Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 56 of 2022
Date of Notice: 01/06/2022

Witness Statement of: Mehmood Akhtar

I Mehmood A will say as follows:-

General

SCHEDULE [No 56 of 2022]

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 was appointed consultant urologist in SHSCT in the early part of 2007, I joined in September 2007 and worked until 30th March 2012. During this time, along with my clinical commitments, I took part in regular governance, and business meetings. I can only describe from my memory, and seeing the documents provided by the Trust team about these activities. Due to the length of time since I left I may not be able to remember

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: M Akhtar

Date: 29/07/2022

all the names and date of these activities. During my time as consultant urologist the department saw the NICAN implementation of MDT meeting locally and regionally (2009-2010). Implementation of the urology service plan (2011). My role during 2007-2012 in department was as follows.

1.2 Role as consultant Urologist: in my substantive post as a consultant urologist, clinical duties included regular weekly clinics, theatre sessions, peer review ward round, attending to admin work in a timely way, and a weekly radiology meeting. I started to attend Local and Regional MDT when established in late 2009. We used to have a monthly business meeting to discuss the KPI (like number of patients on waiting list and for follow-up in clinic) and arrange any extra work to reduce the WLI and FU.

1.3 During my time as consultant urologist at SHSCT we had significant issues regarding:

a. Demand and capacity mismatch as faced by most of the NHS Trusts in NI and UK - There were always issues with the bed capacity not being available and lack of staff.
b. Introduction of the new MDT and cancer pathways and targets. These issues were initial teething problems that would have happened in establishment of new services as mentioned in my letter to Dr. Rankin and Ms. Alison Porter the head of oncology services in CAH. These were resolved very well and any New MDT would have the same issues. *(Letter To Ms. Alison Porter dated 05/07/2010 which can be located at S21 56 of 2022 Attachments 1. MA letter regarding MDT set up issues)*

1.4 We, as a team, addressed the capacity by doing some extra work on the weekend and running the evening clinics.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology*

We had the paper form to fill in and appraisal agreement and objectives were recorded on 'form 4'. Copies of the form 4 attached *and can be located at S21 56 of 2022 Attachments 4. m_akhtar_appraisal_2010 and 5. Appraisal 2011 M Young 29.3.12.*

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 No, I was not involved in the review or appraisals of any other colleagues.

Engagement with Urology staff

34. Describe how you normally engaged with other urology personnel, both informally and formally. Please set out the details of any weekly, monthly or daily scheduled meetings with any Urology unit/Services staff and how long those meetings typically lasted. Please provide any minutes of such meetings (if not provided by the Trust already).

34.1 Apart from clinical engagement, every member had a schedule of meetings weekly for discussing the patient management or any operational issues. Below is a schedule of the regular team meetings:

a. Thursday morning - Radiology meeting to discuss the complex cases and their management. Held for 60 -90 mins in the Radiology Department
b. Peer review ward round attended by all consultants, middle grades, ward staff, and clinical specialist nurses. During this round we used to see all patients in ward and discuss good practice.
c. Informal meetings of clinical staff (Consultants and Middle grade) at breakfast after rounds.

d. Thursday afternoon business meeting with trust Business Manager to discuss the referrals, concerns, Datix and complaints.
e. Local MDT started in late 2009 on Thursday afternoons, followed by regional MDT via video link.
f. Urology steering group meeting started in late 2009, early 2010 every Monday evening in Trust offices on the first floor. These meetings were attended by the Director of Acute Services, Dr. G Rankin, and her team, Associate Medical Director, Mr. Mackle, and urology consultant's team. The Terms of Reference for this meeting included:
    i. Implementation of urology review plan;
    ii. Discuss the capacity and demand issue;
    iii. Agree new job plan in line with the increasing workload of the department.

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 Quality of the service is every member's responsibility, and as a consultant urologist, I looked after my patients and discussed with my peers to provide good practice. But I understood that overall responsibility sat with the Clinical Lead and Business Manager. We were provided with monthly reports and data on clinical incidents, risk, and complaints.

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?

