From: Coleman, Alana
Sent: 31 August 2016 08:34
To: Haynes, Mark
Subject: RE: Patient 93 HCN Personal Information redacted by USI
Importance: High

Ah I found Patient 93 !!

This referral went for triage to Mr O'Brien on the 05/05/2016 – and was not returned.
We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral – the GP originally referred Patient 93 as Routine.
I have attached what was sent for triage – Patient 93 referral is pg25-31.

Thanks
Alana

From: Coleman, Alana
Sent: 31 August 2016 08:14
To: Haynes, Mark
Subject: RE: Patient 93 HCN Personal Information redacted by USI

Morning Mr Haynes,

The HCN is for a Personal Information redacted by USI – referral we got yesterday from SWAH?

If it is definitely Patient 93 your querying do you have a date of birth?

Thanks
Alana

From: Haynes, Mark
Sent: 31 August 2016 07:08
To: Coleman, Alana
Subject: Patient 93 HCN Personal Information redacted by USI

Morning Alana

Could you find out what happened at triage to the referral from 4th May 2016 on this man and let me know please?

Mark

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Wednesday, 31 August 2016 17:40
To: McAllister, Charlie
Subject: FW: Patient 93 HCN Personal Information redacted by the USI

Charlie
Please can you read the series of emails. Suffice to say that although the outcome for the pt would not be any different, this as you know is not the issue that needs to be dealt with.
Await your thoughts
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Corrigan, Martina
Sent: 31 August 2016 13:17
To: Carroll, Ronan
Subject: FW: Patient 93 HCN Personal Information redacted by the USI
Importance: High

Can we discuss please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Haynes, Mark
Sent: 31 August 2016 09:34
To: Corrigan, Martina
Subject: Fw: Patient 93 HCN Personal Information redacted by the USI
Importance: High

Ignore the hcn but the story here is raised PSA referred by GP on 4th may. GP referral as routine. Not returned from triage so on wl as routine. If had been triaged would have been RF upgrade (PSA 34 and 30 on repeat). Saw Mr Weir for leg pain and CT showed metastatic disease from prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Wouldn't change outcome.
SAI?

Sent from my BlackBerry 10 smartphone.

From: Coleman, Alana <Personal Information redacted by USI>
Sent: Wednesday, 31 August 2016 08:34
To: Haynes, Mark
Subject: FW: Patient 93 HCN Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 02 September 2016 14:51
To: Young, Michael
Cc: Weir, Colin
Subject: Urgent for investigation please

Importance: High

Michael,

Please see email trail and Charlie's comments below.

Can you please discuss with Colin when you are back from Annual Leave and advise course of action ?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Carroll, Ronan
Sent: 01 September 2016 13:09
To: Corrigan, Martina
Cc: McAllister, Charlie
Subject: FW: Patient 93 HCN Personal Information redacted by the USI
Importance: High

Martina
Please see Charlie's comments and direction of travel for this issue – can I leave with you to progress and feedback to Charlie and myself when action/decisions have been reached/need to be taken – can we address this asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: McAllister, Charlie
Sent: 31 August 2016 18:37
To: Carroll, Ronan
Subject: Re: Patient 93 HCN Personal Information redacted by USI

My thoughts are that this should go through Mr Young (as Urology lead) first and Mr Weir second (as the CD).

Then happy to become involved.

C

Corrigan, Martina

From: Corrigan, Martina
Sent: 16 September 2016 18:08
To: Weir, Colin
Subject: FW: Urgent for investigation please

Hi Colin

I am not sure if I had forwarded this to you already?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Young, Michael
Sent: 08 September 2016 17:32
To: Corrigan, Martina
Subject: RE: Urgent for investigation please

Few points
1/ GP probably should have referred as RF in first place. A PSA of 34 is well above normal
2/ if booking centre has not received a triage back then I agree that they follow the GP advice
3/ if recent scan had shown secondaries then they were present at referral. As such then this was at an advanced non curable stage even then.
4/ I think the point here is that although non-curable I would have thought that treatment would still have been offered in the form of anti-androgen therapy at some stage over the subsequent few months.
5/ So to follow this to the next step means that if still following our current Routine waiting time would have resulted in the patient not being seen for a year. Some clinicians would have regarded this as resulting in a delay in therapy.
6/ It is not clear if arrangements were made, but the triage letter was not returned ?
7/ The patient was in fact seen within a few months.
8/ The apparent delay of just a few months has however not impinged on prognosis.

My view

MY

From: Corrigan, Martina
Sent: 07 September 2016 12:14
To: Young, Michael
Subject: FW: Urgent for investigation please
Importance: High

As discussed this afternoon

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

40.1 Concerns from members of staff could be discussed with any Consultant in person, by telephone, letter or email and if not resolved could be escalated through the complaints process or via a DATIX for grading to determine if it met the criteria for an SAI.

40.2 Similarly, concerns from patients or relatives would follow a similar process.

40.3 Many concerns and complaints can be resolved informally. Complaints or concerns requiring a formal process can take months to complete, largely because the process relies on the availability of a panel to meet several times to finalise a report. The efficacy of the process is in my view questionable. Sharing learning from this activity is challenging. The volume of information cascading down the management structure means that most if it goes unread and therefore unactioned.

41. Did those systems or processes change during your tenure? If so, how, by whom and why?

41.1 I have not noted any substantial changes to the systems for raising concerns during my tenure. The only change to the process was the introduction of the specialty specific morbidity and mortality meetings in 2015.

41.2 Dr O'Kane supported training for consultants in clinical governance during her tenure as medical director. She also established a forum for Chairs of M&M meetings to meet and share ideas and good practice.

42. How did you ensure that you were appraised of any concerns generally within Urology Services?

42.1 I relied on information brought to the Urology M&M and Cancer MDT as well as discussions with Mr Young and Mrs Corrigan to keep me appraised of any

39. How did you ensure that governance systems, including clinical governance, within Urology Services were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.

39.1 I chaired the Urology M&M meeting from April 2015 and from the outset sought to include all available governance information not just mortality and morbidity cases. This was further developed with the assistance of the Clinical Effectiveness Team. Governance information was fed into the M&M meeting from various sources including: Deaths within 30 days of discharge, mortality lists, morbidity cases, safety graphs, local incidents/themes/ward issues, pharmacy issues, medicine safety alerts, shared learning from complaints / SAI/ IR1 forms / Other meetings / Learning Letters, Shared learning from Litigation / Coroners cases / PM reports / Ombudsman, Safety alerts and Circulars, Local Audit reports/Quality Improvement, Consultant outcome data (NCEPOD / National / Regional / Speciality).

39.2 The Urology M&M meeting served as a forum to share information relating to clinical governance with the whole team. Only those issues identified to me by members of the urology team or the clinical effectiveness team were included in the agenda for the meeting. I now know that there were issues of professional performance relating to Mr O'Brien, that I was not aware of, that had a direct bearing on patient safety.

39.3 I flagged concerns related to patient safety up to the responsible clinical director and or head of service. For example, the issue of non-quoracy at the Urology Cancer MDT was raised with the clinical directors for cancer services and radiology respectively.

40. How could issues of concern relating to Urology Services be brought to your attention as Consultant or be brought to the attention of others? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients or relatives. What

4

Management of systemic anti-cancer therapy

This section reviews how the decision to start the final protocol of systemic anti-cancer therapy (SACT) was made, how it was communicated to the patient and their family and how consent for therapy was obtained. Data on the assessment of the patient before the start of the protocol and how the SACT was prescribed was also explored.

Data on the fitness of the patient to receive SACT before the cycle of SACT that preceded the admission to critical care or death was analysed as part of a review of the prescribing pathway. Finally, the toxicity that resulted from the final cycle of SACT was assessed.

Table 4.1 Service overseeing prescription of SACT – clinician's opinion

	Age				
	0-11	**12-16**	**17-18**	**19-24**	**Total**
Paediatric SACT service	56	23	8	0	**87**
Adult haematology	0	0	4	27	**31**
Adult solid tumour	0	1	5	18	**24**
Other	4	3	3	8	**18**
Total	**60**	**27**	**20**	**53**	**160**

Start of final protocol of SACT

The decision to start a new protocol of therapy is a critical step in the treatment of patients with malignancy. In 111/147 (75.5%) patients the decision was made in a principal treatment centre.

The provision for children and adults was clear with each group being treated by age appropriate teams, but for teenagers the situation was more fragmented. The prescription was not undertaken in a principal treatment centre (PTC) or teenager and young adult (TYA) approved centre in 3/160 patients, all of whom were teenagers.

The protocol was initiated by a consultant in 133/159 (83.6%) patients and in no case was the protocol started by a doctor with less than ST3 level of experience. The specialty of the doctor prescribing the final cycle of SACT was appropriate in all cases reviewed, for which data were available.

The intent of the protocol is noted in Figure 4.1 which compared the intent as documented by the clinician looking after the patient with the evidence the reviewer could find in the case notes. In 16/145 (11.0%) sets of case notes the reviewers did not find evidence that the intent of treating the patient was clear.

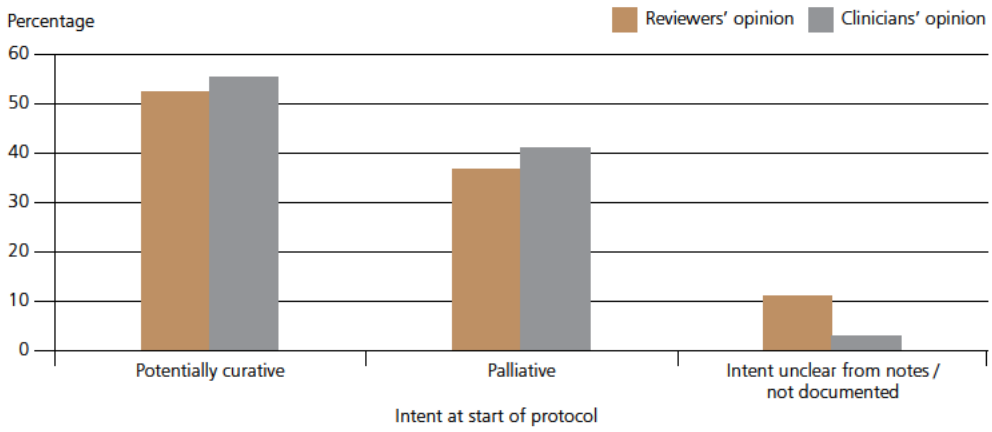

Figure 4.1 Intent at start of protocol

Urology Department Governance Meeting 15th February 2017

1. Minutes of last meeting and matters arising

2. Audits Received

3. Morbidity & Mortality

Hospital	STATUS	Casenote	Health & Care Number	Surname	Forenames	Method of Discharge	Date of Death	DOB	Consultant on Discharge - Name
CAH	Awaiting presentation - specialty specific meeting	Personal Information redacted by USI							Glackin A Mr / McAllister C Dr
CAH	Awaiting presentation - specialty specific meeting								Glackin A.J Mr
CAH	Awaiting presentation - specialty specific meeting								Haynes M D Mr
CAH	IMMIX / M&M proforma to be completed								O'Brien A Mr / McAllister C Dr
CAH	IMMIX / M&M proforma to be completed / Awaiting presentation at combined surgical meeting								O'Brien A Mr / McAllister C Dr
CAH	IMMIX / M&M proforma to be completed								O'Donoghue J P Mr
CAH	IMMIX / M&M proforma to be completed								Young M Mr

Personal Information redacted by the USI Case referred from Medical M&M for Urology review.
Action Ms Morrow to present at next specialty specific Urology PSM on behalf of Mr Haynes.

