Urology Services Inquiry

Oral Hearing

Day 64 – Tuesday, 10th October 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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THE INQUIRY RESUMED, AS FOLLOWS, ON TUESDAY, 10TH OCTOBER 2023

CHAIR: Good morning, everyone. Mr. Akhtar.

MS. McMAHON BL: Good morning. The witness this morning is Mr. Akhtar who was a Consultant Urologist for a time at Craigavon. I understand he wishes to take the oath. 10:02

MR. MEHMOOD AKHTAR, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON, AS FOLLOWS: 10:02

MS. McMAHON BL: Mr. Akhtar, we have met before. My name is Laura McMahon. I am junior counsel to the Inquiry. Can you hear me okay? 10:03

A. I can hear you okay. Can you also hear me?

1 Q. Yes, we can hear you loud and clear. I am going to take you through your evidence. First of all, I'm going to ask you some -- I'm going to ask you about your Section 21 notice that you filled in for the Inquiry. It starts at WIT-41831. If you can have that, please. You'll see your name at the top of the page. It is Section 21 notice, number 56 of, 2022 date of notice was 1 June 2022. If we go to pH WIT-41873 you should see your signature. 10:03 10:04

A. Yes. 41873, yes.

2 Q. You recognise that as your signature that has been imposed on to that document.

A. Yes.

3 Q. Dated 29 July 2022?
A. Yes.
4 Q. You wish to adopt that as your evidence?
A. That is my evidence. This is the date, that is correct when I submitted it yes, please. 10:04
5 Q. Thank you. For the Panel's note, the enclosures with that are WIT-41874 to 41944?
A. Yes.
6 Q. I just want to -- the context of your evidence is that for a time in your career you worked as a Consultant Urologist in the Southern Health and Social Care Trust and that was the period of September 2007 to 30 March 2012. 10:05
A. That's correct. I was --
7 Q. Just before I go in to ask you about your time there, could you just set out your employment history for the Panel as you've set out in your Section 21. Just your various roles to that date. 10:05
A. From the very start I graduated in 1989 after my initial training in Pakistan. I moved to Republic of Ireland where I did the general surgery rotation. Along with that I also passed my FRCS. I joined the Urology Team in Beaumont Hospital in 1998 and completed my training in 2002 when I was granted the special register in Republic of Ireland. Then I worked as a locum consultant in Republic of Ireland before I moved to Cambridge in 2005. Addenbrook Hospital, for further training. My first substantial post was the one in Craigavon which I was successful in the 10:05 10:06

interview, I think the interview was carried out in March 2007, and I joined the post in September 2007. I don't remember the exact date but I think it was the start of September.

Then from there I carried on as a surgical consultant up to 30 March 2012, but I moved to mainland UK at Halford, NHS Trust, where I am currently employed as a Consultant Urologist still to date.

10:06

8 Q. When you left Craigavon, the post that you went to you're now in. 10:06

A. Yes, that's the same. I am in the same post.

9 Q. What I would like to do with your evidence is, I want to set down some background of what your roles and responsibilities were when you joined Craigavon. Then I want to go into some detail. 10:07

The Panel has heard a lot of evidence to date. I've tried to take the key issues from your Witness Statement or from others that might inform their deliberations and their recommendations. So obviously your Section 21 stands alone as your evidence, we have that, we don't need to go through that in any particular detail but what we need to do is highlight some parts of that. So my questions to you will be directed towards information that I think the Panel may make best use of. That doesn't preclude you adding anything, but I'm going to try to stay nice and focused. I know you have you for the day and I would 10:07 10:07

like to finish your evidence comfortably in that time. So with a fair wind we will perhaps be able to achieve that.

A. Sure.

10 Q. I just want to go to some parts of your statement from the outset, your Section 21, just to give the Panel a flavour of what things were like in 2007 when you were in post. If we go to WIT-41832, paragraph 1.2. You set out your role and I'm just going to read this into the record: 10:08

"Role of Consultant Urologist: In my substantive post as Consultant Urologist, clinical duties included regular weekly clinics, theatre sessions, peer review ward round, attending to admin work in a timely manner 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 the FU." 10:08 10:08

Could I ask you about those acronyms. The KPI, "Key Performance Indicators", is that --

A. It's key performance indicators. 10:09

11 Q. And the WLI?

A. It is a "Waiting List Initiated Work" which is done above and beyond your NHS commitment. That is reimbursed or enumerated at an agreed rate at the

NHS Trust.

12 Q. And FU, just at the end of your sentence, what does "FU" stand for?

A. Sorry, what was that word?

13 Q. WLI and FU? 10:09

A. FU, "follow-up".

14 Q. Follow-up, okay. Thank you.

A. It means to review the patients again.

15 Q. We have to make sure we understand the acronyms so that when we are looking back everyone knows what they mean. 10:09 If we could go to paragraph 34.1 at WIT-41852.

A. Can I pull that out on my screen or do you have it on your screen?

16 Q. I have it on my screen. I'll read it out to you if you don't have your Section 21 in front of you. 10:10

A. I have the screen and I can see on that, but is there a screen I can see?

CHAIR: Mr. Akhtar, do you have a bundle of papers with you that was provided?

A. I do. 10:10

CHAIR: It should be within that bundle. If we give the page reference maybe?

A. Please do.

MS. McMAHON BL: The Section 21 is the first document in your witness disclosure bundle. 10:10

A. Yes, I do have it.

17 Q. Paragraph 34.1 of your Section 21.

A. Yes, what's the page number?

18 Q. Page 45 of the bundle.

A. Yes, I am there. Paragraph number?

19 Q. Paragraph 34.1. This question we asked you generally about your engagement with urology staff and both formally and informally, and asked you to set out the details of your meetings within the unit, and generally how long they lasted and what the meetings might be about. 34.1 your answer is: 10:11

"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. Thursday morning: Radiology meeting to discuss the complex cases and their management. Held for 60 to 90 minutes in the radiology Department; 10:11

(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; 10:11

(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; 10:12

Urology Steering Group meetings 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." 10:12

The terms of reference for that meeting included: 10:12

"Implementation of urology review plan, discuss the capacity and demand issue and agree a new job plan in line with the increasing workload of the Department." 10:12

If I stop there just to summarise some of that. This was a time of particular change around Urology, just after you joined, 2007. 2009 saw the review of Urology Services and then plans to implement a new way of delivering that service that was hoped to be more efficient and cost effective. So you were there during that and at the start of that. 10:13

Could you just tell the Panel who the other Consultants

were in Urology when you were there?

A. We were three members of consultant group, myself, Mr. Young, the Clinical Lead, Michael young, and Mr. Aidan O'Brien, our senior member of the staff as a consultant, and myself. So we were three together in the group at the time. 10:13

20 Q. I just want to check with the IT people. The screen seems to have frozen. We can hear you okay, so I'll carry on. I just wanted to draw that to their attention. 10:14

So Mr. Young and Mr. O'Brien, and you were the third member of the team at that point?

A. Yes, I was the third member. We joined the team in September 2007 and I believe -- I'm not sure how many members were prior to me there. 10:14

21 Q. We'll hear from Mr. Suresh next week and he took over from you in 2013, so you didn't cross over with him.

A. No. When I left, I don't think so, there was any other appointment made at the time. But I'm not sure what happened after March 2012. 10:14

22 Q. Now, there's a couple of things in that paragraph that we're going to come on to, the MDT setup and the Urology Steering Group meeting. You have just given us a flavour there of the quantity and the breadth, I suppose, of the meetings that you held during your time, that you were part of while you were there. 10:14

Just as a general question, what was your feeling

around the way in which the consultants and medical management communicated with each other, did you have a good experience of that?

A. It was totally -- can you hear me now and can you see me? 10:15

23 Q. Well, we can see a version of you that's frozen. We could see a version of you that's frozen, but we can hear you. If you can hear me and you're comfortable enough to answer, please do.

A. Yes. I will. I can hear you. Yes. 10:15

When I joined and the changes were happening so obviously there were a few issues in communication at the time or arranging the things in an appropriate way which I would like. Like, for example, setting up my 10:15 MDT -- I can't hear you.

24 Q. Sorry, I think the last thing you said -- the sound isn't particularly great this end, I'm just having trouble hearing.

A. Can you hear me now? 10:15

CHAIR: I think we are going to take a short break, Mr. Akhtar, and hopefully the IT can be solved by the time we get back. Let us know when you're ready.

MS. McMAHON BL: Thank you. 10:16

(Short adjournment - 10:16 a.m.)

CHAIR: Technical Tuesdays, ladies and gentlemen.

MS. McMAHON BL: I've checked Mr. Akhtar can hear us

and see us. If the sound is weakened or goes again, if we cut the visual link the WiFi is apparently weak at the other side. We want to see what we can do.

Perhaps, Mr. Akhtar, that gives me the opportunity to focus very much on what I need to ask you about so we make best use of everyone's time. So rather than take you through the scene-setting issues, the last paragraph we looked at in your statement mentioned a couple of things that I would like to ask you about. I'm going to deal with them in topics rather than in chronological order. 10:31 10:32

The first thing mentioned in that paragraph 34.1 of relevance is the MDT. I would like to start with that. You've said the local MDT started in late 2009 on Thursday afternoons, followed by the regional MDT via video link. Now, this was the start of this formalisation of multi-disciplinary teams during your time. 10:32 10:32

A. Yes. This was as the part of IUG, the Trust was now going to centralise some of the services as well as to see the cancer patients combined so there could be a better decision made out for the management of the patient according to the Guidelines. So that was the remit of the MDT. It was organised. There should be a quorum of the team and we -- as you know, when we start a new service or a new development, it always takes time. I don't remember the exact date but 10:32

I think it was towards the end of 2009 and the start of 2010 when we got up and running. It used to start at half, quarter-past-2 in the afternoon and go up to 5 o'clock sometimes. The last part of the MDT was to have a video link with the Belfast Trust where the Oncology will join us.

25 Q. If we go to an email at TRU-282723. This is an email from Patricia McConville to you and others. What it does is set out that you had been agreed to act as Interim Chair. 10:33

A. Yes.

26 Q. It gives us a sort of starting point. That's TRU-282723, just at the bottom. We'll see -- just back up. Thank you. Patricia McConville, sent on 18 May, 2009, to you, Mr. Young, Mr. O'Brien, Kate O'Neill, MJ McClure, Jenny McMahon, Grainne McCusker, Gareth Maclean and others are copied in. It reads as follows: 10:34

"Dear all, Thursday, 11 June, 12-1:30 p.m., Seminar Room, 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 three 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. 10:34 10:35

Need to define what would be required with regard to the job plans, support, et cetera, 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)."

Then it says:

10:35

"Agenda to follow in due course. Regards Patricia".

The 18 May, 2009, gives us an indication of when there was at least an informal gathering in anticipation of a more formal process and you were to act as Interim Chair. 10:35

A. That is correct. I think that is the date I remember. Not exactly, but that's the time I remember when we decided to meet and that came from Patricia and I think Alison Porter was the clinical nurse at the time, a senior cancer lead. The plan was to get all the stakeholders into one room and then decide. 10:36

Because, as she mentioned in her email, it requires quite a logistic IT Support, as well as job planning for all the consultants and other stakeholders. This was, I think, the initial meeting that was convened in order to go into the future when the meeting start. The actual meeting started later. 10:36

My role as an Interim Chair or to take it as a lead role, because I was coming from Addenbrook, I have some experience of attending the MDTs and arranging with my colleagues at Addenbrook. That's why I was asked, nominated to take as an interim. It was not an election process, it was a nomination process. Later on it was converted into an election, when I left. 10:36

27 Q. Were you asked to take it on or did you volunteer, what was the process?

A. I think everybody was asked, so I volunteered, that's what I remember. 10:37

28 Q. Did you say - I'm sorry, the link is good enough but not brilliant - so you'll bear with me if I ask anything again. Did you say you had previous experience of MDTs? 10:37

A. I do have an experience of MDT, because in Addenbrook the MDT was started some time in 2005 or '6, already going on to discuss the cancer cases where I used to attend regularly as a member of the team when I was at Addenbrook. So I know how it works, how the cases were prepared, and what other stakeholders need to be involved. 10:37

29 Q. So you came to this role with knowledge and expectation of what was required to make this a successful and fully functioning MDT? 10:37

A. At the time when I joined, at that time, that was not anticipated. But when, in 2009, when the process started and the IUG Guidelines need to be implemented, then certainly my previous experience counted in order

to establish this.

30 Q. Now you agreed to act as Interim Chair. Do you know how long that interim-ship lasted for?

A. I think it lasted until the very end. I left in March 2012, for almost two, two-and-a-half years. 10:38

31 Q. Just from this remove, can you recall why you stayed in that post on an interim basis or perhaps you were formally nominated and elected. Was that the case or was it always interim until you left?

A. I don't remember exactly, but I think it was always interim when I left. I never pursued it to become permanent, because the work was happening and I was quite willing to do that. So I wasn't actually fussy about that it should be a permanent or an elected one. Everybody was happy for my work to carry it on, so I have never given any thought about the designations, honestly, at the time. 10:38 10:39

32 Q. Now, the Panel has heard evidence around the MDT and the functioning of that, and MDMs, and the way in which decision-making operated. I would like to ask you some general questions around that to get your take on that, given you were the Interim Chair for a three and a half year period. Now obviously this was in the early days when it started up. 10:39

10:39

You did mention in your previous answer a few moments ago about quoracy and the importance of everyone being around the table. What was your experience from the beginning and during your chairmanship of the MDT, what

was your experience of quoracy?

A. My experience was quite mixed to start with because it was a new venture we were starting, and we needed to have other consultants. Like as I said, it involved the Consultant Medical Oncologist, Clinical Oncologist, X-ray Radiologist, and Pathologist, and also a Consultant Urologist, a couple of them being members of the team, CNS team. So it is quite a big undertaking for the job plan. 10:40

But, once we started, gradually the thing started working well, but there was always teething problems. My experience about the one, especially the Oncology Team on the start, the presence of them was slightly difficult. I think there was nobody in the post for some time. Then, linking in the problem there was some time, I remember Prof. O'Sullivan used to join us on the link when nobody was available. There are a couple of emails which I, during the course of my leadership, I wrote to Alison Porter expressing my concern that not all the members were available so I advised them to look at their job plans and make sure every member is available. 10:40 10:41

But I believe that was the start of an MDT process, so it takes usually time to arrange all the stakeholders, their job planning, logistics, so that was going on. But towards the end of my tenure, it was getting better, the attendance. 10:41

33 Q. Now, you mentioned the MDT, the regional MDT that followed on from that. The Panel have heard evidence that services subsequently provided a pathway to Belfast depending on their complexity following the review. We will move on to that in a moment. Can I ask you, generally did you have any experience or awareness of delays in patients being referred or transferring up to other services as a result of quoracy problems? 10:42

A. My job was to have the outcome, sign it off, then give it to the relevant consultant whose patients they are, and those consultants are responsible. As far as my patients were concerned, I never had any issue. I think we were quite okay, but I was not made aware of, during my tenure, that there was any issues with other patients. If there were, I was not a part of any communication at the time. 10:42

34 Q. So if there were any delays or issues, you weren't aware of them?

A. No. I certainly was not at the time, during my time. We always gave, I think, a couple of weeks after MDT to see those patients in the post-MDT clinic because it was evolving. So there could be some delays for a few days to see those patients, but outcome was very clear, because I was very particular in writing down the outcome and made sure that they are signed on the same evening after the MDT. I spend a couple of hours after finishing off MDT to sit with the coordinators to sign each and every piece of paper which we generate as an 10:42 10:43

outcome, so my job was done. After that I wasn't made aware that there was any delay. I expect every consultant, if an agreement was made to send a patient to Belfast, should act on that.