Corrigan, Martina

From: McConville, Patricia A Personal Information redacted by the USI
Sent: 03 June 2009 10:14
To: Akhtar, Mehmood; Young, Michael Mr; O'Brien, Aidan; O'Neill, Kate; McClure, MJ Dr; McMahon, Jenny; McCusker, Grainne; McClean, Gareth
Cc: Dignam, Paulette; Troughton, Elizabeth; McCorry, Monica; Clayton, Wendy; Freeburn, Gary; Porter, Alison; O'Donnell, Noleen; McGoldrick, Kathleen
Subject: RE: Urology Team Meeting 11 June - AGENDA
Attachments: Urology Agenda 1106.doc

Dear all

Please find attached Agenda for meeting on 11 June.

Regards
Patricia
X Personal Information
<<Urology Agenda 1106.doc>>

From: McConville, Patricia A
Sent: 18 May 2009 14:49
To: Akhtar, Mehmood; Young, Michael Mr; O'Brien, Aidan; O'Neill, Kate; McClure, MJ Dr; McMahon, Jenny; McCusker, Grainne; McClean, Gareth

Cc: Dignam, Paulette; Troughton, Elizabeth; McCorry, Monica; Clayton, Wendy; Freeburn, Gary; Porter, Alison
Subject: Urology Team Meeting - meeting confirmation

Dear all

Thursday 11 June

12.00-1.30 pm

Seminar Room 2, Ground Floor, MEC.

To **confirm meeting** to discuss the implications of moving the MDT to Thursday afternoon to fit in with the regional agreement on the 3 local MDT structure feeding into the regional meeting for complex case discussion, as part of the preparation for Peer Review. This also fits in with the recommendations of the regional urology review which we expect to be communicated to the Trust in the near future.

Need to define what would be required with regard to job plans, support etc for the MDT at that meeting before we arrange to meet with the senior managers to discuss this further. Mr Akhtar has agreed to act as interim chair until we have a formal MDt established to enable a formal nomination and election process (Alison Porter).

Agenda to follow in due course.

Regards
Patricia
Personal Information

UROLOGY

CONSULTANT UROLOGIST: Mr Akhtar
SECRETARY: Elizabeth Troughton
TELEPHONE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI

1st November 2010

Dr Gillian Rankin
In-Term Director of Acute Services
Southern Trust
Administration Floor
Craigavon Area Hospital
Portadown

Dear Dr Rankin

Re: The implementation of Regional Urology

In response to your letter dated 22nd October 2010 regarding implementation of Urology Services in the Region you raised certain points and asked if I agree to that in writing or not.

The first issue is clinic new and review numbers. The Trust is aware of I perform 1.4 clinics per week in the Trust which is once every Monday afternoon here at Craigavon Area Hospital and once a month on a Tuesday afternoon at South Tyrone Hospital. My clinic template has been changed sometime in June 2010 here at Craigavon Area Hospital following MDT discussion because there was a lot of work generated from the MDT relating to the cancer patient which include especially the prostate cancer Day 4 patients as well as the new patients to be seen under the Red Flag target system. I do not have any facility to undertake a specialist clinic; hence I see mix and match of all urological conditions in the one clinic. I think number of patients in my clinic at both sites is already above average, considering the cancer patient need more time to discuss their condition. We should agree to setting up a specialist clinic separately where red flag target patients, patients generated from MDM and histology and Day 4 especially for the prostate cancer patient should be seen, giving them due attention, time to explain and understand their disease, to discuss the outcome of various treatment options. The number of patients seen in these clinics should not be more than 6-7 per clinic.
As mentioned in the letter about the BAUS clinic number are expected to be high then what I see at present, I am sorry to say we are very selective in picking what suits us most from any guideline. It is not mentioned in the letter that these BAUS clinics which, I am expected to undertake should be only of general urology patients as mentioned in BAUS

document. As this is not the case in my clinics so I am unable to change the template of my clinic at present until we separate the cancer patients from the general clinic.

Another issue is the BAUS guidelines which the Trust is referring to is quite old and I have seen the new guidelines which are expected to go for approval soon and in which the general urology patient's number is even less than what is mentioned in the old guidelines. I am sure my Senior Colleagues might have provided you with a copy of those changes expected in the future.