4. Complaints & Compliments

5. Learning from SAI's

   a. Item 6 SAI Report
   b. Item 6 SAI Report
   c. Item 6 SAI Report

   Personal Information redacted by USI

6. Any other Business : Other issues relating to Clinical Governance.

7. Next meetings

Wednesday	15th	March	PM	2017	Combined
Thursday	13th	April	AM	2017	Speciality specific

Urology Department Governance Meeting Minutes, 16 August 2018

1. Minutes of last meeting and matters arising
    a. None

2. Morbidity & Mortality

Health & Care Number	Date of Death	NIECR Consultant(s) in order they are recorded on NIECR	Comment
Personal Information redacted by the USI		Browne G.V. Dr / Glackin A Mr	Await outcome of SAI
		Glackin A Mr	No issues identified
		Glackin Mr	No issues identified
		Haynes M Mr	No issues identified
		Haynes M Mr	No issues identified
		O'Brien A Mr	Presented by Mr O'Brien & Await outcome of SAI
		Jacob T Mr	No issues identified
		McArdle G Mr / Glackin A Mr	Presented by Mr O'Brien
		O'Brien A Mr	NIECR Mr O'Brien to prepare case
		O'Brien A Mr	No issues identified
		Young M Mr / ICU Chair to advise	No issues identified

3. Complaints & Compliments
    a. None discussed

4. Learning from SAI's, DATIX etc.

    a. Form number: Personal Information redacted by USI
    Description:
    The Haematology Registrar brought to the attention of the Lead Consultant for Blood Transfusion and the Area Haemoviglance Practitioner the following, Personal Information redacted male in-patient on 3 south admitted electively for trans-urethral resection of prostate on 3/12/2017. Case discussed with me by a junior Dr several days later due to low HB and platelets. Appears that the patient was transfused 2 units of platelets post-operatively in the absence of bleeding with a platelet count of 80, which is obviously outside guidelines

6. **Morbidity**
   a. Personal Information redacted by the USI **delay in surgery leading to morbidity, to be discussed at next meeting**
   b. Personal Information redacted by the USI **testicular torsion case, to be discussed at next meeting**

7. **Local incident themes : Ward / Unit issues**
   a. **Reduced capacity to see out patients with potential to cause harm to patients by delay in time to diagnosis and treatment**
   b. **Reduced theatre capacity with potential to cause harm to patients by delay in time to diagnosis and treatment**
   c. **Reduced capacity for out-patient urology procedures including prostate biopsy and intravesical therapy with potential to cause harm to patients by delay in time to diagnosis and treatment**

8. **Pharmacy issues, incidents and medicine safety alerts**
   a. **Nil discussed**

9. **Shared learning from Complaints / SAI/ IR1 forms / Other meetings / Learning Letters**

SAI Report 69120

69120 action plan.docx

69120 Report.docx

SAI Report 69133

SAI 69133 Report.pdf

10. **Shared learning from Litigation / Coroners cases / PM reports / Ombudsman**

11. **Safety alerts and Circulars (Safety Quality Reminder) sent to M&M chairs 26/6/2020 and 03/7/2020**
    a. Safety and Quality Reminders

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type
Risk of Serious Harm or Death from Misplaced Percutaneous Endoscopic Gastrostomy (PEG) Tubes	05/08/2020	SQR-SAI-2020-069 (AS/PHC/OPS)	Safety and Quality Reminder of Best Practice Guidance
Rubeosis Needs Urgent Referral and Treatment to Avoid Sight Loss	05/08/2020	SQR-SAI-2020-070 (AS,PHC)	Safety and Quality Reminder of Best Practice Guidance

Minutes of Patient Safety Meeting / M&M Meeting Urology
Thursday 13th August 2020

1. **Welcome , attendance and apologies received by Chair**:
    a. **In attendance Mr Glackin (chair), Mr Haynes**
    b. **Apologies Mr Young , Mr O'Donoghue**

2. **Review of Previous Minutes / Verification of last meeting report**
    a. Nil arising

3. **Items for consideration from other M&M / PSM**

Personal Information redacted by the USI **From Cardiology PSM - email from SML 30/6/2020 to Mr Haynes AMD** for surgery (Mark Haynes) re pre-op clinic guidance

4. **Deaths within 30 days Discharge- item noted**

Anaesthetics and Surgery mortality pos

5. **Mortality Reporting**

8) ALL Urology Outstanding cases at

M&M Meeting Outcome Report

Meeting Details	
Date/time	13-Aug-2020 09:30
Primary Team	CAH - Urology
Joint Team(s)	
Attendees	Anthony Glackin / Mark Haynes

HCN	Full Name	Date of Death	Discussion Details	Lesson Category	Lesson Discussion Details	Action(s)	Outcome
Personal Information redacted by the USI			Appropriate management , expected death.	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
			Appropriate care, expected death from advanced colorectal cancer.	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
			Appropriate end of life care. Expected death	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
			Appropriate care, expected death.	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.
			Await outcome of Coroners PM	N/A	N/A		1. was Satisfactory. There were no particular Learning Lessons.

Prepared for Anthony Glackin (Personal Informatio) on 14-Aug-2020 09:30

Patient 91	Personal Information redacted by the USI	Browne G.V. Dr / Glackin A Mr	Outcome 4. Signed off on NIECR.
Personal Information redacted by the USI		O'Brien A Mr	Outcome 1. Signed off on NIECR.
		O'Donoghue J P Mr	Not discussed. JOD to complete.
		McArdle G Mr / Glackin A Mr	Letter from Mr O'Brien awaited. Once received to be forwarded to Mr Personal Information redacted by USI
		Haynes M D Mr	Outcome 1. Signed off on NIECR.
		Glackin A Mr	Outcome 1. Signed off on NIECR.
		Haynes M Mr	Outcome 1. Signed off on NIECR.
		Mohamed I Dr / Urology Chair to advise	Mr O'Brien to review notes.
		O'Brien A Mr	Outcome 1. Signed off on NIECR.

3. Complaints & Compliments
    a. None discussed

4. Learning from SAI's, DATIX etc.

5. Any other Business :
    a. Clinical Audit Strategy Personal Information redacted by USI
    b. Suggested audits.
        i. Snapshot audit of compliance with NICE guidelines for bladder cancer. Mr Evans and Mr Glackin.
        ii. Audit of waiting times for surgery of patients with indwelling ureteric stents. Mr Hiew and Mr Young.

6. Next meeting PM Friday 16th November 2018 (Laser safety training in Theatres)
Rolling Audit Calendar for Urology Meetings 2019.doc

Urology Department Governance Meeting 15 January 2019

In attendance
Mr Glackin (chair)
Mr Young
Mr O'Donoghue
Mr Haynes
Mr Hiew
Dr Hasnain

Sr O'Neill
Sr McCourt
SN Holloway
SN Campbell
SN McCreesh

Apologies
Mr O'Brien
Mr Evans

1. Minutes of last meeting and matters arising
    a. Stent on strings

    b. M&M matters from last meeting

Health & Care Number	Date of Death	NIECR Consultant(s) in order they are recorded on NIECR	Outcome 15 January 2019
Patient 90	Personal Information redacted by the USI	O'Brien A Mr	SAI not yet completed
Personal Information redacted by the USI	Personal Information redacted by the USI	McArdle G Mr / Glackin A Mr	Case signed off by DHH General Surgical Team

2. Morbidity & Mortality

Health & Care Number	Surname	Date of Death	NIECR Consultant(s) in order they are recorded on NIECR	M&M NIECR team in order they are recorded on NIECR	Outcome 15 January 2019
Personal information redacted by USI			McArdle G Mr / Glackin A Mr	Surgery General/Surgery Urology	Case signed off by DHH General Surgical Team
			Mohamed I Dr / Urology	Medical CAH, Lgn, STH / Surgery Urology	Remains oustanding
			O'Donoghue J Mr	Surgery Urology	Stopping Omeprazole a possible factor in GI bleed. No change in management. Signed off.
			O'Donoghue J Mr	Surgery Urology	Aspiration pneumonia on a background of advanced MS. No learning points identified. Signed off.
			O'Donoghue J P Mr	Surgery Urology	HAP. Frail and co-morbid. No learning points identified. Signed off.
			O'Donoghue J P Mr	Surgery Urology	Expected death from metastatic bladder cancer. No learning points identified. Signed off.
Personal information redacted by the USI	Patient 90	Personal information redacted by USI	Shevlin C Dr/Urology Chair to advise	ICU/Surgery Urology tbc	SAI outstanding

3. Complaints & Compliments
    a. None discussed

4. Learning from SAI's, DATIX etc.
    a. None discussed
5. Audits.
        i. TRUS biopsy of prostate service
            1. Develop a prostate biopsy booking proforma Action: Kate O'Neill
            2. All patients on DOACs require a green form to be completed by Urologist

3. Risk vs Cost analysis for sepsis after TRUS biopsy versus moving to Transperineal biopsy to be undertaken by HOS
   Action: Martina Corrigan
4. Implement a Trust waiting list for prostate biopsy cases to be coded as a nurse led procedure where appropriate
   Action: Kate O'Neill and Martina Corrigan

ii. Audit of waiting times for surgery of patients with indwelling ureteric stents. Mr Hiew and Mr Young.
   1. Not ready for presentation

