An addendum amending this statement was received by the Inquiry on 5 October 2023 and can be found at WIT-103266 to WIT-103269.
Annotated by the Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 62 of 2022

Date of Notice: 7th June 2022

Witness Statement of: JOHN P. O'DONOGHUE

I, John P. O'Donoghue, will say as follows:-

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 I started as a Consultant Urologist in Craigavon Area Hospital on 4th August 2014. My role included inpatient and outpatient treatment, on call duties, teaching and supervision of junior doctors and administration associated with the position.

1.2 The first time I became aware of issues of concern was during Mr O'Brien's sick leave in mid-November 2016. Miss Martina Corrigan, Head of Service for Urology informed the consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) during our weekly departmental meeting that a lot of referral letters for triage had been found in Mr O'Brien's office. They had been found in a filing cabinet and had never been triaged. On his return to work in mid-2017, measures were put in place to enable him to do his triage in a more timely way. Most of the referrals for triage (except those from A + E) went online, He was given the Friday after on call off

Signed:

Date: 24/08/2022

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 62 of 2022

Date of Notice: 7th June 2022

Addendum Witness Statement of: John O'Donoghue

I, John O'Donoghue, will say as follows:-

I wish to make the following amendments to my existing response, dated 24th August 2022 to Section 21 Notice number 62 of 2022:

1. At paragraph 1.2 (WIT-50517), I have stated '*The first time I became aware of issues of concern was during Mr O'Brien's sick leave in mid-November 2016.'* However, paragraph 53.2 at WIT 50545 best describes the position wherein I have stated '*Mr O'Brien went on sick leave in mid-November 2016 and we as a consultant body were informed at our weekly meeting with regard to the triage issues in early January 2017. Attendance at this meeting included Miss Martina Corrigan, MR J O'Donoghue, Mr Mark Haynes, Mr Michael Young and Mr AJ Glackin'.*

2. At paragraph 39.1 (WIT-50538), I have stated '*I attended the weekly departmental meeting and that is where I first became aware of the issue with regard to the failure of Mr O'Brien to triage referrals in early January 2017'*, however, paragraph 53.2 at WIT-50545 best describes the position wherein I have stated '*Mr O'Brien went on sick leave in mid-November 2016 and we as a consultant body were informed at our weekly meeting with regard to the triage issues in early January 2017. Attendance at this meeting included Miss Martina Corrigan, MR J O'Donoghue, Mr Mark Haynes, Mr Michael Young and Mr AJ Glackin.'*

Received from Mr John O'Donaghue on 05/10/2023. Annotated by the Urology Services Inquiry.

per MDM advice 27/06/2019. He was seen in clinic the following week and arrangements were made for him to have surgery in the next few months. He had a nephrectomy in early January 2020. His latest review in relation to this was in early 2022 and he has suffered no consequences as a result of the delay up to now. The investigation with regard to the circumstances of the delay is ongoing'. This should state '*~~The only issue~~ I raised ~~was~~ a SAI from the Uro-Oncology Meeting in 2019. I submitted an IR1 on 03/10/2019 when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. He was seen in clinic the following week and arrangements were made for him to have surgery in the next few months. He had a nephrectomy in early January 2020. His latest review in relation to this was in early 2022 and he has suffered no consequences as a result of the delay up to now. The investigation with regard to the circumstances of the delay is ongoing. I raised concerns regarding a locum consultant* Personal Information redacted by USI *in an email dated* *WIT-53236. My concern related to the quality of his clinic letters which I felt were not of a standard I would expect from a consultant. The registrar also told me about questionable medical management in 2 patients and I mentioned this in the email.*

Statement of Truth

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

Signed: John P. O'Donoghue

Date: 03/10/2023

Received from Mr John O'Donaghue on 05/10/2023. Annotated by the Urology Services Inquiry.

difficult to fill due to lack of interest/inadequately experienced doctors. This particularly impacted during on call and on occasions, the consultant had no junior support. The Trust was supportive and did all in its power to assist by going out to locum agencies to look for junior support.

13. Were there periods of time when any staffing posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were such staffing challenges and vacancies within the unit managed and remedied?

13.1 The following locum consultants covered vacant consultant positions over the last few years.

a) Mr David Hickey 2016
b) Mr Zeeshan Aslam January 2016 for 6 months
c) Mr Derek Hennessy August 2018 – April 2019
d) Mr Thomas Jacob January 2017 – December 2018
e) Mr Shawgi Omer 21/09/2020 – 30/06/2021 (backfill for Aidan O'Brien)
f) Saifeldin Elamin 19/07/2021 – 02/08/2021 (covered backlog clinics)
g) Shawgi Omer 16/08/2021 – 30/10/2021 (backfill for Aidan O'Brien)
h) Nasir Khan 02/11/2021 – to the present (backfill for Consultant 7)

13.2 The Trust did its best to fill these positions so to continue patient care and enable the service to run effectively. The locum doctors worked hard and provided a good service. With several locum consultants passing through the department over the years, it was difficult to provide continuity of care.

13.3 Staffing problems made it difficult to provide an elective clinical service. If one of the substantive consultants had to cover locum UOW, his elective clinical activity was cancelled. This impacted on the waiting list. In my opinion, there was no risk to patient care as red flag patients were always treated first although it did cause a delay in treatment of urgent and routine patients. The delay in treatment would have posed

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f) October 2002 – October 2003 Registrar in Urology, Churchill Hospital, Oxford
g) October 2003 – February 2007 Research Fellow in Urology, Department of Pharmacology, University of Oxford
h) March 2007 – September 2012 Oxford Urology Specialist Registrar Training Program
i) October 2012 – March 2013 BAUS Fellowship in Female and Functional Urology, Leicester General Hospital
j) April 2013 – August 2013 Specialist Registrar in Urology, Royal Berkshire Hospital, Reading
k) August 2013 – July 2014 Locum Consultant Urological Surgeon, Watford General Hospital/St Albans Hospital/Hemel Hempstead Hospital

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 I am a Consultant Urological Surgeon in the Southern Health & Social Care Trust since 4th August 2014.

5.2 My duties and responsibilities include inpatient and outpatient care, 1: 7 on call for Urological emergencies, administrative duties, audit/research and teaching/supervision of undergraduate/ postgraduates doctors. Since 2015, I have been on the rota to chair the Uro-Oncology MDM. I have been Chair of the Patient Safety Meeting since October 2021. I have been Educational/Clinical Supervisor to Foundation Doctors since 2017. I have also been a clinical supervisor to Specialist Registrars in Urology since I began in the Trust in 2014.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments,

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and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

3.1 All other questions are answered separately to question 1

Your Position (s) within SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4.1 **Qualifications**

a) MSc in Biochemistry University College Cork 1990
b) MB BCh BAO University College Cork 1993
c) FRCSI 1997
d) Intercollegiate Speciality Examination in Urology FRCSI (Urol) 2012
e) Fellowship of the European Board of Urology FEBU 2012
f) Certificate of Completion of Training (CCT) in Urology 04/10/2013

4.2 **Occupational History**

a) July 1993 – June 1994 Cork University Hospital Intern / Medicine & Surgery
b) July 1994 – June 1997 Basic Surgical Training University Hospital Galway
c) October 1997 – February 1999 West Midlands UK Diagnostic Radiology Rotation
d) February 1999 – February 2000 Senior SHO Urology James Cook University Hospital, Middlesbrough
e) February 2000 – November 2002 Premier SHO Urology, Sunderland Royal Hospital

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Quality Care - for you, with you

JOB TITLE:	Consultant Urological Surgeon (with a special interest that will complement the Urological team)
SPECIALTY:	Urology
DEPARTMENT / LOCATION:	All Consultants are appointed to the Southern Health and Social Care Trust. The base hospital for this post is Craigavon Area Hospital however the post holder may be required to work on any site within the Southern Health and Social Care Trust.
REPORTS TO:	Mr E Mackle, AMD, Surgery & Elective Care Division
ACCOUNTABLE TO:	Mrs D Burns, Interim Director of Acute Services

INTRODUCTION

This is a replacement post and the successful candidate will join 4 other Consultants to provide the full range of inpatient and outpatient urological services. While the post will be mainly based at Craigavon Area Hospital, there are also existing commitments to South Tyrone Hospital, Armagh Community Hospital, Daisy Hill Hospital, Banbridge Polyclinic and at the new South West Acute Hospital in Enniskillen. As a member of the Consultant team, the successful candidate will play a key role in the promotion of the service including the development and implementation of plans to enhance the Urological service provided by the Southern Trust. It is anticipated that the successful candidate will be able to provide a general urology service for elective and emergency care, though a subspecialty interest that would complement the unit would be advantageous.

