Urology Services Inquiry

Oral Hearing

Day 60 – Thursday, 14th September 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

INDEX

THE HEARING COMMENCED ON THURSDAY,
14TH DAY OF SEPTEMBER, 2023 AS FOLLOWS:

CHAIR: Good morning everyone.

MS. MCMAHON: Good morning. Chair, the witness this morning is Patricia Thompson who is a Urology Nurse Specialist with the Southern Trust, she is going to give her evidence but first of all she's going to take the oath. 10:00

MS. PATRICIA THOMPSON, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS: 10:00

MS. MCMAHON: Good morning.

THE WITNESS: Good morning. 10:00

1 Q. Thank you for coming in to give evidence to the Inquiry. We have already met, but my name is Laura McMahon and I'm junior counsel for the Inquiry. You see the Panel here and I know your legal representatives have familiarised you with the layout. 10:01 So I'm going to take you through your evidence?

A. Yes.

2 Q. And first of all we will go to your Section 21, the reply that you sent in and if I could have that brought up on the screen, it starts at WIT-86640. And you see 10:01 your name at the top. It's notice No. 75 of 2022. And if we go to WIT-86670, we should see your signature?

A. Yes.

3 Q. Do you recognise that as a statement you made on

14th November last year?

A. That is, yes.

4 Q. And you wish to adopt that as your evidence?

A. It is.

5 Q. For the Panel's note, the enclosures to that statement can be found from WIT-86671 to WIT-86880. The Panel has heard quite a lot of evidence to date and I just want to make a few points to put your evidence in context so you'll understand why I'm only asking you certain things and that you have included it in your statement. The Panel has already heard from four members of the SAI team, Dr. Hughes, Mr. Gilbert, Patricia Kingsnorth and Fiona Reddick and you make up the fifth member? 10:01 10:02

A. That's right. 10:02

6 Q. And that's why we have brought you along today, so you can share your experience and your expertise and, perhaps, your learning around that.

We have also heard from Jenny McMahon and Leanne McCourt in witness form but we have heard orally from Kate O'Neill as well, the other CNSs with whom you work? 10:02

A. Yes, that's right.

7 Q. And the Panel has heard evidence on the SAIs that were undertaken, the nine SAIs, they have heard evidence and looked at those at length? 10:02

A. Okay.

8 Q. They have heard about the role of the CNS and the key

worker and from those who have worked with Mr. O'Brien. Because, as I understand it, Mr. O'Brien had already retired by the time you joined the Southern Trust?

A. He did. He retired in June 2021 and I started the Southern Trust on August 2020. 10:03

9 Q. So you weren't, you didn't know him, you didn't meet him at all in that capacity?

A. Not in the key workers Clinical Nurse Specialist capacity. I did meet Mr. O'Brien when I sat in NICaN. He was chair of the NICaN group and I was a 10:03 representative for the South Eastern Trust when I was a CNS with the South Eastern Trust at that time.

10 Q. And that was your previous employer. When you worked with them you had reason to attend the NICaN meetings and Mr. O'Brien was part of that and that's the extent 10:03 of your connection with him?

A. Yes.

11 Q. We have also heard of the way in which staffing is allocated around the CNS and the key worker. The reason you are being called is to provide evidence on 10:04 the use and effectiveness of the governance process that was instigated by the Trust, namely the SAI process?

A. Yes.

12 Q. And before we get to that we'll just look at some 10:04 aspects of your statement. So for your understanding, the areas I'm going to cover, I am just going to generally look at your background?

A. Okay.

13 Q. Then your role. You have given us some communication examples, I just want to look at those to see if there is any learning there. Then the challenges you faced within the unit; concerns; the SAIs. And reviews, you have mentioned some reviews and then some learning and we'll just touch on those at the end. 10:04

A. Okay.

14 Q. So hopefully that's clear?

A. Yes.

15 Q. I'll take you through your background and we can then move on to your role, if that's okay? 10:04

A. Yes.

16 Q. You were first introduced to urology speciality upon taking up a post in the Surgical Operating Theatre Department at the City Hospital in 1999? 10:05

A. That's right and I would have worked between gynae theatres and urology theatres. In 2002 I took up a Senior Staff Nurse post and this was within urology day care, urology day procedure units, urology theatres. The main purpose of the post was the nurse-led urodynamic service, also assisting in day surgery urological procedures, and also being a scrub nurse or anaesthetic nurse in the surgery in the urological theatres. And that would have been for procedures such as radical prostatectomies or bladder cancer surgery. 10:05 10:05

17 Q. Is that while still in the City or was that once you moved to the South Eastern in 2005?

A. That was in the City. I then was accepted as a Macmillan Clinical Nurse Specialist in the South

Eastern Trust. It was the Ulster Hospital at that time. In 2005 my post was Macmillan Clinical Nurse Specialist and I was autonomous with one urological consultant. 50% of my post was dealing with benign patients and also 50% was dealing with cancer patients. I was trained up in flexible cystoscopies. I carried out lower urinary tract symptoms assessments, prostate assessments, cancer liaison and complex, changing of complex catheters and intravesical treatments. 10:06

The post, when I left the South Eastern Trust I had been a CNS for about 14 years and the service had really progressed to being a four CNS nurse-led service. My job still got very busy, I was carrying out more nurse-led flexible cystoscopy for patients with bladder cancer surveillance and prostate cancer review and renal cell cancer review. When I left there was four CNSs and five consultant urologists. 10:07

18 Q. And that was in the South Eastern?

A. That was in the South Eastern Trust. 10:07

19 Q. Then you say you moved in August 2020 to the Southern Trust?

A. Yes.

20 Q. So for most of your nursing career, over 20 years, you have been focussed on urology? 10:07

A. That's right, yes.

21 Q. And particularly around the cancer aspects of that?

A. Yes. I like the cancer aspects of urology.

22 Q. Do you remember what date in August 2020 you started?

A. It was the 3rd August.

23 Q. The 3rd August. Thank you. You have also given us details of your line management. You say that you had no issues with line management and you have always found them to be supportive within the Southern Trust? 10:07

A. Yes, that's right. And Martina Corrigan would have been my line manager and then it would have been Sarah Ward. At present, now, it is Wendy Clayton would be the operational line manager and Paula McKay would be my nursing manager. 10:08

24 Q. She's your Clinical Manager?

A. Clinical Manager, yes.

25 Q. And you have set out and we have heard details around the weekly departmental meetings?

A. Yes, We had the weekly departmental meetings. These were via Zoom. Now these meetings are on a monthly basis and they are on the first Thursday of every month. They are very informative and it keeps us up to date of any governance issues or any new initiatives in urology. 10:08

26 Q. We'll just go to the description of your current role at WIT-86644. Paragraph -- sorry, just at the top of that page where the sentence begins "My current job plan..."

A. Mm-hmm. 10:09

27 Q. "My current job plan is structured and my roles specialise in cancer liaison, key worker, nurse-led renal cancer review and flexible cystoscopy service for patients with red flag symptoms of bladder cancer, and

cancer surveillance with patients with known bladder cancer."

And you say then:

"If I had any concerns with fulfilling my role or in regards to patient safety, I can speak to both Paula McKay and Wendy Clayton." 10:09

So we're talking about the August 2020 period when you started. It would be your experience - and if it is a different experience having worked there now let us know - but it was your experience that there were people to talk to, you felt supported and you felt you had the capacity to carry out the required roles for your job? 10:09 10:09

A. Yes. I found management very, very supportive and when I first started the Southern Trust it was at Covid so a lot of services was restricted. It's only within, maybe, the past 18 months services have started to go back to normal as what they had been pre-Covid. 10:10

28 Q. Because you do mention the issue of Covid in your statement. For the Panel's note at WIT-86656, paragraph 25.2. And what you have said is:

"Lack of CNS provision at the time when CNSs were redeployed in January 2021 for a period of six weeks meant that meetings were not quorate." 10:10

You are talking about MDT meetings at this point?

A. That's right.

29 Q. And you say:

"The systems should have been in place for CNS to be available to be present, such as a rota, to attend MDT." 10:10

So you're talking about a specific period in time. Covid hit not long after you had taken up post, just at the start of 2021, it started to impact around the March and you are saying that that had an impact on attendance at MDT? 10:10

A. It did. Myself and Kate O'Neill and Leanne McCourt, we had been redeployed. I was redeployed to theatres and Leanne and the Kate were redeployed to the wards. We were out for a period of six weeks and we were unable to attend MDT. When Covid first came, in March 2020, when I was a CNS in the South Eastern Trust some of our services we had to be redeployed for a period of maybe four weeks but we were still able to do a rota of attending the MDM meetings. And I felt maybe at that time when we were redeployed at the Southern Trust, in January 2021, there should have been, maybe, provisions made in place that one of us could attend the MDT on a Thursday afternoon. 10:11 10:11

30 Q. Looking at just those comparisons and management around the MDT attendance and the possibilities given the pandemic, who was responsible or what way was it

organised in the South Eastern Trust when you were there in the early 2020, how did that come about, that there was a rota?

A. I worked -- the urology nursing service was under Cancer Services and our manager at that time was Mary Joe Thompson, she would have been the lead, the Head of Service for Cancer Services. And we would then -- most of the nurses who were -- when Cancer Services were redeployed, however she did allow us to attend MDTs. So myself and another colleague, we took that in rota. 10:12

31 Q. Now, the Inquiry has heard evidence around urology sitting just outside the Cancer Services in the way that the structure was divided in the Southern Trust?

A. Yes, that's right.

32 Q. So when you came to the Southern Trust, that link with Cancer Services wasn't there? 10:12

A. That's right.

33 Q. Was that something, because you had come from a Trust where it had been sitting under the same umbrella, if I can put it that way, did you notice that it not sitting under Cancer caused a bit of a breakdown in communication? 10:13

A. I don't think so. It seemed to be the management, the communication and the management structure when I came to the Southern Trust is still very good. We are kept up to date of any changes. It was good to sit under Cancer Services because we were able to sit in the MDM and multidisciplinary team meeting when we were redeployed. There was some, in my team in the South 10:13

Eastern Trust there was a nurse who specialised in benign but she still sat under Cancer Services. But I don't think it really - it didn't make a difference when I attended, when I started at the Southern Trust. It's a question really that would be hard to answer.

34 Q. I suppose if I put it in this context. If the South Eastern Trust urology sat under Cancer Services during the pandemic and, if I'm understanding your answer correctly, that allowed them then to ensure there was a rota for the MDT? 10:14

A. That's right.

35 Q. Southern Trust didn't have that particular structure. You are saying that it wasn't because they didn't sit under Cancer Services that they didn't have a rota. So what was the reason why there was no rota during those six week redeployment? 10:14

A. From what I can remember, we had a departmental meeting prior to us being redeployed at that time and it had been discussed amongst the multidisciplinary team and they felt that maybe the nurses, it wasn't required for us to attend the meetings while we were redeployed at that period of time. 10:14

36 Q. Do you know who made that decision or at what level?

A. I'm not too sure. I can't recall. I think it was the medical staff that came out, felt that they could continue with the meeting without us being present. 10:14

37 Q. And it would be your view that you could have been attending and perhaps should have been?

A. Yes, we could have been, yes, we could have attended.

38 Q. You have mentioned a specialities, areas that you now cover within your role and if I have picked up correctly from that, you carry out flexible cystoscopies. Bladder cancer surveillance I think also falls within your remit? 10:15

A. That's right. I would carry out an all-day flexible cystoscopy service and this covers patients who are on the non-muscle invasive bladder cancer pathway, and also for patients who have red flag symptoms. I also have -- I would have a session in the morning and a 10:16 session in the afternoon and each session would have ten patients. Eight of those patients are either surveillance patients or red flag patients. And I have two protected slots for removal of ureteric stents under local anaesthetic. 10:16

39 Q. So you are actually running your own clinics?

A. I'm running my own clinics. Now, the clinic is under the code of a consultant, it's not under a nurse-led code so any investigations that I request, such as upper tract imaging or cytology the results would go 10:16 back to the consultants. Even though I am the referrer. But the results, they will be highlighted on NIECR to the consultants. However, the consultants are very good and very supportive, they would contact me if a CT urogram has come back that I have requested on a 10:16 patient and they would notify me that the result is available and I would then dictate on that results to the GP and to the patient.

