Day Surgery | Inpatient Surgery |
|-----------------------------|--------------------|------------------|--------------------|--------------------------|
| Craigavon Area | x | x | x | x |
| Daisy Hill | x | x | x | x |
| South Tyrone | x | x | x | |
| South West Acute | x | | | |
| Armagh Community | x | | | |
| Banbridge Polyclinic | x | | | |

1.2 Southern Trust Urological Cancer Services

Since its commencement in 1992, the Department of Urology has endeavoured to provide a complete spectrum of urological cancer services. Surgical services included radical surgery for renal and upper tract carcinoma, radical cystectomy with urinary diversion or orthotopic bladder replacement for bladder cancer, radical prostatectomy for prostatic carcinoma, in addition to the surgeries for penile and testicular carcinoma. The service also included the provision of immunotherapy for advanced renal cell carcinoma and the provision of systemic chemotherapy for advanced transitional cell carcinoma.

Several significant developments have taken place during the past two decades. The complement of medical and clinical oncologists in Northern Ireland has increased markedly. This has facilitated the subspecialisation in the provision of chemotherapeutic and radiotherapeutic services in both centralised and devolved settings. Implementation of the recommendations of the Campbell Report has led to the establishment of a Cancer Centre in Belfast, and to the establishment of dedicated services at the Cancer Units, such as the Mandeville Unit at Craigavon Area Hospital. The expansion of oncological services has also led to increased recruitment to clinical trials. In urological cancer, this has increasingly led to trials being led by the Cancer Centre in Northern Ireland.

Compliance with NICE Improving Outcome Guidelines led to the centralisation of radical pelvic surgery for bladder and prostatic cancer to the Belfast Trust in 2011. Before then, it also led to the establishment of MultiDisciplinary Teams (MDTs) in each Cancer Unit in addition to a Specialist MDT in Belfast Trust. Central to the role and activities of MDTs has been to meet regularly at MultiDisciplinary Meetings (MDMs) to oversee the diagnosis, assessment and management of all patients with a new diagnosis of cancer, and when significant developments occur in the progress of their cancer.

2. Southern Trust MDT and MDM

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

The MDM takes place every Thursday afternoon at 2.15 pm, with the exception of public holidays, and on the rare occasion when it is not possible to have a meeting due to some other event. The Chair of each MDM will have been decided when scheduling takes place at least one month previously. Scheduling has also ensured that time is allocated to the appointed Chair to preview in detail each Wednesday all of the cases to be discussed at MDM the following day. All of the required clinical summaries, results and reports of investigations will have been provided to the appointed Chair for preview. It also enables all multidisciplinary participants to preview cases and to prepare their contributions to the discussion of cases. This provision has greatly enhanced the quality of scrutiny and preparation for discussion of each case.

When discussion of each patient at MDM has been completed, an agreed Plan of further assessment or management is appended in type to the previous clinical summary and narrative. Following termination of the MDM, the entire narratives and Plans are checked by the Chair for their accuracy prior to inclusion in the Cancer Patient Pathway System (CaPPS). The reports are then sent to the family doctor of each patient, in addition to other clinicians as direct referrals or Inter Trust Transfers as agreed at MDM.

3. UROLOGY MDT LEAD CLINICIAN

Mr. O'Brien was nominated and appointed as Lead Clinician by Dr. R. Convery, Clinical Director of Cancer Services, in April 2012 (Appendix 1: Letter of appointment).

3.1 Responsibilities of MDT Lead Clinician

- Consolidation of the MDT and its activities within the wider urological service.
- Development of the concept and responsibilities of the MDT in its delivery of cancer services.
- Oversight of systems to ensure that all cases of cancer or suspected cancer referred to the service are referred in an informative and timely manner to the MDT for their discussion at MDM.
- Chairing or delegating the chairing of MDM.
- Arrangement and oversight of systems to ensure that patients are reviewed following MDM in a timely manner.
- Organising and chairing Business Meetings to advance the development of MDT and its activities.
- Development of an Operational Policy for MDT.
- Compiling Annual Reports and Work Plans.
- Chairing an Annual General Meeting to agree Reports and Plans
- Attending the Urology NSSG meetings (as the Lead Clinician is considered an integral member of the NSSG).
- Ensuring a high quality integrated service, which meets local, regional and national standards.
- Participation in the regular review of the regional guidelines.
- Ensuring collection of appropriate cancer minimum dataset, working with the cancer management team.
- Developing an audit programme and review of outcomes.
- Ensuring governance arrangements are in place.

4. MDT MEMBERSHIP

Membership of the Urology MDT has consisted of core members and extended members in accordance with the Manual for Cancer Services: Urology Measures.

4.1 Core Membership

Four consultant urological surgeons are core members. These are:

- Mr. Aidan O'Brien
MDT Lead Clinician, MDM Chair, Consultant Urological Surgeon
Covered by Mr. Glackin, Mr. Suresh, Mr. Haynes
- Mr. Anthony Glackin
MDM Chair, Consultant Urological Surgeon
Covered by Mr. O'Brien, Mr. Suresh, Mr. Haynes
- Mr. Mark Haynes
MDM Chair, Consultant Urological Surgeon
Covered by Mr. O'Brien, Mr. Glackin, Mr. Suresh
- Mr. Kothadaraman Suresh
Consultant Urological Surgeon
Covered by Mr. O'Brien, Mr. Glackin, Mr. Haynes

The remaining core members include:

- Dr. Fionnuala Houghton
Consultant Clinical Oncologist
Covered by Specialist Registrar
- Dr. Judith Carser
Consultant Medical Oncologist
Covered by Dr. Houghton or Specialist Registrar

- Dr. Marc Williams
Consultant Radiologist
Covered by Dr. M. McClure
- Dr. Gareth McClean
Consultant Histopathologist
Covered by Dr. R. Shah or Dr. K. Dedic
- Mrs. Kate O'Neill
Core Nurse Member, Clinical Nurse Specialist
Covered by Mrs. J. McMahon and by Mrs. Dolores Campbell
- Mrs. Stephanie Reid
Palliative Care Nurse Practitioner
Covered by Mrs. Kate O'Neill
- Mrs. Shauna McVeigh
MDT Co-ordinator, Cancer Tracker
Covered by Mrs. M. Dabbous and Mrs A. Turkington

4.2 Extended Membership

Extended members include:

- Mr. Michael Young
Consultant Urological Surgeon
Covered by Specialist Registrar
- Mr. John O'Donoghue
Consultant Urological Surgeon
Covered by Specialist Registrar

- Mr. Robin Brown
Consultant General Surgeon at Daisy Hill Hospital, Newry
- Dr. Mary Daly
Consultant Psychologist
Covered by Mrs. M. Duggan
- Dr. Tracy Anderson
Consultant in Palliative Care Medicine
Covered by Clinical Nurse Specialist

4.3 Additional Roles of Members

Two consultant urological surgeons, Mr. O'Brien and Mr. Glackin, and two Clinical Nurse Specialists, Mrs. O'Neill and Mrs. McMahon, have completed the Advanced Communication Skills Course, enabling them to practise at Level 2 for the psychological support of cancer patients and their carers.

RAM

Mrs. O'Neill, MDT Core Nurse Member and Clinical Nurse Specialist, has been nominated as having specific responsibility for users' issues and distribution of information to patients and their carers. An emphasis on newly diagnosed cancer patients has been identified as a priority for 2015/16.

Dr. Carser, Consultant in Medical Oncology, was nominated in 2014 to have specific responsibility for recruitment of patients into clinical trials conducted by the Cancer Centre in Belfast. Increased recruitment has resulted in patients with urological cancer being the largest cohort of patients in clinical trials related to cancer in Northern Ireland.

5. MDT CO-ORDINATOR AND CANCER TRACKER

Mrs. Shauna McVeigh is the current Urology MDT Co-ordinator and Cancer Tracker. Her deputy is Mrs Ann Turkington. She may also be deputised by Mrs. Marie Dabbous who has previously been a Co-ordinator and Cancer Tracker for the Urology MDT.

COVER

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5.1 Responsibilities of the MDT Co-ordinator

The MDT Co-ordinator has an extensive number of responsibilities which include:

- Tracking all patients remaining on 31 and 62 day pathways to initiation of their definitive treatment
- Ensuring all cancer patients are discussed at the MDT meeting
- Insertion of Clinical Summaries and Updates into CaPPS.
- Tracking all patients for whom investigations have been requested, to ensure that appointments have been arranged at appropriate times and to schedule them for discussion at MDM with investigative reports uploaded unto CaPPS.
- Disseminating all uploaded information on all patients to be discussed at each MDM to all MDT members one day prior to each MDM.
- Recording the MDT attendance for every MDM.
- Liaising with the Specialist MDT Co-ordinator prior to any MDM when it is intended to discuss patients with that MDT.
- Liaising with MDM Chair to ensure that all information, particularly MDM Plans, are accurately recorded in CaPPS.
- Ensuring that MDM Plans are sent to Family Doctors.
- Ensuring that Direct Referrals or Inter Trust Transfers are implemented.
- Ensuring that all information recorded on CaPPS is copied to the Clinical Records of all patients discussed at MDM.
- Ensuring that all patients with cancer or suspected cancer progress along agreed pathways in a timely manner so as to meet cancer access targets, and to raise delays with the MDT.

6. MDT CORE NURSE MEMBER

The Department of Urology at Craigavon Area Hospital employs two Clinical Nurse Specialists (CNS). Mrs K O'Neill is a Band 7 Urology CNS employed by the Trust on a full time basis (5 days). Mrs J McMahon is a Band 7 Urology CNS employed by the Trust over 4 days (32.5 hours). Both have worked in Urological Nursing for many years, and are experienced in performing urodynamic studies, flexible cystoscopy and transrectal, ultrasound guided, prostatic biopsies. They have been further supported by the appointment of two Band 6 practitioners experienced in urodynamic studies and the provision of intravesical chemotherapy. Mrs. O'Neill has been nominated the Core Nurse Member of the Urology MDT and whose responsibility it is to oversee the responsibilities of all Nursing Practitioners / Key Workers involved in the ongoing assessment and management of cancer patients, as outpatients.

6.1 Responsibilities of the Core Nurse Member

- Participating in service development.
- Holding additional specialist knowledge and experience.
- Contributing to multi-disciplinary assessment and patient care.
- Leading on patient communication issues.
- Undertaking regular psychological assessment of each patient following a diagnosis of a urological cancer, in order to provide specific expert nursing care, advice, support and counselling and where necessary onward referral for specialist psychological input.
- Acting as the key worker or be responsible for nominating the key worker for patients under care of the MDT, dealing with the team in line with the Trust Key Worker Policy.
- Acting as the patient's advocate and counsel when informed discussion may lead to choices being made concerning treatment options or quality of life issues.
- Acting as a specialist resource for patients and the clinical team by the provision of comprehensive advice, information, education and training.
- Participating in educational programmes for nurses and other health care disciplines as appropriate.

- Participating in the provision of information to patients and their carers regarding their disease, treatment and services available at all stages of their disease process.
- Maintaining a support network and contact point for patients/relatives and carers from diagnosis throughout treatment and beyond.
- Being involved in clinical audit.
- Utilising research in the nurse's specialist area of practice

7. OPERATIONAL POLICY FOR KEY WORKERS

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

7.1 Identification of the Key Worker

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

It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each Urology cancer patient has an identified Key Worker and that this is documented in the MDM record and the patient's case notes. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6).

Patients and families are informed about the role of the Key Worker. Contact details are given with written information.

As patients progress along the care pathway, the Key Worker may change. Where possible, these changes should be kept to a minimum. It is the responsibility of the Key Worker to identify the most appropriate healthcare professional to be the

patient's next Key Worker. Any changes should be negotiated with the patient and carer prior to implementation, and a clear handover provided to the next Key Worker.

Urology Clinical Nurse Specialists and Practitioners are present at all patient discussions where the patient is informed of a diagnosis of cancer, or are available if it is considered preferable that the patient have a further period of consultation with the Nurse Specialists or Practitioners following consultation with the clinician. They may also be present, and should be available, when patients attend for further consultations along their pathway.

7.2 Main responsibilities of Key Workers

- Act as the main contact person for the patient and carer at a specific point in the pathway.
- Offer support, advice and provide information for patients and their carers, accessing services as required.
- Ensure continuity of care along the patient's pathway and that all relevant plans are communicated to all members of the MDT involved in that patient's care.
- Ensure that the patient and carer have their contact details, that these contact details are documented and available to all professionals involved in that patient's care.
- Ensure that the next Key Worker has the appropriate information about the patient to fulfil the role.
- Support the patient in identifying their needs, review these as required and co-ordinate care accordingly.
- Liaise and facilitate communication between the patient, carer and appropriate health professionals and vice versa.
- Assist to empower patients as appropriate.

8. MDT QUORUM

The Southern Trust Urology MDT has been cognisant of the minimum attendance of its members required to have MDMs quorate, as stipulated by the Urology Local MDT Measures, as follows:

- One urological surgeon
- One clinical oncologist
- One medical oncologist
(where the responsibility for chemotherapy has not been taken by the clinical oncologist)
- One imaging specialist
- One histopathologist
- One urology nurse specialist
- One MDT co-ordinator

It has been the policy of the Southern Trust MDT to have a minimum of two consultant urological surgeons present at each MDM, and it will continue to be so.

In earlier years, it had not been possible to have a clinical oncologist present at or video-linking with MDM. With the appointment of Dr. Fionnuala Houghton, it has been possible to have her, or her deputy, video-link with MDM on most occasions. There has been the additional benefit that Dr. Houghton and her deputies have been competent in advising on chemotherapeutic management options for patients.

Since the appointment of Dr. Judith Carser as Consultant Medical Oncologist, MDM has had the benefit of her attendance, which has additionally enhanced recruitment of patients to clinical trials.

Dr. Marc Williams is the Lead Consultant Urological Radiologist, who has been covered by or accompanied by Dr. Mark McClure, Consultant Radiologist, to facilitate the presence of an imaging specialist at most MDMs. Both are experienced urological radiologists, and particularly in the field of MRI scanning. The current

unavailability of Dr. McClure presents a significant challenge to ensuring that the management of cancer and suspect cancer patients is completed within target times, in addition to MDT quoracy.

All MDMs have been attended to date by a histopathologist, a urology nurse specialist and a MDT co-ordinator.

In the event of a MDM not being quorate, it has been and will remain the policy of the Southern Trust MDT that the discussion of patients, who definitively do not require the input of the absent member, should proceed. Otherwise, discussion will be deferred to the next MDM, and it will be the responsibility of the Co-ordinator to reschedule the patient, and to notify the absent member of the deferment.

Multidisciplinary meetings have not been held on public holidays or when Trust Mortality & Morbidity meetings have been scheduled. It has only been on other rare occasions when the MDT Lead Clinician, in consultation with other members, will cancel a scheduled MDM. This policy will remain in place. On all of these occasions, it has been the MDT policy to have one of the three Chairs preview the patients who would have been discussed at the cancelled meeting, so that further investigations can be arranged, and on condition that the patients will be discussed at a later MDM, and before any management decisions are made.

9. THE MULTIDISCIPLINARY MEETING

This section of the Operational Policy is in acknowledgement of the central role of the Multidisciplinary Meeting in the assessment and management of patients suspected of cancer, diagnosed with cancer and throughout their further course. There is only one Urology Local MDT and MDM for the catchment area and its population of the Urological Service of the Southern Trust, as previously described.

9.1 Time and Place of MDM

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

The MDM commences at 2.15 pm. Video conferencing with the Specialist MDT is scheduled to take place at 3.30 pm, or as soon as is mutually convenient thereafter. It is the policy of the Southern MDT that all MDMs should finish by 5 pm at the latest. It has been the experience of the MDT that the number of cases to be discussed has had to be limited to 45 in order to enable the MDM to finish by 5 pm.

9.2 Preparation for MDM

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

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

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

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

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

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

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

9.3 Chairing of MDM

The chairing of MDMs is shared by Mr. O'Brien, Mr. Glackin and Mr. Haynes on a rotational basis. The person appointed to chair each MDM is decided at least one month previously when a period of time is also allocated to that person to prepare for the meeting one day prior to meeting.

9.4 Structure of the Meeting

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

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

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

The Chair then proceeds with the discussion of each listed patient. Having previewed each case, the Chair will have familiarised himself with the detail of each case, and will be able to focus on the pertinent issues for discussion. It is the responsibility of the Chair to ensure that each patient is adequately discussed. It is the responsibility of the Chair to ensure that all of the patient's needs are discussed, in so far as is possible. It is the responsibility of the Chair to ensure that an agreed Plan of management is concluded, and documented in real time as the MDM Plan. The MDM Plan should include identification or reaffirmation of the patient's Key Worker, or the need to have a Key Worker identified at next patient consultation, and the need for Holistic Needs Assessment, or provision for needs if an Assessment has already been conducted, and needs identified.

9.5 MDM Documentation

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

It is the responsibility of the MDT Co-ordinator to present to the Chair on conclusion of the MDM, or as soon as possible thereafter, a complete textual record of the Clinical Summaries, Updates and MDM Plans of all patients discussed at the MDM for approval, and for signing of the documentation in correspondence format to be sent to Family Doctors and to other clinicians to whom it had been agreed that patients would be referred.

9.6 Protocol for Patient Management between Meetings

Whilst the purpose of a MDT discussing the assessment and management of patients at weekly MDMs is to ensure that both have been discussed and optimised in a considered manner, there will be occasions when the assessment and / or management of a patient cannot be deferred until the next MDM. It does remain the right and the responsibility of clinicians to ensure that deferral does not contravene the patient's best interest and outcome. In such cases, it is the Policy of the MDT to recommend that assessment and management of such patients in such circumstances be advanced in consultation with other MDT members, and on condition that the patient will be discussed at the next scheduled MDM.

9.7 Membership and Attendance

It is the policy and the practice of the MDT to maintain and update a record in its Operational Policy of the names and roles of all core and extended MDT members. It is the responsibility of the MDT Lead Clinician to ensure the accuracy of these records.

It is also the policy and practice of the MDT to maintain a record of attendance of all members at MDM, so that a record of the attendance of each individual member can be calculated and included in the Annual Report, and the quoracy of each MDM can similarly be determined and included in the Annual Report.

10. MDM BUSINESS MEETINGS

As the Southern Trust Urological Service has increased in size and as referrals have increased in number, and as the resulting challenges and incapacities have emerged, it has become necessary for the Urology MDT to hold regular Business Meetings to address and resolve these issues. Issues discussed to date have included:

- Extension of core membership of MDT
- Advanced triage of Red Flag referrals
- Provision of Clinical Summaries and Updates to MDT Co-ordinator
- Development of Key Workship

It is the policy of MDT to continue to hold regular Business Meetings, at least on alternate months, in order to advance these and other issues as they emerge.

11. CO-ORDINATION OF CARE AND PATIENT PATHWAYS

The entire purpose of the Urology MDT is to ensure that the assessment and management of all patients suspected of or found to have a urological cancer receive agreed treatment that is consistent and equitable, and which is compliant with the Guidelines and Policies of the Northern Ireland Cancer Network (NICaN) Site Specific Group in Urology, which in turn has adopted their Guidelines and Policies, in so far as is possible and practicable, from those detailed in 'Improving Outcomes in Urological Cancers' by the National Institute for Clinical Excellence. The draft NICaN Urology Cancer Clinical Guidelines (March 2015) are attached in Appendix 5.

The demands of and the services provided by the Urology MDT are set in the context of all urological demands and services provided by the Southern Trust Urological Service. The co-ordination of care of patients suspected of or found to have a urological cancer, and the pathways they follow, have been developed in that context.

11.1 Urology Referral Pathways

All referrals from Primary Care have been centralised in recent years to a single referral and booking centre located at the Craigavon Area Hospital. All such referrals are digitalised. However, patients suspected of having a urological cancer, or having symptoms or clinical findings associated with an increased risk of having a urological cancer, are designated Red Flag status in compliance with NICE referral guidelines and pathways. All Red Flag referrals are similarly made electronically or by fax to the Office of Cancer Services at Craigavon Area Hospital, where they are recorded, prior to distribution daily to the Urologist-on-Call for triage.

11.2 Triage of Red Flag Referrals

There had been an aspiration to subject all Red Flag referrals to advanced triage, whereby the Urologist would review all clinical information available on the Electronic Care Record, determine whether further investigation would be required, and with a view to contacting the patient to advise of such, to request those further investigations to be performed prior to first consultation. However, due to the varied duties associated with being Urologist-on-Call, it was not always possible to have the time to conduct advanced triage. It was therefore agreed that the MDT Policy was that advanced triage was not obligatory, but remained preferable, if time permitted.

If time does permit, it is the MDT Policy that patients are contacted, preferably by telephone, to advise of requested investigations, in order to avoid patients being caused confusion or anxiety by receipt of unexpected appointments.

Triaged Red Flag referrals are returned to the Office of Cancer Services where staff will arrange an appointment at a New Clinic or at any other clinic that may have been

requested at triage. The triaging Urologist may also elect to have the patient discussed at MDM without further investigations requested, or following further investigation, and prior to first consultation. If that course of action is considered optimal by the triaging consultant, it is imperative that the patient is advised by telephone, that the Office of Cancer Services is informed and that a Clinical Summary is submitted to the MDT Co-ordinator. An appointment for consultation will then be arranged following discussion at MDM.

11.3 New Clinics

With regard to Red Flag referrals, the Southern Trust Urology Service had conducted Haematuria Clinics and Prostatic Diagnostic Clinics for several years, in addition to other dedicated clinics, such as LUTS and Stone Clinics. With the need to provide equitable access to all Red Flag referrals, it was decided by the Service in 2014 to establish New Patient Clinics along the lines promoted by Guy's Hospital, London. The New Clinic service began in October 2014. There are four New Clinics each week, all held in the Thorndale Unit. The maximum configuration of a New Clinic is that it will be staffed by two Consultant Urologists and by one Specialist Registrar, and at which a maximum of 24 patients will attend, 9 for each Consultant and 6 for the Registrar. The numbers of patients appointed are reduced pro rata depending upon attending doctors. Each Consultant Urologist has one New Clinic each week (Appendix 3).

Red Flag

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

11.4 Patient Review following MDM discussion

If it has been agreed at MDM that the patient is to be reviewed to be advised of the further assessment or management as recommended by the MDT and stipulated in the MDM Plan, a Review Appointment will be made at the Oncology Review Clinic of the responsible Consultant Urologist. Each is provided with six oncology review slots per week (Appendix 3). This number can be adjusted to accommodate increased numbers. It is the policy of the MDT that all patients are reviewed by the end of the first week following their MDM discussion. If that is not possible, the Chair of MDM may exercise the right to allocate the review of any patient to that of another consultant, if possible, and if it is considered pertinent to do so.

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

11.5 Further Patient Follow-Up

Further management, review and reassessment of patients is very dependent upon the nature of their cancer, and by the Clinical Management Guidelines pertaining to their specific cancer (as detailed in the NCCN Urology Cancer Clinical Guidelines). Due to the increasing numbers of patients requiring follow-up, and the limited capacity to do so in addition to the assessment and management of newly diagnosed patients, the Urology MDT is committed to the principles of Transforming Cancer Follow-Up (TCFU). These have been applied to the development of seven follow-up pathways for patients with prostate cancer, encompassing the entire spectrum of treatment modalities. The implementation of these pathways is critically dependent upon the availability of Clinical Nurse Specialists. There are inadequate numbers of Clinical Nurse Specialists in Urological Cancer services at present. It is the policy of MDT to promote the training and employment of more.

12. REPRESENTATION OF MDT AT NICAN SITE SPECIFIC GROUP

Mr. O'Brien, Lead Clinician of the Southern Trust Urology MDT, was appointed Lead Clinician and Chair of the Northern Ireland Cancer Network (NICaN) Site Specific Group in Urology in January 2013. As he has chaired all meetings of NICaN since then, the Local MDT has been represented at all meetings of the Group.

In addition, several core members of the Local MDT have video linked with most Group meetings since January 2013. In particular, these have included Dr. Gareth McClean, Consultant Histopathologist, and Mrs. Kate O'Neill, MDT Core Nurse Member.

13.SUPPORTIVE CARE AND REHABILITATION SERVICES

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

13.1 Physiotherapy Services

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

13.2 Stoma Care

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

13.3 Clinical Psychology & Counselling Services

Dr. Mary Daly, Consultant Clinical Psychologist, is an extended member of the Urology MDT, and is based in the Bluestone Unit at Craigavon Area Hospital.

Two nurse counsellors, Mrs Mavis Dougan and Ms Terri Deehan, have been funded by Cancer Focus NI, are based at Craigavon Area Hospital.

13.4 Community Continence Services

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

13.5 Pre-chemotherapy Education Sessions & Helpline

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

13.6 Complimentary Therapies

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

13.7 Welfare Services

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

13.8 Macmillan Cancer Support

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

13.9 Support Groups

The Southern Trust has developed strong partnerships with local charities and support centres. These agencies also provide feedback to the teams regarding our local services. Generic support groups meet once per month in CAH and occasionally in Southern Area Hospice in Newry. Cancer Choices in Dungannon offer support to both patients and their families when diagnosed with cancer. They offer a range of services such as complementary therapies, counselling, welfare rights advice and short courses etc.

14. PATIENT INFORMATION

Patients are offered written information to explain their diagnosis when it is imparted to them, and to detail support that is available for them following a cancer diagnosis. Patients with prostate cancer are provided with Prostate UK Information Booklets regarding the various treatment options available to them, to enable them to make an informed choice regarding their future management.

Additional information is available on-line on the NlCaN website. Patient information is made available on request in different languages and formats for those patients from different ethnic minorities or disabilities.

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

15. PERMANENT RECORD OF CONSULTATION

It is the policy of the MDT that patients should be offered a permanent record of their diagnostic consultation and later consultations, if required. This permanent record will detail the diagnosis, management options and plan, and review arrangements. The MDT will discuss whether it would be appropriate to adapt the Policy to make available to patients copies of their MDM documentation.

16. PATIENT FEEDBACK

Feedback on patient's experience will be sought using a range of mechanisms including patient surveys, focus groups, complaints, compliments, and participation in the patient and public involvement processes within the Trust.

In addition, the MDT will conduct a survey of user experience offered on a regular basis, and every two years at a minimum. This survey shall include specific questions concerning the conduct of outpatient consultations, the support of key workers, access to a permanent record of consultation and the range of patient information provided. The survey findings will be presented and discussed at an MDT Business Meeting, in addition to Regional Urology Audit Meetings, and an action plan agreed. A Patient Experience Survey has been designed, and will be distributed to patients in May 2015 (Appendix 4).

17. AUDIT AND SERVICE IMPROVEMENT

The Urology MDT will allocate one of its Business Meetings, at least once annually, to decide on the need for audit and to review the results of audits that have been performed. The MDT has appointed Mr. A. Glackin as the Audit Lead responsible for the development of an audit programme.

Mr. M. Haynes has been nominated as the Service Improvement Lead with the principle responsibility of advising the Lead Clinician and MDT of service improvement measures to be considered and adopted.

18.CLINICAL TRIALS

Clinical trials in Urological Cancers are conducted in Northern Ireland, either as participants in UK and International studies, or designed by the Cancer Centre in Belfast. Recruitment of Urological Cancer patients to clinical trials now accounts for over 20% of all cancer patients recruited to cancer clinical trials in Northern Ireland. Dr. Judith Carser, Consultant Medical Oncologist, is the MDT member responsible for recruitment of patients to trials.

Mrs. Leanne McCourt is the Cancer Clinical Trials Nurse for the Southern Trust. It is her responsibility to co-ordinate the portfolio of trials agreed by the Steering Committee of the Northern Ireland Cancer Trials Network). The Research Nurse co-ordinates study set-up, the running of the trial, data management and other duties required depending on each protocol.

This operational policy will be reviewed on an annual basis, or more frequently if required, in response to changes in regional and national guidelines and to feedback from patients and service users. All members of the MDT are expected to adhere to the contents of the operational policy and are valued for the role that each individual plays within the wider team and service.



**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 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% |
| <i>Subtotal</i> | <i>681</i> | <i>865</i> | <i>1249</i> | <i>597</i> | <i>1194</i> | <i>130</i> | <i>149</i> | <i>210</i> | <i>101</i> | <i>202</i> | <i>19%</i> | <i>17%</i> | <i>17%</i> | <i>17%</i> | <i>17%</i> |
| | | | | | | | | | | | | | | | |
| 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 Sureah | Con. Urologist x1 | Dr McClean | Dr Dedie | Dr Shah | Cons. Pathologist x1 | Dr Williams | Dr McClure | Dr Hamill | Con. Radiologist x1 | Dr Houghton | Cons. Clinical Oncologist x1 | Dr Carser | 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 |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | s |
|------------|-----|-------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---|-----|
| 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 | 0 | 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 | Yes |
| 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 | No |
| 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 |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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 | 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**

Quality Care - for you, with you

Urology MDT

Annual Report for January – December 2016

Presented to the MDT on: 1st September 2017

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

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1.0 INTRODUCTION

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

2.0 KEY ACHIEVEMENTS

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

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

3.0 KEY CHALLENGES

Oncology and Radiology

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

Red Flag Referrals

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

Performance

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

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

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

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

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

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

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

New Clinics

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

Operative Capacity

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

Conduct of MDM

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

Development Priorities

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

Conclusion

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

4.0 MDT ATTENDANCE 2016

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

Table: Urology MDT Attendance record January 2016 – December 2016

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

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

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

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

4.1 Attendance at Network Clinical Reference Group Meetings 2016

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

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

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

5.0 MDT Workload January to December 2016

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

5.1 Number of New Diagnoses 2016

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

5.2 Cancers by referral source 2016

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

5.3 Breakdown of first definitive treatments in 2016

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

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

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

5.4 Breakdown of cancer waiting times performance

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

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

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

Trends for breaches

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

6.0 Advanced communication skills training

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

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

7.0 Patient Experience

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

It showed overall 91% of patients in Southern Trust rated their care as excellent or very good which was similar to the NI score (92%) and higher than the NHS England score (89%).

Access to a clinical nurse specialist came out as a key issue although those who were given the CNS contact details found it much easier to contact the CNS compared to England.

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

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

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

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

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

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

Further details regarding feedback from the SHSCT CPES report is available in **Appendix 2**.

A local survey was also carried out with Urology patients in August 2016, a report is available in **Appendix 3**. Following these surveys, a service development action plan has been developed, see **Appendix 4**.

8.0 Communication of diagnosis to GPs

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

9.0 Audit

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

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

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

10.0 Clinical Trials

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

Urology open studies:

HaBio: Haematuria Biomarker Study

12 patients

UKGPCS: The UK Genetic Prostate Cancer Study

4 patients

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

Audits 2014 - 2019

Impact of Audit Findings during 2015

For me, the two audits with which I was associated in 2015 and which had the most significant impact upon my practice, were the All Ireland Study of Side Effects of Prostate Cancer Treatments 2015 and the Northern Ireland Cancer Patient Experience Survey 2015.

The first was essentially a study of Patient Reported Outcome Measures in over 3,000 patients throughout Ireland and who had a diagnosis of prostate cancer. The greatest difference between Northern Ireland and the Republic of Ireland was that patients in the Republic were marginally younger, had earlier stage and lower grade disease, and were more likely to be managed by radical prostatectomy. More patients in Northern Ireland were managed by radical radiotherapy with or without hormonal treatment, in addition to those in both jurisdictions managed by hormonal therapy alone for more advanced disease. Less than 10% patients throughout Ireland had been managed by active surveillance. The overriding outcome from the survey was that the majority of those managed actively had more than one adverse effect of management, whether it be erectile dysfunction, urinary incontinence, bowel dysfunction, fatigue, gynaecomastia, loss of libido, depression or anxiety, and that these require much greater consideration in planning and discussing the management of patients with prostate cancer.

The outcomes of the experiences of our urological cancer patients in the survey of 2015 served to highlight our inadequacies. It is one thing to suspect or know that they exist, it is another to be told so by your patients. Since then, we have made significant progress in emphasising the role of the Key Worker which has proven to be crucial in improving Holistic Needs Assessment and in ensuring that patients are provided with all of the information and support they need and desire.



Southern Health
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Other roles structured reflective template

| | |
|--|-----------------|
| Name of doctor: Aidan O'Brien | GMC No: 1394911 |
| <p>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:</p> <p>Facilitator of All Ireland, population based study of past and current, physical and psychological side-effects following prostate cancer studies.</p> <p>In 2014, I was asked, as Lead Clinician of NICA N Urology, by Dr. Gavin of the Northern Ireland Cancer Registry, to seek the agreement of by urological and oncological colleagues to have our patients included in the above study.</p> <p>The findings as included in the presentation to NICA N and in the paper published in BJUI (both enclosed) have further informed and consolidated my knowledge of the significant burden of lasting adverse effects of the management of prostatic carcinoma.</p> | |
| <p>They also brought the following drawbacks to my main clinical role:</p> <p>None</p> | |
| <p>Date of reflection: 11 November 2015</p> <p>Final outcome after discussion at appraisal:
(Complete at appraisal considering how your approach will improve patient care)</p> <p>Completed Tenure of this
Very important Role</p> | |

Urology Network Meeting 26/9

- All-Ireland population-based study of past and current physical and psychological side-effects following prostate cancer treatments

3348 patients, all ages, 2-18 years post diagnosis
- 2000-2014 (1010 men from NI)

- Treatment Study
- Biopsy Study

Anna Gavin – a.gavin@qub.ac.uk
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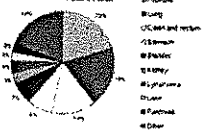
Why Ireland?

- Incidence of prostate cancer is 50% higher in Republic of Ireland than in Northern Ireland
- PSA Testing
- Biopsy Rate



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What we know- Epidemiology



- Cancer with highest incidence in Ireland for men
- In Northern Ireland incidence averages 70 per 100,000 people
- Numbers of cases are on the rise
- Difference in incidence and mortality between north and south of Ireland

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Methods

- Steering Group
- Postal Questionnaire patients identified by Cancer registries, vetted for exclusions (end of life care, not aware of diagnosis, cognitive/ impairment) by Research Nurses/Clinicians/GP's

Ethics and research governance etc

- 2 reminders
- Standardised instruments used (EORTC QLQ C30, EORTC PR25, DASS, Decision regret scale, EQ5D-5L)
- Freephone – high volume of calls (13%)

Honorary Contracts, GCP Training
Questionnaires piloted

R. Rate 54%

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Differences NI and ROI All Prostate Survivors

- ROI patients receive more radiotherapy and surgery and less hormone treatment than NI patients
- More younger men in ROI are diagnosed with prostate cancer than in NI (Average age at diagnosis has fallen from 75 years in 1994 to 70 years in ROI and 71 in NI)
- Rates of diagnosis have been higher in ROI from 1996 onwards

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ROI vs NI

Age Δ < 60, 25% vs 21%, 28% 70+ - ROI younger

Stage 1/11 72% vs 44%
Stage iv 3.5% vs 6%
Gleason* 8-10 16% vs 26%

Treatments more RP 33% vs 16%
Less EBRT + ADT/ 14% vs 29%

ROI less advanced

*(NI Gleason 5-7: 26%)

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| Pre-Diagnosis | ROI | NI |
|----------------------|-----|-----|
| Impotence | 18% | 20% |
| Back pain | 14% | 17% |
| Pain while urinating | 7% | 10% |
| Frequency | 47% | 61% |
| Pain urinary | 7% | 10% |
| Loss libido | 14% | 16% |

Impotence age < 60 : 16%, age 60-69 : 19%, age > 70 : 21%

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Discussions

| | ROI | NI |
|-------------------------------|-----|-----|
| With GP | 50% | 28% |
| Oncologist | 32% | 51% |
| Radiotherapist | 19% | 10% |
| CNS | 20% | 15% |
| Extremely satisfied with info | 66% | 75% |

More discussions in recent years

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Involvement in Decision Making

| | ROI | NI |
|---------|-----|----|
| Passive | 26 | 32 |
| Shared | 28 | 32 |
| Active | 35 | 28 |

For NI 57% reported that was preferred

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Self Reported Treatments

| | ROI | NI |
|---------------|-----|-----|
| RP | 93% | 16% |
| EBRT + ADT | 14% | 31% |
| EBRT - ADT | 34% | 29% |
| Brachytherapy | 4% | 2% |
| HT | 7 | 14 |
| Monitoring | 5% | 6% |

ROI, more RP, less HT, less XRT
*High congruence with Cancer Registry Data

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Post Treatment Symptoms NI / ROI

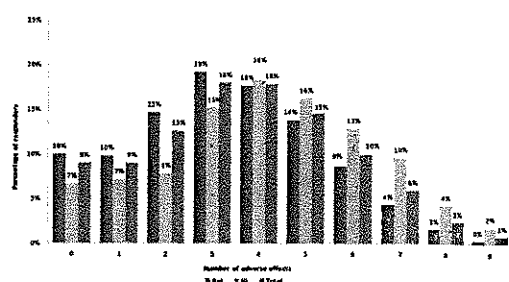
| | Ever | | Ongoing | |
|---------------------------------|------|---------|---------|-------|
| | NI % | (ROI) % | NI | % ROI |
| Urinary Incontinence | 31 | 39 | 16 | 16 |
| Loss interest sex | 65 | 55 | 55 | 43 |
| Impotence | 73 | 67 | 62 | 56 |
| Bowel Problems | 33 | 23 | 21 | 12 |
| Hot flashes | 57 | 33 | 27 | 13 |
| Breast changes | 29 | 14 | 16 | 7 |
| Fatigue | 54 | 55 | 31 | 19 |
| None | 8 | 11 | 17 | 28 |
| Significant difference NI / ROI | | | | |

But NI -- older, more HT, more HRT: need to adjust

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Number of adverse effects ever experienced following a prostate cancer diagnosis: overall and by jurisdiction



| Number of adverse effects | ROI (%) | NI (%) |
|---------------------------|---------|--------|
| 0 | 18% | 28% |
| 1 | 12% | 22% |
| 2 | 10% | 18% |
| 3 | 14% | 24% |
| 4 | 16% | 26% |
| 5 | 15% | 25% |
| 6 | 14% | 24% |
| 7 | 13% | 23% |
| 8 | 12% | 22% |
| 9 | 11% | 21% |

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Men Reported



| | ROI | NI | SC | TY |
|------------|-----|-----|-----|-----|
| Depression | 13% | 18% | 18% | 13% |
| Anxiety | 13% | 19% | 15% | 14% |
| Distress | 8% | 12% | 12% | 8% |

Higher – younger men / ADT/

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Q. Overall were your side effects ...?



| | NI | ROI |
|-----------------------------|-----|-----|
| Same as expected | 27% | 27% |
| Worse than expected | 19% | 20% |
| No side effects experienced | 13% | 18% |

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Regret – N. Ireland



- N = 1010
- Average regret score -12.6% (max 100%)
- 23.6% of men show over 15% regret
- No difference by age or socioeconomic group
- Prostatectomy and active surveillance showed significance towards regret ($p=0.009$ and $p=0.017$)
- Incontinence provides highest levels of regret ($p=0.00$)

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Ever had' side effects



- Almost 90% reported at least 1 of 7 possible adverse physical effects at some time post-treatment, with 61% reporting at least three.
- Most common were impotence (68%), loss of libido (58%) and fatigue (55%).
- Bowel problems (reported by 26%) and fatigue (reported by 55%) were less common among those ≥ 10 years since diagnosis compared to both other diagnosis periods.

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'Current' side effects



- 75% of respondents reported at least one current adverse effect with 29% reporting three or more and 5% at least five.
- 65% reported currently having impotence, urinary incontinence and/or bowel problems, and 57% reported at least one of ... loss of libido, breast changes, fatigue or hot flashes.
- There was little difference in current adverse effects between groups diagnosed at different time periods.

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'Current' vs 'Ever'



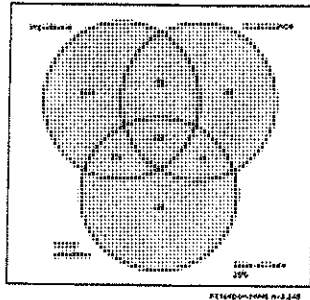
- For each adverse physical effect "current" proportions were lower than "ever".
- The greatest changes were for fatigue (55% to 22%), hot flashes (39% to 16%) and urinary incontinence (37% to 16%), while the smallest change was for impotence (68% to 57%).
- One quarter of survivors (25%) reported no adverse physical effects at the time of questionnaire completion; an increase from the 10% who reported none at any time.

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Post-treatment 'current' impotence, incontinence and bowel problems



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Pre and post-treatment comparisons



- Prior to diagnosis, 19% reported impotence, increasing with age from 16% of those <60 years, to 21% in those 70+.
- Impotence as a new physical effect was reported by 43%, with 5% reporting impotence pre-treatment, but not currently. (total current = 57%)
- Variation by treatment.
- Loss of libido was reported before diagnosis by 15%, with 46% reporting this as current and 5% reporting this pre-treatment but not currently.

