Urology Services Inquiry

Oral Hearing

Day 88 – Thursday, 22nd February 2024

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 COMMENCED AT 10:00 A.M. ON THURSDAY 22ND FEBRUARY 2024 AS FOLLOWS:

CHAIR: Good morning, everyone.

MR. WOLFE KC: Your witness this morning, Chair, is Mr. Mark Haynes. I think technically he should be resworn. I'm not sure it was explicitly said he was released from his oath on the last occasion but certainly I've consulted with him, and no doubt other people have consulted with him in the interim. 09:59

CHAIR: Very well, then. If you don't mind taking the oath again then, Mr. Hayes.

MARK HAYNES, HAVING BEEN RESWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

MR. WOLFE KC: For the record, Chair, Mr. Haynes was last with us in November 2022. I should say December 2022. His evidence was taken over three days. 16 November, you can find the transcript reference. 10:00

CHAIR: December '23?

MR. WOLFE KC: '22, in fact.

CHAIR: It was '22?

MR. WOLFE KC: It was '22. All of us are aging.

CHAIR: Some of us more rapidly than others, Mr. Wolfe. 10:00

MR. WOLFE KC: Yes, it was '22. It was in the early weeks of the Inquiry. Just for your note, the transcript for 16 November is to be found at TRA-00818; for 17 November at 00883, and for 1 December 2022

01282, the prefix, of course, being TRA for each of those references.

CHAIR: Thank you.

MR. WOLFE KC: Also in the interim, Chair, Mr. Haynes furnished us, at the Inquiry's request, with a second Section 21 response, which I'm going to invite him to formally adopt now. The first page is to be found at WIT-103804. You will recognise that, Mr. Haynes. It is number 20/2023. 10:01

You'll recall, Chair, that at some point in the evidence an issue arose about the use of monopolar as opposed to bipolar in TURP process, and the use of glycine or the use of saline. That response or statement is specifically focusing on that issue. 10:02

Then if we go to the last page, Mr. Haynes, we can find that at WIT-103820. 819 to be precise. That's your signature, is it?

A. Yes. 10:02

1 Q. It is dated 2 November 2023. Can I ask you do you wish to adopt that statement as part of your evidence to the Inquiry?

A. Yes.

2 Q. I'm obliged. 10:02

Just to reorient ourselves, you, Mr. Haynes, are a consultant urologist and you remain primarily deployed in the Southern Trust?

A. Yes. I am employed by the Southern Trust and I do clinician activity in Belfast Trust as well.

3 Q. You have held the consultant urologist post since 12 May 2014, and we heard in more detail the last occasion about that. 10:03

You also told us the last time that since December 2021, you've held the role of Divisional Medical Director within Urology and for Urology Improvement, according to the job title? 10:03

A. Yes.

4 Q. Now, in the course of your evidence today, I want to first of all look back and recap on some issues that were raised with you previously. I want to look at those in light of or to take account of some of the 10:04 evidence that we've received since you were last with us. Then, I suppose in the second part of your evidence, we will wish to look at what improvements you have observed and perhaps participated in, given the shortcomings that were exposed primarily as a result of 10:04 the SAIs that were initiated in 2020. But broader than that, we will want to look at the whole area of urology improvement, taking into account some of the evidence you gave the last time about the demand capacity issue and how that has been addressed in the interim. 10:05

If I could start this morning by looking at the issue of private patients which you raised with us in your evidence in November 2022. It will be recalled that

in May 2015 and again in November of 2015, you wrote to Mr. Young to express concerns that you considered that Mr. O'Brien was advantaging patients who he had seen in a private capacity; isn't that right?

A. Yes.

5 Q. In your evidence you explained that you considered the approach that was being adopted by Mr. O'Brien to be immoral. That was the word that you used.

Now, as you explained, you raised those issues with Mr. Young first in May 2015, and then you saw the same problem again in November 2015. The problem, it appeared to you, had not been fixed; is that fair? 10:06

A. Yes.

6 Q. In your evidence in that context of the problem not being fixed, I asked you about the governance around this issue and you said that it was, at best, ineffective. You might remember saying that. 10:06

Can I bring you to this? If we bring up Mr. Young's witness statement; we can find it at WIT-104216. If we just take the bottom half of that from (b) downwards. He is recalling that: 10:07

"I believe that I spoke briefly to Mr. Haynes at some point after the first email". That was the email that you delivered in May of 2015. "I have a recollection it was after a ward round at the nurses's station, and asked him if there was any clinical reason for the 10:07

patient being seen in the time scales in question. I cannot recall if he responded then or later, nor can I recall if I made any attempt to follow up the issue (although, for the avoidance of doubt, I accept that I should have done)". 10:08

I just wanted to ask you about that because I got the sense from your evidence on the last occasion, correct me if I'm wrong, that you felt that the issue raised by you in May 2015, and again in November 2015, had not 10:08 elicited any response from Mr. Young?

A. It had not elicited an effective response; it hadn't changed the behaviour as I saw it. That's what I've highlighted in the later, in the second email, that it continued to happen. 10:08

7 Q. You say continued to happen. It is perhaps not a point lost on the Inquiry that, if we go to TRU-01069, this is the list of patients that were seen privately by Mr. O'Brien which then raised a question for the MHPS investigation. One can see that all of those patients 10:09 which were the subject of Mr. Young's analysis for the purposes of Dr. Chada's investigation were seen and operated upon in the period immediately after - the 12 months or so - immediately after you raised your concerns with Mr. Young. That might prompt the 10:10 conclusion, would it, that the issue had not been effectively tackled?

A. Yes. I mean, it continued happening.

8 Q. Yes. I suppose this issue might be considered

important for the purposes of the Inquiry because it raises a compliance issue. There are rules associated with the management of private patients into the NHS, just as there are rules about triage, there are rules about whether you retain records at home, there are rules about dictation. You are bringing your concerns to a medical manager in the form of Mr. Young and it's your view that the matter was not effectively handled. Mr. Young, just in fairness, I should say, has accepted candidly in his evidence that he dropped the ball, to use his expression, around this, that he should have taken steps; he should have, perhaps, escalated it to more senior management. 10:10 10:11

Can I ask you this: Has anything changed within the Southern Trust Urology Service? If a senior clinician, one of your colleagues, was today being seen to be breaking any of those rules or potentially breaking any of those rules - it might be private patients, it might be any of the other practice areas that I've referred to - have you confidence that it would be better addressed? 10:11 10:12

A. So if you look at this private patient issue here, yes, there is a procedure that was supposed to be followed. If a patient transfers into NHS care, a patient transfer form was supposed to be filled and I don't believe any were filled in at this point by Mr. O'Brien. We know that that procedure has been tightened up within the Trust. There is a -- I know 10:12

that my colleagues who undertake private practice, when they transfer the patients in for NHS care, are completing that form. That form is collated through a central -- I think it is linked to the Medical Director's office. There are audits that are undertaken to check that they have gone through the right steps. In terms of the expediting or bringing people ahead of patients who have been waiting longer for the same procedure, if we look within Urology, we, as a team, function from a pooled waiting list. While someone may be added to the list under my name, that doesn't mean that they are getting their operation under me. They will get their operation when they come to the top of the waiting list by an appropriately trained clinician on the next available list. We have a scheduler who plans and schedules our list rather than us having a direct point. So the ability for a consultant to transfer a patient from their private practice into NHS care and then on to their next operating list is much more limited. 10:13 10:13 10:13 10:14

9 Q. Okay, that's helpful. That's a response centrally to the private patients points. But a little more broadly, as was the focus of my question, the mischief here I'm identifying is -- and, as I say, it is not just private patients, the evidence seems to suggest that it's divergence or compliance issues across a number of practice areas; management, whether operational or professional, knew about them but the private patients example, in your own words, is an 10:14

ineffective response, an ineffective governance response. It is that point that I'm focused on. Has the responsiveness or the culture changed around that? If there is an outlier in terms of one of your colleagues, what is the appetite for addressing that at the coal face? Is there a better approach to escalating these matters, or where does your confidence lie in all of that?

A. So it's only -- fortunately, I haven't had to escalate a noncompliance thing, but we do have monitoring that is ongoing of the entire team on a number of issues directly related to some of the failings that have been identified. I've mentioned there that private practice is -- as I say, I know that this is monitored but I haven't had to escalate it. If we look at management of results, we have a monitoring process, we have an escalation process within that, but I haven't had to go beyond the first step of that escalation at any point. That first step of the escalation is me contacting the clinician. Typically that is that they've fallen behind because they've had a period of leave and they are just over two weeks in terms of actioning their results.

If we look at triage, we have a monitoring process in place, we have an escalation process in place. I haven't had to trigger the higher steps of that escalation process because they haven't happened. So I'm confident that we have processes surrounding

a number of the failings that have procedures linked to when there is a failing identified that escalate it through the system and the medical management structure that will identify the problem and enable it to be tackled.

The very first point, though, is that actually lots of it is self-policing, certainly I found with many things. If you are telling your team of consultants this is how well you are doing at this particular thing and you've effectively got a league table, although you may not portray it as a league table, they make sure that they are not the outlier. So it is self-policing. So before anyone needs to escalate, someone will spot that I'm a bit behind, I better pick myself up.

10:17

10:17

10:17

10 Q. Perhaps later we'll look at some, if you like, of the devices or tools that have been constructed to ensure that outlying behaviours are more quickly picked up. Is it not fair to say to while there have been improvements in the development of those kinds of alarm bells or devices, during the whole triage problem, during the whole notes at home era - put it in these terms - the system knew that the rules were being broken. The problem, perhaps, which I'm pointing to was where was the appetite, where was the culture in terms of properly addressing what was known, in other words, the first line manager speaking to, in this case Mr. O'Brien, or escalating as the case might be. It's that, I suppose, I'm asking you to comment upon.

10:18

10:18

Perhaps it is unfair to do so a little because the problem hasn't come across your desk, you haven't had to deal with an outlier in the years that follow. But is there anything you can say to assist the Inquiry in terms of whether there had been conversations, whether there had been attempts to build a culture whereby talking to the outlier is likely to happen and addressing it effectively is likely to happen if the problem arises? 10:19

A. As I say, with the current team I have not had to do anything beyond that first step, which is talking to, which I have done. As I've said, for most of that that's been delays that are very easily and readily explainable. In terms of taking it further, I think within my first Section 21 I mention clinical concerns about a locum consultant in post that I did address through initial conversations and then took beyond that. So, I know I have done that. I've since had concerns raised with me about a middle grade locum, which I also addressed through conversation initially and then subsequently had to take further. I can assure you that I am happy to have them conversations, which aren't always easy. I haven't had to take them further. 10:20 10:20

11 Q. Thank you. Let me move on. 10:21

The second issue I want to raise with you, which was raised with you perhaps at some length on the last occasion, is the process leading to Mr. O'Brien's

retirement and the decision that, despite his wishes and his intentions, he was not to be permitted to return on a part-time basis. If I could bring up on the screen just to remind ourselves of your thinking TRU-258960. If we scroll down, Ronan Carroll is asking -- this is 15 April 2020. "We're taking Aidan back -- yes?" You respond a couple of minutes later to say: 10:21

"Needs more discussion than can be had at present. In short, yes, but with strings attached and these strings need to be clear and accepted before he is offered anything". 10:22

In terms of your thinking, that's fairly clear. You were of the view that he would or could come back. There hadn't been a big developed discussion at that point but, in principle, he could come back, albeit with strings attached. You proceeded in your evidence on the last occasion to explain what you meant by strings, and that was that there needed to be a very clear way of managing his performance and what those expectations were, and he needed to agree to them; isn't that right? 10:22

A. Yes. 10:23

12 Q. You went on to say in your evidence that thereafter there were discussions and a view was taken that he couldn't come back. I want just to refocus on aspects of that briefly this morning.

First of all, could I ask you, Mr. O'Brien certainly had formed the impression before your conversation with him on 8 June that he would be coming back. Did you ever discuss with him - and if not, why not - your view that he could return with strings attached? 10:23

A. I don't have a direct recollection of ever having that conversation. I think we have to remember where in time this was. This was early COVID, there was a lot happening that this, rightly or wrongly, will have been within a long list of things that I needed to do. 10:24

13 Q. But plainly there were conversations with others, as you've referenced, just not with Mr. O'Brien?

A. Yes. So I've said "Needs more discussion than can be had at present", so I've implied that it needs a lot more discussion and thought through but I've said what my initial thoughts are. Them thoughts are really in line with knowing that there was the return to work requirements, that monitoring thing. So we needed absolute clarity at minimum that them things were going to be adhered to. 10:24 10:25

From memory, what would have happened over the intervening period is my thoughts and consideration of the issue and the risks posed would have evolved, and they would have evolved through conversation with others to a point where I came to a view that the risk was too great, that it was not an acceptable risk to take on and, therefore, came to a view not to proceed. 10:25

14 Q. Yes. If we look again briefly at your conversation with Mr. O'Brien on 8 June. If we bring up AOB-56498. Just at C, you've explained that you've taken the issue, I suppose, forward with a number of conversations within the Trust, with HR, and at Medical Director level. "Unfortunately, the practice of the Trust would be they don't re-engage with people while there's an ongoing HR process". I think you've explained in your evidence that the persons mentioned there were, in terms of HR that would have been Zoë Parks, and at Medical Director level it would have been Dr. O'Kane; is that correct? 10:26 10:26

A. Yes.

15 Q. Just again on the last occasion when I was asking you about this phrase, "don't re-engage people while there's an ongoing HR process", it was the sense of your evidence on the last occasion that that was, in a sense, just a convenient phrase whereas the real reason was that you had no confidence in Mr. O'Brien to deliver? 10:27 10:27

A. If he came back into work, I needed confidence that the failings that had been identified before would be addressed, and I didn't have that confidence. I didn't say in that telephone conversation that I had discussed with his colleagues but I had, albeit informally, my concerns that there were risks attached if he were to come back. I would have discussed it, as I've said there, with the Medical Director, my concerns that if he did come back, it came with risks. We'd had 10:27

a period of time from that first set of SAIs, so 2017 into '18, with a Return to Work Plan, a monitoring process, and we had found during that monitoring that there had been exceptions. I didn't have evidence that there had been practice change, acceptance that there were failings that needed change and, therefore, as I've said, my view evolved to a point where I felt that risk was too great. 10:28

16 Q. In terms of your discussions with HR and with Dr. O'Kane and the Medical Director's office, can you help us with that? Is that you giving your view and seeking their advice on it or was it, in essence, a tripartite decision? 10:28

A. It will have been me expressing my view and seeking support, for instance, with the Medical Director, which the Medical Director did agree with my view. With HR it will have been more 'do we have an obligation to re-engage? Is there any reason why I can't say no?' 10:29

17 Q. We know, and we'll look again briefly in a moment, that you had concerns about how Mr. O'Brien had handled two particular patients and a concern as to whether they were on the PAS, on the waiting list, and we'll come to that in a moment. Are you confident that your conversations with Mrs. O'Kane, Dr. O'Kane, around whether he can come back, did they take place before you were aware or before you were concerned about those two patients? 10:29 10:30

A. From memory - I haven't got the dates in front of me - but from memory the plan for the -- the time for this

planned phone call was set before that email had been sent.

18 Q. Now, we can see from the record of your discussion with Mr. O'Brien that he asked you to commit the rationale for the decision that he wouldn't come back, to commit that to writing. If we look at TRU-163341. Zoë Parks, Human Resources, wrote to you what I think on the last occasion I called something of a script for you to send on to Mr. O'Brien. Could I just ask for your thoughts on one aspect of it. It says in the last sentence: 10:30 10:31

"I have discussed this with the Director of Acute Services and we decided that we are not in a position to re-engage given the outstanding MHPS/GMC processes that have still to be concluded". 10:32

It is noticeable perhaps that this script isn't directing attention to your conversations with Dr. O'Kane or with Human Resources, which we saw in the transcript of your meeting with Mr. O'Brien had been your advisers or your confidants on that issue. Just to be clear, did you seek HR and Medical Director input into the decision? 10:32

A. I will have spoken to them. They will have been aware that I was speaking to Mr. O'Brien, and I've obviously communicated with them afterwards. 10:32

19 Q. Yes. Did you seek the input of the Director of Acute Services?

A. I would anticipate I would have spoken to the Director

of Acute Services at that time as well.

20 Q. That's what Zoë Parks has recorded here but she hasn't recorded, for whatever reason, your involvement with the Medical Director and herself leading to this decision. Can you explain why that wasn't mentioned? 10:33

A. No. That's what I was advised to put in the script.

21 Q. Is it the case that this wasn't sent to Mr. O'Brien by you?

A. I don't know exactly -- I haven't got... I haven't looked to see what happened beyond there, but I think 10:33 then there was a letter received by the Trust from Mr. O'Brien which --

22 Q. There was, in fact, a letter sent that day, 9 June, by Mr. O'Brien that prompted a response on 18 June, nine days later, from Mrs. Toal. Can you recall a conscious 10:34 decision not to respond to Mr. O'Brien as you had promised to do in your discussion the day before?

A. As I say, I think my memory -- I haven't looked at the timeline. My memory is that letter from Mr. O'Brien to Mrs. Toal altered the plan for how to communicate. So 10:34 that then went through that communication with Mr. O'Brien and my letter didn't go.

23 Q. We spent some time on the last occasion looking at Patients 104 and 105. I think you know the names, but they're in the designation list before you. You 10:34 explain in your statement -- I don't need to bring it up on the screen but just for reference purposes, it is WIT-53938 at paragraph 62.11. You explained in your statement, and indeed in your evidence on the last

occasion, how, in your role superintending the movement of patients into the post-COVID operation lists at Daisy Hill using the services of the independent sector, you became concerned when Mr. O'Brien emailed you with a list of ten patients, you became concerned that two of those patients, 104 and 105, did not appear on the Trust's waiting list. Isn't that right? 10:35

A. Yes. So the process at the time in terms of me acting as the gatekeeper for the limited operating available that was across both the Trust and the independent sector providers that were being used regionally during COVID, each specialty had their specialty lead who was supposed to collate those patients who required surgery in the coming two weeks and send me a list. As individual consultants there was a process that was supposed to be gone through before this that got collated by the specialty lead and then sent on to me. So I would have received a weekly email from specific individuals of the specialities, if you like, demand for surgery that needed to be undertaken during that period of COVID. 10:36 10:36 10:36

What I didn't receive from anyone else was any green form waiting list forms. We have to remember that this is in the context of an individual who we already have concerns is not undertaking administrative aspects of his job. In receiving them that I didn't receive from anyone else, and I've checked in my email archive over periods of that time and I didn't receive green forms 10:36

from anyone else, I received a list from specialty leads as to the patients to go on to the urgent bookable list. I then looked at a copy of the waiting list I had at that time which, as we've covered in previous, I have not been able to identify that precise file, and my belief at that time was that them two patients were not on that waiting list on my check of that file. 10:37

As I've accepted previously, as it comes to light subsequently, them two patients were on the list. But my concern was that they weren't and that concern was heightened in the fact that this was an individual who we had concerns that they weren't doing administrative parts of their job, who was also about to leave the Trust. So I had another concern, is there a group of patients who we don't know about who need surgery, should be on a waiting list but aren't currently on that waiting list? So that was, if you like, the thought process, the thinking behind my concern. 10:37 10:38 10:38

What that concern triggered was a look into a number of other patients. Very rapidly, I think within ten days of that -- within a short number of days of that concern, Martina Corrigan had undertaken a review of a number of patients who'd had procedures similar to them two patients, and had identified I think it was the 13 patients who appeared to only have been added to the waiting list at the time planned surgery was given 10:38

a date, not at the point that they had their first surgery, and a further patient who appeared to have never been added to the waiting list but had come in as an emergency and had had their problem dealt with as an emergency. That then led on to a practice review in a number of factors. I think it is the 6 July email from me where I've gone through some individual cases that have been highlighted by Martina Corrigan. I've highlighted a number of my concerns with regards to things this brought to light and I suggested what needed to be done. A further patient review looking at cohorts of patients from MDT discussions, radiology results, pathology and cytology results was undertaken, and that identified I think it was seven of the nine patients within the Hughes SAI. 10:39 10:39 10:39

Now, as I've acknowledged, my concern about them two patients was wrong, but it doesn't mean that we didn't find other problems.