The second point was new to review ratio as you mentioned, that my new to review ratio is what meets the HSCB old requirements but I certainly have some review patients over the last 2 years which at the moment I am working with Martina to clear the backlog.

The issue about triaging of letter in line with NICAN guidelines I am the one promoting that red flag patients should be triaged as soon as possible and seen within the target timeframe.

Yours sincerely

dictated but not signed by

Mr Akhtar MB FRCS (Urol) FEBU
Consultant Urologist

Cc Mr Young, Consultant Urologist, 2 South, Craigavon Area Hospital
Mr Mackle, Consultant General Surgeon, Level 4 Craigavon Area Hospital

5th July 2010

Ms Alison Porter
Head of Cancer Services
Mandeville Unit
CAH

RE: Issues relating to the Urology MDM meeting.

Dear Ms Porter

As you are aware we have been trying to establish our MDM since April 2009 and we started on the ground in April 2010. The previous year we spent in putting things together with promises that once we started everything would fall into place. I was not very happy to start in April as the fundamental infrastructure was not available on the ground but we did start it on the promise that it was a trial run and things would gradually fall into place. Today we completed three months of MDM from the start date and the basic infrastructure and promises are still not in place which is going to create a lot of problems from clinical governance issues as well as patient management and safety. Please see details below for your immediate attention as well as Trust management: -

1. Post MDM follow-up/co-ordination of these patients. This is a very important issue as MDM is running at its full strength at present and there are between 20-25 patients and most of these are prostate cancer patients who require to be seen after the MDM in the clinics. At the moment, as far as I am aware, there are two problems:-

   (a) There is no clinic formalized to see these patients at the moment each individual consultant whenever they get time will see them which could be next week or it could be in a couple of weeks.

   (b) If these patients need any investigations this is again an issue as to who is going to book them and where that is going to be booked. The problem of booking the investigation can be partially resolved if as we have been saying for a long time that a computer is made available in the MDM room as well as the positions already indicated around the hospital (i.e. Theatre 2). Some of these patients have been neglected as there are not appropriate clinic slots available or their investigations were not booked because of the ownership of those patients and responsibilities'.

2. The availability of personnel when some specialties on holiday. I do agree that we do need to take our annual leave but in the meantime we have to have access to some alternative arrangements like colleague cover.

3. There is an issue of availability of microscopy, I have been told that the microscope has been ordered but it is almost 3 months since the microscope has become available and this is a huge clinical governance issue.

4. Arrangement for various treatment especially in the patients with bladder cancer who require intravesical Mitomycin or BCG. Streamlining this process is very important, at the moment we are working on the Ambulatory Care Service in Urology, but we need someone to be present to take this matter further during the MDM as MDM generates almost one third of the patients who might require intravesical Mitomycin or intravesical treatment. There should be clear cut guidelines for those patients treatment and how they are going to be followed up because after the treatment it doesn't finish there and they need further follow-up cystoscopy. At the moment the patients are being left without any follow-up arrangement so they get lost in the system.

When we started in April we were promised that all these issues would be resolved by the 1st June and I am adamant that up to now nothing has been resolved and it is getting very frustrating and I am thinking that there is no point to the MDM if there is no infrastructure in place and arrangements made for the above issues.

Yours sincerely

Mr Akhtar MB FRCS (Urol) FEBU
Consultant Urologist

CC: Dr Gillian Rankin
Mr M Young
Mr A O'Brien
Dr M McClure
Mr E Mackle
Dr M Williams
Dr G McCleane
Sr Tedford
Heather Troughton
Sr Kate O'Neill
Sr Jenny McMahon

26th July 2010

Mr Akthar
Consultant Urologist
Craigavon Hospital

Dear Mr Akhtar

Thank you for your letter dated 5th July, raising your issues regarding the Urology MDM meeting. Firstly may I apologise for the delay in this response due to my annual leave.

Some of the issues which you have raised do not come under my authority or control, so I will take the liberty of copying these to the urology Management team, or relevant area manager. I will address your issues as listed in your letter.

