UROLOGY SERVICES INQUIRY

SCHEDULE

[No 55 of 2022]

General

USI Ref: Notice 55 of 2022

Date of Notice: 7th June 2022

Note: An Addendum amending this witness statement was received by the Inquiry on 03 November 2023 and it can be found at WIT-104215 to WIT-104223. Annotated by the Urology Services Inquiry.

Witness Statement of: Michael Young

I, Michael Young, 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 This statement has been compiled by me, Mr Michael Young MD FRCS(Urol), retired Consultant Urologist.

1.2 I qualified in Medicine from Queens University Belfast in 1983. After general surgical training, I entered formal urological training and being accredited with the qualification of FRCS (Urol) in 1996 (see detailed account at Q4).

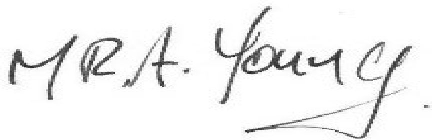
1.3 I was appointed as a Consultant Urological Surgeon with a special interest in Stone Management at Craigavon Area Hospital in May 1998. This post has

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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



Signed:

Date: 22nd August 2022

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 55 of 2022

Date of Notice: 7th June 2022

Addendum Witness Statement of: Michael Young

I, Michael Young, will say as follows:-

I wish to make the following amendments and additions to my existing response, dated 22nd August 2022, to Section 21 Notice Number 55 of 2022:

Amendments to Existing Paragraphs

1. At paragraph 56.7 (WIT-51798), I have wrongly stated, '*There are two SAI events*.' This should, in fact, state, '*There are two **IR1s***'.

2. Also at paragraph 56.7 (WIT-51798), I have referenced '*datix 71988*'. I wish to attach the letter I sent to the patient's GP and copied to Ms McVeigh requesting her to forward the correspondence to the regional team and the oncologists *(see 1. forward letter to BCH march 17)*

3. At paragraph 64.1 (WIT-51815) 2 lines up from the foot of the page, I have stated, '*I think I did this in 2013 for approximately 6 months until his project was completed*.' I believe that this should state, '*I think I did this in **2012** for approximately 6 months until his project was completed*.'

4. At paragraph 66.2 (WIT-51824), I believe that I repeated the date error referred to above. I have stated, '*I offered to help by doing his triage for several months in 2013 to allow him to complete the project'* when I should have stated, '*I offered to help by doing his triage for several months in **2012** to allow him to complete the project.'*

Received from Michael Young on 03/11/2023. Annotated by the Urology Services Inquiry.

			without, as I understand matters, displacing or disadvantaging any other patient.
Patient 117 TRU-01081	Not reasonable	Reasonable	Upon reflection, the timescale in this case was reasonable.

Statement of Truth

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

Signed:

MR A. Young

Date: 3/11/2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 18 of 2023

Date of Notice: 10th October 2023

Witness Statement of: Michael Young

I, Michael Young, will say as follows:-

Knowledge of Concerns

1. In his statement to the Inquiry, at WIT-98844, Mr Chris Hagan discusses a series of issues which concerned him when he was working as a trainee with Mr O'Brien in Craigavon Area Hospital in 2000:

'… there were a number of situations that arose that caused me to feel concerned about some of the practices of Mr O'Brien. With the passage of time it is not now possible for me to recall all the details. I did not keep a formal record at the time. I am afraid it would not have occurred to me to do so. I did raise issues that concerned me with Mr. O'Brien himself, and also with Mr. Young about Mr. O'Brien, during my 6 months rotation. In 2000 that would have seemed like a brave or courageous step from a higher surgical trainee.'

Mr Hagan proceeds to list the issues of concern at paragraph 31 of his statement. The issues which he may have raised with you are: benign cystectomy on young women; excessive time performing TURP with risk of TUR syndrome; Mr O'Brien's approach to ureteric stone treatment; and priapism and penile disassembly.

In oral evidence on Day 61 (19th September 2023), Mr Hagan stated: *'So, undoubtedly, you know, because of the joint ward rounds, I would have expected that Mr. Young would have been aware of some of these patients.*

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11.-13. 20161012 Urology Department Minutes 22 9 2016, A1-A2

7.2 (b) The purchasing was outside of the control of the Urology Department. I raised my concerns at the Theatre Users Group meeting *(see 21. 20150305 THUGS Mtg Notes).* I had made a comment to transfer to the use of saline in 2015, this delay I regarded as relating primarily to funding issues. The Urology Department met in December 2017 and raised the concern of patient safety caused by the delay. Mr Haynes as AMD along with myself raised this with the Assistant Director, Mr Ronan Carroll. Following this escalation, the Acute Director and the Director of Performance re-prioritised the equipment purchase list and the resectoscopes were installed in 2018 as described above.

Statement of Truth

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

Signed: MR A. Young

Date: 31.10.2023

Received from Michael Young on 01/11/2023. Annotated by the Urology Services Inquiry.

Witness Statement

NAME OF WITNESS	**Mr Michael Young**
OCCUPATION	Consultant Urologist
DEPARTMENT / DIRECTORATE	Directorate of Acute Services, Craigavon Area Hospital
STATEMENT TAKEN BY	Dr Neta Chada, Associate Medical Director / Case Investigator
DATE OF STATEMENT	Thursday 23 March 2017
PRESENT AT INTERVIEW	Mrs Siobhan Hynds, Head of Employee Relations
NOTES	The terms of reference were shared prior to the date of statement.

1. My name is Mr Michael Young. I am employed by the Southern Health and Social Care Trust as a Consultant Urologist. I was appointed in 1998 as a Consultant in Craigavon Area Hospital and have held my current position with the Southern Trust since2002.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and / or clinical practice of Mr Aidan O'Brien, Consultant Urologist being carried out in accordance with the Trust Guidelines for Handling Concerns about Doctors and Dentists and the Maintaining High Professional Standards Framework.

3. I agreed to answer questions specifically related to the terms of reference previously shared with me.

4. Mr O'Brien and I were the Trust's only two Consultant Urologists up until 2005 when a third Consultant was appointed. Around 2005, the urology service with Mr O'Brien and I as the two Consultants were under significant pressure due to workloads. We were only able to do emergency work at that time. In fact our 'doors closed' for a short period of time in 2005 – around 80% of our work at that point was emergency work.

5. I recall meetings about the service and being asked by John Templeton if the service was working, it clearly wasn't. An action plan was put in place and it was at that point that Mr Batstone came to work with us for 6 months and then Mr Akthar joined the team. In 2010 there was a Urology review in Northern Ireland and from this work it was determined that the area a unit would cover was to be based on population. A unit covering 400,000 to 500,000 people required 5 Consultants

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d. F.R.C.S. (Urol) Nov. 1996

Occupational History:

4.3 I commenced medical education at Queen's University Belfast in 1978 and qualified in July 1983 with MB, BCh, BAO degree.

4.4 My House Officer Year, (August 1983-84), covered General Medicine / Cardiology and General Surgery at the Lagan Valley Hospital.

4.5 In the first year as a general surgical Senior House Officer (Craigavon Area Hospital August 1984-85), I obtained the First Part of the FRCS examinations. (Fellow Royal College of Surgeons).

4.6 From August 1985 to August 1987, I was an SHO in the Belfast Surgical rotation. This included six monthly rotation between A/E and Fracture Clinic (Royal Victoria Hospital), Urology (Belfast City Hospital), general surgery (Ulster Hospital) and paediatric surgery (Royal Victoria hospital).

4.7 I obtained the Second Part of the FRCS surgical examinations in June 1987.

4.8 Senior SHO Surgical posts in General Surgery followed for a year each in the Ulster Hospital Dundonald (1987/88) and then the Waveney Hospital in Ballymena (1988/89).

4.9 For six months from August 1989, I had surgical rotation in Neurosurgery and plastic surgery followed by six months of General Surgery in Craigavon Area Hospital as a Registrar.

4.10 After successfully gaining a Royal Victoria Hospital Research Fellowship and Department of Health Research grants, an 18-month surgical research post commenced in August 1990. This culminated in a Medical Doctorate by Thesis in Dec 1993.