24 Q. Yes. You wrote to Mr. O'Brien - I think it was 11 July but I'm struggling to find the reference - to set out, if you like, the outworkings of those further investigations that had been prompted by your, as you've said this morning, misplaced or incorrect concern about those two patients. Just to be clear, unambiguously you accept that you had made a mistake in asserting a suspicion that those two patients weren't on the waiting list? 10:39 10:40

A. Yes, but my belief at the time was that they weren't.

25 Q. Yes.
A. I can't tell you when that got -- that came to light. To me, that really -- that came to me last time I was here.
26 Q. Yes. Can I just -- we'll come to the timing of your realisation in a moment. 10:40

In terms of your error in this respect, we spent some time on the last occasion reflecting the fact that you had access to an Excel sheet as opposed to the full patient waiting list, and there was some discussion about whether filters had been applied that, for whatever reason, had removed those two patients from the document that you were looking at. Have you been able to work out since you were last here, in the period since you were last here, how the mistake on your part came about? 10:41 10:41
A. Because I haven't been able to identify that Excel sheet, I can't say definitively. As I did last time, I gave potential explanations but I can't say definitively because I have not been able to find that file. 10:41
27 Q. We know, and we'll come to it perhaps in a moment, that this triggering event, the discovery -- your concern about the two patients, the concern you held at the time - I hope it is not unfair to call it a triggering event - but it's written into, for example, the report that went to the Department in the autumn of that year that, as I say, the explanation is given that because 10:42

of a suspicion around those two patients, investigations followed into other patients. Then, that is read into the record of the Northern Ireland Assembly when the Minister spoke about the issue.

10:43

Since realising that there was, in fact, an error in your analysis around this, has that been formally drawn to the attention of either the Trust Board or the Department?

A. I don't know. 10:43

28 Q. You don't know.

You wrote to Dr. O'Kane about the issue on 11 June 2020. I just want to bring that up on the screen; it is to be found at TRU-252799. Your email is 10:43 just below. You explain your concern. Behind that email are the green forms and the patients that we're talking about, 104 and 105. We don't need to go to that. "This is a really concerning email", Dr. O'Kane reflects, and she sets out a series of questions. What 10:44 I want to ask you about is what follows from this.

If we go to Mr. Devlin's witness statement; Mr. Devlin was the then Chief Executive of the Southern Trust. If we bring up WIT-00096, and just at the bottom of the 10:45 page, please. He says:

"In the middle of June 2020 (I do not have a note in the diary of the exact date) Maria O'Kane, Medical

Director, approached me in my office to raise serious concerns about an issue that had come to her attention. She had been made aware by Mark Haynes, Associate Medical Director, that an email had been sent to Mr. O'Brien to request that his patients that had not been added to the waiting list were to be considered for an urgent bookable list. When Mr. Haynes reviewed this further, it was clear that there were other patients that required to be investigated. 10:45

"At that point Dr. O'Kane had already commenced an administrative review and suggested that the offer for Mr. O'Brien to return to work following his retirement should be withdrawn. I supported this proposal". 10:46

Just over the page to see if there's anything else relevant. Okay. 10:46

Mr. Devlin's recollection in that statement, and I go on to test him on that in his evidence, appears to be that after word emerged about your concerns in relation to those two patients, he had a conversation with Dr. O'Kane and it led to a discussion about whether Mr. O'Brien could return to work, and the decision between the two of them was that he couldn't. So let's try to unpick that a little. 10:47

You had, as everyone agrees, your conversation with Mr. O'Brien on 8 June, telling him he couldn't return;

isn't that right?

A. Yes.

29 Q. And that conversation took place at a time when you had not identified a concern about those two patients?

A. Yes. 10:48

30 Q. I suggested in my questioning of Mr. Devlin that his recollection around this could be faulty. I suppose where his evidence rested was that perhaps he had got it wrong and perhaps Mrs. O'Kane was simply asking his support for a decision that had already been made. 10:48

Can I ask you this, emerging from that: You said already that - it's on the record of your discussion with Mr. O'Brien on 8 June - you've said already that Mrs. O'Kane and the Human Resources officer had been 10:49 the subject of a conversation with you in advance of 8 June about whether Mr. O'Brien could return. Can I ask you again, are you confident that Dr. O'Kane and you discussed this issue before 8 June?

A. Yes. I wouldn't have gone into that conversation with 10:49 a decision either way, given that we had -- we were having discussions and meetings about Mr. O'Brien and the issues regarding the 2018, the Hughes SAI, and the outworkings of the return to work and the concerns there. Given that we were having meetings about that 10:50 and we were discussing things about that and he had been referred to the GMC, I wouldn't have made a decision without having that conversation beforehand so that she was aware that that's the decision I had

come to.

31 Q. Why would it have been important to seek out the Medical Director's view in advance of 8 June before reaching a decision?

A. To ensure that my line management structure were happy with the decision that we'd come to. 10:50

32 Q. Could I bring you to something Dr. O'Kane said in evidence and seek your input on it. It is to be found at TRA-01467. Just pick up at line 11, which is my question to -- sorry, Ms. McMahon's question to Dr. O'Kane. She asks: 10:51

"At that stage did you think it might be best to take some action or to do something around clinical practice of Mr. O'Brien at that point"? The answer is: 10:51

"Mr. O'Brien retired from the Trust on 17th July. When we had discovered difficulties after -- I think I was informed on 11 June and the clinical team, principally Mr. Haynes and Mrs. Corrigan, had been working on an email that they had received that suggested that there was a discrepancy in two waiting lists and that caused them a bit of concern. When they worked their way through that, they realised there wasn't a discrepancy, but what they also discovered on the back of those explorations were the concerns then around the cancer multidisciplinary team meeting". 10:52 10:52

To be clear, the point I'm going to ask you to address is at line 20-21. "When they worked their way through

that, they realised there wasn't a discrepancy...".
Can you help us in terms of what Dr. O'Kane is saying there? She is suggesting that at some point - perhaps in the summer of 2020, she's not putting a specific date on it - that you and Mrs. Corrigan realised that there wasn't a discrepancy in association with those two patients. Can you put a date on when you realised there wasn't a discrepancy?

A. So in preparation, and having seen this, I've been looking through all of our communication that we had around that time as we'd undertook this investigation, and I haven't found anything that's been able to jog my memory as to whether we actually specifically addressed the question as to whether them two patients -- whether that concern was right or wrong. I know that when I was here last time, it was highlighted to me and I accepted it. What we very rapidly became focused on was not them two patients, it was the other findings, and that overtook everything that we were doing. So I don't ever actually have a recollection of going back and answering the question were them two patients actually on the waiting list or not until I was here last time.

33 Q. Okay. We will have opportunity to ask Dr. O'Kane questions that perhaps flow from that in terms of what is she saying precisely about the timing of the realisation that there wasn't, in fact, a discrepancy. On one reading of it, she might be pointing to the time when you were going on to look at other aspects of

Mr. O'Brien's practice, which was the summer of 2020, or she may mean something else entirely. I thought, in fairness, you should have an opportunity to deal with it.

10:55

Certainly you would accept if there had been a realisation that you got it wrong in the summer of 2020, would you accept that that should have been communicated and, in fact, the communications that went from the Trust's solicitor on these and the 10:55
communications to the Department should have corrected the record?

A. Yes. As I've accepted previously, they were on the waiting list, but it doesn't -- as I say, the outworkings of that concern found other concerns that 10:56
were relevant and required further action.

34 Q. Just something you said a moment or two ago. Is it your evidence, doing the best you can about this, that you didn't appreciate the error of your suspicion in the summer of 2020, you only realised it closer to the 10:56
point when you came to give evidence in 2022? Is that your position?

A. Certainly that's when it's definitely I can recognise that I know. It's only as I've gone back and having known that and seen it within the Minister's statement, 10:56
that I've seen how that's been portrayed. I accept, as I've said, they were on the waiting list, but the rest of the concerns that stemmed from that piece of work stand.

35 Q. Can I ask you some questions about the Bicalutamide audit. A submission was made to the GMC on behalf of the Trust at the request of the GMC, and you contributed to that by describing the background to the audit, how it was conducted and its findings. If we can just bring you to that document, TRU-346161. Just at the bottom of the page, please. That's the starting point, I'm going to just bring you to the substance of something you said. If we go forward three pages to 63 in the sequence. 10:57 10:58

You're explaining, in the middle of the page, something of the methodology of the audit. You're saying in terms that you obtained from the Health and Social Care Board a list of all patients across the Northern Ireland Trusts who had received a prescription of Bicalutamide at any dose in the preceding months. I think it was the preceding three or four months; isn't that right? That list was obtained from the Board. But although you obtained information in respect of patients of all the Northern Ireland Trusts, your focus, is it right to say, was only on the lists relating to the Southern Trust, the Western Trust and the Northern Trust; is that fair? 10:58 10:59

A. Yes. So at the time, patients living in them Trust areas could potentially have been managed within Southern Trust. The purpose of this piece of work was to identify patients who needed to be seen, potentially, to have their treatment changed. So my 10:59

focus was those who potentially may have needed seeing, and therefore it was those who would have been seen in the Southern Trust Urology Service, and that Urology Service would have seen patients as a standard from them Trust areas.

36 Q. You also made the remark, if we scroll back to 62 in the series. You've explained to the GMC (middle of the page):

"I have not subsequently reviewed these patients' records and not all of these patients' care has been subject to a Lookback Review as many were under the care of both urology and oncology teams/consultants across multiple Trusts while lookback reviews have been done only on patients managed by Mr. O'Brien". 11:00 11:01

You explained why you took out of your audit patients associated with other Trusts. Is it fair to suggest to you that in the conduct of the audit, your restriction of your analysis to patients managed by Mr. O'Brien might compound a belief that he alone was responsible for inappropriate prescribing? 11:01

A. No, no, because that's not what I've said there. What I've said is that the subsequent lookback review only looked at Mr. O'Brien's patients. What I've done is look at all 764 patients in them Trust areas which included all consultants in the Southern Trust and also included patients who were under the care of urologists in the Western Trust, so the Altnagelvin team; also 11:02

included patients in the Northern Trust which covered some of the Altnagelvin team. So there were patients who were under the care of all Southern Trust consultants, under a number of consultants from other Trusts, and patients who were under the care of oncology teams. So that piece of work was not limited to Aidan O'Brien, but that was not the Lookback Review. That piece of work to identify patients who needed a change in their treatment. 11:02

37 Q. Okay. Just so that we understand better the distinction you're making, the Lookback Review was focused on patients managed by Mr. O'Brien? 11:02

A. Yes. So the Lookback Review which came after this was focused on patients who had been managed by Mr. O'Brien during a time period -- I can't remember that time period but there's a time window. 11:03

38 Q. January '19 to June 2020 in the first stage.

Your audit did identify a small number of patients who hadn't been treated by Mr. O'Brien. If you can recall, whose prescription of Bicalutamide did give cause for some concern? 11:03

A. So from memory, there were three patients who I raised in an e-mail with Darren Mitchell, and there were two other patients, one who's been covered in the evidence with Mr. Glackin. There was a second patient who had been managed by -- who had been treated by Mr. Jacob, and when we looked at that issue, this was a patient that the MDT had recommended that his androgen 11:03

deprivation therapy be stopped. Mr. Jacob had seen the patient and stopped his LHRH analogue injection, which was one of his treatments, but has overlooked the patient was actually on combined androgen blockade and was also on Bicalutamide so had overlooked stopping it, so it wasn't he initiated this treatment.

Mr. Glackin, as I say, has mentioned his. There were three --

11:04

39 Q. We'll come to Mr. Glackin's in a moment but can I raise the more general point, and I suppose it's this: Was the real focus of both the audit exercise and the lookback exercise, the entirely separate lookback exercise, was the focus of those primarily Mr. O'Brien's patients?

11:04

11:05

A. No. The focus was to identify patients who needed to be brought back to clinic, who needed their treatment changed. In identifying them patients, it was clear that this practice was limited to Mr. O'Brien. So that's where I was going to come on to with the oncology patients. There were three patients I raised with oncology. When I look at them --

11:05

40 Q. Yes. Just before, let's just bring that on the screen. It is TRU-280977. This is correspondence between yourself and Dr. Mitchell at the Belfast Trust, which the Inquiry has heard about. You're explaining that below is a list of what appears to be 12 patients under regular oncology review you've picked up on as users of Bicalutamide. You say some are biochemical failure

11:05

post radiotherapy. You say "From a text message over the weekend, we think this is standard practice and okay". You've highlighted three patients on low dose Bicalutamide, and you are asking him to have a look at them to see if there needs to be treatment changes and arrangements for a review.

Help us to understand your thinking. If we can see the three patients referred to. These three are on 50mg, the other nine on high dose Bicalutamide. What was your interest in these patients? 11:06

A. So, as I've said, the focus of this piece of work was to identify patients who may need their treatment changing. When I look at these three patients, what I see for two of them patients is letters in oncology -- from the oncologist that acknowledged that the patient is on a low dose of Bicalutamide. One of them patients I actually -- I can't identify electronically who initiated that treatment. The other patient, I think from memory, had been initiated actually by Mr. O'Brien and had declined to change to the higher dose as recommended by the oncologist who had seen him at that time; subsequently switched to an injection treatment around 18 months later. 11:07 11:07

The third patient I have in error included him in this list. He was a patient who was on 50mg for biochemical failure post radiotherapy; he is Patient 206, I think it is. He had only been seen since that treatment, as

far as I can see, by Mr. O'Brien. He had been started on that treatment by Mr. O'Brien. Unfortunately, because I included him in this list, he wasn't included in the list to come back for a review with me; he'd actually been discharged from review by Mr. O'Brien to his GP.

To compound that, he wasn't caught in the first backlog review because the last recorded contact fell outside of that 2019 to 2020 window. He's been picked up in the second Lookback Review and has had his care reviewed by Professor Sethia and arrangements for follow-up have been put in place now with them concerns that he is on a low dose of Bicalutamide. 11:08

41 Q. Yes, that's the patient, I think we've called him -- 11:09

A. 206.

42 Q. -- 206. I wanted to ask you this question: Of those three patients, from what the Inquiry can discern at least two of them had been treated by Mr. O'Brien at some point? 11:09

A. I think all three had been treated by Mr. O'Brien.

43 Q. It's the Inquiry's understanding that, if you're right all three of them have been commenced on Bicalutamide by Mr. O'Brien, only one of them, that is Patient 25 as we have called him, only one of them was screened in for the purposes of an SAI, or should I say an SCRR exercise. Do you have any familiarity with the reasons for why the other two were not subject to an SCRR? 11:09

A. So the SCRR comes about as part of the lookback

process. Patients who have their care reviewed within lookback window, so that first lookback of 2019 to 2020, they had their care reviewed. Where concerns were identified at that review, they were escalated to at SCRR. These patients' care under Mr. O'Brien fell outside of that window and therefore they weren't part of that Lookback Review process. Patient 206 is within the second lookback window; his care has been reviewed as part of that and that process is ongoing, so we have the initial review form completed for him. 11:10

44 Q. I don't need to bring up the form but, as I understand it, Professor Sethia has reached the view that it doesn't reach the threshold for an SAI.

Can I ask you this: In terms of the focus of the SCRR process, is it the case that, unapologetically perhaps, the focus is on pushing Mr. O'Brien's cases into that process to the exclusion of any other practitioner who may have had management input in respect of these patients? 11:11

A. The SCRR process is part of the Lookback Review process that is focused on Mr. O'Brien's patients. I think in the -- it is even referenced within the Minister's statement that, with a number of SAIs, there needs to be another process developed because we can't continue doing SAIs; or the inference is. So the SCRR process is part of the Lookback Review process, and the Lookback Review applies to Mr. O'Brien's patients in the windows of time as per each Lookback Review. 11:12

45 Q. You've refer to Mr. Glackin's handling of a patient who had initially been under the care of Mr. O'Brien who started him on a low dose Bicalutamide, and that patient is 139. We can see, if we bring on to the screen AOB-83826, that Mr. Glackin reviews Patient 139 in February 2016. We can see under "Current Management" Bicalutamide 50mg once daily, tamoxifen 10mg once daily. He records that he is tolerating his Bicalutamide and tamoxifen very well, and he directs a PSA. He says that this result is stable, that he remains suitable for continued Bicalutamide monotherapy. 11:12 11:13

Let me bring Mr. Glackin's two reviews together before I ask the question. If we go to the record for May 2020, it is AOB-82838. Yes, it is 5 May 2020, Patient 139. Again, current management remains Bicalutamide 50. While it may not be explicit in that, the regime doesn't change. 11:14

You get to look at this case later in 2020. If we look at WIT-04624, you write to the patient and, to summarise, just scrolling down a little, you're explaining to the patient that the treatment he's currently on is not licensed, and you tell him - and I'm summarising here - that the recommended approach is surveillance. 11:14 11:15

If you just scroll over the page and go to the bottom of that page, you're saying:

"If you don't wish to stop the hormone treatment and if you wish to continue hormone treatment as a long term", 11:15
you're recommending one of two alternative courses. One is an injection treatment and the other -- if he doesn't want that, the alternative is to go to high dose Bicalutamide.

11:16

A couple of questions arising out of all of that. Mr. Glackin has maintained the patient on an unlicensed dose of Bicalutamide, the regime having been started sometime earlier by Mr. O'Brien. Should that have prompted something equivalent to an SCRR? 11:16

A. I haven't got the records going in front of me and I haven't got them in mind in terms of when he was diagnosed with his cancer, what the MDT recommendations were so it's difficult for me to answer at this point. Knowing what I know now, yes, it should have. But as 11:17
an isolated case, Mr. Glackin may have - and let's just say Mr. Glackin has spoken to this - he may have made an assumption that there had been a thorough discussion of treatment options, that the reality that starting a low dose of Bicalutamide doesn't provide the patient 11:17
with any benefit in terms of survival or outcome from the prostate cancer. The fact it is off licence, he may have assumed that that had happened.

When he saw the patient, the patient had been established on a treatment for a period of time. I've done lots of these discussions. They are difficult discussions, where patients' confidence in the healthcare system can be shaken. In a patient who was happy and tolerating their treatment with minimum side effects, he may have decided a decision to not shake that individual's confidence in the system and tell them, as I have done on a number of occasions, that you don't need the treatment that you believe you needed for the last X years. 11:17 11:18

46 Q. Is it reasonable to suggest that if Mr. O'Brien had continued to be the managing clinician of Patient 139, it would have automatically have gone down the SCRR route? 11:18

A. Had the patient been pulled into the lookback time window, I would imagine it would have gone down an SCRR route. As we've covered, Mr. O'Brien had initiated this treatment.

47 Q. Does that in any sense suggest an unfairness or bias against Mr. O'Brien in terms of how the management of patients on low dose Bicalutamide is being viewed by the Trust? 11:18

A. Again, I would have to -- so this patient has obviously come back to a clinic where I have changed their treatment. I had been - and I haven't looked for definite - I had been filling in the ten-question reviews at that time. Given that I've changed this patient's treatment, I would have anticipated I would 11:19

have or should have filled in a ten-question review highlighting that this patient required their treatment changing and that would have pulled them into that process. Whether they had been screened in or out, I can't comment on because I'm not sure whether I did that. It may be that I, actually not intentionally, haven't filled in that ten-question review at that time on an assumption that this patient was going to have their ten-question reviewed completed by Professor Sethia. There was -- I think we covered before, I was keen that, as much of this was done not by me, the assessment of care was done by someone else. 11:19 11:19

48 Q. Thank you for that.

It is 11:20; a convenient point for a short break? 11:20

CHAIR: Yes, I think we'll rise now and come back at 25 to 12.

THE INQUIRY ADJOURNED AND RESUMED AS FOLLOWS:

11:20

[Technical pause]

49 Q. MR. WOLFE KC: I'm going to assume that the record didn't catch any of that and just, in any event, repeat the point. I want to look at the area, Mr. Haynes, of missed opportunities we touched upon the last occasion? 11:44

You said at TRA-01370 that the nature of your concerns

about Mr. O'Brien changed in late June into July 2020 when you saw Patient 1. To paraphrase, your concerns were no longer of an administrative type nature but, as you said later in your evidence, the bar was raised.

11:45

Additionally, Mr. Haynes, you offered a personal expression of regret within your first witness statement, WIT-53957 at paragraph 77.1, a regret that there was a failure to recognise in late '17-late '18 that in addition to the factors that gave rise to the MHPS investigation, there was a likelihood of additional issues that would have required investigation. So, that's the kind of points that we looked at on the last occasion.