35 Q. Well if there wasn't quoracy at a particular meeting, did that, in your experience, result in the meeting being cancelled or decisions being put back? If we don't use the umbrella term of "delay" and just look at it from practical purposes. If everyone wasn't sitting around the table who needed to inform a decision, was it the case in your experience that that could have meant that people were referred to the next meeting or a decision had to be delayed? 10:43 10:43

A. There are certain instances which, as a Chair, I will remember. Not remember, but recall, where the patient cannot be discussed, but my references were very clear. I never postponed any patient if relevant, another consultant patient, and the consultant is not available because I spent the time prior to MDT to prepare those patients' information on the piece of paper so that I have all information regarding their clinical presentation, their x-rays or any imaging, their pathologies. So it makes it easier to make a decision. 10:44 10:44

Yes, sometimes the patients are postponed due to the incomplete information available, like pathology results are not available. I don't recall that I ever postponed during my tenure any patients that, 'oh, the consultants are not present in the case', which I think 10:44

was not the essence of an MDT.

36 Q. Thank you for that. We're just trying to get a feel for the way in which the absence of the relevant experts may have impacted on the operational outworking of clinical decisions. From what you've said, there may have been times when delay was a factor. 10:45

A. Yes.

37 Q. But for your particular patients, you had created a way of working that allowed you to have all the relevant information that gave that patient the best chance of being able to be discussed at the MDT at the very least? 10:45

A. Exactly. That's the purpose of MDT. It is not to delay the things, because we cannot be all the time present all of us, but if there is a minimum quorum of the MDT present we can think and make a decision in the guidelines. So I think that's the best way to do. 10:45

38 Q. Was it your experience -- or did you have any experience of having to speak to your clinical lead or any of the medical senior staff around quoracy issues or any aspect of the MDT, the way it operated at all? 10:45

A. I think, if I recall, there might be a couple of emails or communication between me and Alison Porter in which I expressed a few issues regarding the presence of the oncology sometimes. It is not to say that the service was not present, but it was to look at the job of job-planning for other specialists, like radiologists, so that they should be allocated the appropriate time for preparation of the cases. So those were always 10:46

issues and I expect those issues at the start of a meeting, when you start a new meeting will be there. And I believe later on they were resolved during my presence, the majority of the stakeholders were present. 10:46

39 Q. Do you have any recollection of there being a problem or problems that existed at the beginning of your chairmanship of MDT that were still in place at the end when you were leaving in 2012?

A. Sorry, I didn't get it. Can you repeat? 10:47

40 Q. Well I'm looking for any themes of potentially persistent issues in the MDT that hadn't been addressed. I'll give you some context for the question?

A. Of course. 10:47

41 Q. The Panel have heard evidence that quoracy was an ongoing issue for quite a long time. That's recognised for many reasons, including staff retention and getting people in posts. There are also some issues around communication, the way in which decisions were made, 10:47 oversight of those decisions.

I'm asking you, given you were there for quite a period of time and perhaps in an oversight role, even as Interim Chair, if that was the term that was used for 10:48 that period of time. Do you recall if there were issues that threaded their way from the beginning right through until you left when you thought, that's still an issue, that hasn't been resolved at the MDT, that

problem still persists?

A. As I said, obviously the start was always an issue, as I said due to the job planning and not having enough people in the post. Like, oncology was always an issue, I don't know whether it is sorted out now or not but I believe it is, but I cannot now recall after ten years, 12 years, what is the situation there. 10:48

Yes, oncology was an issue because that was not due to any person in specific, it was due to the lack of people in the post. And, yes, I did have some time, not always, but sometimes, not an issue but a concern about the presence of a radiologist on the meeting. But, again, my radiologist Marc Williams, and another Dr. Gareth Williams, they were excellent, but they have to be on annual leave and things like that, so those issues were related to the job plans. I believe when I left some of them were resolved, but not completely. 10:48 10:49

42 Q. What about the level of communication among the team at the MDT? Was it your experience, for example, that there was open discussion around treatment plans that were proposed and was that a collective decision, or did the individual clinician state what their preference was and the MDT only got involved if they felt that there should be another way? 10:49 10:49

A. The purpose of MDT is to provide, given the information about the patient, and the staging of a particular cancer, according to the Guidelines what could be the best treatment for that particular condition. Then

this is conveyed via a communication to the outcome sheet to the relevant clinician to discuss with the patients.

In some diseases there are more than one choices and we mention alternative treatment options, but it is between the clinician and the patient to discuss those options and come to a conclusion, based on the patients's understanding, to give a best -- a treatment to the patient. 10:50

So we were not there to manage each individual's practice, but we were there as an MDT group to give an outcome which, in the form of a guidance, could be conveyed to the patients by a clinician in charge of the patient. But I never had any issues because my communications were very simple, straightforward, and conveyed within 24 hours after finishing the MDT. 10:50

43 Q. Thank you.

Just again for context, we heard a lot about the way in which MDTs operate and I know you are explaining that in your answer. If it helps at all for your answers, the Panel is interested in your experience of how these things operated in practice. We know the theory of an MDT and MDM's general. We know the way they are expected to operate. What we are seeking to elicit from evidence from clinicians is where there might be fracture lines in some of the operations that may have 10:51

allowed issues to emerge, either at the time or subsequently, that have come to the attention of the Panel.

I'm trying to focus my questions so that if you have particular experience, then that would be really, really helpful. But what I'll take from your answer is that from your patients' perspective, this wasn't necessarily an oversight, the clinicians weren't there to look at another clinician's decision, but to share their views on what would be the most appropriate form of treatment based on the current guidelines, is that correct? 10:51 10:51

A. That is correct.

44 Q. Did you have experience at all of decisions having been taken at MDT and then perhaps being brought back to MDT by a clinician who perhaps has changed their mind, for whatever reason, on the proposed course of action? 10:52

A. As a general, my practice or anybody's practice should be that if they notice when they go and see the patients, any change in the patient condition or any wishes of the patients to stray away from the guidelines to bring it back, but I don't recall. Honestly, it is a long time ago, that ever any patients were brought back. If it is brought back, I am sorry, I am not much help to recall this at this moment. 10:52 10:52

45 Q. That is fine, I appreciate it is a long time ago. But perhaps to put that in context, how often would that happen now? If you can't recall it in Craigavon, do

you say now, well, that very rarely happens in MDTs, my experience is that it rarely happens or maybe 5% of patients are reviewed again. What's your feeling after all these years?

A. I can't put a percentage figure but as a clinician, myself and my colleagues which we are working together, we always feel it is much easier that if there is any change in the clinical circumstances. But I said one thing, patient wishes: If a patient wants to go away from the guided treatment, like there is so much on the internet available and they wish to go and do something else, they want to do that. So we always bring it back to the MDT to inform MDT or take a further guidance: What should we do in a scenario like that? I think this is routine practice nowadays. If you ask me, nowadays we have an MDT of around 60 patients on SMDT, RMDT, original MDT every week. We can say there is always one or two patients, but it is always the clinician who brings all the information and then asks a second opinion from all of us. 10:53 10:53 10:53 10:54

46 Q. It may come back either through the particular patient's view on what was offered and they might change their mind, or the clinician may find new clinician information that might inform a different decision? 10:54

A. Yes.

47 Q. In your practice, what way is that information recorded, if at all, in the patient's notes or with the patient. If you have discussions with the patient, for

example, where would one expect to find the evidence of that?

A. Okay. Now, if in a particular -- if I can highlight it with a particular example, like, for example:
A prostate cancer is nowadays one of the majority diagnosed mens cancer and get a treatment which has quite varied options available, from radiation, active surveillance and surgery, but also there are some clinical trials going on, like focal therapy and things like that. 10:54 10:55

If a patient wished to, because they get it from Internet, they get it from Google, they get it from all other multimedia resources nowadays available. Some of them do have a cuttings of the piece of paper and they want to go and see the specialist who is in the news or they have information about. So I always inform my MDT that this patient has taken a decision to take a second opinion regarding treatment, which is not on the guidelines pathway, but maybe in a clinical trial, and we do document that in the MDT outcome. So if tomorrow something else happened, then we have evidence that it was discussed on the patient's wishes. 10:55 10:55

48 Q. I just want to divide my next question up into two parts because of what your answer was there: First of all, you mentioned "guidelines" and I just wonder if you can recall, and applicable now I presume, the guidelines that you adhere to as part of your practice as a Urologist? 10:55

A. Yes, I do always adhere to guidelines. There are various guidelines available for various conditions, especially in the cancer. We do stick to NICE Guidelines. We stick to the European Urological Association Guidelines, okay. The guidelines doesn't mean that we have to be -- it is just a general information and also the best evidence available for a particular treatment. So that's the way we deal with it. But there are always exceptions to them sometimes and if there was exception arise, that's what the purpose of MDT is, to have a maximum information about the patient. 10:56 10:56

49 Q. If you are adhering to the guidelines, that's fine, not everyone fits within that profile. If you want to take a decision to, I won't say step outside the guidelines, but I will ask as a second part of that question; if you were to go off guideline or seek to prescribe a drug in a way it is not licensed for, and we'll move on to an example of that in a moment, but just generally, what steps would you take if you were to do that? 10:56 10:57

A. I would certainly bring it to the MDT that if I feel about some new treatment available, or if I'm going to go -- first of all, I shouldn't do that if there is something not evidenced available for any particular medication. But if I -- if the patient is insisting, then I should certainly go back to MDT and/or another multi-disciplinary meeting, or into the Department at least that, can we adopt that policy or can we look 10:57

into that? And I am sure in today's world, in a Clinical Governance, there are ways of introducing some new treatment if they are beneficial to the patient.

50 Q. I don't know if the system was the same in 2009, but was it the case that you may be the consultant for someone but one of the other consultants may review them at the Outpatient Clinic. So you didn't always get your own patients at Outpatients, other people could have reviewed your patient? 10:57 10:58

A. At the time when I was there it was not a common practice the majority of the time. The patients, after the MDT, are seen by the clinician who is referring them to MDT. But I believe things are changed now because of the certain targets to be achieved. So the patients are majority pooled into a category so they go to the relevant specialist after the MDT to a get appropriate and quick treatment rather than having multiple reference. 10:58

51 Q. Would it be your view that if a patient was to be prescribed something that wasn't licensed, a form of medication or a regime that was unlicensed, that it would be more beneficial to bring that back to the MDT so if the patient got a different consultant on their next review appointment that that consultant understood why they were on that particular regime. Do you think that would be best practice for you? 10:58 10:59

A. Yes. For me it would be the best practice, it will be that, first of all, I will be reluctant to use a target

in general terms about any medication which is not licensed not to use it. But if I take the benefit and a patient wants some more information, I should bring it back to a minimum. If MDT is available, sure, if not, then an inter-departmental meeting to discuss with other colleagues what their experience are under the trial and take it further. 10:59

52 Q. Did you ever have any experience in Craigavon of reviewing another consultant's patient and seeing they weren't on a licensed regime that you realised as being appropriate? 11:00

A. I don't recall any patients which I have seen because everybody was seeing their own patients at that time, fortunately or unfortunately. So I'm not aware of any such incidents which I have seen patients with something which is not approved. 11:00

53 Q. Now the Inquiry have heard evidence in relation to the prescription and administration of Bicalutamide 50 as a monotherapy. Now, are there any circumstances under which you would prescribe or use Bicalutamide 50 as a monotherapy? 11:00

A. No, not in my practice. My practice will be if a monotherapy is going to be used, the clinical evidence which emerged in the late 2000s, 2003 or '4 I believe, was using a Bicalutamide of 150-milligrams and that was also associated with some higher risk factors which need to be negotiated and looked at. So not as an independent, no, I'm not aware of and I never practised that. 11:00

54 Q. You've mentioned in your evidence there about clinical evidence which emerged in the 2000s, I think you said. Was it the case that by 2007 when you joined Craigavon, that Bicalutamide 50-milligrams as a monotherapy was already established as not being effective? 11:01

A. I don't recall any evidence. But I do recall that 150-milligram was established as a monotherapy at that time when I joined Craigavon Hospital, as a monotherapy at 150-milligram, not 50-milligram.

55 Q. Under what circumstances and in what way would you prescribe Bicalutamide 150-milligram as a monotherapy? 11:01

A. Like a patient with prostate cancer who doesn't want to have any side effects of allegoric analogues or castration, number one. Number two, with the patients who want to preserve some of their erectile functions. That was the main reason for that to use it. 11:02

56 Q. Are there any circumstances that you would prescribe Bicalutamide 50 at all?

A. My own personal practice, no, I will not use. I only use it in circumstances where it is -- it is called as a "combined androgen ablation", as a part of LHRH analogues which are the other medications which decrease the amount of testosterone. So this is called anti-androgen and also called as an anti-flare. It is prescribed as a four-week medication, once-daily-dose, while a 50-millgram prior to giving the injection of LHR and HLR if they flare up due to a shortage of testosterone that should be controlled. Apart from that I never used 50-millgram Bicalutamide as an 11:02 11:02

independent treatment on its own.

57 Q. So you would use it for a limited period of time as counteractive flare that might occur and then the patient would come off that and continue on the hormone therapy? 11:03

A. Exactly. This is part of the combined hormone treatment and it is usually on the start of the treatment.

58 Q. If you were to see a patient at a review clinic and they were on Bicalutamide 50-milligrams as 11:03 a monotherapy, and you have indicated in your professional opinion there are only certain limitations for Bicalutamide 50, and monotherapy isn't one of them. If there was a patient in front of you who was on that in that way, what would you do? 11:03

A. I will certainly question the use of a 50-milligram and I will suspect is this a prescription error of 150 instead of 50 used. Then I would request the clinician if they started to review that back and see if we can discuss. 11:04

59 Q. I presume the letter -- I think you said you'd write to the clinician, the letter would also be copied to the GP, I presume, so that there's the care in the community continuity. But would your letter, in your view, be better to indicate that there had been 11:04 a change in treatment regime and the reason for that change. Would you expressly state that?

A. I will certainly hold on for the time being before escalating and certainly question my clinician

colleague if they have decided to use 50-milligram and have a better understanding before I will write that to the GP and make an amendment to the medication, if required.

60 Q. So you would speak informally to the original prescribing clinician, try to understand their reason, and perhaps formalise that in correspondence for the record? 11:04

A. I think so. That is the best course in today's medicine. You should be very clear about it. 11:05

61 Q. Did you ever have any cause to do that while you were at Craigavon?

A. I never remember that ever I seen a patient. I said at that time. We were very, very, meticulous about seeing our own patients. So at the time things were changing. 11:05 So I don't recall that I ever come across any patients with 50-millgram of Bicalutamide.

62 Q. If a patient had been put on to 50-milligram Bicalutamide as a monotherapy and they were being seen by you, and the patient believed that despite your view 11:05 that that was not an effective treatment for them clinically, but the patient wanted to stay on it because they felt some benefit, even though the evidential basis for any benefit hasn't been established to your satisfaction as a clinician, if the 11:06 patient wanted to stay on that medication what would you do about that?

A. Certainly as a clinician, my job is to advise the patient, inform him that there is no clinical evidence

regarding using the low dose so it may not benefit you, but I have to respect the patient. But at the same time I would have to inform the clinician as well as the GP that this is not the correct dose.

63 Q. Would you change the dose? 11:06

A. I would certainly ask the GP to discuss with the patient at the moment the patient has, as you said, the scenario given to me, the patient is quite happy, that's what I need to inform the patient, that is an incorrect dose so you should increase it. If the 11:06 patient wants to increase, certainly I will change it in the clinic. But if he wants to think about it in the presence of my discussion then I will let the GP know about it.

64 Q. Is there a potential that you would leave the patient 11:07 on that treatment regime?

A. At the moment, that is the minimum, I will certainly do that because it is not harming him in any way, but it is not providing any further medication treatment. But I will certainly escalate, as I said before, and ask 11:07 that we should make it very clear as a policy of the Department to change it or see the evidence available.