1. MDM follow up of patients - previously patients requiring appointments for review, results etc have been made by the Consultants secretarial teams. This should still be the case as this is not a role of the MDT co-ordinator. You may be aware that a review of administrative services is ongoing and this is one of the many issues which will be discussed. I do concede your point that these would be better given in a separate clinic or allocated results slots, as previously patients have been significantly delayed in the routine review process. At our last meeting, on the 10th June, we had a long discussion around the results clinic issue. Following that meeting I did discuss this with the urology managers and this was proposed as something which they will discuss within the new funding.

Ordering of onward investigations – as you aware this is the responsibility of the medical staff. We have been able to acquire a laptop for the MDM to support this, however on testing there is insufficient wireless access and we are currently in discussions with IT to provide a second network access point for Tutorial room 1. Hopefully this will facilitate ordering of radiology live in the meeting.

As you are aware we do have a process for red flagging patients with suspected cancer and it would be helpful if this was used by all of the team members as this helps the tracking team and the partial bookers, appointment makers to prioritise appointments for these patients within radiology and pathology services.

The set up of the computer in theatre 2 is currently with that department and the Capps manager.

2. Regarding your second point and holidays, I am not sure what this refers to. Could you please clarify this for me? If this is with regard to the medical staff, this does not come under my remit and would be better addressed with the medical leads for those specialties.

3. During the week of your letter the camera had arrived and was being set up and I understand that this system is now working and enabling the presentation and fuller discussion of pathology.

4. Regarding the management and guidelines of intravesical Mitomycin and BCG. Guidelines are the responsibility of the clinical team within the MDT and do not fall under my direct remit. I would expect that the medical team are working closely with the nursing staff, pharmacy and Urology managers etc to produce these. I am happy to advise as able. I would have concerns if there is no current guidance as I understand that this service has been in existence for some time, and feel that this should be addressed urgently.

I am unclear as to the need for 'someone' to be present at the MDM to 'take this forward'. If the pathways, protocols etc are clearly stated this service should follow similar lines as patients going on for any treatment. Is the role of the CNS or should someone attend from the Ambulatory care service? This decision needs to be taken by the Urology team in discussion with their management.

I am disappointed that you feel frustrated with the process, as I feel that the team has made significant progress in the establishment of its MDM which runs extremely well. The team members have full patient discussion and agree very clear management plans, which has been very helpful for the MDT coordinator.

I hope that some of the issues raised, such as the lap top, will soon be completed, however some others are outside of my remit and I will pass these onto the relevant areas.

Yours sincerely

A Porter
Head of Cancer Services

CC: Dr Gillian Rankin
Mr M Young
Mr O'Brien
Dr McClure

emergency Services. This review was completed in March 2009 and recommended three Urology centers, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the Urology unit in the Southern Trust area.

9.1 The first ever meeting of urology service review took place in March 2009, with Mr. Mark Fordham the consultant urologist from Liverpool leading this review, Trust management team and the consultant urologists (Mr Michael, Young, Mr Aidan O'Brien) were also present. The purpose of the meeting was to discuss the recommendation from the review, and agreeing an implementation process. After this meeting the Trust management team, led by Dr. G Rankin Director for acute services, Martina Corrigan Business manager urology, Mr. E. Mackle, associate medical director and all the consultant urologists (Myself, Mr. Young, and Mr. O'Brien) discussed the recommendations and agreed to form a steering group in Trust for implementation. The group organized regular weekly Monday evening meetings.

9.2 These meetings took place on Mondays (except bank holidays) and continued until late 2010. In these meetings we worked out the number of our clinical appointments, and design and development of the Thorndale Unit, various pathways for the patients' conditions, work force issues and consultant job plan reviews according to the recommendations. (Minutes will be available from the Trust). We also decided to have a named consultant for each of the specialty pathways. I was asked to look after the oncology aspect of the urology service, which I did until my departure in March 2012.