11:45

11:46

Since you were last here, we have heard from some witnesses from the Belfast Trust, notably Professor O'Sullivan and Dr. Mitchell, and we've also obtained witness statement evidence and haven't yet taken oral evidence from, for example, Professor Jain. I want to turn to aspects of that Belfast evidence, Belfast Trust evidence, and seek your views on it.

11:46

Could I start with WIT-96680? This is an e-mail which Dr. Mitchell sent to you on 28 March 2019. Just to put it in context, this is, I suppose, six months or so before Patient 1 comes into the system. What he is relating to you is a concern raised with him by Suneil, and that is Professor Jain. He says:

11:46

"Mark, this is one of the cases we chatted about" -- in full that appears to be Bicalutamide 50 -- then escalated to Bicalutamide 150 and we would probably like to have been involved in the decision-making process a bit earlier. Suneil's history February 2019 is on ECR, gives the full detail. I don't think this is an isolated occurrence". 11:47

Do you remember getting that e-mail? 11:48

A. So I do recall receiving that e-mail and that conversation, having been prompted by Dr. Mitchell's evidence that he gave. I don't think when we'd done my e-mail search for discovery actually had managed to identify this e-mail within the archive. 11:48

50 Q. Certainly we have no evidence of you responding to it in writing. Have you been able to find any written response?

A. No. I have looked at the patient in question and considered what my thought process would have been at this time. 11:48

51 Q. Yes. Before I maybe delve into that, I think it would be helpful to put on the screen Professor Jain's analysis of what the impact was, just to unpack and detail to that e-mail. He has in relevantly recent times, I think within the last four to eight weeks, placed before us his statement. If we go to WIT-106808, it is underneath (i). I think it is fair to say, and maybe the representatives of 11:49

Professor Jain, I think his timeline is a little askew in that he mixes up 2019 with 2020, because his preface here is:

"From memory Dr. Mitchell had been in discussion with Mr. Mark Haynes, who had indicated there was an investigation ongoing into Mr. O'Brien's practice at Craigavon Southern Trust. We therefore agreed that any cases of Bicalutamide 50mg monotherapy prescribing would be highlighted and that Dr. Mitchell would send the details to Mr. Haynes". 11:49 11:50

Just on that, had you initiated any investigation into Bicalutamide 50 in 2019?

A. No. 11:50

52 Q. He then goes on to speak about this patient who is the subject of the e-mail which I put up on the screen. What he has said is this:

"I met this patient for the first time as a new patient on 1 February 2019 at a waiting list initiative clinic. He had been treated with Bicalutamide 50mg monotherapy for a short period of time from January 2013 to May 2013 before this was increased to Bicalutamide 150. He had required a coronary artery bypass graft in 2013 and a TURP in April 2014 for lower urinary tract symptoms and his PSA was very low at 0.11 in June 2014. This would have been a good time to refer him for radiotherapy but this did not happen and the patient 11:50 11:51

continued on Bicalutamide 150. His PSA began to climb and eventually reached 3.35 in December 2018. Around this time, an MRI showed his prostate cancer was locally advanced with extracapsular extension and invasion into the seminal vesicals. He was then referred for consideration of radiotherapy". 11:52

The mischief he is identifying within that paragraph is rather than referring to radiotherapy at the most optimum point, which is back in 2013/2014, the patient was maintained on a high dose Bicalutamide monotherapy. He then explains what he did in 2019 upon discovering this series of facts. He says: 11:52

"I emailed Dr. Mitchell to make him aware of this case on 1 February 2019. He indicated that he would discuss with me and Jonathan" - Jonathan McAleese - "Dr. Mitchell then emailed Mr. Haynes, as we've seen, on 28 March 2019". 11:52

That's the context as explained by him in his statement. Just before I come to the questions, let me just bring you to some emails that are internal to the Belfast Trust which you wouldn't have seen at that time. WIT-106813. Just at the bottom of the page, please. You might be able to help me with some of these abbreviations. It seems to be saying on one February, Jain to Mitchell: 11:53 11:53

"New patient today from Aidan O'Brien. Will get a bone scan but would have been much better if he had been seen by us in 2014. MRI, and on examination locally very advanced now. PSA has go to 3.35. On Bicalutamide."

Up the page then, Dr. Mitchell is saying:

"Bicalutamide 50 initially? I said the next step would be through the clinical director route at Craigavon area Hospital".

Then Professor Jain clarifies for Dr. Mitchell the clinical history. "Short AS period"?

A. Probably "active surveillance".

53 Q. Okay.

Then "50mg." Is that for one month?

A. No, that's January 2103. 150mg 2013.

54 Q. We have seen the rest of that clinical history set out in his statement.

Could I ask you this: When you received this information, can you recall what steps you took?

A. So I haven't got a written report of what steps I took. What I would have done, and what I've done subsequently as well, is I would have looked at this patient's detail on the electronic care record to look through. When I do that, what I see is a letter from Mr. O'Brien

that seemingly explains a reason why he did not refer at that point, and states within the letter that the patient didn't -- I think he uses the term "reticent" to pursue radical treatment and therefore elected to remain on monotherapy. 11:56

Seeing that, I assumed there had been an informed patient discussion and decision to not proceed to radiotherapy at that time and to remain on the treatment that he was on. So my view - which 11:56 subsequently, I would say, was wrong - was there was a reason why this patient wasn't referred. While I can understand the oncology opinion with a documented reason within a patient correspondence for why he wouldn't have done that, there wasn't anything to 11:56 trigger me to look further into this practice. I'd got one patient. In criticism of myself, if I actually look at the timing of that, the timing -- the date that that letter was actually dictated and done was a number of years after that decision would have been made, and 11:57 I obviously didn't pick up on that and that didn't trigger an alert for me.

55 Q. The letter you were looking at was proximate to the referral back to -- the referral for the first time in to Professor Jain? 11:57

A. Yes. It wasn't a contemporaneous letter at that time that treatment had been done. I've drawn my conclusion based on that, not on contemporaneous notes.

56 Q. Yes. To summarise, you received the e-mail from

Dr. Mitchell, you conscientiously went and looked at it and you reached the view on the basis of the information contained in the documents you had to hand that there was a plausible, acceptable explanation for not referring to oncology in 2014? 11:58

A. Yes. So there was an explanation that the patient did not want to pursue that route of treatment.

57 Q. The wider context which I extract from the evidence received by the Inquiry is this: Dr. Mitchell, Professor Jain and perhaps some others, several years before this, before 2019, had become concerned about Mr. O'Brien's prescribing practices in relation to Bicalutamide, which I think in earlier evidence you have indicated, this Bicalutamide practice, is perhaps a hallmark of a more significant issue, which is 11:58 delayed referred in to oncology. But their awareness of this problem, that is the Belfast Trust's awareness of this problem in 2013/2014, leading in 2016 to the preparation by Dr. Mitchell of regional hormone guidelines, their awareness of this problem was, if you 11:59 like, not circulated to the Southern Trust. It was drawn to the attention of Mr. O'Brien in a notable e-mail sent by Dr. Mitchell, and Professor Jain has explained and I think Professor O'Sullivan has explained that on occasion they changed the 11:59 Bicalutamide regime, recognising that it was improper or a shortcoming.

But this e-mail to you in March 2019, I hope I'm correct in saying, was the first, if you like, externalisation of the problem. It was coming to you, wearing what would have been your Associate Medical Director's hat or your clinical director's hat; clearly 12:00
wearing your management hat at that time. When you think about it now, should have done more? Should have asked more questions, perhaps, of your colleagues in Belfast as to the nature of their concern?

A. I think if I look back now, you'd started with 12:00
a preamble around missed opportunities, this is another missed opportunity. I can explain my thought process but in the context, as you highlighted, of issues raised before directly with Mr. O'Brien that I wouldn't have been aware of, in the context of the sort of wider 12:01
concerns you've mentioned, the oncologist -- they may have been aware of additional patients that they just corrected or changed the treatment when they saw them. I should or could have initiated a wider investigation but I didn't have all of that information to hand at 12:01
that point and so I didn't know that. So I guess my review and my decision that actually I couldn't see anything to spark a deeper investigation was one that I formed out of an attempt to be fair to the individual. I'd got a letter that said -- that gave 12:01
a plausible reasoning for why that decision had been made.

58 Q. Yes.

A. If we were to spark an investigation into people's

practice on the back of one concern raised, where that concern actually, on the face of it, doesn't look to be substantiated, we would have very unhealthy practices.

59 Q. Just in terms of what Dr. Mitchell has said about the communication due to him, if we just bring it up on the screen, WIT-96668. Just scrolling down. He says that he spoke to you informally as you attended the regional urology MDM in 2019, and then subsequently emailed you about the off licence prescribing of what he says is Bicalutamide 50 in 2019 and 2020. When you spoke to him -- can you remember speaking to him as well as getting the e-mail? 12:02 12:03

A. So one of the changes that happened, as I've reflected in terms of my working practices but also as a first, if you like, or a new thing in Northern Ireland, was I was no longer just Southern Trust MDT, I was attending the Belfast Trust MDT in my role working across the two sites. So them relationships became, rather than a telelink relationship, they became closer, personal relationships where I was meeting them in person and perhaps we would be present before an MDT started, perhaps we'd have a conversation after an MDT started. So myself and Dr. Mitchell would have had many discussions at many points before and after MDTs about difficult patients, about difficult things. I recall having a conversation with Dr. Mitchell about Bicalutamide. I can't remember the specifics of the date but it's recorded in Darren's e-mail that we discussed on that date, and he followed that up with an 12:03 12:03 12:04

e-mail.

60 Q. What you seem to be clear about is that this seems to have come to you as an isolated concern and you weren't provided with the history of concerns that were raised with Mr. O'Brien, prescriptions changed in 2014/'15 leading to the regional guidelines; that whole context which Dr. Mitchell has given to this Inquiry wasn't shared with you? 12:05

A. Well, it may have been in the discussion but we've got -- when we look at that patient, his management, the point in time he was initially treated was at that period in time. It wasn't a practice that was happening in 2019, this was a patient who was raised in 2019 as a possible problem but whose management by Mr. O'Brien and decision to not refer was back in 2014. 12:05

61 Q. This is coming to you as an issue in March 2019. By this stage, you had perhaps formed a view of Mr. O'Brien's practice. You were certainly aware of the MHPS issues. Dr. O'Kane had become Medical Director shortly after MHPS had reported. She brought you into conversations about the fact that this doctor was to be referred to GMC. The February/March period brought other concerns to your attention. 12:06

If we bring up on the screen WIT-55862, please. This is in the context of the DARO issue. Just scroll down. Mr. O'Brien has written to Colette McCall to express his concerns -- I don't know if you want to see the whole of his expression, I assume you are familiar with 12:06

it. Just down the next page. He's raising concerns about the need to use the DARO system, or for his secretary to use the DARO system, and you come back on that. If we scroll back in the direction we came.

12:07

When you saw that, Mr. Haynes, is it fair to say that you were concerned that DARO was not being used?

A. So those concerns are in keeping with the other, if you like the administrative concerns, the concerns that had been identified with regard to triage, with regard to 12:08
not actioning results. The DARO process is a process to ensure that results are looked at and necessary action undertaken. What I had there was someone seemingly not wanting to participate in that process, which is to act, as I think I've described it, as 12:08
a failsafe. You should have procedures beforehand that ensure that you get your results, with DARO as our backstop so we know all results are being actioned. But Mr. O'Brien is seemingly saying I won't participate in that process because the patient should come to 12:08
a clinic in the face of, in the knowledge of backlog review extending to many years, so them patients not engaging in that process to make sure results are looked at, but accepting they won't get looked at for many years. 12:09

62 Q. Also, this is February into March of that year. You had occasion to raise an incident report in respect of Mr. O'Brien's management of Patient 92. If we bring up on the screen TRU-162123. The incident date was the

year before and, as we can see, you're the reporter on this incident, 12 March '19. You are explaining, in essence, that there had been -- it doesn't say it explicitly there but -- yes, there had been a failure, as the subsequent SAI report acknowledged, a failure on 12:10
the part of Mr. O'Brien to action a set of results leading to delay in treatment, the treatment fortuitously coming back into the system via her general practitioner.

12:11

I put those strands together and there are others around in that immediate period, including Mr. O'Brien's deviation from the action plan which you discussed in the context of triage with Dr. O'Kane. That was in late March of 2019, I needn't bring it up 12:11
on the screen. But I suppose I'm assembling those points and putting them beside what Dr. Mitchell has sent to you in relation to that patient.

Now, you've explained the steps you've taken in 12:11
relation to that patient, and you saw a plausible explanation for it. But when you see all of this together, all that was going on at the same time, you were clearly concerned about Mr. O'Brien's practice in various areas. Can you help us understand why, when 12:11
you see it all together, even allowing for what was, in writing, a plausible explanation about the Dr. Mitchell patient, why at that time the thinking on your part, or on the part of yourself and other management, doesn't

go towards a deeper investigation?

A. As I think I reflected about the 2017 concerns, I failed to recognise, broadly grouped together, the administrative concerns, the concerns that he wasn't actioning results, the concerns that he wasn't triaging; these issues. I failed to recognise that underneath these there was also an individual who wasn't managing patients in the way that they were supposed to be. I didn't have a high degree of suspicion at this time, and that's a failing on my part, that he was doing things in a different way. I wouldn't have imagined that an individual who had acted in the role I fill now as a Clinical Reference Group Chair for our cancer network group, who in sitting in that role had been instrumental in the development of guidelines in how to manage prostate cancer for Northern Ireland, had reviewed the NICE guidance as part of that; as part of that, as we've heard, that group had developed hormone treatment guidelines. I wouldn't have -- it didn't cross my mind as a suspicion that this individual, who seemingly has held positions that direct how things should be managed, is then in his own practice doing something completely differently. 12:12 12:13 12:13 12:13

As I've said, I accept this is another -- I could probably map out a number of points where I feel I personally could and should have identified things sooner knowing what I know now, but hindsight makes

things very easy. Had we not found the other things later or them not existing, I could have initiated an investigation that was unwarranted as well.

63 Q. Yes. It brings to the surface, I suppose, a key question which the Panel will have to wrestle with. 12:14
You have these multiple issues of concern, many of which are -- people have characterised them as administrative in nature, albeit in some cases touching upon the management of patients and therefore of such substance that they could cause risk to patients. But 12:15
where is the threshold for intervention? You've gone through this process, the Trust has gone through this process and we have, obviously, the advantage of hindsight. We can see now these various limbs or straws which weren't brought together in one place, and 12:15
we now recognise, because of what we now know, that they ought to have been more deeply investigated. Have you worked out or can you assist the Panel in trying to work out where is the threshold for intervention?

A. I think it is difficult. I think when you receive, as 12:16
in that case, one e-mail of concern, it is difficult to say that that renders -- does that create a flag.
I think when you have an individual who has gone through an MHPS investigation that has addressed issues of concern, that has raised some issues, I think, in 12:16
Dr. Chada's report to discuss his insight and other issues, I think at that point where you have a process that has identified yes, there are issues of concern with an individual's practice, then that should trigger

a wider review of their practice. Unfortunately, we were -- that process limited itself, if you like, to the known-known and didn't look for the unknowns. So it addressed the problems but didn't look for the other problems. To me, that is the point where, if you have an individual where you have identified problems, where you have identified concerns, then you have to address their wider practice at that point.

64 Q. Yes. It won't have gone without comment that, if you like, the deeper dive here, the broader dive, was performed at the point when, from a Trust perspective, Mr. O'Brien was not going to cause any further risk to patients because he was retiring. So you would readily accept perhaps that the threshold question and the intervention point has to be at some earlier point. There has to be within the employer's armoury some way of trying to grapple with the problem when it still matters. 12:17 12:17 12:18 12:18

A. As I've said, I think when you've got a process that has confirmed issues with an individual's practice, their wider practice needs to be considered within that process. That process can't narrow itself to the problems that you found.

65 Q. What, if any, in your experience are the downsides of, if you like, a premature intervention or a premature challenge to a colleague who may be giving indications of concern but might otherwise be simply practising in a way that is unusual but doesn't give rise to risk? 12:18

A. To be put through an investigation for any clinician is

challenging and difficulty. I have personally triggered an investigation into an individual's practice within a different specialty based on a number of concerns brought to me by a colleague at that time regarding their practice. I witnessed the impact on that individual of what subsequently, after that practice had been looked into, didn't have any concerns about his -- the practice of the individual. It has a huge negative effect on that individual's practice, both during the time of the investigation and afterwards. So, triggering an investigation too early or too often would have a huge negative effect on the way people practise, and could almost be at risk of paralysing their ability to practise. 12:19 12:20

66 Q. Can I ask you about the relationship with Belfast Trust Southern Trust clinicians such as yourself, Mr. O'Brien, regularly refer to the Oncology Unit at the Cancer Centre. So, as we have seen, the oncologists in the Belfast setting have opportunity, which they've taken, to correct what they see as shortcomings in, in this instance, the administration or the prescription of Bicalutamide. But until they wrote to you in March 2019 - and I'm specifically dealing with the Bicalutamide issue here, I know that there was other correspondence on other issues between the two medical directors in or about 2010 or '11 - do you think there are lessons to be learned in terms of the communication between Belfast to Southern Trust when they saw problems with Mr. O'Brien's practice in 12:20 12:21 12:21

respect of Bicalutamide?

A. I think, as I acknowledged in the oncologists' evidence, they said -- other people, you may have said, people would have changed the treatment. At various points in time multiple different individuals have recognised and changed the treatment but not done anything else. I don't know whether there's a barrier that they're two different Trusts so they know how to raise that concern within Trust; how do you raise it without Trust, outside to the other Trust, whether that's an issue. Whether, actually as you've intimated, the history goes back beyond and whether it's happened so often that people have almost given up because they've seen nothing happen. 12:22 12:22 12:23

There were other issues as you suggested there in 2010, 2011. As myself and Mr. Hanbury have lived through the Improving Outcomes Guidance, centralisation of cancer surgery across all of the cancer networks did lead to strained relationships between teams, where some teams were essentially to stop doing certain procedures, whether them strained relationships fed into that. Certainly I feel that the in-reach practice which I have, the outreach practice which has been developed by a colleague of mine from Belfast to Craigavon from a renal cancer perspective, relationships have improved across the region as all of these relationships become closer working relationships, so the ability to raise a concern is much easier. As we've said, Dr. Mitchell 12:23 12:24

raised it with me informally at the MDT. Had I not been there at the MDT because I wasn't in-reaching, how would that case have been raised? Would it have been raised? Who would it have been raised to? We had a relationship; we'd built that relationship up because we worked together. 12:24

I think that it does create challenges. I think there is a role for the network group. I remember sketching out, when Professor Jain asked me to give a talk at a prostate cancer meeting he gave on the role of the network, what the network in Northern Ireland was doing. I separated out a number of the -- a number of where I saw the role of the network. Performance and outcomes, I felt, were a critical part actually of that CRG network group. A good-functioning network group, you would hope, with representation from across teams with good relationships would enable people to say during that network group we've a concern about this, we're getting late referrals from this team, can we work with you, we're seeing this problem with this individual. 12:24 12:25 12:25

I think a well-functioning network group can add to and deliver that. I've tried to structure that network group up to include these things, but we aren't -- I would say we're not at that point yet but we do have the relationships and we do have the ability to talk to. Not the ability, of course we have the ability. 12:25

We do talk to each other, we do raise questions, we do raise concerns, we do ask each other questions about treatment that seems -- or things that have happened that seem a little bit strange.