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CRAIGAVON AREA HOSPITAL GROUP (HSS) TRUST

JOB DESCRIPTION

CONSULTANT UROLOGIST

Preferably with an Interest in Stone Management

December 1997

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 I was appointed as a Consultant Urological Surgeon with a special interest in Stone Management at Craigavon Area Hospital in May 1998. This post has been continuously held till retirement at the end of May 2022. The Job description I was given at the time for my role as a consultant Urologist was an accurate reflection of my duties. ***(Relevant document located at Relevant to HR/reference no 15/19971200-REF15-Mr M Young UROLOGY Job Description.pdf).***

5.2 Work as a Consultant Urologist covered all adult urological conditions (excluding transplantation) and emergency paediatric urology.

5.3 On-Call commitment was initially on a 1:2 weekly basis until 2006, when an additional Consultant joined the team making the rota 1:3. From August 2012 the unit has expanded with rota commitment being between 1:4 to 1:6 pending vacancies in the posts (see: Q16). Initial On-Call commitment up until the introduction of changes following the Regional Urology Review involved emergency urology care and inpatient ward cover on a 24hour basis in addition to normal daytime activity. This practice continued till the new system post urology review was instigated for Urologist of the Week covering emergency work and triage in 2014. ***(The relevant documents can be located at S21 No 55 of 2022, 1. ACTUAL ROUTINE WORK ACTIVITY Word doc 2002, 2. ACTUAL ROUTINE WORK ACTIVITY 2005-2006 3. ACTUAL ROUTINE WORK ACTIVITY 2007-09 4. ACTUAL ROUTINE WORK ACTIVITY 2010 5. job plan autumn 2006).***

5.4 The Elective care duties for my consultant role covered general and specialist outpatient clinics (urodynamic and stone clinics) in Craigavon Hospital on a weekly basis and fortnightly in the outreach facilities in Banbridge Hospital and Armagh Community Hospital. The commitment to the outreach clinics changed following the Regional Urology Review implementation in 2013 when I discontinued the Armagh Clinic and took on the new Urology clinic in the South West Acute Hospital in Enniskillen. This all-day clinic in the SWAH was also on a monthly basis.

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5.5 Operating Theatre lists for Day Surgery were untaken on a monthly basis either in Craigavon Area Hospital or at South Tyrone Hospital throughout my tenure.

5.6 Weekly inpatients operating sessions were solely in Craigavon Area Hospital for 20 years of my tenure, until the Covid period started, when sessions were in Daisy Hill Hospital or NHS facilities at the Ulster independent Clinic in Belfast. Prior to the Regional Urology Review implementation, the theatre lists were primarily all day on a Tuesday but if additional lists became available on an ad hoc basis, these were also availed of. Post Review implementation, my theatre lists were also on a Tuesday but in the afternoon and early evening and, again, ad hoc lists were availed of. Ward rounds to review and assess my patients were generally on a daily basis during the week days, in the pre-urology review period. Review of my post-operative patients were on the first day post procedure as much as possible, in the knowledge that the On-Call team were doing Ward Rounds.

5.7 As part of the stone management service, I designed and set up the ESWL service in the Stone Treatment Centre, Craigavon Area Hospital in 1998. This provided treatment sessions by Extracorporeal Shockwave Wave Lithotripsy and outpatient clinics relating to stone management. The service was provided by myself, a specialist nursing team and radiographers. The principle of the care pathway for the ESWL service and clinics have remained the same until recent years when a more efficient package has been delivered.

5.8 Administrative duties of the Consultant role included triage of referral letters and correspondence with General Practitioners, discharge letters, result sign-off, attendance and preparation for Audit sessions.

5.9 In addition to the Administrative duties, I held the responsibly of a training role as an Educational Supervisor for Urological registrars as well as the general education and monitoring of Junior doctors attached to the Unit. This was a supervisory role covering their education, outpatient assessment and in theatre sessions. It also involved being on the urology panel for the annual urology Registrar assessment for NIMDTA (Northern Ireland Medical and Dental Training Agency).

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5.12 Other posts held within the Trust included being on the Appraisers panel for the annual Medical Appraisal system.

5.12 External to the Trust, I held the post of Programme Director for Urology Training at NIMDTA (Northern Ireland Medical and Dental Training Agency) for five years from 2004. This post had the responsibility of co-ordinating all the urology registrar training, both in their educational programs, placements and assessments of progress. This post reported to Dr T McMurray, Post Graduate Dean of the Faculty of Medicine Queens University Belfast.

5.13 The Programme Director was appointed by the Deanery to manage specialty training programmes at Deanery level within their given speciality. Responsibility for allocation of specialty trainees to posts, supervision of individual training programmes, regular formal assessment including Rita/ARCP process as well as problem solving and feedback on progress were the main aspects of the post. In addition, the programme director had responsibility for looking after 'doctors in difficulty'. This was to support trainees within their programme and deal with individual issues, support the educational supervisors within their programme and provide advice on resolving issues within the programme. This may have involved moving individual doctors to different posts or to bring more serious problems to the attention of the Trust and/or Deanery. This was a challenging but enjoyable post ***(Relevant document located at S21 No 55 of 2022, 7. Letter terry mcm interview 2007)***

5.14 Having completed my period of time as Programme Director, I continued to be an Educational Supervisor. The responsibility of this role included ensuring the overall progress of the doctor through their training with regular appraisals, collation of work based assessments and providing career advice and support as required. The Educational Supervisor's role again also covered the responsibility for doctors in difficulty. Concerns were to be discussed with the doctor in question with regular appraisals. ***(Relevant documents located at S21 No 55 of 2022, 8. Policy re doctors in difficulty (VERSION 2)-August 2008 and 9. Ensuring PMETB standards are met 12 08 09)***

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been continuously held till retirement at the end of May 2022. I have returned to work on a part time basis for elective care (see detailed account at Q5).

1.4 My role and responsibilities as a consultant were service driven with direct patient contact. This involved the direct provision of daily care for patients, to provide a safe environment and care for patients, and to participate in all activities that up-held these principles. This covered activities in the ward, outpatients, theatre, and on-call for emergency urology cases along with the associated administration and clinical governance meetings. My post had a sub-specialty role and responsibility to supervise and provide the stone service for the Trust area.

1.5 Before retirement, I had been Lead Clinician for 20 years. This role was also service driven in terms of its organizational responsibilities, which focused upon the urology medical team's daily work placement. Other roles held were as a Programme Director for urological trainees in Northern Ireland and as an appraiser (further detail on these roles can be found in Q5, Q6, Q7, and Q8).

1.6 The Inquiry has requested a description of any issues raised with me along with any actions and decisions taken.

1.7 There has been a list of issues raised both by and with me over my 24 year tenure as a consultant and Lead Clinician.

1.8 A theme which has coursed throughout my tenure has been the demand put on the service from the significant numbers of patients requiring investigation and therapy within a deficit in the health care system capacity in terms of both facilities and provision of health care staffing. This has resulted in particularly long urology waiting lists for both outpatient and inpatient assessments. The yet undiagnosed and potential hidden pathology is a distinct concern. For those with a known condition suffer from a lack of intervention.

Version 2 (August 2008)

Northern Ireland mdta Medical & Dental Training Agency

GUIDANCE IN RELATION TO THE MANAGEMENT OF DOCTORS AND DENTISTS IN DIFFICULTY

1. Introduction

The policy has been written with a view to defining the procedures for dealing with doctors and dentists in the training grades who are experiencing difficulties within the Northern Ireland Deanery. The aims of the policy are to promote early identification of trainees in difficulty and provide a clear structure for identifying addressing these difficulties. It is based upon the principle of acting fairly, supportively and confidentially when dealing with problem situations that arise and draws and should be read in conjunction with the publication from the Department of Health, Social Services and Public Safety on '*Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS (DHSSPS 2005).'* This guidance provides the disciplinary framework for doctors and dentists in Health and Social Care and requires all HSC bodies to have procedures in place for handling serious concerns about an individual's conduct and capability that reflect this framework. The guidance covers restriction of practice and exclusion from work; conduct hearings and disciplinary matters and procedures for dealing with issues of capability.

