Southern Health and Social Care Trust

UROLOGY
RESULTS LETTER

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

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

05/05/20

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Patient 139
D.O.B.:
Address: Personal Information redacted by the USI
Hospital No: CAH Personal Information redacted by the USI **H&C No:** Personal Information redacted by the USI

Diagnosis: Gleason 7 prostate cancer involving 1 core from the right apex diagnosed January 2020.
Initial PSA 11.3ng/ml.
MRI indicates T2b N0 disease April 2010.

Current management: Bicalutamide 50mg once daily, Tamoxifen10mg once daily.

Thank you for checking this gentleman's PSA, LFT and U+E on 1st May. All the results are satisfactory. PSA is 0.1ng/ml. Patient 139 should continue with his current prostate cancer medication. I will copy this letter to him enclosing a form so that he can have his blood test repeated in November 2020. If Patient 139 is having any problematic urinary symptoms and wishes to be seen at clinic I would be grateful if he would contact my secretary at the telephone number above. Kind regards.

Yours sincerely

Dictated but not signed by

Mr AJ Glackin, MD FRCSI (Urol)
Consultant Urologist

358 Q. And you've --
A. So I haven't had recourse to his paper notes, but I've had recourse to his electronic care record. So, I don't recall meeting this person. And I reviewed, I presume, as would be my practice, I would have reviewed the previous letters. I would have reviewed his chart, if it was available at the time of the clinic, and I took the view that this 79-year-old gentleman with small volume Gleason 7 was not going to be a candidate for curative treatment at six years down the line. His comorbidity would have precluded that. And, therefore, in my mind, in these patients my thinking would be, "Well, he's either for watchful waiting", which would have been my typical approach in this setting, or if the patient develops metastatic disease, they should be for an LHRH analogue. 15:10 15:10 15:10

This patient was already established on treatment. Regretfully, I didn't stop that treatment. Possibly - in fact, not possibly, I should have. I may have had reason for not stopping his treatment; the patient may have expressed to me at the time a desire to remain on treatment. It's my experience that many prostate cancer patients experience an anxiety surrounding their diagnosis and that anxiety is compounded by the periodic testing that we put them through to see is their disease progressing. And I have had it expressed to me by patients: "Can you give me something for my disease?" Now, that's not a reason, in my view, to 15:10 15:11

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.

As discussed on the phone I hope this letter clearly outlines the options and recommendations for treating your prostate cancer going forward.

My recommendation is to discontinue the hormone treatment and move on to surveillance. I have requested one of the Urology Clinical Nurse Specialists to contact you in two weeks again by telephone to discuss your thoughts regarding your treatment options and hopefully make a decision as to how you wish to take things forward.

Yours sincerely

dictated but not signed by

Mr M Haynes, MD FRCS (Urol)
Consultant Urologist

CC Personal Information redacted by the USI

CNS Urology Nurse, CAH

Date Dictated: 03/12/2020	**Date Typed:** 03/12/2020-lh

	Referral was made to Endocrinology by consultant urologist on 18/05/2017.
Summary of discussions re SAI / RCA/ major / catastrophic incident review:	Discussions considered. The current process for tracking cancer patients Was this an isolated occurrence? Further information required-discuss current process with Fiona Reddick **21/09/2017** – Patient 137 has been reviewed by the endocrine team and is for discussion with radiology but likely outcome will be ongoing surveillance Discussions concluded that while this is not an SAI there is learning regarding the processes in MDM. This incident is to be shared with Mr Glackin chair of MDM for discussion regarding current processes **20/10/2017-** Review by Ms Eatok (RVH Endocrine) CT scan of adrenal gland has not shown any change from the previous one. Ms Eatok plans to repeat the scan in 1 year's time. Outcome discussed at screening – NOT SAI **09/01/2018** – Not SEA. Send information to Mr Haynes to see if letter is required. Not SAI – meeting being organised with Chair of MDM – discussed outcome of findings – does this case need included in letter to MY- **27/02/2018** - ? needs letter **14/3/18** – Mr Haynes agreed that a letter should be sent to Mr Young seeking confirmation that his team has a process in place to ensure that MDT outcomes are actioned. **30/04/2018** letter ready for signing 11 07 2018 printed for signing 24/07/2018- Mr Haynes on leave letter to be signed on his return. **Mr Carroll updated 31.7.18 Mr Carroll & Dr Scullion updated – Letter to be signed on Mr Haynes return** **Letter given to Mr Young on 15/08/18**
Decision on Level Review Type AND rationale for this:	Not SEA process to re MDM to be reviewed with Mr Glackin meeting being organised by governance team
Nominated Review Team: *(Consider need / benefit of independent external expertise)*	

1.0 EXECUTIVE SUMMARY

XX was referred to urology services on 20 February 2019 in view of a growth on his foreskin. He was referred for urgent circumcision which was performed on 10 April 2019. Histology confirmed squamous cell carcinoma. There was both lymphovascular invasion and perineural infiltration, both of which are associated with an increased risk of metastatic disease at presentation or subsequently. The MDM – which was a virtual meeting conducted by a single urologist recommendation was that Dr 1 would review XX and arrange for a CT scan of XX's chest, abdomen, and pelvis to complete staging.

He was referred to the regional penile cancer service in February 2020.

On Personal Information redacted by the USI XX passed away. The review team wish to extend their sincere sympathies to his wife and family.

2.0 THE REVIEW TEAM

Dr Dermot Hughes – External Independent Chair: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN).
Mr Hugh Gilbert - Expert External Clinical Advisor from the British Association of Urological Surgeons BAUS
Mrs Fiona Reddick – Head of Cancer Services (SHSCT)
Ms Patricia Thompson – Clinical Nurse Specialist (Formally SET recently SHSCT)
Mrs Patricia Kingsnorth – Acting Acute Clinical and Social Care Governance Coordinator (SHSCT)

3.0 SAI REVIEW TERMS OF REFERENCE

The aims and objectives of this review are to:

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology.
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes.
- To engage with patients / families to ensure where possible questions presented to the review team or concerns are addressed within the review.
- To develop recommendations to establish what lessons are to be learned and how our systems can be strengthened regarding the delivery of safe, high quality care.
- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/ Medical Director of SHSCT/ HSCB/ Family/ Staff involved in the care.

Personal Information redacted by the USI

8.0 LESSONS LEARNED

- The MDM should be quorate.
- If the MDM is not quorate, an accountable Chair should ensure, through appropriate Quality Assurance (QA), that every patient's potential management options are fully discussed and that the MDM's decisions are documented as having been communicated with the patient, their family, and their GP.
- A MDM Chair should ensure appropriate and a comprehensive Quality Assurance (QA) programme, that ensures adequate compliance with the MDM's published guidelines.
- All patients should be independently assigned a Key Worker, usually a cancer nurse specialist, to guide and advise them of their options.
- The MDM should regularly revisit their guidelines and policies to ensure best practice continues to be followed.
- The MDM should agree and audit, as part of QA, the indicative timings for the stages in cancer management.
- All patients whose disease fits the criteria for referral to a specialist MDT should be referred for advice and management at the completion of staging.
- Specialist urological cancer interventions should be delivered by appropriately experienced clinicians, normally at a specialist centre, who continue to demonstrate audited outcomes.

References

1. EAU guidelines for penile cancer: section 6.2.1 (2019)
2. NICE improving outcomes in urological cancer (2002)
3. NICAN Urology Cancer Clinical Guidelines (March 2016), Penile Cancer treatment Section 9.3 (3).
4. Peer review Self-Assessment report for NICaN 2017.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

A MDM Chair should develop an appropriate and comprehensive Quality Assurance programme that ensures adequate compliance with the MDM's published guidelines.

Recommendation 2

The MDM should agree and audit, as part of QA, the indicative timings for the stages in cancer management.

8.0 LESSONS LEARNED

The review identified Cancer Care given by Dr 1 that did not follow agreed MDM recommendations nor follow regional or national best practice guidance. It was care given without other input from Cancer Specialist Nurses, Oncology and palliative care. It was inappropriate, did not meet patient need and was the antithesis of quality multidisciplinary cancer care.

Ensure all patients receive appropriately supported high quality cancer care irrespective of the professional delivering care.

Ensure all cancer care is multidisciplinary and centred on patients physical and emotional need.

Have processes in place to provide assurances to patients and public that care meets these requirements.

That the role of the Multidisciplinary Meeting Chair is defined by a Job Description with specific reference to Governance, Safe Care and Quality Care. It should be resourced to provide this needed oversight.

9.0 RECOMMENDATIONS AND ACTION PLANNING

The recommendations represent an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialist appropriately in care. They are to address what was asked of the Review by families - "that this does not happen again".