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Treatment variations



- RP – higher levels of reported current impotence (76%) and urinary incontinence (28%) and lower levels of bowel problems (9%), hot flashes (7%) and breast changes (3%) than the population average.
- EBRT – highest bowel problems of any treatment group.
- EBRT with HT vs EBRT without HT reported more current loss of libido (58% vs 43%), impotence (64% vs 50%), breast changes (20% vs 9%), hot flashes (28% vs 15%) and fatigue (32% vs 23%).

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- Those receiving BT reported lower than overall proportions of current impotence (43%), loss of libido (26%), hot flashes (2%), and breast changes (2%), while 42% reported no current problems.
- HT alone - reported high proportions of current loss of libido (52%), impotence (51%), hot flashes (41%) and fatigue (28%), while 20% reported no current adverse physical effects.
- 64% on monitoring reported no current adverse physical effects - significantly higher than other treatment modalities.

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- Patients on monitoring, reported impotence (21%), loss of libido (22%), urinary incontinence (7%), hot flashes (4%), fatigue (4%), bowel problems (2%) and breast changes (2%).

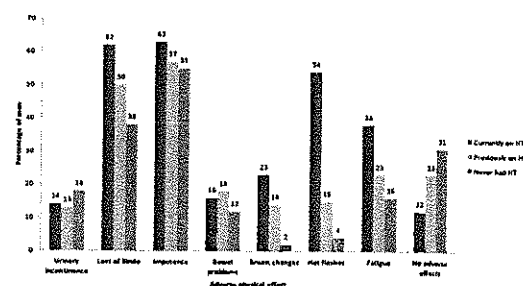


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'Ever' and 'current' by HT



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Strengths



- All ages included and longer period since diagnosis
- 3,448 responders
- Patient reported but congruence levels high
- Information on 'current' and 'ever' experience of adverse physical effects was collected from the same survivors allowing an estimate of change in effects at a population level.
- Documented pre-treatment and current proportions of impotence and loss of libido which should inform decision-making.

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Limitations



- Older persons less likely to respond
- Cross-sectional study
- Recall bias
- The 4% of survivors in the monitoring group reporting current hot flashes may represent some contamination of treatment recall with survivors not recognizing that they are having HT
- No Normative for comparisons

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Conclusions



- Adverse physical effects common and often multiple.
- If extrapolated to population this represents a significant number who require ongoing 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 made prioritised in patient follow-up.

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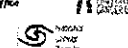
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Acknowledgements



- All men who responded to questionnaire



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Patient-reported 'ever had' and 'current' long-term physical symptoms after prostate cancer treatments

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Objective

To investigate the prevalence of physical symptoms that were 'ever' and 'currently' experienced by survivors of prostate cancer at a population level, to assess burden and thus inform policy to support survivors.

Patients and Methods

The study included 3 348 men surviving prostate cancer for 2–18 years after diagnosis. A cross-sectional, postal survey of 6 559 survivors diagnosed 2–18 years ago with primary, invasive prostate cancer (ICD10-C61) identified via national, population-based cancer registries in Northern Ireland and Republic of Ireland. Questions included symptoms at diagnosis, primary treatments and physical symptoms (erectile dysfunction [ED]/urinary incontinence [UI]/bowel problems/breast changes/loss of libido/hot flashes/fatigue) experienced 'ever' and at questionnaire completion ('current'). Symptom proportions were weighted by age, country and time since diagnosis. Bonferroni corrections were applied for multiple comparisons.

Results

Adjusted response rate 54%; 75% reported at least one 'current' physical symptom ('ever' 90%), with 29% reporting

at least three. Prevalence varied by treatment. Overall, 57% reported current ED and this was highest after radical prostatectomy (RP, 76%) followed by external beam radiotherapy with concurrent hormone therapy (HT, 64%). UI (overall 'current' 16%) was highest after RP ('current' 28%; 'ever' 70%). While 42% of brachytherapy patients reported no 'current' symptoms, 43% reported 'current' ED and 8% 'current' UI. 'Current' hot flashes (41%), breast changes (18%) and fatigue (28%) were reported more often by patients on HT.

Conclusion

Symptoms after prostate cancer treatment are common, often multiple, persist long-term and vary by treatment method. They represent a significant health burden. An estimated 1.6% of men aged >45 years are survivors of prostate cancer and currently experiencing an adverse physical symptom. Recognition and treatment of physical symptoms should be prioritised in patient follow-up. This information should facilitate men and clinicians when deciding about treatment as differences in survival between radical treatments is minimal.

Keywords

prostate cancer, population, patient-reported outcomes

Introduction

Prostate cancer, the most common cancer in males in developed countries, has an estimated 900 000 new cases annually, 325 000 of which occur in Europe [1]. Driven by ageing populations, widespread PSA testing and improved survival, the prevalence of prostate cancer is predicted to rise in the UK from an estimated 255 000 cases in 2010 to 831 000 cases by 2040 [2]. In Ireland, prostate cancer currently accounts for 34% of male cancer survivors (excluding non-melanoma skin cancers) in Northern Ireland and ≈40% in the Republic of Ireland [3–4].

All prostate cancer treatments carry the potential for adverse effects, including erectile dysfunction (ED), urinary incontinence (UI), bowel problems, hot flashes and fatigue [5]. As studies have not conclusively shown survival benefits of one treatment over another for localised prostate cancer, robust population-based estimates of prevalence and duration of symptoms after treatment are valuable for informing treatment decision-making [6–10].

Most studies on side effects to date are from clinical trials that do not compare all treatment methods, exclude older men and do not extend beyond 10 years [11–13]. The aim of

the present study was to investigate the prevalence of physical symptoms that were 'ever' experienced and are 'currently' experienced at a population level, assess burden and inform policy to support medium to long-term survivors of prostate cancer.

Patients and Methods

The study took place in Ireland. Northern Ireland has a predominantly publicly funded healthcare system, whereas the Republic of Ireland has a mixture of public and private healthcare. The same approach was used in both settings to identify and recruit participants. All men diagnosed with invasive prostate cancer (ICD10 C61) between 1 January 1995 and 31 March 2010 and alive at 31 March 2011 were identified through population-based cancer registries (Northern Ireland 5 519 men; Republic of Ireland 17 304 men). A random sample of survivors was screened for eligibility by healthcare providers ($n = 12\,322$, 52% of total

sampling frame). Eligible survivors were: aware of their diagnosis, English speaking-resident in either Northern Ireland or the Republic of Ireland, and well enough to complete a questionnaire (in particular had no cognitive impairment).

In Northern Ireland, eligibility was checked by research nurses, or the patient's GP. In the Republic of Ireland, the patient's GP confirmed eligibility. In both areas, survivors whose eligibility was not confirmed (e.g. non-response of GP were excluded). After this process, 6 559 (53% of the random sample) were deemed eligible for invitation to complete a postal questionnaire (Fig. 1).

A questionnaire including the European Organisation for the Research and Treatment of Cancer (EORTC) QLQ C30, PR25, EQ5D-5L, DASS 21 and Decisional Regret Scale was developed following literature review with clinician and patient input [14–18]. Questions included sociodemographic characteristics and pre-diagnosis symptoms (urinary problems: increased

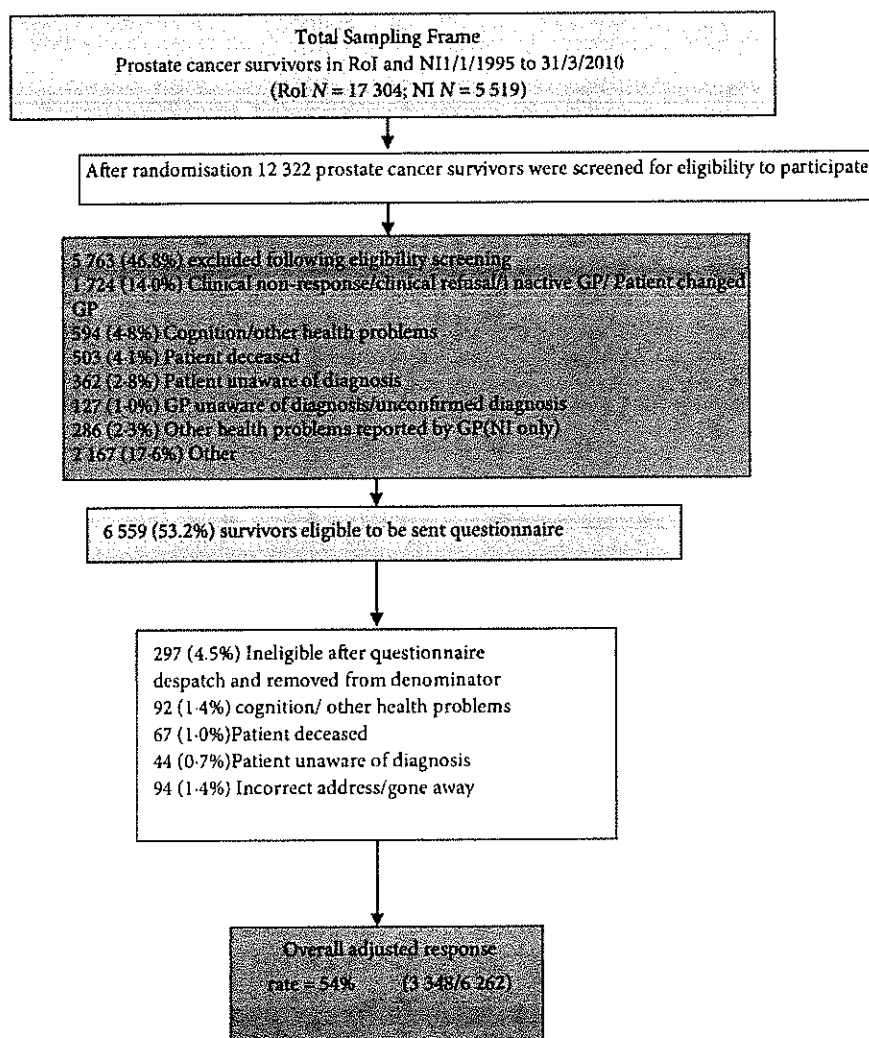


Fig. 1 Recruitment of prostate cancer survivors.
RoI, Republic of Ireland; NI, Northern Ireland.

frequency, pain urinating, blood in urine), bowel problems (diarrhoea, constipation), and/or sexual dysfunction (ED and loss of libido). Information on the last two were requested 'ever' after treatment, 'currently' at questionnaire completion and pre-diagnosis. A list of prostate cancer treatment methods was included and survivors were asked to indicate all treatments received, with dates. Specific questions were asked about seven potential disease- or treatment-related symptoms at two time-points; 'ever' (i.e. anytime since treatment) and 'current' (i.e. at time of questionnaire completion). The symptoms considered were UI, ED, loss of libido, bowel problems, breast changes, hot flashes and fatigue.

The draft questionnaire was pre-tested among 32 survivors of prostate cancer for acceptability, ease of understanding and face validity, and modified accordingly. Questionnaires were dispatched between April and September 2012. Each man received a cover letter, information sheet, consent form and freepost return envelope with their questionnaire. Non-responders received up to two written reminders. Date of diagnosis, clinical stage, and Gleason grade at diagnosis were extracted from cancer registry databases. The Gleason grade is collected and categorised as low (<5), medium (6–7) and high (>8) and not as raw data by the registry. Additional information was sourced for staging/Gleason grade for responders from Northern Ireland, as these data were incomplete in routine data for earlier years.

For survivors who answered some treatment or physical symptom questions, but omitted others from that section, a 'no' response was assumed. Non-response to all of five treatment questions (3%, $n = 93$), or all 14 symptom questions (3%, $n = 102$), were coded as 'missing' but retained in analyses.

To investigate whether symptoms varied by time since diagnosis, respondents were categorised into three groups: 2–4.9 years, 5–9.9 years and ≥ 10 years after diagnosis. To study symptoms by treatment, a variable was created based on a mutually exclusive hierarchy of treatments: each man was categorised once based on primary treatment(s) received: radical prostatectomy (RP) at any time following diagnosis (with or without other treatments); external beam radiotherapy (EBRT) with concurrent hormone therapy (HT) within 6 months; EBRT without HT; brachytherapy (BT), excluding survivors with previous EBRT or RP; HT alone without RP, EBRT or BT; chemotherapy alone; monitoring including active surveillance or watchful waiting.

Survivors were also categorised as: (i) currently on HT, (ii) previously received HT and (iii) never had HT. Pretreatment and post-treatment experience was compared for loss of libido and ED.

Comparisons of symptom proportions across treatment groups were tested for significance at the 5% level using two-sided

z-tests based upon weighted counts rounded to the nearest whole number, with differences in overall distributions tested using chi-square tests. Bonferroni corrections were applied to account for multiple comparisons. The Clopper–Pearson interval method was used to generate exact 95% binomial CIs for weighted proportion estimates [19].

To extrapolate results to the entire prostate cancer survivor population, weighted proportions of symptoms were computed. Respondents' characteristics were compared with those of all prostate cancer survivors in Ireland (i.e. the total sampling frame) and the proportions with each symptom was adjusted with weights based on country, age at diagnosis and time since diagnosis.

Results

In all, 3 348 men responded, representing a 54% response rate after adjusting for eligibility following questionnaire dispatch. Respondents' mean (SD) age was 64.9 (7.6) years. Compared with all prostate cancer survivors, respondents were younger at diagnosis (chi-square 49.6; $P < 0.001$), diagnosed more recently (chi-square 164.8; $P < 0.001$), had their cancer staged (chi-square 673.0; $P < 0.001$) and graded (chi-square 653.1; $P < 0.001$) (Table 1). Two-thirds of respondents (64%) had presented with early disease (stage I/II), while 65% had an intermediate Gleason grade (5–7) at diagnosis. Almost half (48%) were surveyed 2–4.9 years after diagnosis, 32% at 5–9.9 years and 20% at ≥ 10 years. Those in the ≥ 10 -year group were younger at diagnosis, less often had stage I/II disease and more often had low-grade disease compared with those diagnosed more recently (all comparisons $P < 0.001$). They also more often reported RP treatment and less often BT or EBRT with HT (all comparisons $P < 0.001$). At diagnosis over half (51.2%) of men reported urinary frequency, 18.8% ED and 14.7% loss of libido. There were no significant variations in pretreatment symptoms reported between groups diagnosed at different time-periods (Table 2). The responder's treatment categories were compared with data from both cancer registries taken in 2001. The levels of chemotherapy (2% responders, 1.4% registry; $P = 0.11$), HT (45% responders, 44% registry; $P = 0.46$) and RP (27% responders, 38% registry; $P < 0.01$) were within the range of the overall prostate cancer population. The levels of radiotherapy were higher among responders at 58%, 24% registry ($P < 0.01$), in keeping with, but not completely explained by increased use over time (Republic of Ireland average 41% for 2007–2011).

'Ever had' Physical Symptoms (Weighted Proportions)

Overall, 90% of respondents, reported 'ever' experiencing at least one of the seven possible physical symptoms investigated after treatment: 61% reported at least three, 20% reported

Table 1 Characteristics of prostate cancer populations.

| | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 |
|-----------------------------|---|---|---|---|---|
| N (%) | | | | | |
| Age at diagnosis, years | | | | | |
| 0–59 | 5 046 (22.1) | 2 039 (16.5) | 1 329 (20.3) | 799 (23.9) | 530 (16.5) |
| 60–69 | 10 212 (44.7) | 4 891 (39.7) | 2 939 (44.8) | 1 631 (48.7) | 1 308 (40.7) |
| ≥70 | 7 565 (33.1) | 5 392 (43.8) | 2 291 (34.9) | 918 (27.4) | 1 373 (42.8) |
| Time since diagnosis, years | | | | | |
| 2–5 | 9 569 (41.9) | 5 340 (43.3) | 3 101 (47.3) | 1 614 (48.2) | 1 487 (46.3) |
| 5–9.9 | 9 776 (42.8) | 4 324 (35.1) | 2 114 (32.2) | 1 075 (32.1) | 1 039 (32.4) |
| ≥10 | 3 478 (15.2) | 2 658 (21.6) | 1 344 (20.5) | 659 (19.7) | 685 (21.3) |
| TNM stage* | | | | | |
| I/II | 12 761 (55.9) | 5 792 (47.0) | 3 817 (58.2) | 2 126 (63.5) | 1 691 (52.7) |
| III | 2 122 (9.3) | 1 130 (9.2) | 947 (14.4) | 612 (18.3) | 335 (10.4) |
| IV | 690 (3.0) | 445 (3.6) | 267 (4.1) | 141 (4.2) | 126 (3.9) |
| Unknown | 7 250 (31.8) | 4 955 (40.2) | 1 528 (23.3) | 469 (14.0) | 1 059 (33.0) |
| Gleason grade* | | | | | |
| 2–4 | 1 578 (6.9) | 923 (7.5) | 472 (7.2) | 212 (6.3) | 260 (8.1) |
| 5–7 | 11 766 (51.6) | 4 996 (40.5) | 3 609 (55.0) | 2 186 (65.3) | 1 423 (44.3) |
| 8–10 | 2 865 (12.6) | 1 594 (12.9) | 1 060 (16.2) | 625 (18.7) | 435 (13.5) |
| Unknown | 6 614 (29.0) | 4 809 (39.0) | 1 418 (21.6) | 325 (9.7) | 1 093 (34.0) |

*Further information was sourced for TNM stage and Gleason grade for Northern Ireland responders only. This is reflected in the lower percentage with stage unknown among responders compared with the other columns.

Table 2 Characteristics of responders by time since diagnosis.

| | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 | Prostate Cancer
Population
N = 1999 |
|--|---|---|---|---|---|
| N (%) | | | | | |
| Age at diagnosis, years | | | | | |
| 0–59 | 340 (21.1) | 255 (23.7) | 204 (31.0) | 799 (23.9) | |
| 60–69 | 750 (46.5) | 534 (49.7) | 347 (52.7) | 1 631 (48.7) | |
| ≥70 | 524 (32.5) | 286 (26.6) | 108 (16.4) | 918 (27.4) | |
| Age at questionnaire completion, years | | | | | |
| 0–59 | 186 (11.5) | 45 (4.2) | 12 (1.8) | 243 (7.3) | |
| 60–69 | 637 (39.5) | 346 (32.2) | 102 (15.5) | 1 085 (32.4) | |
| ≥70 | 791 (49.0) | 684 (63.6) | 545 (82.7) | 2 020 (60.3) | |
| Stage | | | | | |
| Stage I/II | 1 120 (69.4) | 670 (62.3) | 336 (51.0) | 2 126 (63.5) | |
| Stage III | 323 (20.0) | 183 (17.0) | 106 (16.1) | 612 (18.3) | |
| Stage IV | 81 (5.0) | 36 (3.3) | 24 (3.6) | 141 (4.2) | |
| Unknown | 90 (5.6) | 186 (17.3) | 193 (29.3) | 469 (14.0) | |
| Gleason grade | | | | | |
| Low (2–4) | 66 (4.1) | 51 (4.7) | 95 (14.4) | 212 (6.3) | |
| Intermediate (5–7) | 1 035 (64.1) | 769 (71.5) | 382 (58.0) | 2 186 (65.3) | |
| High (8–10) | 356 (22.1) | 170 (15.8) | 99 (15.0) | 625 (18.7) | |
| Unknown | 157 (9.7) | 85 (7.9) | 83 (12.6) | 325 (9.7) | |
| Symptom at diagnosis | | | | | |
| Frequency of urine | 821 (50.9) | 547 (50.9) | 346 (52.5) | 1 714 (51.2) | |
| Pain while urinating | 103 (6.4) | 88 (8.2) | 65 (9.9) | 256 (7.6) | |
| Blood in urine | 94 (5.8) | 72 (6.7) | 53 (8.0) | 219 (6.5) | |
| ED | 356 (22.1) | 184 (17.1) | 91 (13.8) | 631 (18.8) | |
| Loss of libido | 247 (15.3) | 163 (15.2) | 83 (12.6) | 493 (14.7) | |
| Back pain | 261 (16.2) | 161 (15.0) | 84 (12.7) | 506 (15.1) | |
| Primary treatment | | | | | |
| RP | 374 (23.2) | 305 (28.4) | 255 (38.7) | 934 (27.9) | |
| EBRT with concurrent HT | 383 (23.7) | 179 (16.7) | 68 (10.3) | 630 (18.8) | |
| EBRT without concurrent HT | 484 (30.0) | 391 (36.4) | 213 (32.3) | 1 088 (32.5) | |
| BT | 87 (5.4) | 33 (3.1) | 4 (0.6) | 124 (3.7) | |
| HT | 147 (9.1) | 91 (8.5) | 72 (10.9) | 310 (9.3) | |
| Monitoring | 102 (6.3) | 44 (4.1) | 18 (2.7) | 164 (4.9) | |
| Missing | 34 (2.1) | 31 (2.9) | 28 (4.2) | 93 (2.8) | |

Results are not weighted for survey non-response bias. Chemotherapy was omitted because there were <5 respondents. Respondents may have more than one symptom.

four, one in eight (12.5%) reported five, 6% reported six and 2% reported all seven. The most common were ED (68%), loss of libido (58%) and fatigue (55%). There was significant variation in 'ever' had symptoms by time since diagnosis. Loss of libido was more common in men 2–4.9 years since diagnosis compared with those ≥ 10 years after diagnosis (60% vs 54%, respectively; $P = 0.010$). Bowel problems (26% of all respondents) and fatigue (55% of all respondents) were less common among those ≥ 10 years after diagnosis compared with other diagnosis periods, bowel (2–4.9 years, $P < 0.001$; 5–9.9 years, $P = 0.004$), fatigue (2–4.9 years, $P < 0.001$; 5–9.9 years, $P = 0.007$) (Table 3).

'Current' Physical Symptoms (Weighted Proportions)

Three-quarters of respondents reported at least one 'current' symptom with 29% reporting three or more symptoms and 4% at least five symptoms. About 65% reported currently having ED, UI and/or bowel problems, and 57% reported at least one of the following: loss of libido, breast changes, fatigue or hot flushes (Fig. 2). There was no significant

difference in proportions of 'current' symptoms between groups diagnosed during different periods. For each symptom, 'current' proportions were lower than 'ever'. The biggest differences were for fatigue (ever, 55%; current, 22%), hot flushes (ever, 39%; current, 6%) and UI (ever, 37%; current, 16%), and the smallest for ED (68% vs 57%). One-quarter of survivors (25%) reported no 'current' physical symptoms (Table 3).

Pretreatment and Post-Treatment Comparisons

Pretreatment and post-treatment comparisons were possible for ED and loss of libido. Before diagnosis, 19% reported ED, increasing with age at diagnosis from 16% of those aged < 60 years to 21% of men aged > 70 years. ED as a new current symptom after treatment was reported by 43%, while 5% reported ED pretreatment, but not currently. This varied by primary treatment being highest after RP. Loss of libido was reported before diagnosis by 15% of survivors; 5% reported this pretreatment but not currently; and 46% report 'current' loss of libido but not pretreatment (Fig. 3).

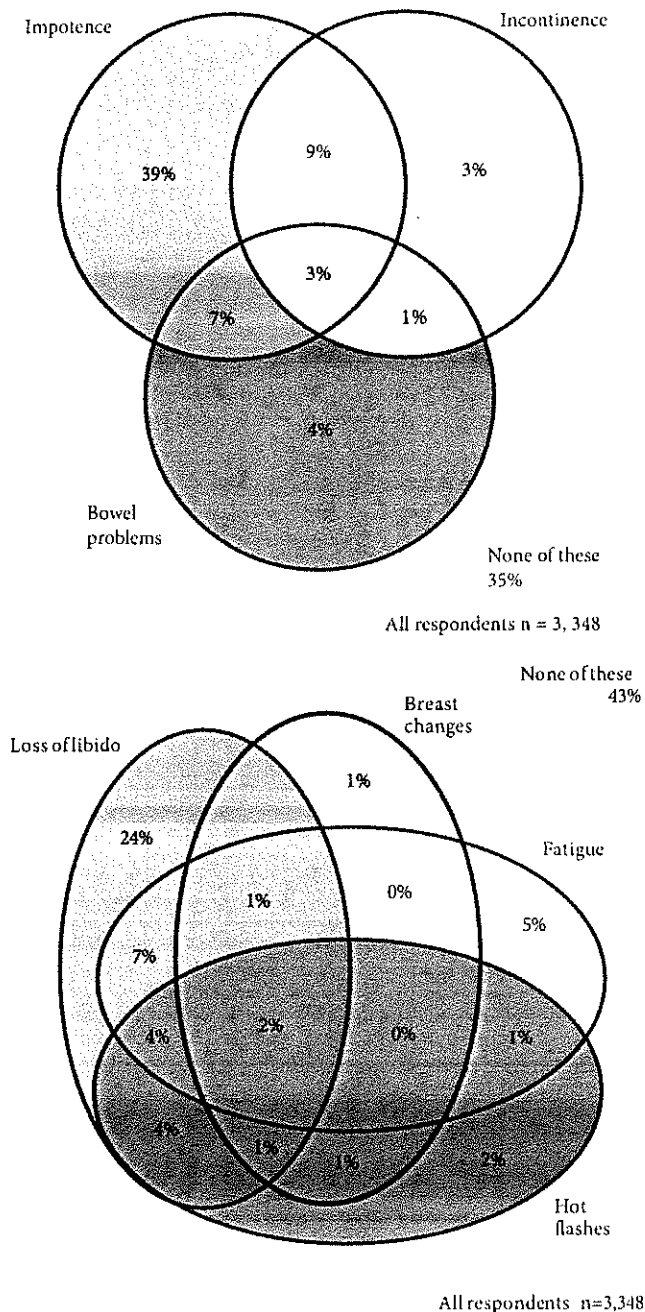
Table 3 Symptoms ('current' and 'ever') reported by prostate cancer survivors, by primary treatment method (weighted for country, age at diagnosis and time since diagnosis).

| | RP | EBRT with concurrent HT | EBRT without concurrent HT | BT | HT | Monitoring | Missing | All respondents |
|--|------------------|-------------------------|----------------------------|------------------|------------------|------------------|------------------|------------------|
| Percentage of men reporting symptom (95% CI) | | | | | | | | |
| Average age at diagnosis, years | 60.5 | 66.4 | 67.1 | 61.7 | 73.5 | 67.9 | 69.0 | 64.9 |
| UI | | | | | | | | |
| Ever had | 70.3 (67.2–73.3) | 24.3 (20.8–28.0) | 27.3 (24.7–3.0) | 28.5 (20.7–37.3) | 21.3 (17.1–26.1) | 12.1 (7.6–18.1) | 23.5 (15.7–33.0) | 37 (35.4–38.7) |
| Current | 27.8 (24.9–30.8) | 10.7 (8.3–13.5) | 11.8 (10.0–13.9) | 8.1 (4.0–14.4) | 14.5 (10.9–18.7) | 6.7 (3.4–11.6) | 12.7 (7.0–20.8) | 15.8 (14.6–17.1) |
| Loss of libido | | | | | | | | |
| Ever had | 59.5 (56.2–62.7) | 74.4 (70.6–77.9) | 55.7 (52.8–58.7) | 41.5 (32.7–50.7) | 58.6 (53.1–63.9) | 26.1 (19.5–33.5) | 37.3 (27.9–47.4) | 57.8 (56.1–59.5) |
| Current | 47.0 (43.7–50.3) | 58.0 (53.9–62.1) | 43.1 (40.2–46.1) | 26.0 (18.5–34.7) | 51.5 (46.0–56.9) | 21.8 (15.8–28.9) | 29.4 (20.8–39.3) | 45.5 (43.8–47.2) |
| ED | | | | | | | | |
| Ever had | 87.6 (85.3–89.7) | 78.7 (75.1–81.9) | 59.6 (56.7–62.5) | 58.5 (49.3–67.3) | 59.2 (53.7–64.5) | 26.1 (19.5–33.5) | 42.2 (32.4–52.3) | 68.2 (66.6–69.8) |
| Current | 75.5 (72.6–78.3) | 64.2 (60.2–68.1) | 50.2 (47.2–53.1) | 43.1 (34.2–52.3) | 50.9 (45.4–56.3) | 20.6 (14.7–27.6) | 29.4 (20.8–39.3) | 57.2 (55.5–58.9) |
| Bowel problems | | | | | | | | |
| Ever had | 16.6 (14.2–19.2) | 41.0 (36.9–45.1) | 33.1 (30.4–36.0) | 21.1 (14.3–29.4) | 14.2 (10.7–18.4) | 3.6 (1.3–7.7) | 9.8 (4.8–17.3) | 25.5 (24.1–27.1) |
| Current | 9.2 (7.4–11.3) | 22.0 (18.7–25.6) | 19.2 (16.9–21.6) | 7.3 (3.4–13.4) | 9.2 (6.3–12.8) | 2.4 (0.7–6.1) | 4.9 (1.6–11.1) | 14.2 (13.1–15.5) |
| Breast changes | | | | | | | | |
| Ever had | 6.2 (4.7–8.0) | 39.6 (35.6–43.7) | 17.7 (15.5–20.0) | 1.6 (0.2–5.8) | 22.8 (18.4–27.6) | 2.4 (0.7–6.1) | 4.9 (1.6–11.1) | 17.2 (16.0–18.6) |
| Current | 3.1 (2.1–4.5) | 20.0 (16.8–23.5) | 8.7 (7.1–10.4) | 1.6 (0.2–5.8) | 17.8 (13.8–22.3) | 1.8 (0.4–5.2) | 1.0 (0.0–5.3) | 9.3 (8.3–10.3) |
| Hot flushes | | | | | | | | |
| Ever had | 15.7 (13.4–18.3) | 79.9 (76.4–83.1) | 40.4 (37.5–43.3) | 11.4 (6.4–18.4) | 60.1 (54.6–65.3) | 6.1 (2.9–10.9) | 5.9 (2.2–12.4) | 38.7 (37.1–40.4) |
| Current | 7.0 (5.4–8.8) | 27.7 (24.1–31.5) | 14.5 (12.5–16.7) | 2.4 (0.5–7.0) | 40.5 (35.3–46.0) | 3.6 (1.3–7.7) | 2.0 (0.2–6.9) | 16.0 (14.8–17.3) |
| Fatigue | | | | | | | | |
| Ever had | 50.4 (47.1–53.7) | 74.0 (70.2–77.5) | 63.4 (60.5–66.2) | 44.7 (35.7–53.9) | 42.0 (36.7–47.5) | 8.5 (4.7–13.8) | 18.6 (11.6–27.6) | 54.9 (53.2–56.6) |
| Current | 18.1 (15.6–20.7) | 31.5 (27.7–35.4) | 22.8 (20.4–25.3) | 13.0 (7.6–20.3) | 28.4 (23.7–33.5) | 4.2 (1.7–8.5) | 4.9 (1.6–11.1) | 21.7 (20.3–23.2) |
| No symptom | | | | | | | | |
| Ever had | 4.3 (3.1–5.9) | 1.2 (0.5–2.5) | 9.6 (8.0–11.5) | 17.1 (10.9–24.9) | 10.9 (7.8–14.8) | 58.2 (50.3–65.8) | 37.3 (27.9–47.4) | 10.4 (9.4–11.4) |
| Current | 15.5 (13.2–18.0) | 16.5 (13.6–19.8) | 29.4 (26.8–32.2) | 41.5 (32.7–50.7) | 19.5 (15.4–24.2) | 63.6 (55.8–71.0) | 49.0 (39.0–59.1) | 25.2 (23.7–26.7) |
| Any symptom | | | | | | | | |
| Ever had | 95.7 (94.1–96.9) | 98.8 (97.5–99.5) | 90.4 (88.5–92.0) | 82.9 (75.1–89.1) | 89.1 (85.2–92.2) | 41.8 (34.2–49.7) | 62.7 (52.6–72.1) | 89.6 (88.6–90.6) |
| Current | 84.5 (82.0–86.8) | 83.5 (80.2–86.4) | 70.6 (67.8–73.2) | 58.5 (49.3–67.3) | 80.5 (75.8–84.6) | 36.4 (29.0–44.2) | 51.0 (40.9–61.0) | 74.8 (73.3–76.3) |

Results were weighted for survey non-response bias. Chemotherapy was omitted because there were < 5 respondents. Respondents may have more than one symptom.

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Fig. 2 (a) 'Current' ED, UI and bowel problems. (b) 'Current' loss of libido, breast changes, fatigue and hot flushes.



Variation in 'current' Physical Symptoms by Primary Treatment

Among men treated with RP proportions of 'current' ED (76%) and UI (28%) were higher than the average for all respondents (weighted proportions; $P < 0.001$) while bowel problems (9%), hot flushes (7%) and breast changes (3%)

after RP were lower than average ($P < 0.001$ for all three comparisons).

Men treated with EBRT with concurrent HT reported the highest proportions of current bowel problems (20%) compared with HT (9%), RP (9%), BT (7%) or monitoring (2%). Survivors treated by EBRT with concurrent HT, compared with those who had EBRT without concurrent HT, reported more 'current' loss of libido (58% vs 43%, $P < 0.001$), ED (64% vs 50%, $P < 0.001$), breast changes (20% vs 9%, $P < 0.001$), hot flushes (28% vs 15%, $P < 0.001$) and fatigue (32% vs 23%, $P < 0.001$).

Those treated with BT reported lower than average proportions of 'current' ED (43%), loss of libido (26%), hot flushes (2%), and breast changes (2%); 42% of this group reported no 'current' problems.

Men treated with HT alone reported high proportions of 'current' loss of libido (52%), ED (51%), hot flushes (41%) and fatigue (28%), while 20% reported no 'current' physical symptoms.

Of the men on monitoring, 64% reported no 'current' physical symptoms, higher than other groups ($P < 0.001$). One in five men on monitoring reported loss of libido or ED (21%, only slightly higher than pretreatment average level of 19%) or loss of libido (22%). Other symptoms were less common in the monitoring group [UI (7%), hot flushes (4%), fatigue (4%), bowel problems (2%) and breast changes (2%)] (Table 3).

Variation in 'current' Symptoms by HT

Overall, 45% reported receiving HT at some point after diagnosis. Current use of HT (19%) compared with past use (26%), and never used (55%) was associated with more hot flushes, (54% current vs 15% past vs 4% never), loss of libido (62% current vs 50% past vs 38% never), breast changes (23% current vs 14% past vs 2% never) and fatigue (38% current vs 23% past vs 16% never) (all comparisons $P < 0.001$) (Fig. 4).

Discussion

This large population-based study adds to the literature in this area by examining seven disease-specific physical symptoms of men of all ages with prostate cancer up to 18 years after diagnosis. All treatment methods were included in two countries with high standards of services and patient care. This has allowed us to estimate the population burden of physical symptoms as reported by men, their patterns following different treatments and their 'persistence'. Considering the uncertainties about optimal treatment from a clinical outcome perspective, this type of information on patients-reported outcomes is potentially extremely valuable for informing treatment decision-making.

Patient-reported long-term symptoms following prostate cancer treatments

Fig. 3 (A) ED pretreatment and currently. (B) Loss of libido pretreatment and currently. Note, only ED and loss of libido are compared before and after treatment as definitions for other conditions differed before and after treatment.

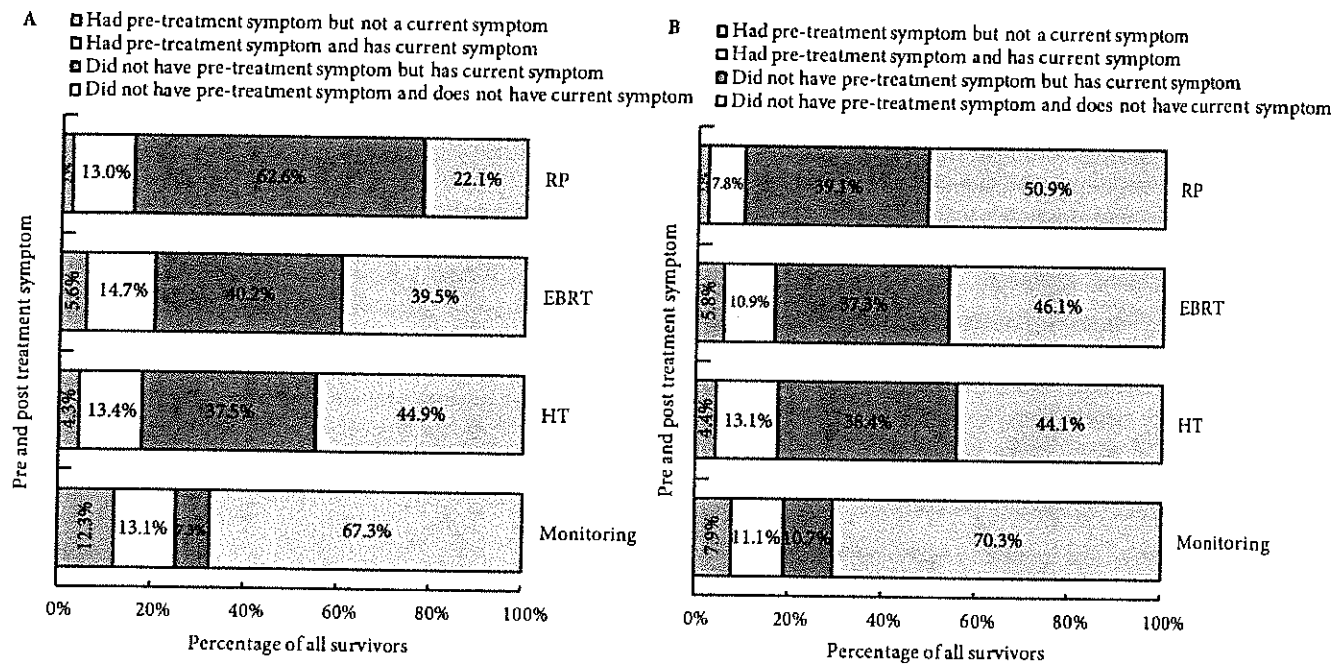
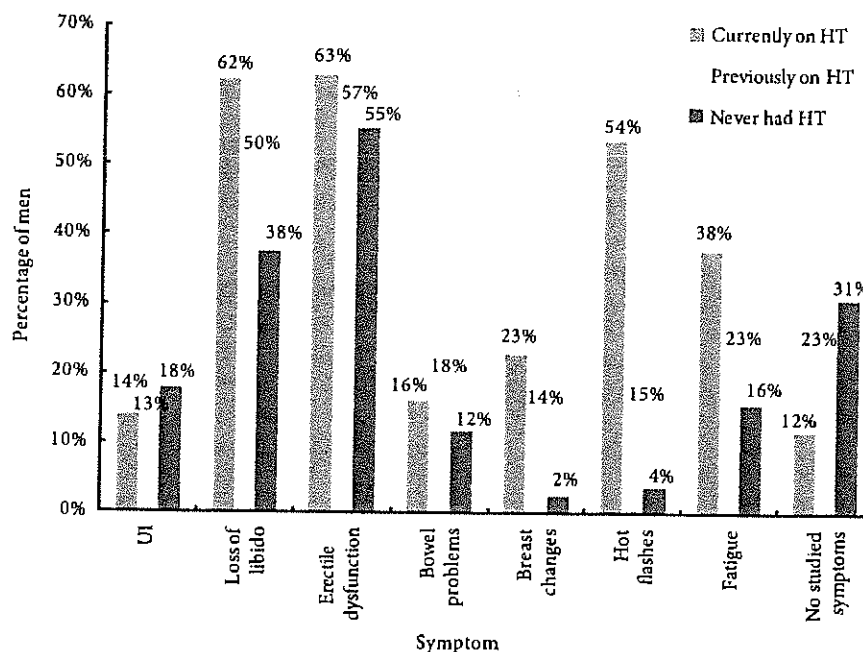


Fig. 4 Current symptoms reported by the survivors of prostate cancer using HT.



The burden of symptoms is high, with many survivors reporting multiple symptoms. Nine out of 10 men reported at least one of the seven possible symptoms at some point after diagnosis and three-quarters reported at least one as 'current'. However, about one in 10 survivors reported no symptoms at any time and 25% were currently symptom free.

Over half (57%) reported 'current' ED, almost half (46%) reported loss of libido and one in six reported 'current' UI, with fatigue a common complaint. UI and ED were more common after RP compared with other treatments, and bowel problems were most common after EBRT. The pattern of these symptoms was as documented in smaller studies

reporting on specific treatments [7,10,20–21]. However, the present study, which looks at survivors at population level, allows an estimate of total burden.

For ED, 'current' levels of 57% and 'ever' levels of 68% were reported. This work extends that of Korfage *et al.* [22], who found that at 52 months after treatment, 88% of men treated with RP and 64% of those who had EBRT with concurrent HT reported ED. We found similar high levels by examining men up to 15 years after diagnosis supporting the Korfage *et al.* assertions that ED is likely to be permanent if present 12 months or more after treatment.