PROFILE OF SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community Trust, Newry & Mourne Trust and Armagh & Dungannon Health and Social Services Trust. Craigavon Area Hospital is the main acute hospital within the SHSCT, with other facilities on the Daisy Hill Hospital, Newry, Lurgan Hospital, South Tyrone Hospital, Dungannon and Banbridge Polyclinic sites.

Craigavon Area Hospital

Craigavon Area Hospital is the main acute hospital within the Southern Health and Social Care Trust and provides acute services to the local population and a range of services to the total Southern Trust area, covering a population of 324,000.

The current bed complement is distributed over the following specialties; General Surgery, Urology, General Medicine, Geriatric Acute, Dermatology, Haematology, Cardiology, Obstetrics, Gynaecology, Paediatrics, Paediatric Surgery, Paediatric Urology, Paediatric ENT, ENT, Intensive Care, Special Care Babies, Emergency Medicine (A&E), Trauma & Orthopaedics.

Many additional specialties are represented as outpatient services including Ophthalmology, Neurology, Maxillo-Facial and Plastic Surgery, Orthodontic and Special

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

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

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

UROLOGIST OF THE WEEK

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

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

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

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

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

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

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

TRIAGE

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

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

Received from Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

30. Were you involved in the review or appraisal of others? If yes, please provide details. Did you have any issues with your appraisals or any you were involved in for others? If so, please explain.

30.1 I was not involved in the formal appraisal of Consultants. I was an educational/clinical supervisor for urology registrars and had no difficulties/issues doing these. I was also an educational/clinical supervisor for foundation doctors and again had no problems or difficulties. These assessments of junior doctors were not appraisals.

Engagement with Urology staff

31. Please set out the details of any weekly, monthly or daily scheduled meetings with any Urology unit/Services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

31.1 Every month, the personnel of the department met to plan clinical activity for the following month. Attendance included head of service, consultant urologists, junior doctors, nurses and administrative staff. Weekly, the head of service and consultant urologists met to discuss issues effecting the department and plans for service improvement. Patient safety meetings occurred monthly and involved the urology department solely or the surgical directorate. A weekly uro-oncology meeting was held involving all staff treating patients with urological cancers to discuss diagnosis and management of patients. Patients with benign conditions needing reconstructive surgery were discussed at a Regional Urology Reconstructive Meeting in Lagan Valley Hospital monthly. Attendees included Mr John O'Donoghue, Mr Aidan O'Brien, Miss Siobhan Woolsey, Mr Alex McCleod and Mr Brian Duggan. A monthly uro-gynaecology meeting was held to discuss patients with urinary incontinence issues. Attendees include J O'Donoghue, Consultant Urologist, Edgar Boggs, Consultant Gynaecologist, Geoff McCracken, Consultant Gynaecologist, Richard de Courcey Wheeler, Consultant Gynaecolgist, Anitha Chinnadurai, Consultant Gynaecologist, Katherine Loane, Consultant Gynaecologist, Jenny McMahon, Urology Nurse Specialist, S Hasnain Urology Specialist Doctor, Katherine Niblock, Consultant Gynaecologist, Wendy McQuillan

to triage and the timeliness of his triage was looked at regularly by Miss Martina Corrigan, Head of Service. I had no involvement in monitoring the timeliness of his triage.

1.3 The failure of Mr O'Brien to triage the referrals for the above-mentioned group of patients was taken as a serious clinical issue. All four substantive consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) triaged the patients as quickly as possible and organised appropriate investigations and clinic appointments. I was not aware of any other clinical issues relating to Mr O'Brien's practice whilst he was working in the Southern Health and Social Care Trust (SHSCT). No person came to me expressing any concerns about Mr O'Brien's practice before he retired.

1.4 I submitted an IR1 on 03/10/2019 ***(relevant document located at S21 62 of 2022 Attachments 1. Datix 03102019)*** when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. The patient was seen in outpatients by Mr Haynes on the 7th October 2019. A plan was made for a nephrectomy and this was carried out in Belfast City Hospital on 9th January 2020. The patient concerned has no evidence of metastatic disease and his last urological review was on 5th April 2022 where he remained well. The datix is still under review in the Trust at present.

1.5 In relation to clinical governance issues, I understood that as a department, we were engaging with all seven pillars of Clinical Governance (Clinical Effectiveness, Risk Management, Audit, Staff Management, Education & Training, Information and Patient/Public Involvement Appraisals were kept up to date and there were no concerns in relation to my practice. I was aware of the Key Performance Indicators (KPI) presented to us at the departmental meeting every month and engaged with efforts to reduce waiting lists and improve performance ***(relevant documents located at S21 62 of 2022 Attachments 2. August 22 Urology Performance, 3. Urology Performance May 2015, 4. Review Backlog 2015).*** KPI included cancer wait times (31 and 62 day targets), red flag/urgent, routine wait times for inpatient, outpatients and day surgery). I engaged fully with the patient safety meeting (Combined and Speciality Specific). I kept up to date with all my patients' results, dictated letters and

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

30.5 My line manager is the Clinical Director for Urology, who in turn is responsible to the Medical Director.

30.6 Clinical Director with responsibility for Urology: Robin Brown Mid 2011 – January 2014, Sam Hall January 2014 – March 2016, Colin Weir June 2016 – December 2018, Ted McNaboe December 2018 – December 2021 – Currently Vacant

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

31. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

31.1 In my opinion the senior managers did not work well with Urology. Engagement with the department by the Clinical Directors, Medical Directors, Assistant Directors for Surgery and Directors for Acute Services was very limited and infrequent in my experience. I do not know how much job planned time they had allocated to management activity.

31.2 Mr Young tried his best to lead the Urology team. However, despite his best efforts Mr O'Brien, Mr Haynes and Mr O'Donoghue frequently failed to attend departmental meetings or arrived late. All too often I sat across the table from Mr Young wondering why my colleagues had not shown up. Due to the number of fronts on which the service was failing to deliver (growing waiting lists for appointments and surgery), it was difficult to achieve a consensus as to how to move forward without engagement from our colleagues.

Amended statement received from Anthony Glackin on 27/09/22. Annotated by the Urology Services Inquiry.

Siobhan Woolsey, Mr Alex McCleod and Mr Brian Duggan. I attended a urogynaecology MDM monthly to discuss patients with urinary incontinence issues. Attendance included J O'Donoghue, Consultant Urologist, Edgar Boggs, Consultant Gynaecologist, Geoff McCracken, Consultant Gynaecologist, Richard de Courcey Wheeler, Consultant Gynaecolgist, Anitha Chinnadurai, Consultant Gynaecologist, Katherine Loane, Consultant Gynaecologist, Jenny McMahon, Urology Nurse Specialist, S Hasnain Urology Specialist Doctor, Katherine Niblock, Consultant Gynaecologist, Wendy McQuillan Continence Nurse, Sharon Ross, Continence Nurse, Anne Marie Anderson and Michelle Kearney, Pelvic Floor Physiotherapists.

7.2 A monthly patient safety meeting, either urology specific or combined surgical directorate was held to discuss clinical cases of concern/ deaths. Learning points were noted. Audits/studies were presented. Directives from various NHS sources were noted ***(relevant document located at S21 62 of 2022 Attachments 10. Urology Department PSM 20022019).***

Lines of management

7.3 Clinical care: Head of Service and clinical lead

a) Miss Martina Corrigan – Head of Service
b) Mr Michael Young – Clinical Lead

7.4 Administration: Head of Service

a) Miss Martina Corrigan

7.5 Lead for Patient Safety:

a) Mr AJ Glackin

7.6 Governance: Head of Service and Clinical Lead

a) Head of Service: Miss Martina Corrigan
b) Clinical Lead: Mr Michael Young

having treatment in a timely manner. A further consequence is that secretaries and consultants are spending time addressing avoidable complaints related to poor access to timely care.

17.2 The trust has no structured system for managing the workload of a departing or retiring consultant. In my experience, this has been managed in an ad hoc manner by redistributing work among the remaining consultants who are already unable to deliver timely care for their existing patients. Due to the volume of the overdue appointments and procedures, it is impossible to know what problems are lurking within the waiting list of a colleague. I simply do not have enough time to take on the work of others in addition to my own workload and to do so would place my patients and myself at risk.

17.3 The clinical governance aspects of the service have been neglected as a consequence of the other demands on the time of the medical staff in the Department of Urology. Without more robust support from the trust in terms of data collection and administration it is simply impossible for busy clinicians to do this important work as well as keep a clinical service running with all the challenges we have.

18. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

18.1 The core staffing within the unit has largely remained constant since 2012. Mrs Corrigan was Head of Service from my arrival in 2012 until Ms Clayton replaced her on an interim basis in May 2021. Mr Young was Lead Clinician until his retirement in 2022. Mr Haynes was AMD with responsibility for Urology from October 2017 to January 2022.