40 Q. We'll just work through that because it touches on a

couple of issues, one of them is communication, just by way of an example. So you have your own clinics. The gateway to your clinics is when the consultant asks you to do a certain procedure or recommends certain care for a patient. They then get sent to you; is that right? 10:17

A. The patients are on a waiting list. The red flag patients are on a red flag patient waiting list and they are appointed by the red flag partial booking office. The patients who are on -- the surveillance patients, these patients are on the waiting list to have their cystoscopy repeated maybe in six months or in 12 months. These are normally appointed by the consultant's secretary. However, now there has been a new urology scheduler has been appointed, so the responsibility will lie with that person. 10:17

41 Q. And does that person make clinical decisions or just provide pathways for people?

A. No, she will not make clinical decisions, it will be -- if a red flag referral has come through for a patient with frank haematuria or a visible haematuria, that will be triaged by the consultants and that will then be referred to the haematuria service. 10:18

42 Q. So it is still the consultant who is the gateway to filter what's the most appropriate pathway? 10:18

A. Yes, that's right.

43 Q. Perhaps send patients to you, wait for those results to come back and then see the patient, having that information. Is that the system, roughly the way the

system works?

A. If it is a patient that has red flag symptoms and there has been a tumour, a potential tumour has been noted on the flexible cystoscopy, I would inform the patient at that day of their procedure. Then I put them on the waiting list for a TR, for the resection, bladder resection. I would request their imaging. The patient would have their surgery. Pathology would come back. They would be discussed at the urology MDM and then they will see the consultant with regards to the results of that procedure. 10:19 10:19

44 Q. So you would give people information like that at the point, at investigation, if you suspected that?

A. I do, yes.

45 Q. Would that be something you do with the consultant or is that something you do as a sole worker? 10:19

A. I would do that, if I'm doing the flexible cystoscopy service I would do that as a loan worker or autonomously.

46 Q. Yes. 10:19

A. I would be with the consultants at the post-MDM clinics or the results clinics, I would be with the consultant at that point as a point of key worker. But if I do see anything suspicious or a patient needs procedures and I am autonomous or I'm doing my own clinic I would inform the patients myself. 10:19

47 Q. And at that point it is potential or suspected and other tests will reveal whether it is actually confirmed?

A. Yes, that's right.

48 Q. And the Panel have heard evidence around the point at which the key worker issue becomes crystallised and when that person should be appointed. You have mentioned that post-MDT you would perhaps be the key worker? 10:20

A. Yes. When I do see something that is a potential tumour, I would give the patient my contact details and they are aware that this is probably a potential cancer. I would give them the relevant information for their procedure. The patient, obviously following service surgery, will be discussed at the MDM and I would make a note of that patient. I would try my best to be at that particular clinic that the consultant is giving the results so there is that continuity. 10:20

49 Q. Just in relation to the MDT and the allocation of key workers, the Trust policy indicates that it is a joint decision from the core member, the nurse and the chair of the MDT and it should be decided at that point. The Panel has heard from Kate O'Neill and through other evidence that that isn't always practical because of scheduling and because of people's duty rota to know exactly who is going to be on at a certain clinic. But is it your understanding that that is, the allocation of a key worker is a jointly responsible role for both the chair of the MDT and the core nurse member? 10:21

A. Myself and Leanne McCourt are the core MDT nurse members and when patients are discussed at the MDT they

are allocated an appointment with the relevant consultant. So the consultants would have a post-MDT clinic. This clinic could have between six to ten patients. We would in advance have a rota made out or our off-duty rota made out and we would be aware of each consultant's MDT clinics, the dates of these clinics. We would allocate staff to be at that clinic. Now, if there is patients who I have maybe carried out flexible cystoscopies on and they are going back a clinic of, for example, Mr. Haynes, I would -- and obviously that day I don't have any clinical activity -- I will ask can I be at that clinic because I know the patients are going to be there. But we do tend to allocate the nurses in advance to attend consultants clinics so they can be the key worker. 10:22

50 Q. Your evidence refers to post August 2020, when you commenced your role?

A. Yes.

51 Q. That's the system you are referring to?

A. That's the system I am referring to, yes. 10:23

52 Q. I suppose just prior to that, because of the Trust policy, and there has been some evidence and some uncertainty around the responsibility of the allocation of key worker, I just want to understand what you thought to be the process whenever you were involved in the SAIs. Did you understand that it was Trust policy to have both the chair of the MDT and the core nurse member jointly responsible for the allocation of key worker or did you think that it operated where the

nurse would look at the rota and see who was on and allocate? What was your sense of understanding then?

A. It was difficult when I started because the services weren't as what they had been pre-Covid. A lot of services had been restricted. I was unaware that really it was responsibility of the MDT core nurse and the chairman to allocate the key worker. When I came into post a lot of the consultants would have had what they called maybe hot clinics and these were clinics to see the patients post-MDT. I note that Kate O'Neill and Leanne McCourt would have tried to allocate these patients to the clinics and would have contacted the secretaries. But it was difficult because services were restricted prior to me -- when I started at the Southern Trust. I do feel that maybe it's run differently to what it had been before I started Craigavon. 10:23 10:24 10:24

53 Q. And post-Covid?

A. And post-Covid, yes.

54 Q. You have mentioned a couple of things in passing, just moving on to the communication aspects, to see if there are possible some rooms for improvement, the Panel maybe get a better understanding of the practicalities of your job and from a governance perspective, how any breakdown in communication or difficulties may impact good governance. So that's the context for these couple of questions I want to ask you. 10:24 10:25

A. Okay.

55 Q. If we can go to WIT-86649. This is your Section 21

reply and you have set out at paragraphs 14.1 to 14.3, "Improvements to methods of communication and action planning". At 14.1, I'll just read out the paragraph for the transcript:

10:25

"In my role as a Urology Nurse Specialist I request imaging for patients who are currently under surveillance for bladder cancer surveillance, renal cell cancer review and for any patients presenting with symptoms suspicious of cancer. As previously 10:25
mentioned, I request these investigations through Sectra or ECR."

Just pausing there. They are obviously internal programmes by which you would order examinations -- 10:26

A. That's right.

56 Q. -- or investigations. Then back to your Section 21:

"However, when the examination has been completed and reported, I am not notified but the consultants are 10:26
informed. The consultant would write to me or notify me of the completed investigation. This is not an issue with the Southern Trust but is a regional issue. However, I can see if a result is available and this has been signed off and actioned by a consultant." 10:26

So from the start of the paragraph the issue is you request a certain investigation but when the result comes back it doesn't come back to you

A. No.

57 Q. Or you're not copied into the result?

A. No, it goes to the consultants. Because the patient's consultant is responsible for their care. This is a regional issue, this is across Northern Ireland, it's not to do with the Southern Trust. 10:26

58 Q. Just in relation, is that because of the way the software, the system operates, do you know, or is it because there is a decision taken that results are for consultants only? 10:27

A. I feel it is a decision for the consultants only. Because even if registrars or speciality doctors or staff grades request investigations it does not go back to them, it goes back to the consultant.

59 Q. And so the consultant has to actually read it in order then to send it on? 10:27

A. They do. They have to read it and they would have to sign it off. They have to write a comment. Normally a comment would say, Patricia Thompson emailed or Patricia Thompson notified and it would be sided off on certain dates. And then when I am notified I would then action any, if a letter has to be dictated to the GP or to the patient, or if the investigation has to be brought to MDM. 10:27

60 Q. So you can't do the next part of your pathway until the consultant has read the report and indicated to you what any further action needs taken? 10:27

A. Yes, I can see the report. The report is available on NIECR or on Sectra. I mean, if I was concerned about

the report and the consultant hasn't signed it off, I could notify the consultant to say I carried out a flexible cystoscopy or I requested a CT urogram or a CT scan on a patient, the result has come back. And, obviously, then I would communicate with the consultant. But for sign-off it has to be carried out by the consultant. 10:28

61 Q. So you can notify them but they still have to action any further steps?

A. Yes, I can notify them. 10:28

62 Q. Is there anything in the system, either for you or for the consultants, that flag up when results have been sitting a while or waiting or if there is any delay in look at them?

A. I know the secretaries, they would, if a patient has been seen in an out-patients clinic and they are having an investigation, they are put on to the patients administration systems as what they call DARO which is discharged awaiting results. This is placed on the PAS. The secretaries would run reports then monthly and this will show if there is any outstanding results that needs to be actioned. So the secretaries could contact the consultants or even myself, if I have requested anything or if there is results available they could contact me. 10:28 10:29 10:29

63 Q. Now you speak about DARO at 14.3 and you say that the CNSs don't have access to the DARO functions?

A. No, that's for the secretaries would have access to that.

64 Q. Do you think that it would improve follow-ups if you did have access? Give us a bit of background to that, why you have said that?

A. I think it would improve my follow-up. You know, if nurses had, maybe, or Nurse Specialist had access to it we could be notified if there is results outstanding or if the result has become available. It would probably be around the same as what NIECR or Sectra would be and it could notify us if we have put in a request and results are available. 10:30

65 Q. I just want to take you to WIT-86645 and paragraph 8.1(a). Maybe the page before that. Just the next page please. Sorry, it might be 8.3. I will just read a summary of the question just so that -- I just cannot find the link where it is. But in relation to DARO you have stated that: 10:31

"Consultant secretaries can DARO and that if a consultant's patient is awaiting results prior to a decision regarding follow-up treatment being made, they must be regarded as discharged and not added to the outpatient waiting list for review." 10:31

A. That's right. The patient, they are recorded as discharged awaiting results and they are put down, they are recorded as an out-patient discharge. They are not -- and then once the result is available, the consultant will make a decision if the patient needs to be reviewed. Then the patient is, out-patient is then 10:32

re-registered again as an out-patient and either they could be put on a protective review or put on the waiting list for a review for three months or six months. If the results has come back and the patient doesn't need to be reviewed, then the patient can be discharged from the out-patients clinic and a letter will be dictated by the consultant.

66 Q. So your evidence is that the decision by the consultant to either review or follow-up brings the patient back into the live system? 10:32

A. It can, yes.

67 Q. Now did you have experience of DARO or any similar system in the former post either in the South Eastern or Belfast?

A. I didn't have any experience of DARO but I would have had experience of NIECR and Sectra. I was able to request upper tract imaging in my last post. Again I wouldn't have not notified with regard to any imaging results that became available. But again I would have been informed by the consultant of the results. 10:33

68 Q. So the other Trusts that you worked at didn't have this system of DARO where people were moved slightly over, discharged awaiting results and then brought back?

A. I am unaware if they did have that system. They would have had patients administration systems so it could have been on their software. 10:33

69 Q. But you were never aware of it?

A. I was never privy to it.

70 Q. So you don't know how they managed people who were

awaiting results, you have no knowledge of that in your previous Trusts?

A. No, no knowledge.

71 Q. You also make a reference again - we'll just go back to WIT-86649, we're back to the communication issues where you have mentioned about the delay in typing. 10:34

A. That's right.

72 Q. At 14.2:

"In the G2 dictation system, as previously stated, some typing is delayed due to low staffing levels. I don't get notified if letters are not typed in a specific timescale. Again as previously mentioned, I can place the letter as urgent or email the secretary or audio typist. I find out if letters have not been typed by looking into the G2 system to view my dictation." 10:34 10:34

Now your phraseology there, that's a problem that existed when you were there in August 2020?

A. It was a problem. This time last year that was a problem with my dictation. I had to mark on the G2 dictation system if it had have been urgent and again email the secretary. For my nurse-led clinics my dictation was delayed up to a period of four to six weeks because we didn't have the administration support. We do now have, administration support has been appointed. 10:34 10:35

73 Q. When was that? Do you know when that was?

A. They were appointed around about three months ago.

Three to four months ago, there has been more administration support available for the urology CNSs.

74 Q. What's the turnaround now on dictation?

A. My renal cell cancer clinics is typed within that week, within that day. 10:35

75 Q. So naturally that must increase the turnaround of patients?

A. Very much so.

76 Q. So your capacity has increased since even three months ago? 10:36

A. Yes, it has increased. Even the typing of the flexible cystoscopy letters, which is done by the consultant's secretaries or the audio typists, they do have a new audio typists been appointed so the turnaround for those letters is a lot quicker than what it had been. 10:36 The turnaround would be around about a week following my flexible cystoscopy list.