The effect of HT in improving survival has been documented, but at a cost of symptoms such as loss of libido, fatigue, hot flushes and breast changes [10,23]. Consistent with this, and reported for a large cohort, those currently on HT were ≈ 10 -times more likely to report breast changes and hot flushes than those who never had HT. High levels of fatigue for those on HT is similar to clinical studies [24].

An important part of our present analysis related to the prevalence of symptoms at different times since diagnosis. The lower proportion of bowel problems reported by survivors diagnosed ≥ 10 years ago probably reflects lower rates of EBRT in that cohort (confirmed by cancer registry data), as well as improvements in technologies. The fact that the proportions who reported 'ever' and 'current' symptoms were similar in each survival period indicates a need for ongoing support after treatment for prostate cancer.

Implications

Current UK guidelines recommend that survivors and their partners are given opportunities to discuss psychosexual problems and that counselling on sexual problems and UI is available as long as needed [6]. Our present results suggest there is likely to be a large need, with three-quarters of men reporting at least one physical symptom, almost 60% 'current' ED and one in six reporting 'current' UI.

Based on the present work, of the 22 823 prostate cancer survivors resident in Ireland at the time of the study, we estimate that $17\ 100 \pm 300$ had at least one 'current' physical symptom, including ED ($13\ 100 \pm 400$) loss of libido ($10\ 400 \pm 400$), fatigue ($5\ 000 \pm 300$) and UI ($3\ 600 \pm 300$). Based upon the 2011 Censuses in both countries, we estimate that 1.6% of the male population aged ≥ 45 years is a prostate cancer survivor with a 'current' physical symptom: 1.2% with ED and 1% with loss of libido. This represents a significant number of men who require ongoing care. The information in the present study could also be used to help inform decisions about investigation and treatment of prostate cancer and survivors' expectation of symptoms [6]. Recognition and

treatment of physical symptoms should be prioritised in patient follow-up.

Strengths

Unlike other similar patient-reported outcome studies in prostate cancer, the present study included men of all ages, treated with all available methods [25–26]. It also covered a longer period since diagnosis [7,20]. High-quality cancer registries provided the basis for sampling and this allowed population representativeness to be assessed and proportions to be weighted, so that estimates are of the symptom burden in the entire survivor population. Self-reported treatment was compared with treatment information from each registry; congruence for RP was 86% in Northern Ireland and 70% in the Republic of Ireland, and for EBRT was 96% in Northern Ireland and 75% in the Republic of Ireland. Weighting allowed us to address some demographic aspects of non-response.

Limitations

As with many questionnaire studies, older persons were less likely to respond but weighted proportions allowed adjustment for this [5]. In addition, as a cross-sectional study, comparisons between groups diagnosed at different time-periods have limitations owing to changing treatment, investigation patterns and different patient profiles. We recognise that accuracy of recall as a potential limitation, for example, the 4% of survivors in the monitoring group reporting 'current' hot flushes may represent contamination of treatment recall with survivors not recognising that they are having HT.

While we have documented symptoms reported by survivors of prostate cancer, we recognise that not all can be attributed to prostate cancer treatments, e.g. ED increases with age [27,28]. We have reported pretreatment and post-treatment levels of ED and these increased with age from 16% in men aged < 60 years, to 18.7% in men aged 60–69 years and 20.4% in men aged ≥ 70 years. The same men responded with to post-treatment levels of ED of 66.4% aged < 60 years, 61.5% aged 60–69 years and 45.9% aged ≥ 70 years. These figures reflect the higher rates of RP in younger men and monitoring in older men. UI in general male populations, without prostate cancer, has been estimated to be between 3% and 11% [29]. UI among the Irish population has been reported at 4.5% for men aged > 50 years, ranging from 2 to 4% for men aged 50–64 years to 4–7% for men aged 65–74 years and 6–11% for those aged > 75 years [30], which is lower than the 16% ongoing UI reported after treatment. Some of the reported physical symptoms may, however, be caused by co-morbidities, or other treatments such as breast changes caused by commonly used medications [29]. Future studies should collect normative data for the male population to better determine treatment effects.

In conclusion, physical symptoms after prostate cancer treatment are common, often multiple and persist years after diagnosis, representing a large health burden.

Acknowledgements

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Conflicts of Interest

The authors declare that they have no conflicts of interest.

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E-mail: a.gavin@qub.ac.uk

Abbreviations: BT brachytherapy; EBRT external beam radiotherapy; EORTC European Organisation for the Research and Treatment of Cancer; ED erectile dysfunction; HT hormone therapy; RP radical prostatectomy; UI urinary incontinence.

Appendix 3: Feedback from the NI Cancer Patient Experience Survey 2015


**Southern Health
and Social Care Trust**

Quality Care - for you, with you

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

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

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

| Question number | Detail | Southern % | NI Average % | Difference % |
|-----------------|--|------------|--------------|--------------|
| Q1 | Saw GP once/twice | 82 | 74 | +8 |
| Q2 | Pt thought seen as soon as necessary | 87 | 86 | +1 |
| Q4 | Pt's health got better or remained about same while waiting | 82 | 84 | -2 |
| Q6 | Staff gave complete explanation of purpose of test | 86 | 84 | +2 |
| Q7 | Staff explained what would be done during test | 89 | 88 | +1 |
| Q8 | Given easy to understand written info about test | 83 | 88 | -5 |
| Q9 | Given complete explanation of test results in understandable way | 80 | 80 | - |
| Q11 | Pt told could bring friend when first told they had cancer | 71 | 76 | -5 |
| Q12 | Pt felt they were told sensitively that they had cancer | 83 | 86 | -3 |
| Q13 | Pt completely understood explanation of what was wrong | 76 | 77 | -1 |
| Q14 | Pt given written info about type of cancer they had | 54 | 48 | +6 |
| Q15 | Pt given a choice of different type of treatment | 67 | 81 | -14 |
| Q16 | Pt's views taken into account when discussing treatment | 63 | 69 | -6 |
| Q17 | Side effects explained in an understandable way | 77 | 75 | +2 |
| Q18 | Pt given written information about side effects | 61 | 64 | -3 |
| Q19 | Pt told about side effects that could affect them in future | 53 | 51 | +2 |
| Q20 | Pt definitely involved in decisions about care and treatment | 71 | 75 | -4 |
| Q21 | Pt given the name of the CNS in charge of their care | 48 | 53 | -5 |
| Q22 | Pt finds it easy to contact their CNS | 88 | 82 | +6 |
| Q23 | CNS listened carefully last time spoken to | 90 | 95 | -5 |

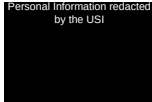
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|------|---|----|----|-----|
| Q24 | Get understandable answers to important questions all/most of the time (CNS) | 90 | 89 | +1 |
| Q25 | Hospital staff gave info about support groups | 47 | 67 | -20 |
| Q26 | Hospital staff gave info about impact cancer could have on work/education | 55 | 60 | -5 |
| Q27 | Hospital staff gave info on getting financial help | 33 | 41 | -7 |
| Q28 | Pt saw cancer research info in hospital | 84 | 79 | +5 |
| Q29* | Taking part in cancer research discussed with patient | 1 | 9 | -8 |
| Q36 | Got understandable answers to important questions all/most of time(doctors) | 72 | 74 | -2 |
| Q37 | Pt had confidence and trust in all doctors treating them | 90 | 86 | +4 |
| Q38 | Doctors did not talk in front of pt as if they were not there | 86 | 80 | +6 |
| Q39 | Pt's family had opportunity to talk to doctor | 56 | 58 | -2 |
| Q40 | Got understandable answers to important questions all/most of time from (ward nurses) | 71 | 75 | -4 |
| Q41 | Patient had confidence and trust in all ward nurses | 81 | 79 | +2 |
| Q42 | Nurses did not talk in front of pt as if they were not there | 84 | 86 | -2 |
| Q43 | Always/nearly always enough nurses on duty | 47 | 60 | -13 |
| Q44 | Pt did not think hospital staff deliberately misinformed them | 81 | 86 | -5 |
| Q45 | Pt never thought they were given conflicting info | 83 | 84 | -1 |
| Q46 | All staff asked pt what name they preferred to be called by | 71 | 67 | +4 |
| Q47 | Always given enough privacy when discussing condition or treatment | 79 | 81 | -2 |
| Q48 | Always given enough privacy when being examined or treated | 93 | 94 | -1 |
| Q49 | Pt was able to discuss worries or fears with staff during visit | 67 | 69 | -2 |
| Q50 | Hosp staff did everything to help control pain all of the time | 83 | 84 | -1 |
| Q51 | Always treated with respect and dignity by staff | 86 | 88 | -2 |
| Q52 | Given clear written info about what should/should not do post discharge | 84 | 78 | +6 |
| Q53 | Staff told pt who to contact if worried post discharge | 78 | 81 | -3 |
| Q54 | Family definitely given all info needed to help care at home | 68 | 59 | -9 |
| Q55 | Pt definitely given enough care from health or social | 59 | 51 | +8 |

| | services | | | |
|-----|--|----|----|----|
| Q57 | Staff definitely did everything to control side effects of chemo | 82 | 82 | - |
| Q58 | Staff definitely did everything they could to help control pain | 78 | 80 | -2 |
| Q59 | Hospital staff definitely gave patient enough emotional support | 71 | 75 | -4 |
| Q61 | Doctor had the right notes and other documentation with them | 98 | 97 | +1 |
| Q62 | GP given enough info about pt's condition and treatment | 91 | 94 | -3 |
| Q63 | Practice staff definitely did everything they could to support patient | 81 | 79 | +2 |
| Q64 | Hospital and community staff always worked well together | 78 | 73 | +5 |
| Q66 | Given the right amount of info about condition and treatment | 83 | 85 | -2 |
| Q67 | Pt offered written assessment and care plan | 9 | 11 | -2 |
| Q68 | Pt did not feel that they were treated as 'a set of cancer symptoms' | 78 | 84 | -6 |
| Q69 | Pt's rating of care excellent/very good | 90 | 90 | - |

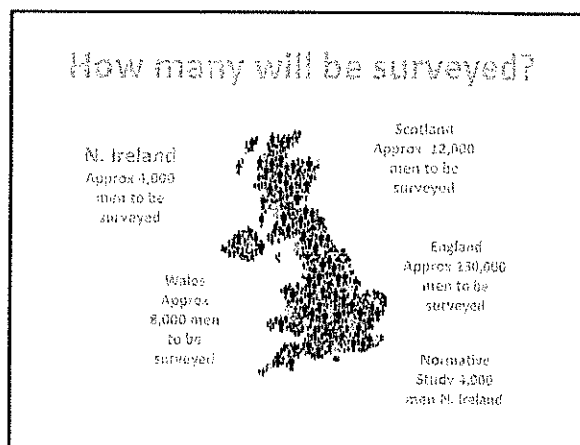
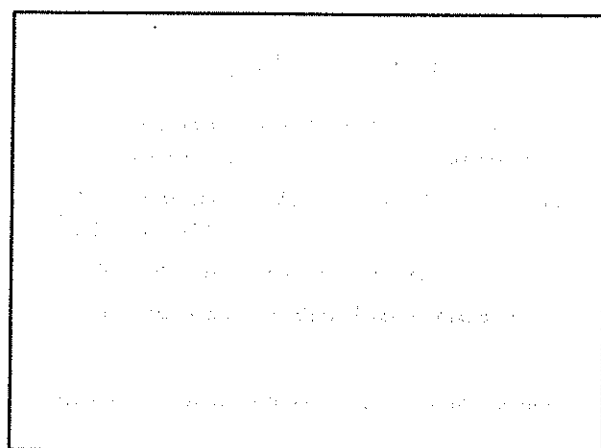
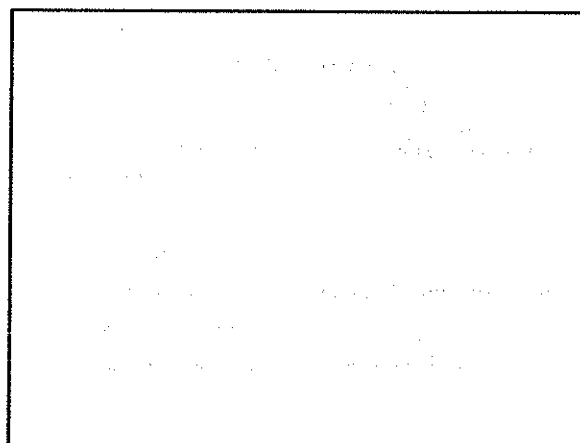
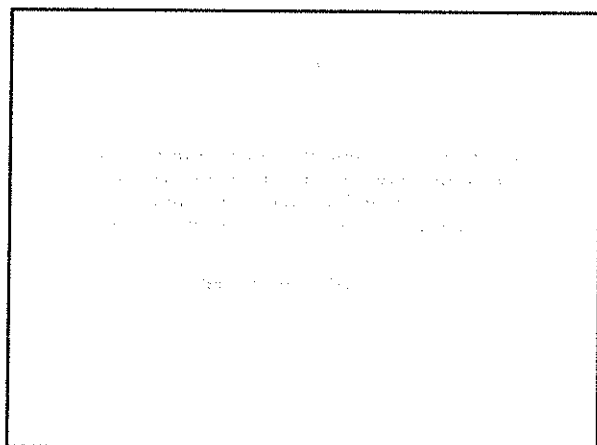
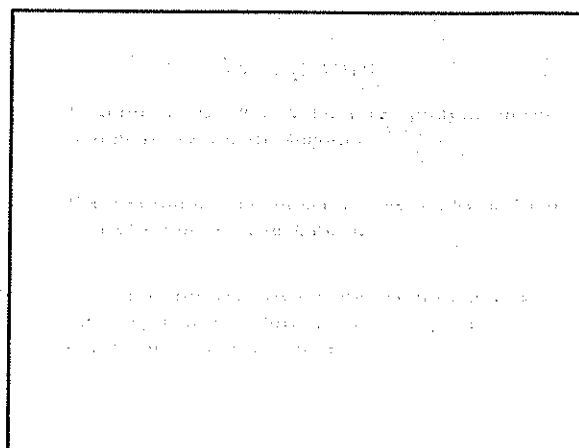
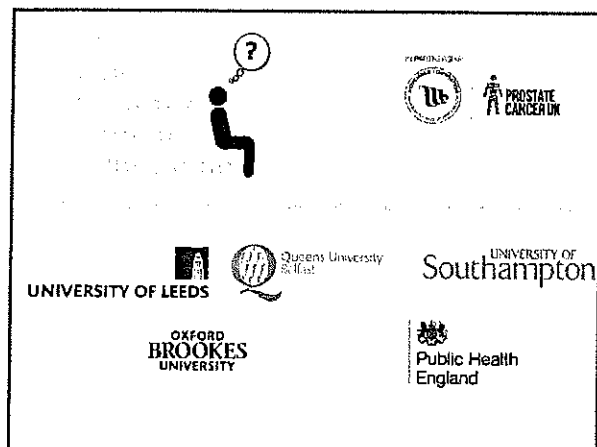


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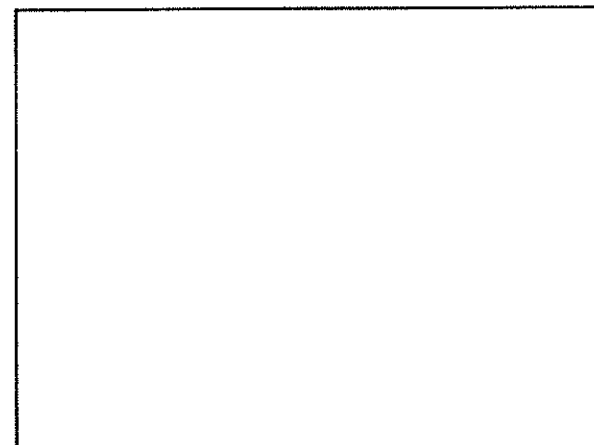
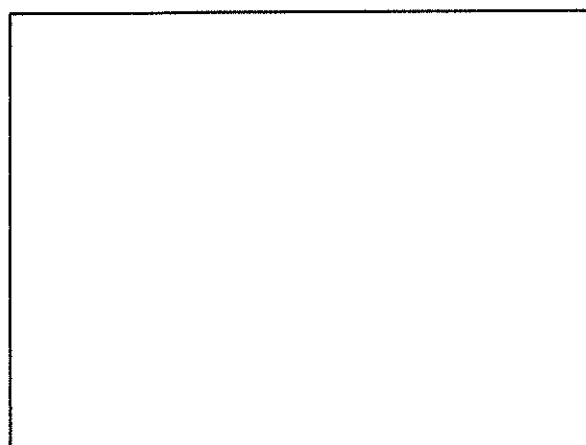
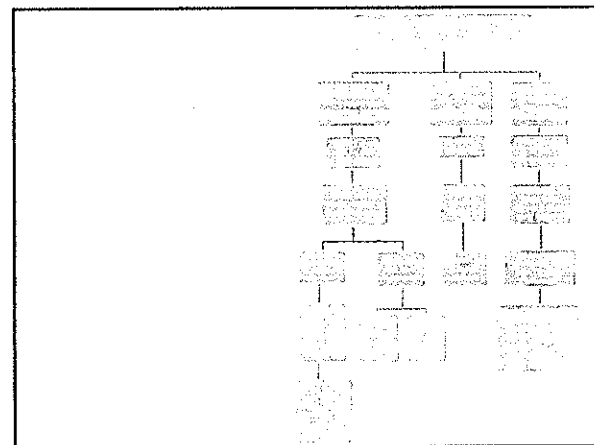
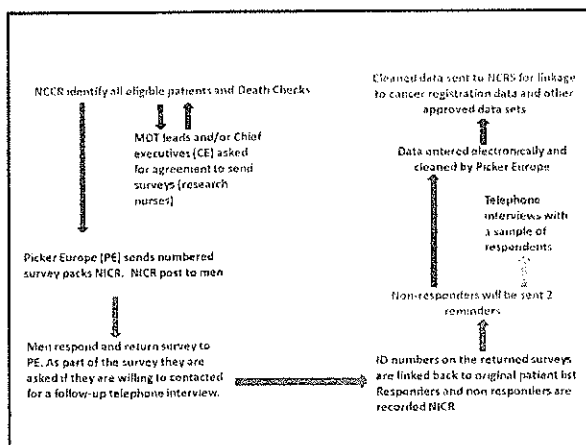
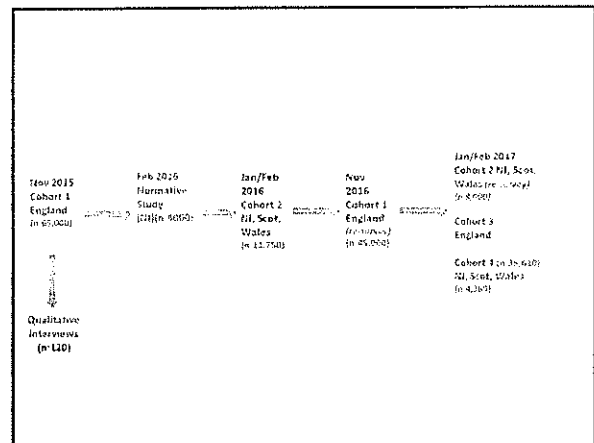
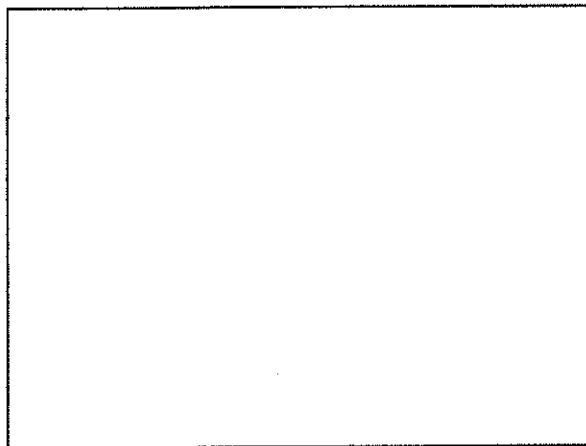
Other roles structured reflective template

| | |
|--|-----------------|
| Name of doctor: Aidan O'Brien | GMC No: 1394911 |
| <p>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:</p> <p>As Lead Clinician of NICA Urology, I facilitated the inclusion of prostate cancer patients in Northern Ireland in a UK wide study of Life after Prostate Cancer Diagnosis.</p> <p>Because of recent changes to Data Protection Law and Patient Confidentiality, it is no longer considered optimal that a third party agency, such as the Northern Ireland Cancer Registry, should contact, survey and hold personalized patient data. Following approach and discussion with NICA Urology, I secured the agreement that all initial communication with patients would be communicated by the three Urology MDT Lead Clinicians.</p> <p>It is anticipated that 4,000 patients will have been surveyed by end of 2017 with a view to reporting in 2018.</p> | |
| <p>They also brought the following drawbacks to my main clinical role:</p> <p>Being a named communicator to a large number of patients is intended to include the responsibility of resolving any clinical issues that arise.</p> <p>The only issue affecting Southern Trust patients to date, has been the recent identification of four patients who replied that they did not have prostate cancer, even though they had histopathological diagnoses and on continued management. All four patients will be contacted in the near future.</p> | |
| <p>Final outcome after discussion at appraisal:
(Complete at appraisal considering how your approach will improve patient care)</p> <p><i>reflected</i></p> <div style="text-align: right;"> <p>Personal information redacted
by the USI</p>  </div> | |

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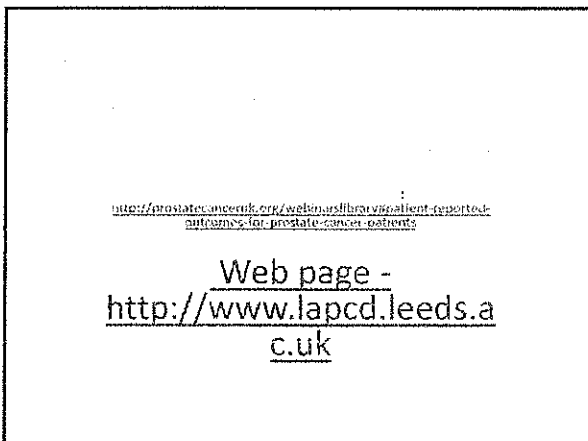
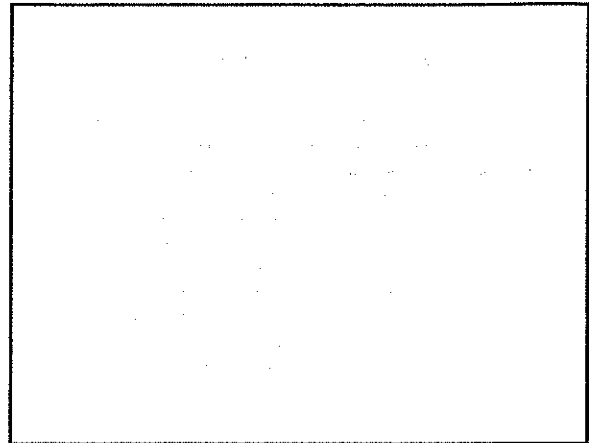
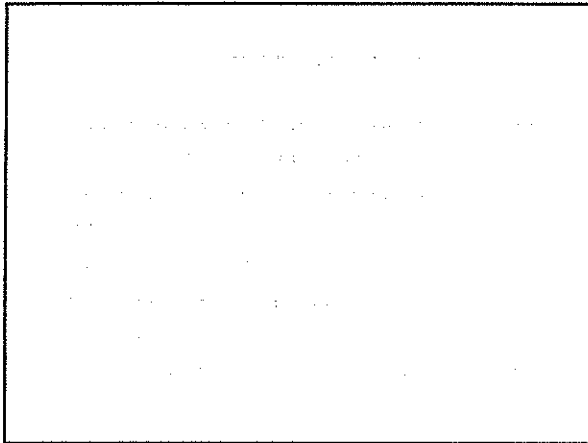
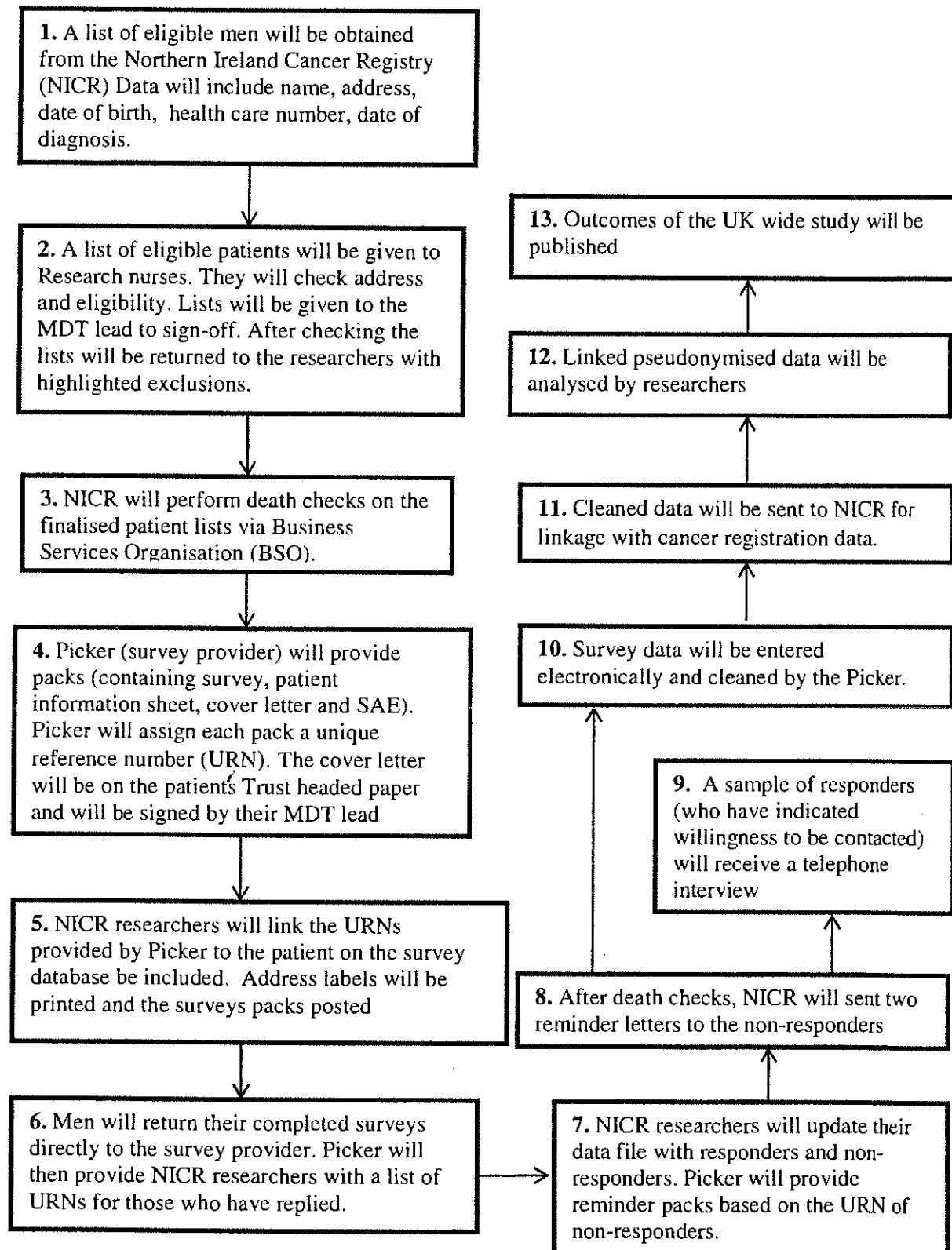
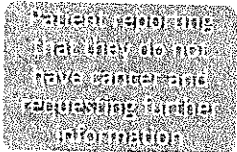


Figure 3: Study data flows





1. Астрономия — наука о небесных
 телах и космосе.
 2. Астрономия — наука о небесных
 телах и космосе.

Figure 6

Figure 6 shows two graphs illustrating the effect of the number of iterations (n) on the error rate (ϵ) for different values of k . The top graph shows the error rate for $k=1$, and the bottom graph shows the error rate for $k=2$. Both graphs show that the error rate decreases as the number of iterations increases, and that the error rate is lower for $k=2$ than for $k=1$.

Foreign Desk
— contact —

**Pregnant
cancer MDT
Lead of
treating
team
tells parents**

These altered
that patient
was considered
in survey but
they denied
diagnosis

Provisional dates:
1981: 1981
1982: 1982
1983: 1983

**Acidology
Letter
sent to
editor**

Registry records updated

圖 1 試驗裝置圖

2001
 2002

**Religious
Terrorists**

Flagged as Big Work Contract

[illegible][illegible]

Investigative Unit
Surrey Police
Surrey Provincial
Crime Register

1. **Ministry of**
Government. The
Dr. G. G. G. G.
1999

Based on outcome of investigation, escalates as appropriate relevant organisations inform and explanation sent to patient

Figure 4: Patient query escalation process

SURVEY PROVIDER

Query recorded in Survey Provider Log and escalated to contact(s) within Study Team - Within 1 working day

STUDY TEAM

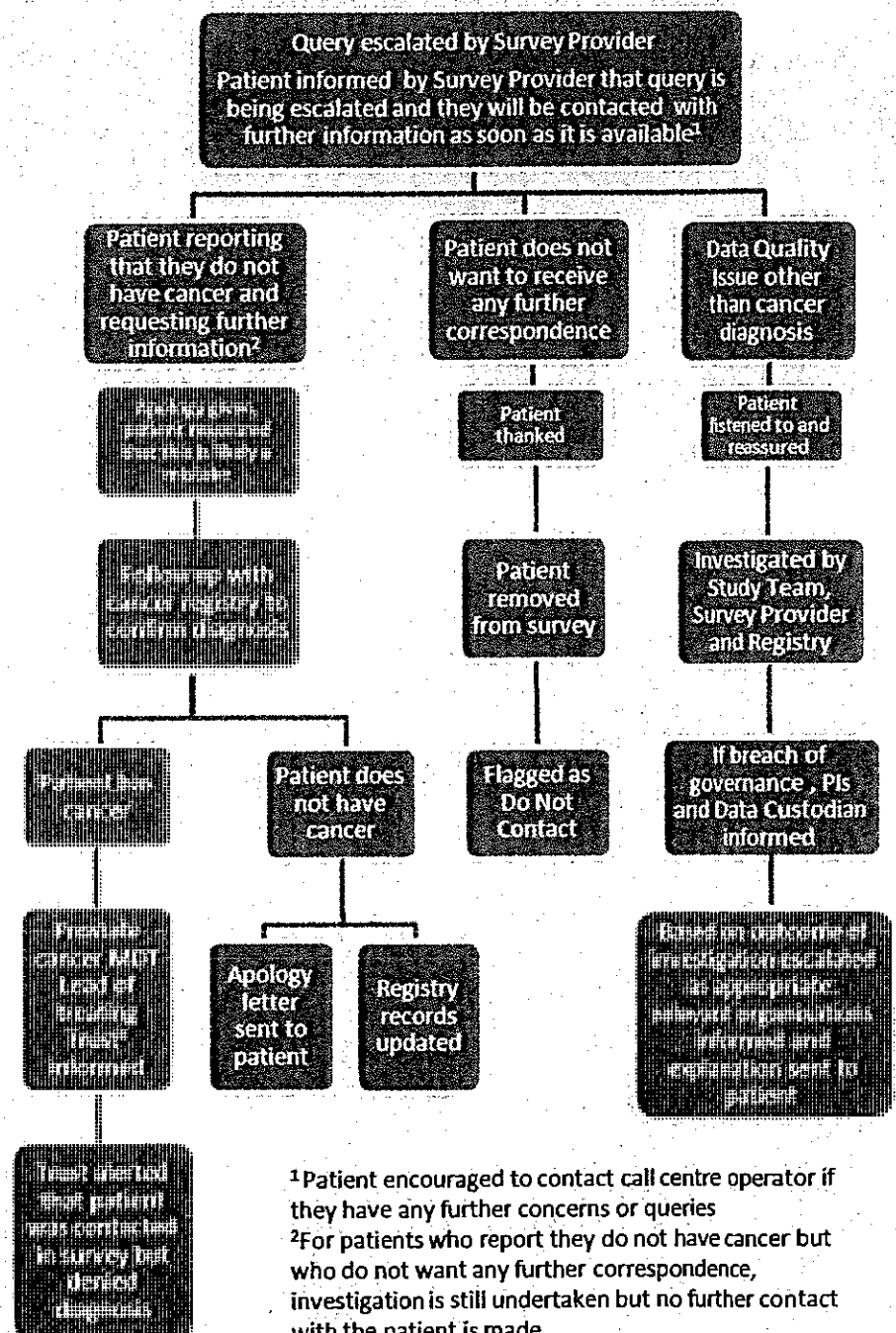
Study Team investigation undertaken within 2 working days

Where a cancer registry, Trust or other organisation is involved, request confirmation that action has been undertaken. Record confirmation and key contact details.

Expectation that patient is re-contacted within 3 working days.

Current status, leads and outcomes recorded in Log and fed back to Survey Provider - Daily

Summary of log provided to Principal Investigators - Weekly



¹ Patient encouraged to contact call centre operator if they have any further concerns or queries

² For patients who report they do not have cancer but who do not want any further correspondence, investigation is still undertaken but no further contact with the patient is made.

³ Clinician informed of the type of evidence the Registry holds regarding this diagnosis

Section Eight: Future contact

Follow-up survey

Thank you for completing this survey. We will be **contacting you again in a years' time** for the follow-up survey. If you decide at that time you would rather not complete the survey again there is no obligation to do so.

Follow-up interview

As part of this work we are going to be interviewing a small number of men and some partners /spouses to gain a better understanding of their experience. This will only involve men and their partners / spouses who indicate they are interested in being interviewed. We would normally only be able to interview either the participant or their partner/spouse. We will not be interviewing couples together.

If you or your partner/spouse is interested in being involved in the interview, please tick the relevant boxes below.

- ☐ I am interested in being interviewed for this work
- ☐ My partner / spouse is interested in being interviewed for this work

We are sorry we will not be able to contact all those who would like to participate in the interview, but we will make sure that we get the views of a varied group. If you are one of the group we would like to interview we will write to you explaining how to get in touch with us to find out more about the interview. If you are still interested, we would arrange a time for the interview. If you think your partner/spouse would like to be interviewed, we would follow a similar process by making the initial contact with you by letter.

You have completed the survey. Thank you for your time.

If you would like to know more about this study then please visit our website:
<http://www.lifeafterprostatecancerdiagnosis.com/>

We very much appreciate the time and thought you have put into completing this survey. If reflecting on your situation has caused anxiety or uncertainty in any way, please do not hesitate to contact your specialist cancer nurse or call one of the specialist nurses on Prostate Cancer UK's Confidential Help Line.

Prostate Cancer UK's Confidential Help Line telephone: **0800 074 8383**

(free from UK landlines)

(Monday – Friday 9-6pm, Wednesday 9-8pm).

They are there to listen to your concerns, and offer support and helpful information

AOB-23199

IN PARTNERSHIP



Life After Prostate Cancer Diagnosis Prostate Patient Reported Outcomes Survey

More men are now living longer after a diagnosis of prostate cancer. We want to find out what life is really like for this group of men. Your answers will benefit other men with prostate cancer in the future by providing information to help clinical teams, service providers and policy makers make decisions about how to improve the quality of services for prostate cancer patients. We would be grateful if you would complete this survey, which asks for information about your health and quality of life.

If you have **not** had a diagnosis of prostate cancer this questionnaire is not relevant to you. Please tick the "no" box below and please accept our apologies for contacting you. Please return the blank questionnaire in the envelope provided and we will correct our records. If you have any questions about this survey please contact the FREEPHONE helpline number: **0808 801 0678**.

Have you ever been told by a doctor that you have prostate cancer?

Yes No

☐ ☐

If you have ticked **yes** to the first question please complete the rest of the survey.

If you have ticked **no**, please accept our apologies for this mistake, and send the questionnaire back to us in the envelope provided.

The survey

This survey is made up of eight sections and will take approximately 30 minutes to complete.

Who should complete the questionnaire?

The questions should be answered by the person named in the letter that came with this questionnaire. If that person needs help to answer the questions then the answers should be given from their point of view – not from the point of view of the person who is helping.

Completing the questionnaire

For each question please tick clearly inside the box of the response that best represents your views, using a black or blue pen. Do not worry if you make a mistake. Just cross out the mistake and put a tick in the correct box. Do not write your name or address anywhere on the questionnaire. The more questions in this survey that you complete, the more we can understand what life is like for those living with and beyond prostate cancer. However, if you feel unable or uncomfortable about answering any of the questions, leave it blank and move on to the next one.

The information you give us will be kept **securely** and treated in **confidence**. We will not publish any personal information that could allow anyone to identify you. We are very grateful for your time and effort in completing this survey.

If you have any queries about the questionnaire, please call the FREEPHONE helpline number: **0808 801 0678**

You can find more information about the study at
<http://www.lifeafterprostatecancerdiagnosis.com/>



IN PARTNERSHIP



Life After Prostate Cancer Diagnosis Research Study

If you are looking at this information sheet this means you have read the covering letter and therefore have had a diagnosis of prostate cancer. If you **have not had** a diagnosis of prostate cancer please return the documents in the envelope provided and they will be destroyed. We have brought this point up again as we are very concerned that contacting men who have not had a prostate cancer diagnosis may lead to misunderstanding and unnecessary worry.

You are being invited to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please get in touch using the numbers at the end of this leaflet if there is anything you are not clear about or if you would like more information.

Thank you for reading this.

What is the Life After Prostate Cancer Diagnosis study about?

We know that prostate cancer is the most common cancer to affect men in the United Kingdom. Each year, over 40,000 men are diagnosed with prostate cancer, and the risk of developing the disease increases with age. We understand that treatment for prostate cancer can affect men's lives in many different ways. It can also affect their partners or spouses. We want to develop our understanding of men's health and wellbeing and how these may be improved.

We want to find out directly from men how a prostate cancer diagnosis and treatment have affected their everyday lives: physically, emotionally, socially and practically. To do this we will be asking men to complete questions, known as Patient Reported Outcome Measures (PROMs) asking them about their experiences. We want to hear from as many men as possible whatever their age, stage of prostate cancer, whether they have symptoms or not and no matter what other medical conditions they may have. All opinions are important.

Why have I been chosen?

We are sending this survey in the post to all men living in England who are 16-40 months following diagnosis of prostate cancer. Surveys will also be posted out to men in Scotland, Wales and Northern Ireland at a later date.

What do we want the research to find out?

In total, around 100,000 men will be sent a survey in the post over the next three years. For the first time ever, this research will give us a very clear and detailed picture of what life is like for men with prostate cancer across the UK. It should tell us how it changes over time, what helps men cope, what gaps there are in support and care services and whether any of these issues change depending on what part of the country you are from.

By collecting information about the experiences of men who have been diagnosed with, treated for and are living with and beyond prostate cancer across the UK, we hope the results will be able to be used to improve the lives of men diagnosed with prostate cancer now and for men diagnosed with prostate cancer in the future.

receive or your statutory rights either now or in the future. No further information will be sought and we will not contact you again.

If you wish to withdraw from the study, please phone the above numbers within 6 months from the date we first wrote to you. This 6-month window recognises that the research team will start using the information you have provided as soon as possible and that it may become difficult to identify what information does relate to you later on.

Who has reviewed the study?

The study has been reviewed by people who have experience of prostate cancer themselves as well as independent experts in this area of research. All health research is carefully considered and approved by a Research Ethics Committee – an independent group of people that works to protect your interests (REC reference 15/NE/0036).

Who is funding and organising this study?

This study is funded by Prostate Cancer UK (PCUK) in partnership with the Movember Foundation Health Outcomes Improvement Initiative. The study is being coordinated by an experienced group of researchers from across the UK with medical, nursing, scientific and patient backgrounds. The team is supported by a prostate patient advisory group and a clinical advisory group. Dr Adam Glaser from the University of Leeds and Dr Anna Gavin from Queen's University Belfast are the Chief Investigators. The organisations involved are Public Health England, the University of

Leeds, Queen's University Belfast, University of Southampton and Oxford Brookes University. The University of Leeds are sponsoring the study.

Where can I get more information about the study?

The full protocol and information regarding the process of obtaining ethical approval are all available on the study website (www.lifeafterprostatecancerdiagnosis.com). The information includes specific details of the data processor and data controller, and all organisations involved in the study.

What if there is a problem?

If you have a concern or questions about any aspect of the Life After Prostate Cancer Diagnosis study, please telephone the survey helpline number on:

Life After Prostate Cancer Diagnosis helpline telephone number: 0808 801 0678

Alternatively, if you wish to make a complaint, you may prefer to contact your local NHS Trust's Patient Advice Liaison Service (PALS) or equivalent, who can provide an independent complaints service.

