Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 63 of 2022
Date of Notice: 7th June 2022

Note: An addendum amending this statement was received by the Inquiry on 03 November 2023 and can be found at WIT-104212 to WIT-104214. Annotated by the Urology Services Inquiry.

Witness Statement of: MATTHEW TYSON

I, MATTHEW TYSON, 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 was employed by the Trust in two different roles, at different times. Firstly and for the majority of my employment as a Urology Trainee Doctor for the times as listed in my answer to question 5. As a trainee during the times listed I had limited access/ knowledge to any concerns or issues raised in the department beyond those that affected the running of the acute Urology part of the service in the form of understaffing concerns at times on Ward 3 South, which as a trainee I and other trainees were informed was known about and being dealt with.

1.2 Secondly as a Consultant Urologist in the Southern Trust, appointed on the 25th February 2019 and leaving on the 16th July 2019 (Including time taken for annual leave). During this time I was not part of the Oncology MDM team, as my sub-specialist interest in Kidney Stones had me attending the Stone Meeting once a week instead.

routine surgery and outpatient appointments and need to staff at times a Urology ward with agency nurses.

71.2 I had no concerns during my time as a Consultant for the 4 months in 2019 related to governance beyond the well-known low staffing levels to the Urology Ward at times, the fact there was a long waits for routine outpatient and surgery and was made aware of no concerns beyond this. I raised my concerns regarding the above to the Urology Team at a Team Meeting sometime between March 2019 and June 2019. I was there for a too short a period as a consultant in 2019 (24th February to 16th July 2019 including annual leave) to gain any reassurance that the process were robust and concerns of long waiting lists and the need at times to staff Urology Ward with agency nurses would be addressed.

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

72.1 There is nothing else I am aware of or could add my comments.

Statement of Truth

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

Signed: Matthew Tyson

Date: 12 August 2022

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 63 of 2022
Date of Notice: 7th June 2022

Addendum Witness Statement of: Matthew Tyson

I, Matthew Tyson, will say as follows:-

I wish to make the following amendments and additions to my existing response, dated 12th August 2022, to Section 21 Notice Number 63 of 2022:

1. I commenced my employment as a Consultant with the Southern Trust on Monday 25th February 2019 and not Sunday 24th February 2019. This should be amended in the following paragraphs:

4.7, 5.1(iv), 6.1(iv), 7.4, 9.2, 10.1, 12.1, 16.1, 17.2, 20.3, 26.1, 28.1, 29.1, 32.2, 33.2, 34.2, 36.1 (x2), 37.2, 39.1 ,40.1, 43.1, 44.1, 46.1, 47(iv) and (ix), 47.2 (x2), 50.2, 51.1, 53.1, 57.2, 60.1, 61.1, 63.1, 64.1, 66.1, 66.3, 66.4, 69.1, 70.3, 70.4 and 71.2

2. At paragraph 14.2 (WIT-42202), I have stated '*Low staffing however from a Nursing and Doctor Perspective leads to a tied and stressed work force and increases the probability of 'things going wrong' from a clinical perspective*.' This should state '*Low staffing however from a Nursing and Doctor Perspective leads to a **tired** and stressed work force and increases the probability of 'things going wrong' from a clinical perspective.*'

3. At paragraph 66.3 (WIT-42222), I have stated '*I have been made aware that there was administrate issues of triage not being returned in a timely manner and that the administration team now ensures they have accounted for all referrals and that the triaging Doctor returns the outcomes in a timely manner*.' This should state '*I have been made aware that there **were administrative** issues of triage not being returned in a timely manner, **not related to myself**, and that the administration team now ensures they have accounted for all referrals and that the triaging Doctor returns the outcomes in a timely manner*.'

Urology Services Inquiry

Current practice is for a dictated discharge to be undertaken immediately following operation, most commonly by the Consultant Urologist, via digital dictation software. Further inpatient discharge is generated by the Foundation Doctor, but with oversight of the Urology Team.

Finally, I would like to state that I handed in my notice on the 25th October 2023 Personal Information redacted by the USI Personal Information redacted by the USI I will be leaving. My employment with the Southern Trust will end on the 18th January 2023.

Statement of Truth

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

Signed: Matthew Tyson

Date: 03/11/2023

11.2 With annual leave taken into consideration I was there as a Consultant for 4 months only for this time period, I do not recall any significant changes to any performance indicators.

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

12.1 I make these observations regarding the time in question, for the time 24th February 2019 to 16th July 2019 as a Urology Consultant in the Trust, and times preceding as a Urology Trainee rotating through the Trust.