67 Q. That's helpful. If we think back to that period 2014 to '16, Dr. Mitchell is driven, it seems, to develop regional guidelines, I think his evidence was with specifically Mr. O'Brien in mind, and yet that's unspoken. I mean, at the very least that should have warranted a communication from one Trust to the other at a management level to ensure that the issue was tackled. I think you reflected earlier, well, there has to be an element of trust here; Mr. O'Brien was central to the NICaN process, he was Chair or clinical lead - or whatever he was precisely - and you would have expected him to comply. In fact, we've seen arguably, at least from the Trust perspective, non-compliance, unlicensed approach to Bicalutamide, and delayed referrals. Patient 1's case is an exemplar and there are other examples. 12:26 12:26 12:27 12:27

Is it enough to leave it to good relations which you seem to have promoted more recently, or is there a need almost for it to be written into the rule book as such that there must be communication between medical directors where you see a problem, a persisting problem that can't be resolved? 12:28

A. I think obviously things need to be escalated where it is not being resolved and the line management

structures are the appropriate measures. But if I go back to the 2014, if I place myself in the position of the recipient of an e-mail from Dr. Mitchell saying effectively that I'm not treating patients appropriately, that would trigger a significant amount of thought of myself, of my own practice. It would trigger an immediate change, a conversation maybe with Darren, say what am I doing wrong? What do I need to change? What do I need to do? Yet that didn't trigger any change; that actually just carried on. Unfortunately, that insight, that self-awareness to accept that actually Darren is a well-respected oncologist, we, all of us, will seek Darren's opinion on difficult patients and Darren will seek our opinion as surgeons on difficult situations. But to have Dr. Mitchell say to you you are not managing patients appropriately - and I appreciate I'm paraphrasing it because I haven't got that e-mail here in front of me - I'd be horrified. That would trigger an immediate change in the way I function. 12:28 12:29 12:29 12:29

The alarm there is notable. To then -- I think the fact that the guidelines are created with the intent but without the voiced intent demonstrates there was a relationship issue, that that was one issue. But absolutely, where that practice had been recognised as continuing, that should have been escalated through to medical director level and through across Trusts. 12:30

68 Q. I'm asking this question in the context of Patient 4,

and maybe rather inelegantly joining it to what Dr. Mitchell was raising with you about that patient in March 2018. Patient 4, just to elaborate, was a patient who you saw when you were Urologist of the Week, I think, in January or February 2020. He had ought to have been started on LHRH in the previous year but that hasn't started; Mr. O'Brien was the managing clinician and he hasn't started him on that. When the patient came in several months later as an emergency, you saw the patient and commenced him on Degarelix; isn't that right? We can see that you, as you've explained in your witness statement, didn't realise that there was a problem here when you saw the patient, you thought it was simply an oversight whereas you now consider that that was a failure on Mr. O'Brien's part to treat the patient properly. Have I summarised that adequately? 12:31 12:31 12:32

A. Yes. So I saw him *in extremis* essentially as an emergency. I treated him surgically. I operated on him as an emergency because of complications of local progression of his prostate cancer, and started him on Degarelix, which is a fast-acting hormone treatment that works in a slightly different way. I just hadn't twigged at that time that this is a pattern of treatment. But remember, at this time still a pattern of treatment of someone with high-risk disease who has been started on 50mg of Bicalutamide, I wouldn't even anticipate that this would be a pattern of standard treatment. We would all start people on 50mg of 12:32 12:33

Bicalutamide for a temporary period before they have their first LHRH analogue injection. I can only presume I have assumed there has been an oversight rather than this representing his standard practice. Again, my degree of suspicion was too low. 12:33

69 Q. Yes. If we can see the steps that you took then later that year in November of 2020, you raised a Datix at that point or an incident report. We can see that at TRU-162168. This, more comprehensively than I achieved a moment ago, sets out the factual background to this 12:34 case, the case of Patient 4. As we can see, it's you raising the Datix in November '20. The history is described in the "Description", where the patient was diagnosed with high grade prostate cancer In July '19, and then the outcome was to commence LHRHa, arrange a 12:34 CT chest and bone scan and subsequent MDM. Where you came into it was in January 2020 where, as you say, the patient came in in extremis, requiring transurethral resection and ureter extent with nephrostomy, and during the in-patient administration it was not 12:35 recognised that he had not been started on the hormone treatment despite that being indicated at MDM some six months or so earlier. As you've explained, you started him on standard treatment in the form of Degarelix. 12:35

In trying to understand these missed opportunities, because I think we'd probably accepted here was another one, you didn't recognise that Mr. O'Brien may have - and I use these words advisedly - deliberately avoided

the MDM recommendation for whatever reason, but you hadn't realised that, you just saw it as an oversight. Is part of the explanation for the missed opportunity, linking it back, as I said I would earlier, with Dr. Mitchell's intervention with you just the year before, is there a sense among colleagues, you and Mr. O'Brien, you and other colleagues and perhaps in other circumstances, that there's a benefit of doubt given, there's a tendency to be restrained from making an allegation of shortcoming for fear that you could be wrong and that you could cause damage by making the allegation? 12:36 12:37

A. I think the first thing to recognise on this patient is he came in as an emergency and I have managed him as an emergency. What I have not done at that time is a forensic look through as to what has happened previously. We've recognised that he needs treatment. I think that it might be a typo within that IR1, I think he was started on his treatment during that in-patient administration. I think it was the day of discharge he had his first Degarelix. But when we looked at it more forensically, because we are managing his emergency admission problem, when I've looked at it more forensically what I've seen is (A) there's the pattern of treatment but there's also delays here which are just difficult to comprehend to me. He's come to clinic in August, on 20 August, he is supposed to be getting some staging scans organised; they have not been requested for six and a half weeks 12:37 12:37 12:37

from when that patient has come. So again that's another factor within the concerns that have been identified.

It goes back to, as we've said earlier, we kind of knew that there were issues, these administrative issues, the delay in doing things, but actually underlying the delays in doing things there were other factors, and that's what we failed to recognise previously. 12:38

In terms of that, if you like, reluctance to trigger investigation early, I think you have to recognise it is the first thing. I don't spend my emergency admission ward round conducting an analysis and critique of every patient's historic management. I've recognised there's an issue. I have not even -- I've managed him acutely, it is only later I've recognised that this fitted a pattern of behaviour. I've figured that it was an oversight, incorrectly. But as I've said, all patients who are going to start an LHRH analogue started on 50mg of Bicalutamide. I wouldn't be continuing it so I've assumed that there's an oversight; incorrectly. 12:38 12:39 12:39

70 Q. Yes. The Panel will be aware that this case was then the subject of review through the SAI process with Dr. Hughes, and it takes its place amongst that collection of cases. 12:39

One of the points I think you made on the last occasion was, I suppose, the impact of the demand capacity problem. You were explaining that really in the way that you and your colleagues had to work and still have to work, as you maybe just expressed a moment or two ago, you don't have that opportunity necessarily to know in detail what your colleagues are doing, or to read back through the file to get to grips forensically with the history. You gave a sense on the last occasion of momentum on to the next case because there really wasn't the time to engage in that kind of scrutiny. Is that perhaps another factor that explains the opportunities that were lost here? 12:40 12:40

A. I think so. I think if you are busy and are keeping your head above water, but only just, you don't have the capacity to be analysing every aspect of another individual's practice. Indeed, you don't get the opportunity necessarily to do that. There are some things even within the busyness that you can change which sort of enable it. I've mentioned the - or I may have mentioned - pooled waiting lists, operating on each other's patients. You get an opportunity in doing that to see how other people are practising because you are coming across their patients as standard, and you develop shared standard practices because you are all operating on the same patients. But that pooling of patients didn't happen at this time. The only times we would have come across Mr. O'Brien's patients would have been during a week, as Urologist of the Week, 12:41 12:41 12:42

which is the busiest week in our cycle when we are covering the emergencies.

71 Q. If you were to identify the key or the singular governance failure that led to the circumstances which triggered this Inquiry, upon reflection what is that or how would you describe it if it's not a singular identifiable failure? 12:42

A. I think as I said before, it is a failure to recognise that an individual who has a series of concerns being raised needs a wider practice look at. There's the longitudinal argument as well. I don't know what sight of the previous concerns from '2010/11 the 2017-2018 MHPS investigation process had. We know that -- you mentioned just recently Dr. Mitchell's e-mail to Mr. O'Brien in 2014, we know that that only went to Mr. O'Brien so they wouldn't have had sight of that. So, there were a number of things that we don't know whether they had sight of. But there were, I would suggest, enough concerns from an MHPS investigation point, to me, to flag a need to look a bit deeper at an individual's practice. 12:43 12:43 12:44

72 Q. I suppose the big question is how can you cure that for the present or for the future as a Trust and as a senior clinician within the Trust. You're seeing what's happened in the past. Is it about changing behaviours so there's increased sensitivity to what can go wrong, or is it about writing a more effective rule book to specify when intervention should take place? 12:44

A. I think it's both. You need to have an environment

where individuals at the very base level raise concerns with each other. You need to have an environment where people feel that they can raise concerns about other individuals' practice or behaviours which are not going to be detrimental to themselves or the other person if they are wrong. And coupled with that, sort of that reporting, you need to have something that mandates that when you have concerns that reach a threshold about an individual, that them concerns automatically move on to a wider look at an individual's practice outside of them specific areas of concern. If that's accepted and recognised as standard practice, then it isn't considered unusual to trigger a wider investigation. 12:45 12:45

73 Q. Thank you for that. I want to move on to look at, as I described this morning, the second part of your evidence, the area of improvement and what specific measures have been taken to address some of the concerns that were exposed in 2020, '21, and later this afternoon into look at some of, if you like, the practice development areas - or the service development areas I should more properly say - in the context of the well-known demand capacity problem. 12:46 12:46

As I explained this morning, you were appointed Divisional Medical Director of Urology Improvement in 2001. Just pull up the job description for that, it is to be found at WIT-54012. We'll look at aspects of that in a moment. 12:46

We observed on the last occasion, Mr. Haynes, that in September of 2001 you had been appointed Divisional Medical Director for Surgery and Elective Care, but in December 2021 you took on this role, the Urology Improvement role. Can I safely assume that the earlier role, the wider role which was responsible for the SEC, it was handed over to somebody else; is that right? 12:47

A. Yes. Mr. McNaboe took on the Divisional Medical Director for SEC as of December 2021. 12:48

74 Q. Is it fair to say that to have a Divisional Medical Director, yourself, appointed to take care of - I hope I'm not wrong in saying this - a modestly sized service within a bigger service, the SEC, is this an unusual or novel step in your experience? 12:48

A. Yes. If you like, as you say a modestly sized service, but with some big challenges.

75 Q. Of course. Undoubtedly.

Is it fair to say in your understanding that the development of this post with a focus specifically on urology and nothing else was as a response to the problems that had been identified and that were bringing the Trust into a public inquiry? 12:48

A. Yes. So it was in response to the issues identified, the public inquiry, and the requirements to make changes within the service, the department, to look to improve things. 12:49

76 Q. The improvement element that's added on to the job

title, can you help us with that? If we look at WIT-54013, if we scroll down the next page, one can see - just that last bullet point on the page - that two specific tasks are carved out for you: Chairing the Urology Quality Improvement Group, and co-Chairing Urology SAI Task and Finish Group responsible for ensuring compliance with SAI recommendations made in the period 2016 to 2021. One can immediately see how improvement in the job title links to those kind of tasks. Were you Chair of the Urology Quality Improvement Group? 12:50 12:50

A. No. So early on in the meeting of that -- sorry, I'm talking about the Task and Finish Group.

77 Q. Let's take the first one. I am not sure what the Quality Improvement Group is as distinct from the Task and Finish Group? 12:51

A. You share my unsureness. As far as I'm aware, the Urology Quality Improvement Group has never existed. Quality improvement within Urology is something that is dealt with within our regular departmental meetings, and it is dealt with regionally through the PIG meetings. So there is Quality Improvement; I do play a role in Urology in Southern Trust and I do sit on the regional PIG Group, which also are looking at quality improvement projects. I'm sure we will come on to some of them as we go through. 12:51 12:52

78 Q. Just so I understand and the Panel understands, you've referred to PIG, that's the Programme Improvement Group, which is a regional committee chaired by the

SPPG which brings together Trust urology providers from throughout Northern Ireland?

A. Yes.

79 Q. We'll look at its role in a moment.

12:52

In terms of locally within the Trust, there's no group called the Quality Improvement Group --

A. There is no urology quality improvement group.

80 Q. But improvement initiatives are, nevertheless, on the Urology Service agendas but they are pursued not through this standalone group, which doesn't exist, but through your normal process of service meetings? 12:52

A. Yes.

81 Q. Secondly, in terms of co-chairing the Task and Finish Group, which has a specific responsibility or did have a specific responsibility for dealing with the SAI recollections, were you co-Chair of that? 12:53

A. No. That's where I started my answer previously. Early on in that group's initial meetings, it was recognised that the recommendations from them SAIs were much broader than just urology. With my remit being urology only, it was felt that the co-Chairing responsibilities needed to have a broader reach. So the initial co-Chairs of that meeting were the Divisional Medical Director from Cancer Services, which is Shahid Tariq, and Ronan Carroll as AD for Surgery and Elective Care. 12:53 12:53

82 Q. Yes. Help us with this then: In terms of improvement, the improvement element of your job title, how would

you define that in practice? What is it improving and what are the structures through which the need for improvement is identified and then pursued?

A. So there are two facets to the improvement. Improvement in relation to the deficiencies and failings that have been identified through the SAIs, as I've said, the Task and Finish Group was looking broader at the Trust. But within Urology Services, I've been ensuring that we ensure that they are delivered within our services. Then there's improvement which is beyond that; that's improving our patient pathways, improving patient access, looking at ways of working differently, changing who, when or where services are delivered to improve the care that patients receive. 12:54 12:54 12:55

If I take the first one in terms of the improvements from the failings that have been recognised, broadly we could group them into, if you like, performance. You could have an MDT aspect, we could have a patient information and support, and a culture section. If we look at our performance, it's touched upon there in the job description. Quantitative performance, so how many patients we can see, how close we are to meeting cancer targets are clearly going to be hampered by how much capacity we have. We have engaged with SPPG, and there has been significant investment in independent sector outsourcing, while we have been carrying --

12:55 12:55

83 Q. I'm pausing here because that is an area I want to

perhaps open up in a bit more detail this afternoon. Each of the elements of the improvement work will also be touched upon so I'm not intending to treat you unfairly by stopping you. I just want to get the building blocks in place before we go to the substance. 12:56

I brought you down the road of helping to explain the improvement elements, but your role is broader than the improvement focus. You carry, I suppose, the entirety of the responsibility typically associated with an 12:56
Associate Medical Director, as we used to call them, but you are not doing that with the support of a clinical director; is that right?

A. No. So Mr. McNaboe, who is now the Divisional Medical Director of Surgery and Elective Care was the clinical 12:57
director. When I moved into this role, Mr. McNaboe replaced me in that role for Surgery and Elective Care and we don't have a clinical director in Urology across ENT services.

84 Q. You do have some support, I see from your witness 12:57
statement. For example, Mr. Tyson was described as Quality Lead and also Standards and Guidelines Lead. We obviously have heard that Mr. O'Donoghue runs the Patient Safety meeting. But in terms of your role, you're, in essence, the senior clinical manager with 12:58
responsibility for Urology; is that an apt description?

A. Yes.

85 Q. It comes with three PAs. One recalls you described the pressures of medical management on the last occasion.

This seems to be a significant role, so how do you manage that in the context of your clinical responsibilities?

A. So, my job plan is essentially written so that I have Mondays set aside purely as my Divisional Medical Director role. I have some additional short periods of time elsewhere in the job plan, which are normally detailed as time for me to keep up with emails and the like. The reality is also on Tuesday, I have other nonclinical roles within my job plan, including my educational supervision sometimes as the NICaN CRG, and my own CPD SPA. The reality is that Mondays and Tuesdays, my Divisional Medical Director activity moves across both of them days. Indeed, where I can fit things in, where there's a meeting on a Thursday and I'm able to get to it in between clinical activities, I will do that as well. 12:58 12:59 12:59

Certainly, I know I have -- the virtual working and Teams and Zoom, as we all know through COVID, have facilitated or enhanced the ability to actually attend a meeting in between two clinical sessions. I might be doing a clinic and, over lunchtime, link into a meeting. 12:59

86 Q. Thank you for that. That's the building blocks in place. Take a break now? 12:59

CHAIR: Two o'clock, everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

87 Q. MR. WOLFE KC: Good afternoon, Mr. Haynes.

Before I explore with you the changes and the extent of the changes in Urology Service over the past several years, I suppose it bears reflection that a service and a Trust that's cast into the storm of a very public inquiry must suffer some form of trauma, or I suppose upset or unsettlement, as a result of the experience. 13:58 13:59

Could you comment from the perspective of a working urologist, as well as a medical leader within urology, just how are things within your service and amongst your colleagues? I think you reflected on the last occasion it has been a difficult period. Have things evened out in the interim? 13:59

A. As I said before, it's obviously difficult. As a team go through an experience like this, they will go through a wide range of emotions individually and functionally as a team. That does affect, inevitably, their working and how they work. Time does allow people to work through them emotions and change -- you know, we all learned at medical school about the stages of grief. I'd say actually them stages are very similar in response to many external stimuli, and this is no different. 14:00 14:00

We've covered vacancies within the consultant body. We know on at least one occasion we've had withdrawal of an applicant from their application for a consultant post citing advice of colleagues given the spotlight the service is currently under. So, we know it's impacted people outside.

I think there has been an inevitable impact on how people practice as well. I think that there's been -- that we have, understandably, developed somewhat of a defensive practice in some things and maybe, where previously we might managed a patient, for instance, on surveillance for a small kidney mass with an unchanged scan ourselves and continuing a standard follow-up protocol, there is a much greater tendency to bring that patient to the multidisciplinary team meeting repeatedly without any change in what would have been the management, so there has been an inevitable impact from that perspective.

However, as a team I think we are in a healthy place. We all get on well; we have good working relationships; we are happy to pick up the phone, and that's across the consultants and across our more junior team and across the nursing team. We have been able to, possibly on the back of part of the improvements, improve our specialist team, and that's taken us to a much better place from a nurse specialist support. We have been able to expand some of our junior team.

These things have improved the environment that we work in, but we're still facing challenges with vacant spaces on the rota. Hopefully sorted, as we'll probably touch on later, with recent international medical recruitment.

88 Q. Yes. Just on one of the points you make there about working well as a team, good relations, ability to pick up the phone, is that by contrast with pre-Inquiry or pre-summer of 2000? Because Mr. O'Brien, not to put a fine point on it, is no longer there? Is that what you are saying, or is it more a recognition that in order to work as a collegiate body, these kinds of conversations, this kind of informality, pick up the phone, share views, is a necessary component?

A. Share views, disagree, accept disagreement. We don't have the elephant in the room.

89 Q. That's what I wanted to extract, to test with you. Is that because Mr. O'Brien is gone and are you saying that was a problem, or are you saying a different reason, that it's actually a recognition that we need to behave in a different way, more collegiately, even on an informal level? From your perspective, and it may not be everybody's perspective.