65 Q. What do you see as the risks of Bicalutamide 50-milligrams -- micrograms -- as a monotherapy? What risks are there of that? 11:07

A. I don't see that there will be any risk apart from any other anti-androgen treatment risk, but rather it has less of a risk factor compared to 150. If you give 150-milligram in monotherapy, obviously there are

increased risk of gynaecomastia, hot and cold flushes, things like that. But with 50 that is a little bit less as compared to 150.

66 Q. I suppose from a Patient Safety and Risk perspective, there arguably could be a couple of issues that arise. The first one being that the patient is on an ineffective treatment? 11:08

A. Yes, of course, that is something which is, as you asked me, the side effect compared to the 150. But this is also that the patient is on an ineffective dose of the treatment so it may not be helping him in any way. 11:08

67 Q. Yes. And being on an ineffective treatment, the corollary of that is that they're not getting the best treatment. That's also a potential because they are not being treated perhaps in a way that would be most effective? 11:08

A. Theoretically, yes.

68 Q. There's also a risk of hormone resistance therapy, is that right? 11:08

A. That is with every hormone treatment. Either you use 150, 50 LUL LHRH analogues. There is a time period when the clonal selection happen and the cancer escape it and then there is hormone resistance. It is a common occurrence after, on an average, between 18 months to 36 months at the maximum, where any hormone treatment given to the patient for treatment for prostate cancer lead to a cloning selection and hormonal resistant treatment, then you need to change 11:09

the treatment.

69 Q. You've said that it is a potential for any hormone treatment that hormone resistance builds up?

A. Yes, of course.

70 Q. Surely the point really is that that's a risk you take if the patient needs to be on hormones. But if they're on hormones and it is not the most effective treatment, then it is a risk that is being taken by the physician in just keeping them on a low dose. So, for example, if they needed a higher dose at a later stage, they could have built up resistance to that and therefore the efficacy of the treatment may be compromised. Isn't that right? 11:09 11:09

A. We're looking at the two different scenarios. One is the scenarios in which a 50-milligram of Bicalutamide is used, which is not a complete hormone blockade, it is just anti-androgen, as compared to the hormone/hormone treatment which include Bicalutamide and anti, and LHRH analogs, or anti-testosterone medications. 11:10 11:10

So, in that case, which is the combined androgen blockade consistent of Bicalutamide and the drugs related to that, plus LHRH analogs, those medications are having certainly hormonal resistance develop on an average between 18 to 36 months, whereas with the Bicalutamide 50-milligrams, I have no evidence how quickly a resistance will develop because you are not using the complete blockade of the testosterone, you 11:10

are using one step of it.

So, it is very difficult for me to give, will it be ineffective. Theoretically I can tell you, yes, it will be ineffective. But will the resistance develop? Theoretically, yes, there will certainly be a resistance developed for escaping the testosterone. But the scenarios which we combine is slightly different. 11:11

71 Q. Would you agree that best practice in medicine means that even in the face of a patient who is very willing to continue a treatment regime that may be clinically ineffective and present long-term risk to them, the best practice means the doctor steps up, as it were, and doesn't prescribe that just to keep the patient happy? 11:11

A. I agree with the statement, yes.

72 Q. I just want to ask you a couple of questions back again about the MDTs, if you don't mind, just based on some of the evidence, just to understand the context. This is really just so we can be sure what the evidence is. 11:12

I think we have looked at this, if we go to WIT-41832. This is simply paragraph 1.1. At the top line of that page you have said: 11:12

"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)."
Do you recall if it was Mr. Young who asked you in 2009 to be the lead clinician of the Southern Trust MDT? Is it your recollection that it was Mr. Young.

A. It was Mr. Young as a lead clinician of Southern Trust Urology throughout my tenure as a consultant at the Craigavon Area Hospital. 11:13

73 Q. Did the MDMs, the multi-disciplinary meetings, did they begin in April 2010, is that your recollection?

A. I think so. I'm not exactly sure but I can recall from some of the emails and the correspondence I read. As I said in my statement, I think it was the end of -- if you remember, the first email went out to start a planning, was in May 2009. So I think, yes, you could be right, that it is towards the start of 2010. 11:13 11:14

74 Q. Before they started in Southern Trust, did you attend the regional MDM in Belfast?

A. No, I never went to Belfast. I only attended via video link when we started here.

75 Q. I think we've already established that you were the Chair of all the urology meetings, except when you were on leave from April 2010 until March 2012. Do you have any knowledge of who might have, and I know it is a long time ago, but who might have deputised for you when you weren't available to act as Chair? 11:14 11:14

A. Usually when I went on annual leave or not available on that particular Thursday, I deputised on the basis of who is available. We always discussed. Because what happened is that we three worked very closely together

and we had a scheduled meeting also actually once-a-month, which was very effectively run by Mr. Young.

We have a spreadsheet on an Excel sheet where we assigned the duties and the roles in the case of an absence. So I'm sure we can look back on that. We always deputise either Mr. Young or Mr. O'Brien to Chair the meeting. 11:15

76 Q. So it was really who was available? 11:15

A. Exactly. Because that's the way most of the MDTs work. It is not there is a particular -- especially when we are only three Urologists. If I am not available, because I have taken it on my own to lead it, which means do all the preparation. So it is my responsibility to make sure either Michael or Aidan are available to before I go on leave to deputise and do the preparation work. 11:15

77 Q. If we go down to paragraph 1.3(b). You said at the start of this paragraph: 11:15

"During my time as consultant urologist at SHSCT we had significant issues regarding 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; 11:16

(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 Craigavon Area Hospital. These were resolved very well and any new MDT would have the same issues." 11:16

I just need to check my reference for that letter. I just want to ask you about that. WIT-282, sorry, TRU-282770. 11:17

We'll see this letter to Gillian Rankin. Go to the very end of the letter, please, to the signature.

This is from you to Gillian Rankin. You have copied Mr. Young and Mr. Mackle into that. It is 11:17
1 November 2010. You say:

"Dear Dr. Rankin, re the implementation of regional urology: 11:18

In response to your letter dated 22 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. 11:18

The first issue is clinic and review numbers. The Trust is aware 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 had been changed some time 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 patients, which include especially the prostate cancer day-four patients, as well as the new patients to be seen under the red flag target system.

11:18

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 the number of patients in my clinic at both sites already are above average, considering the cancer patients need more time to discuss their condition.

11:18

11:19

We should agree to setting up a specialist clinic separately where red flag target patients, patients generated from MDM and histology, day-four, especially for the prostrate cancer patient should be seen giving them due attention and time to explain and understand their disease to discuss the outcome of various treatment options. The number of patients seen in those clinics should not be six or seven per clinic.

11:19

11:19

As mentioned in the letter about the BAUS clinic, numbers are expected to be high than 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 clinic. So I am unable to change the template of my clinic at present until we separate the cancer patients from the general clinic. 11:20

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. 11:20

The second point was new to review ratio as you mentioned, that my new to review ratio meets the old requirements, but I certainly have some review patients over the last two 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 time frame. Yours sincerely, Mr. Akhtar." 11:20 11:21

You have mentioned quite a few things in the letter, there has obviously been a lot of issues rumbling on, one of which is the issue of the applicability of

guidelines, the BAUS. I know you have mentioned the new ones, but if we just move up to the previous page you have said at the bottom:

"As I mentioned in the letter about the BAUS clinic, number are expected to be high...". 11:21

Just at the very bottom of that page:

"...than what I see at present. I am sorry to say we are very selective in picking what suits us most from any guideline." 11:21

I wonder if you could can talk us through the context of that sentence?

A. Of course. This was actually in relation to, as you're aware, the new triage system was coming. We were getting more and more targets for the cancer treatment and cancer diagnosis and following the MDT, the patient needs to be seen within a particular time period, as well as we have to discuss with the patients about their diagnosis. 11:22

So I was actually trying to highlight, number one, that we need a separate clinic for the post MDT patients, which is now quite norm actually in most of the Trust nowadays, but we are talking at the time, things weren't being settled. As we have the same routine when I was working in Addenbrooke, that if a patient is 11:22

diagnosed with a cancer, he would come to a dedicated clinic where he is supported by a nurse, a doctor, taking the time to explain to him that 'you have a cancer diagnosis'. That is breaking the news and then giving them time to listen to the treatment options that are available or further investigation. So that is quite a passionate type of a service that you need to develop. So you can have a patient for almost half-an-hour, sometimes up to 40 minutes to go through one patient. 11:22 11:23

So I was trying to establish that what The Trust was trying to say, my understanding is, that what the previously established template was, we should accommodate this patient into that. So there was two reasons for me to highlight it because that was not the environment I would like to see my patient with cancer in the General Outpatients. They should be in a quiet room or something where we can see them. Then we establish it later on in the Thorndale Unit where we see them and take it through. 11:23 11:23

So, yes, there was some pick and choose from the guidelines, okay. If my manager is saying to me that your BAUS guidelines, the BAUS guidelines say that you can see up to 12 or 14 patients. But when you put a cancer patient into that, which, after coming after MDT, that number should be reduced because cancer patients certainly take more time and an explanation of 11:23

their disease, and giving them a time to take in all those informations which we are providing to them.

78 Q. As a clinician in the MDT you were feeding back what you saw as the operational and clinical difficulties of trying to meet the guidelines while also providing the best service for patients? 11:24

A. Of course. Of course. We actually, we actually then later on developed, after this letter I think, we developed a Thorndale Unit service where I used to see the patients of mine after MDT and giving them a diagnosis of cancer in some unfortunate patients and take them through. And there was a quiet room also, we established a quiet room in that area where the patients and family can sit and have a discussion about the diagnosis. It is a very, very, significant news and life-changing for some patients unfortunately. 11:24

79 Q. Was there any sense from your perspective that when the MDMs had been setup in April 2010 that there was an expectation from the clinicians that it would be resourced sufficiently to meet both the guidelines and the demands of the service. I presume that was the hope, but was it explicitly stated you would get all the support you needed? 11:25

A. Of course when the changes were coming and this MDM was established, it is the one part of that, it is how we are going to deliver that. As you know from the very beginning, even in starting MDM we need a lot of work to do in bringing all the stakeholders. Similarly, the work which related from MDM should be seen somewhere 11:25

appropriately.

So, yes, we were reassured but it always takes time the way things sometimes work. We might have to change our own job plans, we might have to change our own practices sometimes in order to accommodate these changes, which I think I did with the help of our manager and operational team.

80 Q. I just want to take you to another letter, AOB-82521. I hope this is the letter of 5 July 2010. It's to Alison Porter, the Head of Cancer Services. If we look at the bottom we can see who it is from. It is from you and you have copied in Gillan Rankin, Mr. Young, Mr. O'Brien, and several other people including the two CNS nurses at the bottom. Could we go back up, please. 11:25 11:26 11:26

Now this is where you set out the issues in relation to the Urology MDM. The reason why I want to read this and put it on the record and ask you about it is because you identify some concerns. It will be for the Panel to consider whether they may have contributed in any way to governance issues that subsequently emerged, or whether there was an opportunity to address issues early on. So the title is "Issues relating to the Urology MDM meeting": 11:26 11:27

"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 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. 11:27

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: 11:27

1. Post-MDM follow-up coordination of these patients. This is a very important issue as MDM is running at its full strength at present and there are between 20 to 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'm aware, there are two problems: 11:28

(a) There is no clinic formalised 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: 11:28

(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 Room 2. 11:28

Some of these patients have been neglected as there are not appropriate clinic spots available or their investigations were not booked because of the ownership of those patients and responsibilities." 11:29

Paragraph 2 your letter:

11:29

"The availability of personnel when some specialities are on holiday: I do agree that we need to take our annual leave, but in the meantime we have to have access to some alternative arrangements like colleague cover. 11:29

3. There is an issue of availability of microscopy. I have been told that the microscope has been ordered but it is almost three months since the microscope has become available and this is a huge Clinical Governance issue. 11:29

4. Arrangements 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. 11:30

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 can get lost in the system. 11:30

When we started in April we were promised that all these issues would be resolved by 1 June. I am adamant that up to now nothing has been resolved and it is getting very frustrating. I am thinking that there is no point to the MDM if there is no infrastructure in place and the arrangements made for the above issues. Your sincerely, Mr. Akhtar." 11:30

Now you'll see why I read that out, not only the content but the reference specifically to Clinical Governance, patients getting lost in the system. Patients not being followed up. The microscope issue

not being available and there being obviously clinical concerns. It would seem that a lot of the content of what you have drawn management's attention to is outside the hands of the clinicians. Would that be fair? A lot of those issues can't be solved by the medics? 11:31

A. Exactly. It is basically, what it needs is if we go one-by-one to them, the first issue is about: How do we organise the post-MDT coordinated clinics, that is what was required. I think we achieved that gradually by formalising that into some fewer slots with patients to be seen with the presence of a nurse there, okay. 11:31

The second issue, as you said, availability of a person when some specialist is on holiday to take up each other's work so the patients are not delayed. Like my point here was to make sure that if it is Aidan's patient, my patient, or Michael's patient, if one of us is on a period of time on annual leave, so somebody should take over those patients to see them more quickly, rather than they are waiting until the other specialist comes. So it was trying to establish a collaborative force of working together. I think we are then agreed that streamlining the prostrate cancers or the bladder tumour cancer. 11:31 11:32

Microscope was always an issue because it was a very integral part of our MDT, the pathologists need to show us the slides and they need to make sure the slides are

seen. So that's why it was not present at the time when we started. It was one of the issues which had arisen and I took a time, approximately 3 to 4 months before I can remind them. So this letter was a reminder that some equipment was missing and we should highlight it. 11:32

Similarly, arranging -- the majority of the context of this letter was to arrange post-MDT clinics in a better way, that the patients are seen on time and taking an ownership of collectively, and then they should be got back to the follow-up if they are required accordingly. 11:33

81 Q. There seemed to be a package of concerns that would have impacted on that decision-making.

A. Yes. 11:33

82 Q. Just taking the microscope, I think you mentioned a necessity for slides to be available for proper informed decision-making, you said it was almost three months since it has become available.

A. Yes. 11:33

83 Q. At this remove, and I know it is easy to look at that as a very simple issue, but was that a case of purchasing or ordering a microscope, or what in that particular example would have caused a delay of three months? 11:33

A. I don't recall what happened exactly. It was the issue about some sort of funding and who is going to purchase it, which Department it is coming from. So I think Alison Porter wrote back to me on 26 July in the letter

addressing those issues. I think the majority of that was resolved. It is TRU.

84 Q. You've said that Ms. Porter replied on --

A. 26 July 2010.

85 Q. -- 26 July. We are going to look at that in a moment, the detail of that. But what is your recollection from a practitioner's point of view: Did you feel that your letter had galvanised some efforts to improve things or to bring about the change that you hoped by writing this? 11:34

A. You always write the things. First, the way, as the majority of a clinician's work, you always give it time. Nothing can be done in a short period of time. So when we establish a new service, you cannot have all the things available. So the things as we go along, the changes we need to make, that should happen. So my first letter was in July, which was approximately four months after we started MDT effectively, if you can say that. The purpose was to just nudge them that we need to change, we need to change, we need to bring a change about gradually, because it was a new way of working for some of us.

86 Q. Perhaps, just before, if you want, it would be convenient to take a break, if I could look at the reply, AOB-82529. She sent on 26 July to you and I will read Ms. Porter's reply, having read your full letter:

"Dear Mr. Akhtar, thank you for your letter dated 5

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: 11:35

MDM follow-up of patients: Previously patients requiring appointments for review, results et cetera, have been made by the consultants' secretarial teams. This would still be the case as this is not a role of the MDM coordinator. You may be aware that a review of administrative services is ongoing and that this is one of the many issues that will be discussed. 11:36

I do concede your point that these would be better given in a separate letter, a separate clinic, or allocated result slots, as previously, patients have been significantly delayed in the routine review process. At our last meeting on 10 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. 11:36

Ordering of onward investigations: As you are aware, 11:36

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 the ordering of radiology live in the meeting.