12.2 Urology services were/are not adequately staffed given the long waiting lists to be seen in clinic or receive an operation from a Consultant perspective.

12.3 The Urology Ward was at times under staffed from the perspective of skilled Urology Nurses or relying on agency Nurses, and Urology patients were often placed on other non-Urology wards, making ward rounds longer.

12.4 I remember voicing my concern regarding the above at a Urology Team meeting with the Urology Consultants and Urology Manager present, sometime between March 2019 and June 2019. I do not recall the answers given, but understood/was informed these concerns were known and management were working on the issues.

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

13.1 I am only aware of the x1 Consultant post at the time in question, which was unfilled for many years and was filled by appointing Locum Consultants. The impact to the vacancy was minimal since the position was filled with a Locum.

23. 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? Did 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.

23.1 Cancer Nurses help provide insight and support to the patient and their family to their diagnosis, sign posting to extra resources and being an easy accessible contact to the service and their follow-up.

23.2 Urology Nurse Specialist can include a Cancer Nurse Specialist role and also include specialist areas of interest/skills such as providing a biopsy of flexible cystoscopy service or seeing and consulting patients in clinics.

23.3 During this time I had limited interaction with these Nurses as I was mainly involved in Urology Stones and not Cancer during this time in question.

23.4 I was not aware of any issues between the nursing staff and consultants.

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

24.1 There was a good working relationship for the time period I was there. There was recognition that staffing levels could be low at times (as discussed above needing Agency Nurses), but a determination to do the best for each patient and maximise what we did have.

24.2 I had no concerns beyond low staffing levels at times, which management were aware of and beyond raising the issue as stated in answer to question 12.

25. What was your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication

timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices *(sic)* and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.
During your time working in Urology services, was the 'Integrated Elective Access Protocol' provided to you or its contents made known to you in any way by the SHSCT? If yes, how and by whom was this done? If not, how, if at all, were you made aware of your role and responsibilities as a Consultant urologist as to how data should be collected, recorded and reported … to establish good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists for the successful management of patients waiting for hospital treatment?

9.1 I was not provided with a copy, or any reference made to this document for my role as a Urology Trainee or Urology Consultant.

9.2 Upon commencing work as a Consultant for the Trust in 24th Feb 2019 I was informed by Mr Young and Mr Haynes and Urology Manager Martina Corrigan on how to undertake triage of GP referrals (online ECR and paper referrals) and

code to appropriate time to be seen. In relation to listing patients for theatre I was informed on what categories each operation type needed to receive in order to be addressed in the appropriate manner.

10. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits and guidelines, etc., within it) impact or inform your role generally as a Consultant urologist? How, if at all, were the time limits for Urology Services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

10.1 For the period of time I was there from 24th February 2019 to 16th July 2019 (including annual leave) I do not recall whether or not the Urology team received feedback in relation to whether time limits were being met, but I strongly suspect this feedback would be given to the department from management on the basis of the integrated Elective Access Protocol time limits and guidelines to guide resources to achieving waiting times, and where not meeting this should be raised as concern up the line management system.

10.2 I became aware of the fact that waiting times for routine review of Urology patients for the Trust were excessive and I undertook some extra clinics and review of long waiters (April – June 2019) for some of the patients under named Consultants who had left the Trust (Mr. Jacob, Mr. Suresh), as much as one could do for a 4 months tenure for this period.

10.3 With annual leave taken into consideration I was there as a Consultant for 4 months only for this time period.

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

11.1 I believe length of time to be seen in clinic and length of time to have an operation were used as indicators of performance for the department.

so that you may properly carry out your duties. Accordingly, please set out in full all assistance and support which you receive from administrative staff to help you to fulfil your role.

17.1 The service provided secretary support to each consultant, audio typist help for large volume of letters dictated, along with administration staff to record referrals received.

17.2 In relation to 24th February 2019 and 16th July 2019, I received secretarial support from Teresa Loughran for typing of letters, to book operating lists, to ensure results were followed up, and to allow access for communication from other specialities, GPs and patients. There we no issues related to this arrangement.

17.3 There was also audio typists to aid the secretarial work load on typing patient's letters due to the large volume.

18. Did you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular Consultants? How was the administrative workload monitored?

18.1 Each consultant had a dedicated secretary to their practice, I worked with Teresa Loughran. I was unaware of how the administrative workload was monitored, but would have expected to be informed if there were any backlog or delays.