10.The implementation plan, *Regional Review of Urology Services, Team*

10. The review of urological services, completed in 2009, proposed a configuration model with three teams serving the province. The 'Team South' configuration had Craigavon Urology as the core service for the southern part of the province and included Enniskillen. As part of the case for implementation of the review, the Trust set up various groups to meet the expectations of the commissioner. At that time there was an extensive review backlog, the Trust had the worst 'new to review' out-patient ratio of the three proposed teams as well as long waiting lists for surgery. There were significant regional concerns about our ability to be able to deliver the activity to cope with the growing demand, and to modernise the service to make it fit for the proposed expanded service.

11. To enable the expansion of the service, multiple workstreams were set up to deliver an implementation plan. Initially Joy Youart and then Gillian Rankin chaired weekly meetings with the three urologists. These meetings were met with almost unanimous resistance by the urologists, and it involved a huge effort and dogged determination on our part to gradually achieve agreement on the issues needed to modernise the service. The changes in practice that were expected by the commissioners were many and included: management of red flag referrals, triage, pre-operative assessment, length of stay, number of patients per clinic (and thus length of appointment), transfer of radical pelvic surgery to Belfast, role of Nurse Specialists, and team job plans. Throughout these meetings it was obvious that the main resistance to embrace change came from Aidan O'Brien, although as stated above, he did get support from his two colleagues. Aidan O'Brien had quite fixed views on how he wished to practice and deliver a urological service and these did not match those of the commissioners. My main role at the meetings was to provide a clinical challenge function to the opinions re delivery of the service that were being expounded by the urologists so that Gillian Rankin could achieve the desired consensus and outcome.

12. While the weekly meetings were continuing we also had the issue of job plans, both individual as well as for the proposed 5-man urologist team. Despite productivity of the urology service being considered low, Aidan

with myself, Heather Trouton, Martina Corrigan and the three urologists. We would have a pre-meeting at 5pm to plan strategy and aims for the meeting. Then at 6pm we would be joined by the three Urologists: Aidan O'Brien, Michael Young and Mehmood Akhtar for up to an hour and a half. We would then have a debrief until approximately 8pm to discuss what was agreed and to plan the discussion points for the following week's meeting. Following some of the early meetings it was agreed by Gillian Rankin that I would act as a clinical challenge to the Urologists re their opinions and demands so that Dr Rankin could then obtain a reasonable, balanced consensus and agreement. This was a long, drawn-out process and we were met by the three urologists with a lot of suspicion, objection (see Aidan O'Brien's letter of 29 September 2010), obfuscation and obstruction to the process and aims of the project. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101004 Email Private and Confidential*. Frequently, we would find at one meeting that what we considered had been agreed at previous weeks' meetings the urologists would wish to renegotiate. I recall Gillian Rankin stating that she felt their aim was to talk us into submission.

65. Despite considerable progress being made in discussions with Michael Young and Mehmood Akhtar it was necessary for Gillian Rankin to write to Aidan O'Brien on 22 October 2010 regarding a refusal to amend clinical practice re length of time seeing out-patients, a reluctance to improve his 'new to review' ratio. *Document located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Eamon Mackle, 20101022 Email Correspondence to Urologists*. At a meeting on 9 June 2011 Gillian Rankin outlined the requirement for job plans to be agreed, action to be taken on the review backlog, admission on the day of surgery and pooling of lists. *Document located at Section 21 4 of 2022, 20110627-email urology meetings.*

66. The MDM for Urological Cancers was organised by the Cancer Directorate and Mehmood Akhtar took a lead on developing this and worked with Ronan Carroll, Assistant Director Cancer & Clinical Services. My understanding is that the MDM commenced in 2010.

responsibility of the Head of Service and the Assistant Director. Once a month, my weekly Governance meeting with Heather Trouton included Michael Young and Robin Brown. For the majority of these meetings no minutes were taken, rather Heather Trouton would make a note of any action points in her notebook. This joint portion of the meeting generally lasted about an hour and during this time any urology issues were discussed. As noted above, for approximately 18 months during 2009-10 I met with all three urologists for up to 90 minutes at the weekly meetings that Gillian Rankin held on a Monday evening regarding the implementation of Team South plan. I would also have met all the consultants at the monthly Morbidity and Mortality meetings, which lasted up to 2 hours.