11:37

As you are aware, we do not have a process for red flagging patients with suspected cancer and it would be helpful if this was used...".

11:37

Sorry, I think I read that incorrectly:

11:37

"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.

11:37

The setup of the computer in Theatre 2 is currently with that Department and the Capps Manager.

11:38

Regarding your second point on 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 specialities.

During the week of your letter the camera had arrived and was being setup and I understand that this system is now working and will enable the presentation and full discussion of pathology. 11:38

Regarding the management and guidelines of intravesical mitomycin and BCG, the 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 teams are working closely with the nursing staff, pharmacy and urology managers, et cetera, to produce these. I am happy to advise as able. 11:38

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 this should be addressed urgently. I am unclear as to the need for "someone" to be present at the MDM to "take this forward". 11:39

If the pathways, protocols, et cetera, 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? A decision needs to be taken by the Urology Team in discussion with their management. 11:39

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 laptop, will soon be completed. However, some areas are outside of my remit and I will pass these on to the relevant areas. Yours sincerely, A Porter, Head of Cancer Services."

So having read that in, it might be an appropriate time and we can come back to that point if that suits. 11:40

CHAIR: We'll come back, ladies and gentlemen, at five-to-12.

(Short adjournment - 11:40 a.m.)

11:55

CHAIR: Ready to continue?

87 Q. MS. McMAHON BL: Mr. Akhtar, I have read out correspondence back and forth and I wanted to draw the Panel's attention to the chronology of those, 5 July 2010 was your letter to Alison Porter. Her reply was 26 July 2010. Those corresponds were most particularly in relation to the MDM and the outworkings of decisions, et cetera, and the letter that I read perhaps, outside chronological order, was 1

November 2010 which was also making reference to the implementation of the Regional Urology Review, so that's the correspondence on the various issues that you brought to their attention.

11:55

I wonder if I could ask you, given that we've looked at the potential lack of infrastructure around some of the MDM provision, did you consider that inhibited linking-in with the regional MDM or inhibited working with the regional MDM?

11:56

A. I think, in my opinion, it was the start of a new service or the start of a new activity. And at that time, if we look at it, as you and me are talking online nowadays, without me present there - thanks very much for that - but if we go back 12 years and the IT and all that infrastructure was not very much advanced, so there was always a teething problem.

11:56

I believe towards the end of my tenure there, the majority of those linking-in things were resolved. I never had any issue in terms of any resistance to linking-in, because once a thing has to be done and I have been assigned to do that and it is for the betterment of the patient then we did it. But it was time and it was availability of the resources, availability of various equipment, which gradually include, as you see from Alison's letter as we said in July, that microscope was not available. So luckily at that time when she wrote back to me, the microscope

11:56

11:57

was replaced and fixed.

So as I said, as a leader, what you have to do is, you have to gradually nudge sometimes. You don't get all the things in one go, you get them bit by bit in NHS, so that's the way we work. We achieved the majority of the things which we were supposed to get. But if you say within four months, in my view that was quite an achievement within four months that we were up and running and we were linking, but still having teething problems which I think resolved later on during my presence there. 11:57 11:57

88 Q. I would like to ask you a couple of questions about the regional review of Adult Urology Services in April 2010. 11:58

Now, there were 26 recommendations of the review, as the Panel has heard. And for the note, recommendation 19, which can be found - we don't need to go to this - it can be found in TRU-282748, stated that: 11:58

"By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site at Belfast City Hospital by a specialist team of surgeons. The transfer of this work was to be phased in to enable the City Hospital to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed by all parties. There were ongoing discussions." 11:58

I just wonder, given your position on the MDT as Chair at that time and as consultant within Urology, were you involved in any of those ongoing discussions in and around April 2010?

A. I had just become first-time aware of that when we met, 11:59
I think, with Mark Fordham, when a suggestion of centralisation started, but I think it was at the middle or start of 2010. I think that was the recommendation.

11:59

So there are two things here: One is, if there are some changes being made by NHS, we have to abide by it because we are an employee for them. But, do we agree the changes are done in the right way? That is something that's always debatable. In my view we never 11:59
had any resistance in terms of -- we did have some reservation the way it is done, but by the time MDT was up and running, I think it was in August 2010 by that time when the surgery was completely transferred, pelvic surgery was completely transferred to the 12:00
Belfast Trust.

89 Q. Do you recall any reasons why there was any delay around the implementation of that particular recommendation? I think you said about August it had progressed, but do you recall anything in particular or 12:00
your understanding of it?

A. No, I never because I will give you an example; I did feel that there was some lack of clarity in some way. Because the first time I became aware of the surgery,

I was hearing that there was negotiation or changes were going to take place, but no date was given. So we were listing our patients as they were coming in. I think I had a patient listed some time in 2010 when I was told that I can do that surgery and the commissioner has now decided. I have no objection to that. That's fine.

So it was slightly, what do you call that, feeling frustrated that you have to speak to the patient and tell them that now you are going to Belfast, when the patient was waiting for the surgery in the hospital. So that was quite frustrating for me being a surgeon, that I'm doing a operation tomorrow and not to be able to do that. Apart from that I have no reservation. Work which needs to be done at a better place should be done there. So here you go, the things were moved from there onward.

90 Q. So you recognised the direction of travel for the more intensive or complicated surgery and although you, as a surgeon, would want to be involved in that level of complex operation I presume, you understood why there was a need for patients to go to Belfast for those operations?

A. Yes, I do understand and that is why we, in the NHS, always work towards the better outcome for the patient. It was the right decision, but I do have some reservation about how it is implemented and there could have been a better way of dealing with that, which

I did express. Like for example, at that time Belfast have only 2 or 3 surgeons. If they are going to take all the work from other Trusts also there could be a possibility of sharing some of that work. You can make a Centre of Excellence or specialisation in Belfast where surgeons from other Trusts can come, bring their patients and operate.

So that from Clinical Governance point of view and from maintaining the IOG guidelines, it could be a better outcome for the patient and also better satisfaction for the surgeons. But I am afraid that was not discussed ever. But that is me, my reservation, and it doesn't matter when it comes to the changes which are for the goodness of the patient. I just let the patient -- 12:02 12:02 12:03

91 Q. The Inquiry has heard evidence from some consultants from Belfast Trust and there was correspondence that did suggest that if complex radical pelvic surgery was to be done in the Belfast City Hospital then there would be a patient swapping potential, where they would offset some of their theatre time for nonradical pelvic surgery patients to Craigavon. So I think that might have been mooted at some point, but it's not clear if that was ever followed through. Is it your recollection that it probably wasn't? 12:03 12:03

A. I think there was some unclarity about a particular operation, about doing a cystectomy in a noncancer for benign reasons. And I -- going through the evidence

I came across an email, I think, from Eamon Mackle, which I wasn't part of that because it was just part of a bundle, that's what I looked at it, in which there was an indication that it was unclear about where that surgery be performed. But I think in August it was decided all the surgery should be going to Belfast Trust.

My point was not that on clarity, my point was slightly different. My point was to have a discussion with all the teams of three different Trusts in Northern Ireland and making a group of surgeons who can perform the surgery, either it could be at one centre where they all can work together. That was my point. That is slightly different than not -- it was not a resistance that, okay, for me, yes, they need to be done at one centre, sure, fine. That's a better outcome. But who perform that surgery? That was my point. 12:04 12:04 12:04

92 Q. So that's a different point, thank you for clarifying that. 12:04

It also lends itself to what I think you hinted at in your previous answer which was, it might have been more beneficial to have better communication between the teams, get, perhaps, better buy-in and understanding of the reason for it. 12:05

In relation to your patients, I don't get from your answer that you either refused or were particularly

reluctant or tried to in any way stand in the way of patients of yours who fell within the criteria for Belfast City Hospital being transferred up. You just let that happen, I presume?

A. That's the initial answer I said. I have no obstruction to the changes and I have no resistance to the changes. I have my own views to express that this thing should be done slightly differently. The basic point was of all that centralisation, of patients having radical surgery of the pelvis in one centre do better. There is no doubt about that, we all agree to that, but who perform that? Can it be organised at one centre in Belfast, whereas the other surgeons from Craigavon or the other part of the North can come down and have a rotational basis, they have a time allocated to operate on their patients. 12:05 12:05 12:06

My view was, it is better for the continuity of care that if I have a Craigavon patient I operated in one centre, then they come back and follow-up with me at Craigavon. I think that is the majority of the Trust, and England have the same model of working. In this way my view was, there will be better communication and interaction between the surgeons from different Trusts and have a good view for the patients' betterment. That was my only concern. 12:06 12:06

93 Q. Did you make those suggestions in any formal or informal way to those who were making decisions?

A. I did, actually. I think I must have said that and

that's why I still remember it, but not in a formal way because we were never asked about any formal. It's only in the meetings I might have discussed that, that this is the way it should be.

94 Q. Do I take it from your answer that you didn't feel that you had been engaged with properly in relation to the review, the regional review? 12:07

A. The majority of the review happened without us present. We were only present on a meeting with Mr. Mark Fordham, which you might have some notes of the minutes of the meeting. That's the first time I recall. It was quite a feeling for me, in a way, that, yes, we are meeting and we thought, my understanding is when you meet you discuss the things. But the way it came across on to us, I was the junior most fellow so I kept quiet for the majority of the time, but the way it comes to us was entirely a one-way traffic, this is the things that has to be done. 12:07 12:07

95 Q. We will just pick up your statement at this point because you said the same for the level of your involvement. It seems for you and the other clinicians that kicked-in post-recommendation, as opposed to informing the recommendations. If we go to WIT-41837. This is your statement. Paragraph 9.1 and 9.2. 12:08

A. Sorry, four-one-eight? 12:08

96 Q. 41837, paragraph 9.1. It says:

"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. The Trust management team and the Consultant Urologists, Mr. Michael Young and Mr. Aidan O'Brien Were also present. The purpose of the meeting was to discuss the recommendation from the review and agreeing 12:08
an implementation process.

After this meeting the Trust management team, led by Dr. G Rankin, Director for Acute Services, Martina Corrigan, Business Manager Urology, and Mr. E Mackle, 12:09
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 organised regular weekly Monday evening meetings." 12:09

Paragraph 9.2:

"These meetings took place on Mondays (except Bank Holidays) and continued until late 2010. In these 12:09
meeting we worked out the number of our clinical appointments and design and development of the Thorndale Unit, various pathways for patients' conditions, workforce issues and consultant job plan reviews according to the recommendations. Minutes will 12:09
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."

I want to take you to an extract now from Eamon Mackle's statement at WIT-11740, paragraph 11: 12:10

"To enable the expansion of the service...".

This is to pick up the point you have just mentioned in your statement: 12:10

"To enable the expansion of the service, multiple work streams were set-up to deliver an implementation plan. Initially Joy Youart and then Gillan Rankin chaired weekly meetings with the three urologists. These 12:10 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 12:10 the Commissioners' were many and included: Management of red flag referrals, triage, preoperative assessment, length of stay, number of patients per clinic (and thus, length of appointment), transfer of radical pelvic surgery to Belfast, role of nurse specialist, 12:11 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 practise 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 Gillan Rankin could achieve the desired consensus and outcome." 12:11

Then if we go in the same response from Mr. Mackle at WIT-11758. At the very bottom line there you will see the word "frequently". Do you see the second line from the bottom? 12:11

"Frequently, we would find at one meeting that what we considered had been agreed at previous weeks' meetings the Urologists would wish to negotiate. I recall Gillian Rankin stating that she felt their aim was to talk us into submission." 12:12

The previous information in that paragraph indicates that the "their" in that sentence refers to the consultants. So Mr. Mackle appears to paint a picture of resistance and difficulty in trying to persuade the consultants of either the need for change or the recommended pathways for that change. He names Mr. O'Brien as holding out particular views that seemed to be contrary to the direction of travel the Trust 12:12

wished to go down at that point.

First of all, is that your recollection of the tone and content of those meetings?

A. Those meetings were certainly set-up to make the changes and when the changes happen in any Department, it was quite a major change which was going to completely change the practice and working of all of us. So there is going to be a certain degree of resistance, there is no doubt about it. 12:13

But our point throughout the meetings and which I would still maintain was, if we are going to change we should change it with all the resources provided, with all the infrastructure provided. You can't just be saying that you start an MDT, one example, and just go and find out how you do that. No, you need all the other job plans of the so-many-other consultants. 12:13

If you call it resistance or obstruction, look, it's a two-way traffic. Management, if management want a consultant to work in the new way of working, then they should be able to provide the proper infrastructure, proper resources, and if those resources are not available or scarce, then it is not a resistance, I will certainly feel that my patient will be -- the safety of my patients will be compromised. 12:14 12:14

So if Mr. Mackle thinks that that was resistance, then

I'm afraid I disagree with that. I certainly said that we are happy to make changes. You'll see from my email to Alison Porter, sorry, my letter to Alison Porter that we did start at MDT. We did ask for a red flag system to put up. And we did express that we are happy to send the pelvic surgery to Belfast, but this is not the way it has been done. It should be done with communication. So there was certainly a lack of communication from the review implementation on the start. 12:14 12:15

It did improve once we started the Steering Group meeting. I'm not aware that they were playing with us, if Eamon Mackle was challenging and Gillian was going around different, that is the way of management. But certainly we speak what we felt at the time is correct for the betterment of our patient. I'll not recognise that it was a resistance, I'll say that it was an insistence to provide us the resources for to setup all these new changes. 12:15 12:15

97 Q. If I could summarise your answer in the sense that you felt any objections that came from you were based on patient priority of their care and their needs, and you felt that your justifications for responding in those meetings in the way that you did, you were driven by patient -- 12:16

A. Of course --

98 Q. -- putting your patient first, and that any interpretation of those objections by you as being

obstruction, or any other resistance, is one person's interpretation rather than what your intention was. Would that be fair?

A. It would be fair. Can I give you an example to explain that, why it is felt. Suppose you are Mr. Mackle, I am Mr. Akhtar, you ask me 'Mehmood, from tomorrow you are going to see 12 patients in your clinic, five of them will be a cancer patient'. I will certainly say, I said 'Mr. Mackle, I'll be happy to see that, but I need this, this, this thing'. Will that be a resistance? Because I don't feel safe that five cancer patients should be seen in my clinic back-to-back with seven other patients. 12:16 12:16

As Alison also accepted in the letter, there was delays in the clinics because cancer patients take a longer period of time. So will it be a resistance? No. It will be asking for the resources to run a better service. That's what my point is. 12:17

99 Q. Was it your experience that Mr. O'Brien was the main source of resistance to change as alleged? 12:17

A. I never found him, but I believe Mr. O'Brien and all three of us were working in providing better care for the patient. So if he has objected on anything, it will be for the betterment of the patient. He never said that he's not going to do that, he always said 'provide me the resources', I believe, which is my recollection. If there's any other evidence of any correspondence or communication which I'm not aware of. 12:17

100 Q. You also have mentioned in your Section 21 about the issue on job plans and the difficulty, and the Panel have heard some evidence around delays around job plans, difficulties finalising job plans, some job plans were never finalised and you have certainly referred to that. And also in relation to admin time that you can have for your nonclinical aspects of your role.