A. I think that's very difficult. I think I've always practised in that way. If I reflect on my practice before I came to Northern Ireland, I would have had them working relationships in the previous consultant team that I worked in. I mentioned "elephant in the room". We know that -- or it's been covered in others'

evidence as well as my own, that Mr. O'Brien was difficult to challenge. He didn't respond well to challenge, he didn't accept other perspectives and change his view. To a degree we touched on it this morning with the 2014 Dr. Mitchell e-mail. If that was received by any of the rest of the team, that would have led to practice change, but it didn't seem to lead to any change. 14:05

90 Q. Before we move to the 2020 SAIs and what has been the response to those, I want to ask you about a number of discrete areas. Just before lunchtime we were talking about your medical leadership rose and you explained how you were able to carry that out. There's an element of sort of using available time during the week and sort of squeezing things in between sessions to get the job done. I think more particularly when you were here with us on the last occasion, you reflected quite often just you weren't able to get to meetings and there was an almost - and you can correct me if I'm wrong about this - but there was a sense from your evidence that you weren't doing medical management in the way you would like to because simply there wasn't enough space in the working week to do that. Correct me if I'm wrong about any of that, but I wanted to ask you the question and you can tie all of that into your answer, have there been changes, noticeable changes in support for medical management in the last two or three years within the Trust? 14:05 14:05 14:06 14:06

A. In the preamble, you touched on not being able to get

to meetings. That can still be an issue. We have management processes that work over five days, but no medical manager has five days' availability. So a meeting that's always scheduled for a Friday, for instance, I don't get to because I operate in Belfast Trust on Friday. I have to accept that I just can't get to them. 14:07

I don't think there's a good solution to that sort of issue because, inevitably, if all medical managers have between two and three PAs, then having them tie up all at the same time to get all of the things that are required just won't happen. 14:07

I think, from my perspective, things have been simplified because I'm managing one specialty, one team of doctors, one team of nurses, with one head of service and with one AD. Things have been simplified from that perspective, which makes it easier from my perspective. The head of service has planned in the week things that tie in with when I'm available, and does things that don't require me the other times in the week. Similarly with the AD, we do that. But there are still things, as I say, outside that do happen on days that don't suit me and I just have to accept that. 14:07 14:08 14:08

91 Q. I think I'm right in saying that you were clinical director within SEC in 2016, assuming the reins of the Associate Medical Director in late 2017, taking on this

most recent role, the particular focus in urology, in December 2021. It must be a very obvious reduction in, I suppose, the stretch that you have to apply to yourself if you're only required to focus on urology. Have you formed the view that, really, for an associate medical director to do his job effectively, he or she can't be stretched across all the SEC; the role needs to apply to smaller services or divided up so that it applies only to one or two services? 14:09

A. I think it has been useful, me being able to apply myself just to urology. I think that does enable a much greater handle and focus on the issues that require a divisional medical director. In terms of recognition of the breadth of SEC, there are now two ADs for Surgery across what used to be Surgery & Elective Care where there used to one, so there has been additional recognition of that. Even one step above that, what used to be Acute Services is now Surgery and Clinical Services with one director and -- I've forgotten the name of the other group but there's a second director at that same level. Where there used to be one director across all acute services, there are now two, and within that surgical and clinical services group, there are two ADs, assistant directors. 14:09 14:10

92 Q. I suppose that greater focus or lessening of that burden, what has been the impact of that or the advantages of that in terms of the tasks that you're expected to carry out as Divisional Medical Director? 14:10

A. It inevitably improves your ability to maintain a focus

on one thing. When, for want of a better description, when you have multiple fires to put out, you put out the one that is nearest to you. When you have lots of problems and you haven't enough time to address them all, you, unfortunately, inevitably, address the one that's shouting the loudest. That's what happens when you've got too much activity to do. 14:11

93 Q. Yes. I want to ask you briefly about relationships upwards to the Medical Director's office. I think you reflected the last time, or perhaps it was put in your statement, that whenever Dr. O'Kane came in as Medical Director in January or so '19, that triggered, I suppose, a more direct engagement between you at that time as Associate Medical Director and that office. I think you were reflecting that was a positive change compared to what you had experienced before that. There are now, I understand, a number of deputy medical directors; is that right? How is that relationship, that looking-up relationship - or maybe you don't think of it in terms of looking-up. How do you find that? Has there been any positive improvement or initiatives? 14:11 14:12

A. Over time, as I said, there was a change in approach when Dr. O'Kane came in. That approach has been continued with Dr. Austin. We have regular senior medical leaders meeting which, in an attempt to manage the fact that we don't all have our time at the same time, we switch from a Monday one week to a Wednesday on another week. They happen regularly. The presence or the existence of deputy medical directors means that 14:12

there is a much easier line into that senior management. It is not a question of only one person to contact; I can contact one of a number of people depending on the specific issues.

94 Q. I think one of the issues historically was that concerns around Mr. O'Brien weren't leaving the service, they were staying within the service, possibly reaching back in the time of Mr. Mackle, the level of Associate Medical Director but not going beyond that, not being escalated, effectively, to the Medical Director's office until Dr. Wright was, perhaps, told about concerns at the tail end of 2015 into 2016. 14:13 14:13

In terms of the ability to escalate issues, if there were issues to escalate, is that something you feel structurally is more readily available to you as a leader? 14:14

A. I think so, both formally and informally. So, as I've said, with the team as it is, there is a much greater opportunity. The regularity of them interactions as a group mean that the Medical Director isn't someone who feels distant from you, nor are the deputy medical directors. 14:14

95 Q. How often would you see them?

A. The Medical Director? 14:14

96 Q. Or his deputies.

A. So there's the weekly senior leaders' meeting, so that's a regular occurrence in the diary. Now, if I'm doing a clinical activity on a Wednesday and I can't

meet it, I'll make it on the Monday because that fits with me.

I've mentioned previously that relationships between people actually make things easier. Regularly seeing and being in contact with people make things much easier to pick up the phone. But there's also the formal process and, again, I think that started to be instigated by Dr. O'Kane and has continued on with Dr. Austin in terms of the revalidation process. Now, whenever a doctor comes up for revalidation, all of their appraisals are reviewed and discussed by the divisional medical directors with the Medical Director at a formal meeting where any of them concerns are raised. I would hope, had that been the case in Mr. Mackle's time, that he would have had an opportunity there through that formal process, perhaps, to say actually there have been some issues raised here. 14:15 14:15

97 Q. That's an example of the kind of thing that might be discussed formally. What about informally? Can you share? Is the structure, or indeed the relationships, there to discuss, if necessary, and it may not have arisen as yet, but maybe concerns that are in the back of your mind about practice issues, about behaviour of colleagues? 14:16 14:16

A. I would have no hesitation because the relationships are there.

98 Q. In terms of, if you like, the bottom up to you, you

don't have a clinical director in place. If the situation was to arise, how do you ensure that information comes to you? Is that by having more improved meeting space with your clinical colleagues? You mentioned earlier picking up the phone to each other, that kind of thing. How does that information come to you generally?

A. Yes, so there's the simple informal relationships. There's relationships wider than just clinical colleagues. I will and do make a habit of always seeking out and speaking to nursing colleagues on the ward, actively seeking and looking for feedback on how things are going. Again, I think it's that relationship. People need to feel comfortable in speaking to you. I hope I'm not -- not got a false impression but I think people are happy to raise things with me. I think part of that comes from people feeling confident that you might actually look into what their concern is.

14:17

14:17

14:17

99 Q. In terms of the Board level, there might be a sense in the evidence that the Board members, particularly the non-executive directors, may not historically have been well-connected initially into urology; that's what we're focused on. Has there been opportunity for you to meet with the Board, communicate with the Board, any individual Board members, or does that come through the structure of you speaking to the Medical Director and any views that you might have being shared through that process?

14:18

14:18

A. So I have been invited and spoken and met the Board Governance Committee. I have met them on the one occasion. Eileen Mullan has made contact with me personally and spoken to me. Dr. O'Kane, obviously being the chief exec, we had a working relationship before when she was Medical Director, and that working relationship has continued. Again, just like I do with the Medical Director, I feel quite happy to drop her a text and ask her to give me a call if there's anything I would like to speak to her about. 14:19

100 Q. The Inquiry has heard evidence from Board members that whereas, perhaps, in recent years there has been a focus in terms of Board interests on promoting compliance with performance targets, there has been a shift from that more recently, it has been suggested, and that the primary focus is now patient safety, quality. That's much more central, perhaps, than it was allowed to be previously. I'm hoping I'm describing it correctly. That's the sense of some of the evidence that we have received. 14:20

In how I've described it, have you observed a change in focus?

A. I couldn't consciously say I've witnessed a change in focus but I wasn't ever really consciously aware of a focus on times -- however you referred to it. 14:20

101 Q. It seemed to be that these are the targets, the ministerial or statutory targets.

A. I wouldn't have consciously aware that there was

a focus on targets over other things previously either, so I wouldn't have noticed a change.

102 Q. You mention some engagement with the Board through one of its committees. Obviously with Urology in the eye of the storm, have those conversations looked at or focused upon patient safety issues within Urology or what has been the focus of them? 14:21

A. So, the Trust Board governance meeting was around the outworkings of the Lookback Review, so was around the outworkings of that and discussed things, the sort of measures we've taken in light of them findings. That was the purpose of that meeting. 14:22

103 Q. That's an understandable starting point but has there been further contact, building upon that?

A. No. 14:22

104 Q. Do you think there ought to be greater connectivity particularly between your service because of recent history and the Board?

A. I don't know. We reflected at the start of this session on the difficult time we've been through. Allied to this process, we've also had a GIRFT review, we've had an RQIA review. The team have felt under the spotlight anyway. Having the Board come and talking to the team more regularly might make them feel like there's another spotlight on them. I think at the end of the RQIA review, I think we were asked if there was anything that could be done, and the request from the team was leave us alone to get on with what we want to do. Allowing us that freedom to develop our services, 14:22 14:23

with an assurance that we are focused on delivering in the patients' interests, delivering safe, high-quality care but not having to be questioned about it every couple of weeks, every month, there's a significant value in that. 14:24

105 Q. In terms of the Trust having a long-term vision, would you as a senior clinician know what that was? In other words, it's an indirect way of asking you do you feel and do your colleagues feel that you have a share in shaping the vision and outlook of the Trust? 14:24

A. I think everyone involved in healthcare wants to deliver a safe, high-quality service that meets the needs of the population, but the constraints are such that what might be what everyone's intent or golden view is can't be delivered. We know, and it's covered 14:25 elsewhere outside of here, about the infrastructure surrounding many of our hospitals. We know that we don't -- we commission differently in Northern Ireland to, say, in England where Trusts are commissioned by what they deliver, so encouraged to 14:25 meet the demands of the population, where we're commissioned to deliver a set volume of service which doesn't meet the needs of the population. I think that automatically leads to, perhaps, a bit of a tug because if I, as a clinician, want to see patients every day 14:25 who are taking longer to get treatment than I feel they should, then I want to be able to deliver that, but the constraints on the Trust and the service are such that they can't physically do that. So you can get this

feeling of a disconnect between the aims of them two groups of people but actually there's no disconnect, it is just an inability to do it.

106 Q. Yes. Notwithstanding that inability, the disconnect that you speak of, is there ways that you think that could be eliminated so that even if there are these hurdles in terms of delivery, at least your voice and the voice of your experienced colleagues might be better heard in devising mitigations if not solutions? 14:26

A. I think clinicians, and so clinical input, into the design and delivery of every service is required and has to be encouraged. I think without that, you do lose that voice and that ability to guide. As I say, I think the picture at the moment is very difficult because we all know that the focus really is that our hospitals are full and there's emergency departments with ambulances waiting outside and patients waiting too long, and naturally the focus has to be on resolving the emergent problem. 14:27

107 Q. Let me bring you back to, if you like, the fall-out of the 2020 SAIs which were reflected in a series of recommendations. Bring the recommendations up on the screen. They can be found at DOH-00129. The role of doing something with those recommendations was handed to a Task and Finish Group, WIT-11509. There it is described, and its terms of reference being implementing all the recommendations and providing assurance and evidence externally to the Urology Oversight Group and its significant membership. As 14:27 14:28

we can see there, your name is the third down on the left-hand side. You've explained earlier that as things transpired, you were not a co-Chair.

We've looked at some minutes in relation to the meetings of this group. You aren't often in attendance; is that fair? 14:29

A. Yes. The meetings, just like we've covered earlier, were not always at a time where I could attend.

108 Q. Yes. Clearly, as this group went about its work, it was focused not just on urology, as it happened, because it was recognised, following a baseline audit, that the kinds of issues that had emerged from these urology SAIs were of wider import. They affected, essentially, the suite of Urology Services within the Trust; isn't that right? 14:29 14:30

A. Yes.

109 Q. Perhaps for those reasons the ownership of the Task and Finish Group in terms of its Chairpersonship was handed to Dr. Tariq. Is that your understanding? 14:30

A. As I said earlier, my memory is it was co-Chaired by Dr. Tariq and Ronan Carroll.

110 Q. We can see, if we can turn to TRU-30588... I wonder did I leave a digit out? I should have said TRU-303588. Thank you. 14:31

This is a summary of the improvements visited upon or intended to be visited upon cancer MDT workings as of December 2022. I just want to scroll down through it

just so that the Panel can familiarise itself with it. It set out some of the contextual issues that the Trust became aware of in light of the SAIs. For example, MDT meetings had broadly remained unchanged for more than a decade; no commission post to oversee the effectiveness of each MDT; an absence of monthly reports to deal with some of the key issues, including on quoracy. Familiar problems for those of us who have read the SAIs emerging from Urology, these are the kinds of themes - and you can see others listed there, cancer nurse specialist - that Dr. Hughes and his team picked up as part of the SAI reviews. 14:32 14:32

Just scrolling over the page. We're going to just come back to that in a moment, we'll come back to some of the specific actions. This implementation stage of recommendations flowing from the SAIs was taken forward as part of a task and finish approach. I think the last time when we were asking you about Serious Adverse Incidents more generally, you were reflecting - and we can see it, we don't need to bring it up - but we can see at TRA-0964 you were reflecting your concerns that SAI action plans do not get implemented quickly enough. That was perhaps in the context of a number of cases that you were participating in, including the five triage-related SAIs that were taken forward together. 14:33 14:33 14:33

Before we look at some of these actions taken as a result of the Task and Finish Group's work, have you noticed any change in how SAIs are approached in the past 14 or 15 months since you were last with us?

A. In terms of the primary SAI processes, it is very similar in terms of the decision to proceed to an SAI. There is a much greater focus on getting those SAI reports completed and improved and through the acute clinical governance meeting so they are at a point to be implemented. There has also been expansion of the team supporting that process whereby them recommendations can be tracked live through the Datix system, where they couldn't have been previously. 14:34 14:35

There's a retrospective element to that in terms of getting the older recommendations on to the system so they can be tracked as well, as well as the prospective elements. So, there is work undertaken to improve that. The position in terms of SAIs waiting doing, as far as I'm aware, is much better than it was. 14:35 14:35

111 Q. What has been, if you like, the practical remedy that's enabled some speeding up or expedition of reviews in terms of -- does it relate to the personnel or the ability to deploy personnel more readily?

A. Support staff, more than anything. There's still a challenge where you require clinician input, particularly where, say, someone were to come in for Urology, with only three of us in substantive post at the moment we haven't got a huge capacity to be 14:36

managing many SAIs at any time.

112 Q. One of, I suppose, the complaints we've heard said through a number of witnesses is almost there is a disincentive sometimes to raising an incident report, or a Datix as it is sometimes called, because the sense of it was you might raise something you feel quite concerned about and earnest about and you go through the process, and you never hear back or you sometimes don't hear back in terms of how your concern has been viewed by others and how it has been dealt with. I'm not sure I asked you about that on the last occasion; is that something you recognise, and what can be done about it? 14:36 14:37

A. It is certainly something I do recognise. It is like a development of apathy. If you raise a concern and then keep raising a concern but never hear anything back, you ask the question why should I continue raising a concern? One of the challenges with that is how much feedback and when to fee back to individuals through that process. Certainly as a department, SAI reports and recommendations are fed back through our patient safety meeting, so that comes back in to us. What you perhaps don't hear about is the IR1 that's completed that's been screened out as not requiring investigation. 14:37 14:37 14:38

113 Q. Perhaps it seems an obvious point to make, why wouldn't you treat the person who raises the IR1 in the way that you would treat any other complainant? A patient complains; if the Trust is following its normal

protocols, it will regularly update that patient in terms of their complaint - this is what we're doing now, this is why there's the delay, or this is the decision we reached. Would it be very unusual or dramatic to treat a staff member raising an IR1 as you would treat a complainant? 14:38

A. No, I think that's a reasonable question but what you require is the support staff to enable that, rather than it be another task that needs to be done by people who are struggling to meet the demands of what they've already got to do. 14:39

114 Q. The actions taken as a result of the Task and Finish Group's work - and I emphasise this - are only summarised here. What sits behind this report is a spreadsheet that's much more elaborate and sets out, using the red, amber, green system, what has been achieved and what is a work in process. I emphasise that this document affords us a helpful summary but no more than that. 14:39

14:39

It describes a number of new support staff being brought into the MDT arena, including someone whose responsibility is to provide monitoring by way of assurance and -- sorry, a Cancer MDT Administrator and Project Officer, and then a Cancer Information and Audit Officer and, in addition to that, an Interim Lead Nurse For Cancer Services. Are those posts that you have an interaction with in your participation in the MDT? 14:40

A. So in terms of interaction with, yes. In terms of the Thursday afternoon MDT, they're not MDT members, so no. Their roles are very much part of the assurance processes that surround the MDT. If you take the Cancer Information and Audit Officer, that's the individual that does a monthly audit of the outcomes recommended from MDT and are addressing the question are they being actioned, and I get a report from that individual. So yes, I have interaction with them. Their role is that assurance process around MDT. 14:41

115 Q. I want to, in a moment, look more particularly at how some of those actions work. Just scrolling down, we can see under the next heading that in addition to bringing new personnel and embedding them within the MDT arrangements, there's now a suite of new monthly reports that superintend the MDT process, including one focusing on attendance and quoracy; one relating to, as you mentioned a moment ago, audits to confirm that actions agreed by MDT are implemented. There are three reports dealing with the role of a key worker, confirmation that a key worker has been identified and documented, and then an assurance that a key worker has been identified and contact made with the patient, and then confirmation that the CNS or key worker was involved with patients with a confirmed cancer. Then the last of the reports mentioned -- the last of the arrangements mentioned in this list is the connectivity between the labs, the pathology lab and the MDT where there is a case of confirmed cancer. 14:41 14:42 14:42 14:43

You explained earlier that this initiative to bring improvement to the cancer arena broadly, as I understood your evidence, is the subject of a separate piece of work within Urology itself, and that's where your improvement role kicks in. Explain to me the mechanism. Do you know - assumedly you do know - what's going on with the Task and Finish Group, and then it's your responsibility or your team's responsibility to ensure that those kinds of initiatives are implemented for Urology? 14:43 14:44

A. So if you go back to the Task and Finish Group membership, included in that membership is the Urology MDT Chair Mr. Glackin and three specialist nurse specialists. So there is Urology input in there in addition to my being a member. So although I wasn't able to attend, there was Urology input into that. 14:44

My role, as you say, is very much to make sure that these things are implemented in Urology. In Urology, as is highlighted there in the second point, Urology was very much used as the first rollout for these things. That audit of outcomes was done for us first and then has been rolled out across others. There's a dashboard that is produced on a monthly basis which gives us our cancer dashboard in terms of waiting times, treatment times. 14:44 14:45

We have, relatively recently, been liaising with a team in the Cancer Services about the third point, because what we found is a list of patients waiting the longest for diagnosis, all that tends to reveal is patients with very complex pathways which, actually, aren't very easily fixable. What we need to know actually isn't that small number of extremely long pathways, what we need to know is the ways we can fix what are affecting the majority of patients and bring the majority of patients' wait times down. We have asked for a slight change in how we get that sort of problem patients or waiting time problem information escalated or brought to us. 14:45 14:46

The key worker information is well described there. In Urology in order to do that, we appointed two additional posts, which were on temporary funding initially but will be morphed into permanent funding to provide that key working input, so that every clinic that happens in the Urology team, where cancer diagnoses or post multidisciplinary team meeting discussions are happening, we have a clinical nurse specialist present at with the consultant; not called in but present with the consultant. 14:46 14:46

We know from the information provided by this audit report, but also from patient feedback - and it is commented on in the initial feedback from RQIA - that our patients, all of them, recognise that yes, they had

met their key worker, they did know who they were and how to contact them. Them things we have been able to implement within the Urology team.

116 Q. Let me ask you about some specifics of how these, I suppose, governance tools work in practice. One of the matters that's not particularly touched upon here is the whole area of actioning results. So whether it's a pathology result arriving back at you or an images result coming back to you, I think you agreed on the last occasion that it is imperative that they are read and actioned promptly. We won't go over this afternoon the history of difficulties which surrounded that but it is reflected in a number of cases, including two of the 2020 SAIs that we've looked at. 14:47 14:47 14:48

We have been sent this week the administrative and clerical standard operating procedure, which is a policy or procedure that was developed or implemented in April 2023. We can bring that up on the screen. It is TRU-320269. I want to check with you that I'm on the right page with this. Is this the most recent, I suppose, iteration of the way a secretary is expected to conduct him or herself in the arena of working with a clinician with results, whether it's results for a new patient or whether it is subsequent diagnostic results? 14:48 14:49

A. Yes. This was developed by us specifically around the management of results. This is how the secretarial support staff address or manage this, and it includes

escalation. Separate to this, there is how we as consultants manage our results. I can't remember whether it's in there but there is an element of the monitoring for results which comes to myself and Wendy Clayton as a first-line weekly thing that we do through the Splunk report. 14:49

117 Q. I'll move to that in a moment. In terms of this process, if we go over on to the next page and the context is "New Patients". If we scroll down just towards the bottom of this page, I think there's very much an emphasis on trying to get staff to act electronically or use electronic means because it's safer and provides, I suppose, an audit trail to prove things are being done when it is said they are expected to be done. 14:50 14:50

Moving down the page a little bit further, is it fair to say that a particular onus or particular responsibility is placed on the secretary in this regime? In other words, it's the secretary who must keep an eye on things and escalate if his or her consultant is not dealing with the result within the expected timeframe? 14:51

A. As I said, the first step of the monitoring process is undertaken by myself and Wendy Clayton. All of the consultant -- indeed all of the team, so nurse specialists as well within Urology use electronic sign-off for their results management. That's our primary mechanism for managing results. Myself and 14:51

Wendy Clayton, every Wednesday morning, we receive a - for want of a better word - a dump, an Excel file, which contains the details of all radiology results requested by a urology consultant. It goes back six weeks from reporting date. We've written -- I've written a number of formulae within Excel which then take that data and tabulate it for us and covert that into a red/amber/green table for each consultant of their reporting. 14:52

118 Q. I think we can look at an example of that just to illustrate the point. Sorry to cut across you. If we go to TRU-301760. Mr. O'Donoghue will think I'm picking on him but I think there are other examples. Is that what you mean? 14:52

A. Yes. So this is early -- as we were developing this process. Early on, as we were moving to electronic sign-off, I started receiving the Splunk report and monitoring. So this is, as you say, the SOP showed earlier was a 2023 date on it as a starting. 14:52

14:53

I generate this red/amber/green printout for each consultant, and it tells me how long a result has been outstanding and awaiting action. This time in particular for Mr. O'Donoghue, I know, is as we were just switching to electronic sign-off for him, so he was just moving to 100% electronic sign-off, and I can say that I know that now Mr. O'Donoghue is in green every week. We have an escalation process behind that for myself and Wendy. The first thing we do is an 14:53

escalation letter or e-mail similar to this where we just raise the attention of the consultant that they have fallen into amber. Then if they fall into red, we arrange a formal meeting with them and establish a way we are going to get back to the green. 14:54

119 Q. Are you suggesting that, if you like, the mere availability of an overview like this has helped to change the culture?