19. Has your role changed during your tenure? If so, do changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

Amended statement received from Anthony Glackin on 27/09/22. Annotated by the Urology Services Inquiry.

Continence Nurse, Sharon Ross, Continence Nurse, Anne Marie Anderson and Michelle Kearney, Physiotherapists.

Governance

32. During your tenure, who did you understand as overseeing the quality of Services in Urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of Services?

32.1 During my tenure, overseeing the quality of services in urology was within the remit of the Consultant Urologists and Head of Service (Martina Corrigan until October 2020 when Wendy Clayton took over). The Head of Service in turn was answerable to the Assistant Director of Acute Services, Anaesthetics & Surgery (Mr Ronan Carroll). Key Performance Indicators (KPI) including 62 and 31 day targets and waiting list targets (red flag, urgent and routine) were discussed at monthly departmental meetings.

33. Who oversaw the clinical governance arrangements of the unit and how was this done? As Consultant urologist, how did you assure yourself that this was being done properly? How, if at all, were you as Consultant urologist provided with assurances regarding the quality of urology services?

33.1 Those overseeing clinical governance were the Clinical Director Mr T McNaboe, the Associate Medical Directors Mr Mark Haynes and Mr Ted McNaboe and the Clinical Lead Mr Michael Young. I assured myself that clinical governance was done properly by engaging fully with the pillars of clinical governance. In particular, active participation in the PSM, participation in MDMs (uro-oncology, stone meeting, benign reconstruction meeting and uro-gynaecology meeting). I attended educational meetings and training courses ***(relevant documents can be located at S21 62 of 2022 Attachments 5. Appraisal 2018 (Mr M Young))*** and engaged in audit. I was provided with KPI (Key Performance Indicators) at the monthly departmental meetings as an indicator of the quality of urology services.

34. How, if at all, did you inform or engage with performance metrics overseen in Urology? Who was responsible for overseeing performance metrics?

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

29. As Clinical Lead, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

29.1 My role as Clinical Lead, and likewise my role as a Consultant, are service roles, as opposed to management posts. As a senior doctor there is the responsibility to ensure your patients, and patients in general terms, have a high standard of care provided in a safe environment. The following systems, structures, and practices provided me with some assurance regarding patient care and safety in urology.

HOSPITAL SYSTEMS

29.2 Reports provided by the Trust management on a variety of issues were provided on a regular basis, for instance, Waiting list times, ward compliance to infection control, antibiotic prescription compliance, etc.

AUDIT

29.3 The Trust has a calendar monthly Audit meeting. This is for one session per month and has a rolling day date, so as to not affect the same session each month. The Audit session is known as the Mortality and Morbidity meeting or, more recently, the Patient Safety Meeting. This is the opportunity to discuss the deaths of patients and any other issues relating to patient care. The meeting also provided the opportunity to present audits on patient care and research. The meeting is co-ordinated by an assigned Consultant for this role (for a more detailed description, Mr Glackin has held this post till recently, when Mr O'Donoghue has taken over as Chair). These meetings have allowed for an open discussion and, having attended these meetings, I am reassured about the openness and depth of the discussions held.

29.4 Audit meetings in the early part of my tenure involved the surgical and anaesthetic departments as a whole. During the last ten years, they have been mainly involving the individual units with a quarterly joint main meeting. This approach allowed detailed appropriate focused discussions on individual unit issues

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, Services, systems, roles and individuals whom you manage/d or had responsibility for.

6.1 The line management for my roles as a Consultant Urologist and Lead Clinician were to the Clinical Director of Surgery covering Urology, Associated Medical Director, Medical Director and then the Chief Executive (see: Q55).

6.2 The Director of Acute Services and team were also an integral part of the line management structure as an operational management structure. (see:Q55)
My role as a Consultant Urologist had the responsibility for the care of patients from their referral onwards to include outpatient clinics, the operating theatre and their inpatient ward care, along with the administrative paperwork that follows all these activities. I had the specific role of managing the activity of the Stone Treatment Centre for the delivery of the ESWL service. Urological trainees and Staff Grade doctors would have been collectively the responsibility of the consultants in the unit as were other junior doctors in general. This covered their education, training, rostering of activities and monitoring of progress.

6.3 The Lead Clinician role reported to the Clinical Director of Surgery and Director of Acute Services. This role, as a service post, was not responsible for individual team members but was a co-ordinator of activities for the urology team members. Although the Lead Clinician may have co-ordinated activities such as departmental meetings, the role did not manage or have the responsibility for the overall running of the urology unit per se. It did aid the Trust Management structure if asked for clinical direction.

6.4 Those junior doctors in the Staff Grade post were under the collective responsibility of Consultants in the unit, yet led by the Lead Clinician.

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34.1 I engaged fully with Performance Metrics which was overseen by the Head of Service and the information was relayed to the consultants at the monthly departmental meeting. KPI included 62 and 31 day targets and waiting list targets (red flag, urgent and routine). I engaged and used this information to improve my practice. In conjunction with the Head of Service and the other urologists, if patients were not reaching their targets, they were given earlier dates for theatre/clinic with one of the other consultant urologists.

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

35.1 It seemed to me that everyone was engaging with the PSM, attending the uro-oncology MDM and from what I understood, having yearly appraisals. I felt reassured that safe systems were in place to protect patients. Personally, I signed patients' results off on-line and acted immediately if I identified an abnormal result. My secretary sent me hard copies of the results and checked to make sure everything was signed off. I attended the uro-oncology PSM, stone meeting, urogynaecology MDM and reconstruction meeting to discuss relevant patient care.

I undertook annual appraisal and these are included in the list of documents.

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

36.1 All urology consultants participated in the PSM and the multidisciplinary meetings (Uro-oncology, urogynaecology, kidney stone and complex reconstruction). I felt satisfied that patients were receiving multi-disciplinary expert care. Online systems were put in place for triage and to sign off results. As I was having yearly appraisals, I assumed my colleagues were also been appraised.

36.2 I have worked in many hospitals in England and the Governance systems were similar. I had no concerns and felt confident that if issues of concern arose, they would be identified and dealt with immediately.

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

those objectives), providing documentation (where it has not been provided already) or sign-posting the Inquiry to any relevant documentation.

43.1 Performance objectives are set for consultants in the PDP section of their yearly appraisals. My performance objectives included developing the Greenlight laser service and developing a supervisory role for junior doctors ***(relevant document can be located at S21 62 of 2022 Attachments 6. Appraisal 2017 (Mr M Young))***.

44. How well did you think the cycle of job planning and appraisal worked within Urology Services and explain why you hold that view?

44.1 I can only speak from my perspective. I had an appraisal every year and a revalidation in my 5th year as a consultant. I found it immensely useful in that it allowed me to reflect on past performance and plan for the future. I used my appraisal as a way of improving my performance. Job planning occurred yearly and encouraged discussion on planning weekly/monthly job activities.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 Governance concerns impacting on patient care and safety initially can be recorded in the Trust using an IR1 form. This is investigated and reviewed at a level appropriate and proportionate to the complexity of the incident under review. The review team chosen is appropriate for investigation of the SAI. When the review is complete, it is discussed at the PSM (chaired by Mr Glackin) to identify learning outcomes.

47.2 Appraisal is a process of collating information required by the trust to permit medical revalidation. In my opinion, the appraisal process has morphed from a confidential reflective exercise in professional development between two professionals into a formulaic capture of documents such as reflections on complaints, records of continuous professional development etc. to evidence a recommendation for revalidation by the trusts responsible officer.

48. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

48.1 My first knowledge of serious concerns with the practice of Mr O'Brien came at a meeting that took place in January 2017. I acknowledge my conversation with Mrs Trouton noted in paragraph 50.8 but at the time of this conversation I did not perceive this to be an immediate or substantial risk.

48.2 I attended the meeting together with my consultant urology colleagues. I recall that Mr Mackle Assistant Medical Director, Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present. We were informed that the trust had found a number of areas of concern relating to Mr O'Brien's practice. I recall the issue of triage of referrals and the late dictation of clinic letters and results being discussed. We were advised by Mr Carroll that this was a confidential matter not to be discussed outside the group and that Mr O'Brien would not be returning to work until further notice. I recall that we were asked to participate in an exercise to clear the backlog of triage and outstanding results. We agreed to do this work. I undertook triage to clear a backlog. I supplied a list of completed cases to Mrs Corrigan and the Referral and Booking Centre. Similarly, I reviewed charts of Mr

Association of Urology Guidelines, NICaN Guidelines, BAUS Guidelines and NICE Guidelines).