For any prostate cancer specific problems please do not hesitate to contact your specialist cancer nurse, or call one of the Prostate Cancer UK's Specialist Nurses via the Prostate Cancer UK's Specialist Nurse Telephone Line or email: they are there to listen to your concerns, and offer support and helpful information.

Prostate Cancer UK's Specialist Nurse Telephone Line: 0800 074 8383
(free from UK landlines)

(Monday – Friday 9-6pm, Wednesday 10-8pm).

Or email helplineenquiries@prostatecanceruk.org

For general and independent information on participating in research you may contact:

Cancer Help UK

www.cancerhelp.org.uk

Tel: 0808 800 4040 (Monday-Friday 9-5pm)

Thank you for reading this information sheet and considering taking part in this study.

Why are we doing this study?

We know that quality of life after prostate cancer isn't a level playing field – not everyone experiences the same issues and side effects. We want to gather enough information to identify specific factors, such as physical or emotional issues, that put some men at greater risk of poorer wellbeing after prostate cancer.

What would I have to do?

We would like you to complete the enclosed survey. The questions will ask for information about you, your diagnosis and any treatment you may have had, symptoms and side effects, and your overall physical, emotional and social well-being. It will probably take about 30 minutes to complete, but you don't have to answer them all in one go. We want everyone to answer the questions even if they don't have any problems – as it is important for us to know this.

Many men following prostate cancer diagnosis and its treatment experience problems with a number of quite personal issues. It is important we have good information about the extent and severity of these problems to help provide better support in the future. Please be assured that **all** responses are kept completely confidential. We hope you will feel comfortable in responding to all the items in the survey but if you would rather not complete some questions you can simply leave them blank and move on to the next one.

Once completed, please post the survey back to us in the pre-paid envelope enclosed. By sending it back to us, you are agreeing to take part in the study and that your answers can be analysed with the other men's answers (anonymously) by the research team. Please keep this information sheet and the letter enclosed as a record of your involvement.

Taking part will **not** involve visits to the hospital.

Do I have to take part?

No. It is up to you to decide whether or not to take part and if you decide not to, your decision will not affect any care you may receive or your statutory rights either now or in the future. If you do not wish to take part, please send this survey back uncompleted in the envelope provided, so that we can register your response and avoid contacting you again.

Will you contact me again?

If we do not hear back from you, we will send two reminders to you in the post. If you would prefer not to receive a reminder, you can register this by sending the survey back in the envelope uncompleted or by phoning the helpline.

If you take part in this survey, we will contact you again in 12 months' time, with an invitation to take part in a follow-up survey. This will allow us to see if anything has changed for you during this time.

We will also be inviting a small number of men and their partners/spouses to participate in telephone interviews. Men and their partners/spouses will be invited only if they indicate at the end of the survey that they are interested in being interviewed. We are sorry we will not be able to contact all those who would like to participate in the interview and in cases where men and their partner/spouse are willing to be interviewed we may not be able to interview both. However, if you are one of the group we would like to interview we will write to you with more information and explain how to get in touch with us to find out more about the interview.

What will happen to the information I give?

All the survey responses will be completely anonymous and there will be no way to identify any individual man from his answers. The information you give will be analysed by the research team to learn more about which groups of patients are experiencing difficulties in the time after their cancer diagnosis and to identify risk factors which will allow support and aftercare services to be offered where they are most needed.

What do we want to do with the results of this work?

We expect that when this project finishes in three years' time, we'll know far more about what life is like for men with prostate cancer - not only across the UK, but also in different parts of each country - depending on what treatment they've received and how long ago they were treated. We'll be able to understand what men say has most affected their lives after a prostate cancer diagnosis and what needs to happen to improve any unwanted effects.

We want to tell both men and the clinicians treating them about the results of this research. In the future, knowing what other men think has most affected their life after treatment may help men with a prostate cancer diagnosis to choose the treatment that's right for them, as well as helping their doctors to counsel them appropriately.

We also want to use the results we get from this project to influence governments and health providers in all UK nations at all levels - from national decision makers to local hospitals - to make sure they provide the support and care men say is important to them.

The results of the research study will be published in academic journals and shared with NHS teams, commissioners and policy makers. Updates on the study and summary results will be posted on the Life After Prostate Cancer Diagnosis website as the work progresses (www.lifeafterprostatecancerdiagnosis.com). No individual patient will be identified in any report or publication, it will be entirely anonymous.

What are the disadvantages of taking part?

We do not foresee any disadvantages to your taking part in the study. It will not affect your care or treatment in any way. If reflecting on your situation causes anxiety or uncertainty in any way, please do not hesitate to contact your specialist cancer nurse or call one of the specialist nurses on Prostate Cancer UK's Specialist Nurse Telephone Line (telephone 0800 074 8383 free from UK landlines). They are there to listen to your concerns, and offer support and helpful information (Monday – Friday 9-6pm, Wednesday 10-8pm).

What are the benefits of taking part?

There are no medical benefits to your taking part in this research study. Some people gain satisfaction from feeling that they are helping others with cancer in the future. Many patients find taking part in research a positive experience.

Will my taking part in the study be kept confidential?

Yes. It is very important to us to respect your information (data) and keep it confidential. We work within strict rules covering data protection

and confidentiality. Before you were sent a questionnaire, the NHS Trust involved in your treatment was given an opportunity to consider whether it was appropriate to invite you to participate. This process may have involved your NHS Trust looking at some of your personal information that it holds on you.

On the front of the questionnaire you will see a unique study ID number. The purpose of this ID number is to protect your identity. When you return the survey, the information you provide will be checked to see that your responses have not inadvertently disclosed your identity. The anonymised information, alongside your ID number, will be entered onto an electronic database by the approved survey provider, Picker Europe. Your survey will be stored securely by Picker Europe for 15 years from completion of the study, for audit purposes only. Picker Europe will destroy it after this date.

Picker Europe will securely share the anonymised information on the database it has created with the National Cancer Registration Service, who have approvals to work with cancer patient data. In order to fully analyse and interpret the results, the information you give will be linked to other information held about you in existing NHS databases, and the research team will receive anonymised disease and treatment information linked to your survey responses and identified only by your unique study ID number. Your personal information and survey responses will be stored as part of the patient cancer record by the National Cancer Registration Service under the strict data handling rules for patient identifiable information.

The Research Team will not know your identity.

By completing this questionnaire you are giving your consent for the information provided to be used for the purposes set out above.

What if I change my mind?

If you wish to withdraw from the study and have any personal information that identifies you deleted, you may do so by contacting the Life After Prostate Cancer Diagnosis helpline number (0808 801 0678), or the Project Office in Leeds (0113 206 9252). You do not need to give a reason why you want to withdraw. Your withdrawal will not affect any care you may

Section One: Your Overall health today

Under each heading, please tick **ONE** box that best describes your health **TODAY**

1. MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

2. SELF-CARE

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4. PAIN / DISCOMFORT

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

5. ANXIETY / DEPRESSION

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

Are there any additional **HEALTH** issues that are of concern to you?

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6. We would like to know how good or bad your health is **TODAY**.

This scale is numbered from 0 to 100.

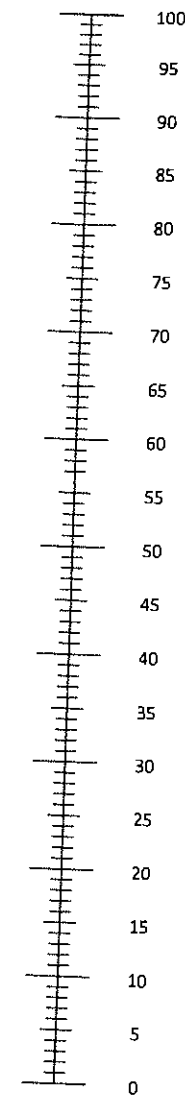
100 means the best health you can imagine.
0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is **TODAY**.

Now, please write the number you mark on the scale in the box below.

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine

Section Two Your diagnosis and treatment

7. How were you diagnosed? Please tick **all that apply**

- ☐ I attended my GP with urinary symptoms (e.g. urinating frequently, blood in urine).
- ☐ I attended my GP with other symptoms (e.g. back pain, joint pain).
- ☐ I had no symptoms and my GP offered to test my PSA (blood test) as part of a general health check.
- ☐ I had no symptoms and I asked my GP to measure my PSA (blood test).
- ☐ I had a PSA test as part of a private health check.
- ☐ Other

Please tell us about this:

8. Please tell us which treatments you have had following your diagnosis of prostate cancer
Please tick **all the options that apply**.

A. Have you had surgery (prostatectomy)?

- ☐ No → Go to B
- ☐ Yes → What type of surgery? Please tick **one** box
- ☐ **Open prostatectomy**
Operation performed through a cut in the abdomen above the pubic bone area (retropubic prostatectomy) or a cut in the area between the testicles and back passage (perineal prostatectomy).
- ☐ **Laparoscopic (keyhole) prostatectomy**
Operation performed through small incisions in the abdominal wall.
- ☐ **Robotic prostatectomy**
Operation performed with the assistance of a surgical robot (Da Vinci prostatectomy).
- ☐ I don't know what kind of operation I had

B. Have you had radiotherapy?

- ☐ No → Go to C
- ☐ Yes → What type of radiotherapy? Please tick **all that apply**
- ☐ **External beam radiotherapy (with or without hormone treatment)**
Radiotherapy uses high-energy X-ray beams to treat the whole prostate. This form of treatments includes both 3-dimensional conformal radiotherapy (3D-CRT) and intensity modulated radiotherapy (IMRT).
- ☐ **Permanent seed (low-dose) brachytherapy**
This involves implanting radioactive seeds into the prostate gland.
- ☐ **Temporary (high-dose) brachytherapy (with or without external beam radiotherapy or hormone treatment)**
This involves inserting a source of high-dose radiation into the prostate gland for a few minutes.
- ☐ I don't know what type of radiotherapy or brachytherapy I had

C. Have you had any of the below treatments? Please tick all that apply

- ☐ **High intensity focused ultrasound (HIFU)**
This treatment uses ultrasound waves to heat and destroy cancer cells in the prostate.
- ☐ **Cryotherapy**
This treatment uses freezing and thawing to kill the cancer cells in the prostate.
- ☐ **Chemotherapy** (not including hormones)
- ☐ **Hormone treatment** (either continuous or on/off treatment)
- ☐ **Abiraterone and/or Enzalutamide**

D. Are doctors and nurses currently monitoring **your** prostate cancer?

- ☐ No → Go to 9.a.
- ☐ Yes → What type of monitoring? Please tick **one** box.
- ☐ **Active Surveillance**
Surveillance is monitoring of low risk, slow growing localised prostate cancer with the aim of avoiding or delaying curative treatment (e.g. surgery, radiotherapy). This involves having regular tests.
- ☐ **Watchful waiting**
Watchful waiting is a way of monitoring prostate cancer that isn't causing any symptoms or problems. The aim is to keep an eye on the cancer over the long term and only having treatment if the cancer deteriorates or the patient gets symptoms. This involves fewer tests than in active surveillance.
- ☐ **Clinical follow-up during or after one of the treatments mentioned above in 8A, B or C**
- ☐ I am unsure about the type of monitoring I am currently having

9. a. Do you think your views were taken into account when the team of doctors and nurses caring for you were discussing which treatment you should have? Please tick **one** of the following boxes:

- ☐ Yes, definitely
☐ Yes, to some extent
☐ No, my views were not taken into account
☐ I didn't know my treatment was being discussed by a team of doctors / nurses
☐ Not sure / can't remember

9. b Please answer the following questions whether or not you were actively involved in the decisions made about your treatment.

Please think about the decisions you made about your treatment for prostate cancer after talking to your doctor, surgeon, nurse, health care professional etc.

Please show how you feel about these statements by ticking **one** box on each row.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|--|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| a. It was the right decision | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. I regret the choice that was made | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. I would go for the same choice if I had to do it over again | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. The choice did me a lot of harm | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. The decision was a wise one | ☐ | ☐ | ☐ | ☐ | ☐ |

Please add anything else you would like to tell us about your diagnosis, treatment, and the decision making process.

Section 3: How things are for you now

We understand that some of the following questions are very sensitive, but we would really appreciate you answering them if possible. As with the rest of the questionnaire, your answers will be kept confidential and no one will be able to identify you.

10. Over the past 4 weeks, how often have you leaked urine?
Please tick **one** box.

| | |
|-----------------------|--------------------------|
| More than once a day | ☐ |
| About once a day | ☐ |
| More than once a week | ☐ |
| About once a week | ☐ |
| Rarely or never | ☐ |

11. Which of the following best describes your urinary control during the last 4 weeks?
Please tick **one** box.

| | |
|-------------------------------|--------------------------|
| No urinary control whatsoever | ☐ |
| Frequent dribbling | ☐ |
| Occasional dribbling | ☐ |
| Total control | ☐ |

12. How many pads per day did you usually use to control leakage during the last 4 weeks?
Please tick **one** box.

| | |
|------------------------|--------------------------|
| None | ☐ |
| 1 pad per day | ☐ |
| 2 pads per day | ☐ |
| 3 or more pads per day | ☐ |

13. How big a problem, if any, has each of the following been for you during the last 4 weeks?
Please tick one box on each line.

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Dripping or leaking urine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain or burning on urination | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding with urination | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weak urine stream or incomplete emptying | ☐ | ☐ | ☐ | ☐ | ☐ |
| Need to urinate frequently during the day | ☐ | ☐ | ☐ | ☐ | ☐ |

14. Overall, how big a problem has your urinary function been for you during the last 4 weeks?
Please tick one box.

| | |
|--------------------|--------------------------|
| No problem | ☐ |
| Very small problem | ☐ |
| Small problem | ☐ |
| Moderate problem | ☐ |
| Big problem | ☐ |

15. How big a problem, if any, has each of the following been for you during the last 4 weeks?
Please tick one box on each line.

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Urgency to have a bowel movement | ☐ | ☐ | ☐ | ☐ | ☐ |
| Increased frequency of bowel movements | ☐ | ☐ | ☐ | ☐ | ☐ |
| Losing control of your stools | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bloody stools | ☐ | ☐ | ☐ | ☐ | ☐ |
| Abdominal/ Pelvic/Rectal pain | ☐ | ☐ | ☐ | ☐ | ☐ |

16. Overall, how big a problem have your bowel habits been for you during the last 4 weeks?
Please tick one box.

| | |
|--------------------|--------------------------|
| No problem | ☐ |
| Very small problem | ☐ |
| Small problem | ☐ |
| Moderate problem | ☐ |
| Big problem | ☐ |

17. How would you rate each of the following during the last 4 weeks?
Please tick one box on each line.

| | Very poor to none | Poor | Fair | Good | Very good |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Your ability to have an erection | ☐ | ☐ | ☐ | ☐ | ☐ |
| Your ability to reach orgasm (climax) | ☐ | ☐ | ☐ | ☐ | ☐ |

18. How would you describe the usual QUALITY of your erections during the last 4 weeks?
Please tick one box.

| | |
|--|--------------------------|
| None at all | ☐ |
| Not firm enough for any sexual activity | ☐ |
| Firm enough for masturbation and foreplay only | ☐ |
| Firm enough for intercourse | ☐ |

19. How would you describe the FREQUENCY of your erections during the last 4 weeks?
Please tick one box.

| | |
|--|--------------------------|
| I NEVER had an erection when I wanted one | ☐ |
| I had an erection LESS THAN HALF the time I wanted one | ☐ |
| I had an erection ABOUT HALF the time I wanted one | ☐ |
| I had an erection MORE THAN HALF the time I wanted one | ☐ |
| I had an erection WHENEVER I wanted one | ☐ |

20. Overall, how would you rate your ability to function sexually during the last 4 weeks?
Please tick **one** box.

| | |
|-----------|--------------------------|
| Very poor | ☐ |
| Poor | ☐ |
| Fair | ☐ |
| Good | ☐ |
| Very good | ☐ |

21. Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks?
Please tick **one** box.

| | |
|--------------------|--------------------------|
| No problem | ☐ |
| Very small problem | ☐ |
| Small problem | ☐ |
| Moderate problem | ☐ |
| Big problem | ☐ |

22. How big a problem during the last 4 weeks, if any, has each of the following been for you?
Please tick **one** box on each line.

| | No problem | Very small problem | Small problem | Moderate problem | Big problem |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Hot flushes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Breast tenderness/enlargement | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feeling depressed | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lack of energy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Change in body weight | ☐ | ☐ | ☐ | ☐ | ☐ |

During the last 4 weeks
Please tick **one** box on each line.

| | Not at all | A little | Quite a bit | Very much |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 23. To what extent were you interested in sex? | ☐ | ☐ | ☐ | ☐ |
| 24. To what extent were you sexually active (with or without intercourse)? | ☐ | ☐ | ☐ | ☐ |

25. Have you used any medications to aid or improve erections since your prostate cancer diagnosis? (e.g. tablets, penis injections, gels)
Please tick **one** box.

| | | | | | | |
|--------------------------|--|--|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I was not offered this | I was offered this but did not want it | I was offered this but have not tried it | I was offered this and tried it, but it was not helpful | I was offered this and it helped, but I am not using it now | I was offered this, it helps and I use it sometimes | I was offered this, it helps and I use it often |

26. Have you used any devices to aid or improve erections since your prostate cancer diagnosis? (e.g. vacuum pump, penile prosthesis)
Please tick **one** box.

| | | | | | | |
|--------------------------|--|--|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I was not offered this | I was offered this but did not want it | I was offered this but have not tried it | I was offered this and tried it, but it was not helpful | I was offered this and it helped, but I am not using it now | I was offered this, it helps and I use it sometimes | I was offered this, it helps and I use it often |

27. Have you used any specialist services to help with your sex life following your diagnosis of prostate cancer? (e.g. counselling, psychosexual clinics, psychology)
Please tick one box.

| | | | | | |
|--------------------------|--|--|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I was not offered this | I was offered this but did not want it | I was offered this but have not tried it | I was offered this and tried it, but it was not helpful | I was offered this and it helped, but I am not using it now | I was offered this, it helps and I am still using the service |

During the past week:
Please tick one box on each line.

| | Not at all | A little | Quite a bit | Very much |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 28. Did you need to rest? | ☐ | ☐ | ☐ | ☐ |
| 29. Have you felt weak? | ☐ | ☐ | ☐ | ☐ |
| 30. Were you tired? | ☐ | ☐ | ☐ | ☐ |

Please add anything else you would like to tell us about your symptoms or the side effects of your treatment.

Section Four: Your everyday life

On each line please tick the box that best describes your answer.

Please tick the '**no difficulty box**' if a question **does not apply to you**.

| During the past month: | | No difficulty | A little difficulty | Quite a bit of difficulty | Very much difficulty |
|------------------------|--|--------------------------|--------------------------|---------------------------|--------------------------|
| 31. | Have you had any difficulty maintaining your independence? | ☐ | ☐ | ☐ | ☐ |
| 32. | Have you had any difficulty in carrying out your domestic chores? (e.g. cleaning, gardening, cooking, shopping) | ☐ | ☐ | ☐ | ☐ |
| 33. | Have you had any difficulty with managing your own personal care? (e.g. bathing, dressing washing) | ☐ | ☐ | ☐ | ☐ |
| 34. | Have you had any difficulty with looking after those who depend on you? (e.g. children, dependent adults, pets) | ☐ | ☐ | ☐ | ☐ |
| 35. | Have any of those close to you (e.g. partner, children, parents) had any difficulty with the support available to them? | ☐ | ☐ | ☐ | ☐ |
| 36. | Have you had any difficulties with benefits? (e.g. Statutory Sick Pay, Personal Independence Payments, Attendance Allowance, Universal Credit) | ☐ | ☐ | ☐ | ☐ |
| 37. | Have you had any financial difficulties? | ☐ | ☐ | ☐ | ☐ |
| 38. | Have you had any difficulties with financial services? (e.g. loans, mortgages, pensions, insurance) | ☐ | ☐ | ☐ | ☐ |
| 39. | Have you had any difficulty concerning your work? (or education if you are a student) | ☐ | ☐ | ☐ | ☐ |
| 40. | Have you had any difficulty with planning for your own or your family's future? (e.g. care of dependents, legal issues, business affairs) | ☐ | ☐ | ☐ | ☐ |
| 41. | Have you had any difficulty with communicating with those closest to you? (e.g. partner, children, parents) | ☐ | ☐ | ☐ | ☐ |

| <i>During the past month:</i> | | No difficulty | A little difficulty | Quite a bit of difficulty | Very much difficulty |
|-------------------------------|--|--------------------------|--------------------------|---------------------------|--------------------------|
| 42. | Have you had any difficulty with communicating with others? (e.g. friends, neighbours, colleagues, dates) | ☐ | ☐ | ☐ | ☐ |
| 43. | Have you had any difficulty concerning plans to have a family? | ☐ | ☐ | ☐ | ☐ |
| 44. | Have you had any difficulty concerning your appearance or body image? | ☐ | ☐ | ☐ | ☐ |
| 45. | Have you felt isolated? | ☐ | ☐ | ☐ | ☐ |
| 46. | Have you had any difficulty with getting around? (e.g. transport, car parking, your mobility) | ☐ | ☐ | ☐ | ☐ |
| 47. | Have you had any difficulty in carrying out your recreational activities (e.g. hobbies, pastimes, social pursuits) | ☐ | ☐ | ☐ | ☐ |
| 48. | Have you had any difficulty with your plans to travel or take a holiday? | ☐ | ☐ | ☐ | ☐ |

49. In the **past week**, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate?
(This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.)
Please tick one box.

☐ None
 ☐ 1 day
 ☐ 2 days
 ☐ 3 days
 ☐ 4 days
 ☐ 5 days
 ☐ 6 days
 ☐ 7 days

Please add anything else you would like to tell us about how your prostate cancer has had an impact on your everyday life.

Section Five: Your emotional wellbeing

Below are some statements about feelings and thoughts. Please tick the box on each line that best describes your experience of each over the last 2 weeks.

| STATEMENTS | None of the time | Rarely | Some of the time | Often | All of the time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 50. I've been feeling optimistic about the future | ☐ | ☐ | ☐ | ☐ | ☐ |
| 51. I've been feeling useful | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52. I've been feeling relaxed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53. I've been dealing with problems well | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54. I've been thinking clearly | ☐ | ☐ | ☐ | ☐ | ☐ |
| 55. I've been feeling close to other people | ☐ | ☐ | ☐ | ☐ | ☐ |
| 56. I've been able to make up my own mind about things | ☐ | ☐ | ☐ | ☐ | ☐ |

The following questions ask about how you have been feeling during the past 30 days. For each question, please tick the box on each line that best describes how often you had this feeling. During the past 30 days, about how often did you feel...

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 57. ...nervous? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 58. ...hopeless? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 59. ...restless or fidgety? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 60. ...so depressed that nothing could cheer you up? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61. ...that everything was an effort? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62. ...worthless? | ☐ | ☐ | ☐ | ☐ | ☐ |

Please add anything else you would like to tell us about how your prostate cancer has had an impact on your emotional well-being.

Section Six: Looking to the future

Even if you are now free from prostate cancer please complete this section.

Please read the statements carefully and tick your responses to them. *Please tick one box on each line.*
If a question does not apply to you please leave it blank.

| | Strongly agree | Agree | Disagree | Strongly disagree |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 62. I am capable of coping with my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 63. I have all the information I need to manage my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 64. I am capable of helping health professionals reach decisions related to my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 65. My family are very supportive | ☐ | ☐ | ☐ | ☐ |
| 66. I need the support of my family and friends | ☐ | ☐ | ☐ | ☐ |
| 67. My family and friends still rely on me | ☐ | ☐ | ☐ | ☐ |
| 68. I can adapt to the changes in my lifestyle | ☐ | ☐ | ☐ | ☐ |
| 69. Health professionals are happy to include me in decisions related to my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 70. I want my family and friends to continue to rely on me | ☐ | ☐ | ☐ | ☐ |
| 71. My friends are always supportive | ☐ | ☐ | ☐ | ☐ |
| 72. I still feel useful in my daily life | ☐ | ☐ | ☐ | ☐ |
| 73. My spiritual beliefs help me cope with my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 74. I accept that I have to change my lifestyle | ☐ | ☐ | ☐ | ☐ |
| 75. Complementary therapies help me cope with my prostate cancer | ☐ | ☐ | ☐ | ☐ |
| 76. I have a lot of confidence in my local GP | ☐ | ☐ | ☐ | ☐ |

| | No impact | A little impact | Quite a bit of impact | Very much impact |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 77. How much of an impact has prostate cancer had on your life? | ☐ | ☐ | ☐ | ☐ |

What have been the most important issues that you have faced since your diagnosis with prostate cancer?

Section Seven: Questions about you

78. How old are you (in years)?

79. What is your legal marital status?

Please tick one box.

- ☐ Married
- ☐ In civil partnership
- ☐ Separated
- ☐ Divorced/dissolved civil partnership
- ☐ Widowed/surviving partner from civil partnership
- ☐ Single (never married/never in civil partnership)
- ☐ Other

80. What was your employment status at the time of your diagnosis of prostate cancer?

Please tick one box.

- ☐ Full time employment
- ☐ Part time employment
- ☐ Self employed
- ☐ Looking after family/home
- ☐ Retired
- ☐ Unemployed, seeking work
- ☐ Unemployed, unable to work for health reasons
- ☐ Other

81. What is your employment status currently? *If on sick leave answer in relation to your usual employment status.*

Please tick **one** box.

- ☐ Full time employment
- ☐ Part time employment
- ☐ Self employed
- ☐ Looking after family/home
- ☐ Retired
- ☐ Unemployed, seeking work
- ☐ Unemployed, unable to work for health reasons
- ☐ Other

82. To which of these ethnic groups would you say you belong?

Please tick **one** box.

White

- ☐ English/Welsh/Scottish/Northern Irish/British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background

Mixed/Multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed/multiple ethnic background

Asian / British Asian

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Black/African/Caribbean/Black British

- ☐ Black African
- ☐ Black Caribbean
- ☐ Any other Black / African / Caribbean background

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group

83. Do you consider yourself:

Please tick **one** box.

- ☐ Heterosexual / straight
- ☐ Homosexual / gay
- ☐ Bisexual
- ☐ Don't know
- ☐ Prefer not to answer

84. Which, if any, of the following conditions do you have?

Please tick **all** the boxes that apply.

- | | |
|--|---|
| ☐ A heart condition | ☐ Kidney disease |
| ☐ Angina | ☐ Diabetes |
| ☐ High blood pressure | ☐ Stroke |
| ☐ Asthma or other chronic chest problem | ☐ Alzheimer's disease or dementia |
| ☐ Liver disease | ☐ Epilepsy |
| ☐ Problems with your stomach, bowels or gallbladder | ☐ Other long standing neurological problem |
| ☐ Problems with your pancreas | ☐ A diagnosis of arthritis |

85. How tall are you?

- feet inches OR centimetres ☐ Don't know

86. How much do you weigh?

- Stone pounds OR kilograms grams ☐ Don't know

87. Have you ever in your lifetime seen a health care professional (such as a GP, psychiatrist, psychologist, social worker, counsellor, psychotherapist, mental health nurse, or any other such professional) for problems with your emotions or nerves or your use of alcohol or drugs?

- ☐ Yes ☐ No

88. Do you look after, or give any help or support (not part of your paid employment) to family members, friends, neighbours or others because of either:

- Long term physical or mental health disability, or
- Problems relating to old age

- ☐ Yes ☐ No

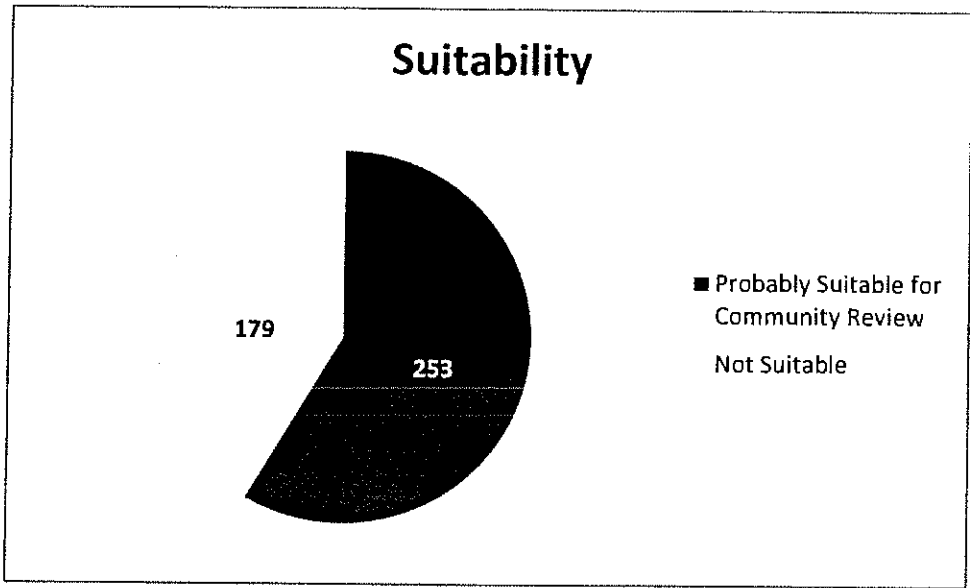
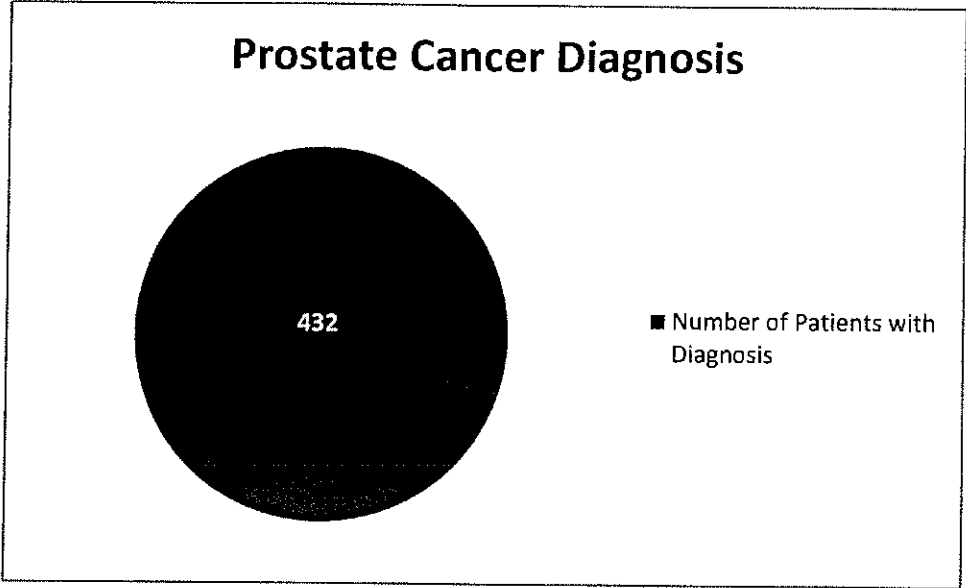
Is there anything else you would like to tell us about what life has been like for you following your prostate cancer diagnosis?

Please would you tell us who filled in this survey? Please tick **one** box.

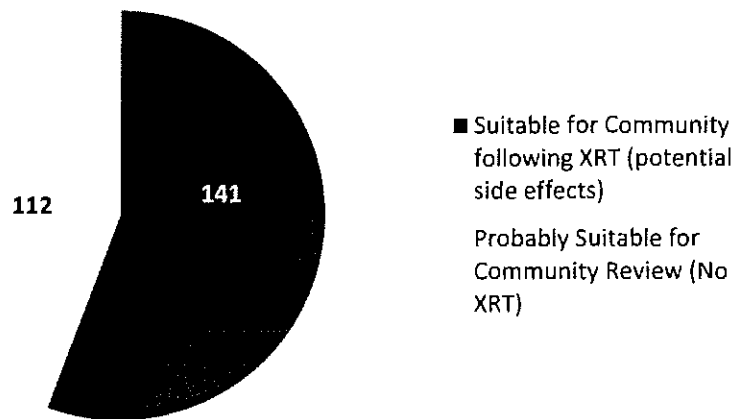
- ☐ The person to whom this survey was sent
- ☐ A representative of the person to whom this survey was sent (e.g. partner, family member, friend)

Southern Trust Prostate Audit 2016 – Dr Gerry Millar

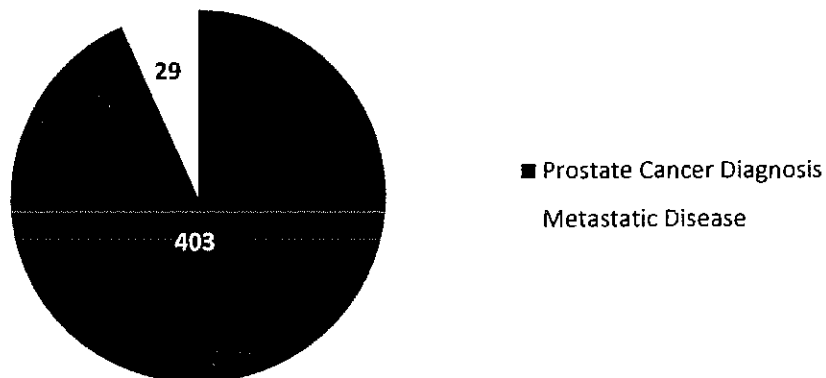
| Types | Statistics |
|---|------------|
| Total Patient Numbers Audited | 60000 |
| Prostate Cancer Diagnosis | 432 |
| Metastatic Disease | 29 |
| On Active Surviellance | 21 |
| Post XRT | 184 |
| Probably Suitable for Community Review | 253 |
| Suitable but too soon | 45 |
| Private Patient | 1 |
| Discharged as cured/no further PSA is needed | 1 |
| Robotic Surgery | 2 |
| Surgical (excluding Robotic) | 66 |
| Hormonal/ Drug Treatment | 258 |
| Suitable for Community following XRT (potential side effects) | 141 |
| Suitable for Community following Surgery | 47 |
| Attending BCH Nurse/ telephone Clinic and suitable for community clinic | 145 |
| GI post XRT side effects noted | 12 |



Potential XRT Consequences



Metastatic Prostate Cancer



3 PRACTICE PROSTATE CANCER REVIEW AUDIT SUMMARY

- Dr Millars Practice, Moy,
- Dr McDonalds Practice, Portadown
- Dr McDowell's Practice, Newry
- Total Patient numbers approximately 10,000
- Patients with Prostate Cancer diagnosis = 58
- Patients with Metastatic Prostate Cancer = 5/58
- Patients on Active Surveillance = 17/58
- Patients with stable PSA following treatments = 15/58
- Patients who have had Radiotherapy Treatment = 26/58
- Patients who would be suitable for "Community" review = 32/58
- Patients likely to be suitable but too early = 3/58
- Suitable but private patient = 1/58
- Discharged as cured following prostatectomy- advised no further PSAs needed = 1/58
- Robotic Surgery = 2/58
- Surgical Intervention(excl. robotic) = 6/58
- Patients having had Hormonal treatment = 29/58
- Suitable for Community RV and h/o XRT = 16/32
- Suitable for Community RV and h/o Surgery = 4/32
- Attending BCH Nurse led/Telephone RV clinic and suitable for Community RV = 14/58
- Already discharged to GP follow up = 9/58
- Mention of GI side effects following XRT = 2/58

bladder Cancer Pathway Audit

Mark Evans ST4

GMC: 7140707

Recurrent haematuria

Visible haematuria

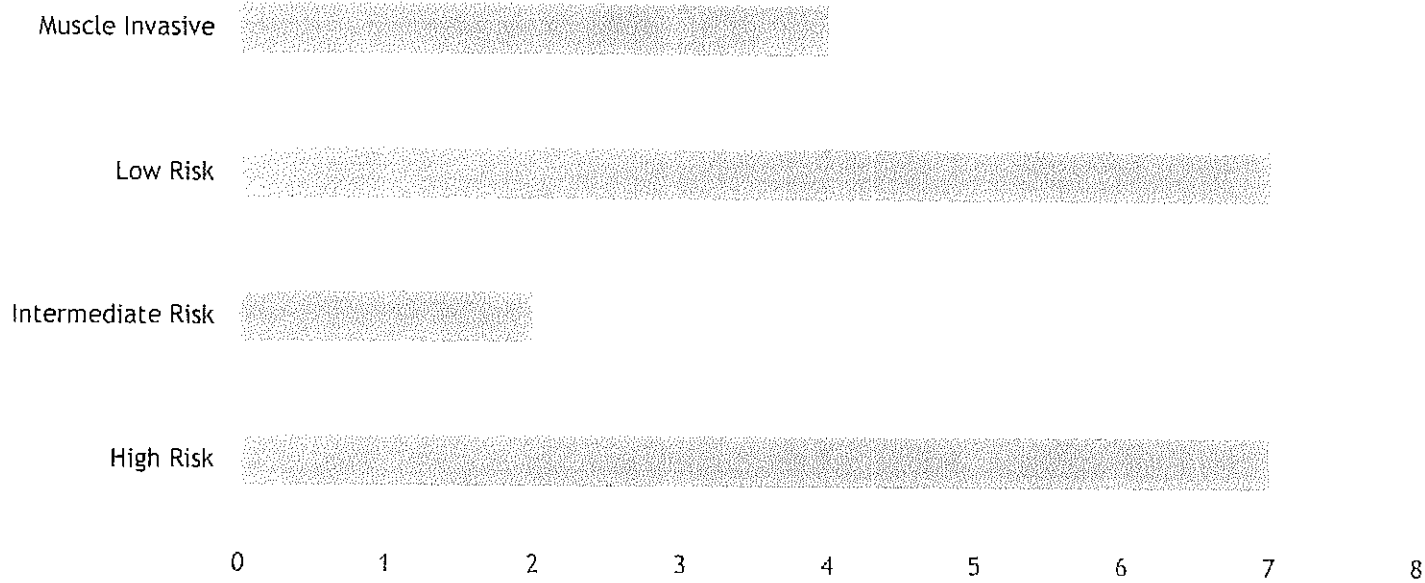
USS finding

Recurrent urinary tract infection

Non-visible haematuria

0 2 4 6 8 10 12 14 16

Risk Category



Top Quality Indicators

Cancer
Specialist Nurse

• 0%

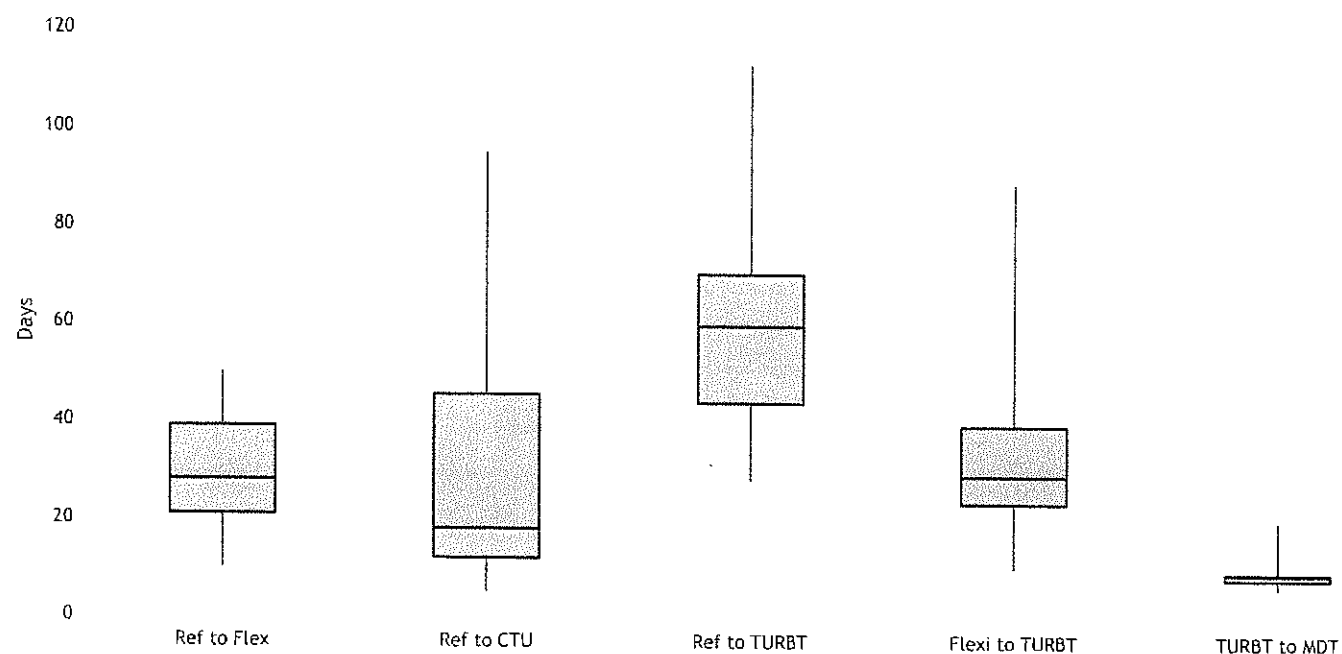
Muscle In TURBT
Sample

• 85%

Risk category
assigned at MDT

• 85%

Waiting Times



Urology Services Patients

1, NVH, Flexible wait 42, CTU wait 49, Flexible to TURBT 25, TURBT to MDT 10, 77 Overall