A. Yes. The full table for all consultants we regularly e-mail around so we all know how each other is doing, 14:54 and no one wants to be bottom of the table. You don't want to be bottom of the class so it generates a culture whereby everyone keeps on top of things. If you get an e-mail that shows you as an outlier, it changes the way you behave. 14:54

120 Q. I just want to better understand the relationship between this process and the policy that I had up on the screen. If you just go back to that. It's TRU-320270. This is setting out, in essence, the relationship between secretary and consultant. Just 14:55 over the page, I just draw your attention to this. There's various steps in this process. If a consultant doesn't respond, the secretary does; the next step and the next step and several weeks might pass by. Then, as we can see in the -- and I'm pressing here in the 14:55 interests of time, but after a further week of no action, secretary informs the service administrator, the head of service for admin and the head of service for the specialty.

I suppose the concern I'm putting to you through this policy is that you have the secretary, perhaps it has to have a close working relationship and a cooperative working relationship with the consultant. The onus seems to be placed on her or him to blow the whistle and escalate, which may not necessarily be an easy task to perform given the need for good working relationships with the consultant. Is that a fair concern to raise? 14:56

A. I don't think so because that initial concern, if you like, may simply be that that consultant has been on holiday for two weeks. So, you return from holiday and get told there's these paper results. This is the second stage, if you like, the second monitoring process. The first line monitoring process is that monitoring of electronic results. If a consultant is signing off all their results electronically, the number of results that are coming through on paper is very few, it is only those that haven't been assigned to the consultant at the requesting stage. It should be very few results coming through on paper. 14:56 14:57 14:57

So as I say, this is a second stage, and that working relationship, I think it is maintained there, because the consultant knows the secretary has to keep an eye on it, but they also know the secretary will come to them first. 14:57

121 Q. If we look back several years, Mr. O'Brien practised in

a way where it would appear to be the case that he didn't always action his results in a timely fashion and was in the habit, perhaps - at least in some cases it is suggested by the evidence - that he would wait until the patient came in on review to look at the result, and he wasn't a user of the electronic sign-off system. So how do present arrangements guard against that problem? 14:58

A. So one of the problems we had previously was we didn't know what had been handed to a consultant in paper form. I think one of the 2015 SAI groups that Dr. Johnson chaired, I think there were a number of letters from an oncology team that had been written to Mr. O'Brien but we had no record as to whether they had ever been received. Part of this is actually recording when we've got something and when it has been handed over for action and the process behind that, so that we know that action has been undertaken. 14:58 14:59

122 Q. I think if we go to the last page of this document. Yes, it's 73 in the series, the last two digits. Scroll down, I think. Just scroll down. It's recorded here: 14:59

"Results are not signed off electronically but arrive in paper form. The secretary must scan to the consultant. Handing a folder over has been proven to be ineffective and increases the risk of a patient being missed for follow-up. By scanning there is proof the results have been sent". 14:59

Is that the point you are making?

A. Yes, that's the point I'm making. We need to know what has been given to someone and when it has been given and when we have received it back. This is what this is aiming to have as a process. 15:00

123 Q. Let me move through a number of the other specifics that arise out of those SAIs. The key worker or the nurse specialist, we didn't ask you on the previous occasion about your engagement with key workers and how well you used them within your practice prior to the 2020 SAIs. You know the problem as presented by the SAI reviews was that Mr. O'Brien did not, across the nine cases, use a key worker or apply a key worker to those patients. The point he has made is that he didn't exclude key workers. He points to the operational policy for the MDT which suggests it is somebody else's responsibility to allocate the key worker. 15:00 15:01

Had you any experience, directly or indirectly, of those key workers not being used by Mr. O'Brien within his practice? 15:01

A. Had I experienced him?

124 Q. Had you observed that as a problem? 15:02

A. I don't know because I know what I know now; I can't recall what I didn't know then. I know from my own practice, I don't recognise that view that it's someone else's job to assign a key worker. I know when I did

clinics, even though we didn't have someone able to sit in clinic with us, I would, either before I started clinic, go through my clinic list and identify to the nurses in clinic which patients were going to require a key worker or, as often has been touched on, I get up 15:02
early, I would e-mail in the morning the patient list to the nursing team with the likely requirements of that patient group, not only key workers but also if they were likely to need additional tests while they were in clinic. 15:02

125 Q. One of the more recent features, I think you've mentioned it earlier, is that there's been further recruitment and a greater number of key workers available to the service than there was historically. Might the shortfall, if it was a shortfall, in the 15:03
number of key workers available in 2018, 2019, 2020, might that explain any difficulty which Mr. O'Brien might have experienced in linking a key worker to a patient?

A. That same shortage would have applied to me and my 15:03
colleagues. It didn't stop me from letting the team know whether a patient required a key worker input.

126 Q. What did you see was the value or the benefit for the patient, or perhaps indeed yourself as a practitioner, in bringing a key worker or providing the circumstances 15:03
in which a key worker could link with a patient?

A. For me, one of the most important things is we know that patients don't retain all information given to them at the time of a consultation. It's why I've

always copied my letters to the patient, so that they have that information as well. But we know that patients get home, they have other relatives, other family members who they speak to and questions always arise. I'm not available on the phone to answer them questions. That's what a key -- you know, a major part of the key worker is that role. It's also the navigator through their care. 15:04

Inevitably, and my dad told me this once, the worst bit of being a patient is waiting. In between visits, you are waiting for the next thing. Inevitably after a period of time, patients will develop some anxiety and they need to be able to contact someone to see where things are at. The key worker can do that. 15:04 15:05

Additionally, there's a safety net aspect for ourselves, for me as a practising clinician. Practising clinicians are busy; there will always be occasions where you overlook something. Say on an electronic requesting of a scan, you don't allow it to go through and it doesn't register. With a key worker, they can actually come back to you and say this patient asked about their scan and actually I've had a look and it doesn't seem to have gone through, can you do it again. So, you do. So there is a safety net aspect for me as well. 15:05 15:05

That safety net aspect extends to the MDT outcome as well. If I've done something different to the MDT outcome, the key worker might raise -- say the MDT outcome says to request a CT and a bone scan and I've neglected to request a bone scan, the key worker can highlight that to me. There's a better chance of it being recognised.

127 Q. Let me take you back to the summary of the improvements, the report from December 2022 which we were on a few moments ago. TRU-303589. Just at the bottom of the second half of the page, I should say, as I highlighted earlier there are now a series of reports directed to the role of the key worker, essentially providing for assurance that those key workers have been identified and, if appropriate, appointed and contact made with the patient, and then involved with every confirmed cancer case. Is that something that is now implemented within Urology to the best of your knowledge? 15:06 15:06

A. Yes, to the best of my knowledge that is all implemented. I think there is an aspect to it that was required for the monitoring, for ease of monitoring, that required some regional input on the CAPP system, the cancer -- the computer system that's used for recording the cancer patients. The actual, the physically doing it and auditing it and recording it is all being done. 15:07 15:07

128 Q. Yes. Just some of the other aspects of reportage and auditing of the processes. Attendance and quoracy is

recorded on a weekly and monthly basis. I'm not sure if that's any different from the historical position because we have statistics available to us showing shortcomings of quoracy over many years. It is the quoracy issue itself I wish to ask you about. The problem historically has been oncological and radiological attendance leading to situations where MDTs have to be -- or consideration of particular patients at MDTs have had to be postponed, or workarounds have had to be developed. 15:08 15:09

Has the quoracy situation improved at all?

A. Significantly. The issue previously, as you highlight, was down to oncology and radiology were our biggest -- most difficult areas, with a single radiologist and a single oncologist. From a radiology perspective, we are in a position where we have three radiologists attending currently, so I don't recall over recent times not having a radiologist present. Pathology cross-cover is always provided. From a urologist perspective, if there aren't two of us available - which is the quoracy number - we don't proceed with an MDT that week. From an oncology perspective, it's dramatically different. We have two medical oncologists who attend regularly. One of them is the Clinical Director For Cancer Services in Southern Trust as well. Our only remaining area of weakness is we have a single clinical oncologist and so we don't have cover when our colleague is off on annual leave or 15:09 15:09 15:10

sick leave. But we're in a much, much better position than we were historically.

129 Q. The next issue on this list is now - again we touched on it briefly earlier - audits performed to confirm that actions agreed by MDT were implemented. Is that something that is now embedded within Urology? 15:10

A. Yes.

130 Q. I suppose the mischief that this audit was intended to correct was the situation that we saw with some of the 2020 SAIs; Patient 1, for example, where the recommendation from the MDT was hormones and referral. I simplify that, of course. That wasn't implemented and there was no report back to the MDT to say it wasn't implemented. Despite disease progression, urinary retention in March of the previous year, the case still didn't come back to the MDT and, of course, there wasn't in place a key worker so there was no safety net. 15:11 15:11

Tell me about how the audit works in practice and how quickly does the MDT Chair, or whoever the responsible person is, become aware of any disconnect between the MDT recommendation and the clinician's action? 15:12

A. So the audit is done on a monthly basis. Where there are, if you like, discrepancies, where there's an outcome or a query regarding the outcome, it is raised first-off with the clinician themselves. As I mentioned earlier, there may be a simple oversight or failure of the requesting process that means something 15:12

hasn't been requested, or it may be that the clinician has forgotten to bring the patient back to MDT when they've changed it, so it allows for the clinician to actually look at it and bring it back if required. But if there's no action, then my understanding is that 15:13
that is then escalated to the MDT Chair to bring it back to the MDT.

131 Q. It may be an unusual situation or an exceptional situation but is there a way of, I suppose, challenging the correctness or the merits of the reasoning that 15:13
might be articulated by a clinician who is saying that he does not wish, or the patient does not wish, to follow the recommendation?

A. So the commonest situation we've had - and from memory it has not been this process that brought the patient 15:14
back to MDT, it has been the clinician who has brought the patient back to MDT - has been where the patient's wishes are different to those that have been put or recommended by the MDT. Where you have that consultation taking place with the clinician and the 15:14
Clinical Nurse Specialist, and you have in that well-counselled patient they are making an effective decision to go with a different plan, it is very difficult to change a patient's decision when they've made a reasoned judgement themselves. We haven't had 15:14
to challenge a clinician, saying I think we should do something different.

132 Q. The final point on this list I wish to deal with is the concern that was exhibited, I think, in one of the nine

SAIs about a result known to the pathology lab that there was a confirmed cancer, but not then known to the MDT, but was known to the clinician, that is Mr. O'Brien, but not actioned, so that the case sat with a positive cancer result and there was delay in follow-up. Is that the mischief that this arrangement, a cross-check mechanism with the laboratory, is designed to address? 15:15

A. Yes. So the MDT process requires someone to initiate the addition of the patient to the MDT. For Urology, there's an electronic form for that MDT addition. That cross-check is so that if there is a patient with a cancer on biopsy who has not been added to the MDT by the clinician, that patient will be brought to the MDT. 15:16

133 Q. Thank you for that. 15:16

Overall, taking into account your experience of working within this MDT before 2020 and knowing the environment now in light of these changes, how would you characterise the improvements? Has there been meaningful progress and is it a safer environment for your patients? 15:17

A. I think there has been significant progress. It's a safer environment for patients. It's also an environment where we as clinicians feel safe. We know that there are processes to make sure that everything is happening as it should be. 15:17

134 Q. Can I turn to some other clinical aspects that captured the attention of the Panel through the evidence. There

have been a number of cases where, in the context of inadequacies in the preoperative assessment to process where it might be said the consent of the patient wasn't adequate -- I'll pull up one example. It experience Patient 90, which was - if you recognise the name, perhaps -- a case where Mr. O'Brien was the presiding surgeon, the patient died shortly after theatre. We can see the recommendation of the SAI, which can be found at TRU-161146. Actually, if we just scroll back before we get to... Scroll back to the page before that, if you would. Thank you. 15:18 15:18

Under the heading "Consent", the review panel was unable to find documentation of detailed discussion of individual risks based on his comorbidities in the medical notes. Just scrolling to the last paragraph in that section: 15:19

"He did not have a full outpatient preoperative assessment which would have identified all his individual anaesthetic risks to be assessed and discussed with the patient to ensure informed consent". 15:19

We have seen another example, I don't need to go to it, the case of Patient 91, which I think you're familiar with. It wasn't one of Mr. O'Brien's cases but it was a stent replacement operation where the patient died because there hasn't been an adequate preoperative assessment to assess the need for a midstream urine 15:20

test or toxicology test. We can see at recommendation 2:

"All patients undergoing elective surgery must have a formal preoperative assessment completed prior to surgery". 15:20

It goes on in recommendation 3:

"Discussions regarding the risks and benefits of surgery must be clearly documented in the record and reflected on the patient consent form to ensure informed consent". 15:20

So, the two issues link. 15:21

Help us with this, Mr. Haynes. Would you, in your experience, appreciate that there are problems in the area of preoperative assessment and consent within the service that you work, or do you consider these kind of cases to be fairly isolated? 15:21

A. In terms of preoperative assessment, obviously these two cases highlight patients where that preoperative assessment hadn't taken place. Certainly, in my practice, I would never intentionally operate on someone who hasn't undergone preoperative assessment. Indeed, the position where we are now with a scheduler planning the lists is such that those patients have to have been passed preop fit before they can go on to 15:22

a list.

Like any other service, the preoperative assessment service is challenged for capacity. From memory, the second patient you mentioned, Patient 91, did have appointments for preoperative assessments but missed them because they were an in-patient, and that hadn't been recognised when the patient was sent for theatre. There was an oversight, if you like, because the patient had an appointment but just hasn't been. 15:22

In terms of this Patient 90, he was having major surgery. Certainly in my own practice, I would never take someone to major surgery without them having a preoperative assessment. Even in an emergency situation, patients get assessed by an anaesthetist prior to attending the emergency theatre, and there's a discussion where that patient carries a high risk and the anaesthetist will ask the question does it need to go now or can we optimise in whatever way possible? 15:23

With regard to consent, it would be naive to say any service or any individual can't improve their consenting process and documentation of consent. Indeed, if we were to look at the medico-legal input into any Trust, we'd find that consent is probably the single biggest factor that arises to claims. 15:23

In terms of how we all practice, we would all give patients standardised information sheets at the time of adding to the waiting list for surgery. We would all document that decision in terms of why they've gone for that operation and the risks that have been discussed and the alternatives that have been discussed. We would look to document that on the consent form as well. We have had an audit of consent done within our audit programme --

135 Q. We can see that. The Panel may not be familiar with it. It is to be found at TRU-320280. This was an audit performed. It is described as a two-stem audit, so it's looking at, as it says there, consent in those two particular procedures. 15:24

As we can see at TRU-320925, I think you would accept it is probably a fairly narrow audit, looking at two procedures. If we go to TRU-320295, it gave the clinicians taking consent from patients a relatively good score, if you like. The standard being applied was the Royal College of Surgeons STARR checklist, the BAUCS guidance, and the other measurement used was the Trust's consent form. It's saying: 15:25

"Most parameters are excellent but significant room for improvement can be achieved in writing down the intended benefits of consent forms". 15:26

I suppose the question comes to this: This is useful

evidence but has there been any initiative, in light of some of the cases that we are aware of, two particularly catastrophic cases, where consent was an issue, preoperative assessment was an issue; has there been any particular initiative within the Trust to try to remove these risks and improve performance or at least improve awareness around the risks of proceeding in circumstances that are less than optimal?

A. First of all, just on the audit, as you say it is limited. It's an audit of the completion of the consent form at the time of the signing of the consent form, not the whole consent process.

In terms sort of that consent piece, there is a piece of work that I am engaged with along with a colleague who's working alongside the litigation team with the Medical Director's office, and that's around improving our documentation across teams of that consent process. Also looking at improving some of the communication strands that have come back in terms of -- I can't remember, I think it was a piece of work for the Department of Health or somewhere, where it looked at patients' awareness of waiting times and communication from Trusts that was done in Northern Ireland. Looking at how, when we add someone to a waiting list, we can provide patients with detail about what they have been added to the waiting list for, detail of all of their risks, but also information about current waiting times and things. I know, because I seen it over lunchtime,

that a draft is there of a standard aspect of a letter for that purpose. That piece of work is ongoing.

The preoperative assessment team are engaged and clinically led to try to improve that position. As I've said, within our service our theatre scheduling is done by our scheduler, so where patients haven't been through preoperative assessment, they are not added, or an active decision needs to be made and is made in communication between an anaesthetic team and a surgical team as to whether it is reasonable to proceed without it. Invariably the answer to that is no. 15:28 15:29

I think the position is there. There is ready access to additional, if you like, enhanced anaesthetic assessments with physiological testing, so CPX testing where we can give, for patients who are having more major surgery, and they do get, a very personalised assessment of their risks of undergoing that major surgery. 15:29 15:29

136 Q. Can you ask you briefly, just finishing on this aspect of clinical aspect shortcomings, triage and the area of dictation following reviews or clinical episodes. Taking them together, what work has been done to better keeping a check on those and escalating those issues if there are shortcomings? 15:30

A. So triage is part of that dashboard that I mentioned earlier that we get. So we get along or within that

dashboard detail of triage and time scales for triage. There is a data limitation within how that's obtained, which means that the time scales applied can be complicated by factors like a patient needing registration or the referral going to another Trust first before being redirected, because the time scale is from the point at which the GP presses refer, not the point at which it is passed to the consultant for triage. So there is a limitation in that but it is monitored and there is an escalation process. 15:30 15:31

I neglected to mention earlier when we talked about results but it applies to the dictation and the triage as well. We also have an in-person interface meeting where myself, the head of service, our manager for our admin and support team, and our Cancer Services manager meet on a monthly basis and run through the performance across the team looking at triage, looking at dictations, looking at results management, and if any other things need to be brought up. You mentioned earlier is it fair for a secretary to be the one who contacts the consultant first. It is not only the secretary that does it, it would come to that meeting as well. 15:31 15:31

137 Q. You spoke on the last occasion, and indeed in real time you were speaking to Dr. O'Kane about the shortcomings of the backlog reports that were being utilised to monitor Mr. O'Brien. In general, I think you expressed the view that they would perhaps give the uneducated 15:31

a false impression of what was outstanding. In a nutshell, you might get a report through the secretary that there's no dictation pending but, in fact, that's only because the dictation hadn't been performed. I think that was the problem you were pointing to. Has that concern around backlog reports been addressed? 15:32

A. That forms part of that monthly meeting, the discussion of the backlog report. At the outset, as we established that meeting, one aspect -- to me the most important aspect is understanding for everyone involved what data is being collected and how it is being collected so that we get consistency in how it is reported, so we can see that. That guidance to the secretarial team in terms of how they collate that data and what the purpose of that is for has been communicated to them. I'm much happier that not only is the data produced reliably but also the way it is produced, and the limitations - because everything we collect has limitations - are recognised by the team as we analyse it and understand it. 15:33 15:33 15:33

MR. WOLFE KC: Thank you. Chair, I would be particularly keen to finish, I'm sure Mr. Haynes would be particularly keen that I finish his evidence today. I probably have another hour, looking at my speaking note. I'm sure you have questions. I'm conscious of the stenographer as well. Should we take a short break now? 15:34

CHAIR: We will take a break. I take it that everybody

is happy to go on beyond five o'clock? Very well, come back then at 3:50.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

15:34

CHAIR: Thank you, everyone.