10.2 I was aware of the Department of Health Cancer targets as set out in the IEAP (31 and 62 day target) and the targets for outpatients (9 weeks) and inpatient/day case targets of 13 weeks. We were made aware if we were achieving these targets at our monthly departmental meetings by the Head of Service. If patient waiting times were breeching the KPI targets, corrective action was initiated. With regard to red flag patients who could not have their surgery under the named consultant, other consultants with extra availability in theatre completed the cases. If red flag waiting times for clinic were breeching targets, they were seen by the next available consultant (***relevant document located at S.21 62 of 2022 Attachments 2. August 22 urology Performance, 3. Urology Performance 2015, 4. review Backlog 2015***).

11. What, if any, performance indicators were used within the Urology unit during your tenure? If there were changes in performance indicators throughout your time there, please explain.

11.1 Key Performance Indicators (KPI) included cancer waiting times (31 and 62 day targets), red flag, urgent and routines waiting times for outpatient, inpatients and day surgery cases. There were no change to the KPI during my tenure.

12. Do you think the Urology services generally were adequately staffed and properly resourced throughout your tenure? If not, can you please expand noting the deficiencies as you saw them? Did you ever complain about inadequate staffing? If so, to whom, what did you say and what, if anything, was done?

12.1 The Urology Department always had difficulty recruiting doctors, both junior doctors and consultants despite actively recruiting on many occasions. Consultant positions were filled by several locum doctors (see question 13). On occasions, urologist of the week (UOW) shifts were covered by the substantive consultants in a locum capacity. This had an impact on clinical activity as clinical sessions were cancelled for the consultant doing the locum on call. Junior doctor positions proved

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a risk to patients, eg ureteric stents were often left in longer than 3 months as it proved difficult to treat the patients sooner.

14. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of Urology services? In your view, did staffing problems present a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples.

14.1 Staffing problems made it difficult to provide an elective clinical service. If one of the substantive consultants had to cover as a locum UOW (Urologist of the week), his elective clinical activity was cancelled. This impacted on the waiting list and resulted in a clinical risk to patients, particularly those with urgent/routine problems as they had to wait significantly longer for treatment.

15. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

15.1 As mentioned in the previous question, several locum doctors passed through the Urology Department during my tenure (see question 13). This occurred after Mr Ram Suresh, Consultant Urological Surgeon left the Trust on 27/10/2016 to take up a post in Great Yarmouth. The locum positions were filled for varying lengths of time, mostly due to the fact that the locum doctors moved to different positions in other hospitals.

16. Did your role changed during your tenure? If so, did changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

16.1 My role did not change during my tenure.

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

Aimee Crilly

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

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

Tony

AJ Glackin
Consultant Urologist
SHSCT

Secretary: Elizabeth Troughton
Personal Information redacted by USI

On 26 May 2015, at 12:39, Suresh, Ram Personal Information redacted by USI wrote:

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

Received from Tughans OBO Mr Aidan O'Brien on 01/05/22. Annotated by the Urology Services Inquiry.

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	17:17

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	17/11/2014
Time (hh:mm)	14:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient was waitlisted for removal of ureteric stent on 17/11/2014, This request was registered in the book in stone treatment centre. A green booking form was also filled in at the same time. But this was overlooked. Patient had to have the stent in unnecessarily too long.
Action taken Enter action taken at the time of the incident	He was reviewed in clinic today and realised that the stent was still ins itu. Arranged to remove the stent only today.
Learning Initial	
Reported (dd/MM/yyyy)	30/03/2015
Reporter's full name	Kothandaraman Suresh
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	14/04/2015
Last updated	Martina Corrigan 09/07/2015 12:32:31
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 136

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Clinical Area
Loc (Exact)	X-ray Dept (Radiology)
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Date started (dd/MM/yyyy)	07/09/2015
Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Minor

Risk grading
Click here

When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	◉	○	○	○
Unlikely (Expected to occur annually)	○	○	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○
	Grade: Medium Risk				

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	040915KR- PAS interogatition confirmed that the green form had been actioned on PAS. Therefore this is not an admin issue. The wait is related to capacity. Communication email sent to HOS to comment and close
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	No

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	discussed at Urology departmental and governance meetings and a new process agreed that all patients that have a stent fitted need to be added to a waiting list with a planned date to come in
Date investigation completed (dd/MM/yyyy)	07/09/2015
Was any person involved in the incident?	No
Was any equipment involved in the incident?	No

Notepad

Notes
Use this section to record any efforts you have made as part of your investigation e.g. phonecalls

Received from Kothandaraman Suresh on 02/09/22. Annotated by Urology Services Inquiry

Urology Department Patient Safety Meeting 19 July 2019 Minutes

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

Apologies
Nil

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

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

    b. Mortality cases discussed

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

Received from SHSCT on 19/05/2022. Annotated by the Urology Services Inquiry

APPENDIX 4
Revised November 2016 (Version 1.1)

INCIDENT REVIEW

SECTION 1	
1. ORGANISATION: **SHSCT**	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Personal Information redacted by USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4.** DATE OF INCIDENT/EVENT: 20 May 2018
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 21 August 2018	

8. SUMMARY OF EVENT:

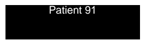
Patient 91 attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 4 March 2018. The impression was an infected obstructed left urinary tract. A computerized tomography scan (CT scan) of the urinary tract on 4 March 2018 reported an '*obstructing left sided ureteric renal calculus with proximal ureteric dilatation and associated moderate hydronephrosis. Imaging findings have not changed dramatically since the previous study, thus an acute on chronic deterioration is most likely*'. Patient 91 went to emergency theatre for a cystoscopy and insertion of a left ureteric stent. Medical notes report Patient 91 recovered well on the ward. Patient 91 was commenced on antibiotics and was discharged home on 8 March 2018 with a plan for follow up in 6 weeks for ureteroscopy and laser (URS). Standard management of infected stones is insertion of temporary stent and treatment of sepsis infection followed by planned definitive stone fragmentation. Patient 91's planned treatment was ureteroscopy and laser fragmentation of stones.

On the 28 March 2018 Patient 91 attended CAH ED and was admitted to a medical ward and was treated for acute kidney injury and a urinary tract infection. Patient 91 was discharged home on 30 March 2018 with the plan for follow up with urology as previously planned.

On the 18 May 2018 Patient 91 was admitted to CAH for a planned left ureteroscopy. The findings noted were an impacted stone in the proximal ureter. The stone was fragmented and 100% was removed. The stone was sent for analysis. Flexible pyeloscopy showed no stone. A 6Fr x 24cm JJ stent was inserted. The plan was for admission overnight and home tomorrow if well.

Patient 91's condition deteriorated post operatively. Patient 91 and was transferred to the intensive care unit (ICU). While in ICU Patient 91 required escalating inotropic support but despite aggressive intensive care management, Patient 91's condition continued to deteriorate. Following discussion with Patient 91's family a do not actively resuscitate (DNR) was put in place. Patient 91's death was confirmed on 20 May 2018.

Patient 91 was discussed with the Coroner and an unsigned death certificate was agreed with the cause of death recorded as:
I a. Multi-organ failure due to myocardial infarction, Sepsis due to
c. left ureteroscopy for renal stone.



Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Recommendation 7
The Trust should review waiting times and put systems and processes in place to minimise waiting times across specialties and continue escalation to the Health and Social Care Board as required.

References

1. Schaeffer *AJ, Schaeffer EM. Infections of the Urinary Tract. In: Wein AJ, editor. Campbell-Walsh Urology. 10th ed. Vol. 8. St. Louis, Mo: WB Saunders; 2012. pp. 258–326.*

2. Guidelines on Urological Infections. European Association of Urology 2014.

3. *BJU International 2017 Ureteric stent dwelling time: a risk factor for post-ureteroscopy sepsis. Nevo A1, 2, Mano R1,2, Baniel J1,2, Lifshitz DA1,2. BJU Int. 2017 Jul; 120(1):117-122.*

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

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

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

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

18. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**19.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

20. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

21. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

22. NAME: Melanie McClements	**23.** DATE APPROVED: 11 October 2019

24. DESIGANTION: Interim Director of Acute Services

Patient 91

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

II. Ischaemic heart disease.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
Mr Mark Haynes, Consultant Urologist	Mr Mark Haynes –Consultant Urologist Mrs Emma Jane Kearney – Lead Nurse Mrs Trudy Reid – Clinical Governance coordinator Mrs Carly Connolly – Clinical Governance Manager

11. SERVICE USER DETAILS:

Male DOB Personal Information redacted by USI

12. WHAT HAPPENED?

Patient 91 was a Personal Information redacted by USI gentleman who was brought in by ambulance to CAH ED on 4 March 2018. Patient 91 presented feeling unwell with an acute all over weakness and hot and cold shivers. The clinical impression was an infected obstructed left urinary tract. A CT of urinary tract on 4 March 2018 reported '*obstructing left sided ureteric renal calculus with proximal ureteric dilatation and associated moderate hydronephrosis. Imaging findings have not changed dramatically since the previous study, thus an acute on chronic deterioration is most likely'*. Standard management of infected stones is insertion of temporary stent and treatment of sepsis infection followed by planned definitive stone fragmentation. Patient 91's planned treatment was ureteroscopy and laser fragmentation of stones.