6. Any other business
   a. Intravesical therapy
      i. Requirement for mantoux testing to be discussed with Microbiology Department
      ii. Maintenance BCG will be for 2 years
      iii. Lead Nurse for Thorndale Unit to organise a meeting with Daisy Hill colleagues to standardise intra-vesical service across both sites

   b. Changes to [redacted]
   c. Lab Matters

7. Next meeting Wednesday 20th February 2019 AM

Urology Department Patient Safety Meeting 19 July 2019 Minutes

In attendance
Mr Glackin Chair
Mr Young
Mr O'Brien
Mr Haynes
Mr Evans
Mr Hiew
Sr McCourt
Sr McMahon
Mrs Corrigan

Apologies
Nil

1. Minutes of last meeting and matters arising
    a. nil

2. Morbidity & Mortality
    a. Personal Information redacted by the USI morbidity: outcome , patients with nitrite and leucocyte positive urinalysis should be discussed on a case by case basis with the responsible Consultant before proceeding to flexible cystoscopy to avoid unnecessary delay in care and potential post-procedure infection

    b. Mortality cases discussed

Health & Care Number	Date of Death	NIECR Consultant(s) in order they are recorded on NIECR	Outcome
Personal Information redacted by USI		Young M Mr	1. was Satisfactory. There were no particular Learning Lessons.
		Glackin A.J Mr	1. was Satisfactory. There were no particular Learning Lessons.
		Haynes M D Mr	1. was Satisfactory. There were no particular Learning Lessons.
		Haynes M Mr	1. was Satisfactory. There were no particular Learning Lessons.
		O'Brien A Mr	1. was Satisfactory. There were no particular Learning Lessons.
		O'Donoghue J Mr	1. was Satisfactory. There were no particular Learning Lessons.
		Tyson M Mr	1. was Satisfactory. There were no particular Learning Lessons.
		Connolly M Dr/ Glackin A Mr	1. was Satisfactory. There were no particular Learning Lessons.
Patient 90	Personal Information redacted by USI	Shevlin C Dr/ O'Brien A Mr	SAI presented at combined PSM. Signed off 19/07/2019

3. Complaints & Compliments
    a. New complaint for investigation H&C [redacted]
    This case highlighted the need for the operating surgeon to make a plan for the removal of a ureteric stent at the time of insertion. All agreed that the surgeon placing the stent is responsible for auctioning the removal in a timely manner. There is no agreed trust protocol in place for this scenario.
    Various suggestions were made as to how to manage this situation but no consensus was reached at this meeting. Further work is needed.

4. Learning from SAI's, DATIX etc.
    a. nil

5. Audits.
    a. Audit of waiting times for surgery of patients with indwelling ureteric stents. Mr Hiew and Mr Young.

6. Any other business
    a. [redacted]
    b.
    c.
    d.
    e.
    f.

7. Next meeting Tuesday 17 September 2019 PM

Aimee Crilly

From: Glackin, Anthony [redacted]
Sent: 26 May 2015 12:54
To: Suresh, Ram
Cc: Young, Michael; O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Corrigan, Martina
Subject: Re: Governance meeting - Stent registry

Ram,
I'd be most grateful if you could present these cases formally so that we can share learning and plan some action points. please let me know the dating codes associated with the cases.
The next meeting is on 16th June.

Tony

AJ Glackin
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton
[redacted]

On 26 May 2015, at 12:39, Suresh, Ram [redacted] wrote:

> Dear Mr. Glackin,
> I have seen a couple of patients recently, with 'forgotten stents', with no mention about the stents in the discharge letter. I have filled in incident forms.
> Can we discuss about this issue in the next governance meeting please, particularly, about the need for stent registry.
>
> Thanks
> Ram Suresh

them that Patient 91's condition had deteriorated post procedure and required overnight admission. The family report they finally made contact with the ward at 18:15 and were advised by the nurse to come down and a nurse would speak with them, however upon arrival the nurse refused to do so. The family requested to speak to a doctor but were told by a member of the nursing staff that it was a Friday night and they would not be able to speak to a doctor now.

The review team acknowledge communication with families post procedure is difficult due to a number of barriers. The review team determined that medical staff would have had a full theatre list booked for the day and were probably dealing with other procedures and work pressures and therefore unable to take time out to update Patient 91's family. The review team have concluded that treatment and care within the recovery ward was appropriate but due to work pressures Patient 91's family were not updated. The review team again have determined the report will be shared with all staff involved in Patient 91's care for reflection and learning.

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breeched, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the planned procedure and any confirmed bacteriuria treated with appropriate antibiotics prior to the planned procedure.

The incident was presented at Urology morbidity and mortality meeting (M&M) on the 19 October 2018.

15. RECOMMENDATIONS (please state by whom and timescale)

Recommendation 1
This report will be presented at morbidity and mortality meetings to share learning with clinical staff.

Recommendation 2
All patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breeched, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the planned procedure and any confirmed bacteriuria treated with appropriate antibiotics prior to the planned procedure.

Recommendation 3
Urology waiting lists should be standardised, to include standardised description of ureteric stent change/removal procedures.

Recommendation 4
Consultant Urologists should ensure that they have a system in place which ensures that patients with ureteric stents inserted are recorded with planned removal or exchange dates in order to ensure patients do not have ureteric stents in place for longer than intended.

Recommendation 5
All patients who have ureteric stents inserted for management of urinary tract stones should have plans for definitive management within 1 month unless there are clinical indications for a longer interval to definitive treatment.

Recommendation 6
Where patients wait longer than the intended time for definitive management with a ureteric stent in situ the case should be reported on the trust DATIX system.

Coroners Service
for Northern Ireland

JOHN L LECKEY LL.M.
SENIOR CORONER
FOR NORTHERN IRELAND

and Chief Nursing Officer,

Re: [redacted] **deceased**

On 16th October 2013 I concluded an inquest into the death of a [redacted] woman, [redacted], who died in the Ulster Independent Clinic on [redacted]

I believe sufficient background information is contained in the Verdict to which is annexed a copy of a statement on behalf of Professor Neil McClure the Surgeon, Dr Damien Hughes the Anaesthetist, the Ulster Independent Clinic and the nursing staff (copies enclosed). Also, I am enclosing a copy of a letter I have sent to the Minister for Health together with copies of the enclosures therein referred to.

At the conclusion of the inquest I stated that in addition to making a report pursuant to the provisions of Rule 23(2) of the 1963 Coroners Rules to the Minister, the Chief Medical Officer, the Regulation and Quality Improvement Authority and the Director of Public Health I would be writing to the Medical Director of all Northern Ireland Hospitals and the Northern Ireland Chief Nursing Officer. I would ask the Medical Directors to provide me with a collegiate response to the surgical and anaesthetic failings that the inquest has identified and I would ask for a similar response from the Northern Ireland Chief Nursing Officer in relation to nursing issues.

I should be grateful if you would acknowledge receipt of this letter and confirm that you will be responding in the manner I have requested. I, and no doubt the family also, require reassurance that all steps have been taken to ensure patient safety and

Tel: 028 9044 6800 Fax: 028 9044 6801
May's Chambers, 73 May Street, Belfast. BT1 3JL
www.coronersni.gov.uk

From the Deputy Chief Medical Officer
Dr Paddy Woods

HSS(MD)14 /2015

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Castle Buildings
Stormont
BELFAST
BT4 3SQ

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

Your Ref:
Our Ref: HSS(MD)14 /2015
Date: 18 August 2015

For Action:

Chief Executives HSC Trusts
Chief Executive HSCB
Chief Executive PHA
Chief Executive RQIA *(for dissemination to independent sector organisations)*

Dear Colleague

POLICY ON THE SURGICAL MANAGEMENT OF ENDOSCOPIC TISSUE RESECTION

ACTION REQUIRED

1. HSC Trusts and independent providers should process this regional policy template for endorsement by the organisational board, or equivalent;

2. HSC Trusts and independent providers should develop action plans to implement the various elements of the endorsed policy;

3. HSC Trusts should work with commissioners to address resource issues arising from these implementation plans in a phased, consistent and timely manner; and

4. the Public Health Agency should report on progress by 30 November 2015.

As a result of the verdict of the Coroner into the cause of death of Mrs Personal Information redacted by USI in Personal Information redacted by USI, work was commissioned on ensuring the safe and effective management of procedures involving the use of distending fluids in endoscopic procedures. In recognition of the limited guidance available on the management of these procedures, local work was commissioned, led by Dr Julian Johnston, Assistant Medical Director in Belfast Health and Social Care Trust.

The attached outline policy is the product of that work and we are now commending it for regional implementation.

5.0 IMPLEMENTATION OF POLICY

This policy, after it is agreed, is to be implemented throughout NI in each of the 5 Trusts.

5.1 Resources

There will be resource implications in terms providing surgical equipment that can be used without needing glycine as an irrigant, fluid flow and pressure controllers and POCT monitoring equipment for theatres and training for staff.

6.0 MONITORING

Trust audit departments will need to monitor that the recommendations are implemented.