Recommendation 1.

The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.

This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.

Timescale – Immediate and ongoing

Assurance - Comprehensive Pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review / External Service Review by Royal College.

Recommendation 2.

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.

9.0 RECOMMENDATIONS AND ACTION PLANNING

This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.

Timescale - Immediate and ongoing

Assurance - Comprehensive Cancer Pathway audit and Patient experience.

Recommendation 3.

TheSHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collatorative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated.

Timescale – Immediate and ongoing

Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, numbers of issues outstanding.

Recommendation 4.

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.

This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans.This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).

Timescale - 3 months and ongoing

Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology / Palliative Care etc.

Recommendation 5.

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.

This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers. A report should

CNS's are an integral part of the cancer MDT. They attend my uro-oncology clinic each week to support patients and provide advocacy. They are in the room for all face-to-face consultations. Lines of communication are open and effective. We engage on a daily basis. I value them and I know from formal feedback that this is reciprocated. I consider that 5 CNSs is sufficient to provide for the needs of our Department and to ensure patient safety.

25.2 The in-patient Urology Theatre at Craigavon has been fortunate to have two excellent lead nurses during my tenure. Despite staffing challenges, they have provided us with a safe theatre environment. On occasions, productivity has been impeded by lack of experienced staff.

25.3 The ward situation has been difficult over the last 10 years with a heavy reliance on agency staff and a lack of consistent senior management. We have suffered from the loss of a dedicated Urology ward. This resulted in patients being nursed on wards where staff were unfamiliar with urology care. Even when the ward was reconstituted on 3 South, there were problems with nurse recruitment and retention of senior nurses to run the Urology ward. We have lost many dedicated experienced nurses from the Urology team.

26. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Do you consider that the specialist cancer nurse, and all nurses within Urology, worked well with Consultants? Did they communicate effectively and efficiently? If not, why not.

26.1 I refer to the first paragraph of my answer to Q25. Essentially there is little difference in the roles of specialist cancer nurse and urology clinical nurse specialist other than the proportion of their time spent dealing with cancer or benign urological conditions. Both have consulting skills and deliver holistic care.

SECTION 3: PATIENT EXPERIENCE

3.1 Key Worker (14-2G-113)

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

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

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

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

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

Key responsibilities of the Key Worker:

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

Northern Ireland Cancer Patient Experience Survey 2015
Southern Health & Social Care Trust

Clinical Nurse Specialist

	Q21. Patient given the name of the CNS in charge of their care		Q22. Patient finds it easy to contact their CNS		Q23. CNS definitely listened carefully the last time spoken to		Q24. Get understandable answers to important questions all/most of the time	
Cancer type	**This Trust**	**N.I.**	**This Trust**	**N.I.**	**This Trust**	**N.I.**	**This Trust**	**N.I.**
Breast	94%	94%	80%	83%	95%	92%	95%	93%
Colorectal / Lower Gastro	62%	63%	93%	90%	100%	95%	96%	96%
Lung		69%		82%		91%		90%
Prostate		70%		81%		97%		98%
Brain / CNS		73%		80%		82%		80%
Gynaecological		82%		78%		94%		88%
Haematological	82%	70%	90%	90%	95%	94%	97%	92%
Head and Neck		69%		82%		96%		92%
Sarcoma		83%		100%		100%		89%
Skin		42%		92%		100%		93%
Upper Gastro		66%		89%		93%		92%
Urological	48%	53%	88%	82%	90%	95%	90%	89%
Other Cancers		62%		78%		95%		96%
All Cancers	71%	72%	85%	85%	95%	94%	95%	93%

In our team, the CNSs also have a range of procedural skills such as flexible cystoscopy, urodynamics, botulinum toxin injections and prostate biopsy. Some of the CNSs are independent prescribers.

26.2 I understand that not all of my colleagues worked in the same manner with the urology cancer CNS's. Kate O'Neill and Leanne McCourt Urology cancer CNS's told me that they found that communication was difficult with some consultants and that they were not invited to be present at uro-oncology consultations.

27. What is your view of the working relationships between nursing and medical staff generally? If you had any concerns, did you speak to anyone and, if so, what was done?

27.1 Overall, I believe that medical and nursing staff worked well together to the benefit of patients despite the many challenges they faced. Apart from my answer above, 26.2, I did not have any concerns regarding the working relationships between nursing and medical staff.

28. What is your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain why, and whether you raised this issue with anyone (please name and provide full details).

28.1 I have courteous professional and effective communication with all members of the administrative team. In my experience the relationships between the Urology Consultants and administrative staff including secretaries was good. I refer to my answer to Q20. I consider that I had appropriate administrative support to fulfil my primary role as a consultant. I refer to my answer to Q23.

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

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

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

Notes of the Meeting.

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

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

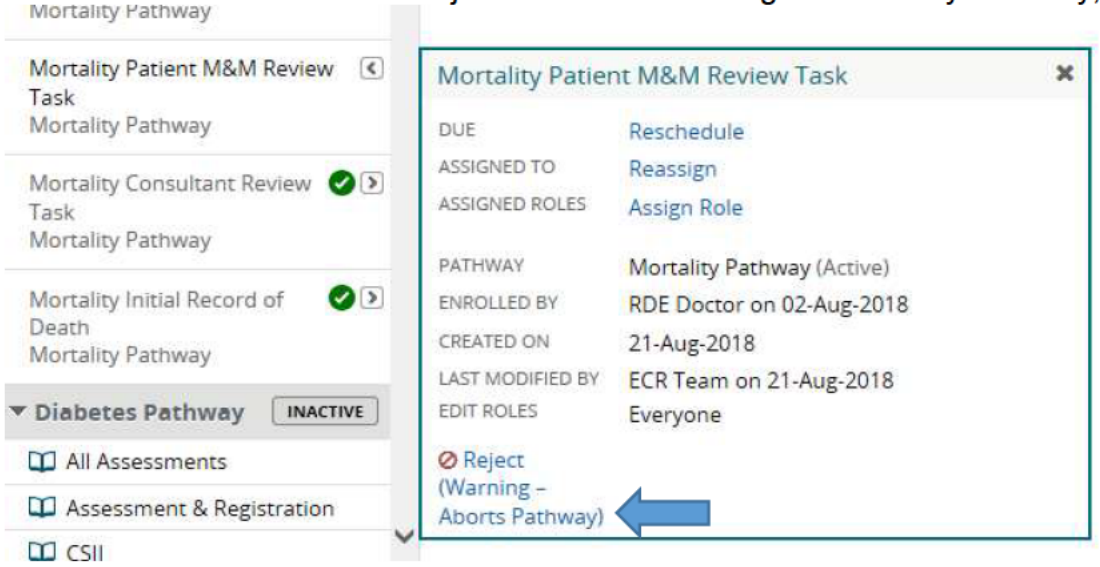
Mr Glackin (AG)- advised that there were only two urology clinical specialist nurses in the Trust to support urology cancer patients and recently the trust have appointed a new clinical specialist nurse from the SET. The nurses are available for clinics held in the acute setting. However, there would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

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

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

General

33. To help deter the use of the 'Reject' button available on every pathway form, which disables the pathway, the button now includes additional text 'Reject (Warning – Aborts Pathway)' highlighting the fact that the 'Reject' button will abort/disable the pathway. There is no need to use the 'Reject' button when using the Mortality Pathway; it is used in other NIECR Pathways.



34. RM&MRS Upgrade – Edit function at the top right hand corner of all forms changed to "Re-open Task"

Southern Health and Social Care Trust

Acute Governance
Urology MDM
Thursday 18 February 2021 @ 12.30pm

PRESENT: **Mr Dr Dermot Hughes (Chair)**
Mrs Patricia Kingsnorth
Mr Michael Young
Mr Anthony Glackin
Jason Young
Jenny McMahon
Martina Corrigan
Kate O'Neill
Mr Mark Haynes
Mr Shawgi Omer
Roisin Farrell, note taker

Dr Hughes introduced himself to the meeting. He provided an update to the meeting. He advised he was asked to chair the Urology review in August. The review team have been working on the review from October 2020 and the draft report is expected to be ready for 28.2.2021. He has met with all 9 families once and is meeting with them between today and tomorrow (18 & 19 February 2021) for the second time and will meet with them for a third time to provide them with the draft report.
Cases in question were: 5 prostate cancers, 1 testicle cancer, 1 penile cancer and 2 renal cancers. He asked if anyone had any questions. – None. He advised in the instance of the prostate cancers there was no adherence to MDM and clinical guidelines of March 2016. Other issues of concern are the timeline for diagnosis, some delays and some were lost in the pathway to diagnosis and follow ups. He confirmed 3 patients have since died. Patient 4, Patient 1 and Patient 3 and other patients are not so well. Dr Hughes advised the group that the external urology reviewer is Mr Hugh Gilbert he was nominated by the professional body that gives professional advice.