19. Did all Consultants have access to the same administrative support? If not, why not?

19.1 I would not know.

46.1 I did feel supported. Mr Young was an excellent mentor and starting as a new consultant in February 24th 2019 he was always either at hand or a telephone away for how any part of the service functioned or any questions a new Consultant may have.

46.2 Martina Corrigan as head of Service had an open door policy, making the team feel supported, and I believe was championing the need to reduce the Trust's Waiting times, especially for Routine Urology Services.

47. The Inquiry is keen to understand how, if at all, you engaged with the following post-holders:-

(i) The Chief Executive(s); Shane Devlin: No engagement

(ii) the Medical Director(s); Dr Maria O'Kane No engagement

(iii) the Director(s) of Acute Services; Melanie McClements No engagement

(iv) the Assistant Director(s); Ronan Carrol No direct regular engagement beyond welcome to the department 24th February 2019

(v) the Associate Medical Director; Mr Mark Haynes Engaged mainly telephone or in-person otherwise email.

(vi) the Clinical Director; Mr Edward McNaboe Engaged to help set up job plan via email

(vii) the Clinical Lead; Mr Michael Young, Telephone or in-person

(viii) the Head of Service; Martina Corrigan, Telephone, in-person otherwise email.

(ix) other Consultant Urologists: Mr Mark Haynes, Mr Tony Glackin, Mr John O'Donoghue, Mr Aidan O'Brien, Mr Derrick Hennessey. (24th February 2019 to 16th July 2019)

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

68.1 Learning is to the administrate and governance processes, I note these have been looked into and the process made more robust in relation to:

a. Referral and recording of Cancer MDM. (I note a new role has been created for Cancer MDT Administrator to focus on audit of MDT outcomes which should identify any deviation from agreed actions for patients)
b. Audit of sign-off of results with the SPLUNK system to monitor and ensure results are actioned from ECR.
c. Triage administration on the requirement to ensure all triage is accounted for by the Trust.
d. A weekly Urology department meeting to improve communication

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

69.1 Given I was there as a Consultant during this period in question from 24th February 2019 to 16th July 2019 (including annual leave) I would not be able to apportion blame either fairly or proportionally or if people or departments had fully engaged with the problems within the service. A longer period of time would have been required to make any such assertions as well in depth knowledge to any concerns and how and if these were escalated and what action was taken.

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

Clayton, Wendy

From: Clayton, Wendy
Sent: 04 May 2022 14:27
To: Haynes, Mark
Subject: FW: Stones

Mark – can we discuss at our next 1:1 meeting please

Regards

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

From: Tyson, Matthew Personal Information redacted by USI
Sent: 04 May 2022 10:24
To: Clayton, Wendy Personal Information redacted by USI; Haynes, Mark Personal Information redacted by USI
Cc: Young, Jason Personal Information redacted by USI; McAuley, Laura Personal Information redacted by USI; ODonoghue, JohnP Personal Information redacted by USI
Subject: Stones

Hi

I have spoken to Jason who is keen to increase his role in the stone side of the team.

I would propose he does a session each morning and we will set up a pathway re.

1. Ureteric stones for the conservative management route. This would allow us to be more towards the Nice and EAU guidelines in having patients renal function checked, as well as calcium and urate as already done, as well as could book the follow-up imaging and discharge if suitable and stone passed along with prevention advice for suitable patients.
2. To include the follow-up at present to ensure Ureteric stents taken out at home by patients (in the long run this should be a more automated approach)
3. Follow-up of long term (not highest risk patients, they should come to me.. cysteine/ spinal/ single kidneys/ abnormal or altered anatomy etc) and short term with view of discharge if stable stone formers, including small unchanged stones discharged with advice.

Would be great if Jason had an ECR account to book this high volume of work under that myself (or myself and John), in our name, that we could provide oversight too that is separate from all our other results so I don't end up doing the work for Jason when I sign all the results off.

I would like to make a website pathway for the regional ESWL, referral only from Urology Teams in the region for direct booking on to the service and then managed by the radiology team. The ESWL service I am very keen to have day to day running by radiology and given a regional service a band 8 for the centre would be suitable given it would be the Northern Irish ESWL Centre at this point.

This would then also include the ED teams in the region for referral to stone MDM as per GRIFT report pathway and then a more robust pathway as the paper form means some are not filled out fully.

