Urology Services Inquiry

USI Ref: Notice 68 of 2022

Date of Notice: 23 August 2022

Note: S21 Notice No. 68 of 2022 can be found at WIT-82399 to WIT-82657.
Addendum No. 1 can be found at WIT-98807 to WIT-98808.
Annotated by the Urology Services Inquiry.

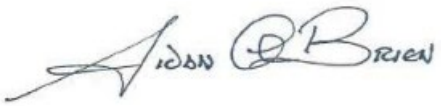
Addendum Witness Statement of: MR AIDAN O'BRIEN

I, Aidan O'Brien, wish to make the following statement as an addendum to my existing response, dated 2 November 2022 and addendum dated 31 July 2023.

Section 1 – The Retained Swab, DARO and Outpatient Waiting Times

1. At paragraphs 132 to 135 of my witness statement of 02 November 2022, I related the concerns that I had concerning DARO (Discharge Awaiting Results – Outpatients) [WIT-82447 to WIT-82448]. At paragraph 135, I referred to email correspondence on 06 February 2019 when I was advised for the first time that any patient who had any investigative test requested on or after completion of a clinical episode, was not to be placed on any waiting list until after the result or report of the requested investigation was reviewed by the requesting clinician, and even when that requesting clinician had already determined the next step in the patient's management at the time of requesting the investigation [AOB-07566 to AOB-07567]. I was alarmed to learn that patients were being completely discharged from the service even though the clinician had already determined the next step in the patient's management and requested that it would be implemented. As exemplified by the case which I described in my email dated 06 February 2019 the report of the CT scan which had been requested was important, but of secondary importance to review of the patient. I was most concerned to learn that DARO would have prevented the patient being placed on the waiting list for review until the report of the scan had been reviewed. I was concerned that test results would not be viewed for whatever

184. I hope that this addendum statement will be of further assistance to the Inquiry. I am happy to provide any further clarifications required.



Signed

Dated: 28 March 2024

instructions of the supervising Consultant. Mr. O'Brien spoke to the patient afterwards, as he was ultimately responsible for the operation. I was not present. I don't know what Mr. O'Brien said to the patient. With hindsight, it is clear to me that the direction I received from the supervising Consultant, to use the EHL, was not appropriate in the situation and that this was an entirely avoidable complication."

(ii) The Inquiry has since been advised on 19 December 2023 that the Trust has investigated this issue and has been able to locate the chart and the operation note in respect of the person the Trust believes to be the patient in question [TRU-320239 – TRU-320241]. The Trust has provided redacted copies of the operation note written by Mr Hagan on 06 May 2010 [TRU-320247) and the discharge summary dictated by me on 03 August 2010 [TRU-320245 – TRU-320246]. There was no record in the operation note of my being present at all during the operation and there was no record of my supervising the operation. On the contrary, Mr Hagan recorded at the end of the operation that I was informed of the proceedings.

Note: As per email (WIT-107947) received on 8th April 2024 the dates highlighted at paragraph 64 (ii) should read "06 May 2000" and "03 August 2000" instead of 2010. Annotated by the Urology Services Inquiry.

(iii) Moreover, the Trust has established that alternative energy sources were unavailable at that time, the Holmium YAG Laser not available until April 2006 and the Swiss Lithoclast not available until March 2014 [TRU-320243 – TRU-320244].

Paediatric Urology

65. At WIT-98849, Mr Hagan relates his surprise to finding that I had acquired a set of paediatric cystoscopes. Having been a Clinical Fellow in Paediatric Urology in Bristol from 1991 to 1992, I appreciated the diagnostic value of being able to examine the lower urinary tract endoscopically. I was for that reason that I acquired a paediatric cystoscope and a resectoscope. They were rarely used, and if used they were usually used for treating older children.

A. That's very fair, yes.

36 Q. We can see, just finally on this broad area, that, I suppose, the service of urology and these resource and organisational shortcomings which you've described not only affected consultant urologists but also affected nursing staff, for example. If I could just bring up on the screen, please, AOB-75761. Catherine Hunter was the ward manager for Ward 3 South, which, and forgive the expression, housed urological patients, but also ENT patients and -- 11:15

A. And some medical patients, yes.

37 Q. -- some medical patients.

She is writing on 12th November '15 to Esther Gishkori, who was the Director of Acute Services at that time, 11:15 copying in a range of people, including yourself, the other consultants and some others about her concerns as ward manager. I suppose it might be described in summary. Maybe if we just scroll down the page and on to the next page, she sets out in a lengthy document - 11:16 it runs to five or six pages - a concern, forgive the summary, but an unsafe ward where there's a significant shortfall in nursing capacity and she's looking to see what management would do about it.

A. That's right. 11:16

38 Q. In your view, was that a snapshot in time that was, if you like, temporary and passing, or is the narrative that she presents typical of a service that was in difficulty in terms of its resourcing for a number of

THE

FUTURE DEVELOPMENT

OF

UROLOGICAL SERVICES

BACKGROUND

Until the 1950s, Urological Surgery in Northern Ireland had a characteristic which it shared with many other areas of surgical practice that were not regarded as distinct and separate surgical specialties. This characteristic was that urological care was provided throughout the province by General Surgeons. Since then, many areas of surgical practice such as Neuro Surgery, Cardiac Surgery, Thoracic Surgery and Plastic Surgery, have long since become areas of specialist expertise concentrated in specialist departments. Specialist Urological Surgery saw its development evolve at Belfast City Hospital, during the late 50s and 60s. Up until the early part of this decade, specialist Urological Surgery remained concentrated at what became known as the Regional Urology Service at Belfast City Hospital, Belfast. During that period of over 30 years, the Regional Urological Service at Belfast City Hospital developed into a large specialist department, led by 6 Consultant Urologists, who contributed to the development of renal transplantation, in addition to establishing a tertiary referral centre for Urological Surgery for the Province. However, throughout the rest of Northern Ireland, the care of patients suffering from urological pathology, was still being provided by General Surgeons, with in many cases, limited training and expertise in Urological Surgery.