Dr Hughes explained that the Cancer Nurse Specialist was excluded from these patients care. 9 patients didn't have the supporting link leading to a greater risk of failsafe measures to ensure pathway is adhere to. Dr Hughes said he was not sure why this happened and he doesn't know if all at MDM were aware. He has been told MrO'B didn't refer patients to Cancer Nurse Specialist. He said these patients needed someone to manage their pathway. He advised he believed MDM was not appropriately resourced leading to a resource deficit in the recommendations referring back to the peer review of 2017. He asked if there were any questions.

Mr Glackin advised he was chair of Urology MDM, he took over from MrO'B. He confirmed nurses were excluded from MrO'B's practice. He doesn't believe there is an issue with other doctors.

Dr Hughes confirmed has been speaking to nurses and will be putting recommendations into the report to reflect this. He is not sure why patients didn't have access to Cancer Nurse Specialist which has caused issues in the community.

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

A. With frequency, and in meeting with Fiona Reddick. I think there is reference to it in notebook evidence that we provided recently, just key points that we had concerns about in terms of achieving them, key worker being one of them, and holistic needs assessment. At that stage we were even asking can you forward the documentation that other teams or other specialties would be using for holistic needs assessment that we could have a look at. And that was 2015. 14:42

402 Q. You have provided a couple of examples of the way in which different consultants approached access to the nurse? 14:43

A. Yes.

403 Q. We'll find that at WIT-80968. Now, the starting point for this is that you never experienced Mr. O'Brien preventing the assistance of CNS or a key worker? 14:43

A. That was our understanding. That was my understanding, that was my experience, yes.

404 Q. Did you ever speak to Martina Corrigan to the effect that Mr. O'Brien doesn't allow us access, or it's difficult, or he is obstructive in any way? 14:43

A. No. The issues I would have raised with Martina Corrigan or any of team on a regular basis would have been more about overrun of clinics or productivity within clinics. I certainly wasn't aware that anyone was being prevented from having access to a key worker in any role, no. 14:44

405 Q. Or not using CNS when available?

A. Yes.

Southern Health and Social Care Trust

Quality Care - for you, with you

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier: **SAI** Patient 128

Date of Incident/Event: 2012-2014

HSCB Unique Case Identifier:

Responsible Lead Officer: Mr Anthony Glackin

Designation: Consultant Urologist

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

7.0 CONCLUSIONS

This SAI investigation was undertaken to investigate why a follow up patient review which was planned for Patient 128 at the Southern Trust Urology Service in June 2013 did not take place. The review team have concluded that the systems and processes in place for organising follow up appointments were followed. Patient 128 was placed on the correct waiting list for review; however, there was an on-going issue with capacity and demand for this service. Uro-oncology Review Clinics were established to address this in February 2013 however the wait for review remains lengthy. The Review Team have established that Patient 128 would not have been called for review from the newly created waiting list until December 2014 by which time Patient 128 had already been re-referred with symptoms of metastatic disease.

8.0 LESSONS LEARNED

There is a "capacity and demand" issue in regard to follow-up review appointments scheduled for the Uro-oncology Review Clinic Service in the Southern Trust. The numbers of patients, who require review, outnumber the number of appointment slots available to review them at the requested interval. This imbalance has resulted in patients being placed on waiting lists for review.

The Uro-oncology waiting list does not stratify the patients with regard to risk of recurrence, or identify those who need to be seen as a priority. There was no formal patient handover arrangement undertaken prior to Dr 3 leaving the Southern Health and Social care Trust. Handover presents an opportunity for the consultant who is leaving to highlight patients who require review in advance of the chronological waiting list schedule. The review team stress formal handover can enhance communication and patient safety but does not negate the need to address the root cause of waiting lists.

All radiology reports require sign off by the responsible clinician, usually a consultant. This provides an opportunity for the individual patient's management plan to be reviewed and altered or actioned if warranted. Due to the lack of formal handover arrangements for Dr 3's caseload this opportunity was lost.

There was a delay in dictating Patient 128's discharge letter post-surgery. In order to enhance seamless care it is important that all relevant information is communicated to primary care/the patient's GP as quickly as possible post patient discharge.

It was not possible to determine from the medical notes the detail of the information Patient 128 had been given regarding cancer diagnosis, follow-up and prognosis. A communication record and named Key Worker are recommended for all cancer patients within Northern Ireland. This facilitates the sign posting of patients so that they can be seen appropriately and in response to changing need as required during follow-up.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Summary of Recommendations

From: Burns, Deborah
Sent: 11 March 2015 13:07
To: Fearon, Paula; Boyce, Tracey
Subject: RE: SAI Draft for consideration SAI Patient 128

Thanks. Do not raise with chair - Tracey to advise. The issue is what did the CT show not whether its included or not – if it had of been reviewed / report looked at - ???Tracey leaving with you
Issue re urology reviews – its not if its right – what are we going to do……

Debbie Burns
Acting Director of Acute Services
SHSCT
Personal Information redacted by USI
Tel: Personal Information redacted by USI

From: Fearon, Paula
Sent: 11 March 2015 13:01
To: Burns, Deborah; Boyce, Tracey
Subject: RE: SAI Draft for consideration SAI Patient 128

Dear Both

I personally don't feel there was any attempt to deflect from the Urology Service re part to play. The Chair was most receptive to get to the root cause of the problem and to try to reduce the likelihood of a similar problem happening again.

CT scan results are included in the Timeline but can also be placed in the body. Initially the entire CT Reports were include but the Chair felt that the information could be difficult for a non-medical person to understand and the conclusion should suffice, this was discussed with Dr Fawzy. If you prefer the full reports can be re-entered.

Martina Corrigan has assured that handover does now occur however this an informal agreement. From the perspective of reducing the likelihood of a similar event happening again the review team is of the opinion that a similar scenario could potentially happen in any area where a Consultant leaves. It was for that reason that it was felt this needed to be considered by all areas.

The waiting times for Urology reviews were checked and verified for this report by Katherine Robinson.

I am happy to address any areas with the Chair and Review Team.

Tracey I will await a response before raising anything with the Chair/RT.

Regards
Paula
From: Burns, Deborah
Sent: 11 March 2015 12:04
To: Boyce, Tracey; Fearon, Paula
Subject: FW: SAI Draft for consideration SAI Patient 128
Importance: High

Hi both
I am not happy with this review on a number of counts – these comments are not for sharing but tracey can you review please and see what you think and then take forward in my absence as on leave:

· This review feels like the urology team have no part to play in this at all – none bar one minor issue of the recommendations falls to them

162 Q. 2015, yes.
A. Yeah, in March. So I think this really describes really well the journey that we were on. Mr. Glackin would have been the Chair of that Review because he wouldn't have been involved in that patient's journey. 12:02
So he was a very skilled Urologist. He understood the context in which that team was operating, and he could peer review how that had went. But it demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the 12:03
systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities. They tried to -- and they were correct and I'm not saying they were wrong -- there was 12:03
20,000 people from a performance report that I read, 20,000 people on a review backlog, 80-something percent of those were not seen in their clinically indicated time -- they had made attempts to pull out another subset waiting list, which was Uro-Oncology Review, so 12:04
they were trying, but they had no capacity to see that person in that time frame. And I accept that. And I guess I accepted -- and David Connolly leaving and no replacement for a period emphasises that capacity and demand mismatch. But there is other things that we 12:04
could do that were glaringly obvious, which was, you know, I couldn't read there the CT scan, so if the CT scan had have been reviewed, we didn't have PACS, we didn't have an electronic system, I get all that. It

36.2 I chaired the Urology Morbidity and Mortality Meeting from April 2015 to September 2022. I refer to my answer to Q7.

37. How, if at all, did you inform or engage with performance metrics in Urology? During your tenure, who did you understand as being responsible for overseeing performance metrics?

37.1 The only metrics presented at the Urology departmental meetings related to waiting times for outpatient appointments and procedures.

37.2 Use of key performance indicators (such as positive surgical margin rates during partial nephrectomy or transfusion rates following prostate surgery) for individual conditions or procedures has not been routine. There is no data collection mechanism to support this activity in the trust. I refer to my answer to 36.1

37.3 Patient related outcome measures are only beginning to be used by the department. For example the routine collection of symptom scores following prostate surgery (REZUM procedure).