A meeting with IT would be great

Thanks

Matt

4. Upon review of my witness disclosure bundle, I have noted at WIT-13114 that Mr Carroll has stated that I was the Standards and Guidelines Lead. In relation to this reference by Ronan Carroll I would say as follows:

I was the Standards and Guidelines Lead for 'Benign Urology', the Cancer related Guidelines were incorporated into the roles of Mr Glackin and Mr Haynes for their specialist roles with Cancer Services and the Cancer MDM. I undertook my role from 24th October 2021 until July 2023. The role was for mainly Urology Stone related guidelines to help transform the Stone Pathways for the SHSCT and development of regional ESWL stone service.

5. Upon review of my attendance record for MDM's from January 2022 until May 2022 (WIT-24251), I would make the following comment:

Attendance at MDM was affected by annual leave, birth of my son, occasional elective theatre list and a possible virtual attendance episode not recorded. I am no longer part of the Cancer MDM due to my sub-specialist role and development of regional stone services.

6. Upon review of Patient 82's notes and records and specifically the discharge letter at PAT-00176, I would like to make the following comments:

I was involved in this case from the perspective of a first year Urology Trainee in 2013, undertaking a supervised injection of Intravesical Botox into the bladder for treatment of bladder storage symptoms under Mr O'Brien. I note a written discharge from Mr O'Brien was provided to the patient and GP upon discharge from the procedure. A further dictated discharge was provided by myself for the procedure as a typed letter. My typed letter states I note the patient to be on 50mgs Bicalutamide and Tamoxifen, which will be from reading the paper discharge summary, my role was to provide a discharge summary for the procedure of Intravesical Botox to the bladder, undertaken as a first year Urology Trainee.

The perceived delay in dictation may relate to the time it took the notes to arrive to Mr O'Brien's secretary's office for dictation, possible annual leave, on-call commitment or the date dictated recorded on the letter may also be inaccurate. This was done at the time on a Tape Recorded Dictaphone and it was the role of the registrar to provide dictated discharge letters for inpatient activity, both acute and elective admissions.

81/CA 51/1

OPERATION NOTES

Aff' Label

Patient 82

[redacted]

HOSPITAL: CROIGDON AREA

Operations Performed
INTRADETRUSOR INJECTION OF BOTULINUM TOXIN

29.05.13

Surgeon
MATTHEW TYSON

Anaesthetist
DES OER

Assistant

Sister

Incision

Blood

Findings

Drains

Packs

PROCEDURE

30 MLS INSTILLAGEL INSTILLED

TRABECULATED BLADDER OF MODEST CAPACITY

500 UNITS ABOBOTULINUM TOXIN INJECTED

- 25 UNITS IN EACH OF 20 SITES

16 F CATHETER

PLAN

- REMOVE CATHETER AT 2 PM
- HOME LATER IF WELL

Personal information redacted by the USI

[redacted]

Signature of Surgeon: .....

WWW439
OS17959

PAT-001769

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN BT63 5QQ

UROLOGY DEPARTMENT
DISCHARGE LETTER

CONSULTANT UROLOGIST: Mr A O'Brien
SECRETARY: Mrs Monica McCorry
TELEPHONE: Personal Information redacted by the USI

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Name: Patient 82
D.O.B: Personal Information redacted by the USI
Address:
Hospital No: Personal Information redacted by the USI **H&C No:** Personal Information redacted by the USI

Date of Admission: 29/05/13	**Method of Admission**
Date of Discharge: 29/05/13	BOOKED ADMISSION
Procedure: INTRA DETRUSOR INJECTON OF BOTULINUM TOXIN	

Patient 82 above operation was undertaken in the day surgery unit and he was discharged home the same day. I know the gentleman has a background history of detrusor muscle over-activity as well as prostatic carcinoma. I know the gentleman is on androgen blockade and I believe he currently takes Bicalutamide 50mg once a day and Tamoxifen 10mg daily. I note his latest PSA is 0.14ng/ml on 1st March 2013. He appears to have this well controlled since 2011.

Many thanks

Yours sincerely

MR MATTHEW TYSON
UROLOGY RESITRAR TO
MR A O'BRIEN
CONSULTANT UROLOGIST

Date Dictated: 23/06/13	Date Typed: 25/06/13-CN

Patient 82's Daughter ?

A. No, it's my own words.

CHAIR: Sorry, your own notes.