[30] In your opinion during your tenure, did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

102. During my tenure Martina Corrigan (Head of Service), Heather Trouton (Assistant Director) and Gillian Rankin, Debbie Burns and Esther Gishkori (Director of Acute Services) and myself worked very well together and had a common aim and purpose. Likewise, I feel that all of the above individuals established good working relationships with most of the urologists. Martina Corrigan, as Head of Service, had a very close relationship with them and would often act as an advocate on behalf of Urology. I have no reason to think that her relationship was not reciprocated. During the 18 months of Monday evening meetings it was obvious that the three Urologists, Michael Young, Mehmood Akhtar and Aidan O'Brien, were in agreement with each other regarding tactics and desired outcomes and, while the meetings were cordial, I felt that they had an underlying mistrust of the process. I feel I have been able, over the years, to maintain a good working relationship with Michael Young despite our differences in 2009-10. Mehmood Akhtar, when he was leaving in 2012, spoke to me and said that he had come to realise that I had urology's best interest at heart.

270. The Directorate of Human Resources will be able to assist the Inquiry in determining the tenures of Directors of Acute Services. The first whom I recall was Ms Joy Youart who held that post at the time of the ward reconfiguration which was a consequence of the Acute Quality Care Project: Surgery & Elective Care in March 2009 [see supplemental October bundle pages 44 – 66] I contributed to our department's response of 26 May 2009 to the Trust's proposals for ward reconfiguration in which the medical and nursing staff expressed their concerns regarding the reconfiguration [see AOB-03510 – AOB-03514]. Ms Youart wrote to me on 1 June 2009 to express her gratitude for my input into attempts to mitigate the risks which we feared would accompany the reconfiguration [see AOB-82230 – AOB-82233]. I wrote to her on 3 June 2009 [see supplemental October bundle page 78] to express the persistent concerns of the nursing staff, and to invite her to address these concerns directly with the nursing staff at a meeting which I arranged for 4 June 2009. The nursing staff was not adequately reassured by Ms Youart when she attended on 4 June 2009. As related elsewhere in this statement, their concerns were justified. Regrettably, the reconfiguration proved to be a regressive step in terms of retention of nursing staff and of quality of inpatient care.

271. I believe that Ms Youart was succeeded by Dr Gillian Rankin who remained as the Director of Acute Services for a considerable period of time during my tenure until she was replaced by Ms Debbie Burns. I recall that in 2011, Dr Rankin and Mr Mackle had a number of meetings with the consultant urologists on an individual basis. I found a number of meetings with Dr Rankin and Mr Mackle to be distressing and traumatic and believe that my two colleagues, Mr Young and Mr Akhtar, were also distressed by the meetings, which may have contributed to Mr Akhtar's subsequent decision to leave the Trust in March 2012.

272. I recall a meeting with Dr Rankin and Mr Mackle 9 June 2011. Mrs Heather Trouton, Assistant Director of Acute Services – Surgery & Elective Care, was also in attendance and provided a note of the meeting on 1 July 2011 [see AOB-00255 – AOB-00256]. The meeting commenced with Mr Mackle reporting to me that I

Montgomery, Ruth

From: Akhtar, Mehmood [redacted]
Sent: 10 December 2009 13:06
To: Loughran, Patrick
Subject: RE: Urology Meeting 7 December 2009 at 1.45, Templeton House
Attachments: Akhtar, Mehmood.vcf; RE Urology Meeting 7 December 2009 at 1.45 Templeton House.htm

Dear Dr Loughran
Thanks for the email
The email below was to express our concerns which I think we can express.
And it did not say we intend to boycott, which is not the right notion to be taken from that email.
I have already emailed Mr. Clegg on 1st dec 1500 pm to inform my unavailability due to other commitment.
I think he should read this email in that context.
I Attach the text of the email so you can see yourself.
regards

M Akhtar

-----Original Message-----
From: Loughran, Patrick
Sent: 10 December 2009 10:41
To: Clegg, Malcolm; Akhtar, Mehmood; O'Brien, Aidan
Cc: White, Laura
Subject: RE: Urology Meeting 7 December 2009 at 1.45, Templeton House

Dear Mr Akhtar and O'Brien
Thanks for the email of Dec 1st. The purpose of the meeting was to discuss safe cover from within EWTD limits. The notion that it is appropriate to boycott a meeting is not one that I would endorse. The agenda did not include the situation which you feared. Mr Young attended and I expect he will report the outcome to you in due course.