38. How did you assure yourself regarding patient risk and safety in Urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

38.1 I refer to my answer to Q7.

38.2 I do not have line management responsibility for my consultant colleagues therefore unless advised by the clinical or medical director I would not necessarily be aware of concerns regarding the practice of my colleagues.

38.3 From a more general standpoint, I had an awareness of SAIs, complaints and mortalities through the Urology M&M meeting.

including dates, notes, records etc., and attendees, and detail what was discussed and what action (if any) was planned in response to these concerns.

(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.

(ix) If any systems and agreements put in place to address concerns were not successful, please explain why in your view they were not and what might have been done differently.

52.1 (a) I am aware that concerns were raised by the nursing staff in the Thorndale Unit about the clinical practice and manner of [redacted], [redacted] [redacted]y. This matter was dealt with by Mr Young and [redacted]

Mackle, Eamon

From: Corrigan, Martina
Sent: 04 March 2016 13:40
To: Mackle, Eamon; Haynes, Mark; Glackin, Anthony; O'Brien, Aidan; Young, Michael; ODonoghue, JohnP
Subject: Actions from AMD and Urology Consultant Meeting

Importance: High
Sensitivity: Confidential

Dear all,

To formalise, please see the notes/actions arising from today's meeting.

Present: Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, M Corrigan. Apologies : Mr O'Brien, Mr Haynes

Mr Mackle advised that the purpose of the meeting today was to follow on from the last meeting which was held on 17 December 2015 as he has a meeting with Medical Director at end of March and he will need to update him on what has been put in place.

Actions agreed:

1. Mr Young to meet with Mr Suresh this week/early next week and explain what processes are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him. (Mr Young to update when this happens)
2. Mr Mackle to meet with Mr Suresh on Wednesday 16 March 2016 at 2:30pm in AMD office, M Corrigan to organise
3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
4. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh
5. Formalise evening cover and the purpose of this will be explained to Mr Suresh in his meeting with Mr Mackle and Mr Young.
   Mr Young to formalise after discussions with the rest of the Team and that this should be shared with all the Team, Mr Mackle and M Corrigan. Mr Suresh is going back oncall on Thursday 17 March (Bank Holiday), Mr Young has agreed that he will do the handover Ward Round and cover Mr Suresh on this day.
6. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and M Corrigan.
7. The Consultants involved in the 'second on call' and Ward Rounds will be renumerated by ½ PA – M Corrigan to organise.

A further meeting in 3 months to be organised in order to update on progress – M Corrigan to confirm date.

Regards

Martina

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

announcement of the USI I had no interaction with the previous Medical Directors (John Simpson, Richard Wright and Ahmed Khan) on matters of governance. I refer to my answer 50(i).

50.4 (iii) I met Dr Gillian Rankin prior to my appointment as a consultant in 2012 as part of a pre-interview visit. I do not recall meeting her again during her tenure.

50.5 I met Mrs Debbie Burns on many occasions during her tenure. The meetings were related to service improvement and management of waiting lists within the Urology Department. I did not have any meetings with her related to governance concerns other than to say that we recognised the harm that could arise from patients waiting too long for assessment and treatment.

50.6 I did not meet or interact with Mrs Ghiskori.

50.7 I have met with Mrs Melanie McClements primarily by video conference to discuss service provision and issues relating to delivery during COVID. I also refer to my answer to 50(i).

50.8 (iv) I met Mrs Heather Trouton when she was AD for Surgery. I recall we had a very brief corridor conversation, following a Urology Team meeting on the administration floor. The entire conversation amounted to 2 or three sentences from my recollection. She expressed her concerns relating to how Mr O'Brien was managing his workload. I cannot recall the exact wording but the substance of it was "how are we going to manage Aidan". No management plan was discussed, nor were any specific details discussed. I did not perceive that there was an immediate or substantial risk, rather I felt that Mrs Trouton was expressing a degree of exasperation with Mr O'Brien's backlog. The backlog was longstanding, widely known and was not solely related to Mr O'Brien. All of the consultant team had backlogs of varying degrees. I think that this conversation took place before I became aware of the SAIs in 2016 and before the subsequent meeting of January 2017 when the Consultant Team was told that Mr O'Brien

(iii) Who raised them?

(iv) Do you now know how long these issues were in existence before coming to either your own, or anyone else's attention?

Please provide full details in your answer. Please provide any relevant documents if not already provided to the Inquiry.

56.1 I was aware from 2012 that Mr O'Brien had a long review backlog for outpatients and in patient operating. He was not unique in this regard. I was also aware that he had a backlog for completing correspondence from my experience as a urology clinical research fellow between 2002 and 2005 and again when I returned as a consultant in 2012.

56.2 On many occasions Mr O'Brien raised concerns at the urology departmental meetings, meetings with directors and Assistant Directors of Acute Services and Commissioners from HSCB.

56.3 At the urology Department Meetings, he expressed the view that he did not have enough time to complete triage of new referrals during his week on call. He also expressed the view that the two most pressing concerns for the urology department were the provision of a safe in-patient service and tackling the long waiting times for surgery.

56.4 Prior to the meeting in January 2017, I was not aware of the extent and range of the issues concerning Mr O'Brien's practice. I acknowledge that I was aware from 2012 that there were differences in performance across the team and that some Consultants had larger backlogs than others. In addition, working styles differed and both aspects were reflected in concerns expressed to me by Mrs Trouton in our conversation noted above 50.8. It is important to note that many of the issues raised by Mr O'Brien featured in the content of the meeting.

61. ~~55.~~ **When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

61.1 Fairly soon after commencing work in Southern Trust I became aware that Mr O'Brien had different ways of working compared with others. It was apparent that many of these were embedded in his working patterns and widely accepted across the Trust as 'his way'.

61.2 Concerns were regularly voiced by all members of the consultant team regarding the frequent lack of clinical information (in the form of letters) following outpatient consultations as this had the potential to impact on us when patients had unplanned (emergency) admissions. This voicing of concerns would have occurred during informal conversations and within departmental meetings including with the HoS. I also recognised that, regularly, patient notes were unavailable in the hospital when patients were admitted and this, coupled with the lack of dictated letters (which would have been available on the patient's electronic care record even if their notes were unavailable), presented a potential for risk during a patient's emergency care.

61.3 I submitted an IR1 regarding such a case [Patient 102] in October 2015 (please see *87. 20141120 -IR1* [Patient 102] *)* , and also commented in an email regarding another patient ([Personal Information redacted by the]) who, in addition, did not appear to have been added to the waiting list after outpatient appointments *(please see 88. 20170111 E re PATIENT* [Personal Information redacted by the USI] - [Personal Information redacted by the USI] *).* These concerns were also voiced by other members of the urology consultant team and, in discussions, it was apparent to me that these were long-standing issues and were essentially recognised as normal practice for Mr O'Brien. I did not receive any feedback following submission of the IR1.

61.4 There were also issues in relation to timely responses from Mr O'Brien regarding complaints and litigation. I recall these were an issue at the time Dr

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number Personal Information redacted by USI is complete.

The remit of Patient 10's Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Personal Information redacted by USI) chart was not able to be found on Trust property at this time. Personal Information redacted by USI's chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Personal Information redacted by USI's consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Southern Health and Social Care Trust

8.0 LESSONS LEARNED

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

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

9.0 RECOMMENDATIONS AND ACTION PLANNING

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

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

completion of management of the metastatic breast carcinoma detected on further staging CT scanning performed in January 2016.

I agree with Dr 8 in his reassurance to Patient 10 in November 2016 that surgery has probably been curative. It probably would have been even more reassuring if there had been a wider normal resection margin, though I believe that the evidence for that is scant. There is the additional concern regarding the high Fuhrman grade and whether it would have been lower had the lesion been resected at an earlier date. Nevertheless, the overwhelming probability is that surgery will have been curative, and that the delay in surgery will not have resulted in a negative outcome.

Comments regarding Triage

In replying with comments regarding the final draft report, I have attempted to do so comprehensively, fairly and honestly. With regard to the referral letter of 29th October 2014, if I had triaged the letter on or after 30th October 2014, I would have retained its routine status. If I were to triage it afresh today, I do believe that I would do likewise. Why?

This was a referral which was graded as routine by Dr 5. I do agree with Dr 8 in his letter of 6th January 2016 that it was entirely reasonable that the referral was routine, even though the patient had a history of bowel and breast carcinoma, and even though Dr 5 believed, probably mistakenly, that the cyst may have been causative of persistent, right renal angle pain. Such referrals are not uncommon. In a minority of cases, larger simple cysts do cause discomfort or pain. The impression that I would have had from the referral letter would have been that her pain had been comprehensively investigated, including by MRI scanning, and that the cyst potentially causative of pain was unequivocally proven to be large and simple. Therefore, I would certainly not have considered upgrading it to Red Flag status. I also do not believe that I would have upgraded it to Urgent status, as the likelihood of a large simple cyst being the cause of persistent pain would have been minimal.