What was your view of how management responded to suggestions from the clinicians that they needed greater facilitation to allow them to complete the administrative aspects of their role? 12:18

A. As a clinician we always are doing administration. Honestly, there is plenty of hours we put in, but what is formalised in the job plan, that needs to be negotiated. So we were asking -- now I think there are proper guidelines that if you do one clinic you deserve one-hour of admin time. So at that time there was not very clear-cut guidelines. So we are always looking for that. We are doing more and more paperwork. We are doing more and more other works which are non-clinical. So we need some type of remuneration in order to compensate for that work we spent. I think my job plan was around 1.25 to 1.5 of admin time which means I was spending around 5 to 6 hours of work doing non clinical work to sort out the patient, triage, looking at investigations, things like that. 12:18 12:18 12:18 12:19

So I never have any issues because those are the things that either you do a diary exercise you cannot prove and administration or medical directors are always on the side of cutting it down. So it's basically always a bone of contention between the two teams. That's the way I take it.

101 Q. I'll just go back to Mr. Mackle's statement where he mentions you. I want to give you the opportunity to comment on it, WIT-11773. WIT-11773 at paragraph 102. I'm just going to read this out. We can start halfway down that paragraph. I'll read the whole paragraph, actually: 12:19 12:19

"During my tenure, Martina Corrigan, Head of Service, Heather Trouton, Assistant Director, Gillian Rankin, Debbie Burns, and Esther Giskori, 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. 12:20 12:20

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 realise that I had Urology's best interests at heart."

Now, just what Mr. Mackle says at the end of that paragraph, is that something you recognise having approached him about? 12:21

A. No. I don't think so. I saw when I was leaving to Eamon Mackle. First of all, I don't recall that I ever said anything. As he said in his -- as I said, it is always a sort of negotiation. We never had any meeting as consultants between three of us before the meetings to make a plan to sabotage anything or to do anything, which is -- we were always good at heart. But as I said, our insistence was, we are happy to make changes but we need resources. As you know -- 12:21

102 Q. I understand that. I suppose, again, if I could ask, just to focus on your experience. I can understand the methodology and the justification behind that. It's just really trying to tease out what the narrative that played out rather than what should have happened. 12:22

One of the things I want to ask you about next is; did you have any meetings with Mr. Mackle and Dr. Rankin on your own, unaccompanied by either of the other two

consultants and, if you did, what was your experience of those meetings?

A. I don't remember or recall ever meeting on my own with Eamon Mackle, except maybe in a theatre sometime, because he used to do a theatre I think on a Friday sometime. Maybe in a tearoom meeting, but that was an informal meeting. I never had any formal meeting on my own without the Departmental meeting. 12:22

103 Q. Well if we go to Mr. O'Brien's statement, WIT-82495, paragraph 27.1. I just want to ask you about this, again, because you are mentioned: 12:22

"I believe that Ms. Youart was succeeded by Gillan 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 2012 Dr. Rankin and Mr. Mackle had a number of meetings with the Consultant Urologists on an individual basis. 12:23

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." 12:23

I just wonder if you could comment on that. First of all, if you found meetings with Dr. Rankin and

Mr. Mackle to be distressing and traumatic and, secondly, if you did, did that contribute at all to your decision to leave the Trust in March 2012?

A. Difficult to say that I have any specific distress but, if I recall, yes, it was to some extent unsatisfactory because they were asking us to do some things which I did all my life, like a pelvic surgery. So it was -- not a kind of distressing, but frustrating could be right for me to leave something which I practice. 12:24

I never had any one-to-one meeting to my recollection with the management team. I don't think that taking away my surgery or making those changes made me decide to leave the Trust in March 2012. That was purely due to my family reasons and my children. 12:24

104 Q. Thank you for that.

A. Yes.

105 Q. Again, just on the issue of communications with line management, obviously one of the issues the Panel is interested in is the culture that exists and the way in which culture may help or hinder the exercise of good Clinical Governance. Some of the correspondences may provide some insight into that. The Panel may consider that to be the case or not, but I just want to look at an email chain at TRU-251051. 12:25 12:25

This is an email chain, you'll recognise the word "boycott" is used in one of the emails I think. I can see your face. I just wanted to say that so you'll

know the emails that we're moving on to, these were in early December 2009.

So we start at the bottom, I think. So this is from an individual to you and others. It's not to you and others on this particular occasion, but it is an email saying: 12:25

"Dear all, Please find attached agenda for the above meeting." 12:26

Sorry, this is 30 November 2009:

"Dear all, please find attached agenda for the above meeting scheduled for Monday 7 December 2009 at 1.45 in Templeton House in Belfast." 12:26

Then if we move up you'll see that this is from Malcolm Clegg to you and Mr. O'Brien. He says:

12:26

"Dear Mr. Akhtar, Mr. O'Brien, please find attached agenda for a meeting to discuss the proposal a Belfast/Craigavon crossover SPR Urology rota. This meeting has been facilitated by the Board Liaison Group, formerly ISG, and it will be held at 1.45 on Monday, 7 December 2009 in Templeton House. Mr. Young has confirmed he will be attending and I understand that Chris Hagan will attend from the Belfast Trust. If you are also able to attend I would be grateful if 12:26

you would let me know and I will inform BLG."

Now this proposal for a Belfast/Craigavon crossover SPR Urology rota, is that a hint of the possibility you suggested earlier about sharing some of the workload? 12:27

A. I think if it is saying SPR, is that correct?

106 Q. Yes, SPR.

A. SPR, that actually was the finding that the junior doctors working between the two Trusts, can they share a rota in order to increase their numbers so that they 12:27 can be on-call for both sides and in a lesser, in a timeframe which would be more WET Working Time Directive compliance. So that's why Mr. -- what's his name -- Mr. Young attended it, because he was in charge of the training programme at the time. 12:28

107 Q. Now you have replied on the same date, 1 December 2009, directly to Malcolm Clegg. You said:

"Dear Mr. Clegg, we do not intend to attend the above meeting as we entirely disagree with any provision of 12:28 on-call cover for our Department by any junior urological staff, other than those working in our Department. Such a proposed cover would only further compromise the standard and quality of care provided. Any risk of any such further comprise is unacceptable 12:28 to us."

Now we have looked at Mr. Mackle's statement earlier about obstruction and resistance.

A. That's right, this is what --

108 Q. I just want to ask you is this an example of that on this particular issue?

A. Yeah. That's not issue-related to any of the clinical services. This is in relation to the provision of the junior doctors across the two Trusts. So if you look at the geography between Craigavon, Belfast, and all that, if you have a Registrar on-call between all three hospitals, or four different hospitals, it will be difficult for the Registrar to come to -- if there are simultaneously two hospitals calling for them, where will he go or she go to attend to? So that was our issue. So we said that this is not safe for having it. And it was something which was -- which cannot happen clinically because -- and that's not a resistance, that's putting the Patient Safety at the heart of it. 12:28 12:29 12:29

109 Q. I just wonder if, given you've explained the Patient Safety context broader than you have put in the email, would going to that meeting have been the best place to express that, and does your reply perhaps indicate poor relationships among the medics and the decision-makers? 12:29

A. Yes, because it was never properly discussed with us that this is the agenda of the meeting you are coming to, so I don't recall exactly, but in a broader context that was the reason that we were never informed about what is it going to be. So you are going just only to discuss how the Registrars are going to work which clinically was not safe. So we just said that. Mr. Young is attending, that's fine, we will not be 12:30

coming to that. That's not obstruction or resistance, that is giving your perspective there and Mr. Young did attend that on our behalf.

110 Q. Well, we will look at the language used by Patrick Loughran in his reply on 10 December 2009 to Malcolm Clegg to you and Mr. O'Brien. He says: 12:30

"Dear Mr. Akhtar and O'Brien, thanks for the email of December, 1. The purpose of the meeting was to discuss safe cover from within the 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 fear. Mr. Young attended and I will expect he will report the outcome to you in due course." 12:30 12:31

So was this a position that you and Mr. O'Brien had decided not to attend but Mr. Young went ahead?

A. No. It was that Mr. Young was representing the Department on our behalf. And we never used the word we are boycotting it. We might not be able to attend. Did we say we are boycotting it? We said we do not feel it is safe to practice. That's what happened exactly when Mr. Young went to the meeting. I believe that it was feel unsafe for such a wider geographic area to be covered by one Registrar at the out-of-hour time and I think it was not safe. 12:31 12:31

111 Q. Do you remember the outcome that Mr. Young reported back around this issue, about the cover?

A. I have no idea, but I think it never happened because it was, as I said, clinically, geographically, it was such a big area to cover by one Registrar from three different places that it is not possible, until and unless we have some other arrangement. 12:31

112 Q. Would you agree with the proposition that these emails, if you stand back from the detail of them, do suggest a certain breakdown in communication, or a resistance between medical management and the consultants for whatever reason? 12:32

A. There seems to be, if you ask me now from outside, it looks to me because my view of that was, you cannot just go on to a meeting and make an arrangement for the Registrar to cover, so there should be a preliminary work to be done with some suggestion posted to you that 12:32 you work on that, some reading to be done, some suggestion taken from the consultant. So, yes, it was both ways sometime.

113 Q. Just given your experience to date, and you're a very senior consultant, would you also agree with the 12:32 proposition that the culture within an organisation and the way in which people engage has an impact on the efficacy of Clinical Governance?

A. In what way? The Clinical Governance at that time, whatever it was related to the patient, this issue was 12:33 not related to the particular you mention, but if you ask me in a wider context we have a significant amount of time spent in order to look at the safety of the patients and communication amongst the Department. So

this particular issue doesn't have any --

114 Q. Just to be clear, I am trying to be very careful the way I word my questions so that you're not in any doubt about the questions being asked.

12:33

Moving on from that point and looking at your experience as a total, in all of your experience as a Consultant Urologist, is it your view that the culture within an organisation and the way in which people communicate within that culture can have an 12:33 impact on Clinical Governance, either positively or negatively?

A. It can have, as a person from outside, a negative effect on the Clinical Governance. There is no doubt about it that if you don't take all the people onboard 12:34 before deciding or making decisions or providing resources effectively, certainly it will have some effect.

115 Q. One of the other issues around the time of the emergence of the MDTs was the use of the Cancer 12:34 Clinical Nurse Specialists. I think you have experience of that as well and the way in which that operated. Now the Panel have seen A Trust document, the policy rests on the premise that the CNS allocation occurs at the MDT meeting that the Chair and the core 12:34 nurse member allocate the CNS to the patient, as needed.

I just wonder if you can recall your experience of the

use of CNS during your time. I know it was in the early days and the capacity wasn't what it was ultimately, but do you have recollections of the way in which that particular service was used and the effectiveness of it, by you as a clinician, and by you as a Chair? 12:35

A. I always found, yes -- actually during my tenure there was only two named CNS that we can say, the Senior Clinical Nurses at the time. One of them was I think on a long-term leave at the time when we started MDT and she joined later on, I think in 2011, if I recall. 12:35

But at that time one person, and another nurse, which was not a specialist nurse, we effectively used them in Thorndale Unit as the role was evolving. So I believe after I left that they decided to put the named CNS. But at my time it was not possible to do that. So whenever CNS is available on the days, we utilised her in the clinic to see the patients together. 12:35

116 Q. So it worked well at that point, but later on the expectation of the attendance was -- 12:36

A. Of course.

117 Q. -- post-review, was slightly escalated, I think?

A. If we look at the clinical review which suggested, I believe, at the time to five CNSs if I'm correct, I may be wrong, but I think that is the number which was escalated, maybe five consultants and three CNSs, I believe. Later on these numbers did increase because the service was evolving. 12:36

What I did as an MDT Chair, I used to the best of my abilities to utilise the CNS in my clinic or any other clinic. I did develop one of them to do the flex-cystos which is quite a significant control, helped me in doing the biopsies and also the Trust process biopsies. So I never had any issues during that time utilising the services and developing the services of CNS. But as you said that it was an initial time, so the role was evolving, and I'm sure they picked it up later on. 12:37

118 Q. I think you said that the nurses at the time, Mrs. O'Neill and Mrs. McMahon were present at the MDMs when you were Chair?

A. Yeah, some of them but I think not all of them. Well to start with, if I recall, I'm not 100 percent, but I think during my tenure when I joined in 2005 she was on leave -- 2007 she was on leave. I think she did join some time in 2011 or something like that. 12:37

119 Q. Were you ever aware, or made aware, or noticed, or had any acknowledge around allegations that Mr. O'Brien apparently excluded or was accused of excluding CNSs from the management of his patients? Was that something that was ever brought to your attention or you saw? 12:37

A. No, no. I had never been made aware of it. As I said, during my time there was only two CNS so they were present wherever they were required and we can only manage them within their timescale. So nobody even brought to my attention that that was happening. 12:38

I believe at that time it was more or less (inaudible) that some clinic may not be provided with the CNS services for each patient. As you know, nowadays, it is totally unacceptable to see a cancer patient without a CNS nurse present to facilitate, giving them diagnosis and taking them any further. 12:38

120 Q. Did you have any experience of Mr. O'Brien being dismissive of --

A. No.

121 Q. -- your views or the views of any of the MDT members, including CSNs? 12:38

A. No, not brought to my attention and never pointed out in my presence ever.

122 Q. I just want to take you to something that Martina Corrigan has said at WIT-26299. Before I read this, I want to remind you what you said in your own witness statement and for the Panel's note this can be found at WIT-41861, paragraph 50.1(ix)A. 12:38

A. 41861, is it?

123 Q. 41861, paragraph 50.1(ix), paragraph A. That's where you describe your relationship with Mr. O'Brien. You have stated that Mr. O'Brien was a mentor to you in your development. That you had regular daily meetings, that you undertook many complex cases together and that he was always available to help and listen. That's your experience of Mr. O'Brien. 12:39

A. That's true. That's what I have written and I still maintain that today, that he was a mentor to me. I was at the start of my career. That was actually, the

Craigavon Area Hospital was my first substantial appointment after I did a locum for a few years. We did the cases together which were complex, and he was always present, he was always there to give me a second opinion.

124 Q. I just need to get the correct paragraph number.

A. It is paragraph number (ix)A.

125 Q. No, that is from your statement, but I am looking at Martina Corrigan's. It has been suggested in this, and I can't see it on this page, but I am going read this out and it if it needs correcting... here we go, 67.2. Paragraph 67.2: 12:40 12:41

"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 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, Dorothy Sharp, 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 be his way or no way. 12:41 12:41

He undoubtedly had a strong personality and that 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)."

We will go back to the previous page now. So you are mentioned specifically by Mrs. Corrigan in her Section 21 with the allegation being that Mr. O'Brien had strong opinions and it would always have been his way or no way. Do you recall sharing this view about Mr. O'Brien with Mrs. Corrigan? 12:42

A. I don't think so. I don't recall that we ever had such a personal level of giving a description of other persons in front of a third party. I'm sorry, I don't recall any such. Because I always regard every member of the Team very high. It would be totally inappropriate of me to be giving such a statement. 12:42 12:43

126 Q. I take it from what you have just said that you don't agree with Mrs. Corrigan, the way she has described Mr. O'Brien in that paragraph?

A. In my experience, yes, that was not correct. I found he was always listening. But Martina and his relationship might be slightly different because that was a manager and a consultant relationship. So I don't say that what Martina is saying from her point of view may be different. But from consultant to 12:43

consultant I never found him, that he ever imposed his feelings or his ways on to us.

127 Q. Now I just have a few general points I want to put to you, hopefully round off your evidence. The Inquiry has already heard a reference from Eamon Mackle who suggested staffing was an issue from 2009 to 2014. That is, for the Panel's note, WIT-11741, paragraph 13. Also Antony Glackin, in his evidence at WIT-42295, 15.1, and WIT-42298, 16.1, the Urology Department was inadequately staffed since he arrived in 2012. It was funded for seven Consultant Urologists but never reached seven substantive consultants. It was dependent on locums, several of which he considered were not up-to-scratch and a constant cycle of recruitment. 12:43 12:44 12:44

Now in relation to the issues around staffing, do those comments made reflect your experience of the staffing problems while you were there?

A. Yes, there was always -- because at the time there was an approval for the new post, but during my time they were never advertised because the agreement was reaching, how do we provide that service, where are the resources, where the time will be, how do we... So I think it was an ongoing thing but we were working within the constraint of our resources which was provided. But, I agree, there was always this under-resourced and under-staffed Department we worked for a long time. 12:44 12:45

128 Q. The Panel has also heard some evidence in relation to the administration of IV fluids and IV antibiotics. Patients being admitted onto the ward for those treatment regimes. In the statement of David Connolly, the Section 21 of David Connolly at WIT-41996, paragraph 70.3, he says: 12:45

"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 the Southern Health and Social Care Trust, but I was not going to practise in the same way. 12:46 12:46

Similarly, he did not like using intravesical BCG therapy for high-risk non-muscle invasive bladder cancer and preferred mitomycin therapy." 12:46

Then it goes on to speak about that. But the first part of that paragraph relates to, well, you are mentioned as being involved with regularly admitting patients with recurrent UTIs for 5 to 7 days to be treated with intravenous antibiotics and fluids. Is that a practice that you undertook, do you recognise 12:46

that sentence as being applicable to you?

A. I will strongly take the view about it because that is the statement of one of the Registrars at the time and it is totally incorrect, first of all.

12:47

It is his view but I can certainly prove it, that you need to look at the record: Did I ever admit a patient with a recurrent infection at my tenure to give them IV antibiotics? I said, very clearly, that I only use antibiotics, IV, with patients with a proper clinical 12:47
(inaudible), like patient with a Pyelonephritis, patient with a temperature, (inaudible) or increased inflammation markers which are acutely unwell. Otherwise, for the patients with a recurrent urinary tract infection, I certainly followed the guidelines to 12:47
prescribe them oral antibiotics after a culture or put them on a rotational prophylaxis or suppressive course of antibiotics.

So I never did from my registrar days until today ever 12:47
admit a patient for IV antibiotics for recurrent urinary tract infection. If Mr. Connolly is talking in terms of a general, then yes, I did admit it, but I said my indications were clinically with the patients who are septic. 12:48

129 Q. Just to break that down to make sure, because David Connolly will come and give evidence and I want to make sure what is put to him is clearly what you say.

First of all, you take from the first line of that paragraph that David Connolly is perhaps intimating on one version, or one interpretation of that, that there was a regular procedure adopted by you and the other two consultants to admit patients with recurring UTIs for 5 to 7 days. He thought this was something that he had never seen in any guidelines which predated his time. He felt that he wasn't going to change the practice so he didn't say anything, which would perhaps suggest that he felt that the way in which it was done was not clinically mandated? 12:48 12:49

A. Certainly there are occasions for IV antibiotics, as I said. Now, it varies from context to context of each patient. In this patient, as I said -- in this scenario which you are describing, patients who are systemic with recurring urinary tract infection, I said very clearly I never admitted for seven days antibiotics. My practice has always been clinically evidence-based on clinical indications. Sepsis, urinary tract infection with (inaudible) and symptoms, then I do give them antibiotics, if it's clinical, and that's after discussing with microbiology, which is the proper one mainly to change after cultures. 12:49 12:49

But that medical scenario I never admitted and I think that is not a correct statement, if it is in that one setting applied to. 12:49

130 Q. So your evidence is that if the patient manifests with sufficient systems that trigger the need for IV

antibiotics, for example, not just a UTI, but with rigors, positive cultures perhaps, other clinical signs, then IV antibiotics and fluids maybe an appropriate treatment and that is patient specific?

A. Yes. 12:50

131 Q. But any suggestion that there was a wholesale approach in some way to regular UTI patients, and that was the administration of IV antibiotics and fluids by you, you reject that suggestion?

A. I do strongly reject that suggestion. 12:50

132 Q. Do you recall if there was in your time or were you ever involved in a subsequent review of the use of IV antibiotics and fluids which resulted in a pathway being introduced to ensure that microbiologists were involved in the decision-making around that? 12:50

A. I do recall. I think Dr. Damani was at the time our clinical microbiologist and he used to give us regular advice. I was not part of any communication but I did know that at the time that Mr. Loughran and also Sam Sloan was our Clinical Director. They set up an MDT 12:51 and I think they were questioning the practice of using it on a regular basis on certain types of patients. The patient was discussed at the MDT if they needed to be admitted, and taking advice from the microbiologist which antibiotics is appropriate. 12:51

133 Q. Do you ever recall there being an audit, an ongoing stewardship. It is actually the word that is used "stewardship audit of antibiotic prescribing in Urology". Did that take place during your time, do

you recall that, where the clinicians would have received feedback on the appropriateness of both the prescription regime and, for example, the duration or type of patient profile, and there would have been feedback from pharmacy. Do you remember that? 12:52

A. I don't think so that happened during my time. It must have been after me.

134 Q. It may have been after, but I just wanted to make sure that while we have you here we ask you anything that might be relevant. 12:52

A. Yes.

135 Q. We're going to take a break for lunch. I don't have a lot more to ask you, but I'll take the lunch break to consolidate that. If you will come back in the afternoon we will finish your evidence off. 12:52

A. No problem.

MS. McMAHON BL: Thank you.

CHAIR: We will come back at 2 o'clock, ladies and gentlemen. 12:52

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT

CHAIR: Good afternoon, everyone.

MS. McMAHON BL: Good afternoon. I just want to check the link with you, Mr. Akhtar. 13:59

A. Yes, can you hear me all right?

MS. McMAHON BL: Loud and clear, thank you. 13:59

I just want to cover some topics briefly that have arisen through the evidence the Inquiry has received, just to get your perspective on those and your way of working so that we can develop an understanding of the way the Unit operated in certain respects. 13:59

We have heard a lot of evidence around record-keeping and notes and things like that. I just want, while you are here, to give you the opportunity to give your evidence on your practice around those particular issues. 13:59

If I start with the issue of patient notes. Now, there's been evidence around removal of notes and justification for that and the necessity of that for offsite appointments. I know that the area covered an outline area and there had to be notes moved. There were formal ways in which the notes were brought back and forward but also staff members as well perhaps put 14:00

them in their cars and that sort of thing. Also, not sending the notes back to Medical Notes and Records.

I wonder could you outline your understanding of your responsibility around notes and also what your practice was while you were in Craigavon. 14:00

A. First of all, we all worked on multi-sites. Our base was Craigavon Area Hospital but each of us has an outlying clinic. I used to go to South Tyrone in Dungannon and I believe Mr. O'Brien goes to Erne Clinic in Fermanagh. Mr. Young goes to Banbridge, something like that. Anyway, it was an arrangement. 14:00

For me, my practice was very clear, that usually Dungannon Hospital was closer to the Craigavon Area Hospital and the Trust has the notes provided there, delivered there before the clinic once-a-month. But there were odd occasions once in a while when they were unable to deliver it on time or some notes are left behind from the record. So I was advised or informed to collect the notes before going to the clinic. 14:01 14:01

So usually I made an arrangement to leave it with my secretary and in the morning I'll collect it before going. On the way back, for me, it was at Dungannon, so I leave it there and the staff then bring it back to the record. I don't remember ever that I needed to bring them myself, apart from occasional, very odd notes that the patient says to you in the clinic the 14:01

next day, so I have been informed. So this was my practice and I think I have never taken any notes home or anywhere outside the pathway of my journey. I made it available the same evening back, if I'm bringing any notes back, to my secretary's office as the determined place. 14:02

136 Q. You have mentioned the secretarial staff just at the end of your answer.

A. Yes.

137 Q. How did you operate with your secretarial staff as regards dictation? 14:02

A. From the very beginning of my training, I'm very particular about writing the notes and dictation immediately after I finish with the patient's consultation. So I don't wait until the end of the clinic, I usually as I go along. Because I do feel that if I have fresh consultancy, everything is remembered, so it should be documented straightaway. I used to have a Dictaphone, I do it, and then on the way back, a worksheet and the Dictaphone dropped to the secretary's office, or I will hand it over the next morning, so she will then type it. 14:02 14:03

So this is one way of dealing with my clinic, but my general admin was that I usually have twice-a-week meeting with my secretary face-to-face because at that time not much in terms of electronically we can do. And I looked at a few things. Number one, look at any concern or any letters from the GPs coming through to 14:03

be addressed directly. Number two, looking at the triage which is assigned to me on my on-call and going through them. Number three, any letters which are typed by my secretaries and I need to correct it or sign them. Number four, I meet once every six weeks for looking in advance for my operating list, because that was the timeframe given in NHS, that I should look at my list to filling it up. I always keep one or two slots vacant for, if an emergency or a cancer patient come in which need an urgent operation, so that was my own practice. That's the way -- but I've a very close liaison with my secretarial staff, meeting at least twice weekly. 14:03 14:04

138 Q. In relation to notes and/or dictation, did anyone ever have to approach you that you had fallen behind on your dictation, or that there was a problem with the time lapse between seeing a patient and dictating a letter, or that notes were missing and they had been traced back to you. Did anyone ever raise those issues with you? 14:04 14:04

A. No, and never have been. As I said, I have certain rules and certain practices which I follow very strictly still today, and that is, it is fresh in your mind, I dictate it. Very oddly sometimes I may be fallen behind, like a patient dictation need a correction and my secretary has left it in my folder, which might take a couple of extra days to correct them. But I have never been informed that I need to do anything in this regard by any administrator. 14:04

139 Q. Did anyone ever bring to your attention that those were issues that had caused some problems in the practice of Mr. O'Brien or potentially caused some problems. Did anyone ever discuss that with you?

A. No, not regarding notes. Never. I never been informed. I thought that it is quite a common practice at the time because of the logistics for other consultants to take notes with them and bring it back. So I never had been informed about, that there was any issues in terms -- 14:05

140 Q. When you say in your answer it was quite a common practice at the time because of the logistics for other consultants to take notes with them and bring them back.

A. Yes. 14:05

141 Q. What are you referring to specifically there, what was common practice?

A. Common practice mean that it was an agreed protocol, that a consultant like going to Fermanagh, any notes need to be taken down there will be taken if Trust is unable to transfer them to that hospital clinic, the consultant will bring it with them. There was a special trolley made out, with boxes, which we used to wheel out with us and take it. So everybody do the same at the time. But in my case I do remember because Dungannon was very close, so I leave the notes after I finish. I only bring those notes back which I was advised to bring, the patient has next morning an appointment at Craigavon, something like that, so 14:06 14:06

that's what --

142 Q. So when you refer to common practice, you are referring to the box that was used to transfer the notes between offsite locations but still Trust property and back to Craigavon records, that's what you are referring to? 14:06

A. Yes.

143 Q. You mentioned also in your answer, when you met your secretary you discussed triage. Now I know that the red flag system come in at the end of 2009, early 2010, so you preceded that and also postdated that system. 14:07 What was your system for triaging during your tenure at Craigavon?

A. My tenure at Craigavon, when I came in at that time there wasn't any red flag system. It was only just an urgent and something like routine type of thing. What 14:07 I used to go through the notes, the letter which is sent to me and pick up the salient feature, and if I feel that there is a suspicious sign of a cancer, which is quite obvious, like a patient with a hematuria, a patient with HYPSA, so I ask my secretary 14:07 to see them within a period of time which is quite soon, urgent-urgent.

But then later on came in a red flag, so we used to have a red flag to put it on the investigation, triage. 14:07 It was quite a practice at the time that an on-call surgeon or an on-call urologist will be looking at their triage and sort them out within a timely fashion.

144 Q. Now, when you were consultant of the week, when

you were completing your triage duties at that time, did you find that you had the capacity to adequately do the triage that was allocated to you while you were on that on-call that week?

A. First of all, when I was there the system was slightly different. There wasn't any consultant of the week. We used to do the on-call on a daily basis, I believe. So I did have my on-call day and I used to do some extra work out-of-hours sometimes to complete my triaging. But I must say that the time was a little constrained to do so much work. But as I didn't have my family with me, so I usually used to stay after work to complete the work, if needed to be. 14:08 14:09

145 Q. I think I meant to say "surgeon on-call", rather than "consultant of the week". I think that preceded, my mistake. 14:09

A. Not at all.

146 Q. But during that week, just to give us a general feel, did you ever have to raise it as an issue that you weren't able to fulfil your triage duties or were you aware of anyone else, including Mr. O'Brien, not being able to fulfil his duties in relation to triage? 14:09

A. It was actually, yes, I always did mine within a reasonable time. As I said, a reasonable time for me was within the same week. Like if I have been informed about the triaging on a Wednesday, I will try to finish it by Thursday or Friday. A couple of occasions, it was not raised as an issue, issue, that it is ongoing, but it was said that, oh, due to leave or that 14:09

Mr. O'Brien has a few letters to be triaged, which certainly as a group of consultants I helped to triage them so that they can be looked at in a timely fashion. But it was not sort of a thing that was quite regular. It happened on two or three occasions, I believe so.

147 Q. Would Mr. Young have also stepped into the breach on occasions like that and assisted with triage, the way you have just described?

A. I think I do remember that once -- I think it was Mr. O'Brien was away or something like that, so there was some gap in there. So, yes, I did quite a bit with Mr. Young also stepping it up. But it was not a very regular phenomenon. It was once in a while. So that's why I think it must not have been raised at the time with us as strongly. But, yes, we did. 14:10

148 Q. You have mentioned two or three occasions and you also said it happened once in a while?

A. So if you take four or five years times of me, then it will be once in a while for me. Not very regular every week or every month. 14:11

149 Q. That's fine, I appreciate it is difficult to remember precisely. Did you get any sense that this was a systemic problem, that it was more endemic than you realised?

A. No, I never realised that it was a systemic problem at the time. I thought it might be that he was on leave or we always have some accumulation of work, we help out each other. So that's the way I perceived it at the time. 14:11

150 Q. Just on that issue, I know we discussed the Bicalutamide 50 issue this morning and I asked you questions around that. Did you ever have cause to have it brought to your attention that any patient, while you were in Craigavon, had been prescribed Bicalutamide 50 as a monotherapy. Was that ever brought to your attention? 14:11

A. I don't remember it specifically, that's what I said. Unless there was any particular case you can refer to, I don't remember exactly. 14:12

151 Q. Do you remember ever seeing a patient of Mr. O'Brien's who was prescribed Bicalutamide 50 as a monotherapy?

A. No. I don't think so I ever have seen any patients in my clinic.

152 Q. I just want to give you the opportunity to remember if you do. You say you don't think so, is it a possibility or do you remember it might have happened or it didn't happen? 14:12

A. I can't say it with certainty. It might have happened. If I have seen it I must have questioned it, but I don't recall it now, because unless there's a specific point of patients and I can see the notes of them. 14:12

153 Q. Did anyone ever mention it to you, even if you didn't see a patient, did Mr. Young, Eamon Mackle, anybody ever say "have you noticed this?". Did anyone raise it with you at all? 14:12

A. No. I never have any communication or any verbal communication or written communication regarding this

issue with me at the time.

154 Q. We also mentioned this morning about the transfer of patients to the Belfast City Hospital, the radical pelvic surgery. I know you were there over 2012 and the Panel have heard some evidence around the system or potential problems around patients being transferred and actions taken in relation to that. 14:13

Did you ever resist, or refuse, or get involved with trying to dictate the terms under which a patient may have been transferred to the City Hospital, for example, indicating what your preferred treatment might be for that patient, or writing to the patient directly, or contacting the consultant in any way about your view on what should happen? 14:13

A. No. I have a very strict policy, once a patient is discussed in MDT and an outcome is written on a piece of paper, which is an MDT Outcome Sheet, it is the responsibility of mine for my patient to see them, explain to them that this is what the outcome of our discussion and I'm now going to refer you, you will be called in from an oncologist or surgeon. 14:13 14:14

I always specifically say that you are going for a surgery or radiation, so you will see within a certain period of time an X, Y and Z specialist from Belfast. Because our oncology were seen at Craigavon at the time, so sometimes they are seen here, so I do mention it to them. 14:14

So it was a quite clear pathway for me and that's the way. And I never informed any consultant about my preferred way, because there is no "my preferred way", there is only guidelines or a decision which we are taking for a particular individual.