77 Q. So you consider the delay problem you have identified in your statement to be sorted?

A. To be sorted, it seems to be resolved. 10:36

78 Q. In relation to communication with patients, you have mentioned a couple of examples in your statement, one of which is that you would be available at the nurses -- sorry, at the consultants results clinic and you would introduce yourself as the Urology Nurse Specialist? 10:36

A. That's correct.

79 Q. And advise of your role as the key worker.

A. Yes.

80 Q. I think you have mentioned earlier and you have mentioned in your statement that you would give people a card so they would have contact details?

A. Yes, when I am present at the consultant's clinic we would introduce ourselves and explain our role and explain our role as the key worker as we would be a point of contact for support, for the support of the patient and support for the family. We would provide our contact details. We would also provide information such as the Macmillan Cancer Core Pack which would have information with regard to the multidisciplinary team. We would also provide site-specific information, such as maybe prostate cancer information or kidney cancer information. They would also give any information for any procedures the patients may need to undergo. When we introduce ourselves as the key worker we do record this consultation on NIECR, on progress notes. We also record this on the cancer patient pathway system, which is called CaPPS and there is a section in this system that is for CNSs and AHPs to record their consultations with, episodes with the patients. This is generated, so this will be generated on the MDM report and this will also be generated on the MDM outcome letter, that the patient was seen by a specialist nurse. 10:37 10:37 10:37 10:38 10:38

We also have a CNS pro forma that we also complete. The reason we will complete this CNS pro forma, because all new cancer diagnosis, it's advisable that they are offered a holistic needs assessment so we complete a

pro forma in the time that if the patient would like to have a holistic needs assessment appointment.

81 Q. That is a description of the service as it was at the time you started, in August 2020, or has developed?

A. It has developed. 10:39

82 Q. We'll take from what you have said that there is now a thread from the moment the key worker is introduced right through the system, so that it's apparent to all people who have contact with that patient subsequent to that introduction that they have in fact got a key 10:39 worker. And it is also searchable on the system, I can go into NIECR and see the key worker. I presume the pro forma is available on the system as well?

A. You can go into NIECR and check progress notes for the Southern Trust and you would see what has been 10:39 documented by myself or by Leanne or by Kate O'Neill. If you went into CaPPS and you went into the patient's record, you could see that there has been an episode with a CNS and you can go in and generate the reports. We also for the Southern Trust, and this has been for 10:39 about six months, we have a spreadsheet that we are notified every month of every new cancer diagnosis. We each in turn go through that spreadsheet and ensure that the patient has had a key worker.

83 Q. And in relation, just so we're clear, in relation to 10:40 the key worker introduction, is that only at clinics where patients receive results or reports confirming cancer or is it any -- does it happen in the benign clinics?

A. It wouldn't happen in the benign clinics. If there was a patient attended the benign clinic and there was maybe a concern there could be a suspect cancer, that patient will be referred to the consultant and referred to the relevant investigation clinic. They may have contact with the nurse and they may have, maybe, their contact details to keep them up to date, that they have referred them on to a consultant or to the haematuria clinic, whatever the investigation needs to be. 10:40

84 Q. Does the scenario now exist, if it did at all before, where you had to wait until the consultant invited you to introduce yourself to the patient or do you do that autonomously? 10:41

A. We do that autonomously. And we ensure that, when we are attending the consultant's clinic we ensure that we are present at the clinic. I wouldn't want to say we're available because we want to ensure that we are present there, that we will be in the clinic when there is a consultation with regards to a patient who has a cancer diagnosis. 10:41

85 Q. And is it your current experience that that works well with other consultants, they understand your role, they understand the significance of that and the patients are leaving with the relevant information following a diagnosis? 10:41

A. Yes, that works very well with the consultants.

86 Q. Now that's the system as it is now and you have explained that very helpfully. In August 2020, when you started, a lot of that process would have been

absent, would that be fair, a lot of that certainty around allocation, around the CNS pro forma, around the marking on the NIECR, around the MDM notes being clear, the key worker being allocated, none of that existed at that time? 10:42

A. It didn't exist, no, the pro forma didn't exist at that time. CaPPS, to be honest, I feel that CaPPS really has made progress in the Southern Trust in urology since I came into post because it would have been a system that I would have used in the South Eastern 10:42 Trust so I was able to bring that experience when I started in the Southern Trust. The NIECR, the progress notes wouldn't have been used either when we first started. It's only that we have been introduced to it really, we would say it was probably around the 10:43 wintertime of 2020 progress notes became available on NIECR.

87 Q. You have mentioned a couple of fail safes, and we'll go back to that word later on, it's been mentioned a few times, but you have mentioned CaPPS progress notes, CNS 10:43 pro forma. You have mentioned that CaPPS existed in your previous job in the South Eastern, that was already in use?

A. Yes.

88 Q. Was the CNS pro forma or the progress notes part of the 10:43 system in the South Eastern Trust?

A. No, there wouldn't have been the progress notes. But we did have -- we would have had -- a Cancer Operational Manager would have sent us CNSs the weekly

spreadsheet of newly diagnosed patients and we would have had our own database of patients who had a urology cancer diagnosis and we would have marked if they had a key worker or who had been in contact with the patient.

89 Q. So when you came to the Southern Trust what was your view of the way in which the key worker allocation was dealt with and documented and visible? Did you have a view, having come from the South Eastern Trust where the process was different? 10:44

A. Well, obviously they didn't have the database or the spreadsheet, what we have now in the Southern Trust, that wasn't -- but we did have that in South Eastern Trust. I note the Leanne and Kate O'Neill were very unfamiliar with CaPPS so I was able to discuss CaPPS with them and get them a password for CaPPS. 10:44

90 Q. Is that something that's freely available across all Trusts? 10:44

A. It is, yes.

91 Q. Could you tell me what that stands for because I can't recall? Sorry. 10:44

A. It's Cancer Patient Pathway Systems.

92 Q. Thank you. And did you ever understand why it wasn't being utilised in the way that it might be for key workers in the Southern Trust when you came along? Did anyone say we don't use CaPPS because X, Y, Z? 10:45

A. No, they didn't say we don't use CaPPS because of, they never said.

93 Q. Just a lack of awareness, was that your sense?

A. I think it was just their awareness of it. They do

find it is very useful. They found it is a very useful system.

94 Q. Did you find the staff open to suggestions from you about how these processes may be improved?

A. Yes. They were very open. They were happy that I showed them the system and they use it very regularly. And it is also a system, too, that you can view MDM attendance and also what patients are going to be discussed at MDM. So if I have a patient had contacted me concerned with regards to a recent investigation and he is discussed at the urology MDM, I can go on to CaPPS and I could look at dates of upcoming MDM and I can see if that patient is going to be discussed. 10:45 10:45

95 Q. So is it your view that CaPPS helps oversight and then helps governance because of that? 10:46

A. It does, yes.

96 Q. Now you said the nurses were receptive to anything, obviously, that improved the process and oversight. When you were - and we'll go on to look at the SAI, just generally your role in that, but just while we're on this point of allocation and the process that was used prior to you coming in. Were you able to really explore the way in which key workers were allocated or understood before you took up post and as a result of your role in the SAIs? Did you go away and really look at that or was that not part of something you felt was expected? 10:46 10:46

A. I didn't feel it was something that was expected.

I was asked by Martina Corrigan could I sit on the Panel of SAI because of my experience and also coming from another Trust. I didn't explore, didn't know that this was something to do with key worker or was it because there was maybe a concern with regards to key worker within these SAIs.

97 Q. We'll come on to look at the email from Mrs. Corrigan in a moment. But when you did find out what it was about, was it ever the case that someone said, look, find out how this process of key worker allocation works because we need to look at different parts of the pathway where it might have been triggered to give us an understanding, was there anything like that?

A. No, there wasn't, no.

98 Q. One other example of a communication, you just mentioned and I just wanted to ask you about it in passing, you mentioned that you completed the advance communications skills training in October 2010, which you said is essential for any clinician whose role involves working with patients who have a cancer diagnosis, it was a two-day course and it helped you in your urology nurse role to communicate with people?

A. That's right.

99 Q. And I presume to break bad news as well is part of that package?

A. That's right.

100 Q. Now that was in 2010. Have you had any training since?

A. I've had motivational interview training and that was provided by Macmillan and that was in 2019. It's

something like the communication skills training and again it was a two-day course.

101 Q. In relation to communication skills training, is that something that do you know is currently mandatory in the Trust? 10:48

A. Advanced communications skills training is to be mandatory for any cancer nurse. It is provided by the Trust, by Cancer Services. There is a waiting list at present for any clinicians or any new Cancer Nurse Specialist who needs to attend this. 10:49

102 Q. Do you know what that waiting list is at the moment?

A. I don't know, I don't know what the waiting list is like.

103 Q. There's been no refresher training for you? Given there is a waiting list for the core training, has there been no refresher training? 10:49

A. No, there's been no refresher training.

104 Q. Do you think you would benefit from refresher training, given it was 2010?

A. Yes, I would benefit. It would be useful to have refresher training for advanced communication. Maybe a day course as a refresher. However, we have had a new nurse had been appointed permanently and she was appointed in January of this year and she still is on the waiting list to have the advanced communications skills training. 10:49 10:49

105 Q. So it is mandatory to do your job but not having it doesn't stop you starting your post?

A. Yes, it doesn't

106 Q. You have mentioned that you have good communication with the consultants that you work with, you have mentioned that certainly systems are in place and processes are in place to improve that from what it might have been prior? 10:50

A. Yes.

107 Q. I just want to move on to the challenges, some of the challenges you have mentioned. Again you started in August, but since September 2020, just after you started, there was an uplift in CNSs to five and you 10:50 have said that you feel that's properly resourced at that number. Is that currently the position?

A. Currently the position, we had five. Kate O'Neill had retired in October 2022 and we had appointed her replacement in January 2023. Kate does come back two 10:50 days a week for 16 hours. We also have appointed two expression of interests CNSs. One of the nurses, Ciara, is 24 hours and the other nurse, Nuala, is 30 hours per week. With these two nurses we're looking at maybe getting them into training, getting them into 10:51 being interested in the Urology Nurse Specialist post, one maybe to veer towards the benign side and the other nurse to work on the cancer side. We want to look at this nearly like succession planning. Because maybe in about, maybe, three or four years time a couple of us 10:51 could be looking at retirement so it would be good to train people who have taken up a post as an expression of interest so they can step in to the service when...

108 Q. And do you feel supported by the Trust in that

succession planning? And the training that needs to be delivered so that people can segue over if anyone leaves, is the training available?

A. Yes, I do feel supported by the Trust. Now, I, myself, I am creating a document for induction for any new specialist nurse, especially if they are an expression of interest or a permanent member of staff and it's to go through the training of to be a urology CNS. So it's putting them through nurse-led clinics, it's letting them see what lower urinary tract systems assessments and they would have to need to do this and have competencies. I would like them to maybe attend different clinics, such as oncology clinic, maybe attend the Cancer Centre, attend such things as urodynamic clinic, the cystoscopy, to maybe attend the ward rounds, also maybe attend theatres. And once they have gained their competences, discuss where they would like to work, do they want to go down the cancer side or do they wan to go down the benign side. But also, it would be ideal to look at education for them, such as maybe looking at the non-medical prescribing course, looking at -- one of the new appointees is actually doing a P cert on the foundations of urology in which she will go through the likes of the prostate assessments, how to set up a nurse-led clinic and also look at flexible cystoscopies and TP biopsies.

10:52 10:52 10:52 10:53 10:53

109 Q. What is the buy-in with consultants in all of that? Do you work parallel with them to identify training and deliver it or is this nurse-led training?

A. The consultants, yes, do buy in with the training. I think the consultants would value if they do do the basics first. And they would like the nurses to look at where service provision is, where there is a need for the service. Yes, they are very open and managers are very open if there is any specific training that needs, such as if they need to be sent for a flexible cystoscopy course or if they need to be sent for the non-medical prescribing, the consultants are very supportive. And also the Nurse Managers would be, there would be support from the Nurse Managers as well. 10:54 10:54

There is also training at present for myself and that would be for the transurethral laser ablation. A girl had come out to assess the Urology Service and they had recommended that this would be an ideal opportunity for the Urology Nurse Specialist to be trained. 10:54

110 Q. What stage is that at? Is that something there has to be separate funding sought for or what way does that work? 10:55

A. There will be funding for the equipment and there will be funding for training. The company will provide training and myself and Jenny, who will be trained in this, will be sent to centres in England to be trained up and to assess for the transurethral laser ablation. We will also have consultants will assess our competencies and we will probably have sign off competencies to be able to do this procedure. 10:55

111 Q. But your view is that the Trust are motivated for this

to go forward?

A. Yes, to bring this forward. Because this will reduce patient waiting time. If they have small bladder cancer reoccurrence, rather than be on a waiting list we can provide this nurse-led service. Also, there are maybe patients who are not fit for general anaesthetic, so we can provide the service for those group of patients. 10:55

112 Q. The Panel may recall that we had looked at a document, quite a while ago now, where Ms. O'Neill was presenting, I think, a paper to the Board and she referred to "innovation overload" and I think that was based on the fact that there was so many new skills they were able to take on but were stymied slightly by capacity. The position now seems to be you are running at optimum capacity, that allows then for others to undertake training that helps reduce patient waiting lists. Is that the sequencing? 10:56 10:56

A. Yes, there is a capacity for the training to reduce patient waiting lists. Also with the new appointees, with the new expression of interest and the new member of staff that has been appointed, they will be trained up at present to carry out even services such as a holistic needs assessment, lower urinary tract symptoms assessment, urodynamics in order for myself and Jenny to carry out more extended roles, such as the transurethral laser ablation. Also, this will allow Leanne to also carry out a further TP biopsy list. 10:56

113 Q. One of the things you mention around communication is

the absence of quoracy at the MDTs, you have said that was a problem, but what is the position now? Because you say you attend, you and Leanne McCourt are core members?

A. Yes, it was an issue when I initially started at the Southern Trust that there was one consultant radiologist and when he was not available there was no radiologist to stand in for him. So a lot of patients who needed imaging to be discussed at the MDT was rolled over to the following week. That is now not an issue as there is two radiologists are available at the MDT and so if one radiologist is off, the other radiologist would be at the MDT. Pathology is not an issue. There is always a pathologist at the MDT. For oncology, we now have a clinical oncologist and she attends virtually at the MDT. And the medical oncologist attends weekly as well. 10:57 10:57 10:58

114 Q. So the rollover that you mentioned just a moment ago, that doesn't happen any more?

A. No, it doesn't happen any more. Unfortunately, it did happen a couple of weeks ago. There was -- the clinic -- or the MDT, there was a few patients had to be rolled over because there was no radiologist available. But that was very rare, that hasn't happened in a long time. But the two radiologists will always try to be available at the MDT. 10:58 10:58

115 Q. So what was previously routine is now the exception?

A. Yes.

116 Q. Just to clarify your understanding of MDM outcomes.

The MDM meeting, is it your understanding that they recommend a course of treatment that they then subsequently may alter based on new information, new clinical information, but that the actual MDM decision is actually a recommendation? 10:59

A. The MDM decision is a recommendation. It's a team recommendation. That outcome is recorded and the patients are informed at their out-patients clinic. It's a recommendation obviously from other, maybe for a course of treatment, such as if a patient has a high 11:00 grade non-muscle invasive bladder there is always a debate should the patient have a cystectomy or should the patient go for intravesical treatment and that is discussed at the MDM. I have never come across any differences of opinion. If there is maybe anything, it 11:00 would be a healthy debate, but there has never been a difference of opinion.

117 Q. Do you feel you can participate okay in the MDMs?

A. Yes.

118 Q. That your role and your view is valued? 11:00

A. Yes, I can participate in the MDM. I have brought patients to the MDM, such as with a flexible cystoscopy, if a patient who has intermediate risk bladder cancer and they are on the pathway and they are due to be discharged, I can bring that patient so it is 11:00 agreed that the patient is suitable for discharge. If I am concerned about, maybe, an imaging result, I can bring it to MDM. And also our opinion is very much valued.

119 Q. If there is a recommendation made in relation to, say, one of the patients that you are managing and subsequently you get a result that may impact that recommendation, or change the potential pathway or mean that the recommendation no longer is possibly the right way to go, what way would you handle that? Would you go back to the MDM or what would you do? 11:01

A. If I brought a patient to the MDM and they decided the pathway or the patient could be discharged, I would notify the patient, I would dictate a letter to the patient to say. I would have already informed the patient that I am bringing their case to the MDM. 11:01

120 Q. But in relation to specifically if there is to be a change from the MDM recommendation or the recommendation no longer holds good because of new information? 11:01

A. Yes.

121 Q. So maybe patient has an infection, there is other tests have revealed other information that wasn't known at the MDM, how would you deal with that particular issue? 11:01

A. I would bring it back to the MDM. If there was something that wasn't present I would bring it back to the MDM.

122 Q. And allow a new recommendation to be considered?

A. Yes, allow new recommendations to be considered. 11:02

123 Q. Would you present that? Would you give the new information and say this is why it is back, is that the way it works?

A. Yes, I can. I have presented, if I have brought a

patient I have said why. The patient will be under a consultant but I would suggest - I would say that I have presented this patient because of recommendations or could we do a change in treatment or recommend a change in treatment. 11:02

124 Q. What if a patient, you bring the recommendation to them from the MDM and the patient refuses treatment, or says that's not for me, or I don't want that, or I'm not taking part, that's me, what do you do with that information? 11:02

A. If the patient doesn't want treatment I would maybe advise the patient and discuss it with the consultant. The consultant will see the patient as well and I would be present at that clinic.

125 Q. And would you record that anywhere in your particular notes? 11:02

A. Yes, I would record that. I would record that in my progress notes and I would dictate a letter to the GP to update the GP that the patient has been discussed at MDM, a course of treatment has been recommended and the patient does not want this treatment, however I am referring the patient back to the consultant. So that would be dictated. And it would be recorded in progress notes or in the patients' notes. 11:03

126 Q. The letter you send to the GP, would the patient get a copy of that? 11:03

A. Yes, the patient would get a copy of it or I would dictated another letter to the patient to say that I've -- you know, I'm referring you to see the

consultant as you may not be happy, want the treatment that was recommended.

127 Q. Is that your particular practice or does it happen that when the GP's letter is sent out that the patient automatically gets a copy? Is that process in existence yet? 11:03

A. That process is -- patients do -- normally we would say would you send a copy of the letter to the patient and that would then get sent. I know the recommendation is now that patients do get sent a copy of their consultation. But when I am dictating the letter and I would like the patient to have a copy I would ask for the copy to be forwarded to the patient. 11:04

128 Q. Do you know when that process came in, where there was an automatic sending out with the GP's letter a copy to the patient? Is that relatively new? 11:04

A. That's relatively new, yes.

129 Q. You mentioned the progress reports, just so I have it straight in my head, are the nursing notes and the medical notes kept separately or does the progress sheet from your intervention sit within the medical notes? 11:04

A. The progress notes sits on NIECR. If I'm documenting in the medical notes I would document in the same, as the same as the medical notes are documented. 11:04

130 Q. So you would chronologically follow on from the last entry?

A. Yes.

131 Q. So if I was reading them I could see one was written by

the consultant, one was written by you?

A. Exactly. If I'm carrying out a flexible cystoscopy there is a difference pro forma to fill in and to document and that would be filed in the patient's notes as well. 11:05

132 Q. I just want to mention this CNS forum that you have mentioned. That was a regional meeting facilitated by NICaN. I think that's when you mentioned, at the start of your evidence, when you first became aware of Mr. O'Brien through attendance at those meetings. You were every three months meeting to discuss the service and new developments and then due to poor attendance those meetings fell away. Did you find those meetings useful? 11:05

A. Those CNS forum meetings is when I first started as a urology CNS, in 2005, and yes, it was useful. Because we, especially with me being new to post, it was useful to be speaking to other urology CNSs. We did try to streamline the services so that we were singing more or less from the same hymn sheet. But, unfortunately, due to poor attendance, the meetings didn't continue. The meetings were supported by drug companies so that probably wasn't available either. 11:05

133 Q. And I think from 2021 there have been another CNS forum for urology CNSs from all Trusts again? 11:06

A. Yes. That has been carried out by NICaN. Now, unfortunately, we haven't had a urology CNS meeting I would say for nearly a year.

134 Q. April 2022, was that the last one?

A. Yes, that was April 2022.

135 Q. 28th April?

A. Yeah.

136 Q. Just when you mention there in passing, and thinking about the CaPPS example, are these meetings potentially the forum at which you could talk about standardising approach to, for example, the allocation of key workers? Is that an opportunity for you all to sit together, what are you doing in the Belfast Trust, what's the South Eastern Trust, doing we have CaPPS, let's use it the way you are, is it that sort of idea? 11:06 11:06

A. Yes, it is. We would discuss each Trust and what services we are providing. And if maybe on the agenda there is about key worker, we would discuss how we would record our key worker activity. If another Trust maybe has their own pro forma of recording it we would say we would record ours on progress notes. We also discuss with regard to nurse-led clinics. It's a discussion of each Trust to see what we are doing and where we are at. 11:07 11:07

137 Q. And the aim is to develop best practice?

A. Best practice, yes.

138 Q. So if you come back with the example of what could be best practice, if you were to do that now, say something some come up in April 2022 at the meeting and you thought, okay, Belfast are doing that, who would you take that idea back to in your line management? What's the route for you to feed back good ideas or potentially best practice? 11:07

A. I bring it back to my Nurse Manager and also bring it back to the consultants to inform them that Belfast Trust are carry out this type of practice and it seems to work very well for their patients.

139 Q. Is that still done informally? Would you say 'I was at a meeting and they mentioned this' or is there a way for you to report that formally and request that certain procedures are implemented? 11:08

A. I could send an email to my Nurse Line Managers, I could email the consultants. We could discuss this at the MDT. We also have a business meeting for the urology MDT and this could be brought to the urology meeting to say that the Belfast Trust are carrying out a practice that we feel would benefit our service. 11:08

140 Q. So you are doing this under your professional obligation to look for best practice? 11:08

A. Yes.

141 Q. And you feel that there are avenues that you can bring new ideas to. And do you feel that those ideas are met receptively? 11:08

A. New ideas are receptive.

142 Q. Just in relation to the concerns, you have never reported any problems, you have never had any reason to report any issues?

A. Not since my tenure starting in the Southern Trust, I have had no concerns to bring. 11:09

143 Q. And you also say that in your previous work in the South Eastern and the City you didn't have any concerns with any practitioners so you didn't have any reason to

instigate any governance processes yourself?

A. No. I had a very good working relationship with my colleagues in the South Eastern Trust and in the Belfast Trust and there was never any concerns about their practice so I was never -- I had no reason to incorporate any governance with regards to their practice. 11:09

144 Q. Now you have said in your statement - just for the Panel's note, at paragraph 30.1 - your views on raising a concern and you say: 11:09

"Raising a concern can be difficult. I believe that a personal grievance may arise from raising a concern. But nonetheless the focus should be on patient safety." 11:10

A. Yes.

145 Q. Could we unpick that just a bit? You believe that a personal grievance may arise, does that indicate that you or others or there is a general sense of, perhaps, reluctance about raising concerns? 11:10

A. I wouldn't have reluctance in raising a concern. If I felt patient safety was jeopardised due to practice I would raise the concern. I know if you did have to raise it, the person that you are raising a concern about could take a personal grudge against you because they feel that you are maybe taking a dislike to them. And it's not taking a dislike. You're looking at patient safety, you're looking at staff safety, you're looking at the person themselves safety as well. 11:10

146 Q. So it's more just a reflection on the fact that if you're close enough to someone or have a close enough working relationship to identify a concern --

A. Yes.

147 Q. -- that may impact on personalities and personal relationships? 11:10

A. It could impact on personalities.

148 Q. But you don't have any experience of that happening to you?

A. No, no experience. 11:11

149 Q. And you feel that you have a free pathway to raise concerns if any were to arise?

A. I would have no problem with raising concerns. And if I was concerned about patient safety I would have no problems in raising it with management. 11:11

150 Q. And just as a final point, it may be a convenient time, you do say in your statement that you found Mr. O'Brien to always be professional in the NICaN meetings.

A. That's right.

151 Q. He engaged with other people's opinions and without any difficulty? 11:11

A. Yes, that's right.

152 Q. And your first introduction to potential areas of concern around his practice or the practice of others was in the SAI process? 11:11

A. That's right. That was the first I was made aware of his practice.

153 Q. We'll move on to that shortly because it's the sort of final topic but one and it might be a convenient time,

chair?

CHAIR: Okay. We'll all come back then at 25 past 11.