The Review Panel have not offered any explanation as to why the status of the referral should have been upgraded, and to which status. I do not know whether it was because of the history of bowel and breast cancer, or whether the Panel were of the view that the report of the MRI scan, and by inference, of any other scans should have been reviewed on NIECR or NIPACS, or indeed whether the images should have been reviewed in addition. If this were the case, then the content of all letters of referral would be ignored, and a complete review conducted on line. As a consequence, it would never be considered defensible to triage a referral on the contents of the letter alone, and as a consequence, considerable cumulative time would be required to do so.

I have believed, and have expressed the view, that the inclusion of the triage of all letters of referral in the duties and responsibilities of the urologist of the week was inappropriate. The introduction of the 'urologist of the week' was borne out of a realisation that the increasing numbers of inpatients and the complexities of their morbid and comorbid status were such that they would be better served by a 'urologist of the week' than by the previous 'urologist on call'. This reality has been acknowledged and implemented by many other specialties.

The purpose and priorities of the 'urologist of the week' are for the consultant to deliver hands-on clinical and operative management of all urological inpatients, all other inpatients in the hospital whose assessment and management was sought, all patients in the Emergency Department whose assessment and management was sought, and importantly, all such patients in other hospitals in our area of responsibility, and particularly, Daisy Hill and South West Acute Hospitals. Optimising the outcomes of all of these patients requires time and commitment. It should not be inappropriately delegated to junior doctors. It requires every attempt be made to carry out definitive surgical management if possible. It should not be compromised by triage of non-red flag referrals. In consideration of their inferred clinical priority, I have always agreed that red flag referrals be triaged by the urologist of the week, and which I have always done, even if I had not always managed to completely do so by the end of the week in question.

I have previously tried to conduct detailed triage of the non-red flag referrals whilst being urologist of the week. I would have reviewed all details on NIECR and reviewed all images, if any, on NIPACS, irrespective of the content of the letters. However, I was not prepared to compromise inpatient management by doing so. I was not prepared to spend time triaging non-red flag referrals rather than operating on patients if at all possible. With around 280 patients on an three year, inpatient waiting list, I could not justify discharging acutely admitted inpatients to that waiting list.

I also found it impossible to have the time to do so when not 'urologist of the week' because of additional work load, due to the continued pressure to minimise the incidence of poor clinical outcomes of patients awaiting long periods of time for admission and readmission for surgery. In 2014, I had arranged and undertaken 22.25 additional, elective, inpatient operating sessions 4 additional, elective, day surgical sessions, and some 19 additional, specialty clinic sessions. I had also previewed, chaired and reviewed all cases discussed at MDM each week, from April 2012, until the introduction of a rota in September 2014.

I do not have any means of knowing how many inpatients I was responsible for from 29th October 2014 to 31st October 2014, or how many emergency operations I performed during that time. I do know that I previewed all of the cases for the Urology MDM of Thursday 30th October 2014. This would have typically taken some three hours during the evening or night of 29th October 2014, in addition to chairing the MDM on 30th October 2014, and spending typically one hour with the cancer tracker that evening reviewing and signing off the outcomes of MDM. I also reviewed ten cancer patients on the morning of Friday 31st October 2014.

I do believe that the inclusion of triage of all non-Red Flag referral letters in the duties of a consultant urologist when urologist of the week has been inappropriate and regrettable. I do believe that it has, on occasion, compromised inpatient care and has, on occasion, resulted in deferment of definitive management of inpatients. It was for all of these reasons that I had advised personnel from the Appointments Office, when we met them to discuss the issue, that I had found it impossible to triage non-Red Flag referrals, whilst urologist of the week, and that another system or method or time was needed for them to be done, if by a consultant at all, and which I believed and advised was not in itself necessary.

Conclusion

Patient 10 had a complex right renal cystic lesion since December 2012. During the next two years, its potential significance had either not been appreciated, or had been appreciated but not reported by at least two radiologists, and not reported to the urological service. Similarly, the potential significance of the lesion had not been appreciated by at least two clinicians who had requested further imaging which had been advised by radiologists in the investigation of the lesion from June 2014 to March 2015, and had similarly failed to refer Patient 10 to the urological service. I believe that the Review Panel may have failed to appreciate the significance of the cyst having changed between 2011 and 2012.

Even though there were failures on the part of clinicians and radiologists who had assessed and investigated Patient 10 and the index right renal lesion, I found the Review Panel's emphasis on the lack of triage of the letter of routine referral as the main cause of delay in Patient 10 having a urological appointment, as remarkably asymmetric. I do believe that it would have been reasonable and defensible to have relied upon the information contained in the letter of referral, and to have maintained the referral as routine. Therefore, lack of triage did not impact upon the time to consultation.

I also do believe that the triage on non-red flag referrals should be revisited, with a commitment to accommodate all views, to discuss who, when and how this challenge can be satisfactorily resolved.

Aidan O'Brien.

25 January 2017

9.0 RECOMMENDATIONS AND ACTION PLANNING

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

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

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Southern Health and Social Care Trust

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

Minutes of Urology Service Development Day

Consultants Meeting

In attendance: Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
(Mr O'Donoghue joined later).

1.1 Urologist of the week working model.

This topic was discussed extensively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved. Where possible definitive care should be delivered during the current inpatient stay.

1.2 Triage of new referrals.

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the curent long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week.

1.3 Annual leave.

The team is define the number of consultants and other members of middle grade staff who can be away at any one time. Discussion of Christmas and Summer holidays should be well in advance of holiday time to permit good planning. A process for agreeing leave should be developed and adhered to.

Other business:

Mr O'Brien tabled a written document setting out his issues of concern for discussion at the meeting. Similarly Mr Young provided an email listing topics for discussion. It was suggested that those items not discussed should be given time at the weekly departmental meetings.

- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning

- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

Meeting of consultants and senior nursing staff

In attendance:

Sr Caddell,
Sr McElvanna,
Sr Magill,
Sr Lockhart,
Sr Magee,
Sr O'Neill
Sr McMahon,
Sr McCourt,
Charge Nurse Young,
Mr Young,
Mr O'Brien,
Mr Haynes,
Mr Glackin,
Mr O'Donoghue

2.1 Ward issues:

1. Outlying of urology patients to facilitate medical inpatients.
2. Staff retention and vacancies.
3. Staff education program for Urology inpatient care.
4. Lack of medical support for medical inpatients on ward 3 South due to locum staff and a lack of continuity.
5. Interruptions to ward rounds.

2.2 Thorndale issues:

1. Too few cystoscopes.
2. Clinics overrunning.
3. Requests for inpatient flexible cystoscopy.
4. Introduction of endoscopy check list.
5. New patient clinic running problems due to time keeping and case mix.
6. Provision of intravesical chemotherapy service.

Sr Leanne McCourt tabled a prostate cancer option grid to be piloted within the Department.

Sr Jenny McMahon tabled the Southern Health and Social Care Trust endoscopy safety checklist.

are Mr O'Brien's colleagues but we knew there were real issues which needed to be addressed. We were already down by one Consultant and so the workload for everyone has increased.

21. I am aware of other cases of non-triage aside from the Patient 10 case. I have been involved in a look back exercise where other cases have been identified. Myself and the other Urology Consultants have all undertaken additional triage and chart reviews. I am not sure if all routine and urgent referrals were left un-triaged or if some were completed by Mr O'Brien. Red-flag referrals are easily identifiable and are generally printed on yellow paper so we can pick them out easily from the other referrals in the bundle.

22. Our routine referrals have increased significantly over the last year. Referral patterns from GPs have also changed. We now have a lot more red flag referrals. We had been seeing red flag referrals within 2 weeks but because of staffing difficulties we are now out to 30 days.

23. I advised that we are averaging 176 referrals for Urology per week. I was asked if this can reasonably be done in terms of triage. I explained that everyone works differently. Mr O'Brien frequently expressed a view that he did not have time to do triage and he flagged that he couldn't manage the situation. Some of us are able to do it contemporaneously however others are not as quick but always got it done.

24. Mr O'Brien raised the issue of triage at our weekly Thursday Consultant meetings and with the Head of Service, Martina Corrigan. This was not the only issue he raised concerns about. He described what work he felt was more important or less important in term of clinical priority. The issue of triage was discussed at the weekly meetings. The response from some of us at the meetings was that style of working and organisation was generating the problem. Mr O'Brien's insistence in terms of advanced triage and phoning people to make arrangements was not in our view the best use of his time. Mr O'Brien expressed the view that due to his long operating waiting list there were clinical activities of less pressing need that he should not participate in such as new patient clinics.