A. It refers to standard clinical practice for Daddy's management, so I presume that's something that's written down that doctors are meant to follow. I would have expected Dr. Taiwany and Mr. Tyson and Mr. O'Brien to have known that. Yet, Mr. Taiwany and Mr. Tyson seen Daddy's medication and never queried why he was on a low dose of Bicalutamide. 10:42

CHAIR: There's some water there, if you need it, Patient 82's Daughter .

A. Sorry.

CHAIR: You're okay, don't worry.

A. It looks like to me that there were two other doctors with knowledge of urology that should have questioned the use of Bicalutamide and tamoxifen in Daddy, and didn't. 10:43

Daddy took a dizzy spell one day in the main street in Personal Information redacted by USI and he was referred to a geriatrician. I understood that to be an expert in the care of the elderly and medicine suitable to that age group. He never questioned it. In fact, he actually reduced furosemide and clopidogrel at that review, and never questioned. 10:43 10:44

Daddy would have complained about hot flushes, and I could say on three occasions I have spoken to the GP

CHAIR: Obviously there's the issue over the nine and a half years' lack of response from the Trust to your complaint, which you say was not designed to get anybody into trouble as such --

A. No.

CHAIR: -- but rather to help others.

A. Improve service.

CHAIR: So there's that issue about communication.

A. Yes.

CHAIR: But if I've heard what you're telling me correctly, you're saying that you were pretty dissatisfied with the level of communication generally from the Trust with patients and families; would that be fair?

A. Yes, yes. I find you write in a complaint and they write back to you what you wrote in. "I wish to complain"; "I see you want to complain", or "You have a complaint; I acknowledge your complaint". But they tell you nothing about the complaint, they don't answer the complaint.

CHAIR: Or give you answers as to maybe what happened in the individual circumstances?

A. Yes.

In terms of the Bicalutamide, you know, somebody has mentioned a -- just to I get all this terminology -- a pathway, a clinical -- a standard for clinical practice.

CHAIR: Sorry, you're reading from a document there,

July 2019 in relation to this time period and not privy to the concerns or any support agreements.

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

65.1 I do not know about the concerns raised by Mr O'Brien and others or therefore how they were handled during the time I was employed.

Learning

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

66.1 I was a consultant between 24th February 2019 and 16th July 2019 including annual leave. I restarted working for the Trust on 24th October 2021.

66.2 I am now aware of the following governance concerns

66.3 I have been made aware that there was administrate issues of triage not being returned in a timely manner and that the administration team now ensures they have accounted for all referrals and that the triaging Doctor returns the outcomes in a timely manner. I had no triage concerns during 24th February 2019 to 16th July 2019 as my triage was always undertaken and returned during the on-call week.

66.4 The significant waiting times (Outpatient and Surgery) for Urology, from becoming aware that the Trust had long waiting list times for outpatient routine appointments and routine surgery as of 24th February 2019 to the 16th July 2019 as a Consultant, which were known to management team and the Urology department. I have been since informed this was indeed on the risk register in 2019 from discussion with Mr Young in May 2022, and the number of patients

awaiting surgery and outpatient appointments greater then I would have expected.

66.5 I have been informed of the recommendations from a department meeting from 31st March 2022 (I could not attend meeting due to clinical commitments) referring to SAI Recommendations MDT Action Plan. Please see attached *(relevant documents can be located in S21 63 of 2022 – Attachments 2. 20220331 question 8 Urology Team Meeting NOTES 31.03.2022 (002) and 3. 20220331 question 8 Urology Team Meeting NOTES 31.03.2022 A1).* I was provided with a copy on 01/08/2022.

66.6 Wendy Clayton Urology Manager has provided assurance that any Urology Governance Concerns are now discussed at Head of Service Meetings.

66.7 The head of service (Wendy Clayton) now provides a weekly update to the Urology team on a Thursday 12:15pm each week, providing any Urology enquiry updates, team performance and including waiting list times and initiative work to external providers. Vacant Urology Consultant posts x2, impacting on the delivery of Urology Waiting Lists.

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

67.1 What appears to have gone wrong is failings in a proc[redacted]s. A process of ensuring that concerns of staff shortages from a Doctor and Nursing perspective are addressed to provide suitable care. A process of ensuring that regular audit of processes is undertaken and disseminated to the department. Audit is a cycle, not a single occasion event, and resources and time to the provision must be provided.

67.2 Performance based on waiting times: if waiting times were noted to be long then addressing and ensuring suitable provision to a service is required (I note x2 new Urology Consultants have been appointed to address the shortage in part). If not able to be provided, then ensuring patients receive consult and treatment externally to the Trust (which I note is now happening).