SHORT BREAK

11:12

THE HEARING RESUMED AFTER THE SHORT BREAK, AS FOLLOWS:

CHAIR: Thank you everyone.

154 Q. MS. MCMAHON: Mrs. Thompson, I just want to move on to the SAI process and discuss it in general terms. The 11:25
Panel have heard a lot of evidence around the SAIs, they have looked at them in detail and various witnesses have spoken to them, including your predecessors on the team who have already given evidence, so it is just really some points I want to 11:25
make out. It's really the lead-up to your involvement and how you undertook your role and what you saw your role as being and how you undertook that role, and then just some general learning from it, to see what your views might be and if the Panel feel that there may be 11:25
something they can look at in relation to that.

A. Yes.

155 Q. Just at the start of the process, as we have already set out, Mr. O'Brien had retired by the time you joined the Trust and you were effectively nominated. After 11:25
having started on 3rd August --

A. Yes, that's right.

156 Q. -- you received an email from Martina Corrigan and if we can go to that email at TRU-303441. I just want to

read out the email from Martina, your reply and then the introductory email from Patricia Kingsnorth and that sets out the sequencing.

So we will see just the second email on this page, from Martina Corrigan, sent 16th August 2020 at 12:53. And it was sent to you and it copied Patricia Kingsnorth in. The subject "SAI Panel" and she writes: 11:26

"Hi Patricia, I hope all is well and you are settling in. Firstly, apologies, as I haven't got to spend any time with you, which hadn't been my attention but as you will have seen last Thursday, it is all a bit mad at the moment. Hoping for things to settle and I will get up to see you for a proper welcome. 11:26 11:27

I had hope to speak with you direct about some serious adverse incident panels that we have nominated you to sit on in relation to some urology cases. Dr. Dermot Hughes (retired Medical Director) is chairing the Panel and had asked for a urology CNS to input. After discussion, it was agreed that since you are new to the team but have the knowledge and experience that you would be best placed to sit with him and Fiona Reddick (Head of Cancer Services). Patricia Kingsnorth (Head of Governance) will be in touch with you next week to arrange the date and time of initial meeting. Speak soon, and thanks." 11:27 11:27

And then just move on please. It is signed at the bottom, "Martina". And we know she is the Head of Service.

So that was your first introduction to the possibility of you becoming involved. It seems to not have been a possibility but you have been put forward? 11:27

A. Yes, that's right.

157 Q. And you reply on the same date. From you on 17th August, the next day, sorry, at 2020 at 11:43, you reply to Martina and copied in Patricia Kingsnorth. And you say: 11:28

"Hello Martina. All is well and settling in very well. Everyone is very helpful. I would be happy to sit on the Panel for SAI with relation to urology. Hope to speak soon. Many thanks, Patricia." 11:28

Mrs. Corrigan had put into her last email that the reason they asked you was because you were new to the team and you didn't know anybody, you didn't know if there were any issues or not and you seemed to be, for their purposes, a natural fit to look at this through, perhaps, fresh eyes. 11:28

A. Yes, that's right. 11:28

158 Q. You had no awareness of any problems at that stage. This was exactly two weeks, I think, after you took up post?

A. That's right, I had no awareness that there was any

concerns.

159 Q. So if we move to the preceding page, TRU-303440. And this is an email sent to you from Patricia Kingsnorth, who we know is the Head of Governance. She sends it to you and copies Martina in and Fiona Reddick. And she says: 11:29

"Hi Patricia, many thanks for agreeing to assist with the SAI process. We have a number of cases to be discussed and will measure them against the existing pathway. Can you be available to meet with the review team on Thursday, 10th September at 9:30am in the meeting room, Trust headquarters." 11:29

And signs it off, "Many thanks, Patricia". So that was the start of your involvement in the process? 11:29

A. That's right.

160 Q. And that was the first meeting that you attended, that was your first introduction. I just want to ask you in general terms, we have looked at the notes and we have looked at the minutes and we have discussed this, in relation to your introduction at the meeting, did anyone set out your role and what was expected of you and what you brought to that particular process in relation to the make-up of the team? 11:29 11:30

A. No. I never had any information of what my role was to be with the team. I gathered that because I had experience of a urology CNS from another Trust, and a lot of experience, it was to sit on to see if there was

any key worker involvements. But I was never given any task to say this is the expectation we would like you as being part of the Panel for the SAI process.

161 Q. When you say key worker involvement, was it indicated to you that that was the purpose for you being involved, was the key worker issue? 11:30

A. No, I don't think it was the purpose of why I was involved. I think it was the purpose because of my experience and what I could bring to the SAI. But there was no criteria or no particular road plan was given to me. 11:30

162 Q. Did you have any knowledge at that meeting or after of the terms of reference of the SAI?

A. There was no terms of reference was formalised at the first meeting. But terms of reference was formalised following that first meeting. And they were written both by Patricia Kingsnorth and Dermot Hughes. 11:31

163 Q. Did you have any input into those terms of reference?

A. I didn't, no.

164 Q. Do you recall those terms of reference Doctor 1? 11:31

A. Yes, the terms of reference were referred to Doctor 1.

165 Q. Now you had no previous knowledge of SAIs or you had never been previously involved in any?

A. No, I had no knowledge of SAIs. I wasn't involved in any or I had never been the subject of an SAI. I never had any training either with an SAI. However, I do note that my role was just to sit on the Panel. It wasn't to be a chair or a governance part of the SAI. But no, I had no previous experience. 11:31

166 Q. Just so we get a feel of it. Something that we're not familiar with, but the SAI, was there a feeling that everyone was an equal member of the team and everyone brought a different lens to it or what was your feeling about it? 11:32

A. My feeling about the whole team, I wasn't given -- only my -- I felt that I didn't have a lot of input into the team. I would have liked to have maybe had more of an input. Such as with my experience and my experience of being a key worker and an experienced Urology Nurse Specialist, I felt my input would have been better if I could have liaised with families and with patients along with Dermot and Patricia Kingsnorth. Because I could have maybe found out more information, I could have spoken to the patients, I could have found out -- because the particular issue and it would tend to be that there was no key worker involvement, I could have maybe spoken to the families and maybe found out more specific information. 11:32 11:33

My role really was to look at the likes of the patient administration system, the appointments process, the DARO, the protective review, but it was never anything such as, you know, being involved with the patients or the families. 11:33

167 Q. So it was more data-led?

A. It was more data-led.

168 Q. You were good for figures rather than facts of processes?

A. It was more of timelines, you know, timelines of patients' appointments and was there a key worker at that clinic and when was the patient seen, was there a letter typed for that particular episode, that was more of my involvement. 11:33

169 Q. Now you have been through that process as a team member, do you think that training into how SAIs should be carried out should be mandatory before anyone undertakes such a role?

A. I think it would be useful if training was to be advised for anybody who wishes to sit on an SAI process. Also, too, it would appreciate what type of SAI is it, is it a Level 1 or 2 or 3. And also, too, what each team member brings to the SAI, such as the chair of the SAI or the governance person of the SAI. 11:34 But I do think it would be a very useful training for anybody who wants to sit on an SAI process is to do the two-day training.

170 Q. I think we established earlier in your evidence that you weren't tasked with or you didn't go away and unpick the process by which key workers were allocated and understand the different, perhaps, nuances that this Inquiry has had the benefit of hearing around how people might record that or how they may consider a key worker is being allocated, the point at which that was done, the individual's understanding of that process, none of that analysis was either asked of you or undertaken? 11:34 11:35

A. No, none of that analysis was asked of me.

171 Q. And, as I said, the Panel have looked at the notes and your voice is quite silent in the notes, if I put it like that, there is very little reference to you or contribution. Does that reflect in any way how you considered your role as viewed or valued or considered by the other team members? 11:35

A. I felt the team, I think it was more -- a lot of the lead was taken on with Dermot. And with Hugh Gilbert and Patricia Kingsnorth, they would have taken more of a lead on the SAI. I wasn't asked anything about -- you know, for my input. It was only really to look at the data or the timelines. Maybe I should have spoke up more. But I don't know what's -- I just felt that they didn't ask me to contribute more to the team. 11:36

172 Q. I suppose, from a learning perspective, would it be your view that it would have been helpful and perhaps allowed you to step forward more had you had a designated set out role and you knew what was expected of you, everyone else knew what was expected of you and you were given help in undertaking the role to bring back to the team, would that be helped? 11:36

A. Absolutely. I think if I had have been set tasks and what was to be expected of you would have been a better contribution on my behalf.

173 Q. I think you have accepted that you didn't go in formally, as part of your role in SAI, go and speak to Leanne McCourt, Jenny McMahon or Kate O'Neill for the purposes of your role at all on the SAI? 11:36

A. No, I wasn't asked formally to speak to the nurses. It

was really an informal query with the nurses with regards to Mr. O'Brien and his -- you know, did he use key workers in his oncology clinic? Did he invite nurses to sit in with him on his consultations?

174 Q. Did that involve you looking at rotas or anything or looking at notes to see if records had been marked about anything? 11:37

A. No, I didn't look at rotas. But I knew from -- Kate O'Neill wouldn't have worked on a Friday so she wouldn't have been really privy to what Mr. O'Brien would have... 11:37

175 Q. And he held his clinic on a Friday?

A. He would have had his clinic on a Friday. But no, it wouldn't have involved me looking at rotas or investigating or even reading the patient's medical notes, because some consultants maybe would document if there was a nurse presence in the room. I wouldn't haven't been... 11:38

176 Q. You didn't look at any of that?

A. I didn't look at that. I really took it from the likes of the GP letters that, maybe, Mr. O'Brien had dictated and he would dictate that he had the patient's -- you know, he had been in consultation with the patient. But in those GP letters there was no evidence that a nurse was present in the consultation. Consultants now would say in their letters that they had seen a patient and they had -- in attendance with a Urology Nurse Specialist and who the Urology Nurse Specialist was. 11:38 11:38

177 Q. Did you look at the other consultant's notes to get a

feel of whether the problem was systemic?

A. No. I have had looked at some notes and consultants, the other consultants would document that if there was, they would document that they had seen the patient and who was present in with the patient. 11:39

178 Q. Just in relation to the SAI and your role in that, did you look at that then?

A. No.

179 Q. Did you do it by comparisons?

A. No, I didn't. 11:39

180 Q. So there was no consideration of whether this was a unit-wide problem?

A. No, I didn't look at notes to see if it was a unit-wide problem.

181 Q. Now, you've said you have no experience of SAIs and you have no training in that, and you have been clear about that from your earlier evidence. Did you understand SAIs to be investigations into events or into people? 11:39

A. I understood it to be an investigation into events as opposed to a person. My knowledge of SAI is to look at an incident or an event that's happened that maybe has caused or potentially caused harm to a patient or to a client or service user or to a member of staff and it's to look at the process to see how it happens, why it happens, what systems could be put in place to prevent this happening again, what learning we can have from this, and also to any recommendations. 11:39 11:40

182 Q. So if, for example, you were looking at the availability or non-availability or non-allocation of a

key worker, you could start at the entry point for the patient, follow their pathway, lead you to the SAI, and track, perhaps, key moments in that journey at which a key worker could have or should have been allocated?

A. Yes. That's right, yes. 11:40

183 Q. So if there were various consultants, district nurses or nurses within that pathway --

A. Mm-hmm.

184 Q. -- then, would it be your view that it might be fair to reflect that they had the opportunity also to allocate 11:40 a key worker and didn't do so?

A. Yes. It would be my reflection if there was other -- if the patients had seen another consultant or if they had been admitted as an in-patient or if they had maybe consultation with another Nurse Specialist from a 11:41 different, maybe, tumour site or a community nurse. If they felt that a patient needed to be introduced to a key worker with regards to their cancer, that could have been, you know, I felt that could have been, maybe, referred to the urology nurses. 11:41

185 Q. Just so I am clear, for example, there may have been multiple opportunities for Mr. O'Brien to have allocated a key worker that were missed and equally --

A. And equally.

186 Q. -- on some of the evidence, for example Patient 9, 11:41 there would seem to be key points in that patient's care pathway in which other medics or nurses were involved in which they also could have allocated a key worker?