It is the duty of all doctors to protect patients where it is believed that a doctor's conduct, performance or ill health constitutes a threat to patients. It is therefore the responsibility of the team with whom a trainee is working to highlight concerns before they become too severe and to enable the trainee to access the right help.

2. Roles and Responsibilities

A trainee has a contractual relationship with his or her employer and is subject to the policies established by the employing body. The employer has responsibility to ensure that employment issues, including performance, health and sickness issues and disciplinary matters are dealt with appropriately to facilitate the trainee's satisfactory performance.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) has responsibility for commissioning education and training whilst the Trusts and other training providers have responsibility for delivering education. Training providers have a responsibility to ensure that mechanisms are in place to support trainees and enable problems to be addressed at an early stage.

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The educational supervisor is the most likely person to be involved initially when a trainee is in difficulty although the Director of Medical Education, Clinical Tutor, Clinical Director, Medical Director, GP trainer, Dental trainer and NIMDTA may also need to be informed depending on the nature and seriousness of individual circumstances. The roles and responsibilities of the various educators all of whom have a responsibility for dealing with doctors and dentists in difficulty are summarised in Appendix 1.

It is the responsibility of the training provider to investigate and manage concerns. Training providers must keep NIMDTA informed of all significant concerns and should inform the Postgraduate Dean in writing of any disciplinary action being taken against a trainee. The flow chart attached at Appendix 2 provides guidance on action which a training provider should take when problems arise.

If through investigation it appears that the problem relates to the trainer or the training post then the Postgraduate Dean must be informed in order that appropriate action may be taken and where necessary the training post inspected.

3. Identifying trainees in difficulty

All possible steps should be taken to identify and act on early signs and symptons of difficulty. The majority of these are behavioural but also include signs of clinical incompetence, for example poor record-keeping; poor clinical decision making and judgement, inappropriate referrals etc.

Successful remediation or support for doctors and dentists in difficulty requires an understanding of the underlying problems. A checklist (Appendix 3) has been developed to help educational supervisors and others to diagnose and manage the early signs of a doctor in difficulty.

Concerns about a trainee's conduct or capability may come to light through:

- an untoward incident
- a complaint or litigation
- appraisal
- assessment
- performance data or clinical outcomes
- clinical audit

Clear evidence should be sought and concerns raised with the trainee at an early stage in order to obtain his or her perspective. The trainer should consult with colleagues to explore the nature and seriousness of the problem. As soon as it is clear that there is a problem with the trainee's conduct or performance action should be taken.

Managing potential risk to patients is the first priority and should be managed by the trainee and trainer/educational supervisor agreeing what the trainee can do safely and ensuring support and supervision from the whole clinical team to allow the trainee to practise safely in areas where he or she is underperforming.

Once the underlying cause of the trainee's difficulties is identified a realistic learning plan should be provided that will motivate and engage the trainee. If it is not possible

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Maintaining High Professional Standards in the Modern HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

Department of Health, Social Services & Public Safety
November 2005

Received from Richard Wright on 20/06/2022. Annotated by the Urology Services Inquiry.

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

Received from SHSCT on 09/11/21. Annotated by the Urology Services Inquiry.

Craigavon Area Hospital Group Trust
68 Lurgan Road, Portadown, Co. Armagh, BT63 5QQ

Urology Department
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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

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19 August 2002

Dr L McCaughey
Medical Director
CAHGT

Dear Liam

Between our meeting and letters of July this year, I have expressed grave concerns about the Trust's provision of services to our urology population and urology manpower. These two points are closely interrelated but they are two separate issues. Undoubtedly there are serious pathological conditions, as yet undiscovered, amongst referrals, and on the existing waiting list. The waiting time of these and especially those whom we already strongly suspect to have a serious condition, is at a level which exposes the Trust to potential complaints or legal involvement. Beyond reiterating the content of my letters of 26 and 31 July 2002, the volume of work performed and expectation of work to be carried out is currently far too excessive. This is compounded further by waiting list initiatives and planned developments. I was hoping for an early response both to how to address the early and medium arrangements (letter 26.07.02). Clinically the short-term address relates to outpatient referrals. It is appreciated that the bed space allocation will not be resolved quickly but an adequate provision must be defined for urology. (letters 26 & 31 July 2002) As you are aware, there is a formula to calculate this allocation. As haematology have only 8 of the beds on the other half of 2 South, there is no reason why the remainder cannot be allocated to urology.

The current manpower and on call commitment, as everyone agrees, are not at the correct levels. This is especially so since Consultants regularly are first on call without Registrar cover, unlike any other Department in the Hospital. The prospect of cover arrangements are also at a significant level.

To date we have been trying to develop the service and with this we have been prepared to accept the 'rough with the smooth'. However, this goodwill is running thin, despite the reciprocal outward appreciation, it is not backed by actions.

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I also regard it as not advantageous to us as Urologists or to the Trust to take unilateral decisions at short notice to cease certain activities (despite these issues being addressed informally and formally with the Trust over the past twelve-eighteen months). Several surveys have been performed and the new Consultant's contract have stalled any implementation. As you are aware certain dates have been suggested. I personally feel, to be fair to all concerned, that the date of the 1 September 2002 was indeed too soon. Others suggested 1 November 2002 as adequate notice, however, as so many initiatives are planned to start in October (TRUS, Urodynamics and Flexible Cystoscopy), I feel this would be counter productive to start and then stop. I therefore regard that the date of 1 October 2002 be defined as having these issues addressed to our mutual satisfaction.

It is appreciated that Consultant and bed space expansion cannot occur overnight. What is expected however is a defined timetable for such events. The main issues to resolve by 1 October 2002 are the matters of on-call commitment and recognition of our 1:2 rota.

If this issue cannot be resolved, then a unilateral decision to reduce the workload will be taken, compatible with what we regard as in keeping with patient's safety and our time management.

Although the Trust has been aware of our concerns for over one year, I would doubt if the Trust has informed the Board of the same. This may appropriate in view of the eminent plans. Sine there has been little progress, I am re-referring this issue back to the LMC again, despite the Committee being aware of our plight one year ago. I do however feel such concerns are probably best channeled in this direction.

It is sad to see these types of issues work for some and not for others.

Yours sincerely

____

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology
/mm

cc Mr. I Stirling, Clinical Director of Surgery, CAHGT
Mr. J Templeton, Chief Executive, CAHGT
Mr E Mackle, LNC – Chairman, CAHGT

Craigavon Area Hospital Group Trust
68 Lurgan Road, Portadown, Co. Armagh, BT63 5QQ

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Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

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17 September 2003

Mr. John Templeton
Chief Executive
CAHGT

Dear John

I write to acknowledge receipt of your letter dated 21 August 2003, which I received, in early September, relating to the status of the urology outreach clinics. Recent communications appear to have been like 'ships passing in the night'. I do however regret you have heard commentary relating to the outreach clinics from external agencies, this certainly was not my intent. As far as I am aware the only communication on this issue was via myself at recent surgical directorate meetings and a more formal letter to the Surgical Director and the Medical Director a week or two ago. I was under the impression, following comments at the recent surgical directorate meeting, that communication to your office was to be via the Medical Director. I apologize if I have misinterpreted this.

Your letter appears to insist on the reinstatement of the clinics. This will be acted upon, as you comment that the Trust has an obligation to the Health Board. These clinics will conform to the usual terms and give adequate consultation time to patients.

Our concerns, excluding the outstanding issue of a job plan, has for sometime related to a lack of urological cover on the Craigavon site on a Thursday afternoon. This has led to some difficulties from an emergency perspective. Recent examples for both Consultants show that there was an intention to attend the clinics but due to emergencies and lack of junior cover (working time directive) a Consultant has had to remain on site. These issues, where large clinics are on occasions run solely by juniors, combined with the clinics being booked so far in advance does led to administrative difficulties – for instance having to return from annual leave to do a clinic rather than our secretaries spending time cancelling patients. We therefore take it that the Trust accepts that it is not always possible to have a Urologist on site and the implications thereof. Furthermore, the Trust and Board proposes to open facilities in South Tyrone Hospital and the Board also will be requesting a Urologist's presence in Daisy Hill Hospital. This will result in a urological presence on five sites. I, and the Surgical Director, do not see this as an appropriate safe option.