2, VH, Flexible wait 40, CTU wait 47, Flexible to TURBT 23, TURBT to MDT 6, 69 Overall

3, VH, Flexible wait 21, CTU wait 19, Flexible to TURBT 30, TURBT to MDT 20, 71 Overall

| Patient Num | Age | Presenting | Referral Date | Flexi Date | Referral to FI USS Date | CTU Date |
|--|-------------|------------|---------------|------------|-------------------------|------------|
| Personal information redacted by the USI | | | | | | |
| 78 | Visible hae | 08/08/2018 | 05/09/2018 | | 28 N/A | 20/08/2018 |
| 62 | Visible hae | 01/08/2018 | 12/09/2018 | | 42 N/A | 06/08/2018 |
| 74 | USS finding | 04/07/2018 | 23/08/2018 | | 50 02/07/2018 | 30/08/2018 |
| 78 | Visible hae | 17/07/2018 | 22/08/2018 | | 36 21/08/2018 | 31/08/2018 |
| 71 | Visible hae | 19/07/2018 | 29/08/2018 | | 41 N/A | 05/09/2018 |
| 62 | Non-visible | 19/07/2018 | 30/08/2018 | | 42 06/08/2018 | 06/09/2018 |
| 75 | Visible hae | 06/07/2018 | 15/08/2018 | | 40 25/07/2018 | 22/08/2018 |
| 67 | USS finding | 14/05/2018 | 07/06/2018 | | 24 12/04/2018 | 22/05/2018 |
| 67 | Visible hae | 18/06/2018 | 19/07/2018 | | 31 N/A | 21/09/2018 |
| 89 | Visible hae | 09/07/2018 | N/A | N/A | 26/06/2018 | 14/08/2018 |
| 73 | Visible hae | 20/06/2018 | 11/07/2018 | | 21 N/A | 09/07/2018 |
| 75 | Visible hae | 13/06/2018 | 11/07/2018 | | 28 N/A | 28/06/2018 |
| 76 | Visible hae | 18/06/2018 | 19/07/2018 | | 31 N/A | 05/07/2018 |
| 78 | Visible hae | 20/06/2018 | 11/07/2018 | | 21 N/A | 02/07/2018 |
| 68 | Visible hae | 11/06/2018 | 21/06/2018 | | 10 N/A | 27/06/2018 |
| 78 | Non-visible | 16/04/2018 | 10/05/2018 | | 24 N/A | 25/04/2018 |
| 82 | Visible hae | 19/06/2018 | N/A | N/A | N/A | 26/06/2018 |
| 69 | Visible hae | 24/05/2018 | 12/06/2018 | | 19 14/06/2018 | 15/06/2018 |
| 74 | Recurrent t | 02/05/2018 | 22/05/2018 | | 20 24/04/2018 | 17/05/2018 |
| 80 | Non-visible | 25/05/2018 | 15/06/2018 | | 21 04/06/2018 | 14/06/2018 |

| Referral to C TURBT Date | Re-TURBT da | Referral to TI Flexi to TURB MDT Date | Other MDTs | TURBT to MC |
|--------------------------|-------------|---------------------------------------|---------------------------|-------------|
| 12 12/10/2018 | | 65 | 37 18/10/2018 | 6 |
| 5 10/10/2018 | | 70 | 28 18/10/2018 20/09/2018 | 8 |
| 57 09/10/2018 | | 97 | 47 18/10/2018 | 9 |
| 45 03/10/2018 | | 78 | 42 11/10/2018 30/08/2018 | 8 |
| 48 24/09/2018 | 09/11/2018 | 67 | 26 04/10/2018 06/09/2018, | 10 |
| 49 24/09/2018 | | 67 | 25 04/10/2018 11/10/2018 | 10 |
| 47 07/09/2018 | 19/10/2018 | 63 | 23 13/09/2018 25/10/2018, | 6 |
| 8 04/09/2018 | | 113 | 89 13/09/2018 | 9 |
| 95 28/08/2018 | | 71 | 40 06/09/2018 01/11/2018 | 9 |
| 36 21/08/2018 | | 43 N/A | 30/08/2018 | 9 |
| 19 10/08/2018 | | 51 | 30 30/08/2018 26-07-2018, | 20 |
| 15 08/08/2018 | | 56 | 28 16/08/2018 19/07/2018 | 8 |
| 17 07/08/2018 | | 50 | 19 16/08/2018 | 9 |
| 12 30/07/2018 | | 40 | 19 09/08/2018 19/07/2018, | 10 |
| 16 25/07/2018 | | 44 | 34 02/08/2018 | 8 |
| 9 18/07/2018 | | 93 | 69 26/07/2018 | 8 |
| 7 17/07/2018 | | 28 N/A | 26/07/2018 | 9 |
| 22 04/07/2018 | | 41 | 22 12/07/2018 | 8 |
| 15 27/06/2018 | | 56 | 36 05/07/2018 19/07/2018, | 8 |
| 20 25/06/2018 | 20/08/2018 | 31 | 10 05/07/2018 30/08/2018 | 10 |

| Cancer spe | Muscle pre | MDT risk ca | Histology | Risk Category |
|------------|------------|-------------|-------------|---------------------------------|
| No | Yes | Yes | pT1 G3 N0 | High Risk |
| No | Yes | Yes | pTa G2 low | Low Risk |
| No | No | Yes | pTa G2 low | Low Risk |
| No | Yes | Yes | pTa G2 low | Low Risk |
| No | Yes | Yes | pTa G3 N0 | High Risk |
| No | No | No | pT3d G3 N1 | Muscle Invasive |
| No | Yes | Yes | pT2a G3 N0 | Muscle Invasive |
| No | Yes | Yes | pTa G3 N0 | High Risk |
| No | Yes | Yes | pT1 G3 N0 | High Risk |
| No | Yes | Yes | pTa G2 low | Low Risk |
| No | Yes | Yes | pT2a G3 N0 | Muscle Invasive |
| No | No | Yes | pTa G2 low | Low Risk |
| No | Yes | No | pTa G2 low | Low Risk |
| No | Yes | No | pT1 G3 N0 | High Risk |
| No | Yes | Yes | pTa G2 high | Intermediate Risk |
| No | Yes | Yes | pTa G2 high | Intermediate Lost to follow up? |
| No | Yes | Yes | pTa G3 N0 | High Risk |
| No | Yes | Yes | pTa G2 low | Low Risk |
| No | Yes | Yes | pT3b G3 N1 | Muscle Invasive |
| No | Yes | Yes | pTa G3 N0 | High Risk |

0.2

Elective Inpatient Operating 2016

Elective Inpatient Operating 2016

| | | | Sessions |
|-----------|-------------|------------------------------------|----------|
| Wednesday | 06 January | Urologist of the Week | |
| Wednesday | 13 January | 9 am – 8 pm | 2.75 |
| Wednesday | 20 January | 12 noon – 8 pm | 2.0 |
| Wednesday | 27 January | 12 noon – 8 pm | 2.0 |
| Wednesday | 03 February | 12 noon – 8 pm | 2.0 |
| Wednesday | 10 February | 12 noon – 8 pm | 2.0 |
| Wednesday | 17 February | Urologist of the Week | |
| Wednesday | 24 February | 9 am – 8 pm | 2.75 |
| Friday | 26 February | 1.30 am – 5.30 pm | 1.0 |
| Saturday | 27 February | 9 am to 1 pm | 1.0 |
| Wednesday | 02 March | Professional Leave: expert witness | |
| Wednesday | 09 March | 12 noon – 8 pm | 2.0 |
| Saturday | 12 March | 9 am – 1 pm | 1.0 |
| Wednesday | 16 March | 9 am – 8 pm | 2.75 |
| Wednesday | 23 March | 12 noon – 8 pm | 2.0 |
| Wednesday | 30 March | Urologist of the Week | |
| Wednesday | 06 April | 12 noon – 8 pm | 2.0 |
| Wednesday | 13 April | 9 am – 8 pm | 2.75 |
| Wednesday | 20 April | Audit | |
| Wednesday | 27 April | 12 noon – 8 pm | 2.0 |
| Wednesday | 04 May | 12 noon – 8pm | 2.0 |
| Wednesday | 11 May | Urologist of the Week | |
| Wednesday | 18 May | 12 noon – 8 pm | 2.0 |
| Wednesday | 25 May | 12 noon – 8 pm | 2.0 |
| Wednesday | 01 June | 12 noon – 8 pm | 2.0 |
| Wednesday | 08 June | Urologist of the Week | |
| Wednesday | 15 June | 12 noon – 8 pm | 2.0 |
| Wednesday | 22 June | Professional Leave: expert witness | |
| Wednesday | 29 June | 9 am – 8 pm | 2.75 |

| | | | |
|-----------|--------------|-----------------------|------|
| Wednesday | 06 July | 9 am – 8 pm | 2.75 |
| Wednesday | 13 July | 9 am – 8 pm | 2.75 |
| Monday | 18 July | 1.30 pm – 5.30 pm | 1.0 |
| Wednesday | 20 July | 9 am – 1 pm | 1.0 |
| Wednesday | 27 July | 9 am – 8 pm | 2.75 |
| Wednesday | 03 August | Urologist of the Week | |
| Wednesday | 10 August | 9 am – 8 pm | 2.75 |
| Wednesday | 17 August | 12 noon – 8 pm | 2.0 |
| Wednesday | 24 August | 9 am – 8 pm | 2.75 |
| Friday | 26 August | 9 am – 5 pm | 2.0 |
| Saturday | 27 August | 9 am – 1 pm | 1.0 |
| Wednesday | 31 August | 9 am – 8 pm | 2.75 |
| Wednesday | 07 September | 12 noon – 8 pm | 2.0 |
| Wednesday | 14 September | Urologist of the Week | |
| Wednesday | 21 September | 9 am – 8 pm | 2.75 |
| Wednesday | 28 September | 9 am – 8 pm | 2.75 |
| Wednesday | 05 October | 12 noon – 8 pm | 2.0 |
| Wednesday | 12 October | 12 noon – 8 pm | 2.0 |
| Wednesday | 19 October | Audit | |
| Wednesday | 26 October | Urologist of the Week | |
| Wednesday | 02 November | 9 am – 8 pm | 2.75 |
| Wednesday | 09 November | 9 am – 8 pm | 2.75 |

Total = 83.25 sessions

Plus 1.5 hours of perioperative patient care for each date: 58.5 hours

= 14.625 sessions

Plus 1 hour of administration time per session: 83.25 hours

= 20.8125 sessions

Total = 118. 6875 sessions

Number of elective inpatient sessions contracted at per Job Plan = 58

GMC Colleague & Patient Feedbacks
&
Reflective Templates
March 2019



Southern Health
and Social Care Trust

GMC Colleague Feedback Report

Participant: Dr Aidan O'Brien

GMC No: 1394911

Survey Initiated: 15/01/2019

Response Summary

| | Number |
|----------------------|--------|
| Total Nominations: | 26 |
| Total Responses: | 17 |
| Opted Out: | 0 |
| Did Not Respond: | 9 |
| Medical Colleagues: | 11 |
| Clinical Colleagues: | 4 |
| Support Colleagues: | 2 |

Total Responses: 17 Colleagues Completed the Survey

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.

Participant: Dr Aidan O'Brien - GMC No: 1394911

Section 1: Overall Summary

This section of the report provides a summary of your overall ratings as viewed by you and your colleagues.

The self column for Q5 displays how you rated yourself. The scoring for the average column is as follows: Poor=1, Less than satisfactory=2, Satisfactory=3, Good=4, Very good=5.

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.

| | Poor | Less than Satisfactory | Satisfactory | Good | Very Good | Don't Know | Self | Colleague Average |
|--|------|------------------------|--------------|------|-----------|------------|------------------------|-------------------|
| 1. Clinical Knowledge | 0 | 0 | 0 | 0 | 17 | 0 | Good | 5 |
| 2. Diagnosis | 0 | 0 | 0 | 0 | 17 | 0 | Good | 5 |
| 3. Clinical Decision Making | 0 | 0 | 0 | 3 | 14 | 0 | Good | 4.82 |
| 4. Treatment (including practical procedures) | 0 | 0 | 0 | 1 | 14 | 2 | Good | 4.93 |
| 5. Prescribing | 0 | 0 | 0 | 0 | 12 | 5 | Good | 5 |
| 6. Medical record keeping | 0 | 0 | 1 | 1 | 14 | 1 | Good | 4.81 |
| 7. Recognising and working within limitations | 0 | 0 | 0 | 2 | 14 | 1 | Good | 4.88 |
| 8. Keeping knowledge and skills up to date | 0 | 0 | 0 | 2 | 12 | 3 | Satisfactory | 4.86 |
| 9. Reviewing and reflecting on own performance | 0 | 0 | 0 | 1 | 15 | 1 | Satisfactory | 4.94 |
| 10. Teaching (students, trainees, others) | 0 | 0 | 0 | 3 | 8 | 6 | Less than Satisfactory | 4.73 |
| 11. Supervising colleagues | 0 | 0 | 0 | 0 | 13 | 4 | Good | 5 |
| 12. Commitment to care and wellbeing of patients | 0 | 0 | 0 | 0 | 16 | 1 | Good | 5 |
| 13. Communication with patients and relatives | 0 | 0 | 0 | 0 | 14 | 3 | Good | 5 |
| 14. Working effectively with colleagues | 0 | 0 | 0 | 1 | 16 | 0 | Good | 4.94 |
| 15. Effective time management | 0 | 1 | 2 | 7 | 7 | 0 | Satisfactory | 4.18 |

Participant: Dr Aidan O'Brien - GMC No: 1394911

| | Strongly
Disagree | Disagree | Neutral | Agree | Strongly
Agree | Don't
Know | Self | Colleague
Average |
|---|----------------------|----------|---------|-------|-------------------|---------------|-------|----------------------|
| 16. I am confident that this doctor respects patient confidentiality | 1 | 0 | 0 | 1 | 15 | 0 | Agree | 4.71 |
| 17. I am confident that this doctor is honest and trustworthy | 1 | 0 | 0 | 0 | 16 | 0 | Agree | 4.76 |
| 18. I am confident that this doctor's performance is not impaired by ill health | 1 | 0 | 0 | 0 | 14 | 2 | Agree | 4.73 |

| | No | Yes | Don't Know | Self |
|--|----|-----|------------|------|
| 19. I am confident that this doctor is fit to practice medicine. | 0 | 16 | 1 | Yes |

Participant: Dr Aidan O'Brien - GMC No: 1394911

Section 2: Written Comments

Colleagues were given the opportunity to add comments. Comments are presented as submitted, with no editing.

Self Comments

Colleague Comments

Please Note: This is an optional question, all colleagues may not have responded.

Aidan is quietly and humbly dedicated to each and every one of his patients, and continues to strive to do his best for them. These qualities exemplify exactly what a clinician should be, and he should be justifiably proud of this.

Mr O'Brien is an extremely caring individual. The welfare of his patients is his number one priority. He is an excellent communicator. He is diligent and goes above and beyond on a daily basis. A great colleague from whom I have learnt a lot.

A excellent and supportive consultant.

Excellent colleague Works very well with other teams in the Hospital

Mr O'Brien is an absolute gentleman who always has the patients best interest at heart. In my time working with Mr O'Brien he always made time to speak to his patients personally and was a great support to them.

Mr. O'Brien displays excellent communication and interpersonal skills. He is also significantly experienced and brings a wealth of knowledge to his everyday clinical practice - he is a pleasure to work with

Mr. O'Brien is always patient with patients and junior colleagues. He is always willing to provide advice, no matter how busy he is. Pleasure to work with!

Aidan is an excellent Urologist. He puts his patients first, his knowledge it up to date and he is a very good surgeon. If I turn out to be half as good as him then I will be extremely happy.

Aiden is an excellent colleague and is very supportive. He works extremely hard and his

main focus is to do his best for patients

Mr O'Brien is an extremely knowledgeable and competent colleague with invaluable years of experience in urology. He is always respectful of opinions of both clinical and non-clinical colleagues and shows great commitment to the care and wellbeing of patients.

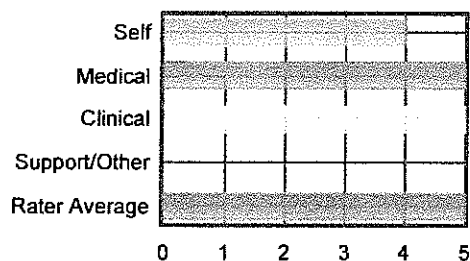
Aidan is a most valued and respected colleague. His clinical skills are excellent, and he sets an example in terms of commitment to his patients, communication and professionalism.

Participant: Dr Aidan O'Brien - GMC No: 1394911

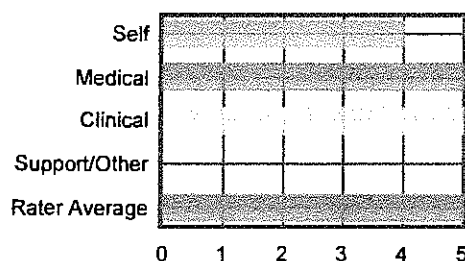
Section 3: Summary Graphs by Question

The following graphs show responses by colleague category. In order to protect the anonymity of colleagues if any category contains less than 3, the responses in that category will not be shown. All responses are included in the rater average.

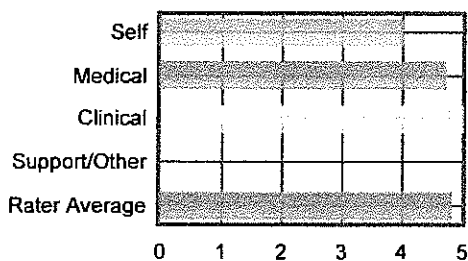
1. Clinical Knowledge



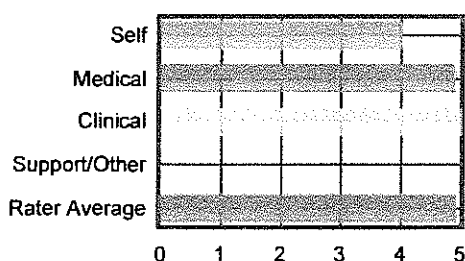
2. Diagnosis



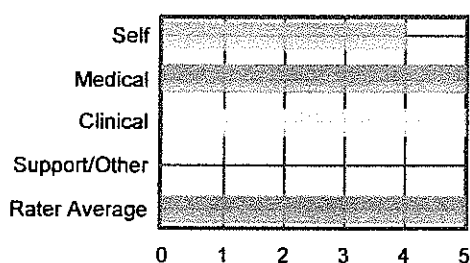
3. Clinical Decision Making



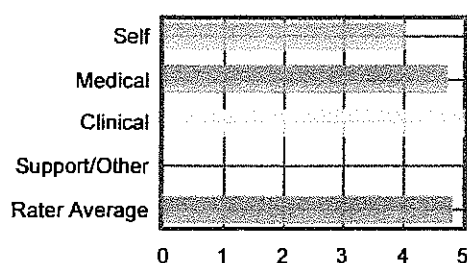
4. Treatment (including practical procedures)



5. Prescribing

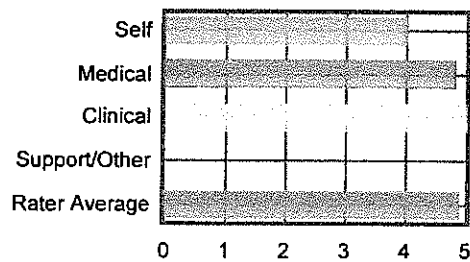


6. Medical record keeping

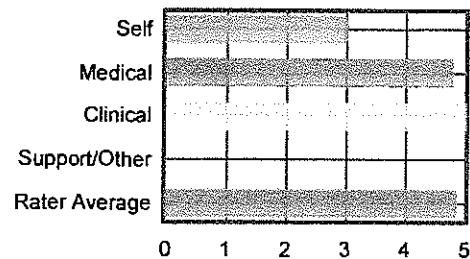


Participant: Dr Aidan O'Brien - GMC No: 1394911

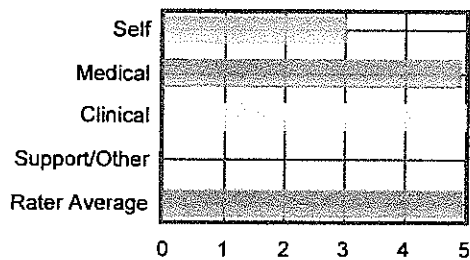
7. Recognising and working within limitations



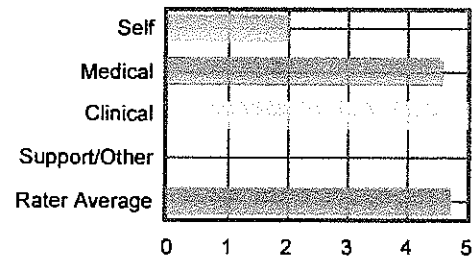
8. Keeping knowledge and skills up to date



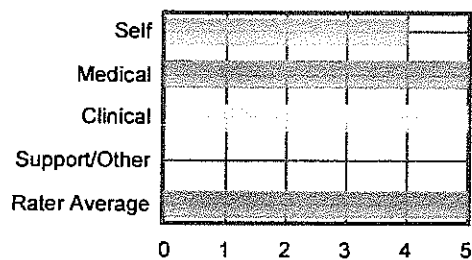
9. Reviewing and reflecting on own performance



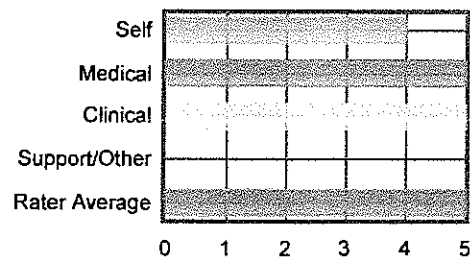
10. Teaching (students, trainees, others)



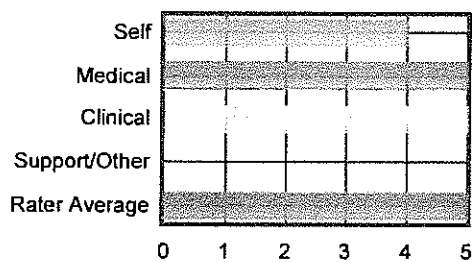
11. Supervising colleagues



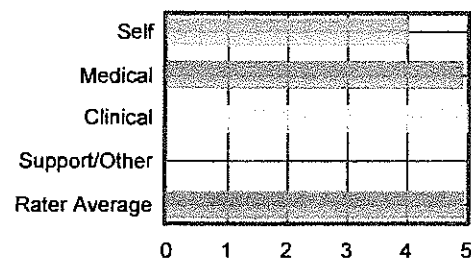
12. Commitment to care and wellbeing of patients



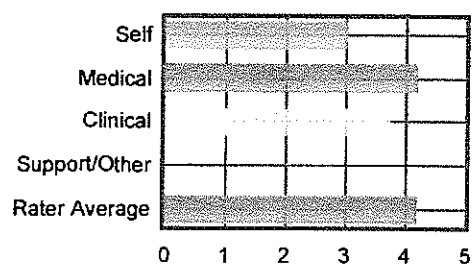
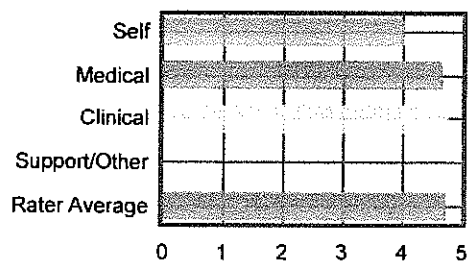
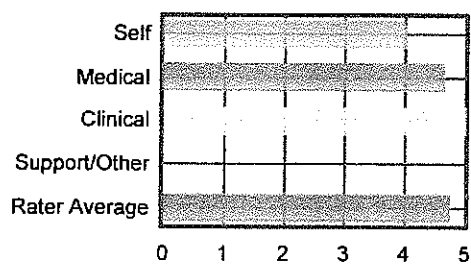
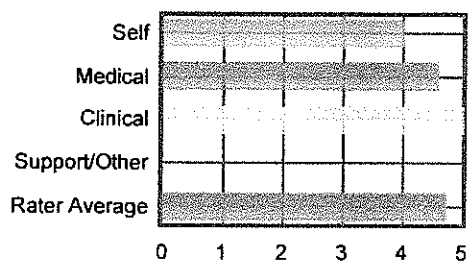
13. Communication with patients and relatives



14. Working effectively with colleagues



Participant: Dr Aidan O'Brien - GMC No: 1394911

15. Effective time management**16. I am confident that this doctor respects patient confidentiality****17. I am confident that this doctor is honest and trustworthy****18. I am confident that this doctor's performance is not impaired by ill health**



Southern Health
and Social Care Trust

GMC Patient Feedback Report

Participant: Dr Aidan O'Brien

GMC No: 1394911

Survey Initiated: 15/01/2019

Response Summary

| | Number |
|-------------------|--------|
| Online Responses: | 0 |
| Paper Responses: | 51 |

Total Responses: 51 Patients Completed the Survey

Rating Scale

Your patients 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 5a - 5g | |
|-------------------|------------------------|
| 1 | Poor |
| 2 | Less than Satisfactory |
| 3 | Satisfactory |
| 4 | Good |
| 5 | Very Good |

Participant: Dr Aidan O'Brien - GMC No: 1394911

Q1**Respondents were asked to add the date of completion.**

This information has been excluded from the report.

Q2 - Q4

This section of the report gives details on who completed the questionnaire and their reason for visiting.

The number beside each category displays the number of patients who responded to that category. Please note that some patients did not respond (DNR) to all the questions.

**Number of
Responses**

Q2: Respondents were asked to indicate who the questionnaire was completed for.

| | |
|----------------------------|----|
| Yourself | 43 |
| Your Child | 1 |
| Your Spouse or partner | 4 |
| Another Friend or relative | 2 |
| Did Not Respond | 1 |

Q3 Respondents were asked to state the main reason for visiting you. Where more than one answer was given, only one is shown here

| | |
|--|----|
| To ask for advice | 4 |
| Because of an ongoing problem | 34 |
| For treatment(including prescriptions) | 2 |
| Because of a one-off problem | 1 |
| For tests | 4 |
| For a routine check | 5 |
| Other | 0 |
| Did Not Respond | 1 |

Q4 Respondents were asked about the importance placed on health and well being as a reason for visiting you.

| | |
|-----------------------|----|
| 1. Not very Important | 0 |
| 2. | 0 |
| 3. | 0 |
| 4. | 5 |
| 5. Very Important | 45 |
| Did Not Respond | 1 |

Participant: Dr Aidan O'Brien - GMC No: 1394911

Q5 Ratings and scores

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 average column 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.

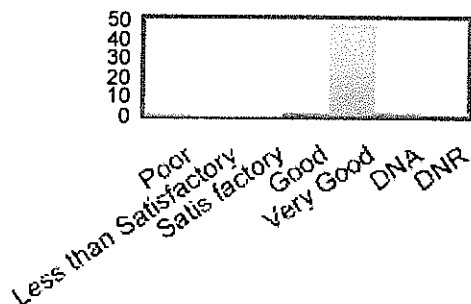
| | Poor | Less than
satisfactory | Satisfactory | Good | Very
Good | Does
Not
Apply | Did Not
Respond | Average | Self | Mean* |
|---|------|---------------------------|--------------|------|--------------|----------------------|--------------------|---------|--------------|-------|
| 5a. Being Polite | 0 | 0 | 0 | 1 | 48 | 1 | 1 | 4.98 | Satisfactory | 99% |
| 5b. Making you feel at ease | 0 | 0 | 0 | 0 | 50 | 1 | 0 | 5 | Good | 100% |
| 5c. Listening to you | 0 | 0 | 0 | 1 | 49 | 1 | 0 | 4.98 | Good | 100% |
| 5d. Assessing your medical condition | 0 | 0 | 0 | 0 | 49 | 1 | 1 | 5 | Good | 100% |
| 5e. Explaining your condition and treatment | 0 | 0 | 0 | 0 | 50 | 1 | 0 | 5 | Good | 100% |
| 5f. Involving you in decisions about your treatment | 0 | 0 | 1 | 0 | 48 | 2 | 0 | 4.96 | Satisfactory | 99% |
| 5g. Providing or arranging treatment for you | 0 | 0 | 0 | 2 | 46 | 2 | 1 | 4.96 | Good | 99% |

Participant: Dr Aidan O'Brien - GMC No: 1394911

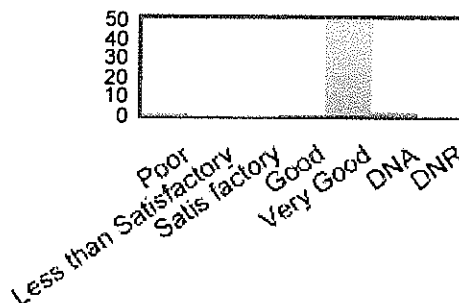
Q5 Graphical Analysis

The following graphs display your patients' responses to Q5.

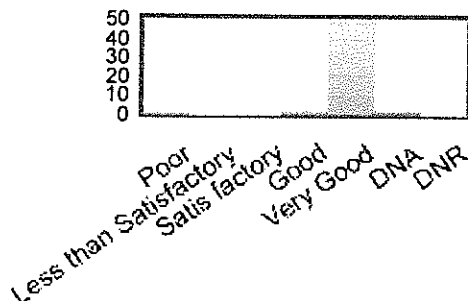
5a. Being Polite



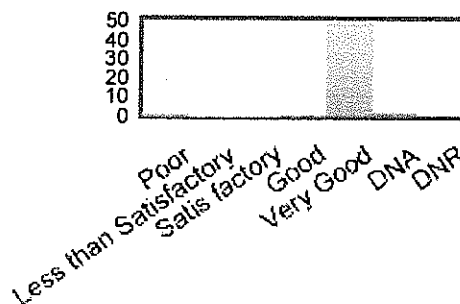
5b. Making you feel at ease



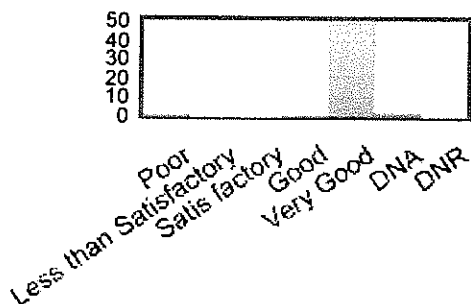
5c. Listening to you



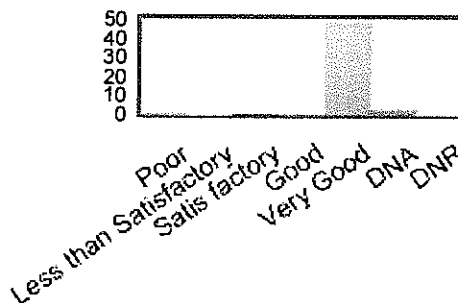
5d. Assessing your medical condition



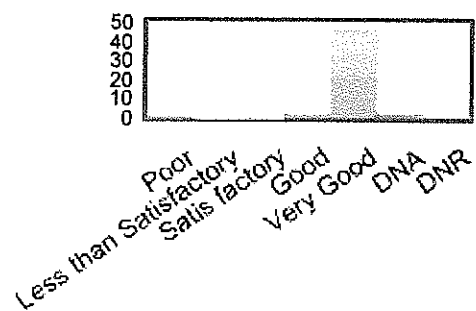
5e. Explaining your condition and treatment



5f. Involving you in decisions about your treatment



**5g. Providing or arranging
treatment for you**

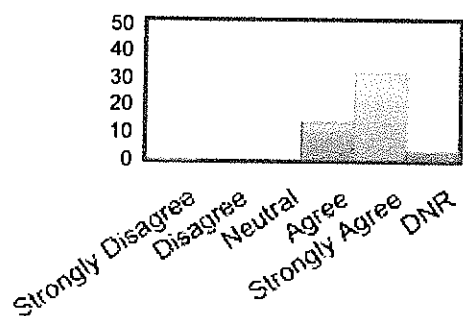
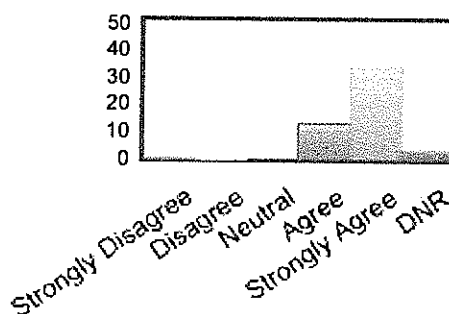


Participant: Dr Aidan O'Brien - GMC No: 1394911

Q6 Ratings and scores

Respondents were asked to agree or disagree with the following statements about you.

| | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Did Not Respond | Mean* |
|---|-------------------|----------|---------|-------|----------------|-----------------|-------|
| 6a. This doctor will keep information about me confidential | 0 | 1 | 1 | 14 | 32 | 3 | 90% |
| 6b. This doctor is honest and trustworthy | 0 | 0 | 1 | 13 | 34 | 3 | 92% |

Q6 Graphical Analysis**6a. This doctor will keep information about me confidential****6b. This doctor is honest and trustworthy**

Participant: Dr Aidan O'Brien - GMC No: 1394911

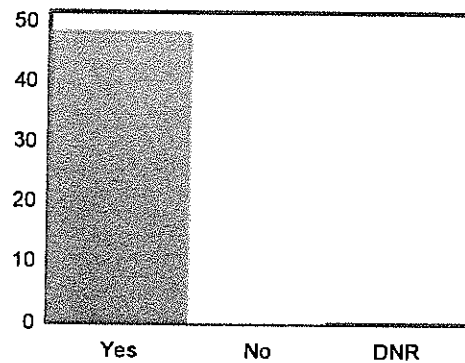
Q7 Ratings and scores

Respondents were asked to reply yes or no to the following statements about you.

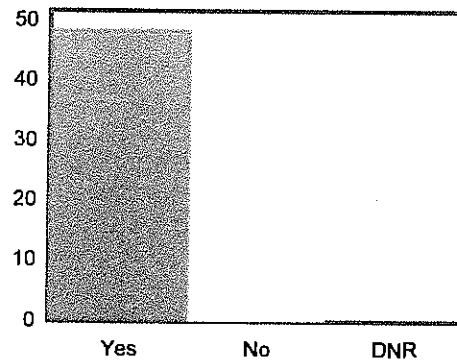
| | Yes | No | Did Not Respond |
|--|-----|----|-----------------|
| 7a. I am confident about this doctor's ability to provide care | 48 | 0 | 3 |
| 7b. I would be completely happy to see this doctor again | 48 | 0 | 3 |
| 7c. Was this visit with your usual doctor? | 31 | 16 | 4 |

Q7 Graphical Analysis

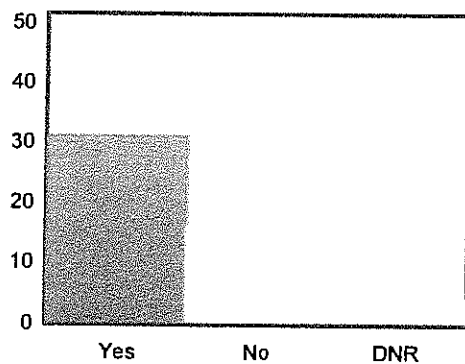
7a. I am confident about this doctor's ability to provide care



7b. I would be completely happy to see this doctor again



7c. Was this visit with your usual doctor?



Participant: Dr Aidan O'Brien - GMC No: 1394911

Q8 Patient Comments

Respondents were given the opportunity to add comments. Comments are presented as submitted, with no editing.

Very happy, a real gentleman.

Very happy with treatment provided.

Dr O'Brien is a real gentleman and is an expert in his field. I have complete confidence in him in every way.

A good surgeon and a gentleman when with his patients.

Empathetic and informative.

Excellent doctor, very knowledgeable. Very good rapport with patient and relatives. Thank you.

He was a gentleman.

Consultant and staff were all excellent. Treated me with dignity and respect as always.

I found the doctor very helpful and very pleasant. Easy to talk to.

A good informative conversation, I felt at ease and continually kept informed of decisions.

Very nice doctor.

Very happy with my treatment.

I have had first class treatment and advice, and surgery, from Mr O'Brien. I hold him in very high regard and have great faith in him, and very pleasant with it.

Very intelligent and professional. Total gentleman.

The doctor gave me confidence and reassurance about myself and my condition. He has a very pleasant personality and puts you at ease. Explained everything very well.

Found Dr O'Brien explained treatment and care plan clearly and answered all my queries. Very happy with his communication and help.

Aidan O'Brien goes out of his way to help me with my concerns and worries, explains with great detail any issues I have and how it can be resolved. Highly recommend Doctor, has been very thorough with surgery and health.

Friendly, considerate, caring doctor.

Dr was very helpful.

Put my mind at ease.

Most professional, when providing care to me in hospital and clinic.

Excellent care and reassurance.

The doctor was very helpful and informative.

Completely satisfied with my consultant from the start of my visits with Mr O'Brien.

Participant: Dr Aidan O'Brien - GMC No: 1394911

Q9 - Q11 Demographic Profile

This section of the report displays the demographic profile of your respondents.

The number beside each category displays the number of patients who responded to that category. Please note that all patients did not respond(DNR) to all the questions.

Number of Responses**Q9 Gender Breakdown**

| | |
|-----------------|----|
| Female | 13 |
| Male | 34 |
| Did Not Respond | 4 |

Q10 Age Breakdown

| | |
|-----------------|----|
| Under 15 | 0 |
| 15-20 | 0 |
| 21-40 | 3 |
| 41-60 | 8 |
| Over 60 | 37 |
| Did Not Respond | 3 |

Q11 Ethnicity Breakdown

| | |
|--------------------|----|
| White | 48 |
| Chinese | 0 |
| Indian | 0 |
| Filipino | 0 |
| Black African | 0 |
| Irish Traveller | 0 |
| Black Caribbean | 0 |
| Black Other | 0 |
| Bangladeshi | 0 |
| Pakistani | 0 |
| Mixed Ethnic Group | 0 |
| Other | 0 |
| Did Not Respond | 3 |

Participant: Dr Aidan O'Brien - GMC No: 1394911

Appendix 1

Benchmarks (Q5, Q6)

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 %* | Min | Lower
Quartile | Median | Upper
Quartile | Max |
|---|-----------------------|-----|-------------------|--------|-------------------|-----|
| 5a. Being Polite | 99% | 70 | 96 | 98 | 99 | 100 |
| 5b. Making you feel at ease | 100% | 69 | 94 | 97 | 98 | 100 |
| 5c. Listening to you | 100% | 61 | 94 | 97 | 98 | 100 |
| 5d. Assessing your medical condition | 100% | 68 | 93 | 96 | 98 | 100 |
| 5e. Explaining your condition and treatment | 100% | 65 | 93 | 95 | 98 | 100 |
| 5f. Involving you in decisions about your treatment | 99% | 67 | 92 | 95 | 97 | 100 |
| 5g. Providing or arranging treatment for you | 99% | 68 | 93 | 96 | 98 | 100 |
| 6a. This doctor will keep information about me confidential | 90% | 59 | 90 | 93 | 95 | 100 |
| 6b. This doctor is honest and trustworthy | 92% | 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.

Participant: Dr Aidan O'Brien - GMC No: 1394911

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 | Does Not
Apply | Did Not
Respond |
|---------------------|------|---------------------------|--------------|------|--------------|-------------------|--------------------|
| Your mean score (%) | 0 | 25 | 50 | 75 | 100 | | |

The following example uses data from question Q5a from your patient questionnaire based on a return of 51 questionnaires

| Questions | Poor | Less than
satisfactory | Satisfactory | Good | Very
Good | Does Not
Apply | Did Not
Respond |
|------------------|------|---------------------------|--------------|------|--------------|-------------------|--------------------|
| 5a. Being Polite | 0 | 0 | 0 | 1 | 48 | 1 | 1 |

$$(0 \times 0) + (0 \times 25) + (0 \times 50) + (1 \times 75) + (48 \times 100) = \text{Total Score}$$

$$51 - 1 - 1 = \text{Responses}$$

$$\text{Total Score/Responses} = 99\%$$



Southern Health
and Social Care Trust

Quality Care - for you, with you

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 2019 | |
| Type of survey:
GMC Patient Feedback Report | |
| <p>What issues can I identify from the exercise?</p> <p>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.</p> <p>The patient feedback was very positive as one rarely knows what every patient thinks of one's performance.</p> <p>The only negative was that one person disagreed that I would keep information about him or her confidential.</p> | |
| <p>What actions will I undertake?</p> <p>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).</p> <p>To ensure that all patients have no reason to doubt their confidentiality</p> | |
| <p>Final outcome after discussion at appraisal:</p> <p>(Complete at appraisal considering how your outcome will improve patient care)</p> | |

GMC Fitness to Practice Referral

April 2019

Fitness to practise referral form

**General
Medical
Council**

This form is for Responsible Officers, Suitable Persons, employers, their nominated representatives, and those acting on behalf of organisations to send fitness to practise concerns to us.