138 Q. MR. WOLFE KC: I want to finish this afternoon, Mr. Haynes, by looking at the area of developments within the service and performance against the background of the demand capacity shortfall that you described at your last attendance. 15:47

Just before we get to that, and briefly, just a final thing in the whole area of patient safety and improvement. I want to ask you about clinical audit and whether the Trust has been able to extend to the Urology Service better support and is there a greater appetite for audit than perhaps there was during a financially straitened era at the tail end of the last decade. 15:47

Can I start by perhaps looking at TRU-320279. This is the Urology Division Annual Clincal Audit Programme for the current year. It's a midyear update from a few months ago. It sets out a number of National Audits which are bracketed in green at the top and then other forms of internal audit and divisional audit.

In broad terms, have you detected increased support for

audit in recent times or has there not been any identifiable change?

A. It's a huge change. So we have a member of staff from the audit team assigned to urology for audit purposes. She attends our Patient Safety meetings with us. She's constantly in communication with us with regard to the ongoing audit projects and, indeed, just yesterday was in contact with me about -- I think it's one of them on there or it's one that's on the current one. It's one of the ones through BAUS. It is there. It's the top one.

So it's a much greater engagement and it's led to a massive improvement through the audit programme that we undertake in the team. As you say, what we have there is multiple levels of priority in terms of the department for audit, and they go down from "external must dos", down to "for interest", if you like, audit. The findings are presented at our Patient Safety meeting by our trainees. They have presented at our regional audit meeting for urology as well, and I know the trainees are looking at -- where appropriate, they're looking to put their projects in for presentation at national meetings as well.

[Technical pause].

CHAIR: I think it might be better if we just sit on -- hopefully you can do it quickly -- rather than rise

again.

MR WOLFE KC: It's called technology Tuesday for a reason.

CHAIR: It used to be Tuesdays but it's obviously getting tired, moving to Thursdays! 15:55

139 Q. So, you were presenting roundly a fairly positive, certainly a picture of progress in terms of the appetite and the support for clinical audit. In terms of, I suppose it may not have happened yet, but if an audit produces evidence of shortcomings in practise, whether it's risk, patient risk or whether it's shortcomings in the way that things are being performed, are you confident that there is a process within the Trust that listens to that and embraces that with a view to facilitating service improvement? 15:55 15:55

A. Yes. But I'd add the caveat; where it's able to be delivered. And as an example of that I'd give one of the standards within one of the audits there which is the NICE bladder cancer management. So, within there is an audit standard which has a specific timeframe for a surgical procedure. I know from that audit that most of those patient day cases, for which that standard was relevant for, failed to meet that six-week standard because we don't have capacity to deliver that standard. So, where there's that sort of challenge, well, it's very difficult to rectify it. Where the standard is achievable and deliverable then, yes, there is support to deliver that change and re-audit to 15:56 15:56

demonstrate delivery of that change.

140 Q. Can you think of any example of where that has manifested itself?

A. We haven't got into that point through these audit cycles to be able to give you an exact example. 15:57

141 Q. Let me turn to that other aspect of your improvement role that you listed for us just before lunchtime. I think you used the term "performance". I think elsewhere you talk about development of services and we know from your evidence on the last occasion that 15:57 you were particularly concerned about the demand, capacity, shortfall. We've seen and we've been over the detail of the paper that you put together for purposes of the HSCB in 2014 concerning resources and, in particular, the need to improve nursing recruitment, 15:58 theatre provision and that kind of thing.

We can observe from the papers that were on your disclosure bundle that in terms of resource improvements, there have been some in recent times, so 15:58 two new cancer specialist nurses appointed, three new consultants recruited internationally, one I think about to take up his position, isn't that right?

A. Yes.

142 Q. And two to come in in the course of this year. 15:58 Additional trainee numbers is something that's being discussed through PIG. A recent appointment of a radiographer to the ESWL service. So, there have been some resource improvements on the ground, is that

fair?

A. Yeah, all those you highlighted, and outreach delivery of surgery. So, one of my colleagues who does renal cancer surgery in Belfast comes out to Southern Trust and does two half-day theatre lists and two half-day clinics a month. 15:59

143 Q. That's Mr. Connolly?

A. No, that's Mr. Evans.

144 Q. Mr. Evans.

A. Mr. Connolly also outreaches, that's part of the regional complex stone surgery service, which is also being delivered in Southern Trust. 15:59

145 Q. Okay. In addition to that in the context of meeting, I suppose, both a local and a regional waiting list problem, we've seen developments both at Daisy Hill and Lagan Valley Hospital in order to try to improve capacity. Is that fair as well? 16:00

A. Yeah. So, for urology across Northern Ireland, Lagan Valley and Omagh Hospital, regional day procedure units have been developed and the breadth of procedures delivered as day cases has been enthusiastically expanded by the urologists. So, procedures that maybe ten years ago would have been done as in-patients are being delivered as day cases on patients who are fit for. Similarly, Daisy Hill offers us the additional option of an overnight stay. So that allows for, perhaps, slightly more complex surgery or slightly less fit patients to undergo surgery. And them surgical centres are ringfenced. There's no issue of emergency 16:00 16:00

admissions coming in and taking up the beds for them patients. It does leave the problem of the patients whose either not fit for them environments or procedure isn't suitable for them environments, we still have that challenge in having to deliver in-patient care. But it has taken a large amount of patients away from the in-patient site and able to have their surgery safely delivered in these high volume, I think high volume, low complexity centres, I think they're determined. 16:01

146 Q. The Panel may have detected from your evidence on the last occasion, as I say, 15/16 months ago, perhaps an air of despondency on your part about the state of the urology services in Northern Ireland, particularly in the context of these burdensome waiting lists. Are you, because of recent developments, slightly more optimistic that things are being tackled in a strategic way and, if so, what is that strategy and what grounds do you have for optimism, if I've detected your mood change accurately? 16:02

A. So, the development of the elective centres is a significant development and Daisy Hill, The Mater as well in Belfast has also been developed as a 23-hour overnight stay centre as well. So, that has increased the capacity for the teams. The approach through the PIG team, through the PIG meeting in terms of looking at things regionally I think is a very positive thing. We are, effectively, using Lagan Valley as a region. So patients, although presently I suspect most patients 16:02

have their operation by a consultant from their host trust, it is a single list that patients are added to in Lagan Valley. So, that's beneficial.

The approach of specialist services being delivered outside of Belfast is a very positive one as an attractant for consultant urologists. So, having the complex stone service in Southern Trust means that people who are interested in wanting to deliver that surgery will be able to be attracted to Southern Trust. And similarly, with the penile cancer service up in Altnagelvin attracting up there. The approach we've taken with Belfast Trust, with Mr. Evans supporting the service in Southern Trust also strengthens the team and that in and outreach, or that single renal cancer team approach for Northern Ireland is recommended in the Northern Ireland GIRFT report, but it was already developed at the time of that. It's something we proactively sought to deliver within Northern Ireland. Indeed, our colleague who works in Altnagelvin comes into Belfast and works with us as well. So, that cross-Northern Ireland approach is much better. We're still faced with the same challenges of a long waiting list, and that is going to still be a challenge, particularly for those patients requiring in-patient surgery. If you like, there's still a mountain ahead of us before we can get to a point where things are at a stable position.

16:03
16:03
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16:04

147 Q. So, in terms of waiting lists, where are we seeing the

movement? Where is the progress?

A. So, one of the impacts there or one of the things that has impacted there has been a proactive investment by SPPG in independent sector outsourcing of new patient referrals. So, if you like, it's slightly turned off the tap. So, if a number of new patient referrals into urology are being managed in the independent sector, it reduces the number of new additions to our waiting list and enables us to be able to tackle some of the backlog. There has also been investment in procedural independent sector outsourcing. So, for instance, patients with catheters in awaiting a TURP had some outsourcing to independent outsourcing providers in the Republic of Ireland which enabled us to bring down our waits for them patients. There have been initiatives which have helped from that perspective. 16:05 16:05 16:06

148 Q. Is what you've described part of a recognisable strategy or is it a series of clever initiatives, perhaps initiated locally within each Trust and then brought regionally for approval? Is there a sense that you're working within a more global strategy that has clear aims and objectives? 16:06

A. So, they're not individual plans that are kind of piecemeal together, they do all come through the same group, through the PIG meeting and have all of that sort of regional collaborative approach. Inevitably, there are going to still remain challenges and we know where the financial position with Northern Ireland has been and my understanding is that independent sector 16:06

outsourcing was stopped in December, so we're in a bit of a hiatus at the minute. And that's been stopped but we're not in a position, yet, where we can provide for everything that's coming in.

Additionally to that, there have been some things which have had the opposite effect of what I've just described. One example I would give of that is a decision that was made to -- I think it was temporarily stop funding primary care provision of vasectomy services. And that meant that patients now, who would have been referred to primary care to have a vasectomy are now being referred into secondary care because there isn't an option anywhere else. So, that's adding to our demand, so that creates a challenge for us. 16:07 16:07 16:08

149 Q. We've looked at some of the resourcing improvements that no doubt help to address the capacity issues or the demand issues, I should say, but it's not just about resources, is it? Has there been discussion, whether within your Trust or regionally about working differently, working more efficiently, using scarce resources in other ways? 16:08

A. Yeah. As you say, that's all -- capacity is only one end of it. If we look at an outpatient resource, we have to change the way we deliver care and move away from, if we like, historic practices where patients were followed up in person ad infinitum. Active encouragement of virtual follow-up pathways rather than 16:08

in-person pathways; active encouragement of early discharge; and patient initiated follow-up initiates, patient initiated follow up, there is a regional task and finish group that's started that I'm sitting on from that perspective. 16:09

Then there's looking at who's delivering care. So does every patient need to be seen by a consultant? Ultimately, the answer is no. And within Southern Trust we have developed the skill set of our 16:09 nurse specialists to deliver a large amount of new patient consultations, the biggest group being men with urinary systems, also for hematuria services,hematuria referrals. We've also developed our nurse specialist skills beyond that. So, our prostate biopsies are all 16:10 delivered by our nurse specialists. Our Botox treatments, our urodynamics, they're all delivered by nurse specialists. We have follow-up pathways for renal cancer follow-up and for prostate cancer follow-up that are delivered by our nurse specialists. 16:10 If we look at the Northern Ireland GIRFT report for Southern Trust and compare it to the other trusts in terms of what's delivered by our nurse specialists, our nurse specialists are delivering more services than elsewhere and the GIRFT report has encouraged that 16:10 expansion of delivery.

150 Q. I think we can see that, just maybe if we can illustrate that point, if we bring up DOH-72326. Down on the next page perhaps. That's the raw numbers at

the bottom of the page, the raw numbers of nursing staff that are employed across the Trusts.

Then if we go over the page, is this what you're referring to? 16:11

A. Yeah.

151 Q. We can see along itself left-hand column, the roles or the services. Then the Southern Trust is providing many of those services. A no against flexible cystoscopy. 16:12

A. That's a no against TULA, so that's transurethral laser ablation that nowhere in Northern Ireland have, but there has been investment in that, the device required to deliver that. And we have a training plan for nurse specialists to deliver that. 16:12

152 Q. Yes. Your point being that more can be done if you think beyond the scarce resource of the consultant, if you up-skill your workforce by the deployment of specialists nurses.

A. Yeah. 16:12

153 Q. That's a useful way to proceed.

A. And the physician associates. We have a physician associate who's worked with us for the last couple of years, and we're looking to develop her role with in the delivery of this. We've also recently interviewed 16:12 for a second physician's associate. So, expanding beyond, if you like, traditional roles to use staff groups to deliver care.

154 Q. To what extent has consideration been given to using

data to more accurately or perhaps more intelligibly understand how you and your colleagues practise to see if, if you like, savings or improvements can be made there?

A. I would love to be able to have update live, if you like, live performance data for the team but, unfortunately, the data collection coding time scales for Northern Ireland are not sufficient to give me that information. 16:13

155 Q. You talked on the last occasion, albeit briefly -- perhaps it's -- sorry, I think it is perhaps just in your statement and we haven't picked up on it with you yet. You explain - and this is at WIT-53899 - that quantitative data has not historically been used in the performance management. This is at 31.3. You see it there. You're now working to incorporate some quantitative performance management reports into the job planning process in your role as AMD. Has that come to fruition since you were last with us? 16:13 16:14

A. I think that's qualitative. 16:14

156 Q. I hoped you were going to say that.

A. So that's really looking at outcomes. If we look across the water and we look at NHS England, what was done previously through BAUS looking at major procedure outcomes, and that data was collected by self-entry by the clinicians, that has been taken over and is now collated centrally through the coding and what becomes the hospital episode statistics. We don't have that ability to collect that data at present. So 16:15

historically we were put in a position where we couldn't input our data into that, say the nephrectomy audit to monitor outcomes. We're now in a position where the HES data is being used in England and we don't have an equivalent option that can collect and risk balance our patient cohorts. 16:15

What I mean by that is if we look at my kidney cancer surgical practice in Belfast Trust, if you took a crude look at my length of stay and my complication rate, you would see me as a dramatic outlier to my two colleagues in Belfast Trust. If you looked at the case type, you'd see that they do almost solely laparoscopic and robotic procedures which are on a lower risk end, and most of mine are open procedures for much higher risk cases. So we haven't got the data to allow us to outcome monitor our surgical practice. 16:16 16:16

157 Q. Is that an aspiration as set out that hasn't been fulfilled to date?

A. Yes. 16:16

158 Q. I suppose in the way that you described it earlier, greater communication within the team, a greater sense of respectful challenge which is, as you portrayed it, now an accepted way of working and doing business, is there an argument that peer-to-peer challenge can help to drive improvements in the way that you work so that, again, that might have some positive effect on how patients are managed and possibly some positive effect on waiting list efficiency? 16:17

A. Of course. Peer-to-peer challenge, peer-to-peer discussion, we all want to improve what we're doing and we're always looking to improve how we deliver care.

159 Q. If these discussions are happening, do you find a supportive environment within the Trust to drive service improvement? 16:17

A. If we look at service improvements in our stone service, for example, we've been very supported both by the Trust and SPPG as we look to deliver the lithotripsy service, so the outpatient treatment, as we look to develop the virtual service with the regular stone meeting, and as we look to bring that regional way of working for patients. So the in-reach of. Mr. Connolly, Mr. Thompson is in-reached as well. We have been very supported in delivering that by both the Trust and the regional groups. 16:18 16:18

160 Q. I want to finally touch upon the GIRFT Report. It published in November of last year a series of, I think, totalling 40 national recollections is the phrase that's particular to the Department. So far as the Southern Trust is concerned, we can see, just to bring it up on the screen, DOH-072344. While we're waiting with that, I'll say it sets out 18 recommendations for the Southern Trust. Those recommendations, Mr. Haynes, break down into workforce issues, facilities issues, outpatients and diagnostics, oncology, urgent and emergency care, and specialist services and outpatient care. 16:19 16:20

It appears we're not able to bring these recommendations up. We have a spreadsheet which shows the progress being made using a RAG status approach, TRU-320313. A number of the recommendations are already in play and some will be implemented in the course of this year. Could you help us, Mr. Haynes, in terms of what's emerged from the Getting It Right First Time analysis, do the kinds of recommendations coming through that present challenges to the Trust or are they broadly to be welcomed by you and your colleagues working within Urology Services? 16:21 16:21

A. Broadly welcomed. The clinicians, through the PIG Group, were all in support of the Northern Ireland -- the GIRFT assessment across Northern Ireland. Many of us, and recent actions are in green for some of them, or well underway, because prior to the inspection GIRFT have issued over the last number of years a number of reports into individual aspects of urological care, which we'd already set about delivering care alongside. There was a GIRFT report in delivering care for stone patients which we'd already set about delivering care according to. Indeed, one of the audits on the previous document was against the standards or the recommends within that document. 16:22 16:22

There's one for bladder outflow obstruction. Similarly, we'd already taken aspects of that and instigated them into part of our service. And our kidney cancer one. So in many respects --

161 Q. Are you saying it is almost giving the --
A. It is supporting the direction of travel we wanted to go.
162 Q. -- what you are seeking to do.
A. Yes. 16:23
163 Q. Sorry. We can work through some of these. Perhaps if we scroll up, I think the recommendations are summarised onto this sheet from the report, and we can see some of them. We don't have the time, perhaps, to work through the fine details, but could you attempt to 16:23 characterise for us what the ambition of these recommendations indicates and where will this bring Urology Service, both locally in your Trust and regionally, if the Department and the commissioner can resource them effectively? 16:24
A. I think effectively the aim of the GIRFT document is about what things outside of more resource can be done to deliver care more effectively. It encourages, as you see within that recommendation that is in front, the use of advance nurse practitioners and physicians' 16:24 associates to deliver care which would have previously been delivered by doctors. It encourages the developments of high-volume, low complexity surgical centres. It encourages network working for a service to support and maintain the service; in the case of 16:24 kidney cancer services in the recommendations in here. It encourages the development of specialist centres, so you make, if you like, the nonspecialist centres attractive to recruitment. It aims to address all the

things outside of more resource being put in that can improve the service for patients but also for the staff delivering that care.

164 Q. We can see, you touched earlier, you touched several times on the role of the region, which is manifest through the operation of PIG, as I described it earlier, the Programme Improvement Group. I think you reflected positively about that group. Can you help us better understand what that group is, how often it meets, what its objectives are, and how does it work? 16:25

A. So I haven't reread but there is a terms of reference that was updated, I think, earlier this year and sent round. Essentially the group is made up of representatives from SPPG, who chair it, there's Department of Health representatives. From each Trust that provide urological services, there are clinical representatives and there's managerial representatives. It is a proactive group at all levels, with good relationships, and relationships that do challenge how things are being done. So we have had discussions that you could describe as lively or challenging, but there is no issue with having them discussions and them challenging conversations. But everyone in that group is working towards a positive outcome in the delivery of care, and the GIRFT report has provided a framework going forwards for many of the work streams that will come out from that PIG Group. 16:25 16:26 16:26 16:27

165 Q. I think it is fair to say that the GIRFT Report wasn't long off the press when it was discussed at the PIG

meeting in November. We can touch on that briefly, TRU-320308. We can see that the attendees at that meeting, including yourself and your colleague Mr. Tyson, Mr. Glackin. As you say, chaired by David McCormack of the SPPG and attended by various stakeholders, including representatives of the Belfast and Southeastern Trust, Southwestern Trust and the Department of Health. If we scroll down, you can see that GIRFT has just been reported and it's on the agenda, summarised by Mr. McCormack. Over the page, he sets out, I suppose, the action that's going to be required, which involves some prioritisation of the recommendations, Task and Finish Groups to be set up within each urology unit but a clear understanding that there would need to be a regional focus. The Inquiry can see from documents supplied that this was the subject of further discussion at the January meeting and no doubt so on. 16:28 16:28 16:28

In terms of the benefits that the implementation of GIRFT might bring, where do you see those benefits being most obvious for the Southern Trust? 16:29

A. As I say, the drive supported the direction of travel we wanted to go. The establishment of a specialist service in Southern Trust provides, I think, some confidence that we will be able to recruit and attract people into a specialist post. The support for the network for kidney cancer service is really important because there has been a change in how kidney cancer is 16:29

managed surgically, which has inevitably meant the number of kidney removals, whole kidney removals, in each Trust has dropped dramatically. The number of open operations for big cancers has dropped dramatically. Left in isolation, there was always a risk of the kidney cancer surgeons finding themselves unable to continue in the districts where support, outreach and cross-network working will hopefully prevent that from happening. 16:30

It's very clinically led so the goals are driven by GIRFT, which is body coming with -- which is clinicians lead the final -- do the inspections and write the report. It is supported by us as clinicians. That clinical leadership in delivery of this will hopefully mean that we will have a service that is not only safe for patients but what we want and what we see as the best way of delivering care. 16:31

I think the name of the group, Getting It Right First Time, gives it away. If someone is referred with suspected kidney cancer, they should see a kidney cancer surgeon, and that's this goal but split across all of the services. 16:31

166 Q. I suppose to bring it back to a slightly more sober place, perhaps, the GIRFT report - I'm not going to try to bring it up on the screen because I think I've lost that battle already - the GIRFT report reflects in its executive summary that Northern Ireland has witnessed 16:31

a 10-year, a decade long, deterioration in its Urology Services. It reflects that in terms of specialist urologists, we in Northern Ireland are underrepresented by reference to our population compared to other regions in this island. There are structures that are not set up to deliver care at its most efficient. 16:32

The implementation of the GIRFT recommendations is not going to correct the waiting lists as they stand; isn't that right? 16:33

A. As we said, the GIRFT recommendations are part of the picture of the not adding in resource. You touched on there that the number of consultant neurologists per head of population in Northern Ireland is lower than elsewhere across the NHS, and that's been the case since I've been here. There's a challenge across the NHS as a whole, and I think it is touched on in the GIRFT report, that there are vacant posts everywhere. 16:33

We have a unique challenge in Northern Ireland. We have a border with another country where the consultant pay package is different to here and so there is a disincentive to people moving across the island. There's a disincentive to people who don't already have a base in Northern Ireland moving from England, Scotland or Wales. They have to uproot and move across the sea and they get paid less, and they are moving into a service which is challenged for waiting times, it is much more stressful when you have 16:33

constant -- you know, every consultation is difficult when the patient asks the inevitable, "and how long will I wait". So there are many disincentives that we can't fix, but we can fix trying to deliver care in the best way. 16:34

167 Q. Thank you for your evidence. I have no further questions for you. I leave you to the Panel.

CHAIR: Thank you, Mr. Wolfe. I know Mr. Hanbury will have some technical questions for you.