Patient 91 went to emergency theatre for cystoscopy and insertion of a left ureteric stent. Medical notes report urine was positive for leucocytes but no other infective source was noted and Patient 91 recovered well on the ward. Patient 91 was commenced on antibiotics and was discharged home on 8 March 2018 with a plan for follow up in 6 weeks for ureteroscopy and laser (URS).

On the 28 March 2018 Patient 91 attended CAH ED and was admitted to a medical ward and was treated for acute kidney injury and an Escherichia coli (E. coli) urinary tract infection treated with antibiotics. Patient 91 was discharged home on 30 March 2018 with the plan for follow up with urology as previously planned.

Patient 91 had an outpatient pre-operative assessment appointment on the 7 March 2018, but was unable to attend due to inpatient status. Patient 91 was subsequently sent another pre-operative assessment appointment for 22 May 2018, four days post operation procedure.

Patient 91 was contacted by hospital staff on the 16 May 2018 for admission on the 18 May 2018 for ureteroscopy and laser (URS). Patient 91 was admitted on 18 May 2018 to CAH for planned surgery. The preoperative assessment on the day noted Patient 91's medical history and noted that Patient 91 was not "*Fit & Well*". He had a previous history of ischaemic heart disease, non-insulin dependent diabetes mellitus and hypertension. His height, weight and clinical observations were noted.

Patient 91 attended theatre and intravenous Gentamicin (antibiotic) was administered prior to the procedure in theatre. The operation a left ureteroscopy was performed by Dr 1(Locum Urology Consultant) and Dr 3 (Urology Registrar). The operational findings noted an impacted stone in the proximal ureter. The stone fragmented and 100% was removed. The stone was sent for analysis. A flexible pyeloscopy showed no stone. A 6Fr x 24cm JJ stent was inserted. A specimen of urine was sent for microbiological testing on 18 May 2018 at 12.10 which isolated E. coli (bacteria). The results were reported the following day 19 May 2018.

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Patient 91's condition deteriorated post operatively. At 13:35 his temperature was noted to be 34.8°C and a warming blanket was applied. At 14:40 his temperature was 38°C and he was noted to be shivering. He was reviewed by Dr 1(Locum Urology Consultant) and intravenous Tazocin was prescribed. He noted rigor post ureteroscopy and the plan was intravenous fluids and urinary catheter.

The nursing notes reflect Dr 2 (Consultant Anaesthetist) was informed and a right radial arterial line was inserted at 15:00. Intravenous paracetamol was administered at 15:00 as per Dr 2 (Consultant Anaesthetist). Intravenous fluids were erected and blood tests including a full blood picture and an ICU profile, and CRP (blood tests which can indicate if infection is present) were taken. An arterial blood gas was carried out. A 12 lead electrocardiogram (ECG) was completed at 15:30 which showed sinus tachycardia (fast heart rate). A right jugular central line was inserted at 16:30 and a Noradrenaline infusion was commenced at 16:35, the rate was subsequently increased to10ml. Blood glucose was measured as 4.0mmols at 4pm, it dropped to 3.5mmols at 16:22; Dextrose 50% 20ml was prescribed intravenously at 16:35 to manage the low blood sugars. Oxygen was administered at 5 litres per minute.

Observations were charted as:

DATE										
TIME	13:35	13:50	14:05	14:30	15:00	15:30	15:45	16:00	16:30	16:45
RESP	17	20	18	16	24	24	20	24	20	18
SPO2 %	100	100	100	100	100	100	100	100	100	100
TEMP	34.8	35.3	38	37.4		38.2			39.5	39.5
BP	143/68	130/52	151/60	150/60	141/56	146/59	97/39	98/39	103/39	99/39
HR	71	83	113	130	134	134	121	125	124	115

Table 1

Blood results are as follows:

	18/8/18	18/8/18 15:00	19/8/18 02:00	19/8/18 07:00	19/8/18 15:25	19/8/18 19:00	19/8/18 21:05	20/8/18 08:00	Reference limits
CRP	29.16	14.92		66.74	76.84	93.16			
Sodium	138	144	137	138	139	136		136	133-146 mmol/L
Potassium	3.8	4.1	4.3	4.1	4.0	4.4		5.2	3.5-5.3 mmol/L
Bicarbonate	8.7	13.8	7.2	12.7	18.9	19.9		17.7	22-29 mmol/L
Urea	6.8	5.0	7.1	6.7	8.1	10.3		7.9	2.5 -7.8 mmol/L
Creatinine	187	107	213	196	215	252		178	59 104 mmol/L
Albumin	26	35	26	30	25	27		26	35-50 mmol/L
Glucose	10.5	5.9	12.9	14.0	7.0	8.5		3.6	4-6 mmol/L
Magnesium	0.88	0.42	1.55	1.13	0.93	0.96		0.09	0.7-1 mmol/L
eGFR	31	59	27	29	26	22		33	
Troponin			400	451			1571	3783	<=14 ng/L
NT-proBNP	430	9610	16672	>70000			>70000		
Amylase	65			149					28-100 U/L
Haemoglobin estimate	90	112	90	106	101	100		98	
Red blood cell count	3.19	3.81	3.01	3.59	3.42	3.38		3.34	
Platelets	173	237	191	147	108	98		61	
White cell count	27.8	2.48	40.5	48.5	53.3	55.0		61.3	

Table 2

Patient 91

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

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

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

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

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

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

15. RECOMMENDATIONS (please state by whom and timescale)

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

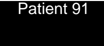
Recommendation 2
All patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breeched, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the planned procedure and any confirmed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

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

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

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

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



Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Clayton, Wendy

Subject: FW: action plan Patient
Attachments: 190821 Draft Action plan Patient 91; Final Report.pdf

From: Clayton, Wendy Personal Information redacted by USI
Sent: 21 September 2021 15:46
To: ODonoghue, JohnP Personal Information redacted by USI; Glackin, Anthony Personal Information redacted by USI
Subject: FW: action plan Patient 91

Hi John

I attach a SAI action plan on Patient 91. Can the following points be discussed at the next patient safety meeting, is that the right forum

Action Plan: Patient 91
Datix ID: Personal Information redacted by USI
HCN: Personal Information redacted by USI

5	All patients who have ureteric stents inserted for management of urinary tract stones should have plans for definitive management within 1 month unless there are clinical indications for a longer interval to definitive treatment.				19/08/2021 Wendy Clayton will discuss with Consultants and advise.
6	Where patients wait longer than the intended time for definitive management with a ureteric stent in situ the case should be reported on the trust DATIX system.				19/08/2021 Wendy Clayton will action with the Consultants.

Regards

Wendy Clayton
Acting Head of Service for ENT, Urology, Ophthalmology & Outpatients
Ext: Personal Information redacted by USI
Mob: Personal Information redacted by USI

From: Bell, Joanne
Sent: 14 September 2021 12:58
To: Clayton, Wendy
Subject: action plan Patient 91

Hi Wendy

This should open fine now

Thanks
joanne

Joanne Bell

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Agenda
Patient Safety Meeting / M&M Meeting Urology
Wednesday 13th October 2021 AM session

1. **Welcome , attendance and apologies received by Chair**:

   Attendance: J O'Donoghue, Leanne McCourt, Kate O'Neill, Laura McAuley, Jason Young, Jenny McMahon, Mark Haynes, Michael Young, Anthony Glackin, Sabahat Hasnain, Fiona Griffen, Conor McCann, Nasir Khan, Nidhruv Ravikumar

   Apologies: Shawgi Omer, Susan Coll, Wendy Clayton, Kishan Tailor

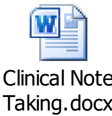
2. **Review of Previous Minutes / Verification of last meeting report**
   a. Matters Arising / outstanding issues - Nil

3. **Audit on Chemolysis/ L McAuley & C McCann**

IP ESWL.pptx

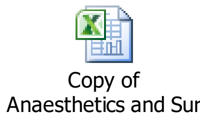
Chemolysis research presentation.pptx

4. **Audit of Medical Notes / Nidhruv Ravikumar**

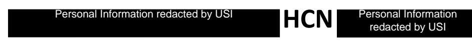


Clinical Note Taking.docx

5. **Deaths within 30 days Discharge**



Copy of Anaesthetics and Sur



HCN

Case to be presented at the next PSM once Mr Haynes has looked at the notes in more detail

Received from SHSCT on 19/05/2022. Annotated by the Urology Services Inquiry

23.1 Specialist cancer nurses provide skilled personalised care, improving the experience of both cancer patients and the multidisciplinary colleagues they work with. In my practice, they work very closely with me ensuring the patients' clinical journey occurs in a timely fashion and provide holistic care to the patients.