By 1992, the Southern Health and Social Services Board had concluded that there was a need to develop a specialist urological service, located in its area, for its resident population. A beginning was made in the process of that development by the appointment of a Consultant Urologist to Craigavon Area Hospital in July 1992. During the following 3 years, it became equally apparent that the need for urological services far exceeded that which could be provided by a single Consultant Urologist. A second Consultant Urologist was therefore appointed by Craigavon Area Hospital Group Trust in December 1995. In January 1997, the Department of Urology at Craigavon Area Hospital obtained approval from the Specialist Advisory Committee in Urology to have one Specialist Registrar post for urological training.

GENERAL DESCRIPTION OF CURRENT SERVICE

Even though the urological service provided by the Trust has developed, particularly with the appointment of a second Consultant Urologist, the need for urological services by the resident population of the Southern Area has far exceeded the service that can be provided. Particularly as a consequence, urological services have thus been targeted at those patients in most need of urological care. Whilst an analysis of the urological pathology necessitating inpatient care does not adequately portray a global view of the spectrum of urological problems suffered by patients, such an analysis however does focus of the areas of urological pathology that services are concentrated upon. These core services can readily be categorized into urological oncology, urinary tract stone

ISSUES FOR PROVIDERS

Urological services throughout the Southern Health and Social Services Board Area are currently provided by Specialist Urologists at and from the Department or Urology at Craigavon Area Hospital. In addition, however significant quantities of service are also provided by General Surgeons at Daisy Hill Hospital, Newry and at South Tyrone Hospital, Dungannon. As urological cancer services become concentrated at Craigavon Area Hospital, and as stone management becomes centralised at Craigavon Area Hospital with the introduction of on-site lithotripsy, progressively less urological services will be and should be provided at other hospitals within the Southern Area.

ISSUES FOR PATIENTS

Since the introduction of Specialist Urological Services at Craigavon Area Hospital in 1992, the resident population of the Southern Area have become increasingly aware of the potential significance of genito-urinary tract symptoms. This increased awareness has been facilitated through the medium of increased awareness on the part of General Practitioners since the introduction of Specialist Urological Services. As greater media attention is directed particularly at mens' health issues, the general awareness of the resident population is certain to increase. As patient awareness increases, increased pressure will be exerted by the general population on Purchasers to purchase increased, more accessible, more efficient urological services on their behalf.

AMBITIONS FOR THE FUTURE

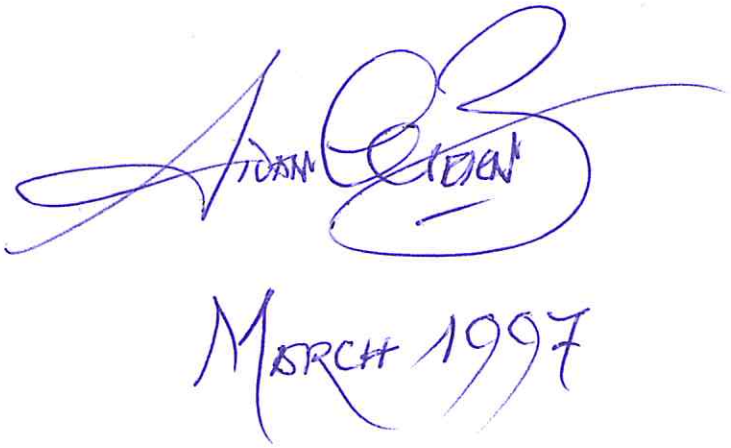
The overriding ambition of the Department of Urology at Craigavon Area Hospital is to provide a service of the highest standard, as effectively and efficiently as possible, to the resident population of the Southern Area, so that the optimal clinical outcome can be achieved for the maximal number of patients. In order to achieve this ambition, the services currently being provided and purchased from Craigavon Area Hospital Group Trust, require urgent and significant expansion. It is the ambition of the Department and of the Trust to ensure that these objectives are achieved with the minimum cost implications to all Purchasers.

Moreover, the Trust and its Department of Urology are fully aware that increased and improved urological services can only be achieved by paying full attention to aspects of training and education of both urological and nursing staff. Both the Trust and the Department are wholly committed to support a flourishing Academic Department as well as a clinical service.

These Developments will result in an ever increasing concentration of inpatient urological services at Craigavon Area Hospital. However, the Trust is wholly committed to extending and expanding the outreach facilities provided from Craigavon

Area Hospital. With the appointment of 4 Consultant Urologists, it is intended that outreach, outpatient clinics will be conducted at Daisy Hill, Banbridge, Armagh Community and South Tyrone Hospitals. In addition, the Department of Urology will be particularly flexible in examining ways of providing daycase urological surgical facilities at both Daisy Hill and South Tyrone Hospitals in the future. As these developments do take place, the traditional provision of adult and paediatric urological services by General Surgeons will be progressively eliminated.

Lastly the Trust and its Department of Urology will critically and positively examine methods of increasing the sharing of urological care with community based, primary health care providers. Such developments should include established protocols for urological assessment and for urological follow up.



MARCH 1997

Executive Summary

In April 2004 the Chief Executive of Craigavon Area Hospital (CAH) asked the Medical Director to carry out a review of the Urology service at 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 Southern Services Board (SHSSB). 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 SHSSB were seen as:

- Insufficient manpower or capacity to deliver a full Urological service.
- Increasing waiting times for outpatient, inpatient and day cases.
- Increasing emergency workload.

A decision was taken to engage an independent external advisor to carry out an impartial analysis of the Urology service and against the current backdrop, to make recommendations for a sustainable way forward. 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 2004)
- visits to all sites within SHSSB where Urology services are delivered
- three meetings of 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 British Association of Urological Surgeons (BAUS) guidance and NHS norms, one should expect in terms of service delivery given the available resources and infrastructure. The external advisor has also looked in detail at Scotland and the Grampian region to establish expected capacity and demand figures for the SHSSB area and what best practices might be viable options for replication in the SHSSB area.

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

chose not to amend his behaviour."

15782, thank you. There it is at paragraph 1.12. I don't know whether you want to read that again, or having read it out to you -- 11:02

A. That's fine.

80 Q. Was that something that persisted during your period in post, a resistance to change or, as you say, perhaps an inability to change?

A. Resistance or inability. Certainly that was a theme throughout, and particularly in the Monday evening meetings, that an issue for change might be agreed and perhaps that was then retrenched or rescinded the following meeting. In terms of making changes in clinical behaviour, whilst help was offered, there was a resistance to making that change. I think the only thing that was requested was additional secretarial time. There was no other help sought in thinking about how he could change his administrative processes to free up time for clinical work, which is primarily what his job was around, the relevant administrative processes to undertake the clinical requirements of the job. 11:02 11:02 11:03

81 Q. Both you and Mr. Mackle met with Mr. O'Brien on occasion to discuss issues. You have detailed one of those at WIT-15827, at 30.2A. If we look at the paragraph just preceding that, you can see that. You will see the question there about informal meetings within Urology. You say: 11:03

1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

Regional Review of Urology Services

Team South Implementation Plan

Document History	
Document Name:	Team South Implementation Plan
Status:	Draft v0.1
Version and Date:	V0.1 14 Jun 10
Origin:	Acute Planning SHSCT

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

RED FLAGS waiting with no dates:

Referral	No waiting	Time Waiting
Urology (Prostate)	**44 patients**	**67 days**
Urology (Haematuria)	**57 patients**	**61 days**
Urology (Other)	**14 patients**	**26 days**

Dr Paul Hughes clinic in DHH has been cancelled for the first 2 weeks of March currently have 11 patients to be booked.

Review outpatient backlog (taken from Business objects) – should have been seen by 31 March 2019

Consultant		
	total	**Longest date**
Mr Young (general)	284	July 2015
Mr Young (stones)	618	March 2015
Mr O'Brien	675	March 2015
Mr Glackin	80	February 2017
Mr Haynes	59	October 2018
Mr O'Donoghue	549	September 2015
Mr Jacob	634	February 2017
Enniskillen	157	March 2016
Total	**3056**	

Total per year

2015	**77**
2016	**198**
2017	**661**
2018	**1485**
2019	**635**

Inpatient and Daycase waiting lists

Total = 924 on waiting list = 172 with dates

249 urgent inpatients without a date longest = 91 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	56 patients	Longest = 84 weeks 38 between 14-84 weeks 19 between 0-13 weeks
Mr O'Brien	112 patients	Longest = 81 weeks 26 > 51 weeks 60 between 14-50 weeks 26 between 0-13 weeks
Mr Glackin	13 patients	Longest = 33 weeks 1 x 33 weeks 12 between 0-13 weeks
Mr Haynes	18 patients	Longest = 52 weeks 6 between 14-52 weeks 12 between 0-13 weeks
Mr Suresh	20 patients	Longest = 25 weeks 7 between 14-25 weeks 13 between 0-13 weeks
Mr O'Donoghue	30 patients	Longest 91 weeks 11 between 14-91 weeks 19 between 0-13 weeks

116 urgent daycases without a date longest = 69 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	48 patients	Longest = 69 weeks 17 between 14-69 weeks 31 between 0-13 weeks
Mr O'Brien	14 patients	Longest = 54 weeks 4 between 14-54 weeks 10 between 0-13 weeks
Mr Glackin	11 patients	Longest = 13 weeks 11 between 0-13 weeks
Mr Haynes	3 patients	Longest = 17 weeks 1 at 8 weeks 1 at 3 weeks
Mr Suresh	23 patients	Longest = 27 weeks 8 between 14-27 weeks 15 between 0-13 weeks
Mr O'Donoghue	17 patients	Longest 35 weeks 4 between 14-35 weeks 13 between 0-13 weeks

Adult Inpatient and Daycase waiting lists – position 19 February 2019 (1805 patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	161	231	66	264	114	208	208	251
Mr O'Brien	216	237	57	237	36	212	23	235
Mr Glackin	53	110	34	119	48	56	38	51
Mr Haynes	91	178	47	225	22	94	50	216
Mr O'Donoghue	119	156	34	195	88	102	26	203
Mr Jacob	37	150	18	161	102	130	117	167
Total	**677**		**256**		**410**		**462**	

Paediatrics Inpatient and Daycase waiting lists – position 19 February 2019 (27 patients)

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Mr Young	0	0	0	0	2	4	1	81
Mr O'Brien	7	55	4	182	1	35	2	134
Mr Glackin	0	0	0	0	0	0	1	11
Mr Haynes	0	0	0	0	1	61	0	0
Mr O'Donoghue	1	9	1	128	0	0	2	105
Mr Jacob	2	70	0	0	2	115	0	0
Total	**10**		**5**		**6**		**6**	

Planned patients that should have been seen

Consultant	
Mr Young	57
Mr O'Brien	42
Mr Glackin	20
Mr Haynes	40
Mr O'Donoghue	41
Mr Jacob	23
Total	**223**

Angela Kerr

From: O'Brien, Aidan <Personal Information redacted by the USI>
Sent: 28 June 2016 01:39
To: Corrigan, Martina
Cc: Elliott, Noleen
Subject: RE: ** Urgent ** CAH Main Theatre Lists Tuesday 28th June until Friday 1 July 2016

Martina,

I find this situation to be quite unacceptable.
I spent almost all of last Thursday rigorously reviewing all 275 patients on my inpatient waiting list, as of 28 April 2016, allocating categories of five categories of urgency to them, as opposed to the inadequate two categories formally allocated.
In doing so, I equated Red Flags patients, those cancer patients who have no Red Flag status, those with indwelling stents for up to two years, those with indwelling catheters for over two years whilst trying to accommodate in some equitable fashion those who have been pleading through various channels, including your own, to have their admissions expedited.

In doing so, I accommodated Patient 130 Patient 130 has had a stent in her right ureter awaiting replacement since 20 July 2014.
She is a brittle diabetes, is on haemodialysis four times weekly in Tyrone County Hospital which has been requesting for months that it be replaced due to recurring infections.
I contacted the staff of the Renal Unit at Tyrone County Hospital to request that they reschedule her haemodialysis from Wednesday morning to this morning which they have accommodated.
They have arranged at my request to do up to date blood tests before this morning's haemodialysis, and after, so we will not have to repeat them as her peripheral access is poor.
They have arranged transport for her, at my request, to ensure that she is back home by 1 pm today.
On Friday last, I contacted the GP Practice manager who has arranged for her to be picked up by ambulance at 2 pm to bring her to Ward 3 South this afternoon.
On the assumption that she will be able to go home on Thursday, The Renal Unit have arranged to reschedule her haemodialysis to Friday and Saturday morning.
Yet Patient 130 is not a Red Flag patient!

Patient 16 has had a stent in his left ureter for relief of left ureteric obstruction due to metastatic bowel carcinoma since 02 April 2015.
He has been awaiting its removal, reassessment of his left upper tract and possible replacement since then.
His oncologist, Dr. Harte, has requested that his admission be expedited due to increasing back pain attributed to it.
But Patient 16 is not a Red Flag patient either!

I could go on but I do not have the time to do so in the early hours of the morning.
I have already invested many hours in selecting and arranging in detail the admissions for surgery on Wednesday.
At this point in time, I do not have the stomach to contact people tomorrow to renege upon the commitments I have entered into with them.
And I do not wish to have anyone do so on my behalf.

The last patient on my list, Personal Information redacted by the USI fell 12 feet from a ladder one month ago, severing his urethra, which I realigned, since when he has both suprapubic and urethral catheters in situ.
He will be attending his daughter's graduation tomorrow at 11 am.
He agreed to forego the graduation lunch to be admitted in the hope of being able to have catheters removed.
But he does not have any flag at all!

As I have said before, we cannot continue like this.
From now on, I will not,

From: Corrigan, Martina
Sent: 23 September 2019 06:40
To: Haynes, Mark; O'Brien, Aidan; Clayton, Wendy
Cc: Carroll, Ronan
Subject: RE: Personal Information redacted by the USI

Good morning Aidan and Mark

I have copied Wendy into this email as she will be able to advise on your patients that were contacted and will also be able to assure that for Urology validation that this has ceased.

Wendy can you please assist?

Regards

Martina

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

Telephone:
EXT Personal Information (Internal)
Personal Information redacted by the USI (External)
(Mobile)

From: Haynes, Mark
Sent: 22 September 2019 21:05
To: O'Brien, Aidan; Corrigan, Martina
Subject: RE: Personal Information redacted by the USI

Thanks Aidan

As I have stated before I was not aware of the process until it had started and when I became aware had requested it cease.

Where the process is administrative only (ie checking patient not deceased, and checking they haven't had it done elsewhere), then it is fine. This process went beyond that and asked if patients wanted the operation (no-one wants an operation), and then I believe offered them an opportunity of an OP review to discuss. Not only does this mean informed decisions are not possible by the patient (as no one is re-discussing the pros and cons of surgery) but is also offering something that we cannot deliver ie a timely review appointment. I believe the process also raises false hope in patients that they may get a date for their surgery in the near future.

Martina – do you know who led this work and are they able to provide the urologists with the details of all the patients who have either asked to be removed from the WL, or requested a review OPA?

Mark

From: O'Brien, Aidan
Sent: 22 September 2019 17:11
To: Corrigan, Martina
Cc: Haynes, Mark
Subject: Personal Information redacted by the USI

Martina,

I write to you regarding this Personal Information redacted by the HSE old, Personal Information redacted by the HSE man who had a stone obstructing his upper right ureter in 2015.
He was managed by ureteroscopic laser lithotripsy.
He was noted to have a grossly enlarged prostate gland on endoscopic assessment.
I advised him that he would be better served by having his prostate resected.
He was placed on the waiting list on 08 October 2015.

On reviewing my waiting list during August, I noted that he had been removed from the waiting list in July 2019.
When I contacted him by telephone, he advised that he had received a letter enquiring whether he wished to remain on the waiting list, or words to that effect.
As his only symptoms was that of nocturia, he replied that he did not wish to proceed with surgery.

I requested an ultrasound scan which has since indicated that he may have recurrence of stone in his right kidney, that he has inadequate bladder voiding with a residual volume of 190 mls, and would appear to have formed a stone in his bladder.
I have again spoken to the patient by telephone, advising him of the above findings.
I have requested a CT Urinary Tract to more clarify his stone status.
He has agreed to being returned to the waiting list for admission for TURP.
I have dictated a letter to the GP requesting that he be prescribed Tamsulosin until admission for TURP, in addition to requesting optimisation of diabetic control prior to admission.

I hope that you will agree that it is appropriate that I bring such a case to your attention.
I believe that it is entirely inappropriate that non-clinical staff should correspond with patient to enquire whether they wish to remain on a waiting list, and entirely for the purpose of reducing the numbers of patients on waiting lists.
Patients have the right to decline proposed management, but should be empowered to make decisions informed by clinical advice.

I would be very reassured if this practice has been discontinued, as you had recently indicated.
I would also be grateful if I could be furnished with a list of those patients of mine who have been so communicated with.

Thank you,

Aidan.

Aimee Crilly

From: Corrigan, Martina <[redacted]>
Sent: 25 September 2019 07:41
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: Validation exercise
Attachments: RE: [redacted] (1.88 MB); RE: [redacted] (86.8 KB)

Good morning

Please see email trail below and attached emails.

Aidan had raised the issue of a patient of his who he had noticed he had been removed from the waiting list, on contacting the patient he was advised that he had received a letter asking him if he still wanted his surgery and he had said no.....

As a result of this Aidan had emailed me and Mark and you will see the email conversations below between Aidan, Mark and Wendy who had been instructed by HSCB to do this exercise.

This had been discussed originally with me as being an admin validation (i.e. determine if they are not deceased, living at the same address, check that they have not had their procedure done elsewhere etc..) however on discovering (through increased MLA and patient enquiries) that this was a letter being sent to patients to ask if they still wanted their surgery I immediately put a stop to Urology and ENT (I believe other specialties are continuing).

However as you will see from Mark and Aidan's emails there has already been fall out from this.

I have attached Wendy's email detailing the information of patients that received the letters and we have agreed that these patients would be reinstated onto the waiting lists and Mark has asked that his patients are seen at clinic as well, I will be guided by what the rest of you want to do (i.e. happier to be reinstated and contacted and/or seen again at clinic?)

Regards

Martina

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

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

From: Haynes, Mark
Sent: 24 September 2019 21:35
To: O'Brien, Aidan; Clayton, Wendy
Cc: Corrigan, Martina
Subject: RE: [redacted]

results set up draws results under the names of 3 locum consultants, Mr O'Brien and myself). However, this is not without challenge. This workload is all the patient-related administrative workload of a colleague, the service is already unable to meet demand and so, to free a clinician from clinical duties to conduct this workload, would result in a widening of the gap between capacity and demand. Additional activity (as Waiting List Initiative / WLI) is offered to the team for this activity but, due to a variety of factors, this offer is often not taken up and the activity often conducted during individuals' own time. When vacancies become longer term, and are associated with outpatient and inpatient waiting lists, they create additional challenge as the remaining clinicians cannot absorb the operative and outpatient workload without negative impact on the patients already under their care.

19. **In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?**

19.1 This matter has already been covered, in part, across questions 16, 17 and 18.

19.2 From a personal perspective, it has had a direct impact on the time committed to my role as AMD. Until November 2021, I did not include the full 3 PA requirement in my job plan as I endeavoured to deliver clinical care and this meant that I was not able to deliver fully my role / responsibilities as AMD. Additionally, at various points during my tenure as CD / AMD, all of the clinical management posts (CD / AMD) have been unfilled adding to the workload of the medical managers in post and, upon commencement and due to the events which led to the departure of the previous AMD (Dr McAllister), I did not receive a handover or induction into this role. I also regularly conduct core aspects of my clinical activity (patient related admin) in my own time (typically from approx. 5:15am in the mornings, both weekdays and weekends). I regularly continue to address patient related admin and results throughout periods of annual leave.

19.3 The mismatch between demand and capacity, and the strains of delivering care within current capacity (with consequent bed pressures, increasing

numbers of complaints, and elected representative enquires regarding waiting times etc.), also means the directorate management team (operational managers / Assistant Directors) spend a large proportion of time managing day-to-day pressures and responding to complaints, with consequent negative impact on their ability to function in a strategic / service planning and development role.

19.4 Vacancies within the urology consultant / clinical team also mean that, while all the individuals make every effort to attend patient safety meetings, acute admissions / annual leave / other activities can result in a reduced team attendance on occasion. In particular, personally my Belfast Trust activity (theatre) often continues during patient safety session half days, reducing my ability to attend.

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

20.1 Medical staffing within the unit continually changes with rotation of training grade doctors, sickness / maternity / retirements and career moves. Trust HR would be able to provide detail of personnel and dates etc.

20.2 Responsibilities also inevitably change during the course of medical careers. Again, details of formal roles (e.g., Clinical Directors / Associate Medical Directors) I would expect to be available from the trust HR team.

20.3 With regards to specific additional roles since my appointment in May 2014, Mr Glackin (and now Mr O'Donoghue) have held the 'Patient Safety Lead' role. I do not have the precise date that Mr Glackin ceased to fulfil this role and Mr O'Donoghue took the role on.

20.4 With regards to Urology Cancer MDM lead, Mr Glackin currently fills this role, having taken it on from Mr O'Brien; again, I do not know the exact date this occurred.

arose in relation to the various concerns that were raised within the context of the formal investigation.

(Q 72)

584. Issues which arose in relation to my practice were inextricably linked to the inadequate system I was working within. That led to recurring issues, for example, in relation to triage as detailed above in my response to Questions 66-67. These issues could have been prevented had the Trust ensured that the Urology Service had adequate staffing and capacity so that a practicable system could have been put in place to deal appropriately with triage.

585. During my tenure, there was a recurring issue with records being kept at my home and office as well as non-dictation of clinics. Again, that could have been prevented had the system within which I was working been adequately staffed and properly run by the Trust.

586. If there was any recurrence in the failure to ensure oncology patients had access to a Clinical Nurse Specialist (CNS), that could have been prevented by those responsible, namely the MDT Lead Clinician and the MDT Core Nurse Member, complying with their responsibilities as stated in the MDT Operational Policy to ensure that such patients had access to a CNS.

587. It could not be said that any issue in respect of my prescribing Bicalutamide recurred during my tenure, as no issue was ever raised with me in respect of my prescribing that medication during my tenure as a consultant urologist with the Trust. As stated elsewhere in this statement, the use of Bicalutamide was known to both the Urology and Oncology Service and no issue was ever raised in respect of Bicalutamide until after the termination of my contract with the Trust.

the ground for patients, meaning one less consultant to tackle the long, unsatisfactory, waiting lists.

592. Below I will refer to a number of examples of failure to provide support to both colleagues and me. The examples relate to the following broad areas:

(1) Overwork of consultants, including me. This has already been dealt with in my comments above under "Staffing". It was, however, the single most concerning lack of support throughout my time at the Trust.

(2) The Trust's knowledge that I was grossly overworked on a chronic basis and its failure to provide realistic job plans and/or support so that I only worked in accordance with those plans. Had I only worked in accordance with the time allowed in my job plan, more and more patients would be waiting longer and longer to see a consultant and/or have treatment. That placed me in an invidious position meaning that I tended to sacrifice my own time to try to address the issue.

(3) Failure to have adequate regard to the views of the team in relation to service delivery.

(4) When it was apparent that I was struggling, in particular with my administrative load, failure to implement systems which would assist me in dealing with that aspect of my practice.

593. In or around 2008/2009 the wards were reconfigured. I have referred to this in the general narrative in my response to Questions 1 and 2 of the Notice. However, I also consider this is relevant here. Previously there was a dedicated urology ward. Having a dedicated inpatient ward for urology patients was important and something that, as a department, we really valued and had been keen to develop. There were obvious benefits to urological patients being in one area. Apart from anything else, that made it logistically easier to see and

things: either it hadn't been dictated or it hadn't been typed. So you could at that time, in the early 2010s, you could check on our system called Patient Centre, because that's where the letters would have went to. So you would open Patient Centre and you would check was there was any correspondence. And if there wasn't any correspondence on Patient Centre, then it was quite clear that it hadn't been dictated or typed, one of those two things. 12:39

152 Q. And is that something you ever spoke to him about? 12:40

A. So, first of all myself, Mr. Haynes and Mr. O'Donoghue would have partaken in that activity, and we all recognised that that was a problem and we raised that with Martina Corrigan, because it meant that when you saw these patients that you were essentially starting from scratch. So that meant that the time that you required in clinic to see that patient was greater than perhaps a straightforward review. So that was raised with Martina. 12:40

12:40

It was also raised with Mr. O'Brien in the departmental meetings, and when, I think was Mr. Haynes raised the particular issue on the particular day, the necessity to have a clinic letter dictated and available in the chart for every patient, and Mr. O'Brien perversely expressed the view, perversely from my perspective, the view that it wasn't necessary to dictate on every patient, that he knew what was going on and he didn't have to write to the GP. I just couldn't get my head 12:40

around that.

153 Q. But that was, from his perspective a full stop, end of conversation, he wasn't changing his practice. Is that your understanding of his stance?

A. Yeah. Yeah, I think he would be digging his heels in. 12:41

154 Q. And was the problem, at least in terms of your experience, more than just a communication issue, a record of what has been done, was it more than that? Was it also a failure to action by a dictation a next step on occasions, a next clinical step? 12:42

A. So I don't know that for sure. But if you're leaving it weeks to months after you've seen somebody - first of all I don't have perfect recall, so I would wonder how anybody else would have perfect recall. So that would leave - if it was me, it would leave me open to 12:42 forgetting to do things. So I just didn't understand the rationale of what he was describing.

155 Q. Did you view it, or did your colleagues view it as potentially a patient safety issue?

A. Well, Mark raised it because he was concerned. Yeah, 12:42 it was an issue.

156 Q. Plainly you didn't have line management responsibility for him. You drew it to the attention of Mrs. Corrigan you've said, so that the system was well aware of it.

A. Yeah. So Mrs. Corrigan knew that we had concerns that 12:43 there weren't letters in the charts relating to Mr. O'Brien's patients. Whether she was there on the day that Mr. Haynes raised that specific issue, I can't recall.

A. Yes, and I've said so in my statement. I think it would have been much better if those issues, and I realise there are sensitivities around some of them, but certainly I think if the medical managers had of discussed with us as a team of consultants the particular issues, and allowed us to understand the breadth of issues, but then also to formulate a support plan, a network, if you like, as to how Mr. O'Brien could return to the team and practice safely. It would also have given us greater oversight going forward as to when, if there were any dips in performance, or non-adherence to agreed behaviours, then we would have been able to identify that at an earlier stage. 12:28 12:28

132 Q. We'll maybe unpack some of that as we go along. What do you identify as being the, if you like, the block or the obstacle that was in place that prevented the development of that kind of approach? 12:29

A. So, I had no knowledge or part to play in the return to work plan. That was developed without input from the whole team. It was developed, as far as I understand, from the medical management side and with some input from the Head of Service, from what I've read subsequently. So those people held that information. It wasn't shared with us. I think if we had of been aware of what they were monitoring and how they were addressing any shortcomings, then we would have been in a position to assist. 12:29 12:30

133 Q. I'm now going to work through what had been described as those shortcomings, and take your view on when you

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

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job title	Originated from
Trouton, Heather	Personal Information redacted by the USI	30/03/2015 17:18:15	Personal Information redacted by the USI		Assistant Director of Acute Services	Level 1 Form
Connolly, Connie	Personal Information redacted by the USI	30/03/2015 17:18:15			Acting Acute Governance Co-Ordinator	Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	Eamon.Mackle Personal Information redacted by the USI	30/03/2015 17:18:15				Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	caroline.moorcroft Personal Information redacted by the USI	30/03/2015 17:18:14				Level 1 Form
Smyth, Paul	Personal Information redacted by the USI	30/03/2015 17:18:14			Head of Unscheduled Care	Level 1 Form
Corrigan, Martina	Personal Information redacted by the USI	30/03/2015 17:18:13			Head of ENT and Urology	Level 1 Form
Glenny, Sharon	Personal Information redacted by the USI	30/03/2015 17:18:13			Operational Support Lead	Level 1 Form
No details found for the contact with ID Personal Information redacted by the USI	cathy.rocks Personal Information redacted by the USI	30/03/2015 17:18:13				Level 1 Form
Newell, DeniseE	Personal Information redacted by the USI	30/03/2015 17:18:12			Head of Diagnostic Services	Level 1 Form
Graham, Andrene	Personal Information redacted by the USI	30/03/2015 17:18:12			Modality Lead	Level 1 Form

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	

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

Southern Health and Social Care Trust

9.0 RECOMMENDATIONS AND ACTION PLANNING

correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner.

An escalation process must be developed within this guidance.

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.

Recommendation 4
The Trust will develop written policy/guidance for the tracking of clinical correspondence, to include relevant email correspondence.

TRUST and HSCB
Recommendation 5
In the same way that the Belfast Trust Cancer service now have their Oncology letters on the NIECR, all other services, including those from other Trusts, should do the same.

Recommendation 6
The Trust, with the HSCB, must implement a waiting list management plan to reduce Urology waiting times.

This will be monitored monthly.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Melanie McClements, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

Patient 16 ” family

Patient 16

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.

Urology Department Patient Safety Meeting 19 July 2019 Minutes

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

Apologies
Nil

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

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

    b. Mortality cases discussed

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

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

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

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

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

7. Next meeting Tuesday 17 September 2019 PM

Subject: FW: ** Urgent ** CAH Main Theatre Lists Thurs 23rd to Mon 27th June
Importance: High

Dear All,

As you will be aware we are experiencing significant bed pressures which are impacting on the running our elective lists. I've already been in touch with those of you operating tomorrow, however a decision has also been taken for lists planned to take place in CAH Main Theatres on Thursday, Friday and Monday – **only red-flag patients are to be operated on.** I would be grateful if you could review your lists and cancel anyone who is not a red-flag.

For lists scheduled for Tuesday 28th June onwards a decision will be taken and communicated later this week.

Any issues please let me know.

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Aidan.

From: Corrigan, Martina
Sent: 27 June 2016 14:36
To: (mariankorda[redacted]); (p.leyder[redacted]); McCaul, David; David McCaul ([redacted]); Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; Mr Reddy; Reddy, Ekambar; Ted McNaboe ([redacted]); Turlough Farnan ([redacted]); (Aidanpobrien[redacted]); ([redacted]); Glackin, Anthony; Haynes, Mark; Mark ([redacted]); Young, Michael; O'Brien, Aidan; ODonoghue, JohnP; [redacted]; Ram Suresh ([redacted]); Suresh, Ram; Tony Glackin ([redacted]); Tyson, Matthew; Matthew Tyson ([redacted])
Cc: McClenaghan, Nichola; McGeough, Mary; Clayton, Wendy; Scott, Jane M; Cunningham, Andrea; Sharpe, Dorothy; Henry, Gillian; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth; Burke, Catherine; Cooke, Elaine; Cowan, Anne; Hall, Pamela; Mulholland, Angela; Wortley, Heather; Sheridan, Patrick; Carroll, Ronan
Subject: RE: ** Urgent ** CAH Main Theatre Lists Tuesday 28th June until Friday 1 July 2016
Importance: High

Dear all

As per my email last week, we have discussed the rest of this week's theatre lists at the bed meeting this afternoon and because the bed pressures have not eased the decision is for the lists that are planned for CAH Main Theatres for the rest of this week, that is, Tuesday 28th, Wednesday 29th, Thursday 30th June and Friday 1 July **are to be red-flag patients only**. I would be grateful if you could review your lists and cancel anyone who is not a red-flag this will unfortunately include any non-red flag patients that had been cancelled previously.

Paediatrics can go ahead but please co-ordinate how many are on each list.

Any issues please advise.

Regards

Martina

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

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

From: Corrigan, Martina
Sent: 21 June 2016 15:53
To: (mariankorda[redacted]); (p.leyden[redacted]); David McCaul ([redacted]); David McCaul ([redacted]); Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; 'Mr Reddy'; Reddy, Ekambar; Ted McNaboe ([redacted]); Turlough Farnan ([redacted]); (Aidanpobrien[redacted]); (my[redacted]); Glackin, Anthony ([redacted]); Haynes, Mark; Mark ([redacted]); michael.young[redacted]; O'Brien, Aidan; ODonoghue, JohnP; [redacted]; Ram Suresh ([redacted]); Suresh, Ram; Tony Glackin ([redacted])
Cc: McClenaghan, Nichola; McGeough, Mary; Clayton, Wendy; Scott, Jane M; Cunningham, Andrea; Sharpe, Dorothy; Henry, Gillian; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth; Burke, Catherine; Cooke, Elaine; Cowan, Anne; Hall, Pamela; Mulholland, Angela; Wortley, Heather

Secretary: Elizabeth Troughton [redacted]

From: Corrigan, Martina
Sent: 01 September 2019 15:15
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: UROLOGY TRAIGE

Good afternoon

Thoughts ??

Regards

Martina

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

Telephone:
EXT [redacted] (Internal)
[redacted] (External)
[redacted] (Mobile)

From: Robinson, Katherine
Sent: 28 August 2019 13:22
To: Corrigan, Martina
Subject: FW: UROLOGY TRAIGE

Will you let us know?

From: Coleman, Alana
Sent: 28 August 2019 12:39
To: Robinson, Katherine; Rankin, Christine
Subject: UROLOGY TRAIGE

Hi Katherine,

We have been receiving a few referrals back from grading recently where the consultants have triaged patients to be booked within 2-4 weeks etc. Example attached.

RF are booking no less than 6weeks at present.

Should these patients not wait longer than RF patients, or at least wait the same length of time?
Or should we just ask the consultants if they are willing for their clinics to be over booked to accommodate?

Thanks
Alana

Alana Coleman

Stinson, Emma M

From: Young, Michael
Sent: 16 December 2021 16:59
To: Stinson, Emma M
Subject: FW: UROLOGY TRAIGE

more

From: O'Brien, Aidan [Personal Information redacted by the USI]
Sent: 02 September 2019 14:01
To: Corrigan, Martina
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP
Subject: FW: UROLOGY TRAIGE

Martina,

I agree entirely with Tony's sentiments.

Even though one would think that I should be inured after 27 years, I find it still remarkable that administrative staff could even consider that one can add another patient or two to a clinic, without any negative consequences for those added or those already appointed, never mind the additional time required by the clinician to administer the additional attendances in their own time.
Moreover, it still remains disconcerting to gain the impression that there is a belief that only cancer, or the risk of it, poses a threat to life or its quality.

It is now exactly one year since we decided as a department to take the exceptional measure of cancelling one whole day's clinical activity to meet with senior management to discuss and address such concerns.
When that day in October 2018 was cancelled, another similar day was scheduled in December 2018.
That too was cancelled!

And one year later, we are left once again a proposal that additional work be dumped upon clinicians by overbooking clinics.

Aidan.

From: Glackin, Anthony
Sent: 02 September 2019 09:37
To: Corrigan, Martina; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: RE: UROLOGY TRAIGE

As I stated in my reply to Alana there are times when non cancer cases are clinically urgent and should be seen within the stated time frame. Based on the information provided in the referral I think I am making a reasonable clinical decision If the trust cannot deliver this then there is an issue of demand outstripping supply. Simply relying on me or any other clinician to overbook a clinic will not solve this supply issue and I am not willing to do this work unpaid or to the detriment of my existing workload.

Regards

Tony

Anthony J Glackin MD FRCSI(Urol)
Consultant Urologist
SHSCT

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
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 the USI 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.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4

additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required.

Yours Sincerely

Mark Haynes

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

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

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

WAITING TIMES FOR ELECTIVE INPATIENT SURGERY

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, Personal Information redacted by the USI old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on 17 October for TURP, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Aimee Crilly

From:
Sent:
To: **Subject:**

-----Original Message-----
From: Corrigan, Martina [redacted]
To: (Aidanpobrien [redacted]) <Aidanpobrien [redacted]>; (my [redacted]) <my [redacted]>; Glackin, Anthony [redacted] Haynes, Mark [redacted] Mark (mark.d.haynes [redacted]) <mark.d.haynes [redacted]>; Young, Michael [redacted] O'Brien, Aidan [redacted] ODonoghue, John [redacted]; [redacted] Tony Glackin [redacted]
Sent: Fri, 30 Nov 2018 14:49
Subject: Monday 3 December

Dear all,

Apologies as I had meant to send this email earlier.

It has been agreed that the away day on Monday is cancelled but that the consultants and I would get together at 10am for a couple of hours to discuss some of the issues that had been raised on 24th September.

I have reinstated the PM activity.

Regards

Martina

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

INTERNAL: [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

45.1 The systems described in my answer to Q44 are passive and in my opinion do not offer any reassurance that corrective action will be implemented. I do not believe that the data collection systems have changed during my tenure.

46. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any performance objectives relevant to Urology during your time (and identify the origin of those objectives), providing documentation (where it has not been provided already) or sign-posting the Inquiry to any relevant documentation.

46.1 Performance objectives are not utilised for Consultant Medical staff. A consultant job plan sets out sessions of direct clinical care and supporting professional activity. It records the frequency of clinics, theatre lists, on call activity etc.. In my case it also captures the time allocated to my roles as an educational supervisor, Training Programme Director, Chair of the Urology Cancer MDT and preparation time for MDT. My job plan does not specify how many patients I am expected to see per clinic or theatre list. It does specify how many clinic and theatre/procedural sessions I am expected to deliver over the course of a year.

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

47.1 My job plan is supposed to be reviewed annually. On the whole, with the exception of the COVID period, this happened by way of an email conversation with the CD or AMD. Job planning happens in isolation from the whole team. There is no discussion with the team about the overarching view of the needs of the service. I am not aware of any standard setting for productivity across the team.