A. Exactly.

187 Q. And would it be your view that, given SAIs are into events and not individuals, that the findings and learnings from those SAIs might have better represented those points were key worker rather than just collectively refer to Doctor 1? 11:42

A. Yes, I felt that it was very much blaming Doctor 1. Whereas if you looked at some of the SAIs, there was events, there was times that a key worker could have been introduced by, maybe, another doctor or a registrar or another Nurse Specialist. And that's learning from the SAI that maybe there could be systems put in process for referral to key workers from other nurses or other doctors if a patient is presented through their journey. 11:42

188 Q. So for learning, if the Trust were to roll out learning --

A. Yes.

189 Q. -- it's better if they see all the weak spots in the system, as it were? 11:42

A. Yes, exactly.

190 Q. If there are any. And try and address those as the patient's journey continues?

A. Exactly.

191 Q. For example, if an individual patient has more than one primary site and they are attending two specialist clinics - and sometimes for people that happens almost simultaneously - is there any communication or pro forma or standardised approach to who should allocate 11:43

the key worker? Should they have one key worker? Should they have two key workers? Give us a flavour of how that operates in practice?

A. If a patient has a prostate cancer and they also, maybe, have a lung cancer, they do see the two different Nurse Specialists with regards to their particular cancer sites. If I had a patient that I was reviewing, such as lung cancer, but had no key worker, I would contact the lung Nurse Specialist to say I am reviewing a patient and he has a newly diagnosed lung cancer, I don't feel this patient has a key worker, could you make contact with the patient. 11:43 11:44

192 Q. So you can do that?

A. I could do that, yes.

193 Q. You yourself can do that? 11:44

A. Yes.

194 Q. And any nurse or medical practitioner can do that, healthcare practitioner?

A. Any nurse, yes, they could do that. There's not really a pro forma. They could send an email or they can send a letter to say I've had this patient and he has no key worker, he is newly diagnosed cancer within your speciality, could you see the patient. 11:44

195 Q. And you have mentioned earlier what could be considered a safety net with the systems now in place, the CaPPS and the documentation and reflection of key worker allocation in parts of the Trust's own system? 11:44

A. Yes.

196 Q. So you would be able to look it up?

A. Yes. If this was recorded on NIECR and progress notes you could see if the patient has been seen by another Nurse Specialist. You can also look at CaPPS because the patients would have different episodes recorded in CaPPS. Such as if a patient has a lung cancer they would be the lung MDT and you can view that lung MDT if a CNS has been in contact with the patient. 11:45

197 Q. So there are different inbuilt fail-safes throughout the system now that allow that to be picked up?

A. There is. That's right. 11:45

198 Q. In relation to the fail-safe issue around CNSs and whether they in fact do represent a fail-safe for follow-up treatment and community care, the tone of your evidence is they are part of a system that allows those processes to be accessed and for follow-up to be looked at or triggered or phone calls to be made, but there has been some pushback from some of the nursing staff against the idea of, essentially, the buck stops with them, if they are not involved then things shouldn't be done, what's your view on that? 11:45

A. I felt that when the word of fail-safe, the other CNSs felt that they were being blamed if a patient got lost or wasn't followed up and that wasn't really the term what Dr. Hughes was referring to, that the CNS is throughout the patient's journey. They have good contact with the patient and their relatives. They will be aware of if the patient has been referred for radiotherapy or for any treatment, such as, for example, if a patient had been referred for 11:46

radiotherapy and they have not received an appointment, that patient can contact me and I could follow that query up of why the patient hasn't been referred yet or is there maybe a waiting list or maybe there is a delay in the referral. Also, too, such as if a patient needs palliative care, we can refer the patient to the palliative care team and that's done by an online pro forma form. 11:46

It wouldn't be a safety net but it is a good standard of care for the patient to have when they are going through their cancer journey. 11:47

199 Q. And you would know all of the issues and care pathways that people might need to explore even within hospital or in the community, so it's that link? 11:47

A. It's that link, yes, that we can refer to, the likes of palliative care. Also, too, with the likes of the holistic needs assessment, we can refer patients out to -- such as if they have finished their treatment and they complain of fatigue they can be referred to the Move More programme, they can be referred to a rehabilitation programme, they can be referred to counselling. If there needs to be a referral to the community nurses to follow-up, we can access and put that referral in process. 11:47 11:48

200 Q. Now you have mentioned about the communication and we talked about that earlier, the importance of that and Fiona Reddick, in her evidence, commented that she felt underutilised on the team. Who do you understand to

have been the person who contacted the families during the SAI process?

A. It was Dermot Hughes and Patricia Kingsnorth were the two that contacted the families.

201 Q. Do you know what they were told or what was discussed with them specifically? 11:48

A. They were discussed with regards to the investigation into their care that was managed by Doctor 1. They went through the process of what their care and how it could have been managed better. They asked had there been any evidence of a key worker involved in their care. 11:48

202 Q. Now Patricia Kingsnorth, in her evidence, said that you had been asked to sound out, in an informal way, from the nurses the way in which key workers were used, do you recall that being asked of you? 11:49

A. I can recall it being asked just to say -- to find out just how did Dr. O'Brien use key workers. It wasn't written or it wasn't asked to me to ask specific questions or to interview each nurse. I would have asked informally with the likes of -- with Kate O'Neill and Leanne McCourt and Jason Young, who had worked in the Thorndale Unit as a Clinical Sister and then left for a period of time and then came back as a CNS, did Mr. O'Brien, on a Friday, did he call in the Nurse Specialist when there was an oncology consultation. And Kate O'Neill, obviously, didn't work Friday's so she wasn't privy to that information. But with Leanne and Jason and also with Dolores Campbell, they had 11:49 11:49

mentioned that no, he wouldn't have called the patients in to the consultations.

Now I am aware that Jenny McMahon did run a clinic parallel with Mr. O'Brien and that would have been with urodynamics and flexible cystoscopy, so he would have maybe had an input with Jenny. But after urodynamics was carried out on the patient he would have brought the patient back in for the consultation, so that Jenny wouldn't have been brought in to that certain consultation. 11:50

203 Q. Did you ask those individuals, in relation to clinics that are breaking bad news, clinics effectively where some people are getting results about cancer diagnosis, did you ask does Mr. O'Brien bring a nurse in or does he stop them coming in, what way were you querying that? I just noticed the word "informal" and I just wonder the way in which you maybe approached that? 11:50

A. I asked him would he have brought nurses in. I wouldn't have said did he stop nurses. I would have asked did he bring nurses in or invited them in. And they would have said no, they wouldn't have been brought in to the consultation. 11:51

204 Q. And they were people that had direct contact on the Friday clinic? 11:51

A. On the Friday clinic, yes.

205 Q. Now there has been some evidence to the Inquiry, Ronan Carroll, in one of his interviews with Dr. Hughes said that many of the nurses were afraid of Mr. O'Brien.

Now I know you didn't work with him, he had retired by the time you joined so, obviously, anything you are hearing is hearsay from others. Did you get a flavour of that at all or did you hear anything about that?

A. I never heard that they were afraid of Mr. O'Brien. They said he was very set in his ways, his culture. But they never would say that they were afraid of him. And I think they were just used to his delivery of care, how he managed the key workers, I think they were just used to that. It wasn't a case of they were afraid of Mr. O'Brien. 11:51 11:52

206 Q. Now in relation to your involvement in the SAIs, is there anything else you would like to add that might assist the Panel in considering whether the effectiveness of SAIs generally as a governance tool or what you think, as having been on a team, might help beyond what we have already discussed, is there anything further? 11:52

A. I feel, obviously, training is very important for the SAI. I think even informing a person what the SAI is about. Because I had no knowledge really of the SAI until I attended the day of the meeting. Now, the day before I note that Kate O'Neill and Leanne McCourt were doing a pathology Lookback Review on Mr. O'Brien and they had discussed that with us and I had mentioned to both Kate and Leanne that I was asked to be involved in an SAI and I was querying would this have been about Mr. O'Brien. They were unsure. But, obviously, when I attended that meeting on 10th September, looking 11:52 11:53

at the SAIs then I realised or worked it out that it was about Mr. O'Brien.

I think it is good to be notified what the SAI is about because I did find the SAIs was very, very comprehensive and very complex. A lot of it was very emotional because a couple of the patients did -- I felt was very emotional about a couple of the SAIs. And I think, too, counselling, if somebody could maybe be very upset with regards to an SAI, because a patient could have catastrophically been harmed and maybe counselling may be something to consider. 11:53

207 Q. Some sort of outreach around patients who have been involved in that process?

A. Sorry? 11:54

208 Q. Some sort of outreach in relation to patients who might have been affected by the SAI process itself?

A. Yes, for the patients been affected by the SAI process. And also staff as well, staff could value from counselling. 11:54

209 Q. So while maintaining the confidentiality of the SAI, when someone is asked they should be given a general flavour of what it is about, what it might entail so that you can make an informed decision as to whether you want to be part of that team? 11:54

A. Yes, I would think that. But if I was informed of what the SAI was about I would still have sat on the Panel, because those patients and relatives were looking for answers and it was something that needed to be

investigated and I didn't want to delay the investigation process. And it was also to look out, to look for another Nurse Specialists because they would have had to go outside the Trust or maybe had to go across over to the mainland to look for a Nurse Specialist. 11:55

210 Q. Thank you for that. Is there anything else about the SAIs that you would like to take the opportunity to say?

A. Nothing, no. 11:55

211 Q. The Panel may have more questions on that. But I just wanted to briefly touch upon the review and some of the updates you mentioned in your statement. One of the things you mentioned was a Urology Cancer Service Patient Engagement Report? 11:55

A. Yes.

212 Q. Could you give us a bit of background to that, is that a new development or is that something?

A. Sorry, that was carried out by Macmillan and this was like a peer review from -- we gave a list of patients 11:55 who had a urological cancer, we gave a list of patients who had bladder cancer, renal cancer, prostate cancer, these patients were interviewed by a group of - patients who had been affected by cancer - on their journey and were they happy with the key worker role, 11:56 did they feel that a Nurse Specialist was helpful in their journey.

213 Q. Has that report been published?

A. It has been published, it had been published last year.

214 Q. Perhaps we can get a copy of that?
A. Yes.
215 Q. And that's a reflection on the service as it was last year based on peer review and patients?
A. It was based on Macmillan. 11:56
216 Q. Macmillan. Macmillan peer facilitators, is that it?
A. Yes.
217 Q. So they spoke to the patients one-to-one got their feedback on what the service was like and the engagement, especially in relation to -- or it includes 11:56 in relation to the CNS and that report has now been completed?
A. Yes.
218 Q. So that would give us a snapshot of what was happening at that time? 11:56
A. Yes, that report was about, you know, with the service and with the key worker, it was with Macmillan. And the interviews were carried out either via telephone or by Zoom from the facilitator to the patients. The patients were notified beforehand, where there had been 11:57 sent information to see if they want to consent?
219 Q. Take part in it?
A. Take part in it.
220 Q. Okay. So that's the update in relation to review. In relation to learning, if I could just go to WIT-86667. 11:57 Hopeful that's paragraph 58.1. Yes, just down at the bottom. You have been asked: "What do you consider the learning to have been from a governance perspective regarding the issues of concern within Urology Services

and regarding the concerns involving Mr. O'Brien in particular?" And you reply at 58.1:

"I consider the learning from a governance perspective regarding the issues of concern within Urology Services and regarding the concerns involving Mr. O'Brien to be strong leadership. A manager or a leader needs to have a skill to ensure staff don't overstep boundaries that can have an impact on the service. These need to be addressed. However, strong personalities can be difficult if issues have to be addressed by managers. I have mentioned issues in my answer to Question 56. 11:58

There was no capability process in place. I am aware that nursing staff go through a capability procedure if there have been concerns with their performance. Do procedures exist in this case for medical staff underperforming? There needs to be learning from this such as the use of the whistle blowing. Each Trust has a policy on whistle blowing but unfortunately staff are reluctant to use this, as they do not want to be seen as a trouble maker." 11:58

Let's just stop it at that one. The capability process that you refer to, is that specific to nurses? 11:59

A. There is a capability process for nurses if they are not performing.

221 Q. What does it involve?

A. It involves, from what my knowledge would be, that they

would undergo supervision, they would have a period of mentorship and then this would be reviewed on a regular basis to ensure that their practice has improved or hasn't, you know, hasn't got any worse. They would report to their mentors and report to their Nurse Managers and then they would decide if the capability process, then that can be finished. 11:59

222 Q. So someone is supported to address the concerns that have been raised?

A. Yes. 12:00

223 Q. So that they can stay in post and patient safety is paramount?

A. That's right.

224 Q. And you don't know if that mirror process applies in any way to medics in urology and where you work at the moment? 12:00

A. I wasn't aware when I was completing my Section 21. However, I do -- I was made aware during the Inquiry that Mr. O'Brien had been under a period of supervision. 12:00

225 Q. In relation to the issue about whistle blowing, where you have said that staff are reluctant to use this, is that a general feeling that you have or is that just something that because you don't really know any whistle-blowers you assume that maybe people aren't keen on going down that route? 12:00

A. Yeah. I feel I don't know a lot of whistle-blowers. So people maybe are afraid to go down the route. If there could be maybe a particular clinician or nurse

could have a very good personality or a big personality and liked by their staff, by their peers but their practice may be concerning, if somebody has maybe raised an issue, they may feel victimised because they have raised that issue about the person. But I don't know any -- I haven't come to any whistle-blower that has raised any issues.