23.2 Urology specialist nurses are experienced trained nurses and are instrumental in reducing unnecessary hospital admissions and readmissions, reducing waiting times, freeing up a consultant's time to treat other patients and most importantly, being available to help, educate and reassure patients on how best to manage their health conditions. They are responsible for a number of outpatient clinics and have additional skills such as performing urodynamics, performing prostate biopsies and carrying out flexible cystoscopies

23.3 Specialist nurses work independently but again in my practice, work very closely with me to provide the best care possible for patients. I have respected and valued their contribution. Communication was excellent on both sides and we communicated effectively and efficiently every day for the benefit of patients. Specialist cancer nurses and urology specialist nurses are roles held usually by different people.

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

24.1 The working relationship between nursing and medical staff in my opinion was excellent and I certainly had no concerns.

25. What was your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

were in charge of the day to day running of the unit. They were answerable to Ronan Carroll. Mr Michael Young, Consultant Urologist was clinical lead. He was answerable to the Clinical Director and Assistant Medical Director.

28. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

28.1 Medical and non-medical managers worked well in urology to run the department effectively and plan for the future. Communication was good and opinions were respected and encouraged.

28.2 In late 2014/ 2015, a plan was developed and brought to fruition to modernise the urology department. Both medical and non-medical mangers worked well to make this happen. Developments included an electronic referral system for GPs, an online platform for GPs to ask questions on clinical cases and the development of a Urology one-stop clinic ***(relevant documents can be located at S21 62 of 2022 Attachments 8. Vision for Urology Services 2015 and 9. Vision for Urology services 2015 (2)).***

29. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and refer to (or provide, if not provided by the Trust already) any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

29.1 Every year I had an appraisal and every 5 years a revalidation. My appraisals are up to date and copies are provided with names of the appraisers. All appraisals from 2014 to 2021 are included.

29.2 I did not have a formal performance review. As part of my appraisal, a personal development plan (PDP) from the previous year was discussed and assessed to see if all goals were achieved. A new PDP for the following year was devised.

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

Data source: BOXI CH3 Universe, run date 16/05/16

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: **#REF!**

Sum of Total Waiting	Weeks Waiting										
Consultant Name	**0-9Wks**	**9+ to 13Wks**	**13+to 18Wks**	**18+ to 21Wks**	**21+ to 26Wks**	**26+ to 31Wks**	**31+ to 36Wks**	**36+ to 41Wks**	**42+ to 52Wks**	**52+Wks**	**TOTAL**
YOUNG	114	3	63	22	16	45	47	11	78	74	473
O'BRIEN	40	67	34	1	61	43	42	6	63	51	408
SURESH	73	46	4	39	45	31	31	11	40	65	385
GLACKIN	86	35	25	46	19	20	3	42	22	80	378
O'DONOGHUE	73	53	48	4	55	41	25	16	17	26	358
HAYNES	71	9	29	0	32	37	37	27	35	76	353
GENERAL UROLOGIST	120	36	24	11	18	24	19	17	26	48	343
UROLOGY CONSULTANT	40	2	0	0	0	0	0	0	0	0	42
A HAEMATURIA CONSULTANT	2	0	0	0	0	0	0	0	0	0	2
BROWN	1	0	0	0	0	0	0	0	0	0	1
TOTAL	**620**	**251**	**227**	**123**	**246**	**241**	**204**	**130**	**281**	**420**	**2743**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team

Received from SHSCT on 23/11/21. Annotated by the Urology Services Inquiry.

Data source: BOXI CH3 Universe, run date 15/05/17

ref 5 (i)- OP NEW CONS LED UROLOGY REG SPEC WAITS (SUBMISSION)

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: **30/04/2017 (Run date 15/05/17)**

Consultant Name	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	42+ to 52Wks	52+Wks	TOTAL
O'DONOGHUE	72	50	80	41	26	39	36	52	73	23	492
YOUNG	89	48	63	17	48	37	29	18	39	47	435
HAYNES	72	21	44	39	69	24	30	5	39	30	373
GLACKIN	62	46	24	11	40	40	2	39	29	29	322
GENERAL UROLOGIST	117	16	15	15	17	30	19	10	58	22	319
O'BRIEN	11	6	4	4	5	23	37	45	56	27	218
E REF UROLOGY	212	0	0	0	0	0	0	0	0	0	212
SURESH	1	1	1	0	2	28	38	13	42	32	158
GENERAL UROLOGY CONS	26	0	0	1	0	0	4	1	1	0	33
BROWN	10	2	5	0	3	1	1	3	2	3	30
JACOB	4	0	0	0	0	0	0	0	4	0	8
TOTAL	**676**	**190**	**236**	**128**	**210**	**222**	**196**	**186**	**343**	**213**	**2600**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team

Received from SHSCT on 23/11/21. Annotated by the Urology Services Inquiry.

Data source: BOXI Monthly Waiting Universe

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Inpatient / Daycase Waiting List for Regional Urology Specialty by Consultant and Waiting Time Bands **30/04/2016** **AS AT RUN DATE 17/05/16**

NOTE: ACTUAL WAITERS EXCLUDE PATIENTS WITH AN EXPECTED METHOD OF ADMISSION - 'PLANNED' AND PATIENTS WHO ARE CURRENTLY SUSPENDED

Consultant Name	0-13Wks	13-17Wks	17-21Wks	21-26Wks	26-31Wks	31-36Wks	36-41Wks	41-46Wks	46-52Wks	Over 52Wks	TOTAL
Young M Mr	146	33	12	18	14	9	13	7	6	73	331
O'Brien A Mr	49	7	15	10	13	18	8	9	7	141	277
Haynes M D Mr	78	23	8	5	5	3	0	1	1	17	141
Glackin A.J Mr	62	23	10	8	8	10	1	0	0	0	122
Suresh K Mr	60	12	9	7	3	5	2	2	1	0	101
O'Donoghue J P Mr	42	5	4	6	3	1	0	1	3	10	75
TOTAL	**437**	**103**	**58**	**54**	**46**	**46**	**24**	**20**	**18**	**241**	**1047**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team.

Received from SHSCT on 23/11/21. Annotated by the Urology Services Inquiry.

Data source: BOXI Monthly Waiting Universe

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Inpatient / Daycase Waiting List for Regional Urology Specialty by Consultant and Waiting Time Bands **30/09/2021** **AS AT RUN DATE 05/10/21**

NOTE: ACTUAL WAITERS EXCLUDE PATIENTS WITH AN EXPECTED METHOD OF ADMISSION - 'PLANNED' AND PATIENTS WHO ARE CURRENTLY SUSPENDED

Consultant Name	0-13Wks	13-17Wks	17-21Wks	21-26Wks	26-31Wks	31-36Wks	36-41Wks	41-46Wks	46-52Wks	Over 52Wks	TOTAL
Glackin A.J Mr	65	10	8	11	1	2	5	2	5	146	255
Haynes M D Mr	64	7	7	12	6	3	3	5	6	163	276
O'Brien A Mr	0	0	0	0	0	0	0	0	1	233	234
O'Donoghue J P Mr	61	14	11	9	5	5	6	17	5	217	350
Young M Mr	123	16	15	19	20	23	26	18	21	379	660
Jacob T Mr	0	0	0	0	0	0	0	0	0	116	116
Omer S Dr	30	15	5	2	4	3	5	6	6	10	86
Tyson M Mr	4	0	0	0	1	0	0	4	0	43	52
Khan N Mr	70	9	14	4	8	5	5	0	0	3	118
Solt G Mr	0	0	0	0	0	0	0	0	0	11	11
TOTAL	**417**	**71**	**60**	**57**	**45**	**41**	**50**	**52**	**44**	**1321**	**2158**

Produced by Directorate of Performance and Reform, Informatics Division, Information Team.

Received from SHSCT on 23/11/21. Annotated by the Urology Services Inquiry.