25. In terms of context – there were 3 Urologists in June 2012 which eventually rose to 5 Consultants by year end. I started in August 2012. Mr O'Brien and Mr Michael Young had extensive waiting lists at this time and this largely remained the case. Both still have long waiting lists and a backlog of reviews. Mr O'Brien frequently expressed the view at Consultant meetings that his most pressing commitment was to in patient care and his operative waiting list. This was a workload issue for him. Most of the other Consultants are not dealing with the same volume in terms of our waiting lists. There is certainly a bit of 'wanting to hold onto things'. Every Consultant makes different decisions about how to manage things. His approach is different to that of his colleagues and I am not saying it isn't good work or safe but Mr O'Brien does fall behind with things. Mr O'Brien sees significantly fewer patients in clinic per year than most of his colleagues. This issue has to the best of my knowledge not been explored, challenged or addressed.

Subject: RE: Sharing of SAI report Patient 10
Sensitivity: Confidential

Dear Tracey,
draft 8 of this report was completed this evening.
I will not be sending the report to Mr O'Brien, I am his colleague and not his manager.

Regards

Tony Glackin

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton Personal Information redacted by the USI

From: Boyce, Tracey
Sent: 10 January 2017 17:45
To: Glackin, Anthony
Cc: Gishkori, Esther; Carroll, Ronan; Corrigan, Martina
Subject: Sharing of SAI report Patient 10
Sensitivity: Confidential

Hi Mr Glackin

At the oversight meeting today the next steps for this SAI report were discussed.

Dr Wright has asked that you, as chair of the SAI panel, now share the report with the two key consultants involved in the SAI so that they have a chance to comment on the report if they wish.

Would you be able to post a hard copy of the report to AOB with a note requesting that he replies with any comments he has by a certain date – I think two weeks from when you send it would be sufficient? Normally we would email reports to consultants however Martina tells me that the only working email address we have for AOB is a personal one, so cannot be used to send a report such as this.

I understand that the consultant radiologist involved in the SAI has now left the Trust, so I will liaise with Heather Trouton about how they wish to handle that.

Thanks for your help with this, it is much appreciated.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy/Acute Governance
Personal Information redacted by the USI

Mr. O'Brien was a close colleague and presumably possibly a mentor? Was there a discomfort around this?

A. I got the impression he felt very conflicted. In your role as Chair of the SAI, that is one of your tasks. You know, when you get to the final working draft, that a courtesy to the staff who have been named in it, you share it with them to ensure when you have spoken to them or captured their -- it's like an accuracy check, they don't get to change the outcome. It is only fair to make sure they get the opportunity to comment on the accuracy of their involvement and if they have been quoted or whatever. So, it is a normal step in the process and it is the Chair's responsibility to do it. 15:06 15:06

Obviously in this one, Mr. Glackin, I understood, was very conflicted, as you say, being a colleague and I understand now that he saw Mr. O'Brien almost like a mentor, as you said. When I had been asked to do that and it came back, obviously I went back to Esther and Richard and it was taken. The MHPS Panel, I understood, took on that. How they shared it, I wasn't involved in sharing it after that. 15:06 15:06

308 Q. Is this a problem you frequently encounter, where somebody from the same department or the same service is the Clinical Lead on the review, and you are placed in this position? 15:07

A. It was the first time I had a Chair not do it or refuse to do it. There's been Chairs not do it maybe because they didn't realise they should do it. In terms of

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

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

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

Notes of the Meeting.

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

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

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

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

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

Mr. Glackin is saying, we simply wouldn't know whether a patient has disease progression or whether he has been brought back to fit or whatever. What is the solution for that? Is the solution different types of tracking or different types of monitoring in Governance terms? 15:25

A. DR. HUGHES: The first solution would be to have a Clinical Nurse Specialist who does a holistic baseline assessment and does another assessment as your needs change. There is little point in having a palliative care team sitting at an MDT if you can only access the first presentation. It makes no sense. The reason you bring more complex patients back to an MDT is to get the benefit for all these multi-professionals and that's about doing the right thing for the patient at the right time, and that's about having the right support. Unfortunately, this cohort of patients didn't have that right support in terms of Clinical Nurse Specialists, but that would not stop anybody else re-referring them to get access to this care. 15:25

232 Q. Just finally, just going to the bottom of the page, Mr. Glackin comes back to deal with the nursing issue. It says that his patients have access to the CNS and are referred to palliative colleagues for support. He described Mr. O'Brien as a holistic physician clinician. Can you contextualise that for us? Was that by way of an excuse or explanation or is that a compliment? 15:26

He described that AOB would have had a proportionate number of patients from the Western Trust and would have reviewed then in Enniskillen there were no CNS available to attend these clinics.

DH referred to the NICAN guidance and the annual business report. There was very limited audit reports.
Where there any issues with colleagues contributing to audit.

AG- both he and MH (Mark Haynes) were involved in the national audit from BAUS. In view of information control issues this audit was terminated by the HSCB. AG advised that Mr AOB didn't participate in audit and was not a member of BAUS.

DH – advised that the MDM was under resourced and under provided with oncology in SHSCT. There was a shortage of radiology and cover had to be obtained from medical oncology and clinical oncology.

DH – asked if any of the oncologist had any concerns about AOB?
AG- said he wasn't aware of any concerns raised. However he did advise that AOB was the chair of NICAN in previous years. Now chaired by MH and that AOB would have been involved in the drafting of the guidelines.

DH advised that a small number of patients were treated outside guidelines and this would normally be discussed with patients.
AG – one of the flaws with the MDM process is that clinicians who are present may be making a decision on patient care with incomplete information. A decision is reached indicating a course of action until you meet the patient in clinic and then have to revise the management.

DH – was it a functional MDT ?
AG – yes there was good involvement from the urologists, radiologists, pathologists specialist nurses and coordinator.

DH- What was the relationship like among the urologists?
AG- it was good up until December 2016 when AOB had a period of sick leave and the Trust took the opportunity to review his practice. After this working relationships became difficult, other issues came out of the woodwork.
Only the AMD was involved in the review – everyone else was left out of it.

AG- When AOB returned to work conversations were strained but got better. Relationships got back on an even keel. But they deteriorated again before AOB retired. There was a change in his demeanour towards the end of June.
MH would know more. One of the consultants Michael Young (MY) has worked with AOB for 20 years. I have known him since before I was a medical student. It is fair to say AOB was very helpful and supportive of me in my new role as consultant. The current investigation should be even handed and proportionate in manner. You should be aware of the good things he has done.

DH recognised the stress this process must be having on the urology team.

would not be returning to work as planned. I do not recall any other discussions concerning governance matters with Mrs Trouton.

50.9 I have met Mr Ronan Carroll in person and by video conference on many occasions. One of my first interactions with him was in January 2017 when the Urology Consultant Team was told that Mr O'Brien would not be returning to work as planned. I was shocked by this information and the extent of the problem outlined to us. It was my impression at the meeting that Mr Carroll and other managers present were party to information about Mr O'Brien's practice that was not shared with the urology consultants at the meeting.

50.10 I have discussed the urology waiting lists and my concerns related to delayed assessment and treatment for patients at meetings with Mr Carroll present. I have participated in a number of SAIs on behalf of the trust. Mr Carroll had sight of the outcomes and recommendations as part of his role as Assistant Director. Similarly, Mr Carroll and I have worked on responses to complaints or enquiries on behalf of patients. Mr Carroll worked with the Urology team to deliver a recovery plan following the findings of the January 2017 meeting.

50.11 (v) I had no interaction with the associate medical director on matters of governance until 2017. Following Mr Haynes appointment to this role, he and I had frequent discussions about how to improve performance and mitigate patient safety risks across the team.

50.12 (vi) I had no interaction with the clinical director with responsibility for urology on matters of governance. As stated previously I did bring concerns regarding the functioning and quoracy of the Urology MDT to the clinical directors for cancer services and radiology.

50.13 (vii) I had frequent engagement with Mr Young in his role as lead clinician. We discussed matters concerning the running of the department informally and at the

27.4.17 1815 - 2000. KG.

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9/2006. last entry OPD.
WL CANC 28.8.2007.

Personal Information redacted by the USI

S/B Z. Aslam 30.1.2017. Plan. OPA 12/12

Personal Information redacted by the USI

No urology entries in chart.
No " " Patient Centre.