226 Q. So the example you gave is an example of group think, where someone might be a popular member of staff or, perhaps, a very powerful member of staff in some staff's eyes and you say that the culture doesn't lend itself to someone standing up against those individuals? 12:01

A. Yes.

227 Q. Given that you work in the Trust and you have a lot of experience, is there anything that you can do about a culture like that? I mean, what would you suggest would be ways of getting around people's fear of raising issues because of the potential personality culture? 12:01 12:02

A. I feel that, maybe, such as, maybe, learning. Maybe sending staff on to courses such as leadership courses could, maybe, look at this, how to deal with conflict courses. In my last post I did a leader management course which I found was very useful and that looked at how to carry out appraisals, how to carry out maybe wanting to speak to a patient or to a member of staff and I did find that very useful. But I do think that maybe more training should be involved if somebody 12:02

wants to raise an issue or has a fear, maybe looking at policies and highlighting and bringing policies to staff.

228 Q. Ownership around policies, if people feel involved in policies and then they feel more comfortable seeking them to be enforced perhaps, is that what you mean? 12:02

A. Yes, taking more ownership in the policies, such as policies dealing with working well together or policies on conflict or policies on bullying or harassment and looking at the policies on whistle blowing or raising a concern. 12:03

229 Q. I think you mentioned the management course you were on, do you think that raising staff confidence generally through courses like that allows them then to perhaps have a stronger voice when they feel they need to use it? 12:03

A. Yes, I do. I found it a very useful course. It was a two-day course that I attended and I found it was very useful with the likes of, maybe, staff appraisals. Also, too, with the service, looking at if staff wanted to maybe look at service provision, seeing where the need was. And it was just I found it a very useful course that a colleague in my previous post attended the course. And even other courses such as managing your emails, they are all useful courses that could help with any issues. 12:03 12:04

230 Q. Courses that are more to do with your role than your actual professional training?

A. Yes, exactly.

231 Q. You don't need those tasks until you come into that professional capacity. In relation to the learning from the SAIs, was there or is there a way in which any learning or findings are rolled out to staff so that people know what happened and what needs to be done so that it doesn't happen again? 12:04

A. In the SAIs, the nine SAIs?

232 Q. Those ones specifically and then your understanding now if it has changed?

A. Yes. The overarching report obviously was rolled out to the team and now what learning has come from that is we ensure that, especially for the key worker, a key worker is always available at the clinics. Obviously the more members of staff that's available. We have more members of the medical team. We have more middle medical staff available. We have physician associates available. We look at competencies. 12:04 12:05

233 Q. You have a greater use of the computer systems to mark when, for example, a key worker has been allocated?

A. Yes. 12:05

234 Q. Would it be fair to say there has been a general filtering out of the concerns that were identified in the SAI in the hope that they can be limited, that any repetition will be reduced?

A. For the likes of our documentation, the likes of the progress reports and CaPPS, that is an excellent way that we can look at. If there was an issue about a key worker, we can look at this and see that there has been a key worker available because we can go back and 12:05

that's recorded.

235 Q. Do you think, given that you were in a unique enough position to be on the team and to be part of the department that was to be involved in rolling out the learning, do you think, on reflection, it would have been better to embed the learning in a different way or to inform staff in a different way of what had been discovered and how that can be remedied? With hindsight, do you think they should have maybe had a meeting or spoke to managers and really, really drilled down into what the issues were? 12:06 12:06

A. I think, yes, I think there should have been a meeting with the CNSs from Dermot Hughes and Patricia Kingsnorth, the interview with regards to any issues that have come up with the SAIs. The overarching report was discussed at a meeting in February 2021, that was the first really information that the CNSs had received about the SAIs or about the outcome of the SAIs. 12:06

236 Q. And that was post the outcome? 12:06

A. That was post outcome.

237 Q. And they were given a copy of the report and they provide their own feedback so there was that route?

A. Yes.

238 Q. But are you saying that there should have been a more formal look at this, this is the issue, how are we going to address this sort of meeting? 12:07

A. Exactly, I think there should have been. Well, I do feel there should have been a more formal meeting with

the chair and Patricia Kingsnorth of the SAIs to speak to the Nurse Specialists with regards to any issues that they felt with regards to the key worker.

239 Q. And having been closely involved in those nine SAIs, how confident would you be that the issues that were raised in those SAIs and the fallout, perhaps, from those issues wouldn't be repeated today? 12:07

A. I am very confident it wouldn't be repeated today as we have more members of staff, we ensure that clinics are covered for a key worker to attend. Medical staff. A couple of the consultants do have outreach clinics or satellite clinics in Daisy Hill Hospital in Armagh Community Hospital, we ensure that those clinics are also covered with a key worker so no patient, just because that's -- 12:07 12:08

240 Q. Their location?

A. Yes, their location. Also, if, unfortunately, a key worker cannot be available at the consultant's clinic - and this could be due to sick leave or study leave - the consultant is made aware, the consultant copies us into the letter and we are cc-ed and we are sent the letter to make contact with the patient and to send out the relevant information. 12:08

241 Q. So there is much greater communication, much greater awareness of where things might fall down? 12:08

A. A lot better awareness. And it's a lot tighter now than what it had been prior to the nine SAIs.

242 Q. Mr. Devlin, the former Chief Executive, gave evidence and he does indicate in his statement, just for the

Panel's note, at paragraph 74, what he considers to have been the outworking of the SAIs - and I can discuss that with Mrs. O'Kane - but from your practical level, you feel assured that any gaps in provision or weaknesses in the system have been addressed? 12:09

A. Yes, these have been addressed. We ensure that all our key worker clinics are covered or their post-MDM clinics are covered. Even if a consultant needs to see a patient, that's what they call a hot clinic, it's an ad hoc that has maybe come in that needs to be seen 12:09 urgently, such as a patient with metastatic prostate cancer or a testicular tumour, we still ensure that there is a nurse available and we will provide information. We also make sure that information is available, especially at the outreach clinics. We have 12:09 a surplus supply of Cancer Core Packs and site-specific information with our contact details.

MS. MCMAHON: I don't have any more questions in relation to that. Unless there is anything you would like to add or anything you think from your statement 12:09 we should discuss. But I think I have tried to cover most of the areas. But if there is anything else you would like to say this is the opportunity to say it?

A. Just that since the nine SAIs, since I started, the service has developed more with the additional of the 12:10 new CNSs that we are having available at the key worker clinics. We also, again as I mentioned previously, we're looking at succession planning. We're looking at training. Also with myself hopefully being trained up

in the transurethral laser ablation, that will give me more scope to have more flexible cystoscopy clinics. Also, the new appointments of staff has given Leanne more scope to have her TP biopsy service. We did come up very, very well with the GIRFT report and we were noted to be one of the top CNS teams who had developed the roles, no other nurses in Northern Ireland was carrying out TP biopsy service. There was very few nurses in Northern Ireland that actually have a flexible cystoscopy service. Jenny also is the only nurse that carries out flexible cystoscopy with administration of botox as well in Northern Ireland. 12:10 12:11

MS. MCMAHON: Thank you for all of the information. I am sure the Panel can consider that. And they might have some questions for you, but I'm finished with my questions. Thank you. 12:11

CHAIR: I can't let you go just yet, Mrs. Thompson. Mr. Hanbury will have some questions first of all.

MRS. PATRICIA THOMPSON WAS THEN QUESTIONED BY THE PANEL MEMBERS, AS FOLLOWS:

243 Q. DR. HANBURY: Thank you very much for your evidence. You will be pleased to know you have answered quite a lot of my questions already, so I'll stick to a few clinical things. You say when you started the kidney cancer follow-up was a little bit ad hoc, could you just expand on that? You mentioned about patients not being seen perhaps as regularly as they should have 12:11

been?

A. In the kidney cancer follow-up?

244 Q. Yes.

A. The kidney cancer follow-up, these patients had been reviewed by the consultant, they had never seen a consultants face to face. They would have had their annual or their surveillance scans and they would have attended the scans and received a letter from the consultant informing them that their scan results shows a stable disease and they will have a repeat scan in 12 months. Those patients never really had any other contact except within they attended for their scans and received the letter from the consultant. Having the kidney cancer follow-up, these patients now have a contact with myself. They would have a contact within six months, every six months or every year. I would discuss with the patients with regards to is there any concerns about, if they are maybe feeling that they have got unexplained weight loss or if they have any night sweats, any fatigue or new symptoms such as the blood in the urine. They like to have that contact with the nurse on a regular basis, so it has improved. 12:12 12:12 12:12

245 Q. Thanks. And you actually see them face to face or is that remote?

A. It's both. Some patients are face to face and some patients are virtual. It all depends, if it is an elderly patient who is unable to attend hospital, yes, I would see them face to face or, sorry, see them virtual. If it is a patient who requires an 12:13

interpreter, it's better to see the patient face to face. Some patients maybe prefer to attend a hospital appointment rather than have a phone call or virtual.

246 Q. You say you organise the bloods and the CTs or ultrasounds yourself? 12:13

A. That's right.

247 Q. But there is still this frustration that the results don't come back to you primarily?

A. That's right.

248 Q. Is that something that you can fix or? 12:13

A. For the imaging unfortunately, as I had previously mentioned, it's a regional issue with NIECR. However, I have completed a form to the labs, so I can get a code that, when I'm carrying out any bloods or anything such as urine for cytology, I can be notified myself 12:14 with regard to the results would be available.

249 Q. Thank you. Your protocol for this is very impressive, is that your own work, is that a protocol thing? Have other colleagues used that?

A. That is my own work. I had completed that protocol, 12:14 that guidelines when I worked in the South Eastern Trust and then I transferred the protocol and adapted it to the Southern Trust.

250 Q. Does that use sort of BAUS or European guidance is embedded with that, I think I saw that? 12:14

A. It is, yes.

251 Q. Okay. Just looking at, not all patients are post nephrectomy and some you are following small kidney matters, and we have seen problems with that in one of

the SAIs that you looked at. If patients, for example you're following a small kidney mass, it gets bigger do you have easy access back to MDM, is that discussed at a regional level, what's the process?

A. If I had CT results that come back and is showing an increase in the kidney mass, I would bring this to our local MDM. However, they may suggest that it goes to a small renal mass meeting to be discussed to see if the patient would require at that stage maybe a partial nephrectomy or a nephrectomy or ablation. 12:15

252 Q. How is that actually done, is that part of your MDM or?

A. When I bring it to our local MDM.

253 Q. The small renal mass?

A. And the small renal mass, the small renal mass gets referred on another pro forma and that is sent by the cancer tracker. Then that is sent to the small renal mass meeting, which is held twice monthly. 12:15

254 Q. And that's at?

A. At the Belfast City Hospital.

255 Q. At Belfast. So that's sent as an intra-trust transfer? 12:16

A. Yes, it's intra-trust. Unfortunately, we don't have availability, you know we don't attend that small renal mass meeting. We would receive the outcome from the cancer tracker or CaPPS would give us information of what the outcome was. 12:16

256 Q. So that's a much more robust system that was perhaps in place --

A. It is, yes.

257 Q. -- leading up to your time. Thank you. Moving on to

sort of bladder cancer anaphylaxis - that's very impressive what you say - do you also give bladder chemotherapy and BCG yourself, or is that done by a colleague?