I do interfere if I found something on a patient's consulting, where a particular treatment may not be beneficial, which I can tell them, look, you have this medical condition, so XY treatment may not be suitable, so that's why I'm referring you to the specialist for other treatment.

155 Q. So it's your understanding the way this system operated was that once the patient was transferred to Belfast that clinical team could be informed by previous decisions in Craigavon, but were free to make their own decisions around the most appropriate care?

A. No. It's actually very specific, as I tell you, that's the way, I will give you an example: If it is a patient with the bladder cancer and there is no other way, you need to tell the patient that you need a surgery or you need a chemo first and given a surgery afterwards or a radiation. You tell them.

Whereas there was slight degree of a difference in the prostate cancer because you mention to the patient that you have more than one choices of a treatment according to the guidelines and you give them the pros and cons of each treatment and then let the patient decide.

Sometimes we give them a cooling-off period for a week or two to go back and discuss with the family or anybody else they want to and then come back. If they inform us that they want a particular treatment, like not surgery, radiation, then we refer them to the radiation oncologist, or medical oncologist. If they want surgery, then they go to the Belfast colleague for surgery, but this is very clear.

156 Q. I think we're talking at slightly cross-purposes. I understand the process you are setting out, the patient is informed and they are guidelines, not tramlines, and that they can be sidestepped if necessary depending on the clinical profile. 14:16

But my question is a little bit more specific about your potential involvement if a patient of yours is being sent to Belfast City Hospital under the transfer of the regional review regime and you have a view on a certain type of treatment, that you would tell the patient that treatment, and also tell the receiving consultant in the hospital what you anticipate the treatment should be. Would that have been your practice? 14:16

A. No, clearly not. That's not my practice. My practice is as I outlined before. That's why I was trying to be more specific. I never interfere with any of the treatment. It is always patient choice and giving them options. 14:17

157 Q. In relation to your involvement with results and the

way in which you accessed results during your time at Craigavon, the system I know has changed, and probably the system you operate under now is completely different. But if you can cast your mind back, was it printed-off in hard copies? What way did you access and how often did you access results for tests that had been ordered for your patients?

A. As I mentioned earlier, that I have a meeting with my secretary, so I have two different folders. One was the folder for my investigations, so she will bring that with her, and I will see them on the spot when we are meeting. And I keep some of them for a later action, but reasonably, within the reasonable period of time, within the same week when I receive, I will action them. If a letter is to be written I will do that, and if I need to recall the patient, I'll do that. So that was a very strict policy that I follow. My secretary used to keep the record from my dictation, which investigation I have ordered.

158 Q. Did you have your secretary identify results for you or was she neutral in that she merely allowed them to be accessible? Had you a system of having them flagged-up if they were particularly significant?

A. Yeah, that's what she does actually because my letter at the end says what investigations are dictated or are ordered for that particular patient and what my concerns are. So she will put it on to a little Excel sheet, I believe, and keep a record on that when it is done, so to let me know.

159 Q. So she picked up from your dictation what was the order, you know the tests that had been ordered, anticipated the likely time for the results, and when they come in put them in a folder?

A. Yes, that's the way it was working at the time. 14:19

160 Q. I think you said you did that a couple of times a week, did you?

A. Yeah, I have a regular twice-weekly meeting actually. I'm very particular about organising my work stream, so that's what I do it and I still maintain the same. 14:19

161 Q. In relation to any private patients that might have formed part of your clinical practice while you were at Craigavon, did you see patients privately while you were there?

A. Very few and for a very short period of time. I did 14:19 a clinic in Newry Clinic which is very far away and that facility has some local anaesthesia surgery so I used to perform there. But I didn't recall any patients to be admitted from there to the Craigavon Hospital. And if it needed to be, I would certainly 14:19 refer them back to the GP to send it to the NHS.

162 Q. So you didn't have any patients, I think you said you used the Newry Clinic at the time?

A. Yes, that was the clinic.

163 Q. You didn't have any patients who were transferred. You 14:20 may have brought some into Craigavon or it wasn't something you did as part of your private practice?

A. No, I hardly did any. It was a very small amount of private practice. The majority of them were small

little lumps and bumps that I managed locally in the clinic. So there was a facilitate for local anaesthesia.

164 Q. I think you said you might have brought some in, if you were bringing a private patient in for treatment in Craigavon, what was the procedure that you undertook to access facilities for that patient? Was there a protocol you followed or was that something for each individual consultant to organise? 14:20

A. Look, if it was a cancer patient then I usually sent them through the NHS, asked the GP to send it as an urgent and bring them in via the NHS route. If there is a patient who is noncancer, I don't remember I did any noncancer patient, honestly, at Craigavon. 14:20

165 Q. If you did a patient, like for a reversal of vasectomy? 14:21

A. Yes, that reminds me, because my anaesthetist was Dr. Brown at the time, we were discussing and going back, I think I did something but it was out-of-hours, it was not during my NHS practising time, which I did one reversal of vasectomy at that time. 14:21

166 Q. Was that a patient that you brought into Craigavon to carry out that procedure on as a private patient?

A. Yes.

167 Q. If we just use that example, what is the gateway by which you facilitate access to Craigavon through your private practice. How does a patient end up in Craigavon. What was the system by which the consultants operated to use that gateway? 14:21

A. I think there is a proper gateway. You need to fill in

a Form and there was a Private Patient Form so the hospital can charge them. If you do it on your NHS list, then you usually give that time back to the NHS. And if you decide you are going to do out-of-hours, then it is up to you when you do that and you need to organise your theatre time. That is the standard practice in any NHS. So I think that particular patient, if I recall, I think I did it out-of-hours in the evening by mutual arrangement with our private practice thing, filling in a Form. 14:22

168 Q. It was surgery done out-of-hours I think you said there.

I want to just ask you a question around something you have mentioned in your statement. I will just bring it up to make sure I'm quoting it correctly. WIT-41866, at paragraph 56.1. You say: 14:22

"During my tenure from July 2010 to 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 six months ago." 14:23

If we just stop there for the purposes of the transcript. That would have been a call from Mr. O'Brien in early 2022? 14:23

A. Yes.

169 Q. Your statement was dated 29 July 2022?

A. Yes, I do recall that. I think we can pull up the telephone record. It was -- I received a phone call -- a message and then we have a phone discussion. It was quite late in the night. And Mr. -- I became aware that there was some Inquiry going on and he explained it to me. But the reason for the call was that he was a little bit disappointed with me because, as you showed me that Eamon Mackle's point, earlier on, remember in our discussion when Eamon Mackle said that when I was leaving I said that you were doing a great thing or something in that line? 14:23 14:24

170 Q. That we referred to earlier today.

A. Yes.

171 Q. So the context was Mr. Mackle, he was looking at Mr. Mackle's statement and saying he was disappointed you in? 14:24

A. Yes. Because I -- he was asking me did I say that and I said that I don't recall anything. Then, certainly we had a discussion about what is going on, about his difficult time. At the time he was having MHPS what do you call that, Inquiry. And then after that when I -- a few months after that I received the notice for Section 21. He didn't inform me that I will be called for any evidence. I was not sure at that time. 14:24

172 Q. Well, just procedurally, it is the Inquiry who makes the decision about which witnesses to call, but you've indicated the contents of that phone call. Was there anything else about that phone call, given the nature of your evidence, that would be helpful for the Inquiry 14:25

to hear about?

A. No. It was quite a long discussion between us with his difficult time and how did he feel that the investigation going through when he had MHPS Inquiry. Apart from that, no other discussion happened. 14:25

173 Q. So he informed you about the MHPS Inquiry which postdated your tenure, it was 2017, you had already gone by then?

A. Yes.

174 Q. I see from your statement as well that you got a copy of Dr. Chada's report given to you. 14:25

A. Yes.

175 Q. Did Mr. O'Brien mention anything about having lodged a grievance himself in 2018. Was that some information that he provided to you or that he had replied to the allegations against him. Did he indicate any of that? 14:26

A. No, I don't remember discussing anything he has done. He did mention about the USI is going on, Urology Service Inquiry.

176 Q. And, of course, Dr. Chada's report doesn't touch upon the evidence that you can provide as it postdates. 14:26

A. No.

177 Q. But just in the general context of the issues that arose around that time, and we've touched upon most of them through your evidence today, the various topics that I've asked you about, I'm sure you won't be surprised that they were the issues that I was going to address given that the Inquiry has been provided with evidence that suggest that they are matters of, 14:26

perhaps, concern around governance.

Is it your evidence that you had no knowledge of any issues around anyone in Urology, or in relation to Mr. O'Brien in particular, on the matters we discussed. 14:27
You had no knowledge of any of that?

A. As far as I remember, the Clinical Governance has become more, what do you call that, expanded in its role. At the time the Clinical Governance around looking after patients, around (inaudible) and things 14:27
like that, was, as I said, we used to have a business meeting. We used to have a monthly meeting with other managers and we used to discuss all the details or any concern raised about the patients and things like that. There wasn't any pattern or any behaviour which I can 14:27
pinpoint that was going to be any concern about anybody's practice or conduct in the future.

178 Q. I'm going to have to be a little bit firmer, I'm afraid, in getting an answer from you on that. I think you have explained the procedures by which you might 14:27
have heard, but is it the case that you did not hear anything, do not know anything, and were never informed of the Clinical Governance issues that are of interest to this Inquiry?

A. No. I don't remember that anybody ever raised or 14:28
communicated through to me with any communication that there was any Clinical Governance issues. As I said previously, I did triage some letters but that was, at the time, was not considered, it was considered over

work and capacity issues which we helped out each other.

MS. McMAHON BL: Thank you. I have covered the issues that I wanted to discuss with you today. As I said at the opening, the Inquiry Panel have your Section 21. They have your attachments to that and the documentation you rely on in support of that and obviously they have all other evidence around that. So unless there's anything you want to say at this point that you feel might assist the Inquiry in fulfilling their Terms of Reference, I'm content to hand you over to the Panel and they may have more questions, if that's okay. Thank you. 14:28 14:29

END OF EXAMINATION OF MR. AKHTAR BY MS. McMAHON 14:29

CHAIR: Thank you, Ms. McMahon.

MR. MEHMOOD AKHTAR, HAVING BEEN SWORN, QUESTIONED BY THE INQUIRY 10:21

CHAIR: Thank for coming to give evidence today. I'm going to ask Mr. Hanbury, our Consultant Assessor, to ask you some questions, then Dr. Swart will ask you some questions and then I'll round them up. So, Mr. Hanbury. 14:29

MR. HANBURY: Thanks for your evidence so far. I have a couple of clinical things that I would like to ask, if I may, in no particular order.

As part of your job plan you mentioned on the Thursday morning radiology meeting when you discuss complex cases, that's correct, isn't it?

A. It is correct. Yes, this is correct, sorry. 14:29

179 Q. The Inquiry had found out since the MDM started that that fell into disuse, shall we say, the meeting finished. Was that during your time there or...?

A. It was still happening because that meeting was actually meant to be noncancer. Initially it was for 14:30 everybody but later on we used it for a while, I think for other complex cases which are noncancer. So it still keep on going, although the attendance might be an issue. But it was quite a regular occurrence while I was there. I don't recall that it was stopped, 14:30 honestly, when I left.

180 Q. But it was becoming less well-attended?

A. Quite possible. Because the radiologist, I remember it Sam Hall was the Clinical Lead for the X-ray, he used to be present, Mark McClure, and Dr. Gareth Williams, 14:30 these are the names I remember of my colleagues in Radiology.

181 Q. I suppose I'm coming from the point of view that that was a good opportunity to discuss complicated noncancer cases and, if it's not happening, were those cases 14:31 being discussed. Would you have a view on that?

A. I think if it was not happening, then they still have an opportunity on -- after their ward round on a Thursday morning, we still sit down together and in

that possible time we can discuss if there is any difficult case we need a second opinion from our colleagues.

182 Q. Right, but that obviously wasn't with the radiologist then? 14:31

A. No.

183 Q. Just moving on, with your attachments there was a complaint that you answered about a case for a tumour orchidectomy I think with an obstructed kidney that needed a stent and orchidectomy. I wasn't quite sure 14:31 what happened afterwards, but I think the stent came out after three years or so. Just fill in the details there a little bit?

A. Yeah. What happened was, I think -- I did responded to that when I was here. It was brought to my attention 14:32 and I apologised to the patient. I think what happened, the patient went for chemotherapy in Belfast because it was a regional tumour, as you know, and standard practices are for orchidectomy and insertion of a stent. 14:32

Then I was expecting when he will finish the chemo will be sent back to us, I will be informed. So either I missed or I was not informed, it was brought to my attention. As soon as it was brought to my attention 14:32 I immediately took the steps. So I really apologise to the patient and luckily the stent didn't cause any encrustation or stone formation, so I was quite lucky that it was all okay. But the patient did lodge

a complaint which I responded to.

184 Q. That brings in the issue, sort of, why didn't you have him on record for a stent change at six months or a year. I know this is an old chestnut and every Urology Department struggles with this a bit, but what should have happened and what went wrong in that situation? 14:33

A. I think I should have initially mentioned it. I was expecting that he will be finished his chemo and I will get a letter back to me from my oncology colleagues that we are finished, so we can then look at his CT scan and his (inaudible) has resolved, or that should we change it, or should we take it. But it was an oversight obviously in this regard and we didn't mention anything to our stent register, so that was certainly a fault on us. 14:33

185 Q. So you did have a stent register then, did you?

A. I think so there was a stent register there.

186 Q. So obviously there was a glitch with the scheduled waiting list. 14:33

A. Yeah.

187 Q. I suppose, just to follow-up on the waiting list management, did you -- you say you organised all your cases at a six-week rolling, that was done with the secretary, was that? And how did you ensure that scheduled cases such as a stent change didn't get forgotten about, what system did you have for that? 14:34

A. I think that particular case was not put on the repeat to come in for a stent change, that's why we missed it.

But otherwise we have a robust system of -- we have a priority. First, any cancer patient who is waiting to be done, we put them on the list first. After that urgent patients, like patients with a catheter, long-term, and things like that and then routine. I also have access to a daycare surgery once in a month, I believe so, so I did some of them over there. 14:34

188 Q. Okay, thank you.

14:34

Going on to MDM management, you mention about clinical oncology being a problem with quoracy, but radiology we are also aware was a problem. What was the approximate difficulty in that. Was it sort of one-in-two or what sort of percentage were they not available? 14:35

A. During my tenure, as I said, it was the staff of MDT. So obviously, as we said, we need to discuss the job plans and giving them appropriate time for preparation, which took some time to resolve. Then I used to have two radiologists, a very good radiologist, Mark McClure and Gareth Williams. They were both attending one or the other the majority of the time. 14:35

But then another issue arise, which I think was resolved after I left was, to declustering the patients. Like they don't want to be present for all the MDT, so they need to be informed in advance, so cut-off times, the usual issues which arise which can be addressed by job planning. And I do remember that 14:35

they were resolved after I left with the team.

But during my tenure they were -- I will say that more than 70 percent of the time they were present.

189 Q. Thank you. We talked about pelvic surgery and radical prostate cancer going to Belfast. There are a couple of other subgroups of interest, one is the small kidney masses. You move on to the specialist part of your MDM. How did that work, the small kidney masses? 14:36

A. At the time the small kidney masses were discussed at -- at that time I think we used to discuss if they are indeterminant at the regional MDT and the majority of them go on surveillance. If anybody need a partial nephrectomy they used go to the Belfast after establishment of MDT because that's where it was done. We did for some time a partial here, but then we moved all together to the Belfast because the laparoscopic service was provided there. 14:36

190 Q. Fine, so you weren't aware of any particular problems with that group of patients. Okay. 14:36

So the other one we're interested in and there was a case that cropped up, was a penal cancer. Obviously you were involved in the setup of the NICaN IOG guidance, it needed a particular pathway. What's your recollection of how that was set-up, these rare cases which you will see maybe two or three a year. 14:37

A. Yeah. I think remember Mr. Keane, Patrick Keane, one of our senior urologist at the Belfast City Hospital,

used to do a quite a significant amount of penile preserving surgery.