Paddy

-----Original Message-----
From: Clegg, Malcolm
Sent: 02 December 2009 09:19
To: Loughran, Patrick
Cc: White, Laura
Subject: FW: Urology Meeting 7 December 2009 at 1.45, Templeton House

FYI

-----Original Message-----
From: Akhtar, Mehmood
Sent: 01 December 2009 19:39
To: Clegg, Malcolm
Subject: RE: Urology Meeting 7 December 2009 at 1.45, Templeton House

Dear Mr. Clegg
We do not intend to attend the above meeting as we entirely disagree with any provision of on-call cover for our department by any junior urological staff, other than those working in our department. Such a proposed cover could only further compromise the standard and quality of care provided. Any risk of any such further compromise is unacceptable to us.

M Akhtar, A O'Brien

-----Original Message-----
From: Clegg, Malcolm
Sent: 01 December 2009 13:24
To: Akhtar, Mehmood; O'Brien, Aidan
Subject: FW: Urology Meeting 7 December 2009 at 1.45, Templeton House

Dear Mr Akhtar/ Mr O'Brien,

Please find attached agenda for a meeting to discuss the proposal for a Belfast/ Craigavon cross cover SpR Urology rota.

This meeting has been facilitated by the Board Liaison Group (formally ISG) and will be held at 1.45pm on Monday 7th December 2009 in Templeton House, 411 Holywood Road, Belfast. Mr Young has confirmed he will be attending and I understand that Mr Chris Hagan will attend from the Belfast Trust. If you are also able to attend I would be grateful if you could let me know and I will inform BLG.

Kind regards

Malcolm

-----Original Message-----
From: Laura Lee Quigley [redacted]
Sent: 30 November 2009 16:08
To: cathy.jack[redacted]; Loughran, Patrick; Clegg, Malcolm; graemeh.mcdonald[redacted]
chris.hagan[redacted] Moore, Rachelle; Young, Michael; Mark Roberts
Cc: White, Laura; aine.shearermih[redacted] Dignam, Paulette
Subject: Urology Meeting 7 December 2009 at 1.45, Templeton House

"This email is covered by the disclaimer found at the end of the message."

Dear All

Please find attached agenda for the above meeting scheduled for Monday 7 December 2009 at 1.45pm in Templeton House, 411 Holywood Road, Belfast.

If you require directions or any further information please contact me directly.

Kind regards

why this wasn't the case was due either to (i) the other members of the team trying to resolve these issues among themselves rather than escalate them or (ii) the others in the team not being aware of an issue (e.g., for some issues such as the bicalutamide prescribing). A personal observation is that the Urology Team are a close-knit team and, whilst they considered that I was one of that team, some of them recognised that I was also a senior manager so that, once they escalated issues to me, I would always have acted on them. This may have inhibited them in raising some concerns with me as they still tried to 'protect' Mr O'Brien.

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

67.1 I have reflected on the response to this question and the explanation that I will give is based on my own opinion as to what went wrong within the urology services. I will also acknowledge from the outset that there have been failings on my part which contributed to the Mr O'Brien problems during my tenure but also in my opinion I believe that there are others who have worked with me over the course of my tenure who also contributed to these mistakes. I have provided more detail on these mistakes, both by me and others, in my response to question 70 below.