7.0 EVIDENCE BASE / REFERENCES

1. Hahn RG. Fluid absorption in endoscopic surgery. Br J Anaesth 2006; 96: 8–20.
2. Varol N, Maher P et al. A literature review and update on the prevention and management of fluid overload in endometrial and hysteroscopic surgery. Gynaecological Endoscopy 2002; 11: 19-26.
3. Practice Committee of the AAGL Advancing Minimally Invasive Gynaecology Worldwide. Practice Report: Practice Guidelines for the Management of Hysteroscopic Distending Media. Journal of Minimally Invasive Gynaecology (2013) 20, 137–148.
4. Gravenstein D. Transurethral Resection of the Prostate (TURP) Syndrome: A Review of the Pathophysiology and Management. Anesthesia & Analgesia. 1997; 84: 438-46.
5. S. Gravas, A. Bachmann et al. European Association of Urology April 2014. Guidelines on the Management of Non-Neurogenic Male Lower Urinary Tract Symptoms (LUTS), incl. Benign Prostatic Obstruction (BPO).
6. Marszalek M, Ponholzer A et al. Transurethral Resection of the Prostate. European urology supplements 8 (2009) 504–512.
7. Mamoulakis C, Ubbink DT et al. Bipolar versus Monopolar Transurethral Resection of the Prostate: A Systematic Review and Meta-analysis of Randomized Controlled Trials. European Urology 56 (2009) 798 – 809.
8. Michielsen DPJ, Coomans D et al. Bipolar transurethral resection in saline: The solution to avoid hyponatraemia and transurethral resection syndrome. Scandinavian Journal of Urology and Nephrology, 2010; 44: 228–235.
9. Omar MI, Lam TB, Alexander CE et al. Systematic review and meta-analysis of the clinical effectiveness of bipolar compared with monopolar transurethral resection of the prostate (TURP). BJU Int 2014; 113: 24–35.
10. NICE Lower urinary tract symptoms: Evidence Update March 2012. https://www.evidence.nhs.uk/evidence-update-11
11. NICE consults on plans to support new device for surgery on enlarged prostate glands. October 2014. http://www.nice.org.uk/news/press-and-media/nice-consults-on-plans-to-support-new-device-for-surgery-on-enlarged-prostate-glands
12. The TURis system for transurethral resection of the prostate. NICE medical technology guidance [MTG23] February 2015.
13. Venkatramani V, Panda A et al. Monopolar versus Bipolar Transurethral Resection of Bladder Tumors: A Single Center, Parallel Arm, Randomized, Controlled Trial. Journal of Urology 2014; 191: 1703-1707.
14. Black P. Bladder Tumour Resection: Doing it Right. Journal of Urology; 191: 1646-47.
15. Lethaby A, Penninx J, Hickey M et al. Cochrane Collaboration review (2013) Endometrial resection and ablation techniques for heavy menstrual bleeding (Review).
16. NICE. Treatment options for heavy menstrual bleeding - pathway. April 2014.
17. Personal Communication.
18. Blandy JP, Notley RG et al. Transurethral Resection. Pub, Taylor and Francis 2005. http://www.baus.org.uk/Resources/BAUS/Transurethral%20Resection.pdf
19. Loffer FD, Bradley LD et al. Hysteroscopic Fluid Monitoring Guidelines. Journal of the American Association of Gynecologic Laparoscopists. 2000; 7: 167–168.

Southern Health and Social Care Trust

ACTION PLAN

Reference	HSS (MD) 14/2015
Title of Clinical Guideline / Standard	Policy on the surgical management of endoscopic tissue resection, for example during urological, gynaecological and other relevant surgery
Date of Endorsement and Issue from External Agency:	18/08/2015
Submission Date for Assurance Response / Action Plan to HSCB:	31/10/2015 was the initial deadline date Letter from Dr Little (DHSSPSNI) received 03/11/2015 requesting an update Two week extension given – new deadline for submission 23/11/2015
Directorate/s affected by guideline recommendations	Acute Services
Operational Director	Mrs Esther Gishkori
Identified Change Leader	Mrs Mary McGeough – Head of ATICS Mrs Wendy Clarke – Acting Head of Midwifery & Gynaecology Dr G. McCracken – Clinical Director IMWH Mrs Martina Corrigan – Head of ENT and Urology Mr Young – Lead Consultant Urologist

Actions for Trusts					
Recommendation	**Current Control Measures**	**Current level of compliance (%)**	**Action plan**	**Designated Lead**	**Deadline for completion**
1. Preoperative workup **must** be geared towards prevention of the TUR syndrome.	All of these patients are optimised for surgery and as part of the pre-operative work up, the risk factors pertaining to TUR syndrome are identified and managed. Within Urology all patients are provided with a BAUS information Leaflet and at clinic appointment are advised verbally of the risk factors. All patients have standard haematology and electrolyte analysis completed and have careful consideration regarding blood grouping and cross matching.		An audit will be carried out to review the consent process for patients to determine if the patients have been "*truly made aware of the hazards of endoscopic resection using irrigation fluids*". Patients will be identified from Theatre Management System. Recent Investigations aimed at establishment of pathological anatomy and degree of Surgical risk to be scoped Availability of reports of such investigations prior to commencement of surgery to also be scoped	Mrs Mary McGeough (Head of ATICS)	31/12/2015
2. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.	Within Gynae services bipolar resection equipment is in place within CAH and DHH (with the exception of one Consultant). Glycine is not used at all. The only exception to this is when there is a failure of the bipolar equipment		Ensure robust and monitored control measures are in place for the use of Glycine within urology services	Mrs Mary McGeough (Head of ATICS)	Ongoing

	is over 500 and then go no further when the maximum fluid deficit threshold is at 1000		specified.		
11. Operations should, if possible, not last longer than 60 minutes, a. Theatre teams **must** have an established mechanism for measuring time and procedures for alerting surgeon and anaesthetist.	The recording of resection time is adhered to. It is also a required field within the ATICS fluid management documentation sheet		The draft standard operating procedures need to be reviewed to ensure this requirement is specified prior to implementation within the Trust.	Mary McGeough Head of ATICS Brigeen Kelly Lead Nurse ATICS	31/12/2015
12. Completion of the standard WHO surgical checklist **must** be adhered to. Adoption of a modified WHO checklist for this kind of procedure should be investigated and piloted	Completion of the standard WHO surgical checklist is adhered to.		The Trust has taken the stance that the WHO checklist will not be modified for this kind of procedure since deviance from the standardised WHO checklist could create its own set of risks for the organisation	Ongoing	Ongoing

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 07 February 2016 21:22
To: Corrigan, Martina; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: RE: Standard Operating Procedure for Fluid Management during Urology surgery

Dear All,

I suspect that any comments from me will be perceived to have been prejudicial.
However, I honestly did approach using the much hailed Olympus with a view to giving it a fair wind.
And was I bowled over?
No!
I resected two small prostates.
I found it deficient in two respects:

1. It is my understanding that there is no blended current on cutting with the result that haemostasis was inferior to monopolar during cutting
   You resect, it bleeds and you coagulate.
   This slowed the resection.
   It also had me wondering whether one would have increased fluid absorption as a consequence.

2. The rate of irrigation was much slower than with the monopolar resectoscopic, with the result that there was an intermittent fog which I had to stop resecting to wait for it to clear.

I was so glad that neither prostate was large, as I certainly would not have used the Bipolar.

The Audit asks the question whether the trialist would be 'happy' to use it.
My answer was a definite 'No'.
I will do if I have to.
I just do hope that the Operating procedure will allow me to continue to use Monopolar, as it is very much superior,

Aidan

From: Corrigan, Martina
Sent: 07 February 2016 17:55
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Subject: FW: Standard Operating Procedure for Fluid Management during Urology surgery

Any comments?

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Corrigan, Martina

From: O'Brien, Aidan [redacted]
Sent: 30 March 2016 16:17
To: Young, Michael; Corrigan, Martina
Cc: Glackin, Anthony; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP
Subject: Bipolar Resection

Michael and Martina,

I wish to take the opportunity to update you on my experience of trying bipolar resection systems.
I have tried the models on trial to date, and did so having disabused myself of any prejudice against their use.
As reported previously, I found their performance inferior to monopolar mainly as a consequence of the intermittency of the current, the lack of any small vessel fulguration whilst cutting and the much reduced rate of continuous irrigation.
I last use bipolar two weeks ago to resect the moderately enlarged prostate gland of an elderly patient.
I had to abandon bipolar resection after 10 minutes because of bleeding, poor irrigation and visualisation.
The intraoperative comparison of both systems was remarkable.
Bipolar resection placed this patient in intraoperative danger, and salvaged by monopolar resection.

I have therefore pledged not to do so again.
I will not use or try bipolar resection again,

Aidan.

DEPARTMENTAL MEETING 22nd SEPTEMBER 2016

Chair: Mr Young

Present: Mr Glackin, Mr O'Brien, Mr Suresh, Mr O'Donoghue, Pamela Johnston, Theatre Manager & Sr. England

Apologies: Mr Haynes , Mrs Corrigan

TOPIC: SALINE RESECTION

The specifications for the saline resectoscope system were presented. Mr Young outlined the history behind the move to the saline resection, also explaining that the last year had been spent trialling the various resectoscopes. Mr Young asked the forum if they had regarded enough time had been given to each of the resectoscope providing companies so that an adequate assessment could be made for each of the scopes. The unanimous decision was that the trial period for each of the resectoscopes was adequate to make an opinion.

We all agreed that the appraisal form used was of a good standard and certainly adequate to make a surgeons' assessment of each scope. The overall assessment looked at scope quality, ease of use, product design and effectiveness of the core principal of diathermy and resection of tissue. Second component to be evaluated were costs of generators and disposables. Thirdly was the topic of CSSD and backup. Scoring was undertaken from the feedback forms with the result that the WOLF system was the poorest and was not fit for purchase. In third place was the TONTARRA system which was described as having a variable performance with regards to the resection loop activity. The STORZ and the OLYMPUS system scored virtually equally on the various points with an overall equal score. It was recorded that there was no cystoscope present on the OLYMPUS resectoscope tray for evaluation but we generally felt that this was not an issue to take into account. There was general record of a fairly good ease of use and that the vaporisation module component was good. Several negative points related to the working element of inflow/outflow not being ideal; there were some comments on excessive bubble formation on the resectoscope loop as well as some other comments relating to slow resection. Overall however this was a system that could be purchased. With regards to the STORZS system, it was felt that the cutting modality of the resectoscope loop was excellent. Overall the scope components were easily constructed and there was a generalised good ease of use. Comments with regards to consistency and haemostasis had been positive. One of the major points in its favour was that the STORZ system could be easily changed if required on an urgent basis to the use of glycine. This in the current climate of change from one system to another in association with the range of urologists within the unit was a more suitable system for the team in Craigavon Area Hospital. The STORZ system certainly was a system that could be purchased.

Purely on the ease of use principal, excluding other criteria (i.e. cost and CSSD), the option came down to either STORZ or the OLYMPUS system, the other two being excluded. Four surgeons voted for the STORZ, one electing for the OLYMPUS. Mr Haynes was not present for this vote but on subsequent conversation later in the day, Mr Young put the same question to Mr Haynes asking for his comments on ease of use and again he had no particular preference and was happy to run with the global opinion.

On reviewing the various costs, it was noted that the disposables did have a variable range. It was accepted that loop quality did vary and that loops could be purchased from different sources. We all felt that this was not a particularly focused point for making a decision (namely cost of loop).

The price of the individual resectoscope systems was recorded noting that the OLYMPUS system was significantly more expensive in totality. The OLYMPUS system would have to be purchased completely whereas the STORZ system could be involve both new scopes and modification of current sets. (The costs set out for this meeting were significantly in favour of the STORZ system but it was appreciated that if a STORZ completely new systems was to be included that this information was to be presented to the forum before a final decision was made).