16:34

THE WITNESS WAS EXAMINED BY THE INQUIRY PANEL AS FOLLOWS:

168 Q. MR. HANBURY: Mr. Wolfe has asked most of my questions but I just have a few outstanding ones. I'll try to keep it narrowed down. 16:35

Looking at preop assessment, we have talked about Patient 90 and 91, there was still an opportunity to avoid the problems that ensued with the WHO checklist. I wonder what your thoughts are on perhaps why those cases slipped through the net there, and are you confident that that's working better now? 16:35

A. Yeah. I mean, of course there are opportunities for them cases to not proceed. Both patients were seen on the morning by an anaesthetist and a surgeon. There was an opportunity at the time of the checklist to discuss whether the patient was optimally assessed. 16:35

I know from my own practice that I have had them discussions where myself and the anaesthetist have come to an agreement that a patient isn't optimally worked up, and cancelled the case or change the case to a different procedure for a diagnostic rather than what was intended. It comes down to the individual's switching and changing and recognising that, and that's got to be in a discussion because there is always the potential that a case who hasn't been through preoperative assessment maybe is a very low risk 25-year old athlete who actually doesn't require any additional preoperative assessment and could potentially proceed without. 16:36 16:36

On the other side, if we take Patient 91 who hadn't had a preoperative urine tested, my colleagues who do stone surgery would be fairly rigid now on the requirements of pre-operative urines and how they manage patients who haven't had a urine specimen sent, particularly those who have stents and stones in that they know about. 16:36 16:37

169 Q. Just on the issue of regional referrals, which is less of a problem now, I think, that there's a lot more subspecification happening. Certainly the time the Inquiry was looking at, there was not much capacity for HoLEP, that is laser surgery for the very large prostates, and surgery for penile cancer in the region as well. Those issues seem to have been fixed. Are you sort of happy with the way that's going now in 16:37

general in the region?

A. If we look at the specialist surgical procedures, robotic surgery and penile cancer were two of the issues. The penile cancer service is in Altnagelvin in the Western Trust, delivered by a specially trained consultant supported by a colleague who is recently retired but is back still supporting that service. The robotic surgery, we have the robot in Belfast. For renal cancer, we have two robotically-trained renal cancer surgeons, and we have three trained robotic prostatectomists. We are still challenged with capacity, and still - certainly up until very recently - there's been outsourcing of patient care, but to Dublin rather than across to England, which is different to previously. 16:37 16:38 16:38

HoLEP service is something that is still being developed; it has not been developed yet. It had been earmarked to be developed by Southeastern Trust, and perhaps some of the heated or challenging discussions we've had at PIG meetings have been concerning the developments of the HoLEP service. 16:38

There are additional areas of practice which we still don't have in place. We don't have a urethral sphincter service; we don't have a penile implant service. We have surgeons who have been trained to deliver them but we haven't got, if you like, that benign andrology. The GIRFT Report discusses that 16:38

female and reconstructive urology element that needs some thought regionally. There's still some way to go on delivering, if you like, a full urology service.

170 Q. We have heard from the Director of Commissioning that referrals out of province are still funded if the consultant asks for them. 16:39

A. Yes.

171 Q. Thank you. National audits or audits in general, I was very impressed with your presentation there, also the subregional ones. I noticed the National Prostate Cancer Audit wasn't represented. That is something that has been quite well-established in England, I'm sure you know. Is that one of the ones you're thinking of? 16:39

A. We can't contribute to it. 16:39

172 Q. That's part of the...

A. Yes. Professor Clarke was over at -- I touched on a meeting I talked on that Suneil Jain had organised. Mr. Clarke was over presenting the National Prostate Cancer Audit at that, but essentially we can't contribute currently. 16:40

173 Q. That's a feature of the litigation that you mention in your statement, because there are other departments who have done national audits.

A. Yes, I can't remember it is the means in which the data is collected. 16:40

174 Q. But you are doing some other BAUS studies which --

A. Yes. They are collected through different means so there's no patient-identifiable aspect to the data that

is transferred.

175 Q. But where it is possible, you are obviously looking for things you can do?

A. Yes.

176 Q. Thank you. Moving on. Just maybe about the long waiters and we heard a lot about the challenges there. Probably still got a lot of people waiting over a year. Are you doing harm reviews on them? Are people contacting patients who have been on the list a long time? 16:40 16:41

A. That's always a -- that is a challenge. There are patients waiting many years for surgery still on routine waiting lists. One of the things certainly we encourage is certainly if you have been waiting five years, you shouldn't come just straight to an operating list, you need another review before you come because your situation could and may well have changed. But there is a challenge in going out of the blue and providing a review to all them patients. First of all, what do we stop doing to deliver them reviews? There's also a patient expectation thing. If they get called to a review when they have been waiting four years for an operation and you say you're going to wait another few years as yet and we'll probably see you again beforehand, it can set patient expectations up to a difficult position. 16:41 16:41 16:41

177 Q. Hopefully your surgical hubs might help there. I suppose the other end of -- my question is about low priority things. You mentioned vasectomies, and I saw

on your waiting list there was someone waiting a long time for a vasectomy reversal, and I was amazed in a way that in this sort of atmosphere, you were offering vasectomy and vasectomy reversals?

A. You all know, I think it was called the procedures of limited therapeutic benefits list, had been generated many, many years ago. Indeed, I can remember, even as an SHO in Cardiff in the early 2000s, vasectomy reversal wasn't offered on the NHS, and yet I moved here in 2014 and vasectomy reversal is still offered on the NHS. That procedure that aren't offered has now been signed off. Those are not being added to but we still have this legacy problem of patients who were added to the waiting list a long time ago. The irony obviously being that, as we know, the longer they wait, the less likely it is to be successful anyway. 16:42 16:42 16:43

178 Q. Thank you. Just one thing on GIRFT. It was a sort of structural review, obviously a very helpful one, it seems, that the urologists in Northern Ireland have looked at almost excitedly. The next phase when GIRFT comes back is the sort of deep dive into what you actually do and the helpful peer-to-peer comparisons. Will that be possible or is that a problem without the HES? Hospital Episode Statistics, I should say. 16:43

A. So there was a deep dive element to the visits where they ran through data, but it was limited by the data that could be collected and how that could be compared across Trusts, and even whether it was felt reliable within Trusts. I know there were concerns that it 16:43

under-represented the case volume. I think if you look in the report, it talks about cystectomy volumes, and I think it talks of a volume of around 40 to 50. We don't recognise that as cystectomists; we recognise a volume of 80 to 90 a year. At the initial draft phase, I fed back in because I had a monthly tally of patients who have had cystectomies, and we were at that annual volume which had been provided in the data at six months into the year. So... 16:44

179 Q. Okay. But I guess with time, that may... 16:44

A. We hope it will improve. I think it will lead to some improvement in that coding and outcome of data.

180 Q. Thanks. Final question. Clinical directors, over a lot of time that you were there and previous, the Urology Department had CDs that were essentially general surgeons, obviously looking after big departments of their own and lots of hungry mouths to feed wanting surgical lists, and there's a disincentive to give theatres to the annoying urologists with the very long waiting time. Do you think, looking back, that was a major factor? Do you regret that the urologists weren't given the opportunity to have a CD of their own from amongst your ranks? 16:44 16:45

A. So, I think that ideally you need a medical management representative from each specialty. Certainly during my time in Southern Trust, even I wasn't CD for urology, I feel I have banged the drum regarding theatre allocation when there has been downturns and looking at proportionality of demand as a driver not, 16:45

if you like, an equal reduction. You know, if you've got a service like, unfortunately, urology in Northern Ireland, where almost all of their surgery that's being delivered is urgent and red flag, why should they have their capacity reduced by the same percentage as a service which is able to deliver a significant volume of routine surgery? I think somewhere within my evidence there are example emails where I've raised that.

181 Q. But if you'd been CD it might have -- 16:46

A. Well, I was AMD when I was raising it, so...

MR. HANBURY: Okay. No more questions. Thank you very much.

CHAIR: Dr. Swart?

182 Q. DR. SWART: I just want to ask you a few things about your improvement director role to start with, clearly this important senior titled role. Who sets your framework for you, if you like, in a practical way? Do you have a work programme that you've set out yourself that somebody's helped you design? Do you report to a Medical Director to someone senior in a kind of mentoring way? How does that all work? 16:46

A. So, obviously I report to the Medical Director. In terms of a framework for much of what we've been delivering, it's been based on the findings that have come through the various reports/recommendations. 16:47

183 Q. But is it set out for you? Have you kind of sat down and said: 'Right, this is my plan, this is what I need to deliver the plan.' I'm really coming to the support

to delivery?

A. So, in terms of setting out that, I've tried to do that as a team-based approach rather than me saying this is what I want to do. This is what the team want to do. And that's why it's all being delivered through our departmental meetings, through our consulted meetings, in that format, rather than me saying: 'This is what we're doing.' 16:47

184 Q. And have you got a RAG-rated thing or have you got metrics? What have you got to assist you in terms of reporting? I mean I'm conscious that you made the comment everybody's on your case. You know, RQIA did a review and there's GIRFT, and there's the Inquiry, and there's everything else, and I can imagine that's quite onerous. Have you been given any support to create some kind of updating reporting mechanism to make it a bit easier for you? 16:47 16:48

A. No, I haven't. And essentially we've moved from managing each thing we're looking to work and then we move on as we get through them. 16:48

185 Q. Do you think you've been got enough managerial support to take on the totality of that work? I'm talking about people working to you rather than --

A. Yeah. So, our Head of Service covers Urology and ENT, and I think outpatients as well. So she is split three ways, which I would imagine, if you asked, does create some challenge in terms of workload. But that's what we're faced with. We do have support to us as well in terms of creating, or data to support what we're doing 16:48

from what within the limitations that we can provide. And some of that support is doing things like our monitoring in terms of stented patients on the waiting list, how many there are, how long they've been waiting; looking at delivery of our ESWL service and the efficiency of that. So, we've got that support aligned to us.

186 Q. But you don't have a project manager working to you,for example, specifically for this?

A. No. 16:49

187 Q. And the data support, is that helping you to produce some things that can be put into regular reports in the way that you've done for triage? So far I'm thinking for the stents for example, the time from first procedure to stent and surgical removal, or whatever? 16:49

A. I haven't got round to looking at how to take the data that we've got collected and put it into that same report. I mean I touched on, if you like, the triage dashboard's been developed by the Cancer Services Team. The results thing, I developed that and I did the 16:50 background coding within Excel for that. I've mentioned a couple of times online forms. The Java script coding I've done. We haven't got anyone who can do that.

188 Q. So, would it help you if you had specific project 16:50 management support for this sort of thing?

A. Absolutely. If they have the skills that we need. I'm not alone in having written that Java script and I know for online forms I know my colleagues in Belfast Trust

have done exactly the same. It's been developed by them.

189 Q. Because although everybody's on your case and this must have been a very difficult experience, you could look at it the other way and see it as an opportunity to really showcase the work of Urology, take the GIRFT recommendations and change the dialogue considerably. So, what conversations have you had about the Trust about that, about what you've learnt from taking on this specific role and how that could be used to benefit in the rest of the Trust? 16:50 16:51

A. I haven't had any specific conversation because I don't consider that I've finished my role as yet.

190 Q. I'm not suggesting that you have.

A. I'm still developing things as we do. It's the -- as I've touched on, I've had support in how we develop things along the lines of GIRFT. I've not been having to push doors down, they've been open in front of me. 16:51

191 Q. What thing that you've achieved are you most proud of so far - bearing in mind I'll ask you next about what you still have to do. But if you think now, actually, I'm so glad I sorted that out, and you can see that it's a benefit to the service and to patients? 16:51

A. Probably, for me, it's the -- so we touched on that I've worked across Trust for a number of years. For me, or widening that out so it's not just me, so there are a number of individuals now working across Trusts, demonstrating that can work has been to me -- that will be the thing that enables us as services to drive 16:52

subspecification and still maintain our services in the local hospitals.

In terms of the biggest bit for me to still do I think is finishing off that single renal cancer service, which needs -- we need to get to a point where we have a single MDT that every renal cancer surgeon is part of so that the whole of that process is embedded as a single Northern Ireland service. And I think if or when we get to that point, that will be a major change for me and that will be the first, if you like, whole of Northern Ireland service that's not based in one hospital. 16:52 16:53

192 Q. So, do you think the PIG, as it's set up, has the potential to effectively become the regional planning group for Urology as a single service? How do you see that going? 16:53

A. Most of us have the goal or the vision that that's what we should see be functioning as in Urology. We're not a big specialty. We should be looking to deliver the services across Northern Ireland as one service. And indeed, it's been asked by many of us at veracious points, why are we not a single employer, why are we not a single service? 16:53

193 Q. And if you look at the demand capacity issue, for example, and you've described and we've heard about lots of the initiatives, there's the independent sector work which clearly is only temporary from what you've described, you've got some surgical sites and so on, 16:54

could you say at the moment that there is a regional plan for demand and capacity for the future set out in steps. Does that exist as such?

A. I don't think so, because as I touched on earlier, when we -- unfortunately I don't think -- well, I think the SPPG representatives, when they came, touched on, we aren't in a position to commission for demand for at present, we're so far behind. It is unfortunate that some things that, as touched on by Mr. Hanbury, like vasectomy reversal took so long to be withdrawn from the offer. And it's unfortunate that decisions have been made which have, if you like, added to the demand on secondary care. I touched on the vasectomy example where certainly my understanding in England is it's commissioned in primary trust, and that model was in place and that funding is no longer in place and then patients are now coming to secondary care. So, they're very unfortunate decisions which will have a direct impact on the demand within the Urology Service. 16:54 16:54 16:55

194 Q. Does the group see as part of its role to develop such plans with the help of SPPG and others? Because without that you can't really -- 16:55

A. Absolutely. And have been supported in delivering alternative treatments. So we touched upon HoLEP, but Rezum steam treatment for prostates, that has been supported and is delivered in Lagan Valley as a day case procedure. If that takes a volume of patients away from needing traditional TURPs, then that gets us to a point with a much quicker procedure that's 16:55

deliverable as a day case deliverable through an elective care centre where you can meet demand more efficiently.

195 Q. Just going back to slightly more mundane things. If, at this stage, that you had a urologist who was using medicines indication contrary to guidelines and outside of licence, how would that be picked up in your current systems? And if you thought it might be a problem, how would you deal with it now bearing in mind you will have learnt a few things from hindsight, experience, and so on? 16:56 16:56

A. So, if we look at the starting point, so, the starting point for that patient would be a recommendation from MDT for specific treatment. As was touched upon earlier, the concern about Bicalutamide wasn't Bicalutamide per se, the concern was the patient not receiving the appropriate prostate cancer treatment. The audit process that we've touched upon of the MDT outcomes would highlight that patient who has not had that treatment, and that would bring that back both to the consultant and to the MDT. So, that would allow for peer challenge. 16:57 16:57

Where that peer challenge failed I would expect - and it's difficult because I'm talking about something where I'm a member of the MDT as well as, if you like, the line manager as well - I would expect the MDT chair to bring that then to the medical line management of 'this has been identified, we've attempted to address 16:57

it through the MDT and have failed, can you take this on.'

196 Q. So you would escalate it?

A. Yeah.

197 Q. Quicker? 16:57

A. Yeah. And it would be identified quicker.

198 Q. What tools do you have now? I mean you've more audit which hopefully would pick these things up better. What else has changed in terms of the atmosphere of the department or the atmosphere of the Trust that would 16:58 assist you in exploring these issues?

A. I think, from my perspective, I've more experience in challenging these things so I would be -- I think I'd be better at challenging directly. As a team I've touched on we are much happier to raise these problems 16:58 before they become a problem, if that makes sense.

The audit processes will identify where there are issues. So, I would anticipate that would all work much better. 16:58

In terms of support and input, I did mention earlier in terms of contact directly through our Deputy Medical Directors and our Medical Director that those relationships and the regularity of meetings are there 16:59 such that it would be able to be raised. Then I mentioned the revalidation group where it's a further opportunity where the question is asked: 'Are there any issues that you're aware of that may not be here

that we need to talk about?'
DR. SWART: Thank you. That's all from me.
199 Q. CHAIR: You'll be glad to know I don't have very much to ask you. I just wondered, certainly just in response to Dr. Swart, what you're saying is that there 16:59
seems to be -- the impression that you're giving us anyway is there's now more visibility around a consultant's practice in the Urology Service that would mean that the problems that have been identified in the nine SAIs and through the work of this Inquiry 16:59
would be less likely to happen; is that your opinion?
A. Yeah. Absolutely. There's more visibility both in terms of how we work. We don't work -- I mentioned pooled waiting lists and the like. The CNS availability, the numbers of CNS' means that there's 17:00
always other people present in these consultations and the audit facilities mean that it's always checked on as well.
200 Q. So, would I be right in my belief then there's less working in silos more working in a multidisciplinary 17:00
way, generally, never mind in cancers?
A. Yeah.
201 Q. Just finally, we have to make recommendations at the end of all of this. Obviously we can't have a pot of money and a magic wand that will give you the people 17:00
that you need and the resources that you need, but what would you like to see? What one recommendation would you like to see us make?
A. This is like where you have a job interview and you're

asked --

202 Q. Yes, it is. I appreciate it's difficult, but we want to make recommendations that will be of benefit generally to Southern Trust, to the Urology Service and the service across the region. 17:01

A. I think you probably touched on the most important aspect and that is that visibility. Whatever we do, we have to remove the opportunity of people just delivering their own practice in isolation without ever being -- well, with the opportunity to never have other 17:01 people looking in on that practice. I think that's dangerous for the individual as much as it is for the patient. Because you can find yourself, if you like, heading down a road of what you think is right and never having an opportunity to be pulled back. So, 17:01 that way of working where you function as a team, where there is pooling of patients, where there is multidisciplinary input, where there is allied health professional input and delivery of care rather than all within a consultant's practice, is what I'd see as the 17:02 biggest thing that can, if you like, reduce the risk of this happening. Many of the other things that I've done are all about proving that it's not happening, whereas removing the opportunity is the most important thing. 17:02

CHAIR: Thank you very much, Mr. Haynes. You'll be delighted to know that we probably will not have to hear from you again and you're free to go.

But just before I release everybody else, I just wanted to reiterate a couple of dates. We're getting to the end of our hearings now and I think I've indicated that 31st May is when I will expect written submissions from all Core Participants, and I want to emphasise again 17:02
that those should be directed to the Terms of Reference as far as possible. I'm not hamstringing you in saying if there's certain points you want to make beyond that, then please do, but please try and focus on the Terms
of Reference. 17:03

Secondly, on 13th June you will be invited to deliver oral submissions to the Inquiry. That will give us some time to read the written submissions between
31st May and 13th June. We are hopeful that that will 17:03
be the last public sitting of the Inquiry before I do all my work and deliver a report. That's just to give you the heads up as to the timetable, ladies and gentlemen, so you know what to look forward to.

17:03

Thank you very much everyone. See you in two weeks' time.

THE INQUIRY THEN ADJOURNED TO TUESDAY, 12TH MARCH 2024