Getting help

Guidance for completing this form is available in the [referral guidance](#). The guidance provides assistance on making fair and accurate referrals based on GMC thresholds.

Responsible Officers, Suitable Persons and their designates can seek advice and discussion about concerns and whether they meet our [threshold](#) for investigation. For details about the employer liaison adviser for your region, please visit [our website](#).

If you are a professional raising concerns in your individual capacity or a member of the public, please visit our website to fill in our [online form](#).

Returning the form

Please return this form to us, using practise@gmc-uk.org. You should also copy in your employer liaison adviser into the email.

If the concerns are of a serious and urgent nature and completing the form could cause a delay, please e-mail practise@gmc-uk.org straight away with as much detail about the concern as possible.

Details about the doctor

Doctor's full name

Mr Aidan O'Brien

GMC number

1394911

Doctor's specialty

Urology

Doctor's job title

Consultant Urologist

Doctor's grade

Consultant

The doctor's work details

Organisation the doctor was working for, or contracted to, or providing services for at the time the concerns arose.

Southern Health and Social Care Trust

How long have they worked here?

Appointed 6 July 1992

Other organisations where the doctor is known to work or contract with (eg independent hospital, locum agencies)

Mr O'Brien sees private patients from his home.

Your relationship to the doctor

Are you the doctor's Responsible Officer?

Yes ☒ No ☐

If no, please specify your connection to the doctor.

If no, and you have been able to identify the doctor's RO or Suitable Person, have you shared your concerns with that individual?

Yes ☐ No ☐

Have you shared your concerns with the doctor ?

Yes ☒ No ☐

If yes, when did you do so?

The concerns were initially shared with the doctor in March 2016 and again in December 2016 prior to commencement of a formal investigation into the concerns.

Is the doctor aware that you are making a referral to the GMC?

Yes ☒ No ☐

Do you need to detail concerns about another doctor?

Yes ☐ No ☒

Summary of concerns

Have you discussed your concerns with an employer liaison adviser?

Yes ☒ No ☐

If yes, did the ELA advise you to make a referral to us?

Yes ☒ No ☐

Please use the box below to provide the following details:

- summary of the concern(s) including location and who else was involved
- a chronology of events
- details of risk to patient safety (if applicable)
- summary of all local action taken and on-going investigations (if any)
- please indicate where you have been unable to verify information contained within this referral (eg where the information is from a source outside of your remit, where a local process is on-going or where you believe there is an evidential conflict)
- details of any other relevant concerns or previous complaints you are aware of at this time (and local actions and outcomes). This will help us assess whether this incident is part of a pattern of behaviour.

The concerns

A Serious Adverse Incident (SAI) investigation was commenced within the Trust in April 2017 in respect of a patient Patient 10 a patient of the Urology service. A referral had been received by the Trust in 2015 however the patient was not seen until February 2016. The patient was seen by Mr Mark Haynes, Consultant Urologist.

Mr Haynes reviewed the patient and the referral and was concerned about the delay for the patient. As a result Mr Haynes completed a Datix form to alert the Trust to the issue of concern.

Mr Anthony Glackin, Consultant Urologist chaired the SAI investigation which commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged. Further assessment of the issue identified a significant number of patients who had not been triaged.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such.

The Timeline

A full chronology is within the attached formal investigation report.

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns.

Four broad concerns were identified:

- Untriaged outpatient referral letters - It was identified at that time that there were 253 untriaged referrals dating back to December 2014.
- Current Review Backlog up to 29 February 2016 - It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.
- Patient Centre letters and recorded outcomes from clinics - The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.
- Patient's hospital charts at Mr O'Brien's home - The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr Richard Wright in late December 2016. As a result of the concerns raised with Mr O'Brien on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Mr O'Brien may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken.

03 January 2017

Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017

During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion.

23 January 2017

On 23 January 2017, Mr Weir wrote to Mr O'Brien seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to Mr O'Brien but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017

The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017.

26 January 2017

In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Mr O'Brien's immediate exclusion and to determine if, from the initial preliminary enquiries, Mr O'Brien had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting.

At the case conference meeting, it was determined by the Case Manager, Dr A Khan that Mr O'Brien had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as exclusion was not deemed to be required. Instead, Mr O'Brien's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017

Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period.

20 February 2017

Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Mr O'Brien was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

January and February 2017

During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale.

16 March 2017

The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list.

April, May and June 2017

During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified.

19 June 2017

Mr O'Brien requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Mr O'Brien requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern.

16 October 2017

A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017

A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018

By 15 February 2018, Mr O'Brien had not provided the comments he had previously advised he wished to make and therefore this was queried with Mr O'Brien and an update sought.

22 February 2018

No response was received and a further email reminder was sent to Mr O'Brien on 22 February 2018. On the same day, Mr O'Brien responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018

Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Mr O'Brien requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018

No comments were received from Mr O'Brien.

29 March 2018

A final opportunity was provided to Mr O'Brien to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018

No comments were received from Mr O'Brien.

2 April 2018

Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

The Findings from the investigation

There were 783 un-triaged referrals by Mr O'Brien of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Mr O'Brien stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing but the review team is satisfied with Mr O'Brien's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Mr O'Brien gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Mr O'Brien's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients .

GMC Liaison officer recommended referral on 19.01.19. Recently appointed MD reviewed and discussed concerns re insight.

Local restrictions

Please provide details of any restrictions on the doctor's practise at a local level:

See attached management plan in place for Mr O'Brien.

Supporting documentation

Please list in the box below any available supporting information and mark which items are included with this form. Please forward to us any further supporting information which subsequently becomes available as soon as possible and, if possible, indicate in the box below which information you expect to be able to send at a later stage.

Supporting documentation (where available) could include:

- ☒ notes, reports and transcripts of internal investigations or disciplinary documentation on this matter or related previous concerns
- ☒ complaint letter
- ☒ anonymised / redacted medical records
Where supporting information contains patient identifiable details, we may ask you to seek consent from those individuals, where you have not done so already.
- ☒ expert report(s)
- ☒ relevant Royal College reviews
- ☒ relevant audit findings
- ☒ NCAS assessment reports and other relevant NCAS correspondence
- ☒ conviction / caution cases: criminal records check or certificate of conviction
- ☒ health cases: (1) details of any relevant sickness absence; (2) medical records and (3) notes of any meetings where the doctor's health has been discussed
- ☒ where the incident being referred is part of a pattern of behaviour - all supporting documentation relating to the other concerns.

Formal investigation report and appendices (send via post to GMC)

Case Manager's determination (attached)

Management Action Plan for Mr O'Brien (attached)

NCAS advices (attached)

Other sources of information

Please use the box below to detail any organisations and bodies (eg regulatory bodies, coroners, ombudsman, the police) that may be able to assist with providing relevant information to us. Where possible, please include the contact details of a named person within that organisation.

Patient safety concerns

To your knowledge, has the doctor whom you are referring raised concerns about patient safety with your or any other organisation that patient safety or care is being compromised by the practice of colleagues, the system, policies, procedures in the organisations in which they work?

Yes ☒ No ☐ Explanatory guidance on patient safety concerns can be found in the [referral guidance](#).

If yes, when did the doctor raise their concern? Also, please indicate the nature of the concern.

Has raised concerns throughout about waiting lists which are well recognised

Have the concerns been investigated?

Yes ☒ No ☐

Please list any supporting information available in regard to the investigation and the patient safety issues raised. If the concern was not investigated, please provide an explanation below.

Supporting documentation (where available) could include:

☒ Reports or notes of internal / external enquiries or investigations

To mitigate effects of this Consultant of the week with triage was introduced to identify patients who should have been red flagged at referral.

Declaration

In accordance with my duty to raise concerns about the fitness to practise of doctors, I refer the named medical practitioner(s) to the GMC. In so doing, I confirm that:

the referral is made in good faith, based on all the information that is available to me at the present time

I have taken reasonable steps to ensure that the referral is fair and accurate.

Signature

Date

Your full name

Your role

Organisation

Where you are a nominated delegate, please provide the name and role of the person you are acting on behalf of, if applicable:

Acting on behalf and with the knowledge of

Role (eg Responsible Officer, Suitable Person, Medical Director, or Chief Executive)

Organisation

CONSULTANT APPRAISAL
Complaints: 1.1.18 - 31.12.18

Mr A O'Brien

NIL

CONSULTANT APPRAISAL
Incidents: 1.1.18 - 31.12.18

Mr A O'Brien

NII



Southern Health
and Social Care Trust

Quality Care - for you, with you

Record of Attendance Morbidity and Mortality Meetings 2019

CRAIGAVON AREA HOSPITAL

CONSULTANT UROLOGY

Mr Aidan O'Brien

7 out of 9 = 78% 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.

M&M Certificate 2019

COMPLAINTS
Consultant Appraisal 1 January - 31 December 2019

Mr Aidan O'Brien

| ID | First received | Record name | Description | Outcome |
|--|----------------|--|---|--|
| Personal Information redacted by the USI | 20/05/2019 | Personal Information redacted by the USI | Partner of patient who had surgery and treatment for renal cell carcinoma in 2012 is concerned at the lack of follow-up care provided by the Trust. | Detailed explanation of care provided to patient since 1999 including surgery performed and follow up. Advised that there was no evidence of recurrence or progression of renal carcinoma 2012 and that in 2013 patient failed to attend 2 review appointments. Further review planned for 2014 and patient failed to attend on 2 occasions in 2015. No evidence of recurrence or progression of disease in 2016. Further x-rays of left knee planned for 2016 but patient did not attend. Patient then attended in June 2017 and was referred to Orthopaedic Services. Ongoing care, including palliative radiotherapy, provided to date. Consultant confirmed that no cancer was left behind in the kidney following surgery in 2012 and explained that there still has been no evidence of carcinoma present in the right kidney as recently as June 2019. Apology offered for lack of support / counselling services. Meeting offered for clarity. |

INCIDENTS

Consultant Appraisal 1 January - 31 December 2019

Mr Aidan O'Brien

NIL

Courses Attended Record

Courses

Aidan O'Brien

Urology

Date Record Created 22/04/2020

| Date | Year | Title | Days | CPD | Cost | Ex Funded | Inc PDP | Claimed | Ref | Class |
|------------|-----------|--|------|-----|----------|---------------|---|---------|--------------------|-------------|
| 14/03/2019 | 2019 | Annual meeting of European Association of Urology - Spain
Request to the Trust for Reimbursement of £1385 | 3 | 20 | £2185.00 | CURE | ☒ Yes | £800.00 | MDMOK/MH/1819/2867 | O/Seas Trip |
| 25/06/2018 | 2018 | BAUS Annual Scientific Meeting - Liverpool | 3 | 18 | £1125.73 | | ☒ Yes | | MDAK/MH/1819/2498 | Uk Trip |
| 15/03/2013 | 2013 | annual meeting of European association urology MILAN full sponsorship | 2 | | £1652.14 | Takeda UK Ltd | Yes | £0.00 | TB03/13/14 | O/Seas Trip |
| 23/02/2012 | 2012/13 | Annual meeting of European Association of Urology PARIS | 4 | ? | £0.00 | Takeda UK Ltd | Yes | £0.00 | TB02/12/07 | O/Seas Trip |
| 28/03/2011 | 2011/2012 | Urocon 2011, KARDCHI Pakistan SPEAKER at confer | 6 | ? | | | Yes | | TB03/11/09 | O/Seas Trip |

Mandatory Training Passport

Aidan O'Brien, Urology, Date Record Created 22/04/2020

[Print as PDF](#)

| CORE MODULES | | | ADDITIONAL MODULES | | | | | | |
|---|------------|--------------|-----------------------|------------|--------------|-------------------------|------------|------------------|------------|
| Module | Date | Date Renewal | Module | Date | Date Renewal | Module | Date | Module | Date |
| FIRE | 24/10/2017 | 24/10/2018 | FRAUD AWARENESS | | | NEWS | | PRESCRIBING | |
| INFECTION CONTROL | 22/11/2018 | 21/11/2020 | MAPA | | | OEWs | | CLINICAL TRIALS | |
| SAFEGUARDING | 24/10/2017 | 23/10/2020 | EQUALITY | 22/11/2018 | 21/11/2021 | PEWS | | VTE | |
| INFORMATION GOVERNANCE | 21/11/2018 | 20/11/2021 | RECRUITMENT SELECTION | | | CONSENT | 06/07/2010 | SAFE SEDATION | |
| H&S COSHH | 22/11/2018 | 21/11/2021 | SICKNESS ABSENTEEISM | | | BLOOD CULTURE | | GASTRO ENDOSCOPY | |
| BACKCARE | 22/11/2018 | 21/11/2021 | DoLs Lvl 2 | | | PERIPHERAL LINE | | CHEST DRAIN | |
| RPRB DESIST? | | | DoLs Lvl 3 | | | USE OF ANTICOAGs | | BLOOD GAS | |
| RPRB THEORY | 15/12/2015 | 14/12/2018 | DoLs Lvl 5 | | | NG TUBE | | APPRAISER | |
| RPRB COMPETENCY | 20/12/2017 | 19/12/2020 | DoLs Lvl 4 DESIST? | | | ACTIONS FOLLOWING DEATH | | APPRAISSEE | 08/03/2016 |
| | | | DoLs Lvl 4 | | | PM CONSENT | | NEGLIGENCE | |
| ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW | | | | | | Complaints / Incidents | 08/10/2013 | CORONERS | |
| | | | HYPO DESIST? | | | | | | |

Mandatory Training Passport

Aidan O'Brien, Urology, Date Record Created 28/01/2019

Print as PDF

CORE MODULES

| Module | Date | Date Renewal |
|------------------------|------------|--------------|
| FIRE | 24/10/2017 | 24/10/2018 |
| INFECTION CONTROL | 22/11/2018 | 21/11/2020 |
| SAFEGUARDING | 24/10/2017 | 23/10/2020 |
| INFORMATION GOVERNANCE | 21/11/2018 | 20/11/2021 |
| H&S COSHH | 22/11/2018 | 21/11/2021 |
| BACKCARE | 22/11/2018 | 21/11/2021 |
| RPRB DESIST? | | |
| RPRB THEORY | 15/12/2015 | 14/12/2018 |
| RPRB COMPETENCY | 20/12/2017 | 19/12/2020 |

| Module | Date | Date Renewal |
|---|------------|--------------|
| FRAUD AWARENESS | | |
| MAPA | | |
| EQUALITY | 22/11/2018 | 21/11/2021 |
| RECRUITMENT SELECTION | | |
| SICKNESS ABSENTEEISM | | |
| HYPONATRAEMIA | | |
| ENTER CPR COURSE NAME, COMPETED DATE AND RENEWAL DATE BELOW | | |
| Complaints / Incidents | 08/10/2013 | |
| Coroners Cases | | |

ADDITIONAL MODULES

| Module | Date | Module | Date |
|-------------------------|------------|------------------|------------|
| NEWS | | PRESCRIBING | |
| OEWS | | CLINICAL TRIALS | |
| PEWS | | VTE | |
| CONSENT | 06/07/2010 | SAFE SEDATION | |
| BLOOD CULTURE | | GASTRO ENDOSCOPY | |
| PERIPHERAL LINE | | CHEST DRAIN | |
| USE OF ANTICOAGs | | BLOOD GAS | |
| NG TUBE | | APPRAISER | |
| ACTIONS FOLLOWING DEATH | | APPRAISSEE | 08/03/2016 |
| PM CONSENT | | NEGLIGENCE | |

COURSES FOR RECOGNISED TRAINERS

| Activity | Activity date | Activity date expires |
|----------|---------------|-----------------------|
| | | |
| | | |
| | | |
| | | |

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Revalidation details

[My Account](#)The [date you last revalidated](#) was 28/04/2014.[My Registration](#)All fully registered doctors with a licence to practise need to revalidate to show th
more about [revalidation](#).**My Revalidation**Please check the designated body information below. If you're happy it's correct p
If it's not correct please click 'Change designated body'.[My Appointments &
Workshops](#)If you don't know your designated body you can use our [online tool](#) to help you fi
If you are sure you don't have a designated body please click 'I don't have a conr[My Surveys](#)[My Tests](#)

| | |
|--|--|
| Designated body | Southern Health and Social Care Trust |
| Responsible officer | Ellen O'Kane |
| Designated body email address | medical.revalidation@shscaretrust.nhs.uk <small>Personal information redacted by the UST</small> |
| Next submission date | 04/11/2019 |
| Designated body last updated by | General Medical Council |
| Designated body last updated on | 16/04/2012 |

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Consultant Level Indicator Programme

Consultant: Mr Aidan O'Brien

Personal Information redacted by the UST

10100 - Urology

Southern Health and Social Care Trust

Generated 21st February 2019

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About CHKS

CHKS is a provider of healthcare intelligence and quality improvement services. Over the last 30 years our team of NHS data experts, clinicians and quality managers have worked with more than 400 healthcare organisations around the world to improve population health.

We enable providers and commissioners to make better decisions at patient, service, organisation and population level and deliver sustainable improvements in care quality, patient outcomes and service efficiency along the entire patient pathway.

Our services include:

- Healthcare benchmarking and analytics - we identify what to improve and model the impact of change at patient, organisation and population level
- Clinical coding, data quality and costing services - we ensure data used for payment and decision making accurately reflects the care delivered
- Care quality, assurance and accreditation - we work to the latest international standards of best practice within a proven framework of continuous improvement

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1. Report Overview

This report has been produced based on information extracted from the organisation's patient administration system. The individual consultant and the data period are both detailed on the front cover of the report.

You have been assigned to a specialty based on a combination of the specialty your organisation assigned you to and the clinical information about the patients you treated. For example, you may have been assigned to trauma and orthopaedics by your organisation but based on the clinical information recorded about the patients you treated CHKS have subdivided this specialty further to hand, hip, knee, etc. The same criteria are then applied to both the local and selected peer ensuring that comparisons are as appropriate as possible.

The analysis included in this report frequently refers to consultant, local peer and selected peer which are explained below:

- **Consultant** - displays the consultant value, shown as an index, percentage/rate or ratio depending on each indicator's calculation. Where applicable the actual value (numerator) is shown.
- **Local Peer** - displays the local peer value which consists of consultant colleagues' average value within the same organisation and same specialism.
- **Selected Peer** - displays the external peer value which consists of a selection of consultants' average value within the same specialism but from external organisations.

The scorecard view also contains a Peer Range which displays a comparison with the selected peer group ONLY and is shown graphically within a RAG spectrum. The linear spectrum shows the consultants value plotted between the 10th to 90th percentile values of the selected peer. If the consultant's value is outside this range then it is displayed as a diamond.

| Rating | Interpretation |
|---|--|
|  | Consultant value falls within the top 75% percentile of the peer |
|  | Consultant value falls between the 75% and 25% percentiles of the peer |
|  | Consultant value falls within the bottom 25% percentile of the peer |
|  | Consultant has no data |
|  | Insufficient peer data available to make a meaningful comparison |

* Data suppressed due to small number rules.

Risk adjusted indicators should be reviewed in conjunction with a range of other quality indicators and contextual information. Variation from the expected can be due to a range of issues and it is important that all are investigated and understood. These might include data quality issues and differences in service configuration. Accurate measurement of outcomes and risk also require sufficient numbers to develop robust statistical models.

Indicator definitions are either included in your report, are available locally or can be obtained by emailing info@chks.co.uk, including the name of the organisation you work for along with your GMC number and name.

| Peer Sites | | |
|--|--|--|
| Isle of Wight NHS Trust | Barts Health NHS Trust | The London North West Healthcare NHS Trust |
| Royal Surrey County Hospital NHS Foundation Trust | Weston Area Health NHS Trust | Yeovil District Hospital NHS Foundation Trust |
| University Hospitals Bristol NHS Foundation Trust | Bradford Teaching Hospitals NHS Foundation Trust | Southend University Hospital NHS Foundation Trust |
| Royal Free London NHS Foundation Trust | North Middlesex University Hospital NHS Trust | The Hillingdon Hospitals NHS Foundation Trust |
| Kingston Hospital NHS Foundation Trust | Taunton And Somerset NHS Foundation Trust | Dorset County Hospital NHS Foundation Trust |
| Walsall Healthcare NHS Trust | Wirral University Teaching Hospital NHS Foundation Trust | St Helens And Knowsley Hospitals NHS Trust |
| Mid Cheshire Hospitals NHS Foundation Trust | Northern Devon Healthcare NHS Trust | Bedford Hospital NHS Trust |
| Luton and Dunstable University Hospital NHS Foundation Trust | York Teaching Hospital NHS Foundation Trust | Harrogate And District NHS Foundation Trust |
| Airedale NHS Foundation Trust | The Queen Elizabeth Hospital King's Lynn NHSFT | Royal United Hospital Bath NHS Trust |
| Poole Hospital NHS Foundation Trust | Milton Keynes Hospital NHS Foundation Trust | Basildon And Thurrock University Hospitals NHSFT |
| Colchester Hospital University NHS Foundation Trust | Frimley Park Hospital NHS Foundation Trust | The Royal Bournemouth And Christchurch Hospitals NHSFT |
| South Tyneside NHS Foundation Trust | Royal Cornwall Hospitals NHS Trust | Aintree University Hospital NHS Foundation Trust |
| Barking Havering And Redbridge University Hospitals NHSFT | Barnsley Hospital NHS Foundation Trust | The Rotherham NHS Foundation Trust |
| Chesterfield Royal Hospital NHS Foundation Trust | Peterborough And Stamford Hospitals NHS Foundation Trust | James Paget University Hospitals NHS Foundation Trust |
| Colchester Hospital University NHS Foundation Trust | West Suffolk NHS Foundation Trust | Cambridge University Hospitals NHS Foundation Trust |
| Royal Devon And Exeter NHS Foundation Trust | University Hospital Southampton NHS Foundation Trust | Sheffield Teaching Hospitals NHS Foundation Trust |
| Portsmouth Hospitals NHS Trust | Royal Berkshire NHS Foundation Trust | Guy's And St Thomas' NHS Foundation Trust |
| Lewisham and Greenwich NHS Trust | Croydon Health Services NHS Trust | St George's Healthcare NHS Trust |
| South Warwickshire NHS Foundation Trust | University Hospital Of North Midlands NHS Trust | Derby Hospitals NHS Foundation Trust |

| | | |
|--|--|---|
| Northern Lincolnshire And Goole Hospitals NHS Foundation Trust | East Cheshire NHS Trust | Countess Of Chester Hospital NHS Foundation Trust |
| King's College Hospital NHS Foundation Trust | Sherwood Forest Hospitals NHS Foundation Trust | Plymouth Hospitals NHS Trust |
| University Hospitals Coventry And Warwickshire NHS Trust | The Whittington Hospital NHS Trust | The Royal Wolverhampton Hospitals NHS Trust |
| City Hospitals Sunderland NHS Foundation Trust | Wye Valley NHS Trust | George Eliot Hospital NHS Trust |
| Norfolk And Norwich University Hospitals NHSFT | Salford Royal NHS Foundation Trust | Bolton NHS Foundation Trust |
| Tameside Hospital NHS Foundation Trust | Great Western Hospitals NHS Foundation Trust | Hampshire Hospitals NHS Foundation Trust |
| Dartford And Gravesham NHS Trust | The Dudley Group NHS Foundation Trust | North Cumbria University Hospitals NHS Trust |
| Kettering General Hospital NHS Foundation Trust | Northampton General Hospital NHS Trust | Salisbury NHS Foundation Trust |
| Doncaster And Bassetlaw Hospitals NHS Foundation Trust | Medway NHS Foundation Trust | Royal Liverpool And Broadgreen University Hospitals NHSFT |
| Mid Essex Hospital Services NHS Trust | Chelsea And Westminster Hospital NHS Foundation Trust | The Princess Alexandra Hospital NHS Trust |
| Homerton University Hospital NHS Foundation Trust | Heart Of England NHS Foundation Trust | Gateshead Health NHS Foundation Trust |
| Leeds Teaching Hospitals NHS Trust | Wrightington Wigan And Leigh NHS Foundation Trust | University Hospitals Birmingham NHS Foundation Trust |
| University College London Hospitals NHS Foundation Trust | The Newcastle Upon Tyne Hospitals NHS Foundation Trust | Gloucestershire Hospitals NHS Foundation Trust |
| Northumbria Healthcare NHS Foundation Trust | Derby Hospitals NHS Foundation Trust | Oxford University Hospitals NHS Trust |
| Ashford And St Peter's Hospitals NHS Foundation Trust | Surrey And Sussex Healthcare NHS Trust | South Tees Hospitals NHS Foundation Trust |
| University Hospitals Of Morecambe Bay NHS Foundation Trust | North Bristol NHS Trust | Epsom And St Helier University Hospitals NHS Trust |
| East Kent Hospitals University NHS Foundation Trust | North Tees And Hartlepool NHS Foundation Trust | Southport And Ormskirk Hospital NHS Trust |
| Pennine Acute Hospitals NHS Trust | Hull And East Yorkshire Hospitals NHS Trust | United Lincolnshire Hospitals NHS Trust |
| University Hospitals Of Leicester NHS Trust | Maidstone And Tunbridge Wells NHS Trust | West Hertfordshire Hospitals NHS Trust |
| East And North Hertfordshire NHS Trust | Stockport NHS Foundation Trust | Worcestershire Acute Hospitals NHS Trust |

| | | |
|--|---|--|
| Warrington And Halton Hospitals NHS Foundation Trust | Calderdale And Huddersfield NHS Foundation Trust | Nottingham University Hospitals NHS Trust |
| East Sussex Healthcare NHS Trust | Mid Yorkshire Hospitals NHS Trust | Brighton And Sussex University Hospitals NHS Trust |
| Sandwell And West Birmingham Hospitals NHS Trust | Blackpool Teaching Hospitals NHS Foundation Trust | Lancashire Teaching Hospitals NHS Foundation Trust |
| County Durham And Darlington NHS Foundation Trust | Buckinghamshire Healthcare NHS Trust | East Lancashire Hospitals NHS Trust |
| Shrewsbury And Telford Hospital NHS Trust | Imperial College Healthcare NHS Trust | Western Sussex Hospitals NHS Foundation Trust |
| Manchester University NHS Foundation Trust | Torbay And South Devon NHS Foundation Trust | |

2. Scorecard

The scorecard below is a collection of performance and efficiency indicators at consultant level. For each indicator consultant, local peer and selected peer values are displayed along with a peer range based on a RAG spectrum. See overview for explanation of values.

| Indicator | | Consultant | Local | Peer | Peer Range |
|---|------|------------|----------|----------|--|
| Average Length of Stay (FCE - zero trimmed) | 1524 | 4.03 | 4.20 | 3.30 | <div><div></div><div></div><div></div></div> |
| Elective Average Length of Stay (FCE - zero trimmed) | 416 | 2.87 | 3.04 | 2.41 | <div><div></div><div></div><div></div></div> |
| Non-elective Average Length of Stay (FCE - zero trimmed) | 1108 | 4.76 | 4.98 | 4.02 | <div><div></div><div></div><div></div></div> |
| Elective Average Pre-Op Length of Stay (Spell - zero trimmed) | 5 | 0.05 | 0.07 | 0.09 | <div><div></div><div></div><div></div></div> |
| Day Case Rate | 568 | 78.34% | 82.99% | 72.40% | <div><div></div><div></div><div></div></div> |
| Day Case Overstays | 19 | 3.24% | 5.32% | 8.08% | <div><div></div><div></div><div></div></div> |
| Elective IP - procedure not carried out | 0 | 0% | 0.93% | 0.63% | <div><div></div><div></div><div></div></div> |
| Elective IP - procedure not carried out - patient reason | 0 | 0% | 0% | 0.02% | <div><div></div><div></div><div></div></div> |
| Elective IP - procedure not carried out - other than patient reason | 0 | 0% | 0.93% | 0.61% | <div><div></div><div></div><div></div></div> |
| Elective IP - no procedure | 1 | 1.01% | 0.94% | 0.83% | <div><div></div><div></div><div></div></div> |
| Mortality Rate | 4 | 0.41% | 0.25% | 0.26% | <div><div></div><div></div><div></div></div> |
| Mortality Rate - Elective | 0 | 0% | 0% | 0.02% | <div><div></div><div></div><div></div></div> |
| Mortality Rate - Non-elective | 4 | 0.41% | 0.25% | 0.23% | <div><div></div><div></div><div></div></div> |
| Readmissions within 28 days | 55 | 5.73% | 4.62% | 7.45% | <div><div></div><div></div><div></div></div> |
| Complication rate - attributed | 11 | 1.13% | 0.52% | 1.41% | <div><div></div><div></div><div></div></div> |
| Misadventure rate | 0 | 0% | 0.06% | 0.19% | <div><div></div><div></div><div></div></div> |
| Outpatient New to follow-up ratio | 680 | 1 : 2.07 | 1 : 1.13 | 1 : 1.72 | <div><div></div><div></div><div></div></div> |
| Outpatient DNA Rate | 39 | 3.72% | 3.70% | 6.98% | <div><div></div><div></div><div></div></div> |
| Outpatient DNA Rate - New Attendances | 16 | 4.64% | 4.70% | 6.45% | <div><div></div><div></div><div></div></div> |
| Outpatient DNA Rate - Follow-up Attendances | 23 | 3.27% | 2.80% | 7.29% | <div><div></div><div></div><div></div></div> |

3. Activity

The activity tables display a collection of activity based indicators split by inpatient and outpatient workload.

Admitted Workload

| Indicator | Consultant | | Local | Peer |
|------------------------------|------------|--------|---------|--------|
| Total FCEs | 1016 | - | 1071.80 | 451.32 |
| % Elective FCEs | 763 | 75.10% | 82.38% | 71.34% |
| % Elective FCEs - Inpatients | 172 | 22.54% | 15.83% | 27.85% |
| % Elective FCEs - Day Cases | 578 | 75.75% | 72.80% | 70.53% |
| % Regular Attenders | 15 | 1.97% | 11.51% | 1.97% |
| % Emergency FCEs | 193 | 19% | 14.07% | 26.62% |
| % Other FCEs | 60 | 5.91% | 3.55% | 2.04% |

Outpatient Workload

| Indicator | Consultant | Local | Peer |
|--|------------|--------|-----------------|
| Total Attendances (OP) | 1009 | - | 1388.80 2757.07 |
| Total New OP Attendances | 329 | - | 652.20 1012.03 |
| Total Follow-up OP Attendances | 680 | - | 736.60 1743.41 |
| Outpatient Attendances with a Procedure | 81 | 8.03% | 3.01% 38.12% |
| New Outpatient Attendance with a Procedure | 78 | 23.71% | 5.52% 46.34% |
| Follow-up Attendances with a Procedure | 3 | 0.44% | 0.79% 33.38% |
| New Outpatient Attendance - referred by GP | 144 | 43.77% | 63.23% 49.93% |
| Total DNA's | 39 | - | 53.40 206.91 |
| % of DNA's New Attendances | 16 | 41.03% | 60.30% 33.73% |
| % of DNA's Follow-up Attendances | 23 | 58.97% | 39.70% 66.27% |

4. Risk Adjusted Indicators

This analysis displays a collection of risk adjusted indicators for the target consultant by elective and non-elective activity. The indicators compare the observed numbers in the relevant indicator to the expected number. The indices are expressed as percentages. An index of 110% suggests 10% more than expected, whilst 90% suggests 10% fewer than expected. See indicator definitions for an explanation of values for each index.

Please note that risk adjusted indicators should be reviewed in conjunction with a range of other quality indicators and contextual information. Variation from the expected can be due to a range of issues and it is important that all are investigated and understood. These might include data quality issues and differences in service configuration. Accurate measurement of outcomes and risk also require sufficient numbers to develop robust statistical models.

| Indicator | | Consultant | Local | Peer |
|---|------|------------|--------|--------|
| Risk adjusted mortality index 2017 | 4 | 72.77 | 63.82 | 48.71 |
| Elective | - | - | - | 55.71 |
| Non-elective | 4 | 78.91 | 73.02 | 48.08 |
| Risk Adjusted Length of Stay Index 2017 | 1363 | 95.40 | 102.76 | 82.61 |
| Elective | 345 | 126.55 | 118.93 | 80.08 |
| Non-elective | 1018 | 88.05 | 97.33 | 83.83 |
| Risk adjusted readmissions 2017 | 56 | 90.68 | 77.60 | 108.71 |
| Elective | 23 | 80.83 | 69.40 | 112.21 |
| Non-elective | 33 | 99.10 | 88.86 | 105.63 |

5. Focus

Focus displays the top 10 procedures / diagnoses at consultant level split by day cases, inpatient procedures and the top 5 outpatient procedures. In medical specialties the inpatient profile will be the top diagnoses while for surgical specialties it will be procedures. The day case procedure profile includes the volume, day case rate and day case overstay rate; the inpatient profile includes the volume and average length of stay and the outpatient profile shows volume of procedures.

Please note that if your organisation or your selected peer does not clinically code, or only partially clinically code outpatient activity these values may not reflect activity. Your local clinical coding department will be able to advise you.

Day Case Top 10 Procedures by Volume

| Procedure | Actual Day Cases | | | | | | Day Case Overstays | | | | | |
|---|------------------|--------|-------|---------|---------|---------|--------------------|-------|------|-------------|-------|------|
| | Number | | | Rate | | | Number | | | Average LoS | | |
| | Cons | Local | Peer | Cons | Local | Peer | Cons | Local | Peer | Cons | Local | Peer |
| M45 - Diagnostic endoscopic examination of bladder | 219 | 288.60 | 40.56 | 97.33 % | 97.11 % | 88.24 % | 0 | 2.40 | * | 0 | 1.67 | 1.53 |
| M49 - Other operations on bladder | 199 | 104.80 | 28.84 | 100% | 99.81 % | 96.13 % | 0 | 0 | * | 0 | 0 | 1.71 |
| M43 - Endoscopic operations to increase capacity of bladder | 30 | 16.60 | * | 85.71 % | 95.40 % | 87.65 % | 2 | 0.20 | * | 2.50 | 4 | 1.44 |
| N30 - Operations on prepuce | 10 | 12 | 11.51 | 100% | 92.31 % | 92.06 % | 0 | 0.40 | * | 0 | 2 | 1.25 |
| M29 - Other therapeutic endoscopic operations on ureter | 7 | 19.20 | 7.34 | 53.85 % | 72.18 % | 67.49 % | 2 | 3.80 | * | 3.50 | 2.74 | 1.93 |
| X33 - Other blood transfusion | 6 | 0.40 | * | 100% | 100% | 77.14 % | 0 | 0 | * | 0 | 0 | 3.32 |
| M16 - Other operations on kidney | 5 | 3.60 | * | 62.50 % | 69.23 % | 43.55 % | 0 | 0.60 | * | 0 | 9.33 | 2.83 |
| M48 - Operations on bladder | 5 | 0.20 | * | 100% | 33.33 % | 60.19 % | 0 | 0 | * | 0 | 0 | 1.31 |
| M77 - Diagnostic endoscopic examination of urethra | 4 | 1.20 | * | 100% | 100% | 89.24 % | 0 | 0 | * | 0 | 0 | 1.76 |
| N15 - Operations on epididymis | 3 | 1.60 | * | 100% | 100% | 90.34 % | 0 | 0 | * | 0 | 0 | 1.12 |

Inpatient Top 10 Procedures by Volume

| Number | Pre-op Average LoS | IP Average LoS |
|--------|--------------------|----------------|
|--------|--------------------|----------------|

| Procedure | Cons | Local | Peer | Cons | Local | Peer | Cons | Local | Peer |
|---|------|-------|-------|------|-------|--------|------|-------|------|
| M27 - Therapeutic ureteroscopic operations on ureter | 43 | 34.40 | 6.44 | 0.11 | 0.07 | -37.54 | 2.77 | 3.41 | 1.81 |
| M65 - Endoscopic resection of outlet of male bladder | 40 | 14.60 | 10.98 | 0.06 | 0.06 | -42.63 | 4.05 | 3.29 | 2.20 |
| M29 - Other therapeutic endoscopic operations on ureter | 29 | 21.80 | 8.36 | 0.12 | 0.03 | -28.39 | 4.03 | 4.42 | 2.49 |
| M42 - Endoscopic extirpation of lesion of bladder | 27 | 27.60 | 15.75 | 0 | 0.23 | -56.88 | 4.30 | 2.95 | 2.07 |
| U21 - Diagnostic imaging procedures | 26 | 19.80 | 13.84 | - | - | 1.94 | 4.85 | 6.16 | 2.51 |
| M45 - Diagnostic endoscopic examination of bladder | 17 | 15.40 | 6.65 | - | 0 | -16.23 | 3.94 | 2.84 | 1.61 |
| M47 - Urethral catheterisation of bladder | 9 | 9.20 | 19.39 | - | 0 | 0.75 | 2.89 | 4.30 | 2.69 |
| M16 - Other operations on kidney | 8 | 3.40 | * | 0 | 0.25 | -2.55 | 1.88 | 6.35 | 3.55 |
| M79 - Other operations on urethra | 8 | 1.80 | * | 0 | 0.12 | -6.56 | 0.75 | 4.22 | 1.09 |
| M30 - Diagnostic endoscopic examination of ureter | 7 | 4.20 | * | - | 0 | 0.18 | 4.71 | 4.29 | 1.60 |

Outpatient Top 5 Procedures by Volume

| Procedure | Consultant | Local | Peer |
|---|------------|-------|-------|
| M47 - Urethral catheterisation of bladder | 79 | 35 | 23.48 |
| M49 - Other operations on bladder | 2 | 0 | 20.72 |

6. Trend

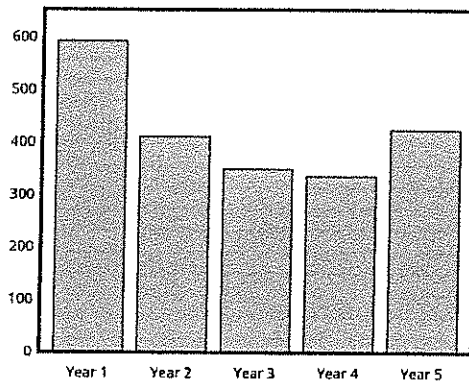
This analysis displays a collection of performance and efficiency indicators for the target consultant comparing performance year on year data for the selected time period. Up to a maximum of five years can be displayed depending on the availability of data.

Data may be missing if your organisation has not submitted historical data to CHKS or if you became a consultant at the organisation within the last five years.

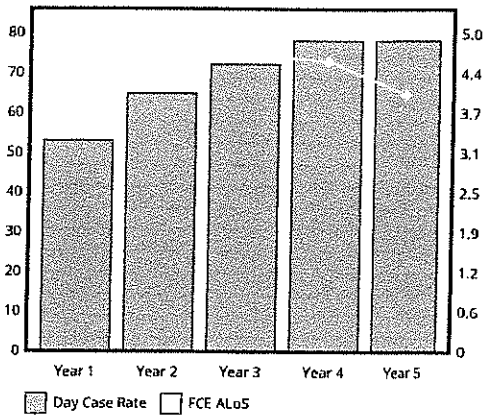
If a period of less than 12 months is selected then this is also the period that will be reported for the previous years. For example, if the selected period is January - June 2016 then the previous four years will be the January - June period in each year.

| Indicator | Jan 14 - Dec 14 | Jan 15 - Dec 15 | Jan 16 - Dec 16 | Jan 17 - Dec 17 | Jan 18 - Dec 18 |
|---|-----------------|-----------------|-----------------|-----------------|-----------------|
| Total FCEs (Exclusions: Standard and Day-cases) | 594 | 412 | 351 | 337 | 425 |
| Average Length of Stay (FCE - zero trimmed) | 4.88 | 4.83 | 4.67 | 4.55 | 4.03 |
| Day Case Rate | 53.17% | 64.98% | 72.35% | 78.31% | 78.34% |
| Mortality Rate | 0.39% | 0.37% | 0.60% | 0.33% | 0.41% |
| Readmissions within 7 days | 2.92% | 2.20% | 2.16% | 1.10% | 2.92% |
| Readmissions within 14 days | 4.63% | 3.79% | 3.24% | 2.64% | 4.58% |
| Readmissions within 28 days | 6.14% | 6.11% | 4.68% | 3.96% | 5.73% |
| Total New OP Attendances | 285 | 462 | 347 | 430 | 329 |
| Total Follow-up OP Attendances | 614 | 647 | 573 | 509 | 680 |
| Outpatient DNA Rate | 4.06% | 3.90% | 5.25% | 2.80% | 3.72% |
| Outpatient DNA Rate - Follow-up Attendances | 4.36% | 2.41% | 4.82% | 2.12% | 3.27% |

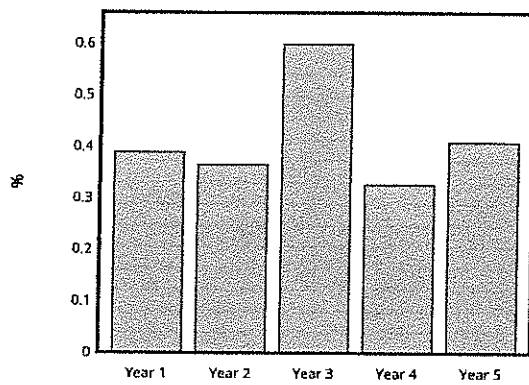
Total FCEs



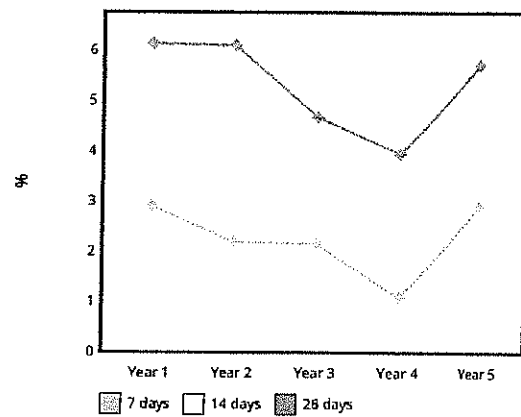
Day Case Rate & FCE ALoS



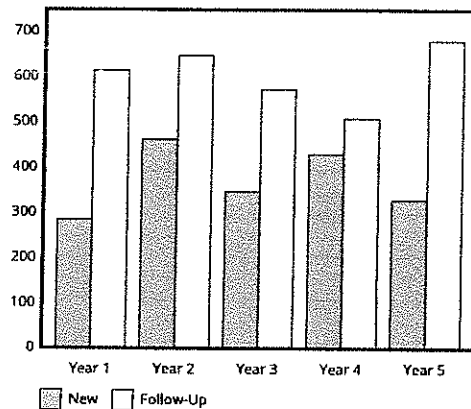
Mortality Rate



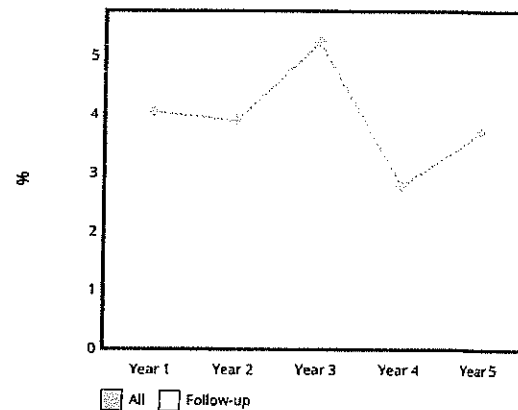
Readmission Rate



Outpatient Attendances



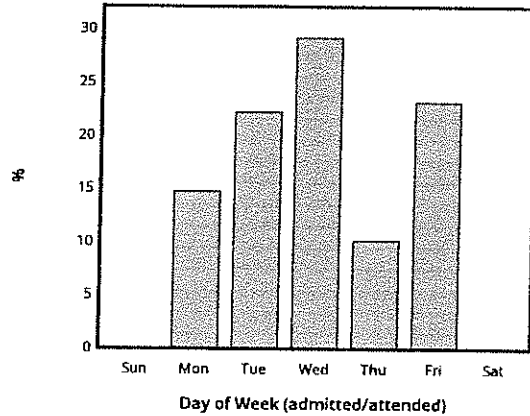
Outpatient DNA Rate



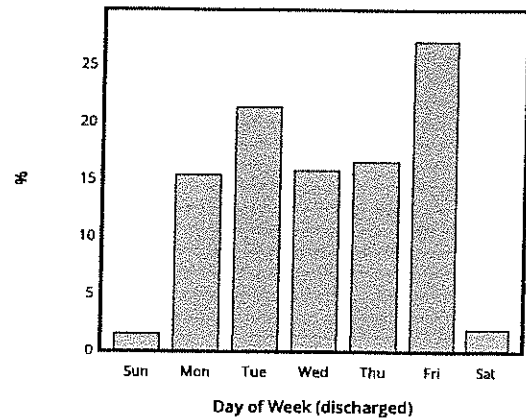
7. Schedule

This section displays the consultant profile for a selection of indicators by the day of the week of admission and discharge.

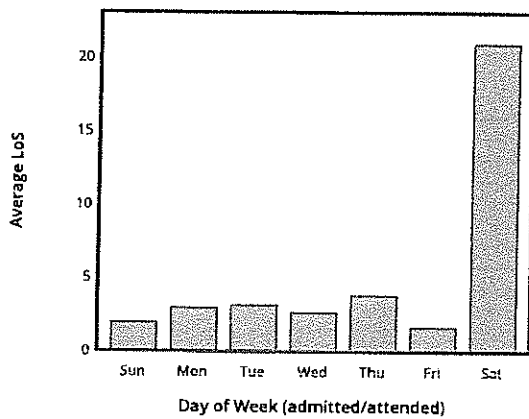
Elective Inpatient Admission Profile



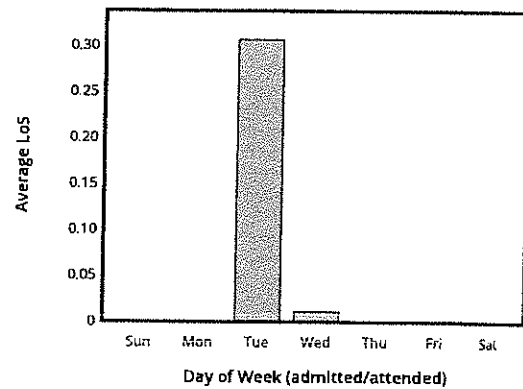
Elective Inpatient Discharge Profile



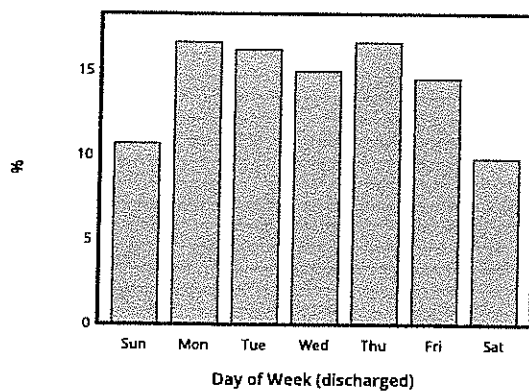
Elective Inpatient ALoS Profile



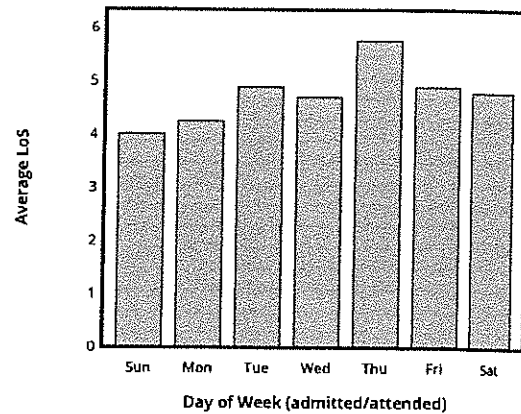
Elective Inpatient Pre-op ALoS Profile



Non-Elective Inpatient Discharge Profile



Non-Elective Inpatient ALoS Profile



From: Haynes, Mark <[REDACTED]>
Sent: 04 April 2019 09:46
To: O'Brien, Aidan
Cc: Elliott, Noleen
Subject: Today

Personal Information redacted by the USI

Importance: High

Morning Aidan

As per my text messages could you confirm that you will be attending the meeting today with Dr Khan (10:30 in the Medical Directors office)?

Thanks

Mark

A

B

4 April 2019

C

FILE REFERENCE: 21

D

AIDAN O'BRIEN
Accompanied by MICHAEL O'BRIEN
DR KHAN
SIOBHAN HYNDS
(DR KHAN)

E

Audio Transcription Prepared by:

Personal Information redacted by USI

F

G

H

4 April 2019

A

DR KHAN: Hello.

MR O'BRIEN: Hello.

DR KHAN: Hello, Aidan. How are you?

B

MR O'BRIEN: I am very well.

DR KHAN: Come on in. I am using Dr O'Kane's office. She is not here but I am just using her office here. Come in, please. Take a seat. How are things?

MR O'BRIEN: Okay.

DR KHAN: Okay?

C

MR O'BRIEN: Yeah.

DR KHAN: Right. I suppose I just wanted to meet you today in relation to a development happening in terms of GMC referral. So I suppose today's meeting is to inform you about what is happening in the background. So GMC, as you know last time when we met in October, I provided you with my report. I also informed that the GMC is aware of the case. So they requested a -- they formally requested to make a referral to GMC for fitness to practise and that is what Dr O'Kane, as your responsible officer now, has done it.

D

I, as the case manager, I have to provide you with this information. So I suppose that is the purpose of today's meeting. Just to, I suppose, provide you with a copy of this and also background, why, what is the reason. So that's I suppose I thought to meet you face-to-face rather than over the phone or email, but that's I suppose is the reason for today. I have a copy for you as well. That I suppose is a standard kind of fitness to practise referral from the GMC.

E

So Dr O'Kane has discussed with the GMC liaison officer in advance of this, she has discussed with, you know, other relevant people as well. She, as a responsible officer, I suppose it is going from Dr O'Kane, as the medical director, to GMC but she asked me, because I am a case ~~management~~ manager, she asked me do discuss with you, to inform you I suppose. And that is what I suppose the purpose of today's meeting. I know it was a short notice and everything else.

F

G

Now, in terms of the contents of this, this is a factual -- really information taken out from the report.

H

~~FEMALE SPEAKER~~ SIOBHAN HYNDIS: You will see there the concerns are the broad concerns and appended to the referral you will see the documents that have been shared. I haven't given you another ~~copy~~ copy of those, Mr O'Brien, at this stage because you have them all. If there is something additional that you feel you need again, you can absolutely let us know and we will get you a copy of that. But anything that has gone, you already

have. So that is why I have not given you that again this time.

A

The information there is information that you already will have sight of as well in terms of the concerns that arose, the timing of events and the findings of the investigation. Okay.

~~MR MICHAEL~~ O'BRIEN: Right. Okay.

B

DR KHAN: So I suppose, and I know obviously, you know, the case outcome of the report is on hold because you have made a formal request for obviously to formal grievance hearing, so that will be obviously taken once the formal grievance process is completed with the report. And the actions of that report is on hold basically at this stage. But obviously as medical director Maria, Dr O'Kane, has made the referral and she asked me to inform you.

C

~~MR MICHAEL~~ O'BRIEN: Okay.

DR KHAN: Okay. Is that okay?

~~MR MICHAEL~~ O'BRIEN: That's fine.

D

DR KHAN: You can take that with you. And then, you know, if you need any more information, although all three or four points in this you have all that, all this information already in addition to this referral. Okay.

~~MR MICHAEL~~ O'BRIEN: Okay.

E

F

G

H

HOURS

DCC

SPA

WEEK 1

44

4.5

WEEK 2

42.5

—

WEEK 3

55

3.5

WEEK 4

51

—

WEEK 5

57.5

3.5

TOTALS

250.0

11.5

MEANS

50.0

2.3

1 Wednesday
(305-60)

HOURS 12.

| | |
|-------|-----------------------------|
| 8.00 | |
| 8.30 | |
| 9.00 | INPATIENTS OPERATING |
| 9.30 | 9 AM - 5.30 PM |
| 10.00 | |
| 10.30 | EMERGENCY OPERATING |
| 11.00 | |
| 11.30 | 6 PM - 8 PM |
| 12.00 | |
| 12.30 | PREPARATION OF PRESENTATION |
| 1.00 | FOR M + M : 8 PM - 9 PM |
| 1.30 | |
| 2.00 | |
| 2.30 | |
| 3.00 | |
| 3.30 | |
| 4.00 | |
| 4.30 | |
| 5.00 | |
| 5.30 | |
| 6.00 | |
| 6.30 | |
| 7.00 | |
| 7.30 | |
| 8.00 | |

Evening

November 2006

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

HOURS: DCC 7.5
SPA 1.5

Thursday 2
Tax Week 31 (306-59)

| | | |
|-----------------|----------------|-------|
| 10 AM - 12 NOON | GRAND ROUND | 8.00 |
| 12.30 - 2 PM | IMPLEMENTATION | 8.30 |
| | GROUP MEETING. | 9.00 |
| | | 9.30 |
| | | 10.00 |
| 2 PM - 5 PM | BPC CLINIC | 10.30 |
| | | 11.00 |
| 6.30 PM - 9 PM | ADMINISTRATION | 11.30 |
| | | 12.00 |
| | | 12.30 |
| | | 1.00 |
| | | 1.30 |
| | | 2.00 |
| | | 2.30 |
| | | 3.00 |
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| | | 4.30 |
| | | 5.00 |
| | | 5.30 |
| | | 6.00 |
| | | 6.30 |
| | | 7.00 |
| | | 7.30 |
| | | 8.00 |

December 2006

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

Evening

3 Friday

(307-58)

HOURS: DCC 2
SPA 3

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

November 2006

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

Saturday 4

(308-57)

WEEK BEGINNING 30.10.06

DCC 8.5 SPA 4.5
14.0
12.0
7.5
2.0
44.0

DCC = 44 HOURS = 11 PAS

SPA = 4.5 HOURS = 1 PAS.

December 2006

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

Monday: 9 am - 2 pm: URODYNAM.
 2 pm - 3 pm: UROPATHOL
 3 pm - 5 pm: INPATIENTS
 5 pm - 8 pm: ADMISSIONS
 Tuesday: 9 am - 1 pm: DAY SURGERY
 2 pm - 6 pm: OUTPATIENTS
 6 pm - 9 pm: ADMINISTRATION
 Wednesday: 9 am - 6 pm: OPERATING.
 Thursday: 8³⁰ - 10 am: RADIOLOGY
 10 am - 12 noon: GRAND ROUND
 12.30 - 1.30: MEETING
 2 pm - 6 pm: CLINIC
 Friday: 9 am - 1 pm: PROSINE REV!
 2 pm - 5 pm: PRIVATE
 Saturday: 10 am - 2 pm: ADMIN
 Sunday: SPA 2.5 sessions.

5 Sunday
(309-56)

| | |
|-------|--|
| 8.00 | |
| 8.30 | |
| 9.00 | |
| 9.30 | |
| 10.00 | |
| 10.30 | |
| 11.00 | |
| 11.30 | |
| 12.00 | |
| 12.30 | |
| 1.00 | |
| 1.30 | |
| 2.00 | |
| 2.30 | |
| 3.00 | |
| 3.30 | |
| 4.00 | |
| 4.30 | |
| 5.00 | |
| 5.30 | |
| 6.00 | |
| 6.30 | |
| 7.00 | |
| 7.30 | |
| 8.00 | |

Evening

November 2006

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

Monday 6
(310-55)

| | |
|---------------------------------------|-------|
| 10.00 - 11.00:- INPATIENT MANAGEMENT. | 8.00 |
| 11.00 - 2.00 - URODYNAMICS | 8.30 |
| 2.00 - 3.00 : PATHOLOGY | 9.00 |
| 3.00 - 7.00 : ADMINISTRATION | 9.30 |
| 7.30 - 10.00 : ADMINISTRATION | 10.00 |
| | 10.30 |
| | 11.00 |
| | 11.30 |
| | 12.00 |
| | 12.30 |
| | 1.00 |
| | 1.30 |
| | 2.00 |
| | 2.30 |
| | 3.00 |
| | 3.30 |
| | 4.00 |
| | 4.30 |
| | 5.00 |
| | 5.30 |
| | 6.00 |
| | 6.30 |
| | 7.00 |
| | 7.30 |
| | 8.00 |

HOURS: DCC 10.5 HOURS
SPA 1.0 HOUR.

December 2006

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

Evening

7 Tuesday

(311-54)

8.00 9.30 - 12.30 : DAY SURGERY

8.30 9.00 2.00 - 5.00 : CLINIC

9.30 10.00 5.00 - 7.00 : WAITING LIST MANAGEMENT

10.30 11.00 7.30 - 10.00 : DICTATION
11.30 ADMINISTRATION

12.00 12.30 1.00 HOURS: 10.5 DCC

1.30 2.00 + ? LUNCH 0.5

2.30 3.00 + ? TEA 0.5

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

November 2006

| | | | | | |
|---|---|---|----|----|----|
| M | . | 6 | 13 | 20 | 27 |
| T | . | 7 | 14 | 21 | 28 |
| W | . | 1 | 8 | 15 | 22 |
| T | . | 2 | 9 | 16 | 23 |
| F | . | 3 | 10 | 17 | 24 |
| S | . | 4 | 11 | 18 | 25 |
| S | . | 5 | 12 | 19 | 26 |

Wednesday 8

(312-53)

9.30 - 5.00 : OPERATING

5.30 - 6.00 : TEA

6.00 - 8.30 : ADMINISTRATION

HOURS: DCC : 10

+ ? TEA : 0.5

December 2006

| | | | | | |
|---|---|---|----|----|----|
| M | . | 4 | 11 | 18 | 25 |
| T | . | 5 | 12 | 19 | 26 |
| W | . | 6 | 13 | 20 | 27 |
| T | . | 7 | 14 | 21 | 28 |
| F | . | 1 | 8 | 15 | 22 |
| S | . | 2 | 9 | 16 | 23 |
| S | . | 3 | 10 | 17 | 24 |

Evening

9 Thursday

(313-52) Tax Week 32

8.00 9.30 - 10.00 : XRAY CONFERENCE : SPA

8.30 10.00 - 10.30 : BREAKFAST.

9.30 10.30 - 11.00 : WARD ROUND

10.00 11.00 - 12.30 : FUNERAL

11.30 12.30 - 1.00 : BREAK

12.30 1.00 - 2.00 : ADMIN

1.30 2.00 - 5.00 : CLINIC IN ARMAGH

2.30 HOURS: DCC : 1.5

3.00 SPA : 0.5.

3.30

4.00

4.30 → HOURS: DCC : 5.5

7.30

8.00

Evening

November 2006

| | | | | | |
|---|---|----|----|----|----|
| M | 6 | 13 | 20 | 27 | |
| T | 7 | 14 | 21 | 28 | |
| W | 1 | 8 | 15 | 22 | 29 |
| T | 2 | 9 | 16 | 23 | 30 |
| F | 3 | 10 | 17 | 24 | |
| S | 4 | 11 | 18 | 25 | |
| S | 5 | 12 | 19 | 26 | |

Friday 10

(314-51)

9.00 - 11.30 : PRIVATE

8.00 11.30 - 12.00 : INPATIENT MANAGEMENT

8.30 12.00 - 12.30 : PRIVATE

9.30 12.30 - 1.00 : INPATIENT CARE

10.00 1.00 - 1.30 : PRIVATE

10.30 1.30 - 2.00 : LUNCH

11.00 2.00 - 2.30 : PRIVATE

11.30 2.30 - 3.00 : INPATIENT CARE

12.00 3.00 - 3.30 : PRIVATE

12.30 3.30 - 4.00 : ADMIN

1.00 4.00 - 4.30 : PRIVATE

1.30 4.30 - 5.00 : BREAK

2.00 5.00 - 7.30 : WARD ROUND

2.30 7.30 - 8.30 : THEATRE

December 2006

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

Evening

11 Saturday

(315-50)

WEEK 45

AOB-00071
2006 November

Sunday 12

(316-49)

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

November 2006

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

December 2006

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

TOTAL:

DCC = 41 HOURS = 10.25 PAS

SPA = 1.5 HOURS = 0.25 PAS

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

13 Monday

(317-48)

8.00 10.00 - 1.00 : INPATIENT CARE
8.30 AND URODYNAMICS
9.00
9.30 1.00 - 1.30 : LUNCH
10.00
10.30 1.30 - 2.00 : ADMIN
11.00
11.30 2.00 - 3.00 : PATHOLOGY
12.00
12.30 3.00 - 5.30 : INPATIENT CARE
1.00 AND URODYNAMICS
1.30
2.00 6.00 - 10.00 : ORGANISATION OF
2.30 ADMISSION UP TO 03.12.06
3.00 AND OTHER ADMINISTRATION
3.30
4.00
4.30 Hours : DCC : 10.0
5.00
5.30 SPA : 1.0
6.00
6.30
7.00
7.30
8.00

Evening

November 2006

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

Tuesday 14

(318-47)

9.30 - 11.30 : DSU 2.0
11.30 - 12.00 : PRIVATE DSU 8.30
12.00 - 1.00 : BREAK 9.00
1.00 - 2.00 : ADMIN 9.30
2.00 - 6.00 : CLINIC 10.00
6.00 - 7.00 : INPATIENT 1.0
7.00 - 11.30 : ADMIN 4.5
12.30
1.00
1.30
2.00
2.30
3.00
3.30
4.00
4.30
5.00
5.30
6.00
6.30
7.00
7.30
8.00

HOURS : DCC = 12.5 .

December 2006

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

Evening

15 Wednesday
(319-46)

| | | |
|-------|-----------------------|-----|
| 8.00 | 9.30 - 6.30 : THEATRE | 9.0 |
| 8.30 | | |
| 9.00 | 6.30 - 7.30 : BREAK | |
| 9.30 | | |
| 10.00 | 7.30 - 10.30 : ADMIN | 3.0 |
| 10.30 | | |
| 11.00 | | |
| 11.30 | | |
| 12.00 | | |
| 12.30 | HOURS : DCC = 12.0. | |
| 1.00 | | |
| 1.30 | | |
| 2.00 | | |
| 2.30 | | |
| 3.00 | | |
| 3.30 | | |
| 4.00 | | |
| 4.30 | | |
| 5.00 | | |
| 5.30 | | |
| 6.00 | | |
| 6.30 | | |
| 7.00 | | |
| 7.30 | | |
| 8.00 | | |

Evening

November 2006

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

Thursday 16
Tax Week 33 (320-45)

| | | |
|-------------------------------|------|-------|
| 9.00 - 10.00 : RADIOLOGY | 1.0 | 8.00 |
| 10.00 - 10.30 : BREAKFAST | | 8.30 |
| 10.30 - 12.30 : GRAND ROUND | 2.0 | 9.00 |
| 12.30 - 2.30 : IMPLEMENTATION | 2.00 | 9.30 |
| 2.30 - 4.00 : LUIS REVIEW | 1.5 | 10.00 |
| 4.00 - 6.00 : THEATRE | 2.0 | 10.30 |
| (PARENT / TEACHER MEETING) | | 11.00 |
| | | 11.30 |
| | | 12.00 |
| | | 12.30 |
| | | 1.00 |
| | | 1.30 |
| | | 2.00 |
| | | 2.30 |
| | | 3.00 |
| | | 3.30 |
| | | 4.00 |
| | | 4.30 |
| | | 5.00 |
| | | 5.30 |
| | | 6.00 |
| | | 6.30 |
| | | 7.00 |
| | | 7.30 |
| | | 8.00 |

December 2006

| | | | | | | |
|---|---|---|----|----|----|---|
| M | . | 4 | 11 | 18 | 25 | . |
| T | . | 5 | 12 | 19 | 26 | . |
| W | . | 6 | 13 | 20 | 27 | . |
| T | . | 7 | 14 | 21 | 28 | . |
| F | 1 | 8 | 15 | 22 | 29 | . |
| S | 2 | 9 | 16 | 23 | 30 | . |

Evening

November 2006

WEEK 46

17 Friday

(321-44)

2006 November 18
AOB-00074

Saturday 18

(322-43)

8.00 9.30 - 12.30 : PRIVATE 1.5
8.30
9.00 12.30 - 2.00 : IMPLEMENTATION 1.5
9.30 DECEMBER REVIEW
10.00 PHL'S
10.30
11.00 2.00 - 3.30 : PUBLIC PATIENT 1.5
11.30 REVIEW (MEERA)
12.00
12.30 3.30 - 4.00 : PRIVATE
1.00
1.30 4.00 - 4.30 : PUBLIC PATIENT 0.5
2.00
2.30 5.00 - 10.00 : ADMINISTRATION 5.0
3.00 - REFERRALS
3.30
4.00
4.30
5.00
5.30
6.00
6.30
7.00
7.30
8.00
Evening

HOURS : DCC : 7.0
SPA : 1.5

November 2006

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

1.30 - 3.00 : INPATIENT CARE 1.5 8.00
8.30
3.00 - 4.30 : SHOPPING 9.00
9.30
4.30 - 9.00 : ADMIN 4.5 10.00
10.30
11.00
11.30
12.00
12.30
1.00
1.30
2.00
2.30
3.00
3.30
4.00
4.30
5.00
5.30
6.00
6.30
7.00
7.30
8.00
Evening

HOURS : DCC 6.0.

December 2006

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

November 2006

WEEK 46

19 Sunday

(323-42)

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

November 2006

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

WEEK 47

AOB-00075

Monday 20

(324-41)

10.30 - 1.30 : INPATIENTS : 3.0 8.00

PROSTATE DIAG : 8.30

1.30 - 2.00 : LUNCH 9.00

2.00 - 2.30 : PATHOLOGY 0.5 9.30

2.30 - 11.00 : INPATIENTS 8.5 10.00

ADMIN 11.00

HOURS : DCC = 11.5 1.30

SPA = 0.5 2.00

December 2006

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

Evening

8.00 ~~8.00~~
8.30
9.00 12.00 - 2.00 : Admin : 2.0
9.30
10.00 2.00 - 5.00 : OPT : 3.0
10.30
11.00 5.00 - 6.00 : PREP NARD
11.30 ROUND 1.0
12.00
2.30 6.00 - 6.30 : BREAK
.00
.30 6.30 - 10.00 : Admin 3.5
.00
.30 - CLINIC
.00 - REFERRALS
.30 - ADMISSIONS
.00 - URO
00 - DSU ETC
30
00

Hours: DCC = 9.5.

November 2006

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

December 2006

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

November 2006

23 Thursday

(327-38) Tax Week 34

WEEK 47

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

9.00 - 10.00 : RADIOLOGY

(10.30 - 3.30 :

Personal Information redacted by USI

FUNERAL

3.30 - 6.00 : INPATIENT MAN.

2.5

6.00 - 8.00 : ADMIN

2.0

HOURS : DCC = 4.5

SPA = 1.0

November 2006

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

AOB-00077
2006 November

Friday 24

(328-37)

8.00

8.30

9.00

9.30

10.00

10.30

11.00

11.30

12.00

12.30

1.00

1.30

2.00

2.30

3.00

3.30

4.00

4.30

5.00

5.30

6.00

6.30

7.00

7.30

8.00

Evening

10.30 - 12.30 : PRIVATE

12.30 - 1.00 : PUBLIC REVIEW

0.5

1.30 - 1.30 : LUNCH

1.30 - 3.30 : PRIVATE

3.30 - 4.00 : PUBLIC REVIEW

0.5

4.00 - 4.30 : PRIVATE

4.30 - 6.00 : NARD ROUND

1.5

6.00 - 7.30 : ADMIN

1.5

HOURS : DCC = 4.0

December 2006

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

25 Saturday
(329-36)

| | | |
|-------|------------------------------|-----|
| 8.00 | 1.30 - 4.00 : INPATIENT MAN. | 2.5 |
| 8.30 | ADMIN | |
| 9.00 | | |
| 9.30 | 4.00 - 6.00 : THEATRE | 2.0 |
| 10.00 | | |
| 10.30 | 6.00 - 9.00 : ADMIN | 3.0 |
| 11.00 | | |
| 11.30 | | |
| 12.00 | HOURS : DCC = 7.5 | |
| 12.30 | | |
| 1.00 | | |
| 1.30 | | |
| 2.00 | | |
| 2.30 | | |
| 3.00 | | |
| 3.30 | | |
| 4.00 | | |
| 4.30 | | |
| 5.00 | | |
| 5.30 | | |
| 6.00 | | |
| 6.30 | | |
| 7.00 | | |
| 7.30 | | |
| 8.00 | | |

Evening

| November 2006 | | | | | | | | | |
|---------------|---|----|----|----|----|---|--|--|--|
| M | . | 6 | 13 | 20 | 27 | . | | | |
| T | . | 7 | 14 | 21 | 28 | . | | | |
| W | 1 | 8 | 15 | 22 | 29 | . | | | |
| T | 2 | 9 | 16 | 23 | 30 | . | | | |
| F | 3 | 10 | 17 | 24 | . | . | | | |
| S | 4 | 11 | 18 | 25 | . | . | | | |
| S | 5 | 12 | 19 | 26 | . | . | | | |

Sunday 26
(330-35)

| | |
|--------------------|-------|
| HOURS : 49.5 - DCC | 8.00 |
| 1.5 - SPA | 8.30 |
| | 9.00 |
| | 9.30 |
| | 10.00 |
| | 10.30 |
| | 11.00 |
| | 11.30 |
| | 12.00 |
| | 12.30 |
| | 1.00 |
| | 1.30 |
| | 2.00 |
| | 2.30 |
| | 3.00 |
| | 3.30 |
| | 4.00 |
| | 4.30 |
| | 5.00 |
| | 5.30 |
| | 6.00 |
| | 6.30 |
| | 7.00 |
| | 7.30 |
| | 8.00 |

December 2006

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

Evening

27 Monday
(331-34)

WEEK 48

12.00 - 2.00: INPATIENT: 2.0

2.00 - 3.00: PATHOLOGY: 1.0

3.00 - 4.00: Personal Information redacted by the USI 1.0
REVIEW

4.00 - 5.00: INPATIENT: 1.0

5.00 - 5.30: BREAK -

5.30 - 10.30: ADMIN 5.0

HOURS: DCC = 9.0

SPA = 1.0

November 2006

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

AOB-00079

Tuesday 28
(332-33)

9.00 - 12.30: DSLI 3.5

12.30 - 1.00: BREAK -

1.00 - 2.00: WARDS 1.0

2.00 - 5.00: OPT 3.0

5.00 - 6.00: PREOP 1.0

6.00 → : TRUSTEES -

HOURS: DCC = 8.5

December 2006

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

November 2006

WEEK 48

29 Wednesday

(333-32)

8.00 9.00 - 7.00 : OPERATING : 10.0

8.30 7.00 - 8.00 : ICU : 1.0

9.00 8.00 - 9.00 : NARD : 1.0

10.30 9.00 - 10.30 : Admin : 1.5

11.00 10.30 - 11.00 : ICU : 0.5

12.30 HOURS : DCC = 14.0

November 2006

| | | | | |
|---|---|----|----|----|
| M | 6 | 13 | 20 | 27 |
| T | 7 | 14 | 21 | 28 |
| W | 1 | 8 | 15 | 22 |
| T | 2 | 9 | 16 | 23 |
| F | 3 | 10 | 17 | 24 |
| S | 4 | 11 | 18 | 25 |
| S | 5 | 12 | 19 | 26 |

AOB-00080

2006 November

Thursday 30

Tax Week 35 (334-31)

St. Andrew's Day

9.00 - 9.30 : ICU : = 0.5

9.30 - 10.00 : BREAKFAST = ~~0.5~~

10.00 - 12.00 : GRAND ROUND = 2.0

12.00 - 12.30 : Personal Information redacted by the USI = 0.5

12.30 - 3.00 : IMPLEMENTATION = 2.5

3.00 - 5.30 : SHOPPING -

5.30 - 7.00 : NARDS 1.5

7.00 - 10.30 : HENIRE 3.5

HOURS : DCC = 8

- SPA = 2.5

December 2006

| | | | | |
|---|---|----|----|----|
| M | 4 | 11 | 18 | 25 |
| T | 5 | 12 | 19 | 26 |
| W | 6 | 13 | 20 | 27 |
| T | 7 | 14 | 21 | 28 |
| F | 1 | 8 | 15 | 22 |
| S | 2 | 9 | 16 | 23 |
| S | 3 | 10 | 17 | 24 |

Evening

December 2006

WEEK 48

1 Friday

(335-30)

8.00 10.00 - 11.30: Personal Information redacted by the USI : 1.5
 8.30
 9.00 11.30 - 12.00: ICU : 0.5
 9.30
 10.00 12.00 - 1.00: PRIVATE —
 10.30
 11.00 1.00 - 2.00: LUTIS REVIEW 1.0
 11.30
 12.00 2.00 - 4.30: PRIVATE —
 12.30
 1.00 4.30 - 5.00: BREAK —
 1.30
 2.00 5.00 - 5.30: NARDS 1.5
 2.30
 3.00 6.30 - 8.30: ADMIN 2.0
 3.30
 4.00 8.30 - 9.00: ICU 0.5
 4.30

5.00
 5.30 HOURS: DCC = 7.0
 6.00
 6.30
 7.00
 7.30
 8.00

Evening

December 2006

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

AOB-00081

Saturday 2

(336-29)

11.00 - 12.00: NARD ROUND : 1.0
 8.00
 12.00 - 1.30: SHOPPING : — 8.30
 9.00
 1.30 - 3.00: INPATIENT : 1.5 9.30
 MAN. 10.00
 3.00 - 4.30: ADMIN : 1.5 10.30
 11.00
 4.30 - 6.00: THEATRE : 1.5 11.30
 12.00
 6.00 - 6.30: BREAK : — 12.30
 1.00
 6.30 - 10.00: ADMIN : 3.5 1.30
 2.00
 2.30
 3.00
 3.30
 4.00
 4.30

HOURS = DCC: 8.0
 5.00
 5.30
 6.00
 6.30
 7.00
 7.30
 8.00

Evening

January 2007

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

December 2006

WEEK 48

3 Sunday

(337-28)

8.00 00.30 - 02.00 : THEATRE

9.00 19.30 - 21.30 : THEATRE.

11.00 HOURS: DCC = 3.5 :

6.00 HOURS: DCC SPA
57.5 3.5

December 2006

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

WEEK 49

AOB-00082

Monday 4

(338-27)

| | DCC | SPA | |
|---------|------|------|-------|
| WEEK 1: | 44 | 4.5 | 8.00 |
| WEEK 2: | 41 | 1.5 | 9.30 |
| WEEK 3: | 53 | 5.5 | 10.00 |
| WEEK 4: | 49.5 | 1.5 | 11.30 |
| WEEK 5: | 57.5 | 3.5 | 12.30 |
| TOTAL | 245 | 16.5 | 1.30 |

MEAN 49 3.3 HOURS

Notes: NO READING
NO MDI
TOTAL DCC NOT DCC

January 2007

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

Evening

Craigavon Area Hospital Group Trust
Consultant Job Plan Review Template
 Prospective plan for 1 April 2007 until 31 March 2008

Personal details:

Name: Mr A O'Brien

Contract:

Specialty/Directorate: Urology

☒ Whole Time ☐ Part Time
On-call availability supplement:

Rota Frequency: 1 in: 3

Rota Category

☒ Category A☐ Category B☐ N/A**Management Allowance:**☐ Medical Director☐ Clinical Director☒ N/A**Summary Of Programmed Activities:**

Direct Patient Care:

8.38 PA's

Supporting Professional Activities:

1.38 PA's
*Total SPA's with annualised
activity as detailed below
= 1.63*

On-Call Allocation:

 Predictable
0 PA's

Unpredictable

1.57 PA's

Any Annualised Activity

*(Reflecting any work undertaken outside the time included
in the proposed job plan. Detailed information must be
given):*
0.25 PA's**Details:**
 Will spend on average 0.25 PA's per week on an
annualised basis on SPA activities. Undertaken
outside of the time contained in the job plan.
This covers additional local training
commitments and province wide SpR teaching.

TOTAL PA's:
(Rounded to nearest 0.25)
11.5 PA's

Private Practice: Please provide details of any private practice commitments and/or fee paying activity undertaken in normal working hours but which has not been included in the Job plan template:

JOB PLAN TEMPLATE - Average Weekly Programmed Activities

WEEK 1,2,5

| DAY | Time | WORK ACTIVITY | LOCATION | HOURS | | Total | Prem |
|---------------|---------------|---|----------|-------|-----|-------|------|
| | | | | DCC | SPA | | |
| Mon | 9.00 - 12.00 | Urodynamic Studies | CAH | 3 | 0 | 9 | 0 |
| | 12.00 - 13.00 | Mictimetry, scanning, other procedure | CAH | 1 | 0 | | |
| | 13.00 - 16.00 | Urodynamic Studies | CAH | 3 | 0 | | |
| | 16.00 - 18.00 | Change of catheter, other procedure | CAH | 2 | 0 | | |
| Tues | 8.30 - 14.00 | Operating - DSC | CAH | 5.5 | 0 | 9.5 | 0 |
| | 14.00 - 18.00 | OP Clinic & Dictation & Admin of Clinic | CAH | 4 | 0 | | |
| Wed | 8.30 - 17.30 | Theatre - inpatient operating | CAH | 9 | 0 | 10 | 0 |
| | 17.30 - 18.30 | Post ward round / Day case admissions / Admin | / | 1 | 0 | | |
| Thurs | 8.30 - 10.00 | X Ray Meeting | CAH | 1 | 0.5 | 10 | 0 |
| | 10.00 - 12.30 | Ward Round | CAH | 2.5 | 0 | | |
| | 12.30 - 13.30 | Implementation Group Meeting -Clinical Mangt. | CAH | 0 | 1 | | |
| | 13.30 - 14.00 | SPA - Clinical Management | CAH | 0 | 0.5 | | |
| | 14.00 - 18.00 | Review of patients & SPA | CAH | 2 | 2 | | |
| | 18.00 - 18.30 | Patient Admin | CAH | 0.5 | 0 | | |
| Fri | 9.00 - 13.00 | Private Patients | / | 0 | 0 | 0 | 0 |
| | 13.00 - 17.00 | Private Patients | / | 0 | 0 | | |
| TOTAL HOURS | | | | 35 | 4 | 38.5 | 0 |
| AVERAGE HOURS | | | | 8.6 | 1 | 9.625 | 0.00 |

WEEK 3&4

| DAY | TIME | WORK ACTIVITY | LOCATION | HOURS | | Total | Prem |
|---------------|---------------|---|----------|-------|------|-------|------|
| | | | | DCC | SPA | | |
| Mon | 9.00 - 9.30 | Patient Administration | CAH | 0.5 | 0 | 9 | 0 |
| | 9.30 - 11.30 | Ward Round / Patient Admin / Relatives | CAH | 2 | 0 | | |
| | 11.30 - 12.30 | MDT Meeting | CAH | 0 | 1 | | |
| | 12.30 - 14.00 | SPA Activities | CAH | 0 | 1.5 | | |
| | 14.00 - 15.00 | Histopathology Meeting | CAH | 1 | 0 | | |
| | 15.00 - 18.00 | Admin of Urodynamics & Patient Admissions | CAH | 3 | 0 | | |
| Tues | 8.30 - 14.00 | Operating - DSC | CAH | 5.5 | 0 | 9.5 | 0 |
| | 14.00 - 18.00 | OP Clinic & Dictation & Admin of Clinic | CAH | 4 | 0 | | |
| Wed | 8.30 - 17.30 | Theatre - inpatient operating | CAH | 9 | 0 | 10 | 0 |
| | 17.30 - 18.30 | Post ward round / Day case admissions / Admin | / | 1 | 0 | | |
| Thurs | 8.30 - 10.00 | X Ray Meeting | CAH | 1 | 0.5 | 10 | 0 |
| | 10.00 - 12.30 | Grand Ward Round | CAH | 2.5 | 0 | | |
| | 12.30 - 13.30 | Implementation Group Meeting -Clinical Mangt | CAH | 0 | 1 | | |
| | 13.30 - 14.00 | SPA - Clinical Management | CAH | 0 | 0.5 | | |
| | 14.00 - 18.00 | Review of patients & SPA | CAH | 2 | 2 | | |
| | 18.00 - 18.30 | Patient Admin | CAH | 0.5 | 0 | | |
| Fri | 9.00 - 13.00 | Private Patients | / | 0 | 0 | 0 | 0 |
| | 13.00 - 17.00 | Private Patients | / | 0 | 0 | | |
| TOTAL HOURS | | | | 32 | 6.5 | 38.5 | 0 |
| AVERAGE HOURS | | | | 8 | 1.63 | 9.625 | 0.00 |

Objective Setting

Please provide detailed of the agreed personal objectives: You will be expected to:

- To participate fully in appraisal and the job planning process
- To participate in the teaching of medical students, medical trainees and other professions.
- Ensure you meet the CME targets set by the relevant College.
- Cooperate with colleagues in planning leave and periods of absence.
- Seek approval for all new external duties, which may impact on your ability to deliver your job plan.

This will be reviewed at least yearly and you will have the opportunity to highlight reasons why this may not be achieved.