A further significant contributor to decision making was the generator needed for the electrical input. Although the OLYMPUS company was going to offer a free £40,000 generator, we did record that we may need up to three generators in view of the amount of urology sessions occurring at the same time. (The forum did not know if the company would supply three free generators. They felt it unlikely but enquiries would be made). The current generator system available within the Trust is multifunctional and therefore would already suit the STORZ system more appropriately. Even with the OLYMPUS generator system, this would result in increased machinery parking within the theatre environment. Overall this was regarded as a fairly substantive pointer in favour of the STORZ system.

CONCLUSION

In concluding, the vote on several aspects namely ease of use, cost, generator type were all in favour of the STORZ system. All the urologists have backed this decision with a unanimous vote.

This decision was based on the information supplied with a final decision pending the outstanding enquiries, namely the cost of a completely new STORZ resectoscope system and the cost of the OLYMPUS cystoscope. This would give a truly like for like comparison. The additional enquiry related to the OLYMPUS generator issue.

Mr Young will add an addendum to this document when the above information becomes available before final sign off.

The paperwork with regards to this has been forwarded to the Service Administrator, Martina Corrigan and to Pamela Johnston, Theatre Manager.

M Young
22nd September 2016
Chair of Session

Stinson, Emma M

From: Haynes, Mark [redacted]
Sent: 20 November 2017 09:23
To: Conway, Barry
Cc: Young, Michael; Carroll, Ronan; Gishkori, Esther
Subject: Fw: Saline TUR
Attachments: Trust Action Plan against the Surgical Management of Endoscopic Tissue R....docx; HSS MD 14 2015 - POLICY ON THE SURGIVAL MANAGEMENT OF ENDOSCOPIC TISSUE ....pdf; REVISED Policy on surgery for endoscopic tissue resection V0 5 after PHA....pdf; Letter to Trusts Surgical Policy 17 Sept 15.doc

Morning Barry

Apologies, I should have included you in this email.

Mark

Sent from my BlackBerry 10 smartphone.

From: Haynes, Mark [redacted]
Sent: Sunday, 19 November 2017 07:42
To: Gishkori, Esther; Carroll, Ronan
Subject: Saline TUR

Morning

With regards recent capital expenditure decisions with respect to saline resectoscopes / infusion pumps, attached is the guidance issued to the region following a patient death and subsequent review. I also attach the trusts response to this guidance including the action plan. You will note the following two standards and the trust response / timelines (I have highlighted the specific actions / timelines).

1. Introduce Bipolar resection equipment. During the switchover to bipolar equipment, limit the use of glycine following careful risk assessment of individual patients. If glycine is still being used, strictly monitor as detailed in recommendation 5.	Within Gynae services bipolar resection equipment is in place within CAH and DHH (with the exception of one Consultant). Glycine is not used at all. The only exception to this is when there is a failure of the bipolar equipment and there is a need to revert back to the monopolar equipment. In the event of this rare occurrence there is strict monitoring of glycine in compliance with recommendation 5.		Ensure robust and monitored control measures are in place for the use of Glycine within urology services	Mrs Mary McGeough (Head of ATICS)	Ongoing
	Within Urology Services a trial of bipolar resection equipment is currently being undertaken by all of the Urology Consultants. Glycine is still in use.		Complete trial of bipolar equipment - There are 4 pieces of equipment being trialled for 6 weeks each to allow the Team to agree which is the most suitable.	Mr Young (Lead Consultant Urologist)	31/03/2016
			Commece procurement process if equipment is deemed suitable	Mrs Mary McGeough (Head of ATICS)	31/03/2016

7. Investigate instilling irrigation fluid by using a pressure controlled pump device and purchasing flow/pressure controllers.	Infusion pumps are used by gynae teams Infusion pumps are not used by urology teams because at present the pumps are not deemed suitable		No action required Work is currently being carried out by Lead Urology Consultant and equipment supplier to improve the efficiency of the pumps for urology purposes – at present the pumps are not suitable. In the meantime flow is being regulated as per 6(a) and 6 (b) If the equipment is deemed suitable sufficient funding will be required to ensure procurement can proceed	- Urology Consultants led by Mr Young Dr Wright Medical Director	- 31/12/2015 31/03/2016

From a region wide perspective, Southern Trust is the only urological team that are unable to meet this guidance with Saline resection being routine in the other units.

I note Mr Young's recent email regarding this issue. As he states the ST urology team are in a vulnerable position were a TUR syndrome death or significant morbidity to occur where glycine was used as a resection medium.

Given the above information (which I am unsure was reviewed at the time of recent capital expenditure decisions), I wonder whether there is any potential for reconsideration of this issue?

Mark

Belfast to changing their equipment and technique, but over time there was a gradual adoption of bipolar TURP and other safe techniques such as laser prostatectomy.

59. Some years after this policy was developed I was contacted by phone by Dr Charlie McAllister, a consultant anaesthetist in CAH. I cannot be sure when exactly I received this call, but I believe it was sometime between 2017 and 2019. Dr McAllister wished to discuss TUR surgery, TUR syndrome and use of bipolar resection. He explained that they had an issue in CAH with an individual surgeon carrying out prolonged TURP resections with glycine and some "bad" TUR syndromes. He did not name the surgeon specifically. He wanted to know my experience with introducing TURP in saline. I explained that the experience in Belfast was good, that the technique was similar to monopolar TURP with glycine and that with modern equipment, in my view, it was unjustified and unsafe to continue to use glycine due to the safety profile of it as an irrigating fluid. From a personal perspective, I have carried out TURP in saline for around 10 years and see no justification for the use of glycine.

60. I cannot myself provide more detail in relation to this issue, but I have referred to it lest it is relevant to the Terms of Reference of the USI and the open questions that have been asked of me.

Conclusion

61. I have endeavoured to assist the USI through the provision of this witness statement. I hope I have answered the various questions posed to me in the section 21 notice. I have to accept that my memory will not be perfect, and consequently I may not have remembered all examples, or even remembered fully those examples that I do recall. However, I have done my best, and I will continue to assist the USI in any way I can.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: [redacted] _____

Date: 9 August 2023

69.7 Mr O'Brien also expressed concern at various points regarding the amount of time it took him to arrange things (e.g., elective admissions). It was clear from his descriptions that the issue he was facing was as a direct result of him not engaging with the wider support team available to him and electing to undertake many of the administrative tasks himself (e.g., phoning patients to advise them of planned admission dates / times, a task that the secretarial team undertake for all others). This was not due to a lack of available support but an unwillingness / inability to delegate these tasks appropriately to members of the wider team.

69.8 He expressed concern regarding volume of patient and GP enquiries, and yet could not recognize that, if he provided comtemporaneous written documentation to GPs, many of these enquiries would not have been necessary. As has subsequently been identified it would have also been the case that if he had ensured that every cancer patient had been seen with a CNS, many patient enquiries would have been able to have been addressed through the CNS team.

69.9 Mr O'Brien had raised a concern in an email regarding the DARO process (*please see 145. 20190207-email-patients awaiting results*). This is a 'safety-net' process whereby patients who have investigations requested are added to a list on the Patient Administration System which is then reviewed on a regular basis by secretarial staff to check if the investigation has been done and, when result is available, that it is passed on to the consultant for review and action. Although this email was not directed at me, I replied advising that the process was required for patient safety and should be followed. It has since become apparent that, despite this, Mr O'Brien and his secretary did not utilize the DARO list, and I believe this is a factor in patients who did not get test results reviewed and acted upon in a timely manner (e.g., Patient 5, Patient 92).

69.10 In August 2015, HSS(MD)14/2015 required trusts to take action with regard to a regional policy on the surgical management of endoscopic tissue resection. For urology teams this related to switching from monopolar transurethral resection (in glycine) to bipolar resection (in saline), with the work on the policy having been commissioned following a coroners verdict in October 2015. Mr

O'Brien engaged in the process of assessment of new bipolar resection equipment. However, he subsequently expressed the view that he would be continuing to use monopolar resection in glycine, thereby not conforming with the policy. On reflection, this unwillingness to conform with recommendations from others should have provoked concern regarding wider aspects of his practice, especially with regards to delivering treatment in line with NICE guidance / MDM recommendations. *Please see 7. 20181205 E re Transperineal Prostate Biopsy Equipment, 8. 20171120 E re Saline TUR, 9. 20171120 E re Saline TUR A1, 10. 20171120 E re Saline TUR A2, 11. 20171120 E re Saline TUR A3 and 12. 20171120 E re Saline TUR A4.*

69.11 Previously, concerns regarding the clinical decision making relating to emergency admissions were raised within the consultant urology team regarding a former consultant colleague (Mr Personal Information redacted by the USI). I believe it was Mr O'Brien who raised this concern following an emergency re-presentation of a patient he had operated on. These concerns were also backed up by some concerns from other members of the consultant team regarding some emergency admissions. These concerns were raised with the consultant in question and additional support was provided in addition to the consultant attending some educational courses regarding emergency urology. *Please see 77. 20151217 - Confidential Meeting* Personal Information redacted by the USI.

70. ~~**64.**~~ **Did you raise any concerns about the conduct/performance of Mr O'Brien?**

If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr. O'Brien, why did you not?