Personal Information redacted by the USI

No Urology entries in chart.
" " " Patient Centre.

Personal Information redacted by the USI

24.5.2016 Listed UDS + Flex. Cystо
14.2.2017 CNC P

Personal Information redacted by the USI

28.5.2016 Att. AOB.
20.2.2017 Att MDH. - Discharged.

Personal Information redacted by the USI

No Urology entries in chart
" " " Patient centre.

Personal Information redacted by the USI

S/B AJG 22.2.2017 - Discharged.

Corrigan, Martina

From: Haynes, Mark <Personal Information redacted by the USI>
Sent: 24 January 2017 12:03
To: Glackin, Anthony
Subject: FW: Urgent Cases

Hi Tony

Below is the AOB list he sent. It is apparent that there may well be patients on the WL for TURBT type procedures who are not listed as RF and may have been waiting a significant period. I plan to review the list to pull these patients out.

I have highlighted the cases I haven't done. 2 cases highlighted we have been in contact with and have noted the detail of this contact in red.

Mark

From: O'Brien, Aidan
Sent: 07 November 2016 16:00
To: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP
Cc: Corrigan, Martina
Subject: Urgent Cases

Dear All,

Due to my being unable to electively admit patients until January 2017, I am concerned for those patients most urgently requiring admission.
I have selected the following ten patients whose admissions I would have next arranged if not off.
I would be relieved if it were at all possible to have some of these patients admitted so that they do not have to wait until 2017.
I certainly appreciate that it is a pain to be asked to take on another's patients in addition to your own.
I have provided some commentary on each patient.
They are listed in chronological order:

- Personal Information redacted by the USI CAHE Personal Information Personal Information Removal / Replacement of Left Ureteric Stent

  (This man has had a stent in situ since March 2016 following a para-aortic lymphadenectomy and segmental ureterectomy for metastatic colorectal adenocarcinoma infiltrative of the left ureter.
  He continues on palliative systemic chemotherapy.) – I offered this man a date for this week and he declined stating that his cancer has returned, he is undergoing treatment and the stent is not giving him any trouble so he does not wish the procedure at present

- Personal Information redacted by the USI CAHE Personal Information Personal Information TURP ? TURBT

  (TURP for relief of bladder outlet obstruction in patient with previous carcinoma of bladder) – has date 10/2/17 Mr Jacob

- Personal Information redacted by the USI CAHE Personal Information Personal Information Removal / Replacement of Right Ureteric Stent & Ureteroscopy

  (Stent in situ since March 2016 following Left Nephrectomy, Right Ureterolysis and Segmental Ureterectomy in patient with Retroperitoneal Fibrosis)

Hynds, Siobhan

From: Corrigan, Martina [redacted]
Sent: 07 June 2017 18:25
To: Hynds, Siobhan
Cc: Carroll, Ronan
Subject: undictated clinics
Attachments: OC 1.pdf; OC2.pdf; OC3.pdf; OC4.pdf; OC5.pdf; OC6.pdf; OC8.pdf; OC9.pdf

Hi Siobhan

To update on the findings from the undictated clinics:

There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he had returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow.

Katherine Robinson's team are currently recording the outcomes from these and these will all be backdated to when the clinics happened.

There were 3 patients whom the consultants have concerns on and I had arranged urgent appointments for them. One has since been sorted and no further concerns. The other two have cancelled their appointments themselves and have been rearranged for beginning of July so I will keep an eye on these and make sure there is no more concerns.

Other comments made by the consultant were:

1. Patient seen by 6 times at clinic and notes written in the patients chart but no dictated letter
2. Patient seen initially as a private patient and there is a letter in chart for private visit but none for NHS visit
3. Patient seen x 14 times at clinics (so well looked after) but no letters so how does the GP know what is going on?
4. Patient seen at clinic on 19/9/16 letter dictated retrospectively on 28/02/17.
5. According to PAS the patient attended the clinic but according to handwritten notes they DNA and Mr O'Brien had asked that they be sent for again
6. Patient seen on 11/04/16 but letter was dictated on 22/02/17.

If there is anything further in respect to this please do not hesitate to contact me

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

60.1 (i) The impact on patient care and safety relates to delayed time to assessment and treatment, the risk of failing to appropriately escalate routine referrals to urgent or red flag at triage, delays to treatment caused by the absence of or late correspondence to GPs and others.

60.2 (ii) These concerns were known about before the meeting in January 2017, but it was only at this meeting that I became aware of the range and extent of the concerns.

60.3 (iii) and (IV) I refer to my answer to Q53. I consider that the responsibility for carrying out a risk assessment and planning further management lay with the CD with responsibility for Urology and the AD for Surgery and Elective Care. Each was answerable to the Medical Director and the Director of Acute Services respectively. I would have expected that the Medical Director and the Director of Acute Services would have been fully briefed given the seriousness of the matters advised to us at the meeting of January 2017.

61. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

61.1 I was not party to any discussion about Mr O'Brien's return to work in 2017 or any measures put in place by the trust to monitor performance at work. I became aware later in 2017 that Mr O'Brien's work was subject to managerial oversight. I am not aware of any specific restrictions or conditions made on his practice or the methodologies used by the trust to assess compliance.

62. Do you have knowledge of any metrics used in monitoring and assessing the effectiveness of any agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? Who was responsible for overseeing any agreed way forward, how

65. Did Mr O'Brien raise any concerns with you regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise (and if not with you, with whom), and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something? How far and in what way would you expect those concerns to escalate up the line of management?

65.1 I refer to my answer to Q56.

65.2 I do not recall any specific input at meetings from the Medical Directors (John Simpson, Richard Wright, Ahmed Khan & Maria O'Kane), Assistant Medical Directors (Eamon Mackle & Charlie McAllister) or Clinical Directors with responsibility for Urology (Robin Brown, Sam Hall, Colin Weir & Ted McNaboe) regarding Mr O'Brien's concerns. In my recollection, it was mostly the operational managers (Mrs Corrigan HOS, Mr Carroll AD, Mrs Trouton AD and Mrs Burns Director of Acute Services) who were present when issues were raised. I would have expected the Head of Service and AD to escalate concerns to the Director of Acute Services who in turn should notify the Trust Board and risk register. Similarly, I would have expected any concerns notified to the Clinical Director to have been shared with the Assistant Medical Director and Medical Director.

65.3 It is my view that the operational side was very aware of the performance issues with respect to waiting times, triage etc. I have no knowledge of how well informed the medical managers were prior to 2017. From 2017 onwards the medical managers were involved but again communication to me from them was minimal.

I do not recall a single meeting to discuss governance issues or patient safety concerns related to Mr O'Brien or the Urology Department with any of the following post holders who held tenure in the period following the meeting in January 2017 up until June 2020: Medical Directors (Richard Wright, Ahmed Khan & Maria O'Kane), Assistant Medical Directors (Eamon Mackle & Charlie

McAllister) or Clinical Directors with responsibility for Urology (Colin Weir & Ted McNaboe)

66. Are you aware of any support being provided by the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

66.1 I am not aware of any support provided by the trust to Mr O'Brien.

66.2 I advised my medical and nursing colleagues to engage with their union and indemnity organisation following the ministerial announcement in 2020.

67. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to, unless already provided. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

67.1 I do not know if any issues raised by Mr O'Brien were included on the Trust's risk register.

67.2 At a video conference meeting in 2021 with senior medical and operational mangers with the Urology Team, I sought assurance from Mrs McClements that the known issues of long waiting times for appointments and surgery as well as the lack of in-patient bed and theatre capacity were on the Trust's risk register.

Learning

68. Are you now aware of governance concerns arising out of the provision of Urology services which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether

you could and should have been made aware and why you consider you were not.

68.1 I am not aware of any new governance issues since the meeting of January 2017. The issues surrounding long waiting times for outpatient appointments and surgical procedures remain a risk to patient safety.

69. Having had the opportunity to reflect, do you have an explanation as to what went wrong within Urology services and why?

69.1 The failure by the trust to deliver timely care and to monitor the performance of individual consultants activity arise from the absence of performance management of clinicians and managers and longstanding issues regarding inadequate resources to provide a timely safe service for the population. Workload pressures meant that we spent most of our time trying to keep our heads above water balancing the competing interests in an inadequately resourced department.

69.2 In my experience of working in the trust as a consultant since 2012 performance data was not collected, shared or discussed routinely. The trust used data from CHKS for the CLIP report, but this was viewed by clinicians as inaccurate. I refer to my answer 14.3

Behaviours of individuals, custom and practice went unchallenged with respect to the timeliness of correspondence, triage and results, monitoring of volumes of activity and chronological listing of cases for theatre.