Resource Requirements

Details of any resources requirements required to help carry out the job plan commitments:

Pay Thresholds *(To be completed by the Clinical Director /Medical Director)*

During the past year, has this consultant:

| | |
|---|-------|
| Made every reasonable effort to meet the time and service commitments in the previous job plan? | Y / N |
| Participated satisfactorily in the appraisal process? | Y / N |
| Participated satisfactorily in reviewing the Job plan and setting personal objectives? | Y / N |
| Met the personal objectives in the Job Plan, or where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so? | Y / N |
| Worked towards any changes identified in the last Job Plan review as being necessary to support achievement of the Trust objectives? | Y / N |
| Taken up any offer to undertake additional PA's that the Trust has made to the consultant in accordance with schedule 6 of the Terms and Conditions of Service? | Y / N |
| Met the standards of conduct governing the relationship between private practice and HPSS commitments set out in Schedule 9 of the Terms and Conditions of Service? | Y / N |

The Medical Director must be formally advised if one or more of the above criteria have not been met in the past year, as this may defer pay progression.

Job Plan Approval:

This job plan is subject to review, once a year following appraisal, between the named consultant and his/her Clinical Director, who is acting on behalf of the Chief Executive.

| | |
|---|---|
| <p><i>I accept the proposed Job Plan:</i></p>

<p>Signed: _____
Consultant</p>

<p>Date: _____</p> | <p><i>I support the proposed Job Plan:</i></p>

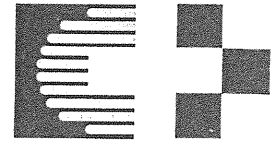
<p>Signed: _____
Clinical Director</p>

<p>Date: _____</p> |
|---|---|

Once signed, this form must be **forwarded to the Medical Director** for final Trust approval. Assuming approval is granted, the MD will forward a copy of the "Job plan Review Template" to the Medical Staffing Department for processing.

If it is not possible to agree a job plan, at the Job Plan Review meeting or following further discussion, the procedure laid down in Schedule 4 of the Terms and Conditions of Service will be followed. The unsigned "Job Plan Review Template" should be forwarded to the Medical Director. The consultant will have 2 weeks from the date of the Job plan meeting to request facilitation via the Medical Director.

| |
|---|
| <p>Final Approval <i>(To be completed by the Medical Director on behalf of the Chief Executive)</i></p>
<p>Job Plan approved:</p> <p>Signed: _____</p> <p>Date: _____</p> <p>or:</p> <p>Facilitation requested ☐</p> <p><i>This form should be copied to the Medical Staffing Department within 1 week of receipt</i></p> |
|---|



**CRAIGAVON
AREA HOSPITAL
GROUP TRUST**

Department of Urology
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.
Caring Through Commitment

12.12.2007.

Dr. S. Hall,
Acting Medical Director,
Southern Health and Social Care Trust,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Stephen,

Re: Offer for Additional Programmed Activities.

Thank you for your letter of 4 December 2007 in which you confirmed the Trust's offer of 11.5 Programmed Activities, the additional Programmed Activities reflected in the prospective job plan forwarded to you by my Clinical Director. You state that the offer is based upon the workload that the Trust requires to be undertaken in the forthcoming year. You have requested that I decide whether to accept, or to proceed to facilitation, in accordance with Schedule 4 of the Consultant Terms and Conditions of Service (Northern Ireland) 2004.

Firstly, I would like to avail of this opportunity to explain how my misunderstanding of the Job Plan has probably contributed to this current offer. When asked by my former Clinical Director in October 2006 to provide him with my Job Plan, I still then mistakenly believed that I was to provide a Schedule or Plan which itemised the starting times of regular, fixed commitments as they were at that time. The Job Plan that was then constructed, and which forms the basis upon which the Trust has made its offer, is both minimalist and incomplete. It is neither a complete or true portrayal of my workload.

Moreover, it is by now, so out of date. There are several examples of this. In October 2006, I was so involved with my colleague, Mr. Young, in developing and establishing ICATS that both of us were no longer attending outreach clinics, availing of the availability of Mr. Batstone, then Locum Consultant to do so in our stead. Since his departure, and the appointment of a third consultant, we have resumed doing so.

Also since 2006, the meeting of ever increasing targets has impacted significantly upon our regular workload, particularly by increasing the time spent in administration (in the organisation and meeting of PTL's, triaging of referrals etc). This administrative burden will assuredly increase in the coming year with the advent of cancer targets. Currently, I am participating in additional urodynamic service provision (without additional remuneration).

Headquarters:

Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ

Tel: [REDACTED] Personal Information redacted by the USI

The increased service demands has also had an impact upon what relatively little private practice that I did have, and to the extent that I no longer accept new private patients. In the year 2007, I will have conducted 135 private patient consultations, 37 of which I did while on annual leave, leaving 98 during normal working weeks, an average of 2 – 3 per week. By way of contrast, I will have reviewed 95 public patients at office level, nearly all cancer patients, and due to the ever increasing delays in review of patients at normal clinics.

As you have requested, I have indeed considered the Trust's current offer carefully. The Job Plan upon which it is offered is detached from the reality of the work required to provide the urological service which the Trust is obliged to provide. I have carefully constructed a Job Plan which I have no doubt is the minimum required to meet those obligations. There is no exaggeration in any part of it. On the contrary, I have been somewhat reductionist in order to ensure that no part has been embellished.

Whilst it is anecdotal, I finished my outpatient clinic yesterday at 5.30 pm. I went to the ward at the request of my colleague, Mr. Acktar, to assess and advise on the further management of a patient of his who is quite ill. At 6 pm, I reviewed and met all the patients admitted for today's inpatient operating. At 7.15 pm, I went to see a patient in Ward 2 North to advise upon his further management. When I returned to my office at 7.45 pm, I was asked to speak to the brother of one of our terminally ill patients. When finished, I returned to dictate on the clinic patients, finishing at 9pm. This is what is required to provide the quantitative and qualitative service that I am contractually obliged to provide. In fact, it is very representative of the demands met during administrative time.

In any case, since provision of that inadequate and outdated Job Plan in October 2006, I have no discussions or review of that Plan with any Clinical Director since, in accordance with Schedule 3 of the above Terms and Conditions. I had anticipated that there would be before facilitation was required. Nevertheless, if that is not now possible, I write to confirm that I request facilitation,

Yours Sincerely,

Aidan O'Brien,
Consultant Urological Surgeon.



21.4.08

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

16th April, 2008.

Dear Mr O'Brien

On brief review of the impact of consultant appointments on on call allocations it has been brought to my attention that your on-call PA allocation for emergency workload was not amended following the substantive appointment of your colleague Mr Ackhtar in September 2007.

I understand that you were allocated and are currently being paid, the maximum 2.00 allocation - following a diary exercise which outlined 11.4 hours of emergency workload for the specialty.

Therefore following the introduction of Mr Akhtar on a substantive basis in September this should have been amended to reflect 3 colleagues undertaking the workload:

$11.4 \text{ Hours} / 3 \text{ Hours [premium time PA]} = 3.8 \times 52 \text{ weeks of the year} = 197.6 \text{ Annualized hours} / 42 \text{ working weeks [to allow for prospective cover for you and your colleagues]} = 4.70 \text{ PA's} / 3 \text{ consultants} = 1.56 \text{ PA per consultant}$



Southern Health
and Social Care Trust

On the basis of this I will ask personnel to make the necessary financial adjustments.

If you have any queries on the above please contact either myself or Mr Mackle.

Yours sincerely,

Dr P Loughran
MEDICAL DIRECTOR

Cc: Mr E Mackle, AMD in Surgery
Anne Brennan, Senior Manager
Zoe Parks, Medical Personnel

From: Akhtar, Mehmood <[Redacted: Personal Information redacted by the USI]>
Sent: 22 October 2010 14:56
To: Corrigan, Martina; [Redacted: Aidan O'Brien's email address]; [Redacted: Michael Young's email address] O'Brien, Aidan; Young, Michael
Cc: Rankin, Gillian; Trouton, Heather; Mackle, Eamon
Subject: RE: Draft Job Plans

Hi Martina

I think it needs a proper meeting with time set a side with no other business to discuss this document.

Cannot tell the issues on the e mail

Serious issues for me

1. Monday OPD
2. SPA
3. MDT
4. Friday OT times

Regards

Mehmood Akhtar

From: Corrigan, Martina
Sent: 22 October 2010 14:07
To: [Redacted: Aidan O'Brien's email address]; [Redacted: Michael Young's email address]; Akhtar, Mehmood; O'Brien, Aidan; Young, Michael Mr
Cc: Rankin, Gillian; Trouton, Heather; Corrigan, Martina; Mackle, Mr E
Subject: Draft Job Plans

Dear Aidan/Michael/Mehmood,

I am attaching draft job plans for a three consultant model as well as draft sessions for a five-consultant model.

I would appreciate if could consider these drafts and have constructive comments available for the 5pm meeting on Monday 25 October in Meeting Room, Admin Floor.

Many thanks

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust



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 | |

Corrigan, Martina

From: Corrigan, Martina [Personal Information redacted by USI]
Sent: 01 July 2011 15:35
To: O'Brien, Aidan; [Personal Information redacted by USI]
Cc: Mackle, Eamon; Trouton, Heather
Subject: O'Brien Aidan DRAFT job plan Jun 2011
Attachments: O'Brien Aidan DRAFT job plan Jun 2011.doc

Importance: High
Follow Up Flag: Follow up
Due By: 08 July 2011 13:00
Flag Status: Flagged

Dear Aidan,

Following your recent submission of your current job plan and taking into consideration the requirements from the Regional Review, please find attached draft job plan for your consideration and comments.

I would be grateful if you have any comments that you forward these to Eamon and copy Heather and I into the response and we would need these comments back by next Friday 8th July by the latest.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Southern Health and Social Care Trust
Craigmavon Area Hospital

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

Corrigan, Martina

From: Aidan O'Brien's email address
Sent: 07 July 2011 22:57
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Dear Martina,

I only became aware of the Draft Job Plan Proposal of 01/07/2011 late on Sunday 03/07/2011 when Mehmood contacted me by telephone to advise that he [Personal Information redacted by the USI] was unable to return to work on Monday 04/07/2011. You may be aware that Michael has responded on our behalves to advise that we simply did not have the time or opportunity to consider or discuss the proposals, due to Mehmood's absence, having to cover for him and with only one registrar. In my case, this was further compounded by the acute admission to hospital of [Personal Information redacted by the USI]. All of this made submission of comments by 08/07/2011 impossible.

We three have planned to meet to discuss the proposals on 11/07/2011. I will be on annual leave next week, and will have time to submit comments by Friday 15/07/2011 at latest,

Aidan.

—Original Message—

From: Corrigan, Martina [Personal Information redacted by USI]
To: O'Brien, Aidan [Personal Information redacted by USI]
CC: Mackle, Eamon [Personal Information redacted by the USI]; Trouton, Heather [Personal Information redacted by the USI]
Sent: Fri, 1 Jul 2011 11:35
Subject: O'Brien Aidan DRAFT job plan Jun 2011

Dear Aidan,

Following your recent submission of your current job plan and taking into consideration the requirements from the Regional Review, please find attached draft job plan for your consideration and comments.

I would be grateful if you have any comments that you forward these to Eamon and copy Heather and I into the response and we would need these comments back by next Friday 8th July by the latest.

Many thanks

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Craigavon Area Hospital

Tel: [Personal Information redacted by USI]

Mobile: [Personal Information redacted by USI]

Email: [Personal Information redacted by the USI]
<mailto:[Personal Information redacted by the USI]>

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Southern Health & Social Care Trust archive all Email (sent & received) for the purpose of ensuring compliance with the Trust 'IT Security Policy', Corporate Governance and to facilitate FOI requests.

Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Corrigan, Martina

From: Mackle, Eamon [Personal Information redacted by the USI]
Sent: 07 July 2011 23:56
To: Aidan O'Brien's email address
Cc: Trouton, Heather; Corrigan, Martina
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

I am sorry to hear about [Personal Information redacted by the USI] admission.

The job plans are individual and not team based so a response doesn't require a joint reply.

I am happy to meet you Friday before your holidays

Eamon

From: Aidan O'Brien's email address
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather
Sent: Thu Jul 07 22:57:15 2011
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Dear Martina,

I only became aware of the Draft Job Plan Proposal of 01/07/2011 late on Sunday 03/07/2011 when Mehmood contacted me by telephone to advise that he [Personal Information redacted by the USI] was unable to return to work on Monday 04/07/2011. You may be aware that Michael has responded on our behalfs to advise that we simply did not have the time or opportunity to consider or discuss the proposals, due to Mehmood's absence, having to cover for him and with only one registrar. In my case, this was further compounded by the acute admission to hospital of [Personal Information redacted by the USI]. All of this made submission of comments by 08/07/2011 impossible.

We three have planned to meet to discuss the proposals on 11/07/2011. I will be on annual leave next week, and will have time to submit comments by Friday 15/07/2011 at latest,

Aidan.

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

From: Corrigan, Martina [Personal Information redacted by USI]
To: O'Brien, Aidan [Personal Information redacted by the USI]
CC: Mackle, Eamon [Personal Information redacted by USI]; Trouton, Heather
Sent: Fri, 1 Jul 2011 11:35
Subject: O'Brien Aidan DRAFT job plan Jun 2011

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Following your recent submission of your current job plan and taking into consideration the requirements from the Regional Review, please find attached draft job plan for your consideration and comments.

I would be grateful if you have any comments that you forward these to Eamon and copy Heather and I into the response and we would need these comments back by

next Friday 8th July by the latest.

Many thanks

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Craigavon Area Hospital

Tel: [Personal Information redacted by the USI]

Mobile: [Personal Information redacted by the USI]

Email: [Personal Information redacted by the USI]
<mailto:[Personal Information redacted by the USI]>

The Information and the Material transmitted is intended only for the person or entity to which it is addressed and may be Confidential/Privileged Information and/or copyright material.

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Southern Health & Social Care Trust IT Department [Personal Information redacted by the USI]

Corrigan, Martina

From: Aidan O'Brien's email address
Sent: 14 July 2011 18:01
To: Mackle, Eamon
Cc: Corrigan, Martina; Trouton, Heather
Subject: Re: Comments regarding Draft Job Plan Proposal
Attachments: Job Plan Comments.docx

Eamon,

I attach Comments pertaining to Proposed Job Plan as requested.

Aidan.

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

From: Mackle, Eamon Personal Information redacted by USI
To: Aidan O'Brien's email address
Cc: Trouton, Heather Personal Information redacted by USI; Corrigan, Martina
Sent: Thu, Jul 7, 2011 7:36 pm
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

I am sorry to hear about Personal Information redacted by the USI admission.

The job plans are individual and not team based so a response doesn't require a joint reply.

I am happy to meet you friday before your holidays

Eamon

From: Aidan O'Brien's email address
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather
Sent: Thu Jul 07 22:57:15 2011
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Dear Martina,

I only became aware of the Draft Job Plan Proposal of 01/07/2011 late on Sunday 03/07/2011 when Mehmood contacted me by telephone to advise that he Personal Information redacted by the USI was unable to return to work on Monday 04/07/2011. You may be aware that Michael has responded on our behalves to advise that we simply did not have the time or opportunity to consider or discuss the proposals, due to Mehmood's absence, having to cover for him and with only one registrar. In my case, this was further compounded by the acute admission to hospital of Personal Information redacted by the USI. All of this made submission of comments by 08/07/2011 impossible.

We three have planned to meet to discuss the proposals on 11/07/2011. I will be on annual leave next week, and will have time to submit comments by Friday 15/07/2011 at latest,

Aidan.

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

From: Corrigan, Martina [Personal Information redacted by the USI]
To: O'Brien, Aidan [Personal Information redacted by the USI]
CC: Mackle, Eamon [Personal Information redacted by the USI]; Trouton, Heather
Sent: Fri, 1 Jul 2011 11:35
Subject: O'Brien Aidan DRAFT job plan Jun 2011

Dear Aidan,

Following your recent submission of your current job plan and taking into consideration the requirements from the Regional Review, please find attached draft job plan for your consideration and comments.

I would be grateful if you have any comments that you forward these to Eamon and copy Heather and I into the response and we would need these comments back by next Friday 8th July by the latest.

Many thanks

Martina

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

Tel: [Personal Information redacted by USI]

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<mailto:[Personal Information redacted by the USI]> ?> >

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Corrigan, Martina

From: Mackle, Eamon [Personal Information redacted by USI]
Sent: 22 July 2011 16:59
To: Corrigan, Martina
Subject: Fw: O'Brien Aidan DRAFT job plan Jun 2011

From: Aidan O'Brien's email address
To: Mackle, Eamon
Sent: Fri Jul 22 10:37:32 2011
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

Thank you for amended job plan proposal. I appreciate the attention that has been given to previously submitted comments. I am left with a few issues to be clarified or resolved:

1. Going to Banbridge on Fifth Monday of month. I am confused as to how one calculates recognition of that, both with regard to travelling time and clinic time. I have not been allocated any travelling or clinic time in the proposal. Is it difficult to do so for Fifth 'Anything' in the month? Would it be better or easier not to do clinic on Fifth Monday?
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I do hope that these proposed amendments are received as being helpful and constructive, as they are sincerely intended to be. I would hope that they can be considered in that light, as I would much prefer to avoid facilitation etc,

Aidan.

Comments relating to Draft Job Plan Proposals of 01/07/2011

In considering the Job Plan Proposals, I have categorized my comments into those that are 'General', and those that are 'Specific' to the weekly schedule. There may be some overlap and duplication in application of the 'General' to the specifics of the weekly schedule.

The comments are ordered to comply with the order in which the topics / issues appear in the Proposed Job Plan. The order does not imply any other significance.

GeneralJob Plan Dates

It would be possible for the proposed plan to be effective from 01/07/2011 for several reasons:

- The draft proposals were only issued on 01/07/2011
- I only became aware of their issue on 03/07/2011
- The invited comments are being submitted on 14/07/2011
- Most importantly, it is now impossible for the proposed changes, if agreed, to be implemented before 01/09/2011

Summary of Programmed Activities

- I believe that the total number of 8.18 PAs allocated to Direct Patient Care is inappropriate, inadequate and unsafe for reasons that are detailed below
- One of the main reasons for my transfer to the New Consultant Contract was that it had within the basic job plan an allocation of 2.5 PAs to Supporting Professional Activities. For years, I have looked forward to having a Job Plan with 2.5 SPAs to enable me to conduct audit, and audit-generated research. It has been my understanding that the allocation of 2.5 SPAs is a contractual right, with the agreement of the Trust with respect to activities conducted. For reasons detailed below, an increased allocation of SPAs will be required to conduct such audit.

Regional Job Planning Guidance

I am unaware of the Regional Job Planning Guidance referred to in the Template. I would appreciate being provided with a copy of the Guidance, or advice on its access.

Developments and Objectives

On discussing Job Plan Proposals with my two colleagues, there has been uncertainty and disagreement concerning whether objectives discussed in recent months come into effect when these proposed job plans come into effect, or instead do not do so until the 5 consultant model has been established. This particularly relates to outpatient clinic. I do believe that it should be explicitly clarified whether the new / review ratio of 1:1.5 and 15 appointments per 4 hour clinic etc., are expected to be implemented when the proposed job plans are agreed and come into effect. This will allow us to advise on any conditions or resources required to achieve the objectives.

Inpatient Management

I presume that it has been an oversight, the almost complete lack of any time allocated to inpatient management from one Thursday to the next when Grand Rounds take place. I presume that it does not need to be said that such would be entirely untenable and unacceptable, and that a daily agreed period be allocated to inpatient management.

Administration

The allocation of 2.5 hours per week for all of the administration involved in the effective execution of my job, is wholly inadequate, and reflects how detached the proposed plans are from the realities of our jobs. There are four main planks of administration which require allocation of adequate time:

- Administration arising from outpatient clinics
- Administration arising from enquiries from GPs, patients
- Dealing with all correspondence, including referrals for triage
- Arrangement of all admissions

Unremunerated Periods

There would appear to be a tendency to have unremunerated periods during the course of some days in the proposed plan. This would be a departure from the practice to date, and, in my view, ~~will be counterproductive~~. In reality, we do not take lunch breaks. I do not want to have a lunch break. I would not want to have a break during the day when I would do nothing. If you can do without on an Theatre day, why would it be different any other day.

SpecificMonday

- Quite happy to take on outreach clinics every Monday morning though Michael Young is not particularly enamoured by no longer doing so.
- Do I effectively take over Michael Young's outreach clinics and the patient cohorts attending them, or are the patients to be transferred to his clinics elsewhere?
- Is there a particular reason for the departure from having Banbridge Clinic on weeks 1 & 3 (&5) to weeks 1 & 4?
- There is a particular issue regarding the clinic in Armagh. That clinic is staffed by nurses based at Banbridge Polyclinic, and who travel to Armagh. There has been no problem starting the Armagh Clinic at 9 am, but the nurses have to leave Armagh at 12.30 pm at the latest, to staff afternoon clinics in Banbridge. In effect, this means that the clinic would have to be limited to 3 hours duration.
- I believe that it is an historical anachronism to have the above staffing arrangements for the clinic in Armagh, and that it should be staffed by nurses based in Armagh Community Hospital. This would hopefully enable the conduct of a four hour clinic.
- I do not agree to unremunerated break.
- Allocation of 30 minutes to administration following outreach clinic is both welcome and probably adequate for the administration arising from that clinic.
- Allocation of time to inpatient management is required.

Tuesday

- I am prepared to start Day Surgical operating at 9 am, on condition that I am remunerated from 8.30 am to obtain consents. There will be no problem in having patients arriving at 8 am to facilitate the earlier start. With careful patient selection, this should increase the throughput of this session.
- Once again, I disagree with the unremunerated break at 1pm. I usually return to the outpatient department from DSU via Thorndale at the request of staff there to address their queries. This would not take place if there is to be no time allocated to it.
- The Tuesday afternoon clinic currently starts at 1.30 pm. Is there any particular reason why this may not continue to be the case?
- Time needs to be allocated to administration arising from the clinic, following the clinic.
- Time needs to be allocated to inpatient management.

Wednesday

- The allocation of a total of 8.5 hours to a day that includes 8 hours of inpatient operating is remarkable in its inadequacy. I have been advised that the BAUS recommendation is that 10 hours (2.5 PAs) be allocated to an inpatient operating day. This would seem reasonable to be. The current proposal is unacceptable.

Thursday

- Same issue regarding unremunerated time. Trust choice!
- Additional time required following MDM to execute recommendations of MDM

Friday

- I do presume that the specialist clinic will continue to facilitate patients attending for urodynamic studies, and patients attending for oncology review. One clinic per week will be inadequate.
- Administration time is required following the clinic for administration arising from the clinic.
- Time need to be allocated to inpatient management.

Supporting Professional Activities

I believe that the Cancer MDM set-up requires the conduct of audit, not least to satisfy peer review. Mr. Akhtar, Chair of MDM, has asked be to lead audit activity. There certainly is much to be done. I would be keen to discuss and agree particular audit objectives, provided adequate SPAs are allocated.

Private Practice

I think that I probably fall into third category.....to be clarified!

From:
Sent:
To:
Subject:

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

From: aidanpobrien Personal Information redacted by the USI
To: Eamon.Mackley Personal Information redacted by the USI
Sent: Fri, 22 Jul 2011 10:37
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

Thank you for amended job plan proposal. I appreciate the attention that has been given to previously submitted comments. I am left with a few issues to be clarified or resolved:

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I do hope that these proposed amendments are received as being helpful and constructive, as they are sincerely intended to be. I would hope that they can be considered in that light, as I would much prefer to avoid facilitation etc,

Aidan.

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From: Mackle, Eamon [Personal Information redacted by the USI]
To: aidanpobrien [Personal Information redacted by the USI]
CC: Trouton, Heather [Personal Information redacted by the USI]; Corrigan, Martina
Sent: Thu, 7 Jul 2011 19:36
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

[Personal Information redacted by the USI]
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I am happy to meet you friday before your holidays

Eamon

From: aidanpobrien [Personal Information redacted by the USI]
To: Corrigan, Martina
Cc: Mackle, Eamon; Trouton, Heather
Sent: Thu Jul 07 22:57:15 2011
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

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[Personal Information redacted by the USI] All of this made submission of comments by 08/07/2011 impossible.

We three have planned to meet to discuss the proposals on 11/07/2011. I will be on annual leave next week, and will have time to submit comments by Friday 15/07/2011 at latest,

Aidan.

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From: Corrigan, Martina [Personal Information redacted by the USI]
To: O'Brien, Aidan [Personal Information redacted by the USI]; Aidanpobrien [Personal Information redacted by the USI]
CC: Mackle, Eamon [Personal Information redacted by the USI]; Trouton, Heather [Personal Information redacted by the USI]
Sent: Fri, 1 Jul 2011 11:35
Subject: O'Brien Aidan DRAFT job plan Jun 2011

Dear Aidan,

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From:
Sent:
To:
Subject:

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

From: aidanpobrien [Personal Information redacted by the USI]
To: Eamon.Mackle [Personal Information redacted by the USI]
Sent: Wed, 24 Aug 2011 11:04
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

I do not accept the revised Job Plan proposal of 10 August 2011 for following reasons:

- I find it unacceptable the proposal to travel to Banbridge on the morning of the fifth Monday of the month, to conduct a clinic, lasting four hours, without credit in a Job Plan. If it cannot be accredited, I would prefer that it would not be included in a Job Plan.
- I believe that it was both important and reasonable to have time allocated to addressing patient management issues arising in Thorndale Unit. Last Friday, I spent one hour doing so. That included contacting the GP of a patient whose serum PSA had increased from 8 ng/ml to 803 ng/ml in less than one year. I had proposed the inclusion of a nominal time allocation of 30 minutes per week (on Tuesdays 1.00 to 1.30 pm). I believe that Urology ICATS cannot function safely without consultant urologists providing advisory input, and I believe time allocated to that function should be included in Job Plans.
- I believe that it remains a necessity to allocate time to conduct a ward round on Tuesday evening. Irrespective of practices in other specialties, I would anticipate that we will continue to have some patients undergoing surgery, and who will not have been admitted electively on the day of surgery. In any case, all patients admitted electively will have given prior consent. Even if that prior consent is in written form, I believe that it would be better practice to review the patient following admission, and that it would be inappropriate to defer that review to the morning of surgery. Moreover, this round is not solely for the purpose of obtaining written consent from patients undergoing surgery the following day, but for all inpatients.
- The time allocated to administration remains inadequate. I note a recent expectation that the results of all investigations (presumably of outpatients) be read by consultants as soon as the results are available. How much administrative time will this consume? How much time will be allocated in Job Plan?
- Lastly, I would propose to increase SPA time by one PA per month to conduct audit in urological oncology. I have included this in Professional Development in appraisal for coming year, and as stated previously, I believe that audit must begin in order to satisfy MDT peer review. It will not begin with current SPA allocation.

Aidan

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

From: Mackle, Eamon [Personal Information redacted by the USI]
To: aidanpobrien [Personal Information redacted by the USI]
Sent: Wed, 10 Aug 2011 12:54
Subject: RE: O'Brien Aidan DRAFT job plan Jun 2011

Aidan

I have written comments in red below and am attaching a revised job plan. If you are in agreement will you let either myself or Martina know and we can get the document printed for signature

Eamon

From: aidanpobrien Personal Information redacted by the USI
Sent: 22 July 2011 10:38
To: Mackle, Eamon
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

Eamon,

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1. Going to Banbridge on Fifth Monday of month. I am confused as to how one calculates recognition of that, both with regard to travelling time and clinic time. I have not been allocated any travelling or clinic time in the proposal. Is it difficult to do so for Fifth 'Anything' in the month? Would it be better or easier not to do clinic on Fifth Monday? I talked to HR and to date it has been taken as swings and roundabouts.

2. I go to Thorndale Clinic on Tuesdays between Day Surgery and Outpatients Clinic, to address any issues there. These are to decide management of patients who have attended Nurse Led Clinics. So it would be impractical to do Ward Round between 1pm and 1.30 pm. In fact, it would be good to have that half hour built into every Tuesday, irrespective of whether I am in Day Surgery on Tuesday mornings, or doing Admin, and to have instead half hour for ward round from 5.30 to 6.00, which will enable be to visit and consent any patients who are admitted on Tuesday for surgery on Wednesday, and who would not have been admitted at the earlier time in any case. We have moved in colorectal to admission on the day of surgery so consents are either done in the OPD or during the preop ward round.

3. It is my view that it would be better to have Inpatient Theatre session extended to 5.30 on Wednesday, followed by allocation of one hour for Ward Round. I do believe that doing so will enable theatre utilisation to be maximised. I believe that terminating the theatre allocation time at 5.00 will certainly result in a drift to have operating actually finishing at 4.30 to 4.45, reducing theatre utilisation and productivity. I believe that would be a negative and short-sighted development. Theatre staff are already annoyed at overruns and I am constantly reminded by Ronan Carroll that the all day list is from 9 until 5.

4. I believe that we three have accepted the split between DCC and SPA on Thursday mornings, but strongly believe that 'Grand' should be restored to 'Ward Round'. Grand has been inserted. When we become five, we would intend to split the team into two firms, in some way, to ensure that Grand Rounds can still be conducted, as we believe that it is a vital component of clinical governance, and wish to retain it.

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Aidan.

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From: Mackle, Eamon [Personal Information redacted by the USI]
To: aidanpobrien [Personal Information redacted by the USI]
CC: Trouton, Heather [Personal Information redacted by the USI]; Corrigan, Martina [Personal Information redacted by the USI]
Sent: Thu, 7 Jul 2011 19:36
Subject: Re: O'Brien Aidan DRAFT job plan Jun 2011

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[Personal Information redacted by the USI]
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From: Corrigan, Martina

Personal Information redacted by the USI

To: O'Brien, Aidan

Personal Information

Aidanpobrien

Personal Information redacted by the USI

CC: Mackle, Eamon

Personal Information redacted by the USI

Trouton, Heather

Personal Information redacted by the USI

Sent: Fri, 1 Jul 2011 11:35

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Many thanks

Martina

Martina Corrigan

Head of ENT and Urology

Southern Health and Social Care Trust

Craigavon Area Hospital

Tel:

Personal Information redacted by the USI

Mobile:

Personal Information redacted by the USI

Email:

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COMMENTS AND CONCERNS REGARDING PROPOSED JOB PLAN

In preparation for Meeting of Facilitation

There are several areas of concern arising from the proposed Job Plan, giving reason for my being unable to agree to it. These are

- Inadequate time for administration relating to direct patient care
- Lack of lunch / rest breaks
- Specialist clinics on Friday mornings
- Availability whilst on – call
- Date of effect of Job Plan

Inadequate time for administration relating to direct patient care

The total amount of time allocated, in the proposed Job Plan, to administration relating to direct patient care is grossly inadequate for the provision of an effective, efficient and safe service, and is markedly divergent from the reality of the total time required. Moreover, the severity of that inadequacy is reflected in there being days when no time at all is allocated for administrative tasks that cannot or should not be deferred. Indeed, the Job Plan includes weeks when several days will pass before time is allocated to administration that needed to be carried out previously. In order to appreciate the totality of administration required, I have detailed below the range of administration required of the Job:

Arrangement of Admissions and Attendances

This consists of the arrangement of all

- Inpatient admissions
- Admissions to Day Surgical Unit
- Flexible cystoscopies
- Urodynamic studies
- Ward attenders for
 - Intravesical therapies
 - Intravenous therapies
 - Trial removals of catheter

Review of Waiting Lists

I review all four waiting lists once weekly to ensure that forthcoming capacity is being offered to those with greatest clinical priorities. These lists comprise a total in excess of 400 patients.

Enquiries from GPs and Patients

My secretary receives more than 40 queries each day relating to patients, a significant proportion of which come from GPs, their practices, community nurses and from patients themselves. She selects and passes on to me 3 to 5 of the most clinically urgent cases to address. These are clinical issues which cannot be addressed by my secretary alone. All are best addressed as soon as is possible. For the safety of the patient, each day there will be some which do need to be addressed on the day on which they arise.

Referrals

We receive personalised referrals on any day for triaging. We receive anonymised referrals during weeks when on call. These include red flag, urgent and routine referrals. I believe that there is an expectation that red flag referrals are triaged daily, and that all referrals are triaged within 3 days (or one week?) of receipt.

Correspondence

There is a considerable amount of correspondence, particularly from oncologists, received weekly, and all of which has to be read, as some requires action, rather than just filing.

Reports and Results

It has recently been proposed that all laboratory results, and radiological and pathological reports, pertaining to outpatients, be read when available, in order to ensure that appropriate action is taken, when indicated and in a timely manner, in order to avoid unsafe delay whilst waiting for patients to be reviewed. This clearly is a major issue of clinical governance. I believe that this is currently conducted on an ad hoc basis only, and that it will require a significant consumption of administrative time if it is to be done completely. I am unable to quantify that amount of time.

Dictation arising from Outpatient Clinics

Particularly due to the increasing volume of patients attending consultant led clinics for oncological review due to inadequate capacity at specialist clinics, it has not been possible to complete dictation on all patients attending. This relates particularly to review of men in the early stages of management of prostate cancer. These patients

are particularly time consuming. This result in increasing amounts of time on dictation outside of clinic time, particularly for onward referral.

Administration arising from Urological Cancer MDT

This relates to administering the implementation of outcomes from MDT, such as requesting scans, arranging admissions, and informing patients of these arrangements. Upon my request, an adequate 30 minutes of administrative time has been allocated following MDT on Thursday afternoons.

Administrative Time arising from Thorndale Unit

This relates specifically and solely to the time required to be consulted by other practitioners regarding the further assessment and management of patients attending the Thorndale Unit. It does not relate to administration arising from Specialist Clinics run by me in the Thorndale Unit. I had requested and had allocated 30 minutes for this purpose on Tuesdays, 1.00 to 1.30 pm, between Day Surgery and Outpatients Clinic. However, for reasons relating to my preference for a break at that time, I would prefer to have it deferred to Fridays when I will be in Thorndale Unit conducting a Specialist Clinic. I would prefer to have administrative time allocated for this purpose following completion of the Specialist Clinic.

Administrative Time required to review Outpatient Backlog

There is a large backlog of patients intended for review, and who have not been reviewed. I spend a minimum of one hour per week, and often twice that time, reviewing the documentation relating to these patients, including updated results and reports, in order to determine their further management.

Since proposed Job Plans were first submitted in July, and particularly since Facilitation was requested on 02/09/2011, I have made note of the actual amounts of time consumed weekly by the above activities. As a result, I am able to submit bare minimum amounts of time consumed by these activities each week:

- | | |
|-----------------------------------|-------------------------------------|
| • Admissions and Waiting Lists | 2.0 hours (usually approx. 3 hours) |
| • Enquiries from GPs and Patients | 1.0 hour |
| • Referrals and Correspondence | 1.0 hour (2 hours) |
| • Dictation | 2.0 hours (usually 3 – 4 hours) |
| • MDT | 0.5 hours |
| • Thorndale | 0.5 hours |
| • Results and Reports | to be determined |

The inadequacy of the time allocated to administration in the Job Plan is most reflected in its complete absence on several days. In fact, if I do an outreach clinic on a Monday morning, day surgery on Tuesday morning, followed by a 30 minute lunch break (instead of administration), and similarly doing so on Thursday, a whole week will have passed before having one hour of administrative time on Friday. If the total amount of time were in accordance with the minimums listed above, then there would be administrative time each day.

In listing these minimum times, I am honestly conscious that I will spend considerably more time in carrying out the above administrative components of the Job. It would seem the prevalent experience of my colleagues in Northern Ireland, and in Great Britain, that they feel pressurised, obliged into agreeing to Job Plans which allocate grossly inadequate times to administration. In fact, I have had my request for an increased allocation of administrative time answered by a reduction, solely on the criterion that the new allocation was commensurate with those allocated to my colleagues, irrespective of whether their allocations are adequate. I believe that it is wrong and unjust to be expected to do so.

Lack of Rest / Lunch Breaks

In earlier exchanges regarding lunch breaks, I declared that I did not take lunch breaks and that I did not want to have any. My request was granted, breaks being replaced by time for Ward Rounds or Travel Time or Administrative Time. I now appreciate that I was mistaken, as one should have a break during a long working day. I would therefore request to have half hour breaks restored on Mondays, Tuesdays and Thursdays (impractical on Wednesdays: operating days).

Specialist Clinics

I am entirely pleased to have a specialist clinic each Friday morning as in Job Plan. I raise the issue here only to highlight the fact that it has been proposed that Mr. Young would also have a shorter specialist clinic, from 10 am to 12 noon, each Friday morning, in the same location. It is not possible for both of us to conduct two specialist clinics in the one space at the same time. At present, our proposed Job Plans are unworkable.

Availability whilst On Call

The issue of the availability of consultants, while on call, has not been raised or addressed during this round of Job Planning. It is now all the more significant a problem with reduced numbers of registrars. It is particularly an issue when a consultant on call is carrying out a fixed commitment or session off site, and no less when doing so on site, particularly when unable to abandon the fixed activity to respond to an emergency. I have found this to be increasingly the case, and particularly when operating, or being committed all day in

Thorndale Unit. It has been an increasingly frequent experience to be required in another theatre, or in Labour ward. Whilst a balance between availability and substitution for non-availability is required, there has been no consideration of this most important issue at all.

Proposed Amendments to Job Plan

I would propose the following amendments to the Job Plan:

Monday

- Mornings unchanged until 1.30 pm
- Break 1.30 – 2.00 pm
- Ward Round 2.00 – 2.30 pm
- SPA 2.30 – 6.00 pm
- Administration 6.00 – 7.00 pm

Tuesday

- Day Surgery (2 weeks per month) unchanged
- Administration (2 weeks per month) 9.00 – 1.00 pm
- Break 1.00 – 1.30 pm
- Outpatients Clinic 1.30 – 5.30 pm unchanged
- Ward Round 5.30 – 6.00 pm unchanged
- Administration 6.00 – 7.00 pm

Wednesday

- Preoperative Ward Round 8.30 – 9.00 am unchanged
- Theatre 9.00 – 5.00 pm unchanged
- Postoperative Ward Round 5.00 – 6.00 pm unchanged
- Administration 6.00 – 7.00 pm

Thursday

- Radiology meeting 8.30 – 9.30 am unchanged
- Grand Ward Round and SPA 9.30 – 12.00 noon unchanged
- Departmental meeting 12.00 – 1.30 pm unchanged
- Break 1.30 – 2.15 pm
- MDM 2.15 – 5.00 pm unchanged
- MDM Administration 5.00 – 5.30 pm unchanged
- Administration 5.30 – 7.00 pm

Friday

- Specialist Clinic 9.00 – 1.00 pm unchanged
- Thorndale Administration 1.00 – 1.30 pm
- Ward Round 1.30 – 2.00 pm

Date of Effect of Proposed Job Plan

I would be happy to have a Facilitation meeting during week commencing Monday 26 September 2011, whilst on annual leave (except for Friday 30 September when I have other commitments), to reach agreement on a Job Plan which can become effective from 1st October 2011.

Aidan O'Brien

19 September 2011

17 October 2011

Dr. P. Murphy,
Associate Medical Director,
Medicine and Unscheduled Care,
Southern Health and Social Care Trust,
Craigavon Area Hospital.

Dear Philip,

Thank you for your letter of 12 October 2011, advising me of the outcome of the facilitation meetings of Wednesday 28 September 2011 and Friday 7 October 2011. I am truly appreciative of the time you gave to me, and the manner in which it was conducted. However, I do need and seek some clarification.

Your letter gives me the impression, perhaps mistakenly, that the only issue addressed has been the time allocated to administration in the proposed job plan. Perhaps most pointedly, I may not have adequately emphasised that the proposed job plan is physically impossible as it proposes that I carry out a specialist clinic, consisting of urodynamic studies and oncology reviews, in exactly the same rooms, and using the same equipment and staff, as Mr. Young will be doing at the same time as proposed in his job plan, which he has already accepted and implemented. Either Mr. Young's job plan requires amendment to allow me to accept and implement my proposed job plan, or mine is amended to enable it to be acceptable and implementable. Has this issue been addressed? If so, what is the proposed outcome?

Has the issue of lunch breaks been addressed and what is the outcome? Will the proposed job plan be amended to accommodate breaks?

Has the issue of availability for emergencies been addressed and what is the outcome? This is an issue arising with increasing frequency, and no later than today. In particular, if one consultant is on leave, I believe that the other two cannot be off site, with one of them on call for emergencies.

At present, I have a proposed job plan which cannot be implemented. I need your advice and clarification as to whether I am to receive an amended job plan proposal which can actually be implemented, and including amendments referred to above, and which may or may not have been addressed, before deciding whether to accept the proposals regarding

administration time as outlined in your letter, and all before the deadline of Tuesday 25 October 2011. Whilst administration time was raised by me as a substantive issue, it was not the only issue. What has been the outcome of facilitation with respect to the others?

I would be grateful for your advice by Friday 21 October 2011, if at all possible. For ease of communication, you are welcome to email me at Personal Information redacted by the USI

Yours Sincerely,

Aidan O'Brien,

Consultant Urologist.