ID	Ref	Site	Directorate	Loc (Type)	Detail	Type	Incident date	Time	Days to report	Severity	Description	Consequence	Likelihood of recurrence	Grade	Lessons learned
Personal Information redacted by USI		CAH	ACUTE	THEATR	OTHTMT	CLINIC	05/02/2011	0920	1	LOW	Patient for a turp, this is the extra list. Patient subsequently developed turp syndrome and is presently still in Recovery Ward on prolonged observation. Staff went through 10 boxes irrigation fluid and he received 3 units of blood and required cardiology input. This patient was also a diabetic non insulin.	MIN2	LIKE4	6-11LO	

ID	Approval status	Description	Directorate	Site	Loc (Type)	Loc (Exact)	Division	Speciality / Team	Service Area	Severity	Incident date	Reported
Personal Information redacted by USI	Finally approved	A patient developed acute severe hyponatraemia during TURP surgery. He had general anaesthesia with an LMA and spontaneous ventilation (he was very anxious about having a spinal) and had an arterial line inserted after induction. His initial sodium on the ABG was 140 mmol/l. The surgeon told me that the blood loss was more than average and I did an ABG. This was about 30 minutes after surgery commenced. The patient's sodium was 131 mmol/l. I informed the surgeon who decided to limit surgery to the left side. I stopped his IV fluid (450ml of Hartmanns had been given). Fifteen minutes later his sodium was 122mmol/l and surgery was completed as soon as possible. I gave 40mg furosemide IV. Overall surgical time was 55-60 minutes. The patient had 25450 ml of glycine infused and there was 26400ml in the suction. The patient emerged from anaesthesia uneventfully and was transferred to recovery at approximately 17:15. His initial sodium in recovery was 126mmol/l (on an ABG). This was taken within 5 minutes of entering recovery. The patient was asymptomatic and remained so. I discussed him with the ICU consultant on call, who accepted care for the patient in recovery for electrolyte management and the patient was commenced on 1.8% NaCl at 50 ml/h. The lab U&E that was sent at 17:30, reported a sodium of 130mmol/l. He remained in recovery for 24h and was transferred back to the ward on Saturday evening when his sodium was 136mmol/l.	Acute Services	Craigavon Area Hospital	Anaesthetics/Theatres/ICU area	Theatres 1-4 CAH	Surgery and Elective Care	Anaesthetics	Anaesthetics, Theatres and IC Services	Minor	20/03/2015	23/03/2015
Personal Information redacted by USI	Finally approved	Patient undergoing TURP under spinal developped symptomatic hyponatraemia. Procedure using Glycine. Sodium checked at the beginning (Baseline = 141), then 30min after Glycine irrigation was started (138). After 60min, I advised the surgeon to stop the procedure in view of the length of the procedure (and 15,000mls of fluid irrigation). The following Sodium level came back markly low (127). Team leader was Ann Henning. The surgeon was Mr Suresh.	Acute Services	Craigavon Area Hospital	Anaesthetics/Theatres/ICU area	Theatres 1-4 CAH	Surgery and Elective Care	Theatres	Anaesthetics, Theatres and IC Services	Minor	24/01/2014	24/01/2014

Southern Health and Social Care Trust

Quality Care - for you, with you

Urology Cancer MDT Operational Policy - Agreement Cover Sheet

This MDT Operational Policy has been agreed by:

Position	Director of Acute Services
Name	Mrs Esther Gishkori
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal information redacted by the USI

Position	Clinical Director Cancer Services
Name	Dr Rory Convery
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal information redacted by the USI

Position	MDT Lead Clinician (on behalf of MDT members)
Name	Mr Anthony Glackin
Organisation	Southern Health & Social Care Trust
Date Agreed	1st September 2017
Signed	Personal information redacted by the USI

The MDT members agreed this Operational Policy on:

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

SECTION 1: STRUCTURE AND FUNCTION OF THE MDT

1.0 Purpose of the MDT

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

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

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

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

1.1 Membership Arrangements

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

Core Membership **(14-2G-101)**

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

Mr Glackin suggested TURP's was not a good diagnosis for prostate cancer.

Dr Hughes asked if there were any issues of concern raised outside MDM.

Mr Glackin advised management were aware of no nurses.

Dr Hughes advised he had spoken to AD in CCS who was not aware of issues.

Mr Glackin advised they did bring issues of concern a number of years ago. Their reaction was a shrug of shoulders and said "what do you want us to do".

Dr Hughes said he noted staff at MDM was generally locums and that oncology were not attending.

Mr Glackin said he had suggested suspending the Trust MDM due to attendance.

Dr Hughes advised one of the recommendations would be to provide resources for MDM.

Mr Haynes – AMD. He believes there is an enormous disconnection between services and feels consultants are blamed when they fail but at the same time CCS will take credit when they succeed. He referred to occasions where at MDM meetings issues were bounced back to urology. He asked what they can do.

Dr Hughes advised he attended a meeting and was stunned to hear staff was aware of the issues. He feels it's hard for staff if they feel isolated. He added when the report is complete staff need to feel supported.

Mr Glackin said there was no input from outside of MDM, no support from CCS.

Dr Hughes agrees staff do need support and feels supported to raise concerns. He suggested these concerns need minuted and actions taken. He advised he was going through the process of meeting families which has been quite upsetting to patients and their families.
Dr Hughes asked the meeting if they wanted to meet again or if they wanted to raise concerns directly they could contact him.
He advised he has struggled a little regarding the governance, he feels staff were told to sort out themselves which is not appropriate especially when people are paid. He questioned if there was the same issues in breast screening.

Mr Haynes advised breast screening was under the same remit; the same team CCS and they meet their targets.

Dr Hughes advised 8 or 9 recommendations from MDM were appropriate.
One of the safety checks to oncology, if had oncology been attending patient could have got referred.

Mr Glackin advised they use Belfast MDM. He suggested he doesn't feel comfortable making referrals to oncology. He added this has all been minuted at a governance meeting.

Dr Hughes advised them they focusing on the 9 patients.

Glackin, Anthony

From: Glackin, Anthony
Sent: 16 January 2017 10:32
To: Reddick, Fiona; Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: RE: Urology MDT Peer Review

Dear Fiona,
can I meet with you to discuss ongoing problems with quoracy at the Urology cancer MDM. The Urologists are coming to the view that this meeting is no longer sustainable in view of the pressures on our single handed Radiologist and the infrequent oncology attendance.

Kind regards

Tony

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton Personal Information redacted by the USI

From: Reddick, Fiona
Sent: 06 January 2017 11:49
To: Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: Urology MDT Peer Review

Dear all,

Please find attached the External Validation report from the recent validation process required for Urology Peer Review for circulation amongst all members of the Urology MDT.

This year Urology MDT were required to undertake a self- assessment which was then externally validated by the National Peer Review Team. We have been advised by HSCB that when MDTs are self -assessing that the feedback from National Peer Review team will be directly uploaded unto CQUINs rather than a formal feedback report coming into Trusts via Chief Executive.

As you can see the overall self- assessment score achieved 55% and this score of 55% was maintained by the external team.

The National Peer Review Team have indicated that the Urology MDT will have to undertake a self- assessment again in September 2017 and Mary Haughey will continue to work with the Urology MDT to prepare for this process.

I am conscious that at a Business meeting prior to Christmas leave that concerns were expressed by members re inadequate quoracy of the MDT particularly for Radiology and Oncology. I have escalated the concerns to Prof O'Sullivan Clinical Director – Cancer Centre and we are due to meet Tuesday 10th January to agree improved representation for Oncology input. Dr Gracey is aware of the concerns re Radiology.

Glackin, Anthony

From: Reddick, Fiona
Sent: 20 January 2017 17:13
To: Glackin, Anthony; Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: RE: Urology MDT Peer Review

Tony

Yes I understand that there have been and are ongoing challenges with quoracy at the Urology MDM. This has been escalated at HSCB level particularly from an Oncology perspective as the Lung and GU service is currently facing staffing issues. The North West Cancer Centre opened recently and recruitment of Oncologists there has depleted the service within Belfast Cancer Centre and there currently is not the same number of Oncology registrars available to provide cover within clinics.

Rory and I attended a meeting last week with colleagues from Belfast Trust and commissioners to explore options to address the current difficulties. I have highlighted that there is a risk that the Urology MDM here in SHSCT is at a point where full quoracy is making it extremely difficult to function. We are due to meet again next Friday and hope to have potential solutions agreed by then.

I am happy to meet with you in the meantime to discuss further.

Regards

Fiona

Fiona Reddick
Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Personal Information redacted by the USI
Personal Information redacted by USI

From: Glackin, Anthony
Sent: 16 January 2017 10:32
To: Reddick, Fiona; Carroll, Ronan; Clayton, Wendy; Corrigan, Martina; Haynes, Mark; O'Brien, Aidan
Cc: Convery, Rory; Glenny, Sharon; Haughey, Mary; Hogan, Martina; Trouton, Heather
Subject: RE: Urology MDT Peer Review

Dear Fiona,
can I meet with you to discuss ongoing problems with quoracy at the Urology cancer MDM. The Urologists are coming to the view that this meeting is no longer sustainable in view of the pressures on our single handed Radiologist and the infrequent oncology attendance.

Kind regards

Tony

Aimee Crilly

From: Glackin, Anthony [redacted]
Sent: 26 January 2017 10:30
To: Reddick, Fiona; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Cc: McVeigh, Shauna
Subject: RE: Radiology at Urology MDM

Dear Fiona,
please see below, we are at the point of closure.

Can you attend today's Meeting to discuss with those present.

Many thanks

Tony

From: McVeigh, Shauna
Sent: 26 January 2017 10:28
To: Glackin, Anthony; O'Brien, Aidan; Haynes, Mark; ODonoghue, JohnP; Young, Michael
Subject: Radiology at MDM

Hi,

Just to make you aware, I have been advised by Dr Williams that he won't be at MDT until 02 March due to combination of leave and departmental commitments.

Thanks

Shauna

Glackin, Anthony

From: McCaul, David
Sent: 26 November 2018 16:15
To: Yousuf, Imran; Glackin, Anthony
Cc: Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; Williams, Marc; McConville, Richard
Subject: RE: radiology presence?

Hi all it would be great if we have a long term solution

David

From: Yousuf, Imran
Sent: 26 November 2018 14:00
To: Glackin, Anthony; McCaul, David
Cc: Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; Williams, Marc; McConville, Richard
Subject: RE: radiology presence?

Hi Tony,
I am aware of the situation and am working with Richard to try and improve Urology MDT cover.
Urology MDT is on a Thursday which coincides with Richard's interventional list.
Presently , we do not have any other Radiologist who feels competent enough to provide Urology MDT cover. We only have two radiologists who can report prostate MRI scans.

The Urology MDT is a significant workload in terms of preparation time and Presentation. 1 full PA will be required in addition to training time. Hopefully, attendance will improve with further recruitment in the new year.

In the meantime, we can find ways to reduce Marc's "other" clinical commitments and also try to free up Richard in advance for leave cover. Happy to discuss in person.

Regards,
imran

From: Glackin, Anthony
Sent: 26 November 2018 10:19
To: Yousuf, Imran; McCaul, David
Cc: Reddick, Fiona; Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Dear Imran and David,
Please see the email trail below setting out the concerns of our Consultant Radiology colleagues at the Belfast Trust regarding the Craigavon Urology MDT meeting and Radiology cover.
As you are aware this is an ongoing issue. Since the departure of Dr McClure we have had Dr Williams attending as the sole Consultant Radiologist. Due to other clinical priorities he has not been able to attend every week.
The clinicians and Trust are in a very exposed position if a clinical decision made at the Craigavon Urology MDT meeting without the review of a Radiologist turns out to be incorrect and a patient(s) comes to harm.
I am seeking your advice on how we should proceed until such time as a Radiologist can attend all meetings.
For completeness it should be noted that we do not have oncology input present at the Craigavon Urology MDT meeting, except over the video link from the Specialist Urology MDT meeting when we link in for cases listed for central discussion. That is to say that the majority of cases do not have the benefit of an oncology opinion either.

MDM Date	Mr Anthony Glackin	Mr Mark Haynes	Mr John O'Donoghue	Mr Matthew Tyson	Mr Nasir Khan	CONSULTANT UROLOGIST (x2)	Dr Gareth McClean	CONSULTANT PATHOLOGIST (x1)	Dr Marc Williams	Dr Richard McConville	Dr Ryan Connolly	CONSULTANT RADIOLOGIST (x1)	Dr Adam Uprichard	MEDICAL ONCOLOGIST (x1)	Dr Elizabeth Baird	CLINICAL ONCOLOGIST (x1)	Mrs Leanne McCourt	Mrs Kate O'Neill	Mrs Patricia Thompson	CLINICAL NURSE SPECIALIST (x1)	Miss Shauna McVeigh	Cover	MDT CO-ORDINATOR/TRACKER (x1	QUORATE	Reason for not being quorate
06/01/2022	1	1	1	1	1	Y	1	Y	1	0	0	Y	1	Y	0	N	1	0	0	Y	1	0	Y	No	No Clinical Oncologist
13/01/2022	No MDM																								
20/01/2022	1	1	1	1	0	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
27/01/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	1	1	Y	1	0	Y	No	No Radiologist
03/02/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
10/02/2022	1	0	1	0	0	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
17/02/2022	1	1	1	0	1	Y	1	Y	0	0	0	N	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
24/02/2022	1	0	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	0	1	Y	Yes	
03/03/2022	1	0	1	1	0	Y	1	Y	0	0	0	N	1	Y	0	N	1	0	1	Y	0	1	Y	No	No Radiologist or Clinical Oncologist
10/03/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Radiologist
17/03/2022	No MDM																								
24/03/2022	1	0	1	1	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
31/03/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
07/04/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	Yes	
14/04/2022	1	0	0	1	0	Y	1	Y	1	0	0	Y	0	N	0	N	1	0	1	Y	1	0	Y	No	No Clinical or Medical Oncologist
21/04/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
28/04/2022	No MDM																								
05/05/2022	1	1	1	0	1	Y	0	N	1	0	1	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
12/05/2022	1	0	0	1	1	Y	0	N	1	0	1	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
19/05/2022	1	1	1	1	0	Y	0	N	0	0	1	Y	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
26/05/2022	0	0	1	0	1	Y	0	Y	1	0	0	Y	0	Y	1	Y	1	1	0	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced

(ii) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.

(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?

(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

49.1 a. On the clinical aspects there were some discrepancies in the practice of individuals in terms of choice and usage of antibiotics.

49.2 i. & ii. For example, Mr Aidan O'Brien admitted a patient for administration of intravenous antibiotic just based on the symptoms. I do not recall the exact date or month. I directly discussed with him, during the joint ward rounds, about seeking the advice of microbiologist. He paid attention to my suggestion and acted accordingly. I recall Mr O'Brien contacting the microbiologist over the telephone on the same day and decided to withhold the antibiotic and to wait for culture reports. I cannot recall the exact date nor the details of the patient.

49.3 a. 2 I can also recall of a patient under the care of Mr. O'Brien, being on unconventional treatment for prostate cancer – being treated with low dose tablet bicalutamide, over a few years. I noticed it when a patient turned up in my clinic for the follow up. I do not recall the exact date.

49.4 I copied my clinic letter to Mr. O'Brien with my concern that it was unconventional treatment and added in the agenda of the next Urology Multi-disciplinary team meeting. The consensus was that treatment with long term low dose bicalutamide was unconventional and that Mr O'Brien was to review the patient in the clinic and to discuss the appropriate options with the patient. I remember the presence of Mr. Aidan O'Brien in the meeting but cannot recall the entire attendance.

49.5 iii. In my view, the deviation from the antibiotic policy or long term treatment of prostate cancer with low dose bicalutamide could have had negative impact on patient's care and safety. That's why I acted promptly by discussing the issues directly with Mr Aidan O'Brien and in the relevant meetings as mentioned previously.

49.6 iv. Mr Aidan O'Brien was in agreement with views of all other consultants and therefore there was no need for me get involved further. I do not know whether any measures were taken to monitor implementing the changes. However, there was antibiotic stewardship undertaken by pharmacists reviewing prescriptions of antibiotics for inpatients.

49.7 v. I recall, circulation of emails by pharmacists the data on prescription of antibiotics and any breaches in compliance. These emails were circulated to all the consultants. So, I presumed, it would be the duty and responsibility of individual consultants to ensure compliance with the policy. I do not know any further measures taken in this regard.

49.8 vi. I was not given any assurance by anybody. But, I was aware of ongoing antibiotic stewardship by pharmacists.

49.9 vii. I can just recall that, with continued antibiotic stewardship, the breaches from compliance in antibiotic prescription across the trust were getting less and less.

49.10 viii. I do not know who monitored the antibiotic stewardship. I think, the chief pharmacist may be able to answer this question.

50. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in

Angela Kerr

From: Mitchell, Darren < [redacted] >
Sent: 20 November 2014 13:35
To: O'Brien, Aidan
Subject: [redacted]

Aidan –could I ask you to have a look at this case which was passed to me as the regional MDT chair.

Looks like young man with high grade organ confined disease from 2012. From my prospective he would have been considered for neo-adjuvant hormones for 3-6months followed by EBRT in early 2013. He may have been suitable for combined EBRT + BT (pending LUTS assessment). His high grade disease would have encouraged us to offer him 2-3years of adjuvant hormonal therapy after EBRT depending on 2008 or 2014 NICE guidelines and pt tolerance.

I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monotherapy.

I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation.

I'm not aware of supportive research for 24months of neo-adjuvant hormones prior to EBRT but the trans-tasmin group 0 vs 3 vs 6 and the Canadian 3 vs 8 are already quoted in our radiotherapy protocol and based on those studies we typically think of 6 months neo-adjuvantly in this kind of case.

6 months of LHRHa prior to EBRT is also recommended in the STAMPEDE protocol for men with high risk non-metastatic disease who are for radical radiotherapy.

I'm also told that he was on Bicalutamide 50mg OD for the first year of his management.

The NICAN hormone protocol (in process) would be useful in standardising our therapy across the region but Bicalutamide 50mg is not licenced for mono-therapy use and will not be recommended in the protocol other than within the licenced context for the management of flare with LHRHa.

The MRHA site provides information on 'off-label' prescribing and our responsibilities within that.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990

Happy to discuss this further.

Southern Health and Social Care Trust

UROLOGY
OUTPATIENTS LETTER

Craigavon Area Hospital
68 Lurgan Road
Portadown
Co Armagh
BT63 5QQ

Consultant Urologist: Mr Mark Haynes
Telephone: Personal Information redacted by the USI

Patient 139
Personal Information redacted by the USI

Dear Patient 139

Re: Patient Name: Patient 139
D.O.B.:
Address: Personal Information redacted by the USI
Hospital No: Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI

Date/Time of Clinic: 02/12/2020	**Follow Up:** CNS telephone review 2 weeks

Diagnosis:
Small volume intermediate grade prostate cancer diagnosed on prostate biopsy late 2009/early 2010
Commenced on Bicalutamide 50mg early 2010 and remains on Bicalutamide 50mg and Tamoxifen10mg
Recent PSA May 2020 0.1

Outcome:
Recommend treatment
Discontinue Bicalutamide and Tamoxifen and move to surveillance strategy for managing prostate cancer
Alternative option switch to LH RH analogue as androgen deprivation therapy

I write following our telephone consultation on 2nd December 2020 during which I spoke with your wife. We discussed your diagnosis of prostate cancer which was made on prostate biopsy performed in late 2009/early 2010. The prostate biopsy you had at the time had shown a single small focus of intermediate grade prostate cancer in a single core taken from your prostate. An MRI scan performed as part of your staging investigations was satisfactory and showed features consistent with a small organ confined (cancer which has not spread outside of the prostate or spread elsewhere prostate cancer). You were commenced on treatment with Bicalutamide 50mg and Tamoxifen 10mg at this time and have remained on this treatment since. Your prostate blood test is low at 0.1.

We discussed on the phone that the treatment you are currently taking is a dose of Bicalutamide which is not licensed for use and evidence shows it is an inferior

treatment to the licensed and recognised treatments. This is the case now and was the case in 2010. There is also concern that patients treated with this low dose of Bicalutamide are at risk of having a less favourable outcome from their prostate cancer than those treated on the licensed dose.

For men who present with small volume intermediate grade prostate cancers such as yours the standard recognised treatment options are those of active surveillance or consideration of curative treatment with either surgical or radiotherapy. Hormone treatment alone is not a recommended treatment for small volume early prostate cancer as studies show that hormone treatment does not prolong life expectancy and there are risks associated with longterm hormone treatment.

Active surveillance is a treatment where men do not have any active treatment for their prostate cancer but remain under follow up with regular blood tests and more recently regular MRI scans have become part of active surveillance protocols. The purpose of active surveillance is to identify those men whose prostate cancers do need treatment as a significant number of men with prostate cancer such as yours will never need treating for their prostate cancer during their lifetime. This is very likely the case with your prostate cancer.

Curative treatments such as surgery or radiotherapy are also offered at diagnosis and may also be offered to patients who have been treated previously with active surveillance where there are signs of the prostate cancer growing.

Hormone treatment alone does not rid a man of prostate cancer and only works for a temporary period. It reduces the growth of prostate cancer but does not stop it growing and over time prostate cancers develop the ability to grow despite the hormone treatment.

As discussed on the phone given that you had a small volume prostate cancer at diagnosis which would have been entirely suitable for active surveillance this would remain my recommended treatment options for your going forward. Therefore my recommendation is that you should stop the current Bicalutamide 50mg and Tamoxifen 10mg treatment. The advantage of this to you is that any side effects that you experience from the Bicalutamide will cease and in addition the risk of longterm effects of hormone treatment will not be a continued concern. If on surveillance we find that your prostate cancer were to be growing then we would be able to reassess the prostate cancer and consider a curative treatment if the cancer remains suitable for curative treatments.

If you do not wish to stop hormone treatment and wish to continue hormone treatment as a longterm treatment recognising that evidence shows that this treatment will not increase your life expectancy and that continued hormone treatment does continue to give side effects then the recommended hormone treatment would be an injection treatment which is given every three months. If you were to elect to proceed with this treatment there would need to be a two week overlap with your current Bicalutamide treatment after your first injection treatment (the injection treatment is Decapeptyl 11.25mg intramuscularly). An alternative hormone treatment would be to increase your Bicalutamide dose to 150mg daily. The recommended hormone treatment however is the injection treatment.