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Our other concern of this issue relates to a satisfactory job plan, which take into account the various facets of the service we provide. This has not been forthcoming. This recent step has been taken, out of frustration, as a temporary measure to both reduce and improve our contribution.

To return to the main issue, I fully accept and welcome a review of urological services. I am however more than disappointed that you would give serious consideration to the continued viability of the urology services. The urology service has indeed been viable and vibrant for some ten years. Our figures from the recent recovery plan were exceptionally favorable and we have made many suggestions to improve the situation and the service but unfortunately they have not been acted upon.

My concerns with regards to a review of the urology services are several fold. Although welcoming an external review, which I suspect might suggest more than we are requesting, my regret would be that since someone to fill the planned post is now available (but not prepared to wait around endlessly) will only slow the proceedings up significantly longer. I have also not observed a review of any other services when making a case for employing additional Consultants – why is this the case for us? I feel that an external review of the urology services, at this stage, will only delay the steps forward we are endeavouring to achieve. These steps, as you are aware, have been discussed previously in detail and were based on national guidelines.

Since taking on the Lead Clinician role several years ago, we all acknowledge that there were difficulties and shortfalls in the ability to cope with the volume of urological workload. I feel that I have put a considerable amount of time and effort into trying to address the urological issues with a fair and logical approach. Firstly we defined the problems using data supplied by the Trust. Secondly, formats to supply urological provision and national guidelines were presented as a model for Craigavon Area Hospital. Both these presentations were fully accepted by yourself and the Medical Director earlier this year. At that stage you stated that you would give a written indemnity to cover the urological service status. This would appear to give full support, despite the known difficulties. On this premise I have been working towards defining an adequate and acceptable way forward.

However recently the 'goal posts' appear to have been moved on this front, but despite this I had proceeded to speak to and then formally write to the individual departments involved in the provision for the requirements of a 3rd Consultant. To date most have not replied and those that did suggested leaving this until after the summer months. In mid August an attempt to get all concerned around the table was not possible until the end of September or even early October being suggested. This is a frustratingly slow process. I appreciate some of the administration is up to myself, but as a busy Clinician, I do not see my role as having to chase after everything and everyone.

We have raised the plight of urology with the Trust management over the past few years, seemingly drawing to a head this time last year at which stage we had suggested a course of action with you. We were at that stage under the impression that an improvement was imminent hence no changes on our behalf were taken.

It will be interesting to note if this review

- takes into account national guidelines,
- elicits why the four extra urology beds promised did not materialize,

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external review of urology services for Craigavon Area Hospital Group Trust in 2004. The executive summary notes the Chief Executive of Craigavon Area Hospital asked the Medical Director to carry out a review of the urology services in CAH. The medical director established a Review Group consisting of members of the management team and clinicians to undertake a comprehensive review of urology services within the Southern Health and Social Services Board. The aim was to improve the service provided to the community and resolve some, if not all, of the challenges facing the current urology service. The key challenges adversely affecting the urology services in the SHSSB were seen as insufficient manpower or capacity to deliver a full urological service, increasing waiting times for outpatients, inpatients and day cases, and noting increasing emergency workload. The external advisor carried out this analysis utilising a series of one-to-one consultations with clinicians, nurses, managers and administrative staff in May and July of 2004, visiting all sites where urology services were delivered in the Southern Board and meeting with the entire Urology Review Group in May, July and August 2004. The information gathered was used to create a comparative analysis picture of what, under the British Association of Urological Surgeons guidelines and NHS norms, one should expect in terms of service delivery given the available resources and infrastructure. Comparison was made to a similar Grampian unit in Scotland. Membership of the Review Group included Dr C Humphrey, Medical Director and Chair, Mr. J Mone Director of Nursing and Quality, Mr Stirling, Clinical Director Surgery, myself, Mrs McAlinden, Director of planning SHSB, Dr D Corrigan, Consultant in Public Health Medicine, Dr G Millar General Practitioner, Miss A Brennan, Planning Department CAH, Mr J Marley, Nurse Lecturer Practitioner Urology CAH, Mr H Campbell, Finance Department CAH, Mr S McClinton Consultant Urologist External Advisor, and Jean Mansfield, Project Coordinator.

15.9 The outcome of the analysis led to the following proposals for the way forward suggested by Mr McClinton: ***(Relevant document located at S21 No 55 of 2022, 39. McClinton urology report 2004 page 4)***

'a/To give serious consideration to increased levels of staffing to address current critically low levels.

'knock on effect' of removing pelvic surgery from the hospitals located outside of Belfast with reference to training and competences required in general urology practice when assisting our Surgical and Gynaecological colleagues and in addition to dealing with complex pelvic emergency urology. I also noted that units covering 500,000 patients still offered a viable oncology approach and felt it unwise to take the 'all eggs in one basket' scenario. This started my involvement in the urology steering group of 2009. ***(Relevant document located at S21 No 55 of 2022, 10. Urology review letter to McNicholl 01 12 08)***

9.2 The Urology review March 2009 covered the reorganization of Urology service provision in Northern Ireland. This was chaired by Mr Mullen, but the Clinical Lead was by Mr Fordham, Consultant Urologist. The Southern Trust team constituted of Ms Joy Youart, Acting Director Acute Services, Jenny McMahon, Nurse Specialist, and myself, as Lead Clinician. From my recollection the other urologists, Mr O'Brien and Mr Akhtar, were also involved in several of the meetings when discussing the future plans.

9.3 The Regional urology review of 2009 recommended that:

a) Urological procedures should be performed by urologists or a surgeon whose work was substantively urological;
b) Referrals to urology had no undue delays;
c) NICaN should have agreed referral guidelines for suspected Cancer;
d) New consultants should take into account special interests;
e) Collaboration with general surgery and A&E for protocols and care pathway for acute admissions;
f) Trusts to provide equity of urology admissions for hospitals without a urological unit namely, Antrim, Erne, and Daisy Hill;
g) Undertake an ICATS review;
h) The Trusts' implementation plans were to evidence the delivery of the key elements of the Elective Reform Programme for capacity, demand and activity;
i) An urgent redesign to enhance capacity to provide single visit outpatient and diagnostic services for suspected cancer;

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10.7 The report did acknowledge that there was in-house and independent sector activity yet there was still a significant waiting list backlog. I do, however, note that extra waiting list initiative clinics were undertaken by Mr Akhtar.

10.8 Monitoring of the process was provided by the hospital administration with data presented to the department. My recollection is that the Head of Service and Sandra Waddell monitored the situation.

10.9 In my view, the process did not achieve its aims. The roll out of change was slow in my opinion. There was under-staffing of the unit in medical terms and Nursing posts were not advertised to my knowledge or at least not filled. The Consultant posts were slow to be filled. The document notes a 48-week year activity whereas, in practice, with leave it should have been a 42-week year and the consultant clinic template was not correct. The outpatient backlog persisted.

11. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems with, for example, a backlog of patients, persist following the setting up of the Urology unit?

11.1 I wrote to Dr Rankin in September 2010 with regards to the clinic arrangements and the volume of cases per clinic. I did note the 2000 BAUS guidelines etc. but did point out the impact of the introduction of the ICATS service and the prior number of doctors helping at our clinics were now not as sufficient and there was a heavy reliance on patient DNA rates. I pointed out the improved new review rates I had achieved. I had suggested a urologist of the week to be triaging and arrange investigation or contact the GP – this had 'fallen on deaf ears' previously. I had pointed out that CAH urology was instrumental in introducing the DoH ICATS principle as we had started this process before they had raised the possibility ***(Relevant Document located at S21 No 55 of 2022, 22. Urology outpt Gillian Rankin sept 10).***

11.2 Correspondence to Dr Rankin in October 2010 in relation to clinic activity notes our issue with the numbers of patients to be seen at clinics. We noted the difficulty with the volume and recorded the new way BAUS was planning services to

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15.27 The Trust has endeavoured to advertise vacant posts on a regular basis without my specific prompting.