Urology PERFORMANCE – August 2022

New Out Patient Waiting List (with no dates) report 1				
	06/07/2022		01/08/2022	
Urgency	No on WL	Longest Wait	No on WL	Longest Wait
Red Flags	45	17 weeks	129	16 weeks
Urgent	165	295 weeks	119	295 weeks
New Red Flag with 352	224	20 weeks	177	22 weeks
New Urgents with 352	190	203 weeks	220	297 weeks
Routine	3383	337 weeks	3366	339 weeks
Total	**4007**		**4011**	

New URGENT/ROUTINE Outpatients waiting with no dates. ***As at 01/08/2022***

- Removing the patients transferred to IS the total number of New Urgents is .
- Due to patients, returning to trust for reasons such as not being suitable for IS or refusing IS our Trust longest waiter is **weeks**. If we do not count the patients, who have been offered IS but returned to trust our Longest would have been **weeks (Due to upgrade from Urgent).**
- The average longest waits for patients who have not be transferred to IS is 1Weeks.
- All upgrades and new add ons will be transferred to 352 in Quarter 2

Total activity to date with 352 as at 01/08/2022

352 Activity
14.06.22

	Complete					Booked			TOTALS
	February	March	April	May	June	July	Aug	Sept	
Consultation	421	419	228	474	193		1	0	
Investigation	342	413	244	549	330		0	0	
Procedure	12	105	107	143	102		1	0	
Post Op Review	0	0	11	7	11		0	1	
Review	0	10	84	72	98		1	1	
TOTALS	775	947	674	1245	734		3	2	

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	6208	517
2018-2019	6622	551
2019- 2020	6338	528
2020-2021	4589	382
2021-2022	5747	479
2022-2023 (to July 2022)	1974	494

Review outpatient backlog update (as at for 1st August 2022)

	July 22		August 22	
	Total	**Longest Date**	**Total**	**Longest Date**
Glackin	52	Nov 20	46	Nov 20
O' Donoghue	422	March 17	408	March 17
Young	507	Dec 16	498	Dec 16
Haynes	105	Feb 19	108	Feb 19
Omer	41	Feb 21	32	May 15
Khan	91	Dec 21	84	Dec 21
O' Brien	143	March 16	137	Feb 17
Tyson	28	Oct 19	26	Oct 19
Jacob	34	July 17	33	Jul 17
Total	**1423**		**1372**	

Adult Inpatient and Day case waiting lists – position as at 01/08/2022

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	47	334	69	280	51	198	44	206
O'Donoghue	139	336	59	375	41	278	55	382
Young	148	411	72	**416**	128	388	142	**396**
Haynes	63	357	55	392	35	274	42	317
Khan	19	84	25	90	37	83	14	80
O'Brien	90	**417**	32	398	9	**415**	13	379
Tyson	33	189	28	228	18	167	24	282
SOM	8	381	0	0	27	102	7	89
TJA	9	313	13	331	8	244	21	299
Total	**556**		**353**		**354**		**362**	

Review Backlog position as of 30 April 2015

CONSULTANT	URGENCY	OPWL CODE	TOTAL	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0
MR M YOUNG	ROUTINE	CURMYR	406	Dec-12
MR M YOUNG	URGENT	CURMYUR	57	Jun-14
MR M YOUNG	ROUTINE	CMYUOR	0	0
MR M YOUNG	ROUTINE	CMYSTCR	286	Feb-14
MR M YOUNG		TOTAL	755	Dec-12
MR A O'BRIEN	ROUTINE	CAU4R	80	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	10	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	448	Dec-11
MR A O'BRIEN	URGENT	CU2UR	105	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	273	Sep-13
MR O'BRIEN		TOTAL	916	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	206	Apr-13
MR A GLACKIN	URGENT	CAJGUR	45	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	5	Apr-15
MR GLACKIN		TOTAL	256	Apr-13
MR K SURESH	ROUTINE	CKSR	54	Apr-13
MR K SURESH	URGENT	CKSUR	174	Apr-13
MR K SURESH	ROUTINE	CKSUOR	28	Feb-15
MR SURESH		TOTAL	256	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	0	0
MR MD HAYNES	URGENT	CMDHUR	0	0
MR MD HAYNES	ROUTINE	CMDHUOR	0	0
MR HAYNES		TOTAL	0	0
MR JP O'DONOGHUE	ROUTINE	CJODR	27	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	3	Feb-15
MR O'DONOGHUE		TOTAL	30	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	Feb-15
ENNISKILLEN		TOTAL	48	Dec-13
MR AKHTAR	ROUTINE	CMAR	125	Dec-12
MR AKHTAR		TOTAL	125	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2386	Nov-11

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were relevant to the operation and governance of Urology Services, differed from and/or overlapped with the roles of the Clinical Lead, Clinical Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.

8.1 My role was to provide safe, appropriate and efficient urological care to the patients that I was looking after. As a urology team, we developed services to improve efficiency and care. My roles overlapped with that of the Clinical Lead (Mr M Young) in that we were both Consultant Urologists striving to provide an excellent and efficient service for our patients. In terms of overlap with the Head of Service, we were both concerned with the efficient running of the Urology Department. She made me aware of the KPI targets so that my patients were treated in a timely manner. We were both involved in modernising the department ***(relevant document can be located at S21 62 of 2022 Attachments 8. Vision for Urology Services 2015).*** The Clinical Director, Medical Director and Associate Medical Directors were all concerned with the safe, efficient and effective running of the department which was our common aim.

8.2 My role differed from the Head of Service, Clinical Director and Medical Director in that I am a practicing urologist with direct clinical contact with urology patients. They would have had more managerial responsibility. As both the incumbents of the Clinical Lead and Associate Medical Director positions were urologists, we had similar clinical roles but again, they would have had more managerial responsibility.

Urology Services

9. For the purposes of your tenure, in April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

1.1 INTRODUCTION

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists
Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a [Personal Information redacted by USI] male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Haynes, Mark [Personal Information redacted by the USI]
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waiting	Total on waiting list
Urology	596	208	237	225	378	173	541	212	1752 patients
ENT	29	1x38 19	142	64	64	23	923	80	1158 patients
General Surgery	113	147	75	139	437	131	901	121	1526 patients
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38	50 patients
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128	2290 patients
Gynae	28	11	168	50	26	1 x 26 6	106	44	328 patients

As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, I cannot see a solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

From: Gishkori, Esther
Sent: 22 May 2018 18:05
To: Haynes, Mark
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M
Subject: RE: Urology Waiting Lists

Dear Mark,
Thank you for sharing this.
Prima Fascia, it looks like the death of this Personal Information redacted by USI could have been avoided.
Ronan,
For this reason, please begin the SAI process in the first instance. Once screened, we can grade appropriately.
Also though, Mark reports here that the longer urology patients have to wait, the higher the incidence of an adverse incidence occurring.
I know that regionally urology is an issue but during our conversation with Mark today, he told us we had the longest waiters. I need to understand fully why this is but also if we have it within our gift to improve the situation within the Trust without making any other service unsafe or unstable.
I would also be grateful if you would, in the first instance, set up a meeting with Mark, you, me, Martina and Barry so that initial steps to reduce this waiting list can be discussed and actioned.
Shane,
For your information only at this point. I will keep you informed as we go but am happy to discuss at any point.
Dr Khan,
You are welcome to join us any time although the first few steps in this are probably operational. I will of course copy you into all correspondence.

Many thanks
Best,
Esther.

From: Haynes, Mark
Sent: 22 May 2018 13:31

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From:	Haynes, Mark Personal Information redacted by USI
Sent:	11 October 2019 08:24
To:	Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; Glackin, Anthony; Tyson, Matthew
Cc:	Carroll, Ronan; Corrigan, Martina
Subject:	Emergency admissions of patients on waiting lists
Importance:	High

Morning all

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trusts targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

Going forwards, can we each submit an IR1 form for any patient who has waited longer than a time we consider 'reasonable' for elective treatment and is subsequently admitted as emergencies, in particular those with positive gram negative blood cultures, but including any patient whose emergency admission would have been avoided if they had received timely elective surgery? This will clearly document to the trust and HSC the patient risk and harm.

What constitutes 'reasonable' is up for debate and has to be left to each of our clinical judgement. As an initial thought I suggest;

>1 month delay for planned change of long term stent or beyond planned timescale for ureteroscopy for stone in stented patient.
>3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.
>1 year wait for routine elective treatment

As onerous as it may be completing these forms, the documentation will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a speciality (not urology) in an NI trust has come in for criticism because it did not flag / document delays in cancer treatments which are felt to have resulted in patients coming to harm.

Hope this is OK with all. The IR1 form link is;

Irrelevant information redacted by the USI

Mark

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

30.5 My line manager is the Clinical Director for Urology, who in turn is responsible to the Medical Director.

30.6 Clinical Director with responsibility for Urology: Robin Brown Mid 2011 – January 2014, Sam Hall January 2014 – March 2016, Colin Weir June 2016 – December 2018, Ted McNaboe December 2018 – December 2021 – Currently Vacant

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

31. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

31.1 In my opinion the senior managers did not work well with Urology. Engagement with the department by the Clinical Directors, Medical Directors, Assistant Directors for Surgery and Directors for Acute Services was very limited and infrequent in my experience. I do not know how much job planned time they had allocated to management activity.

31.2 Mr Young tried his best to lead the Urology team. However, despite his best efforts Mr O'Brien, Mr Haynes and Mr O'Donoghue frequently failed to attend departmental meetings or arrived late. All too often I sat across the table from Mr Young wondering why my colleagues had not shown up. Due to the number of fronts on which the service was failing to deliver (growing waiting lists for appointments and surgery), it was difficult to achieve a consensus as to how to move forward without engagement from our colleagues.

Amended statement received from Anthony Glackin on 27/09/22. Annotated by the Urology Services Inquiry.

Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 The only issue that I was aware about concerned difficulty with triaging. The Trust managed this and wasn't something I had input into.

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

65.1 I did not have access to the Risk Register and have never seen it. I don't know if Mr O'Brien's concerns if there were any, are reflected in it. I also don't know if concerns raised by others are reflected in the register.

Learning

66. Are you now aware of governance concerns arising out of the provision of Urology Services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1 In my opinion, there were no issues of concern with urology per se. The issues of concern were with Mr O'Brien and his failure to carry out various tasks like triaging urology referrals and referral of patients from the uro-oncology MDM to other clinicians. His failure to perform these tasks were picked up and dealt with appropriately.

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

67.1 On the basis of the information presently available to me, I don't think anything went wrong with the Urology Service. In my experience, issues arising within the Service are dealt with effectively and efficiently. Miss Martina

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

70. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

70.1 No I do not think mistakes were made by either me or others in handling the concerns identified. When concerns were identified (failure to triage referrals, failure to follow through on MDM recommendation), systems were put in place to protect the patients.

70.2 Triage was improved by going online, ensuring that referrals were not lost and completed in a timely fashion.

71. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

71.1 The clinical concerns with regards to Mr O'Brien were identified and appropriate action taken to protect the patients. As the systems in place addressed the problems, I felt reassured that they were working.

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 There is nothing else I would like to add as I feel I answered the questions as comprehensively as possible.

<u>Statement of Truth</u>

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

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. Do you now know how long these issues were in existence before coming to either your own or anyone else's attention? Please provide full details in your answer.

53.1 I was first aware of concerns about Mr O'Brien whilst he had been on sick leave.

53.2 Mr O'Brien went on sick leave in mid-November 2016 and we as a consultant body were informed at our weekly meeting with regard to the triage issues in early January 2017. Attendance at this meeting included Miss Martina Corrigan, MR J O'Donoghue, Mr Mark Haynes, Mr Michael Young and Mr AJ Glackin.

53.3 My understanding was that triage letters which had not been triaged were found in a filing cabinet in his office. I was not aware of the reasons why his office was searched and was not aware over what period this triage covered. I was involved in triaging the letters for the Trust.

53.4 I also raised an IR1 as chairman of the uro-oncology MDM in October 2019. See question 54.

54. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:

(a) Outline the nature of concerns you raised, and why they were raised?
(b) Who did you raise it with and when?
(c) What action was taken by you and others, if any, after the issue was raised?
(d) What was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr. O'Brien which were known to you, please explain why you did not?

Corrigan identified that a number of referrals had not been triaged by Mr O'Brien. The missing referrals were found in Mr O'Brien's office, triaged by the urology consultants (JODonoghue, AJ Glackin, M Haynes & M Young) and the patients needing urgent treatment seen in clinic quickly. Most of the referrals now for triage are on line so an issue like this is unlikely to occur again.

68. What do you consider the learning to have been from a governance perspective regarding the issues of concern within Urology Services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

68.1 In my opinion, the main learning point is to make sure robust systems are in place to ensure all 7 pillars of clinical governance operate effectively. This would involve fully engaging with Clinical Effectiveness, Audit, Risk Management, Patient & Public Involvement, Staff Management, Information and Clinical Governance.

69. Do you think there was a failure to engage fully with the problems within Urology Services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1 Yes, I think there was a failure to engage by Mr O'Brien with the Urology Service

69.2 Mr O'Brien failed to triage urology referrals and he failed to refer a patient from the uro-oncology MDM onto another clinician. With regard to his failure to triage, he should have let the Head of Service know that he was struggling to complete the triage. I am not sure if the failures to triage could have been picked up sooner as the referrals at the time were hard copies.

69.3 With regard to his failure to refer a patient for a biopsy from the uro-oncology MDM, he should have involved the cancer nurses to provide oversight that these referrals were done.

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

Clayton, Wendy

Subject: FW: Triage

From: Carroll, Ronan Personal Information redacted by USI
Sent: 10 March 2016 17:12
To: Trouton, Heather Personal Information redacted by USI; Reddick, Fiona Personal Information redacted by USI; Clayton, Wendy Personal Information redacted by USI; Glenny, Sharon Personal Information redacted by USI; Corrigan, Martina Personal Information redacted by USI
Subject: RE: Triage

My view is that they only way this will work is the 72hrs turn around being complied with

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by USI

From: Trouton, Heather
Sent: 10 March 2016 17:06
To: Carroll, Ronan; Reddick, Fiona; Clayton, Wendy; Glenny, Sharon; Corrigan, Martina
Subject: RE: Triage

Dear All

It is my understanding that there is an area within Urology where delays can occur in Triage and this is in train although not easy to sort.

So in the meantime we have already agreed the process in Urology with Katherine where if the referrals are not returned in the preferred timescale then they are booked according to the GP category.

The wait for routine and urgent in Urology is such that a longer triage for urgents and routines ok.

Redflag referrals are booked and seen within 2 weeks . The gap therefore is in the case where the Consultant may upgrade to red flag during the triage .

I agree that this does need sorted to ensure that every referral is triaged in a timely manner to give every referral the opportunity to upgraded if appropriate but we know that there are not many upgrades in Urology.

Happy to discuss further.

Heather

From: Carroll, Ronan
Sent: 09 March 2016 22:14
To: Reddick, Fiona; Clayton, Wendy; Trouton, Heather; Glenny, Sharon
Subject: Fw: Triage

FYI

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan Personal Information redacted by USI
Sent: Wednesday, 9 March 2016 22:12
To: Carroll, Anita
Subject: Re: Triage

Yes need to chat this through too important to not get a solution

Sent from my BlackBerry 10 smartphone.

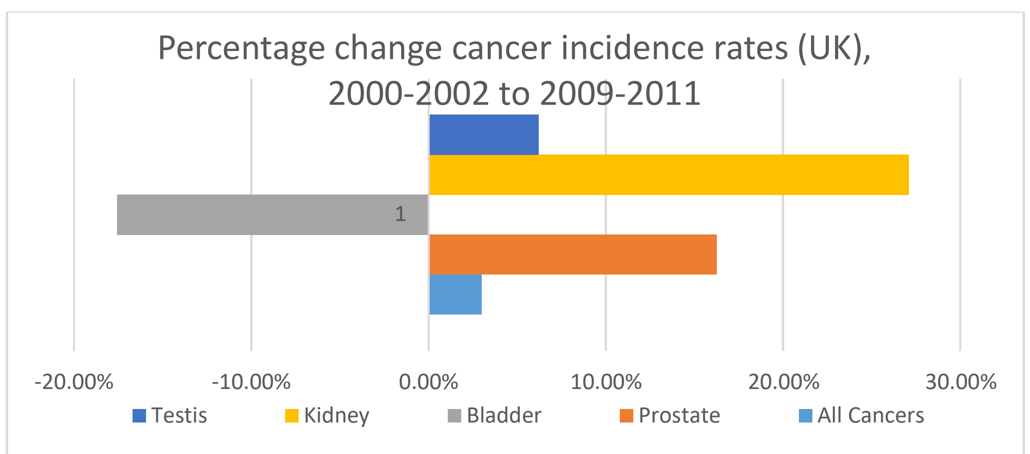
Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

The Vision for Urology Services
Southern Health and Social Care Trust

Background

One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Extracorporeal shock wave lithotripsy (ESWL- Stones)

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within Trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requirement for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. Follow-up demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been performed prior to the first outpatients attendance. Where investigations are arranged, writing with results and if required telephone follow-up. Those patients who do need to attend for follow-up will be seen either by CNS or consultant. A significant proportion of this required follow-up will be consultant led and nurse delivered (in particular oncology follow-up), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led

Received from John O'Donoghue on 02/09/22. Annotated by Urology Services Inquiry