Southern Health and Social Care Trust

UROLOGY
OUTPATIENTS LETTER

Consultant Urologist: Mr Glackin
Secretary: Elizabeth
Telephone: Personal Information redacted by the USI

Personal Information redacted by the USI

Dear DR Personal Information redacted by the USI

Re: Patient Name: Patient 139
D.O.B.: Personal Information redacted by the USI
Address:
Hospital No: Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI

Date/Time of Clinic: 22/02/16	**Follow Up:** PSA write with results

Diagnosis: Gleason 7 adenocarcinoma of the prostate involving 1 core from the right apex diagnosed January 2010.
Initial PSA 11.3ng/ml.
MRI indicates T2b N0 disease April 2010.

Current Management: Bicalutamide 50mg once daily, Tamoxifen 10mg once daily.

This gentleman was reviewed as a long waiter in my clinic this evening. He does not report any bothersome lower urinary tract symptoms. He is tolerating his Bicalutamide and Tamoxifen very well.

His PSA was 0.74ng/ml in March 2015. This has been repeated this evening. I note that his U+E and alkaline phosphatase were both normal on 2nd February 2016. I will write to Patient 139 with the result in due course. If the result is stable then he remains suitable for continued Bicalutamide monotherapy. Kind regards.

Yours sincerely

Mr AJ Glackin, MD FRCSI (Urol)
Consultant Urologist

Results
PSA 1.02ng/ml

Date Dictated: 22/02/16	**Date Typed:** 24/02/16 - ET

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	13:43

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	17/05/2017
Time (hh:mm)	16:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at MDM 12th January 2017. Outcome = to be referred to endocrine MDM. Unfortunately this did not happen. Further GP referral 12/5/17 brought this to my attention and a referral has now been done.
Action taken Enter action taken at the time of the incident	Referral made to endocrine MDM on 17/5/17 (4 month delay). See ECR for relevant letters etc.
Learning Initial	
Reported (dd/MM/yyyy)	18/05/2017
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	23/11/2017
Were restrictive practices used?	
Does this incident involve a safeguarding concern which is alleged/confirmed?	
Has safeguarding been considered?	
Has an APP1 been completed?	
Last updated	Martina Corrigan 12/05/2017 16:14:55
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 137

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery

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

14 August 2018 Ref: Datix: [redacted] ID: [redacted]

Private and Confidential

Mr Michael Young
Consultant Urologist

Re: [redacted]

Dear Michael

This Datix Report has been reviewed by the Surgical Adverse Incident Screening Panel, of Mr M Haynes, Mr R Carroll and Mrs T Reid on Tuesday 9th January 2018 in relation to the delay in referring [redacted] to the Endocrine Service in the Belfast Health and Social Care Trust.

On 12th January 2017 [redacted] was discussed at the Urology MDM. Please see attached Appendix 1- Urology MDM outcome.

This MDM outcome was not actioned, and on the 12th May 2017 [redacted]'s GP sent a referral letter to Urology highlighting that [redacted] had not received an appointment. On receipt of this letter a referral was then made to Endocrinology by another consultant Urologist on 18th May 2017.

The review team concluded that following MDM, any actions must be progressed by the Consultant nominated as responsible for the action required as per the MDM outcome report. Referrals for specialist care need to be sent from Consultant to Consultant.

Can you provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner?

Yours sincerely

[redacted]

Associate Medical Director

David Cardwell

SHSCT GOVERNANCE TEAM (IR2) Form - NEW June 2018.

Incident Details
ID & Status

Incident Reference ID	Personal Information
Submitted time (hh:mm)	20:25

Incident IR1 details

Notification email ID number	Personal Information
Incident date (dd/MM/yyyy)	20/11/2014
Time (hh:mm)	17:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient discussed at Urology MDM on 20th November 2014. Recorded outcome Patient 102's Re-staging MRI scan has shown organ confined prostate cancer for direct referral to Dr H for Radical Radiotherapy. For OP Review with Mr O'B.' Was reviewed by Mr O'B in OP on 28th November 2014. No correspondance created from this appointment. Referral letter from GP received 16th October 2015 stating that Patient 102 had not received any appointments from oncology.
Connie Connolly 18/11/2015 14:31:09	PATIENT DISCUSSED AT UROLOGY M
Action taken Enter action taken at the time of the incident	Patient 102 has now been referred to Oncology. This has been done by email and letter. Investigation with MDM team, direct referral was generated at CAH but no record of being received in Belfast.
Learning Initial	
Reported (dd/MM/yyyy)	21/10/2015
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	18/11/2015
Were restrictive practices used?	
Does this incident involve a safeguarding concern which is alleged/confirmed?	
Has safeguarding been considered?	
Has an APP1 been completed?	
Last updated	Andrew Noble 01/31/2023 13:50:39
Andrew Noble 31/01/2023 13:50:39	David Cardwell 06/17/2016 09:17:40
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 102

Location of Incident

48. Of much less significance was the inappropriate correspondence Mr O'Brien sent to both the patients and me. It placed unreasonable pressure on me to carry out a treatment plan in two patients that was not in the best interests of the patient, and which was not supported by the regional MDM. I have provided the USI with a 27 September 2010 letter that Dr Rankin, the then Southern Trust interim Director of Acute Services, ultimately wrote to Mr O'Brien about the correspondence he had sent.

49. I did also subsequently receive an email on 3 October 2010 from the PHA's Dianne Corrigan acknowledging that the correspondence written by Mr O'Brien was not helpful. Ms Corrigan said:

> *"Dear Chris*
>
> *I meant to speak to you at Friday's meeting but did not get an opportunity. I wanted to thank you and your colleagues for accepting the CAH cancer transfers at such short notice and operating so promptly on the first couple.*
>
> *I heard from Mark Fordham that letters were sent from the CAH consultant to the patients' GPs, the patients and yourself which were not helpful. When you were going out of your way to do something which was in the best interests of the patients concerned that must have been hard to take. Things will get better."…*

2016 delay in referral of patients from CAH

50. The Urology Services Inquiry has also asked at question 6 in the section 21 notice about an issue I raised in 2016 in respect of a delayed referral of a case from CAH for consideration of cystectomy and the conducting of unnecessary tests. On 21 June 2016 I expressed my concern about this to Ms Lee, the then Oncology Service Manager in the Belfast Trust.

51. In patients with muscle invasive bladder cancer, patients treated more than 90 days after primary diagnosis show a significant increase in extravesical disease (81% vs

AOB10

MailMeter

Message ID - 98b2777eeb5d4efabe32a36308cf1a29 - 203615745
Archived on 26/08/2016 12:19:54. Printed on 18/05/2023 05:51:20.

Time Sent	26/08/2016 12:19:39
Time Received	26/08/2016 12:19:39
Time Archived	26/08/2016 12:19:54
From:	mitchell, darren < [redacted] >
To	aidan o'brien [redacted]
CC	mcveigh, shauna [redacted]
Subject:	Case for review
Attachments	Patient 127 [redacted]pathway.xls 33.0 KB

Aidan – this was one of the bladder cases flagged up from the review of timelines for muscle invasive bladder cancer – I think she has been seen by Chris Hagan and was deemed unfit for surgery.

We' ll review it here and I suspect you' ll want to do a case note review there and see if there is any shared learning from it either regionally or locally?

Thanks

DMM

Dr DM Mitchell FRCR
Consultant in Clinical Oncology
Northern Ireland Cancer Centre
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB

☎ - [redacted]
✉ - darren.mitchel[redacted]
Secretary - elizabeth.burgess[redacted]

1.5 Chairing of meetings

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

1.6 MDT Review (14-2G-103)

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

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

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

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

Responsibilities of the MDT Coordinator:

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

Staging:

MDMUpdate

CONSULTANT MR GLACKIN: This Personal Information redacted by the USI **gentleman had a CT urogram which has demonstrated a filling defect in the bladder and a large prostate gland. He does not report any bothersome lower urinary tract symptoms. He has type II diabetes controlled with diet. His U+E showed an EGFR greater than 60 and his haemoglobin was 154g/L. He is a current smoker of 5-7 cigarettes per day having previously smoked 15-20 cigarettes per day. Flexible cystoscopy showed a normal urethra. He has an enlarged prostate which protrudes into the bladder. I was unable to see either ureteric orifice due to the shape of the bladder neck. He has a papillary bladder tumour in the region of the right UO and right lateral wall. Digital rectal exam finds an enlarged prostate with a soft smooth nodule in the mid line. This does not feel suspicious. TURBT, 22.12.17 - await pathology.**

MDMAction

Discussed at Urology MDM 28.12.17. Defer for pathology.

	Surgeon	Oncologist	Clinician	Palliative Medicine
	O'DONOGHUE J P MR (C8245)	None	None	None
Personal Information redacted by the USI	DOB: Personal Information redacted by the USI Age:	Personal Information redacted by the USI	Personal Information redacted by the USI	Target Date 06/12/2017

Diagnosis: Prostate cancer

Staging:

MDMUpdate

CONSULTANT MR O'DONOGHUE: This Personal Information redacted by the USI **gentleman was referred with symptoms suggestive of polymyalgia rheumatica. He has been started on steroids and his symptoms have improved. His PSA on 31st August was 4.92ng/ml, a repeat PSA on 26th September was 5.25ng/ml. His**

Subject: RE: CAH [redacted] Patient 138
From: Glackin, Anthony
To: Troughton, Elizabeth
Cc: ONeill, Kate [redacted], Graham, Vicki
Sent: 26/10/2018, 09:32:09

Liz

Please advise the surgery:

Book patient to next available slot CAJGUO or CAJGTDUR to see me. Will need flexi same day.

Prev pTa G2 TCCB, low risk disease in 2017

Thanks

Tony

From: Troughton, Elizabeth
Sent: 25 October 2018 11:42
To: Glackin, Anthony
Subject: CAH [redacted] Patient 138

Hi Tony,

This patient's GP contacted me with a query about this patient's follow up following his TURBT in 2017. I have checked it with Shauna and there has been a mistake made and this patient has never been discussed. He was listed for 28/12/2017 and he was deferred for Pathology. Their tracking was closed off as he had a low grade bladder cancer. Shauna has told me she will have him listed for discussion this week.

What do I tell the GP practice? I was speaking to [redacted]

Thanks

Regards

Liz