16. 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?

16.1 The McClinton review of 2004 recommended that a locum Urologist be immediately employed followed by a substantive post with a further post being advertised in 2007. When the independent sector work in the South Tyrone Hospital had been completed, as a result of this Review, the Trust offered the Resident Consultant Urologist, Mr Batstone, the post of Locum Urologist. He held this post till the third substantive Consultant post was taken by Mr Akhtar in September 2007. The fourth post recommended in the McClinton Review never materialized.

16.2 Although the Regional Review was dated 2009, by the time the Review had been assessed by the Trust, and there was a plan for the extra urologists to be in place for February 2011, it wasn't until late 2011 before one locum Consultant had taken up post before the substantive five urologist team was in place for the end of 2012. Three urologists were appointed on the same day - Mr Glackin, Mr Connolly and Mr Pahuja. There was a short spell when there were only two substantive urologists working in 2012 after Mr Akhtar had resigned to take up a post in England.

16.3 In 2013, two of the most recent consultant appointees (Connolly and Pahuja) left for posts in Belfast, and there was only one applicant when their posts were initially re-advertised, this being filled in December 2013 by Mr Suresh. However, a subsequent advertisement was more productive for the fifth vacant post. There were two strong candidates, Mr Haynes and Mr O'Donoghue, who were both offered posts, with the Trust going 'at risk' on the sixth post. From August 2014 the Southern Trust Urology team had six consultants until Mr Suresh left in October 2016. A Locum Consultant followed the next year. There had been no applicants for the substantive post until February 2019 when Mr Tyson joined the Team. Mr Tyson had a pre-arranged one-year fellowship appointment in New Zealand from autumn 2019

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Year	Non Consultant Funded posts	Non Consultant Posts Occupied with comments (note this does not include Clinical Nurse Specialists)
2009	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2010	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts
2011	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 2 vacant Trust Staff Grade Posts until November 2011 then Dr Sani Aminu commenced
2012	3	1 Substantive post filled by (Dr Rogers x 7 clinical sessions and Jerome Marley x 2 clinical sessions) 1 post filled by Dr Sani Aminu (resigned July 2012) Dr Hirron Fernando took up locum post October 2012 Dr Maurice Fernando commenced November 2012 J Marley stopped providing clinical sessions in December 2012
2013	3	Personal Information redacted by USI was terminated in January 2013 Dr Rogers resigned in April 2013 Dr M Fernando resigned in August 2013 3 vacant posts from August 2013 Continued to advertise through agencies and usual media forums
2014	3	1 substantive post holder (J Martin) commenced October 2014 Continued to advertise through agencies and usual media forums
2015	3	1 substantive post holder (J Martin) 2 vacancies and continued to advertise through agencies and usual media forums
2016	3	Dr Martin resigned in August 2016 L Devlin took up locum post in December 2016 3 vacancies from August 2016 and continued to advertise through agencies and usual media forums
2017	3	L McAuley took up Staff Grade post in January 2017 as full-time and in September reduced her hours to 3 days per week which is whole time equivalent of 0.60 L Devlin resigned her post in February 2017 1 vacant post and continue to advertise through agencies and usual media forums
2018	3	1 part-time staff grade in post (L McAuley) 1 vacant post filled with locum (Hasnain) Posts advertised – one successful applicant S Hasnain
2019	3	2 staff in substantive post (McAuley/Hasnain)

and, due to Covid, was unable to return to his Southern Trust post until January 2022. Also in 2019, Mr Haynes' tenure to the Southern Trust team reduced to a three-day week work schedule with the other days in Belfast.

16.4 Although the substantive post allocation to the Southern Trust had increased to seven, in reality during the latter part of 2020, it was down to four as Mr Tyson was in New Zealand and Mr O'Brien had retired, in addition to Mr Haynes being part-time in our Trust. Two Locum consultants were appointed, one remaining for a year. Mr Tyson returned in January 2022 and I retired in May 2022.

16.5 There has only been a brief period between 2014 and 2016, when the unit has had a complete substantive Consultant body. Before this, the number of consultants were deficient as defined by the McClinton Review of 2004 and the Regional Review of 2009. Spells of either a shortfall in numbers or filled by locum consultants were the norm. Some Locums were employed longer than others (some only for a few months).

16.6 The shortfall in the expected numbers of consultants results in a deficit of provision in overall output of FCE, outpatient, elective surgeries episodes and hindered target achievement potential. The turn-over results in reduced productivity and disjointed patient care in terms of when a consultant leaves then their patients are left in a degree of limbo till the post is replaced. The new personalities have to be engaged and learn how the system functions. The Trust made regular advertisements in the national press for replacements, mostly without success until recently. With the team being short of members, it resulted in the added onus of extra On-Call commitments and the work that follows in the triage of letters etc. In-House Waiting List Initiatives both for outpatients and theatre activity combined with external private sector work were the only remedies possible.

16.7 Not only was there a shortfall in the consultant complement, there was also a deficit in the middle grade level of urological staff. There were three funded Staff Grade posts from 2009 till recently. With extra funding, following the Covid period and in recognition of the further recent needs of the urology unit, more posts have been created.

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17.3 Junior staff of speciality doctors and registrars were originally doing clinics on their own but a Training review by the Royal Colleges and NIMDTA stopped this activity. (Mr Glackin, as Programme Director of Training, could define when this was precisely). The vacancies and the change-over of middle grade staff would result in the decreased number of patients at a clinic, which puts further delay on other patients being seen.

17.4 Undoubtedly, the times of shortfall in the consultant number have had a significant impact and the burden of the backlog has never been adequately addressed (either by the Trust or the DoH, in my opinion). This feature related to volume and timeliness of provision. An interruption from a lack of a consultant's presence also delayed the 'hidden oncology cases' being defined at an earlier stage, potentially. The lack of overall numbers on the team also delayed the known oncology throughput. Sepsis rates are well known to be higher in men with a catheter in situ awaiting prostate surgery. This also certainly applied to the stone service where sepsis rates are increased in relation to delays in intervention for patients with a ureteric stent in situ. Other factors such as theatre availability were also part of equation but staff shortages are certainly a major contributor to the delay in a timely service.

17.5 A further feature is when a Consultant leaves, their workload and waiting list is generally put on hold until the post is filled. If the post is indeed re-filled promptly then patient care continues, however, if unfilled or significantly delayed then this group of patients are potentially at risk from not being seen in outpatients or offered surgery.

17.6 The shortfall in the Clinical Nurse Specialists numbers has hindered the progression of the oncology program and MDT. I understand, that despite advertising, there had been difficulty in finding suitable candidates until recently. The overall provision of the MDT has been enhanced by the presence of this team and certainly has allowed follow up provision to have been tightened up as well as improving patient experience.

17.7 The Trust has, however, endeavoured to fill these posts by multiple applications over the years. After the initial apparent slowness following the Regional Review of 2009, the Trust has had difficulty in recruiting the appropriate staff. In-patient care

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AOB-01811

O'Brien, Aidan

From: Haynes, Mark
Sent: 22 May 2018 13:31
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 Tughans OBO Mr Aidan O'Brien on 26/11/21. Annotated by the Urology Services Inquiry.

overseen by the Director of Acute Services and the associated management team, who oversaw the operational governance of the unit. The Medical management of Clinical Director, Associate Medical Director and the Medical Director were, in addition, responsible for oversight of the clinical aspects.

39.2 Following the regional urology review our department endeavoured to move to the one stop clinic principle to aid quality and throughput of patients. This was primarily for the haematuria service but did also applied to the prostate biopsy service. As noted in Q32, this was part of the reason our department won the overall / main Southern Trust award in 2016. Our Head of Service continues to produce regular data reports on the wait times for these services and, if they stray, extra clinic or outsourcing of the activity is undertaken as necessary

39.3 An application for a Trust research grant was made in 2018 so assess the outcome of stone clearance rates for kidney and ureteric stones using the lithotripter in the Stone Treatment Centre in Craigavon Areas Hospital. The objectives were to assess patient demographics, pre-treatment stone factors and ESWL parameters that affected outcomes in addition to patient satisfaction. Pain relief assessment project and an important component of this research was to assess the changes in care following the introduction of the Stone MDT. Qualitative and quantitative assessments were made with a team approach for this research involving Stone centre research Nurse, a radiographer and medical input of a senior Urology Adept Fellow, staff grade and myself as the Lead Consultant ***(Relevant document located at S21 No 55 of 2022, 69. Assessment of Kidney and ureteric stone clearance).***

39.4 Evaluation of the recently introduced Stone Meeting Pathway identified significant progress in the timeliness and completeness of the necessary data information with the introduction of a Stone MDT principle. The Stone Meeting processed patients on their care pathway at a quicker rate than before. Areas assessed included wait time for first urology contact after ED presentation, wait time from referral date to definitive plan for ureteric stone, assessment of completion of key biochemical workup for patients within six months of presentation, assessment of signposting of patient to information regarding self-care and risk reduction for further stone formation, capacity assessment of stone clinic versus stone meeting, cost savings, patient feedback questionnaire and ED staff feedback. This project

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the daily tasks and in the planning of services, however, understaffing issues were frustrating.

25.8 For instance, understaffing inhibited the full delivery of the intravesical chemotherapy pathway, the level of CNS provision for MDT follow-up was delayed, outreach location CNS provision was never considered, training and provision for the andrology service did not get off the ground, delays in the stone nurse led services and ward-based urology being fragmented are a few examples of where patient-based services are lacking and the associated risks are defined. This is not necessarily a Trust point but an underfunding of the overall service from a higher level than the Trust.

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

26.1 The ethos of the urology service has been to encourage nurse training in the advancement of their careers. This may have been to different levels, from taking on specific roles though to the level of independent practice. Education has been via courses, attending meetings, in-house mentoring and degree courses. All the specialist nurses are encouraged to work in teams and not alone. The environment of having a dedicated urology unit in the Thorndale Unit, and more recently also in South Tyrone Hospital, has promoted, provided and encouraged this principle.

26.2 The Specialist Urology Nurses are in two groups with a little overlap. My understanding of the role of the Specialist Cancer Nurse is to provide a nursing angle to the care and support of patients with an oncological diagnosis. This can be a holistic provision, to provide additional information and back-up the consultation the patient has had with their consultant, to help in the consultation when the

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consultant is with the patient, provide a contact point for the patient if they request further information at a later date, to ensure there is a follow-up plan and the patient is aware of their planned care pathway, to attend the oncology MDT meeting and engage to know the planned pathway. The role has evolved with time from initially having an holistic role and providing information leaflets through to the current provision of partnering of oncology care along with the consultant in patient consultations and performing diagnostic and follow-up tests such as flexible cystoscopy and prostate biopsies.

26.3 With regards to my oncology practice, the nursing input has evolved. The introduction of the ICATS service in 2005 provided a Specialist Nurse for the oncology section of the service as well as general urology and this role progressed as noted above ***(Relevant document located at S21 No 55 of 2022, 52. Proposal for urology nurse specialists 060505).*** With the Urology review of 2010, this role became more solely focused on oncology but there was only one post at the CNS level and an independent workload was not part of the provision. It was, as noted, a holistic and information provision service. My clinic for oncology patients following their MDT discussions was on a Friday afternoon in the Thorndale Unit, Craigavon. If the Oncology CNS was not available (due to work rostering or leave) then a senior Staff nurse took over this role. If the CNS was not available the patients were given contact details and vice versa, is my understanding. With the employment of additional Oncology CNS staff in recent years, there has been a significant improvement in the provision of Oncology CNS to cover the clinics. The CNS for Oncology work in partnership with myself at these Thorndale Craigavon clinics. If they are not physically in the room at the time of the consult then I specifically ask for their presence at the end of the consult to firstly introduce the CNS to the patient and family members and secondly to summarize the outcome and information discussed with the patient so as the CNS and the patient have a clear understanding of the care pathways. This clinic is booked on a weekly basis but the CNS team have access to speak with myself whenever I am in Craigavon Hospital, which would be anything between 3 to 5 days per week. The same applied if I needed to liaise with a CNS. A CNS is present in the Thorndale Unit most of the sessions a week and messages are easily left if necessary. Clinics in Banbridge and the South West Acute Hospital did not have a CNS presence which is failing in the system. These

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1 clarity regarding their consultation with any of the
2 consultants. Had I not been present during the
3 consultation the patient was referring to, I would have
4 viewed the dictated letter from NIECR for clarity in
5 relation to their questions, or sought clarity from 14:47
6 their consultant. For many years, I have worked a
7 four-day week".
8
9 I think we have established that?
10 A. Yes. 14:47
11 413 Q. Okay, I think that's the relevant part of that extract.
12 There are different ways in which the consultants
13 access different services. You have mentioned one
14 incidence of resistance to nurse-led activity in your
15 statement? 14:47
16 A. Yes.
17 414 Q. When you talk about prostate biopsy in relation to
18 Mr. Young?
19 A. Yes.
20 415 Q. Was that just a little bit of resistance to nurses 14:47
21 taking on that role or was it something else?
22 A. Well, possibly. I guess if the majority of your work
23 had been in Northern Ireland only, you weren't used
24 with the CNS wraparound service that would have been
25 more visible in sites throughout England. So, my 14:47
26 feeling for it at that time was it just took Mr. Young
27 that wee bit longer to engage with it. My way of
28 assisting that process was to ensure that I audited the
29 services that I was providing and presented those

1 audits at either departmental meetings or patient
2 safety meetings to ensure that my clinical work was
3 robust and safe. It was a gradual process but we got
4 there in the end, and referrals into the nurse-led
5 service began. 14:48
6 416 Q. The resistance, is it dissipated entirely?
7 A. Oh, it's gone and it didn't delay anybody in any way
8 because we didn't have a waiting list as such for
9 prostate biopsy. They were done within a week or two
10 unless there was some other medical reason that they 14:48
11 couldn't be done in that time. I also had a consultant
12 radiologist doing a list, so for a period of time I
13 would have put Mr. Young's patient on to his list and
14 that meant there was no delay in the pathway for them.
15 417 Q. You've mentioned briefly Fiona Reddick as Head of 14:49
16 Cancer Services?
17 A. Yes.
18 418 Q. Do you have much of a link or contact with her?
19 A. Very little. It would really only perhaps have been at
20 the AGM of MDT. 14:49
21 419 Q. She says in her statement that she highlighted to
22 Martina Corrigan that urology patients should have a
23 key worker urology cancer nurse specialist as part of a
24 key performance indicator. Is that something that you
25 are familiar with, or is that -- 14:49
26 A. That would have been something I was familiar with but
27 again, it was always back down to the resources that
28 hadn't been put in place.
29 420 Q. For the note, that statement from Fiona Reddick is

36.6 Since 2018 there has been a weekly Stone meeting to discuss patient management (similar to the oncology Meeting)

36.7 The Rota Scheduling Meeting was on a monthly basis at Thursday lunchtime and lasted slightly longer than an hour (more information on this point is recorded in Q45).

Governance – generally and in your role as Clinical Lead

37. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role as Clinical Lead, how did you assure yourself that this was being done properly?

37.1 Clinical governance was overseen primarily by the Director of Acute Services and the associated management team. This would have been shadowed by the higher management structure and the Associate Medical Directors.

37.2 This would have encompassed the Patient Safety Meeting along with the Medical Lead for this meeting.

37.3 The Lead Clinician role was service driven and the assurance for governance responsibility would have been as with that of the other consultants.

37.4 I assured myself that the Patient Safety Meeting was effective by attending and partaking in the discussions.

38. As relevant to your position as Clinical Lead, how did you assure yourself that governance arrangements within Urology were appropriate and effective? Please explain and refer to documents relating to any procedures, processes or systems in place on which you rely on in your answer, and provide any documents referred to (unless provided already by the Trust).

38.1 There were several systems in place to assure myself that there were mechanisms available for governance to be presented or discussed. The Patient Safety / Audit meeting was a regular monthly meeting with a quarterly full surgical / anaesthetic meeting for the whole theatre, ICU and surgical teams to meet and

discuss a variety of points. Other departments like Microbiology and pharmacy attended regularly as well. These meetings were minuted and the minutes distributed.

38.2 The monthly Scheduling meeting defined a precise team workplace allocation for its members. This would define the appropriate number of patients that could be seen or have had a procedure. For instance, a pre-defined number of patients to be booked to a clinic or day surgery list would depend on the level of seniority of clinician attending and also the number of clinicians attached to the individual session. This way, sessions would theoretically not be overbooked, or indeed be booked at all if there were absent sessions. This scheduling meeting was effective and ensured as productive a use of members time as possible.

38.3 Our Departmental meetings have given team members opportunity to discuss and raise any point they wished. These meetings may have had an agenda but often would include pressing issues a consultant would like discussed with his colleagues or with the Head of Service. Although these meeting often were not minuted, it was the opportunity for one of the team or the Head of Service to take issues forward. Minuting was an issue as either a clinic or the MDT immediately followed this meeting. The Departmental meeting over the past 18 months is better structured and run by W Clayton, Head of Service.

38.4 My specific governance role in the unit I regarded as maintaining the work schedule for the whole medical team, and as such this was operational. My line management is recorded in Q7-8 for my roles. Assurance of governance was as a hospital consultant but the responsibility of governance lay with management structure and the Medical Director's team.

39. How did you oversee 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?

39.1 I, as a consultant, was part of the urology team and as such had a responsibility to maintain the general quality of the urology service. This was

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55.9 The Medical Director system from 2007 onwards with regards to my role as Lead Clinician was generally one directional. If there was an issue, the Medical Director would liaise with me directly or more likely through the Acute Service leads. This was infrequent with specific reference to urology. The Medical Director's Office does however issue general patient safety documents on a frequent basis and the principle of 'office door was always open' applied if a physician wanted a conversation. As Lead Clinician, if I noted a governance issue, it would be raised first with the Head of Service and/or Director of Acute Services of the time.

55.10 Specific incidents of the Medical Director liaising with myself were when Dr Loughran, after consulting with the microbiology departments, resulted in the elective admissions to the urology ward for intravenous antibiotics and fluids were to cease. This dialogue was via meetings and correspondence. (Ref: see Q 63)

55.11 During Dr R Wright's tenure, he oversaw the governance of the temporary suspension of Mr O'Brien in 2017. Interaction between the Medical Director's Office and myself was via the Acute Services Director, Mrs E Gishkori, though I had spoken with Dr Wright in reference to Mr Suresh (see Q57). The same principle has applied to Dr M O'Kane and dialogue has been via the departmental meetings which have resulted from this Inquiry.

55.12 Apart from the issues pertaining to Mr O'Brien (detailed further below), contact with the Medical Directors in relation to other staffing or urological safety issues was minimal.

Directors of Acute Services

Name & Dates in Post
Ms Joy Youart Apr 2007 – Dec 2009
Dr Gillian Rankin Jan 2010 – Mar 2013
Mrs Debbie Burns Mar 2013 – Aug 2015

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(AMD), Mr Weir (CD) and Mr Young (urology team lead). Any encounters I witnessed were professional and often good humoured. I would have described the team dynamic at this level as appropriate, professional, and patient focused. Team members were not afraid to express their views robustly when required. However, I did not have the opportunity to witness how the team worked at a more operational level. I would have described the team dynamics between Mr Haynes, Mr Weir, and myself as strong and professional.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1. As the lead doctor within the Trust, I was the Executive Director who was primarily responsible for the Clinical Governance matters relating to doctors. There is often a blurring of boundaries, so this responsibility would be shared with the relevant service director. In this case that would be Mrs Gishkori. This role was delegated through the line leadership structure to the Associate Medical Director for Surgery, through the two surgical Clinical Directors, then through to the urology team lead and finally to consultants and other medical staff including trainees and SAS (Staff and Associate Specialist) doctors. There was also a shared governance responsibility through the Associate Medical Director Team across the Trust specialities.

31.2. Operational governance issues were the primary responsibility of the Acute Service Director (Mrs Gishkori).

31.3. Minor day to day issues would be expected to be managed by the Clinical Directors with the service managers and Assistant Director but more serious clinical governance issues would have been escalated to the Associate Medical Director and then to the Service Director .

CHKS CLIP Programme :- Indicator definitions cont.

High Volume Procedures

Day Case Rate

Numerator: Count of elective day case FCEs
Denominator: Count of elective FCEs
Exclusions: Well babies and regular attenders

Day case overstays

Numerator: Count of elective episodes intended to be a day case with a provider spell LoS > 0.
Denominator: Numerator + actual day cases
Exclusions: Well babies, regular attenders and renal dialysis

In-Patient Procedures

Top 10 elective Inpatient Procedures
(Total FCE's -Day Cases)

Inpatient pre-operative ALoS

Numerator: Total inpatient pre-operative bed days
Denominator: Inpatient spells with an operative procedure
Operative procedures as defined by CHKS
Exclusions : Well babies, regular attenders and renal dialysis

FCE Inpatient Average Length of Stay (DC Trimmed)

Numerator: Total FCE bed days
Denominator: Total IP FCEs
Exclusions:
- day cases
- Well babies, regular attenders and renal dialysis

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Where necessary, the Trust will guarantee that the clinician will be afforded time and training to become fully re-engaged with the original clinical team at the end of their term of employment

5.2 Specialty Lead

5.2.1 Nature & Scope:

Specialty Lead posts are required to bolster medical management capacity and ensure co-ordination within a specialty.

5.2.2 Accountability

Specialty Leads will account managerially and professionally to the Clinical Director of their division.

5.2.3 Career Progression:

Usually, the post of Specialty Lead is a 'taster' role for those who want to try medical management out. The post may become a stepping stone to a wider management role, or may prove to be as much as the post holder wishes to take on for a longer period. Many will wish to progress to the post of Clinical Director.

5.2.4 Personal Development:

The amount of management-related personal development needed in this role will be influenced by the career intentions of the post holders. Those wishing to proceed into a more substantial medical management role can undertake a 'full' management development programme – as determined by coaching, assessment and feedback. Those not wanting to progress a career in medical management will need fewer development inputs.

5.3 Clinical Director

5.3.1 Nature

Clinical Director posts are required to ensure the smooth-running of services. They are needed to contribute both strategically and operationally, to both the management and professional agendas of their division.

5.3.2 Scope

This is a significantly wider role than that of Specialty Lead. Clinical Directors will be responsible for ensuring that the highest standard of clinical care is delivered and that all targets and objectives are met in line with national and local standards,

Clinical Directors, by agreement with their senior manager, have powers of delegation and will usually manage those to whom they delegate responsibility and authority (most frequently, Specialty Leads).

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AMD role, I would have had to stop my special interests. My PA allocation as a Consultant surgeon post AMD was equivalent to 12.5 which meant I technically was allocated 1.5 PAs to fulfil the AMD roles. I gather there are now three CDs in the Surgical Division to support the AMD Surgery while for part of the time I only had one CD and a maximum of two. Between the AMD and Medical Director is now a new tier of Assistant Medical Director. These new changes have, I expect, improved the governance structure and the Assistant Director tier has increased the support for both the Medical Director and the Associate Medical Directors.

42. On reflection, one can see where things went wrong and what should have been done. The post of AMD was difficult due to the pressures of clinical work, the time available to fulfil the role, and the fact that I was covering not only Urology but also all the other Surgical Specialties. Urology in total probably took up more time and effort than any other subspecialty despite being one of the smallest. Heather Trouton, the Acute Directors, and myself relied on the assurance of Michael Young and Robin Brown that there were no clinical concerns. The current system is such that an AMD has to rely on his CD and Lead Clinician to supply accurate assessments on the clinicians in their team.

43. The failure by Aidan O'Brien to complete timely triage should have triggered a greater scrutiny of his administrative processes. It also should have generated a discussion between the Acute Director and the Medical Director regarding a review of his practice.

44. At the time of the urology review, the service in Craigavon was under significant pressure with a demand that outweighed the capacity. This led to a concentration on provision of services for emergencies, cancer and urgent patients. To deal with the rising backlog of outpatients and operative cases, consultants from within the specialty were being asked to provide additional sessions on top of their recognised sessions. These extra sessions generated more review patients and more administrative tasks for the consultants. There was difficulty in attracting and retaining sufficient staff at consultant

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25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

25.1. Day to day clinical management would have been carried out by the lead clinician, Michael Young, and any other team member to whom they delegated tasks such as MDM lead. During my tenure, Michael Young would have reported to me or Eamon Mackle (AMD). I use the term "reported" to describe lines of communication rather than the exchange of actual reports. I do not recall any concerns raised by Michael Young. I would have reported to Eamon Mackle. Non-clinical management would have been the responsibility of the Head of Service (Martina Corrigan) reporting to the Assistant Director (Simon Gibson and Heather Trouton).

26. What, if any role did you have in staff performance reviews?

26.1. In my role as a CD, I was not involved in any staff performance reviews. I don't know if anyone did performance reviews then or at any time since then.

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide 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.

27.1. I did not have a performance review of my CD role. I had yearly appraisal by a peer doctor as is normal practice for appraisal and revalidation. Appraisal is a confidential exchange between the appraisee and a suitably trained appraiser. Appraisal is not performance or governance management but an opportunity for an individual doctor to reflect and discuss, confidentially with a peer, their achievements and challenges over the previous year, to assess progress against agreed personal objectives and to agree new personal objectives for the incoming year. I don't think that I would have included any information on my management role in my appraisal. I have no documents relating to performance review or appraisal of my CD role.

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have demanding day jobs, ensuring the flow of patients both electively and as emergencies, and the day to day running of their services. It would benefit those managers if they had more input and support in responding to complaints and queries, and had the time to identify trends and patterns in areas such as complaints/SAI/queries coming in from, e.g., MLAs and MPs, which could then be discussed with the Divisional teams. I think that the accountability should still lie with the Divisional team but it would assist greatly if there was someone who could gather information for complaints and meet with consultants, organise patient meetings, etc. and if this member of staff could be part of the Divisional team.

e. In my opinion, another area that I consider should be taken into account with respect to learning is the need for a clear management structure of medical staff. For clinical staff they need to know who this is and what authority they have as their accountable manage. It is my observation that there wasn't a clear line of accountability/management whilst I was in post. So, whilst the consultants were directly accountable to their Responsible Officer, the Medical Director, I believe that they were unsure who was responsible for managing them on a day-to-day basis. Whilst there was a Clinical Lead (Mr Young), and whilst I believe it was understood that he should be managing the rest of the Urological consultants, Mr Young never had an actual job description outlining what this should entail and (from my recollection) only got 0.5 PA to be the Clinical Lead, so I don't believe that he ever felt that this was his role (although this would be a matter best addressed with him). I do feel that it was unfair in any event to have peers attempting to manage peers as these were their colleagues and it was hard to hold them to account when they were of the same grade. Equally, it was difficult for a non-urologist clinician to manage them as they were not familiar with the way the service worked, hence the reliance on the Head

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databases associated with identifying concerns. These collective data systems of waiting lists, datix and SAI are a productive mechanism in highlighting specific areas of concerns for groups and in identifying individual areas of concern, as raised later in the Mr O'Brien section of this statement.

48. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

48.1 Generally, these systems collect a lot of data but only on the individual patient as opposed to overall trends. However, it is the methods that offer the overall collective assessment of the data which identifies trends and this is where the Datix system is meant to contribute. For instance, if there are repeated Datix reports on patients admitted with sepsis and this group of patients are identified to be overdue a surgical treatment, this produces a trend report. SAIs may also identify common themes. Albeit that the triage issue had already been identified, I believe that the Datix system would have highlighted the point by the booking system at an earlier stage and flagged to the governance team in charge of this system, which is an independent system to the Booking Office. The Datix system, I believe, did define the trend in the inappropriate dosage of the prostate cancer drug being prescribed. The SAI reports also suggested a trend and were the trigger for the subsequent Root Cause Analysis. These two data collecting methods have been introduced in recent years and are showing their efficacy.

48.2 I am unaware of any other significant upgrade in these hospital systems.

49. As Clinical Lead, what was your role and responsibilities with regard to the Consultants and other clinicians working in Urology Services, including in matters of clinical governance?

49.1 As noted previously the Lead Clinician role is service-based and did not have a direct responsibility for other consultants other than a working relationship alongside them as colleagues on a daily basis and offering support and advice.

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also be raised with the Head of Service and possibly with the Clinical Directors. In more recent times, the Associated Medical Director would have been an early contact point as Mr Haynes, Consultant Urologist, was in this role. An example of this would have been when I recognised an issue with Personal Information redacted by USI operating capability, I mentioned this to both Mrs Corrigan as Head of Service and Mr Haynes as AMD. Initially, I had thought that Personal Information redacted by USI was just trying to get familiar with our theatre equipment but highlighted my potential concern nonetheless. This initiated a closer review of Personal Information redacted by USI practice amongst all the consultants. This process ultimately resulted in his dismissal, as detailed further below at Q57. This identified that my concerns delivered verbally were addressed. ***(Relevant document located at S21 55 of 2022, 115b. 20200309 11:19 Patient 12 in confidence).***

54. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

54.1 During my initial ten years or so in Craigavon, it was evident that there was a struggle for the Trust to appreciate the level of need the urology department required. It was not until the External Review of the Southern Trust Urology in 2004 that this was understood. It was always an uphill and slow process. In saying this, Mr Templeton was very supportive when I had specific concerns about patients and when I hosted the BAUS national endourology meeting in the hospital in October 2003. On recognition of the issue, the ICATS service and the independent medical service of ASPEN was engaged on his instruction. The Clinical Director, Mr Stirling, and Medical Directors, Dr McCaughey, Dr Orr, and Dr Hall, were all supportive of my role as Lead Clinician and as a fellow consultant colleague. It was my opinion that the block in progress was therefore at a higher level in the management hierarchy or in the DoH.

54.2 Following the 2009 Review, I felt my role as Lead Clinician was very much supported by the immediate line management system of Heads of Service and Clinical Directors covering Urology. They have been supportive and deeply involved in all the projects our department have put forward. The immediate period following

Aim

- To report current standards in removing stents following ureteroscopy (NICE 118)
- To report any stent-related symptoms to A & E
- To facilitate enhanced recovery following ureteroscopy by introducing stents on string in selected patients

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Proposal of change

- Checklist for stent removal on strings
- Improve logistics in removing stents with flexible cystoscopies using a pooled list
- How can we remove stents at a realistic timeline?

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6.5 As an Appraiser, the role reports to the Medical Directors Office.

6.6 The Programme Director for Urology reported to the Post-Graduate Dean at NIMDTA and was responsible for the overall training and assessments of Urological trainees in Northern Ireland and the Urological Consultants providing the trainees education. The post-Graduate Dean during my Tenure was Dr T. McMurray.

7. With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, clinical

7.1 My operational role and responsibilities as a Consultant Urologist, Lead Clinician, Programme Director for training in Urology, and Appraiser are recorded in my answer to Q5 and for each role my line manager is recorded in my answer to Q6.

7.2 Governance in Urology as a clinician follows the GMC guidance of safeguarding high standards of care by maintaining competency and revalidation, monitoring of risk and, if a concern is identified, to respond promptly and manage. Mechanisms need to be in place to provide quality assurance for accurate, timely and reliable data that can derive constructive information for continuous improvement or identifying concerns.

7.3 My role in clinical governance was as a doctor in the position of being a consultant. This involved mentoring junior staff and providing a continuous high standard of care for patients by maintaining competencies and partaking in the regular hospital audit, M&M / patient safety meetings . This, on occasions, involved chairing SAI episodes and providing advice on complaints.

7.4. As noted in my response to Q8 below, my responsibilities were primarily service driven with direct patient care.

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