So if the case is a small cancer which is diagnosed, it is always discussed and referenced to him for any further treatment. We never did anything more than circumcision and, very rarely, I think, have a partial or a penectomy done at the time, but I think it was done all in Belfast. 14:37

191 Q. So is it your recollection that penal cancers were always discussed at the regional -- 14:37

A. During the time that I was there, yes, of course.

192 Q. Thank you.

Just on the same subject, MDM working, and going back to some of your evidence today: There was some question when you were setting up the MDM about patients with bladder cancer having BCG and Mitomycin coming back for follow-up check cystoscopy, and there was a problem there. But that would seem to predate the MDM. What was the process? 14:38

A. The process is usually, as according to the patient histology, you decide either Mitomycin will be the first choice or a BCG. Then you just give it -- I think it was given in Thorndale Unit at the time, which was an ICAT Unit outside the hospital but in the premises of hospital done by the nurses and then usually book it from there. 14:38

So there was not a clear process, I believe, but it was ongoing for a long time. But when I found out, we just corrected it. So the patients get their BCG. At the time we usually give only, and in 2007 onward, we only give the induction BCG which was six-plus-three sometimes, but maintenance came later on. So it was usually the --

193 Q. My question wasn't so much giving it, but was it the responsibility of the specialist nurses giving the BCG to then schedule the check cystoscopy? 14:39

A. That's the way it should be and we are just sorting that out I believe.

194 Q. The implication of your evidence was that wasn't happening properly. Was that a problem of the specialist nurses filling in the right forms, or was it a capacity problem for check cystoscopy? 14:39

A. I think it was -- during my time it -- there was some capacity issue but mostly, because we only have one working nurse at the time, Kate O'Neill. Jenny McMahon was off sick. That must be the issue, the manpower. 14:39

195 Q. Sorry, manpower giving the BCG or manpower doing the flexible cystoscopy?

A. Both.

196 Q. Thank you. Just a couple of quick ones, the episode with middle grade cover and the email with Belfast, what was your middle grade cover at the Southern Trust when you were there? 14:40

A. I think we used to have a four middle grade, a four out of five. There was one GP with a special interest,

they used to cover out-of-hours quite regularly throughout the week with the consultant on-call. So it was quite focused locally and the patients are seen in A&E by the A&E doctors and then referred to the middle grade who was on-call. 14:40

197 Q. So you had a one-in-four rota?

A. Yes.

198 Q. Thank you.

Very lastly, we mentioned the antibiotics and IV fluids for the nonseptic patients with UTIs, obviously not under your care. Were you aware of that happening? 14:40

A. I was aware of -- that there are some times the patients are admitted through the outpatient or on-call, but not on a scale. At that time I think it was already being discussed with the microbiology. I do not know what was routine before me, but at the time when I joined it there was an MDM which used to take a discussion about these patients. That may not happen regularly, but it was attending physician's responsibility to discuss with microbiologist. 14:41

199 Q. But before that happened were you -- that was obviously a process that was brought in by the Medical Director at that time?

A. Yes. 14:41

200 Q. When you were first aware of it, and it obviously it seems as though you weren't happy with that, did you discuss that with Mr. O'Brien or Mr. Young?

A. Because I have seen some of the consultant down on the

south side of the border used to have that routinely, admitting the patients who are chronically getting infections, who get an IV antibiotics, they are admitted on demand. So I thought that it is going on but never been discussed from my point of view that -- as there was an MDT discussion happening about those patients.

201 Q. But you didn't sort of challenge Mr. O'Brien or Mr. Young on the issue?

A. No. 14:42

MR. HANBURY: Thank you. I think that's all. Thank you very much.

CHAIR: Dr. Swart.

DR. SWART: Thank you for the evidence so far. Just a slightly different tact, can you tell me what you did about copying letters to patients? 14:42

A. I don't remember it exactly, but I think my practice was to have patients informed via GP, a letter goes to the GP and a copy to the patient. If a patient particularly asked for, then I would certainly make sure that he get the copy. 14:42

202 Q. As far as we can see, it wasn't routine instruction for patients to get copies of letters.

A. No. You're talking about --

203 Q. -- many patients had no copies of any letters. Why do you think that was? Because, as you know, in England this has been routine practice for many years now. Why do you think that was so different in Belfast now that you've kind of moved on. Do you have any reflection on 14:43

that?

A. Not really. Because I thought it was just routine the GP get it and the people doesn't have an access to it -- no, sorry, the people just get it from their GPs. So that's what I think it was, routine going on. So I never -- 14:43

204 Q. You didn't think about it and there was no direction from The Trust in this regard?

A. No.

205 Q. No. Okay. 14:43

The complaints that have come through that we've seen in Urology have been actually mainly about waiting times. There are large numbers of patients complaining about appointments and various things of that nature. 14:43 What would you do with that, if your secretary told you that patients were ringing up and complaining about waiting times, or the Complaints Department told you. What was your personal practice?

A. My personal practice will be certainly to give an attention to that and then try to resolve it if the patient is waiting to be seen. I'll make sure that I make an arrangement for them to be seen urgently if there is a medical condition. Otherwise I just reflect and go back to the GP if they are a non-urgent. 14:44

206 Q. How did you assess whether there had been a change in their medical condition. Did you have a process for that?

A. Of course. Sometimes I do ring the patients if there

is some genuine things coming through, otherwise I will have asked the GP to see the patients and let us know.

207 Q. Okay.

There's been a lot of mention of culture in every single Inquiry that I'm aware of and particularly medical culture. So just as a starting point, who did you regard as your boss, if you like, your line manager? Who did you think you answered to within the Trust? 14:44

A. First of all, when we are appointed as consultant, we are our own boss, unfortunately or fortunately. But there is certainly a person with an operational duties or line management. So my immediate line management was two-directional, one was clinical line management, which was Mr. Young. Then there was an operational, from point of view, and I believe it was Martina Corrigan which I usually -- 14:45

208 Q. How did that play out for you, did that cause any tensions? 14:45

A. No. I have never had any issue with anybody because I always work collaboratively. If anybody has any -- if I have any difficulty, I go straight to them and if they have any operational issues, they come to me and we can sort it out. Because that's the only way we can work in NHS. 14:45

209 Q. How did you see the role of the Clinical Director at Craigavon?

A. Clinical Director, there's a clinical lead, is

Mr. Young. But I think Clinical Director in my time was Colin Weir, he was one of the --

210 Q. Did you have much to do with him?

A. No, no, he was vascular surgeon so we hardly had -- only apart from meeting in the theatre changing room when we have the list, and I do recall Eamon Mackle was Associate Medical Director. 14:46

211 Q. Did any of these people sit you down as a group of Urologists and talk to you about your strategic plans for the future or try to facilitate something. I know you were involved in the Urology Service Review but that was more or less imposed and so on. Did anybody sit down and say, right, what needs to be done here and what are your ideas? 14:46

A. I don't recall any, apart from this review meeting which started on Monday evenings and out of our time. But I don't recall there was any other meeting which we have on purpose to discuss. 14:46

Because the majority of the time, if administration need anything or operational-wise, it was conveyed to us by Martina, our Operational Team Leader, but we work very, very, closely with each other. And it was not a long-term planning which I always felt like that could be lacking on reflecting back now, but, yes, a day-to-day operation was run by that. 14:47

212 Q. Yes, I mean all doctors have a duty to improve their services, don't they?

A. Of course, yes.

213 Q. You did have the opportunity to talk about that.

Was there a mistrust of people that had gone to, sometimes it is called the dark side of medical management, did you feel there was a tension between frontline clinicians and medical managers at all? 14:47

A. No, I didn't. Because I never have any much interaction with the senior management, apart from those Monday. But my own relationship or my own dealing with my operational manager was always welcoming and it was helping each other, that's the way I believed to work. 14:47

214 Q. You talked about the Clinical Governance meetings which actually I think turned into Patient Safety meetings, but actually it is a meeting where things were discussed. 14:48

A. Yeah.

215 Q. What is your view as to how effective those meetings were in terms of changing things that needed to be changed? How did it work from your perspective. Say there had been a serious incident and some things had gone wrong. Who took responsibility, for example, for putting in changes? 14:48

A. It was the responsibility of -- on a higher level was clinical lead and also the operational lead. But if it was particular to a patient then it was the responsibility of the reflection of the consultant attending physician. And then we took, as a whole, responsibility the Department to implement if any 14:48

change need to be made.

216 Q. So can you think of times when you made big changes as a result of a serious incident, for example?

A. I don't recall anything, because it was only four years I was there. But I do remember that we did change that we are going to be more vigilant in looking at our patients' waiting list and things like that. That that should be sorted out in a timely fashion. 14:48

217 Q. Another thing that has come out through the evidence we have heard to date is a lack of investment in clinical audit. Can you tell us how you found clinical audit in your time and whether you had any problems with resources for that, or whether you can remember that being discussed as an agenda item, or whether there was any input into national audits? 14:49

A. I don't believe -- I don't think so there at that time in Urology, any national audit was running. We need to look back 20, 15, 13 years ago. I don't think so there was any national audit I was aware of. Because I'm quite actively involved in the majority of the national audits, (inaudible) and things like that. So there was local audits, yes, there was. Sometimes we do our own, like looking at patients with catheters and things like that. But as such, if we see as a Clinical Governance point of view at that time, there wasn't much going on. 14:49 14:50

218 Q. Where do you think the impetus for that should come from. I mean, what's your view on the atmosphere that allowed that to happen, because there was a lot of national audit going on then?

A. Of course. But I'm not aware in Urology that any national audit of any urological condition was going on. If it was, we were not part of it. Yes, there was some cancer related which would come through MDT and we used to send the patient. The impetus should come from, actually, the clinician himself to look at and reflect on their practice and they see that if they need to change accordingly and should come. But it only comes when you have some spare time. 14:50

219 Q. So what was the main impediment from your perspective then? 14:50

A. We were working so much on a day-to-day basis, working on, and just fighting a fire which was uncontrollable. So you just finish one list, you are now looking forward to what is next on your plate to deal with it. Targets were coming at the time. You have a target of achieving triaging within 72 hours. You have a target of decreasing the 52-week wait, longer patients. So all these were going. So we were running right, left and everywhere to achieve those targets. So once I have some time, then certainly we will be -- 14:51 14:51

220 Q. What targets did they set with respect to quality of service?

A. Sorry, I didn't get that?

221 Q. What metrics or targets did they set with respect to the quality of the service? Did anybody talk to clinicians about that? 14:51

A. I don't remember that apart from discussing the waiting list and discussing the long wait, discussing the

triage, any other matrix were discussed ever in any meeting with us.

DR. SWART: Thank you.

CHAIR: Thank you, Dr. Swart.

14:52

Just a couple of things from me, Mr. Akhtar. We have heard discussion this morning about the recommendation from an MD going back to the patient where you would discuss with the patient and you would outline if there were options, rather than just one clear-cut recommendation, or even if there was one clear-cut recommendation and the patient said, well I don't want that. Where would you record that? 14:52

A. It should be recorded in the patient's clinical note and the letter. And preferably to bring it back to the MDT and informing MDT that this patient is deciding on his own slightly differently, and the patient is taking control on his own hand. So there is a mechanism of recording it. One is the patient's clinician notes, the second is to inform the GP, and the third one to go back to MDT. That is the best practice. 14:52 14:53

222 Q. That is best practice, so you would expect that most consultants would know to do that?

A. Of course. That's what I think everybody will do that.

223 Q. Okay. 14:53

A. Sorry, should do that. Sorry, not "will", they should do that.

224 Q. They should do that?

A. Yes.

225 Q. The first you were aware that there was any issue with regard to Mr. O'Brien's practice was this telephone conversation that you had with him in January of 2022. First of all, you hadn't been in touch with him in the ten years after you had left Craigavon, so this phone call must have come out of the blue? 14:53

A. Yeah. We had been in touch with each other, like meeting on regular meetings, on peer review meetings mostly out of the country. I do remember for the first couple of years we used to go to the European Urology Oncology meetings in Europe. Then after, I think two or three years that becomes less and less frequent because we all got busy. Then the first time after that I come across, I think. From 2014 that was the first time I come across that. It was quite out of the blue. 14:53 14:54

226 Q. I take it you were surprised to hear from him after that length of time?

A. Yes, I was. Certainly he text me first, I think I still have that message telling me that, are you free, I just spoke to him then. 14:54

227 Q. So he text you and asked him to call you, is that it? So you had the telephone conversation. What I'm wondering is, he was asking you a specific question about Eamon Mackle. Was it only later that you found out about what the situation was, what the complaints were in relation to the SAIs for example, to the MHPS? So Mr. O'Brien didn't tell you that, you found that out as a result of your involvement with the Inquiry, is 14:54

that fair?

A. No. He did mention to me that MHPS Inquiry, MHPS investigation happened, but he did mention that -- I wasn't -- I can't recall it exactly, that either he said that it is in relation to Urology Service Inquiry. 14:55
He did mention there was an parliamentary Inquiry going on and in which the evidence he read from, because preliminary evidence was given to him, so he read it, from Eamon Mackle, which he said that he was slightly disappointed with me. 14:55

228 Q. Can I ask, when you did get information, both from The Trust initially so that you could reply to the notice that we had sent to you, and when you later received a bundle of information from the Inquiry, how did you feel? 14:55

A. It was difficult for me because there was clearly mention in it that Mr. O'Brien hasn't done some triaging, also some clinical patients' clinical decisions. For me it was quite difficult to take that in, that this thing can happen. But obviously I feel 14:56
sorry for Mr. O'Brien, as well as for the patients which was informed that there was some mismanagement happened. But that's -- it was disbelief for me, honestly.

229 Q. This is someone who you described earlier to us as your 14:56
mentor?

A. Yes.

230 Q. Would it be fair for me to ask then, he said he was disappointed in you, was that reciprocated when you

discovered all of this information?

A. No, it was not. Because he was my senior so if he felt that some of my comments which is attributed to me, not said by me, certainly he has a right to ask me because he had done so much in terms of my training and the work together. 14:56

So as a junior to him, I did feel it, if anything wrong he has a right to ask me and I said that I will explain it, that I didn't say that. So it was no reciprocated but I certainly feel sorry for him when I heard all of that and it was quite traumatic. 14:57

CHAIR: Thank you very much. I have nothing further to ask you.

MS. McMAHON BL: Just one point I've been asked to clarify. 14:57

Mr. Akhtar, just to confirm if you can, if this is your evidence, that it was the Trust and not Mr. O'Brien who provided you with the Chada report and Dr. Khan's determination. 14:57

A. Yes. Mr. O'Brien didn't provide me any sort of paperwork. It was only conversation we had and since then we haven't had any conversation.

231 Q. You weren't provided with Mr. O'Brien's response or the details of Mr. O'Brien's grievance? 14:57

A. No. The only bundle I get was on this platform which is a sharing when I was informed to write on my statement, which included various documents which was

relevant to my response of this Inquiry.

MS. McMAHON BL: Thank you. Thank you for clarifying that. No further questions.

CHAIR: Thank you. Thank you, Mr. Akhtar. I think that concludes the evidence today? 14:58

MS. McMAHON BL: Yes.

CHAIR: 10 o'clock tomorrow morning, ladies and gentlemen.

THE HEARING WAS THEN ADJOURNED TO WEDNESDAY, 10TH OCTOBER 2022, AT 10:00 A.M. 14:58