67.2 Mr O'Brien was a well-established consultant urologist who took up his role in 1992 as a single consultant urologist. I understand that this came about with the splitting of the retired consultant surgeon's post into a consultant general surgeon (Mr Eamon Mackle) and a consultant urologist (Mr Aidan O'Brien). I have been advised by others (such as: Mr Mackle; Mrs L Devlin, Head of Service; Ward Sisters who are since retired, for example, Mrs Dorothy Sharpe; nursing staff, for example, Paula McKay, now lead nurse; other consultants such as Mr Young, Mr Akhtar, and so on) that, from the outset, Mr O'Brien had strong opinions and it would always have been his way or no way. He undoubtedly had a strong personality and it would appear that, right through to his retirement in 2020, this came out in

his dealings with others; so much so that I believe that others (including myself) didn't challenge him enough because, when we did, he always challenged back and he wore people down to the extent that, in my opinion, he was able to continue to do his own thing (whether that was the correct way to do things or not). Mr O'Brien's response to me on numerous of occasions was, 'are you, as a non-clinical person, questioning my decisions?'. Examples of when he would have said this would have been when he was admitting patients straight from home a few days before they were going to theatre for work-up and the hospital system was struggling with bed pressures and trying to get the emergency department freed up to see other patients. When I took advice from other clinicians on this issue (as I always did first), they would have told me there was no need for them to be admitted so early in advance of their surgery and they would have detailed what needed to be done and what could be done in the community or via a visit to hospital outpatients in advance of being admitted. I always would have advised Mr O'Brien of this but he would then get cross, as he considered that I was going 'behind his back', and maintain that what the others were saying was incorrect.

67.3 From other consultants, I have heard some of them saying that Mr O'Brien was their mentor, either during training or when they came to work in Craigavon Area Hospital, and therefore I believe this made it more difficult for his colleagues to challenge his practice as they respected him too much.

67.4 Urology are a close-knit team with the majority of the team having been together for a long number of years and I think Mr O'Brien's practice became accepted, that there was a view that, when issues have been raised, nothing was done to him, and that people (including myself) became complacent. People would have said, 'it is just Aidan and, sure, that is the way he has done things for years'.

67.5 It is my opinion, on reflection, that outside influence from the Trust Chair (Mrs Brownlee) in dealing with Mr O'Brien's practices and Mr O'Brien

70.3. For example, Mr O'Brien (and Mr. Young and Mr. Akhtar) used to regularly admit patients with recurrent urinary tract infections to the Urology ward for 5 to 7 days to be treated with intravenous antibiotics and fluids. I never saw this in any guideline but accepted that this was the standard practice in the unit, which predated my time. I felt that I was never going to change this practice in the short time that I was planning to stay in SHSCT but I was not going to practice in the same way. Similarly, he did not like using intravesical BCG therapy for high-risk non-muscle invasive bladder cancer and preferred Mitomycin therapy. I was informed (I do not recall if this was by Mr. O'Brien himself or someone else), that Mr. O'Brien had a patient soon after BCG was first introduced that developed a small capacity, poorly functioning bladder as a side effect of the BCG treatment and since that time, he did not like using BCG. I did not have this experience and continued to advise BCG for my patients. Over time, there may have been the opportunity for me to challenge some of the differences between our practices but I never felt that was a realistic prospect during my short tenure at Craigavon Area Hospital.

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

71.1. In hindsight I do not think the Governance arrangements were fit for purpose. I did not appreciate this at the time as this was my first consultant job and the processes in SHSCT appeared to be similar to other units I had worked in during my urology training. As a result, I did not raise this as a concern. As outlined in my answer to Question 67, this was my experience of all the Units I worked in during my Urology training and as a Consultant until the last 5 years or so. I have noted within Belfast Trust in the past 5 years that governance procedures have become far more formalised. The recording and documentation of issues, and the independent oversight of these has greatly improved. I suspect this relates to lessons learned from the Dr. Michael Watt case.

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

72.1. No.

documents if not already provided to the Inquiry.

56.1 During my tenure from July 2007- March 2012, I never came across or became aware of any specific concerns or issues regarding Mr. O'Brien. The first time I heard any concerns about this was, when Mr. O'Brien called me some 6 months ago. This was the only conversation between us since I left the trust. Later on after my Section 21 notice was received, Ms. A Frizell sent me a copy of the Chadha and Khan Report about the investigation about Mr. O'Brien. As I said before, triaging the referral according to urgency (Red Flag, Urgent, and Routine) was new to the department, sometimes we all had difficulties to triage on time and helped each other.

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

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

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

57.1 As said in answer of question 56, I was not aware of, and no one raised to me, any specific issue or concerns about Mr. O'Brien.

58. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail