Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice ...5... of 2023

Date of Notice: 17 April 2023

Witness Statement of: Professor Joe O'Sullivan

I, ...Prof Joseph O'Sullivan.....will say as follows:-

1. You were interviewed by Dr Dermot Hughes on 4 January 2021 in relation to the investigation of a number of SAIs concerning former patients of Mr Aidan O'Brien. The record of that interview states as follows: 'JOS advised that when he came into post initially about 17 years ago, he had concerns in relation to the use of bicalutamide and that they had frequently challenged him about the treatment. He made recommendations in clinic letters questioning the use of bicalutamide 50mgs instead of the standard 150mgs or LHRH agonist therapy. In the cases he had seen, the dose of bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore wasn't escalated further. JOS said he was aware that his colleague DM (as MDT Chair) had raised our concerns about AOB's bicalutamide prescribing with the then CD foroncology SMcA, probably in 2011.' [TRU-162262]

(i) Confirm whether the above is an accurate record of the discussion during interview. To the extent that it is not, please identify any alleged inaccuracies and offer clarification of same.

The above statement is accurate except:

a. I don't recall saying 'frequently challenged'. My intended phrase was 'challenged on a number of occasions'.
b. I was incorrect about the date Dr. Mitchell discussed with Dr. McAleer – it was 2019 and not 2011. The discussion was about a proposed regional protocol concerning the use of hormone therapy in prostate cancer, rather than specifically about Mr. O'Brien's prescribing. I did have a discussion with Dr. Mitchell in 2014 regarding my recollection of a few cases (involving prescription of bicalutamide 50mg daily as monotherapy in prostate cancer) that I had encountered early in my consultant career.

(ii) Please identify 'SMcA'.

Dr. Seamus McAleer, Clinical Director of Oncology, Belfast Trust at the time.

practice but did not escalate the issue to the SHSCT – this is something both individuals regretted and reflected upon.'

(i) To the best of your recollection, please provide details of every occasion on which you wrote directly to Mr O'Brien about his practice and, where possible, provide copies of this correspondence together with any response received.

As per answer 1(vi) above, I replied to referral letters outlining the need to change from the 50mg monotherapy dose to the standard dose. I did not write to Mr. O' Brien separately about the issue. I do not have recall of the patients involved.

(ii) Please explain why the issue was never escalated to SHSCT, providing details of any real or perceived obstacles to such escalation.

I did not escalate the issue as I didn't feel it was serious enough.

(iii) Please provide any further comments/ reflections you may have on the failure to escalate, setting out what might perhaps have been done differently.

On reflection, I should have challenged Mr. O'Brien more directly about his prescribing of bicalutamide 50mg monotherapy. There were no particular obstacles to escalating concerns apart from the fact that I was a relatively junior consultant at the time and likely felt reluctant to challenge an established senior colleague.

5. Please indicate whether, at any stage, you had concerns about or knowledge of issues around the use of Clinical Nurse Specialists. To the extent that your answer is affirmative, please provide further details.

I have no concern or knowledge of issues regarding the use of clinical nurse specialists.

6. Please provide any further details which you consider may be relevant to the Inquiry Terms of Reference.

I have nothing further to add.

Statement of Truth

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

Signed: _____

Date: 17th May 2023

SAI Urology Review

Meeting with Dr Joe O'Sullivan
Monday 4 January 2021 via zoom at 11:15

Attendees
Dr Dermot Hughes and Mrs Patricia Kingsnorth

Dermot Hughes (DH)
Dr Joe O'Sullivan (JOS)

DH thanks JOS for meeting with him and explained the process to date regarding the SAI review involving 9 patients (one with penile cancer, 1 testicular cancer, 5 prostate cancers and 2 renal cancers).

He asked if JOS was aware of any issues regarding the practice of Mr AOB?
JOS advised that when he came into post initially about 17 years ago, he had concerns in relation to the use of bicalutamide and that they had frequently challenged him about the treatment. He made recommendations in clinic letters questioning the use of bicalutamide 50mgs instead of the standard 150mgs or LHRH agonist therapy. In the cases he had seen, the dose of bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore wasn't escalated further. JOS said he was aware that his colleague D M (as MDT Chair) had raised our concerns about AOB's bicalutamide prescribing with the then CD for Oncology, SMcA, probably in 2011.

JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago.

DH advised that there were a number of delays of people being referred for oncology/ palliative care.

DH said that there were issues regarding lack of oncologist attending MDM as it was on the same time as lung MDM and that there was inadequate cover for CAH MDM.

JOS agreed he did want it recognised that there was a lot of good work from urologist in CAH and good involvement in MDT in particular he named two consultants Mr MH and Mr AG.

DH wanted to assure JOS that the SAI review will also recognise the good work the MDT are doing and recognised that the concerns relate to one person's practice. It would seem he worked in isolation despite being involved in a multi-disciplinary team. JOS said that was his impression of Mr AOB

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He asked if JOS was aware of any issues regarding the practice of Mr AOB?
JOS advised that when he came into post initially about 17 years ago, he had concerns in relation to the use of bicalutamide and that they had frequently challenged him about the treatment. He advised that he had raised concerns to Mr AOB in writing but Mr AOB produced evidence to support his practice. JOS advised that as the drug did not apparently cause harm they didn't escalate further.

JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago. AOB was seen as an outlier.

JOS said that Mr AOB was an objector to recommendations and did not engage with or respect the MDM process.

DH advised that there were a number of delays of people being referred for oncology/ palliative care.

DH said that there were issues regarding lack of oncologist attending MDM as it was on the same time as lung MDM and that there was inadequate cover for CAH MDM.

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Comment [JO1]: I would have made recommendations in clinic letters questioning the use of bicalutamide 50mg OD (instead of standard 150mg OD dose, or LHRH agonist therapy). I didn't write any formal letter of concern. In the cases I had seen, the dose of bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore wasn't escalated further.

Comment [JO2]: I'm sure exactly when Mark and Tony started there.

Comment [JO3]: This was just my view, I can't speak for other's views.

Comment [JO4]: I didn't say that exactly- please remove

(1)

11.15 4.1.2021.

Phone call Joe O'Sullivan.

- major issue - didn't prescribe LHRHa.
- bicalutamide
frequently wrote back to him - Aidan provided
- evidence base for SOMQS - use -
- not life threatening - appeared to get better.
- Darren Mitchell - raised to MDT Chair -
outside standard practice -

DH
- late referral oncology - out of window.

3 - of 5 - potential curative.
- thought - was resolved - with newer urologist.
Aidan seen earlier

-

impression of isolated practitioner -
- wrote to him -
- unaware -
no ST ... - oncologist - for CAH -
- no adequate cover -
didn't refer. Sean -

- at MDT meeting - objector - didn't agree
with the new recommendation
leniolar -
didn't engage with MDT - didn't respect
it -
- Role of MDT -
- consultant oncologist - would have -

-

Urology Services Inquiry

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b. I was incorrect about the date Dr. Mitchell discussed with Dr. McAleer – it was 2019 and not 2011. The discussion was about a proposed regional protocol concerning the use of hormone therapy in prostate cancer, rather than specifically about Mr. O'Brien's prescribing. I did have a discussion with Dr. Mitchell in 2014 regarding my recollection of a few cases (involving prescription of bicalutamide 50mg daily as monotherapy in prostate cancer) that I had encountered early in my consultant career.

(ii) Please identify 'SMcA'.

Dr. Seamus McAleer, Clinical Director of Oncology, Belfast Trust at the time.

(ix) Please give details of any discussions you had with Dr Mitchell regarding shared concerns.

Dr. Mitchell, as chair of the Urology MDT raised concerns in 2014 to Mr. O'Brien in relation to a particular case which had been referred to the MDT and was receiving bicalutamide 50mg daily as monotherapy for prostate cancer. At that time, I mentioned to Dr. Mitchell about the historical cases I had remembered from my early years as a consultant in Belfast. This discussion would have taken place at one of our Thursday morning pre-clinic meetings at the Northern Ireland Cancer Centre.

(x) Were you aware of others who had knowledge of these issues or who may have shared similar concerns? Please provide details.

I can't recall any specific discussion but I believe there was a general awareness of the issue amongst the oncology team treating prostate cancer.

(xi) Please identify every occasion on which you escalated concerns regarding Mr O'Brien's prescribing practices in respect of Bicalutamide and identify the individual(s) to whom your concerns were escalated. If it is the case that you did not escalate your concerns, please indicate why.

I did not escalate my concerns as I felt there was no substantial harm to patients from the bicalutamide prescribing I had encountered in my practice.

2. **The Inquiry is aware of significant issues around the quoracy of SHSCT Urology MDMs, particularly in terms of Oncology attendance. On this issue, the record of the interview of 4 January 2021 (at TRU-162262) states: 'JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago.' Please explain this further and offer any further comments or observations which may assist the Inquiry in understanding this issue.**

I do not have a detailed knowledge of the oncology cover at the Southern Trust. This was a general comment in which I was referring to my personal understanding of the oncology presence at the Southern Trust Urology MDT. I understood that oncology cover had been absent or patchy for a period of time but that there had been new oncology consultants appointed who were job-planned to attend the MDT.

3. **During the interview referred to above (at TRU-162262), in response to a comment by Dr Hughes to the effect that 'it would seem he [Mr O'Brien] worked in isolation despite being involved in a multi-disciplinary team', it is recorded: 'JOS said that was his impression of Mr AOB.' What led you to have this impression of Mr O'Brien? Please provide full details.**

This impression was based on my experience with the cases that had been prescribed bicalutamide 50mg as monotherapy. My view was that an MDT would be unlikely to recommend this therapy and that it was probably the decision of Mr. O'Brien alone.

4. In his Section 21 Statement to the Inquiry, at [WIT-84157] in reference to you and Dr Mitchell, Dr Hughes states: 'They had also written to him [Mr O'Brien] directly about his

(iii) When did you first become concerned about the use of Bicalutamide?

I can't recall the exact time I became aware of the issue, but it was during my initial few years as a consultant in Belfast (2004-2008). The vast majority of my referrals were from the Belfast City Hospital Urology team however I also received occasional referrals from Mr. O'Brien or other members of the Southern Trust urology team.

(iv) What was the cause of your initial concern?

My concern was about the use of the oral anti-androgen, Bicalutamide 50mg as monotherapy for the treatment of localised prostate cancer. The correct monotherapy dose of bicalutamide is 150mg or alternatively LHRH agonist therapy. I noticed several cases where patients had been on bicalutamide 50mg as a monotherapy, prescribed by Mr. O'Brien. My concern was that bicalutamide 50mg was a sub-optimal dose of hormone therapy when used as a mono-therapy.

(v) Please indicate what, at that time, your specific concerns in relation to the use of Bicalutamide were.

My specific concern was that patients were receiving a non-evidence based hormone therapy dose which might be sub-optimal therapy for patients with prostate cancer.

(vi) Please provide full details of the occasions on which you 'frequently challenged' Mr O'Brien about the treatment.

As per point (i) above, I 'challenged on a number of occasions' in clinic letters. I don't have a record of these cases, but I estimate at least 3 patients were involved. I would have stated something along the lines of 'the patient was receiving a sub-optimal dose of bicalutamide and I have now changed to the evidence based dose of 150mg daily or to another form of hormone therapy e.g. a Lutenising Hormone releasing hormone agonist'

(vii) Please provide further details in respect of the recommendations in clinic letters referred to above. Please provide the Inquiry with copies of any relevant clinic letters demonstrating the questioning of prescribing practices.

I do not have any record of the patients involved. My recommendation would have been to commence evidence-based hormone therapy and radiotherapy if appropriate.

(viii) Please provide any further comments you may have in respect of your indication that 'the dose of bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore wasn't escalated further.'

I believed that the harm to patients in the cases I had encountered was relatively low, and therefore did not feel the need to escalate. I was content that my clinic letters to Mr. O'Brien had adequately addressed the issue.

Angela Kerr

From: Mitchell, Darren <[redacted]>
Sent: 20 November 2014 13:35
To: O'Brien, Aidan
Subject: [redacted]

Aidan –could I ask you to have a look at this case which was passed to me as the regional MDT chair.

Looks like young man with high grade organ confined disease from 2012. From my prospective he would have been considered for neo-adjuvant hormones for 3-6months followed by EBRT in early 2013. He may have been suitable for combined EBRT + BT (pending LUTS assessment). His high grade disease would have encouraged us to offer him 2-3years of adjuvant hormonal therapy after EBRT depending on 2008 or 2014 NICE guidelines and pt tolerance.

I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monotherapy.

I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation.

I'm not aware of supportive research for 24months of neo-adjuvant hormones prior to EBRT but the trans-tasmin group 0 vs 3 vs 6 and the Canadian 3 vs 8 are already quoted in our radiotherapy protocol and based on those studies we typically think of 6 months neo-adjuvantly in this kind of case.

6 months of LHRHa prior to EBRT is also recommended in the STAMPEDE protocol for men with high risk non-metastatic disease who are for radical radiotherapy.

I'm also told that he was on Bicalutamide 50mg OD for the first year of his management.

The NICAN hormone protocol (in process) would be useful in standardising our therapy across the region but Bicalutamide 50mg is not licenced for mono-therapy use and will not be recommended in the protocol other than within the licenced context for the management of flare with LHRHa.

The MRHA site provides information on 'off-label' prescribing and our responsibilities within that.

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087990

Happy to discuss this further.

WIT-96678
AOB2

MailMeter
Message ID - 292349e8743d4571b4a2c28b2d725874 - 146321847
Archived on 20/11/2014 13:47:53. Printed on 18/05/2023 05:20:41.

Time Sent	20/11/2014 13:38:19
Time Received	20/11/2014 13:38:19
Time Archived	20/11/2014 13:47:53
From:	mitchell, darren < Personal Information redacted by the USI >
To	jellett, lucy Personal Information redacted by the USI >
CC	'joe.osullivan@ Personal Information redacted by the USI suneil jain Personal Information redacted by the USI
Subject:	FW: Patient 126

Lucy (Joe & Suneil) – I've emailed Aidan to open discussion on this case.

Copy below for your information only.

DMM

Dr DM Mitchell FRCR
Consultant in Clinical Oncology
Northern Ireland Cancer Centre
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB

☎ - Personal Information redacted by the USI
✉ - Personal Information redacted by the USI
Secretary - Personal Information redacted by the USI

From: Mitchell, Darren
Sent: 20 November 2014 13:35
To: 'O'Brien, Aidan'
Subject: Patient 126

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I'm not aware of any of his co-morbidities or performance status.

As hormonal therapy in this case we would use LHRHa or occasionally Bicalutamide 150mg OD monc

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Aimee Crilly

From: Glackin, Anthony [redacted]
Sent: 09 September 2016 14:47
To: O'Brien, Aidan
Subject: RE: Urology MDT each Thursday

Very good news, I've always found Dr Lyons patient letters to be of a very high standard.

Tony

From: O'Brien, Aidan
Sent: 09 September 2016 14:45
To: Young, Michael; Glackin, Anthony; Suresh, Ram; Haynes, Mark; ODonoghue, JohnP; McClean, Gareth; Williams, Marc; Newell, Kate; McVeigh, Shauna
Subject: FW: Urology MDT each Thursday

Dear All,

Please to share with you some positive news regarding Oncology at MDM.
Hope that it proves to be satisfactory,

Aidan

From: OSullivan, Joe [redacted]
Sent: 09 September 2016 09:01
To: O'Brien, Aidan
Cc: Reddick, Fiona; Wightman, Debbie; Traub, Gillian; Mitchell, Darren; Wright, Richard
Subject: RE: Urology MDT each Thursday

Dear Aidan and Fiona, I agree that cover for the SHSCT Urology MDT has been less than ideal in recent months.

As you know, this has resulted largely from a SHSCT vacancy which remains unfilled since Dr. Carser's departure last year. This gap has placed significant strain on the GU/Lung clinic.

I am delighted to inform you that we in BHSCT have appointed an excellent Locum consultant, Dr. Ciara Lyons, to join Dr. O'Hare in covering the GU/Lung clinic. Dr. Lyons will link with the Uro MDT from next week onwards. She has outstanding Uro-oncology credentials having just completed a 3 year PhD fellowship in prostate cancer here at QUB/BHSCT.

We clearly need a more sustainable long term solution in due course and discussions are in train in this regard.

Kind Regards,
Joe

From: O'Brien, Aidan [redacted]
Sent: 09 September 2016 07:39

To: OSullivan, Joe [redacted]
Cc: Reddick, Fiona [redacted]
Subject: FW: Urology MDT each Thursday

Dear Joe,

I would like to echo the concern expressed by Fiona.
For some time, we did have an improved input from Oncology when Fionnuala Houghton linked in, and Judith Carser attended, even though neither were available for a whole meeting.
Since their deployment elsewhere, the input from Oncology has deteriorated to the extent that it has become non-existent.
The last time we had a link in from Oncology was in July.

I have had the view expressed by my colleagues that it is no longer tenable for us to continue as a MDT unless this issue is resolved satisfactorily.
I do believe that this does need to be addressed so that it can be determined whether we can continue as a MDT,

Thank you,

Aidan.

From: Reddick, Fiona
Sent: 08 September 2016 13:24
To: OSullivan, Joe [redacted]; Wightman, Debbie; Traub, Gillian [redacted]
Cc: O'Brien, Aidan; Convery, Rory
Subject: Urology MDT each Thursday

Joe,

On behalf of the Urology MDT at Craigavon Area Hospital, I wish to highlight our concerns at the inadequacy of attendance, by video link, of an Oncologist at the Southern Trust weekly Urology MDT. This was highlighted as a serious concern following last year's Cancer Peer Review visit and unfortunately the attendance is actually worse this year to date.

We are happy to meet at your earliest convenience to try to resolve this situation as the Urology MDT is not quorate.

Regards

Fiona

Fiona Reddick

Fiona Reddick
Head of Cancer Services
Macmillan Building
[redacted]
[redacted]

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

SCHEDULE

[No 57 of 2022]

General

USI Ref: Notice 57 of 2022

Date of Notice: 31st May 2022

Note: An addendum amending this statement was received by the Inquiry on 7 September 2023 and can be found at WIT-100352 to WIT-100353. Annotated by the Urology Services Inquiry.

Witness Statement of: Anthony Glackin

I, Anthony Glackin, will say as follows:-

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

1.1 I graduated MB BCh BAO from University College Dublin in June 1998. Following completion of internship at St Vincent's University Hospital in Dublin, I commenced a two-year basic surgical training programme in August 1999 rotating through SHO posts at the Royal Victoria Hospital in Belfast, Musgrave Park Hospital and Altnagelvin Hospital. I completed one year as a Surgical SHO in General Surgery at Craigavon Area Hospital between August 2001 and July 2002. I was appointed to a Urology Clinical Research Fellowship post based at Craigavon Area Hospital and Queen's University Belfast in August 2002. Based

Urology Services Inquiry

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

74.1 I have nothing further to add.

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: 15th August 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 57 of 2022

Date of Notice: 31st May 2022

Addendum Witness Statement of: Anthony Glackin

I, Anthony Glackin, will say as follows:-

I wish to make the following amendments to my existing response, dated 15th August 2022 to Section 21 Notice number 57 of 2022:

1. At paragraph 7.1 (WIT-42287), I have stated *'I held the role of Lead Clinician for the Urology Morbidity and Mortality (M&M) meeting from its establishment in April 2015 until September 2022 when I handed this over to Mr O'Donoghue, Consultant Urologist.*' This should be amended to '*I held the role of Lead Clinician for the Urology Morbidity and Mortality (M&M) meeting from its establishment in April 2015 until September **2021** when I handed this over to Mr O'Donoghue, Consultant Urologist.'*

2. At paragraph 1.7 (WIT-42282), I have stated *'I attended the meeting on 3rd January 2017 with my consultant urology colleagues. I recall that Mr Mackle Assistant Medical Director, Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present.'* Mr Mackle was not present at his meeting and it should therefore be amended to '*I attended the meeting on 3rd January 2017 with my consultant urology colleagues. I recall that Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present.'*

3. At paragraph 36.2 (WIT-42311) I have stated '*I chaired the Urology Morbidity and Mortality Meeting from April 2015 to September 2022. I refer to my answer to Q7*.' This should be amended to '*I chaired the Urology Morbidity and Mortality Meeting from April 2015 to September **2021**. I refer to my answer to Q7*.'

Urology Services Inquiry

Statement of Truth

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

Signed: 

Date: 7th September 2023

Witness Statement

NAME OF WITNESS	**Mr Anthony Glackin**
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	Wednesday 3 May 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 Glackin. I am employed by the Southern Health and Social Care Trust as a Consultant Urologist.

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. In respect of TOR 1 I was asked if I was aware of if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process. I am aware of patient referrals which were not triaged.

5. I Chaired a Serious Adverse Incident (SAI) investigation in the autumn of 2016 and through this SAI it became clear to me that the patient had not been triaged. A 'look-back' exercise was completed by the Governance team which identified 7 other patients which had not been triaged. This alerted the Trust to the issue of concern and I now understand there have been a significant number of referrals identified that were not triaged.

6. The SAI investigation completed in April 2017 and was in respect of a Patient 10. This issue arose because of a referral which came into the Trust in 2015 but the patient was not seen until

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

SCHEDULE

[No 57 of 2022]

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

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

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

UROLOGIST OF THE WEEK

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

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

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

j. Supporting professional activity to meet the requirements of annual appraisal and medical revalidation

1.3 The duties are described in my job plan in terms of the time allocated per week to each activity. My job plan has evolved over time. My job plan does not and did not ever describe: accountability arrangements, objectives, supporting resources, expected volumes of activity, timeframes for completion of triage of referrals or correspondence for results etc.

1.4 I held the role of Lead Clinician for Urology Morbidity and Mortality meeting from April 2015 to September 2021. I have not been provided with a job description for this role. I refer to my answer to Q7.

1.5 I have held the role of Lead Clinician for Urology Cancer MDT from 16th November 2016 to date. I have not been provided with a job description for this role. I refer to paragraphs 7.7 and 7.8 below. Since 2021 I have worked with Dr Tariq, AMD for Cancer Services to develop a Job Description for all Cancer MDT Lead Clinicians in the SHSCT. This work is almost complete and has formed part of the SHSCT Task and Finish response to the recommendations made by Dr Hughes's Independent Review into 9 SAIs.

1.6 I took up the post of Urology Training Programme Director at the Northern Ireland Medical and Dental Training Agency in February 2019. I have 3 hours per week in my job plan for this role which is adequate. NIMDTA provide training which has enhanced my ability to manage doctors in training with difficulties and also to keep me up to date with best practice in equality, recruitment and selection. One shortcoming of the role is the lack of administrative support available to me as TPD.

1.7 I have had patient safety concerns, since 2012, related to the long waiting lists for appointments and procedures within the Urology Department. I also have concerns regarding inadequate numbers of Consultants in the Department to deliver a safe timely service. Since my first experience of working in the

Department of Urology in 2002 and upon my return to the department in 2012 as a new consultant it was clear to me that there was and remains a persisting problem with excessive waiting times for new appointments, review appointments and surgical procedures. In contrast, my experience as a urology trainee in the West Midlands between 2006 and 2012 was incomparable. I would operate on urgent cases within weeks of listing and routine cases certainly with the same year, this was a revelation compared to the situation in Northern Ireland.

1.8 Other than a general sense that we were struggling to deliver a timely outpatient and surgical service I did not have any concerns regarding clinical governance processes within urology until January 2017 and again in 2020 following the Trusts announcement of the Independent Review of 9 SAIs related to Mr O'Brien's practice.

1.9 My first knowledge of serious concerns with the practice of Mr O'Brien came at a meeting that took place in January 2017. I was aware from a brief conversation with Mrs Heather Trouton that she had concerns before this time regarding the practice of Mr O'Brien (paragraph 50.8).

1.10 I attended the meeting on 3rd January 2017 with my consultant urology colleagues. I recall that Mr Mackle Assistant Medical Director, Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present. We were informed that the trust had found a number of areas of concern relating to Mr O'Brien's practice. I recall the issue of triage of referrals and the late dictation of clinic letters and results being discussed. We were advised by Mr Carroll that this was a confidential matter not to be discussed outside the group and that Mr O'Brien would not be returning to work until further notice. I recall that we were asked to participate in an exercise to clear the backlog of triage and outstanding results. We agreed to do this work. I undertook triage to clear a backlog. I supplied a list of completed cases to Mrs Corrigan and the Referral and Booking Centre. Similarly, I reviewed charts of Mr O'Brien's patients with outstanding results or clinic letters. I actioned the results and where necessary flagged up cases that

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

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

SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

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

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

Data source: BOXI CH3 Universe, run date 08/10/21

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

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Number of Patients Waiting on a Consultant Led First Outpatient Appointment for Regional Urology Specialty by Consultant and Waiting Time Bands AS AT: **30/09/2021 (Run date 08/10/21)**

Consultant Name	0-9Wks	9+ to 13Wks	13+to 18Wks	18+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 41Wks	41+ to 52Wks	52+Wks	TOTAL
A UROLOGIST (E)	422	76	96	61	104	123	88	63	142	1575	2750
GENERAL UROLOGIST	109	23	26	23	15	14	20	15	28	540	813
HAYNES	2	1	0	0	1	3	1	1	3	377	389
GLACKIN	4	0	3	0	2	1	6	1	3	325	345
YOUNG	9	2	3	1	1	1	2	1	7	314	341
O'DONOGHUE	5	4	2	1	4	1	0	2	12	264	295
O'BRIEN	0	0	0	0	0	0	0	0	0	220	220
SURESH	0	0	0	0	0	0	0	0	0	48	48
KHAN	1	0	3	0	0	2	1	1	2	3	13
JACOB	0	0	0	0	0	0	0	0	0	12	12
OMER	0	0	0	0	2	0	1	0	3	0	6
TYSON	0	0	0	0	0	0	0	0	0	3	3
BROWN	0	0	0	0	0	0	0	0	0	2	2
TOTAL	**552**	**106**	**133**	**86**	**129**	**145**	**119**	**84**	**200**	**3683**	**5237**

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

Data source: BOXI Monthly Waiting Universe

SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

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

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

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

Data source: BOXI Monthly Waiting Universe

SOUTHERN HEALTH AND SOCIAL CARE TRUST

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

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

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

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your opinion of how this impacted on the unit. How were such staffing challenges and vacancies within the unit managed and remedied?

16.1 Consultant and junior medical staff posts have remained unfilled since I arrived in 2012. At present we are working with 4 full time Consultant staff (one of whom is a locum) and 2 less than full time Consultants (one working 60% of his time for SHSCT with the remaining 40% for BHSCT and the other 40% of full time at SHSCT alone). The impact on the unit has meant that we have growing waiting lists for outpatient appointments and surgical procedures. It has meant that existing post holders are working beyond capacity. During periods of leave or sickness, the team is stretched to provide cover for all the routine activities and this has meant cancellation of activity to try to sustain a safe core service for emergencies and in patients. The trust has repeatedly asked existing post holders to fill gaps for locum cover for out of hours work. This is not sustainable or safe.

16.2 For as long as I can remember since 2012 we have been continually trying to recruit substantive Consultant staff. There is a shortage of suitably qualified candidates. I have experience of interviewing candidates that are simply not appointable as a safe day 1 NHS consultants.

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

17.1 I refer to my answer to Q16. Staffing problems have led to delayed care for patients. This has also contributed to staff stress trying to balance competing interests with too little resource. In particular, the shortage of trained theatre staff has led to a sustained downturn in activity meaning many patients are waiting much longer than is acceptable for routine or urgent care. In some cases, this has led to patients presenting multiple times for the same problem and others developing complications or more advanced disease as a consequence of not

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

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

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

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

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

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

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

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

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

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

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

Aimee Crilly

From: Hunter, Catherine [redacted]
Sent: 12 November 2015 09:18
To: Gishkori, Esther
Cc: Haynes, Mark; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Young, Michael; Suresh, Ram; Hall, Sam; Korda, Marian; Reddy, Ekambar; Farnan, Turlough; McNaboe, Ted; McCaul, David; Leyden, Peter
Subject: 3 South Concerns
Attachments: Ward 3 South Concerns 2015.docx

Importance: High

Esther,

I refer to my recent e-mail correspondence with Heather Trouton, a copy of which I attach.
I have also raised my concerns with Mr Hayes and at his request, I have copied this e-mail to all the consultants attached to the ward.
While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters.
Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.
In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation.

Catherine Hunter
Ward Manager
3 South

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.

O'Brien, Aidan

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

Dear Esther

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

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

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

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

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

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

Thanks

Mark

Stinson, Emma M

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

Importance: High

Morning all

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

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

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

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

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

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

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

[redacted]

Mark

15.5 Theatre provision across the Craigavon site is inadequate for the demands of a modern urology service. When I arrived in 2012, we shared nine half-day in patient lists across the team of five Consultants. In an effort to improve waiting lists, we collectively worked extra Saturdays. For a time this worked well however, within a few short years the year round bed crisis made this activity impossible. Another factor that hampered this effort was that the theatre nurses were expected to undertake this work as part of their normal shift pattern and were not paid additionality like the medical staff. In an effort to improve in patient theatre access 3 session days were trialled on Tuesdays and Wednesdays. This was not sustainable in the long term due to staffing issues from an anaesthetic and nursing perspective. The productivity of the 3 session days was not as good as we had hoped. In my view job planning for each Consultant Urologist should include 3-4 theatre sessions per week with a mix of in-patient and day case sessions to deliver the needs of the patients. For a team of 7 Consultants this would mean 21-28 sessions per week, a more than doubling of our current provision.

15.6 The trust has a long-standing problem with a shortage of trained theatre staff, which remains a live issue. We have not been able to get back to 11 in patient sessions per week since the pandemic.

15.7 The infrastructure across the trust is out of date for modern urology. We have no dedicated purpose built day case facility. The day surgery units in Craigavon and Dungannon are housed in facilities with insufficient space for patients to recover and this limits the case mix that can be accommodated, resulting in many cases appropriate for day case surgery having to go through the in-patient theatres in the main building at Craigavon. During my tenure, we have had meetings with planners and managers in the trust about development of new facilities but this has all come to nothing.

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

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.

Kind regards

Liz

_____

Liz Hynes
HR Business Partner (Medical and Dental)
Pay and Employment Unit, Workforce Policy Directorate, Department of Health and The Board Liaison Group, (BLG), HSC Board
Tel: Personal Information redacted by USI
email: Personal Information redacted by USI
email Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Please note that I usually work for the DoH Monday - Thursday and BLG on Fridays.

Roberts, Naomi

From: Dawson, Andrew
Sent: 08 March 2018 14:59
To: Hynes, Liz
Subject: FW: Maintaining High Professional Standards in the Modern HPSS
Attachments: Employee Relations Comments - HPSS.docx

Liz

As discussed.

Apologies.

Thanks.

A

From: Lutton, Gemma [redacted]
Sent: 26 February 2018 12:10
To: Dawson, Andrew [redacted]
Subject: FW: Maintaining High Professional Standards in the Modern HPSS

Hi Andrew,

Is it past the deadline for giving responses in relation to Maintaining High Professional Standards in the Modern HPSS.
Please see comments attached if not.

Many Thanks

Gemma Lutton - Personal Assistant

PA to: Mrs Elizabeth Brownlees
Director of Human Resources, Organisation Development and Corporate Communications
Northern Health and Social Care Trust, Antrim Area Hospital
Trust Headquarters, Bretten Hall,
Bush Road, Antrim, BT41 2RL

Telephone: [redacted]

On 12 Feb 2018, at 22:01, Brownlees, Elizabeth [redacted] wrote:

> Doh are minded to review this but only on the basis that we provide a list of what doesn't work in the current document.
> Gemma will be happy to collate your thoughts if you wd pl send to her by end of next week.
> Many thanks
> Elizabeth
>
> Sent from my iPhone
>
> Begin forwarded message:

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

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

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

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

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

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

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

31.3 In my opinion Mrs Corrigan was asked to cover too many departments (Urology, ENT, Ophthalmology and out patients). It was clear that urology was always struggling and this meant that the process was reactive and not strategic.

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

32.1 My role is not subject to performance review.

32.2 My role is subject to an annual appraisal with a medically qualified appraiser in order to meet the requirements for medical revalidation. This is not a performance related review. Appraisal in this context is a confidential reflective conversation between 2 colleagues. My appraiser has been a consultant from within the Trust on all but one occasion when the role was fulfilled by an associate specialist doctor. My appraisers have come from Urology, ENT, General Surgery and Emergency Medicine backgrounds. Since 2019 the trust has allocated the appraiser to all doctors, prior to this we had a choice of appraiser. The appraisal meeting usually takes 2 hours and is completed using an online portfolio. The appraiser ensures that all the necessary documentation is presented by the appraisee to meet all the domains of good medical practice set out by the GMC. At the end of the process the appraiser makes a recommendation to the medical revalidation team in the trust.

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

33.1 I am not involved, nor have I been involved in the appraisal or performance review of consultants or nurse colleagues. I am responsible for the Annual

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

65.1 I refer to my answer to Q56.

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

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

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

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

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

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

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

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

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

Governance

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

35.1 During my tenure, no one person held responsibility for quality assurance of urology services. In a broad sense, each clinician was responsible for their own practice. The degree to which individuals engaged with quality improvement or audit was variable and there was no mandatory element or structure to this activity. Audit activity remains poorly supported by the trust and is left up to clinicians to complete with minimal administrative support. From my own perspective I completed and presented audits related to prostate, kidney, bladder and testis cancer at the Urology M&M. With the help of Mary Haughey, Cancer Services Improvement Lead, I completed peer review and authored annual reports for the Urology Cancer MDT. I participated as an external peer reviewer for the Urology Cancer MDT at the South Eastern Trust.

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

36.1 In order to assure myself of the quality of my own practice I completed audits of cancer outcomes relating to kidney, bladder, testicular and prostate cancer management. The audits were presented at the departmental patient safety meeting. Mr Haynes and I submitted data to a national urology audit for kidney cancer surgery until instructed to stop by the trust due to data control concerns specific to NI law. The data was measured against key performance indicators for kidney surgery and compared to peers and units across the UK.
I refer to my answer above 35.1

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

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

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

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

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

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

38.1 I refer to my answer to Q7.

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

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