69.3 Routine collection of outcomes data was not supported by appropriate infrastructure. Prescribing practice was not routinely audited. This meant that it was difficult to recognise variance in practice across the team and to have a meaningful discussion as to why variance was occurring.

Willis, Lisa

From: Trouton, Heather
Sent: 02 November 2015 15:33
To: Corrigan, Martina; Mackle, Eamon
Subject: FW: UROLOGY DSU LIST 03/11/15
Attachments: MR O'BRIEN IN PATIENT THEATRE LIST 04/11/15.eml

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear martina

Have you the lists for this week?

Heather

From: McGeough, Mary
Sent: 02 November 2015 13:51
To: Donnelly, Rachel; Kelly, Brigeen; Corrigan, Martina
Cc: Trouton, Heather; Carroll, Ronan
Subject: RE: UROLOGY DSU LIST 03/11/15
Importance: High

Martina

Please see email below regarding Mr O'Brien's patients for his day surgery list tomorrow. As you will see 3 out of the 5 patients have not been to pre-op. Could you please investigate and advise why these patients were never sent to pre-op as to get this level of notification of their surgery is as I am sure you will agree unacceptable. We are now in a position where we are unable to get these 3 patients pre-assessed due to the extremely tight timeframe before their surgery. I have also attached a second email from Rachel with regard to Mr O'Brien's inpatient list on 4th November and again there are a couple of patients on this list who have not been to pre-op. Have all of these patients been seen somewhere other than at his outpatient clinic? If yes then a system will need to be put in place ASAP in order to ensure that these patients are pre-assessed well in advance of their surgery being scheduled.

Happy to discuss

Mary

Mary McGeough
Head of Anaesthetics, Theatres and ICU
Craigavon area Hospital
Tel: Personal Information redacted by USI

From: Donnelly, Rachel
Sent: 02 November 2015 12:42
To: Kelly, Brigeen; McGeough, Mary
Subject: UROLOGY DSU LIST 03/11/15

Dear Brigeen and Mary

Linda came to me this morning with the attached list – Mr O'Brien DSU AM list for 03/11/15.

anaesthetist that Patient 90 did not attend his appointment.

The review team concluded that even if Patient 90 had been able to attend this appointment, it was not a timely referral to pre-operative assessment. The referral did not give sufficient time to appropriately pre-operatively assess and optimise Patient 90 for surgery considering his significant comorbidities.

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

15. RECOMMENDATIONS (please state by whom and timescale)

Recommendation 1

The Trust should develop and implement guidance for clinical result sign off
Monthly audit of sign off will be presented to the Governance Forums

Recommendation 2

All patients undergoing elective surgery must have a formal pre-operative assessment completed prior to surgery, including liaison with other specialties to ensure maximal optimization of patients prior to procedure. The Trust will update the pre-operative guidance to recommend appropriately timely referral times and escalation of non-attendance.
Audit of surgical patient pre-operative assessment should be undertaken and be presented to the Governance Forums

Recommendation 3

Discussions regarding the risks and benefits of surgery must be clearly documented in the patient record and reflected on the patient consent form, to ensure patients are able to make informed consent.
Audit of surgical patient consent should be undertaken and be presented to the Governance Forums

Recommendation 4

Blood loss during procedure should be escalated during and at the end of the procedure, the blood loss must be recorded on the operation note.
Blood loss post operatively must be escalated to the surgical and anaesthetic teams.
Monthly audits will be conducted and result presented to the Governance Forums

Recommendation 5

VTE risk assessment must be completed for all patients prior to surgical intervention.
Monthly audit of VTE risk assessment in the patient record/medicine prescription and administration record and WHO surgical safety check list blood loss section will be presented to the Governance Forum

16. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

17. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

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.

I will need assistance when replying to this email.

Thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

From: Personal Information redacted by USI
Sent: 25 August 2011 15:37
To: Corrigan, Martina
Subject: Re: Results and Reports of Investigations

Martina,

I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:

- Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?
- Are all results or reports to be reviewed, irrespective of their normality or abnormality?
- Are they results or reports to be presented to the reviewer in paper or digital form?
- Who is responsible for presentation of results and reports for review?
- Will reports and results be presented with patients' charts for review?
- How much time will the exercise of presentation take?
- Are there other resource implications to presentation of results and reports for review?
- Is the consultant to report / communicate / inform following review of results and reports?
- What actions are to be taken in cases of abnormality?
- How much time will review take?
- Are there legal implications to this proposed action?

I believe that all of these issues need to be addressed,

Aidan.

-----Original Message-----
From: Corrigan, Martina < Personal Information redacted by USI >
To: Personal Information redacted by USI Personal Information redacted by USI >; Akhtar, Mehmood Personal Information redacted by USI >; O'Brien, Aidan < Personal Information redacted by USI >; Young, Michael < Personal Information redacted by USI >
CC: Dignam, Paulette < Personal Information redacted by USI >; Hanvey, Leanne < Personal Information redacted by USI >; McCorry, Monica < Personal Information redacted by USI >; Troughton, Elizabeth Personal Information redacted by USI >
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results
Dear all

Willis, Lisa

From: Trouton, Heather
Sent: 29 January 2016 12:51
To: McAlinden, Matthew
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: Radiology and Patholoy results

Follow Up Flag: Follow up
Flag Status: Flagged

Matthew

Could you please send the email below to all the consultant surgeons that I gave you this am ?

Happy to discuss if required
Thanks

Heather

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

Corrigan, Martina

From: Young, Michael
Sent: 27 May 2015 21:36
To: Haynes, Mark; Corrigan, Martina
Subject: RE: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15

Internal email for those on this circulation only

Point taken
Agree
Play a straight honest game.
We are best placed defining our lists but at risk if above comments not taken on board.
Management not playing straight either by resetting patients clock.

But this is not the approach I want for the Dept

Few issues not prepared to put on paper about process = so discuss later.
Discussion required.

Mark's points very valid – I fully appreciate the questions raised

MY
Lead

From: Haynes, Mark
Sent: 27 May 2015 20:54
To: Young, Michael; Corrigan, Martina
Subject: FW: UROLOGY TOTAL URGENT WAITING LIST - AS AT 27.05.15
Importance: High

Dear Michael / Martina

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

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

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

Corrigan, Martina

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

Morning Michael

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

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

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

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

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

Mark

some dissent among other members of the team. When we became aware that the dictation was not done it was bitter to hear.

35. Productivity from the SWAH clinis was poor in comparison to other clinics in part due to travelling time but also in terms of numbers seen, so to hear the admin was not completed was difficult. CHKS publishes data in terms of productivity so everyone can see what their peers are doing. Mr O'Brien is an outlier in terms of out-patient clinic activity.

36. I was asked if there was other work Mr O'Brien was doing which may have impacted on clinic dictation and triage. I explained Mr O'Brien held a number of other roles – he was Chairman of the local MDT and Chairman of the Regional NICAN group which would have been a reasonable workload for him.

37. I am aware that Mr Young informally did some of Mr O'Brien's triage but I am not aware of any formal agreement between them. I haven't done any triage for Mr O'Brien.

38. In terms of the undictated clinics, of the small sample I have looked at there are a small number of patients who have not had management plans actioned. So far I have looked at 2 boxes with about 12 charts in each box. I have come across 1 patient who should have been a red flag referral but there is no letter or outcome on PAS so I am not sure if an outcome decision was made or communicated. Mr O'Brien had identified the procedure to be done but there is no letter on file to say that the patient was referred on.

39. I was asked about Mr O'Brien's private patients and if any had been seen faster than is in keeping with waiting list times. I advised that I have no evidence of this however with the look back exercise, it does appear that some patients have been seen sooner than anticipated given the trusts waiting lists.

40. I was asked if I knew what senior management within the Trust may have known. I explained that Urology has been a problem area in terms of waiting times for out-patients and surgery so I can't see how managers wouldn't have been aware of the concerns. I know managers and the other consultants would have been aware of his workloads but the scale of un-dictated clinics and un-triaged referrals was a shock to me and I am not sure if managers were aware of the extent of the performance issues. I feel some aspects of Mr O'Brien's performance have suffered over the time I have been in post. His way of working doesn't help- letters were too long and over detailed, when they were there. He expresses very clear views on how triage should be done yet we find out he has not been doing it in a lot of cases. Mr O'Brien has a different working style which is very different from his colleagues but it is clear to me that his workload along with all Consultants has increased significantly. This raises serious issues in respect of burnout and excessive workloads which has been a factor for a long period of time.

41. The Trust has tried to address the long waiting lists and the numbers of referral with new pathways.

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]