A. That's done by a colleague. We have a full-time Band 6 nurse who administers the bladder mitomycins and the BCGs. She also administers the cystistats and the iAluRil treatments. She has a very good rapport with the patients. She would be even seen as their key worker, because some of these patients do require maintenance treatments so they are attending this nurse for a period of time. 12:16 12:16

258 Q. Okay. Thinking about one particular case we heard on earlier this week that had an original small bladder tumour, then seemed to be lost to follow-up because of pathology delays and MDM, now presumably when you personally pick up a new bladder tumour you can introduce yourself, I mean would that happen now, do you think? I mean, you don't do all the flexible cystoscopies, I guess, or maybe you do, can you just expand on that? 12:17 12:17

A. Well I wouldn't do all the flexible cystoscopies. Some of the flexible cystoscopy referrals do get sent out to the independent sector. They would have a contract with the Trust and they would be seen by urologists who either work in Northern Ireland or come over from England to see these patients. I haven't been aware of any patients that have been lost to follow-up, a lot of patients do come back. I would actually receive 12:17

correspondence from the Trust clerical staff who deal with the patients that have been sent to the independent sector advising about the outcome of the patient's flexible cystoscopy and I would liaise with secretaries which will now have to liaise with the scheduler if the patient needs a repeat cystoscopy or if they need followed up at MDM.

259 Q. And that's the history, your comment about there being a backlog when you started and people waiting too long for their first check cystoscopies particularly? 12:18

A. That's right.

260 Q. Now that has greatly improved, is it?

A. That has improved, yes.

261 Q. Thank you. In 2015 there was a review of patient experience and the oncology specialist nurses mentioned 75% had been introduced, obviously the implication is 25% weren't, what do you think should have happened at that time? 12:18

A. They should obviously have looked at where the deficits were and there should have been maybe plans put in place such as, if 75% or 25% patients weren't introduced to a key worker, they should have looked at this and looked at maybe is there a need for more staff. They should have obviously written up a job plan or referred. They could have maybe trained up some of the Band 5 nurses to be available to give information. I know they couldn't do the role of the key worker but at least if the patient had information. 12:19

262 Q. And who should have done that? Is there someone higher

up in the organisation that --

A. For myself it would be hard for me to really answer that question for the Southern Trust because I, at that time I was in the South Eastern Trust. I was aware of the survey of 2018. There was obviously a deficit in some of the answers, and our Nurse Manager did look at some of the deficits. We tried to look at job plans to see -- because my job plan in the South Eastern Trust was both benign and cancer, and I was Macmillan, tried to see was there an area in the benign side of my job plan that I could step down or allocate to somebody else and I could work on the key worker. 12:19 12:20

263 Q. Thank you. Nearly there. Just one other question about the specialist part of the MDT. You have already said the small kidney masses, they go down a separate avenue. Things like muscle invasive bladder cancer, perhaps patients coming up to cystectomy; and another group, younger patients with prostate cancer being considered for radical surgery, do they also go on an ITT or are they discussed at your local MDM but with colleagues on the telelink or the videolink? 12:20 12:20

A. They are discussed at our local MDM. They can be referred to the regional for discussion if the patient is suitable for radical prostatectomy or if they need cystectomy. Mr. Haynes, who sits on our MDM, does do the cystectomies, so if patients who require that are discussed in our local MDM. 12:21

264 Q. So you actually have specialist expertise locally?

A. Yes, we do.

265 Q. Fantastic. Just very lastly. Now you say you have got a clinical oncologist and a medical oncologist there. So, for example, if a new testicular cancer comes in, your medical oncologist will pick that up or hear about it at your local MDM? 12:21

A. The testicular cancer is discussed at a specialist MDM and that is a testicular MDM. They are discussed at our local MDM, but if they need referral they are discussed or, if they are referred, they are discussed at a testicular MDM and a referral is processed to the 12:22 testicular team in the Belfast Cancer Centre.

266 Q. The fact that the medical oncologist is there must oil the wheels to make that happen efficiently?

A. It does, yes.

267 Q. And prevent people slipping through the net, to use 12:22 that expression?

A. Yes.

DR. HANBURY: Okay. Thank you very much.

CHAIR: Dr. Swart?

268 Q. DR. SWART: So I think you have described quite well a 12:22 complete change in culture in terms of the attitude to the importance of key workers in urology in the department at Craigavon from the time you started there perhaps --

A. Yes. 12:22

269 Q. -- spurred on by this series of SAIs at the time. That change in culture means that the whole department really has to work together and support it, which I think you have also alluded to, this is not a one

person task ever?

A. No.

270 Q. How did you feel, when you were on that SAI Panel and you discovered that all of these patients had basically not had access to a key worker for whatever reason, and, as you were feeling that, did you talk to the other nurses about it and how did they feel about it? What was your sense of the impact of this? 12:23

A. Well, I was upset to know that the patients, the majority of the patients didn't have access to a key worker. When it was discussed with my colleagues, they were upset to know that these patients hadn't a key worker. They did meet about two or three of the patients but this was after the issue, the concern was raised and the Datix had been completed. But they were upset as well with regards to -- that patients were lost, they didn't have the service that they should have received. 12:23

271 Q. Do you think the department as a whole really understood that this was a whole department team responsibility at that time? 12:24

A. I feel -- initially they felt that it was blamed on Doctor 1 because he didn't call patients in. But then an overview that there was maybe --

272 Q. Mm hmm. 12:24

A. -- episodes where patients could have access to key worker, such as when they were admitted to the ward or when they attended an ambulatory clinic or when they attended for another appointment such as urodynamics.

There is more awareness now that these patients could be --

273 Q. My own experience over the years is that you can always, even if you haven't got a nurse actually available, you can always arrange it afterwards, if it really is important to you? 12:24

A. Yes.

274 Q. But the thing that makes the difference is the team culture of discussing what's important for patients?

A. Mm hmm. 12:25

275 Q. Does that happen now, do you feel properly involved in framing the strategic discussions for the department?

A. Yes, I do feel very involved in framing the strategic [sic] for the department. There is that culture now, that they very much -- they want key worker. Our manager wants to ensure that there is key worker available. 12:25

276 Q. What other issues? I mean, this is the department which would have gone through a hugely difficult time, you have described lots of improvements, lots of really good nurse initiatives, the future is all about professions working together? 12:25

A. Yes.

277 Q. But you have to plan it; are you getting support as a department to plan the strategy going forward? 12:25

A. Yes. We are being supported as departments, being supported from the consultants, our management is supporting. Everybody is very much -- we have, at our team meeting every month, we do have a lunch prior to

the team meeting. We have away days to work together as a team to see -- like team building days, to work together.

278 Q. Is that having a positive impact?

A. It is having a positive impact because we are discussing any issues or any concerns we have maybe to work as a team. There isn't as many -- to my knowledge I don't see any concerns as a team. I think we work very well together, we're very tight. 12:26

279 Q. And specifically the whole issue of specialist nurse development, who is giving you your professional nursing leadership, mentorship, challenge, development, both in the trusts and in Northern Ireland as a whole, is that being taken forward in a way that you can recognise or is that still something that needs some work? 12:26

A. It is probably something that would need some work. We do have good nursing support, our managers gives us good nursing support.

280 Q. But is that in a specialist cancer field at all, is it people saying, look, like this is what is happening? 12:27

A. There used to be -- Queen's would have done a specialist nurse qualification.

281 Q. Mm hmm.

A. That would have been, especially for cancer that would have been oncology. There is also the push for doing the non-medical prescribing. Also there is a push for the advanced nurse practitioner. 12:27

282 Q. So where is that coming from? Who within the Trust is

1 championing that, do you know where to go with all your
2 brilliant ideas?
3 A. I would go to the management. There is the education
4 department in the Southern Trust. There is Commission
5 courses to attend for the likes of the specialist 12:27
6 practice or the non-medical prescribing or advanced
7 nurse practitioner.
8 283 Q. Perhaps not the network in Northern Ireland wider that
9 you talked about before?
10 A. No, unfortunately we don't have that network. 12:28
11 284 Q. This issue about getting results and all of that, is
12 there a working party pushing this forward to resolve
13 some of this, because it's quite clunky, isn't it?
14 A. It is quite clunky. As I had previously mentioned, we
15 went to our managers to see and filled in forms, filled 12:28
16 in online forms to the laboratories so we could be
17 given access to blood results, to urine results and to
18 cytology results. The only unfortunate is just the
19 imaging results we cannot have access to.
20 285 Q. This is a UK-wide problem, isn't it? 12:28
21 A. It is.
22 286 Q. Are you aware of any work that's been done to unravel
23 this, because it's not really logical for nurses to
24 take on more and more specialist tasks and more and
25 more responsibility, and the system needs them to do 12:28
26 that --
27 A. Yes.
28 287 Q. -- without giving them the tools?
29 A. Yes.

288 Q. Or a range of tools?
A. I'm not aware of any work in progress at present.
DR. SWART: Okay. Thank you very much.
THE WITNESS: Thank you.
289 Q. CHAIR: A couple of things from me. You were saying the DARO system that operates in the Southern Trust and how it would be useful to have access to that, I mean we're talking about the clunkiness of systems here. But you can say you can find the reports that are back through Sectra and the ECR, so I am just wondering why then do you feel the need to have access to DARO as well, because is that not just another means to find out the same thing that you can at the moment? 12:29 12:29
A. The DARO would obviously notify, they issue a report. It's only by myself that I go into NIECR, if I have requested a CT scan on the patient I would go into that myself to look for the patient's CT report. 12:29
290 Q. Okay. So you have to be proactive to go and find whether the result is back whereas DARO might tell you it's back? 12:30
A. It's back.
291 Q. So that would be the advantage there?
A. Yes. It's just me being proactive that I am looking for the results.
292 Q. Now when you came to the Southern Trust you were clearly familiar with the CaPPS process and following up through that as a key worker and as a Cancer Nurse Specialist, why do you think the nurses, your colleagues, why did you have to tell them about it, why 12:30

did you have to train them, why were they not aware of, do you know?

A. I don't know. I think it was just something that they didn't use. They probably were aware of CaPPS, but they probably were unaware that they could have recorded their consultations with the patients. They probably were unaware that they could look up MDMs that maybe has future MDMs. It was something that they just didn't use.

293 Q. My point really is why not. I mean, was that a result of resources or training, why were they not aware in the Southern Trust of what you were aware of in the South Eastern? 12:30 12:31

A. It could have been for resources. It could have been maybe they weren't aware of the advantage of CaPPS. They maybe had a lack of training in that system. 12:31

294 Q. Okay. Talking about how they felt when they found out, when you were sent, during the SAI process when you were sent informally to speak to them and they were telling you they weren't called into consultations with Mr. O'Brien even if they were available to do, as you said Jenny was doing a test but she wasn't then brought in for the discussion about that test with the patient. You say that Ronan Carroll was wrong in saying that they were afraid of him, but do you think that there was an issue here about the strong personality that they couldn't challenge, was that something that came across to you? 12:31 12:32

A. I believe that it could have been his strong

personality, that they wouldn't have challenged Mr. O'Brien why they couldn't attend his consultation. I know Jenny felt that he had done a holistic approach to his care, but I feel it was more his strong personality that they felt they could not challenge. 12:32

295 Q. And do you think that -- I mean in informal discussions with him do you feel that that was true of other consultants? Would they have been able to say to another consultant, 'you really should have me in there' or not? 12:32

A. They were able to speak to other consultants and advise the consultants that I would be available or I would be present at your clinic today to see a post MDM patient. They would have just been -- they just would be present. It wouldn't have been a case of having to 12:33 challenge the other consultants or to ask the other consultants could they attend.

296 Q. So, just to be clear then, in terms of them attending the other consultants who were there at the same time as Mr. O'Brien, there was never an issue with a key 12:33 worker being present at the consultations, it was only in relation to Mr. O'Brien?

A. It was only in relation to Mr. O'Brien.

297 Q. Okay. Whenever they discovered -- well, first of all, I mean you have explained to Dr. Swart how you felt 12:33 when you discovered that these nine patients didn't have key workers, and your colleagues were very upset when they found out also, did anybody ever get to the root as to why that had happened and why those

patients, did you ever get an explanation as to why that had happened?

A. No. Nobody looked in to see why it happened and why those patients did miss out on the key worker.

CHAIR: Okay. Thank you very much, Mrs. Thompson. I think that's it? 12:34

MS. MCMAHON: Yes.

CHAIR: I think that actually concludes our evidence for today. I know there was some suggestion that Mr. Wolfe was going to give some sort of opening statement for what's to come, but that isn't happening, Ladies and Gentlemen, so you're getting a shorter day today. We'll see you again next Tuesday at ten o'clock. Thank you. 12:34 12:34

THE HEARING WAS CONCLUDED