Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mrs. Heather Trouton
Executive Director of Nursing, Midwifery & AHP
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

3 March 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Issued by the Urology Services Inquiry on 3 March 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 2 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Heather Trouton**
Executive Director of Nursing, Midwifery &AHP
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by 12 **noon on 31st March 2022.**

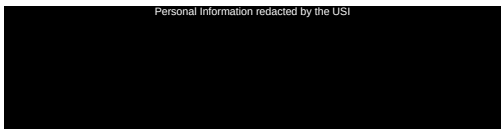
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 24th March 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 3rd March 2022

Signed: 

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 2 of 2022]

General

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

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for. It would be helpful for the Inquiry to understand how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Associate/Medical Director(s) and the Head of Urology.

7. It would also be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day basis. It may be helpful for you to explain the level of your involvement in percentage terms, over periods of time, if that assists.

2009 - 2010
Urology services

8. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust- to treat those from the Southern catchment area and the lower third of the western area. Set out your involvement in the establishment of the urology unit in the Southern Trust area.

9. What performance indicators were used within the urology unit at its inception?

10. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog. What is your knowledge of and what was your involvement with this plan? How was it implemented, reviewed and its effectiveness assessed? Did the plan achieve its aims?

11. How, if at all, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Please provide any documents referred to.

2010 - 2018
Staffing of the unit

12. Explain the original plan for the unit, to include details of staffing required to properly deliver all aspects of the service. How did this plan differ from what had previously been provided?

13. How were staffing needs for the unit identified? Was staffing for the unit optimal from the outset?

14. Are you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom. How have staffing challenges within the unit been responded to?

15. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and explain how this impacted on the unit and how these vacancies were managed and remedied.

16. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

17. Have staffing posts, roles, duties and responsibilities changed throughout the existence of the unit? If so, how and why?

18. Explain how the unit was to be supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Furthermore, was there an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants?

19. Who was in overall charge of the day to day running of the unit? To whom did that person answer, if not you?

Engagement with unit staff

20. Describe how you engaged with all staff within the unit. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

Governance - generally

21. What was your role regarding the consultants and clinicians in the unit, including on matters of clinical governance?

22. Who oversaw the clinical governance arrangements of the unit and how was this done? How did you assure yourself that this was being done appropriately?

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

24. How could issues of concern concerning urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

25. Have these systems or processes changed since the unit's inception? If so, how and why?

26. How did you ensure that you were, in fact, appraised of any concerns generally within the unit?

27. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

28. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

29. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

30. What is your view of the efficacy of those systems? Have those systems changed over time and, if so, what are the changes?

Concerns regarding the urology unit

31. Following the inception of the urology unit, please describe the main problems you encountered in respect of the operation of the unit? Without prejudice to the generality of this request, please address the following specific matters: -

    (a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

    (b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps did not take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

(j) What, if any, support was provided to any urology staff, including Mr Aidan O'Brien (Consultant Urologist), by you and the Trust, given any of the concerns identified?

2009 - 2020
Mr O'Brien

32. Please set out your role and responsibilities in relation to Mr O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the

years (your answer may be expressed in percentage terms over periods of time if that assists)?

33. What, if any, was your role and involvement in the formulation and agreement of Mr O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

34. When and in what context did you first become aware of issues of concern regarding Mr O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?

35. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr O'Brien, whether with Mr O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

36. What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

37. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so, what steps did you take to mitigate against this? If not, why not?

38. If applicable, please detail any agreed way forward which was reached between you and Mr O'Brien, or between you and others in relation to Mr O'Brien, given the concerns identified.

39. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

40. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

41. Did any such agreements and systems put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

42. What support was provided by you and the Trust to Mr O'Brien given the concerns identified by him and others?

43. What, if any, steps were taken to address the concerns identified following *Maintaining High Professional Standards Formal Investigation, Case Manager Determination* (prepared by Dr Khan, 28th September 2018) both regarding Mr O'Brien, as well as in respect of the wider systemic failings within urology services? Explain how the impact and effectiveness of such steps taken were monitored and reviewed.

44. What, if any, metrics were used in monitoring and assessing the effectiveness of these measures? How did these measures differ from what existed before?

45. Is it your view that the problems identified by Mr Khan in his report were adequately addressed? If yes, set out how. If not, explain why you consider that to be the case.

46. How, if at all, were the concerns raised by Mr O'Brien and others, and identified in the report of Mr Khan, reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to.

47. What is your view of the adequacy and/or effectiveness of the measures put in place during or at the conclusion of the MHSPS process, given what we now know of the problems which the Trust identified in respect of Mr O'Brien in 2020?

Learning

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

49. What have you learned from a governance perspective from the issues of concern within urology services and the unit, and regarding the concerns involving Mr O'Brien in particular?

50. Do you think there was a failure to engage fully with the problems within urology services? Please explain your answer.

51. Do you consider that mistakes were made by you or others in handling the concerns identified? If yes, please explain. What could have been done differently?

52. In your view, would the systems of governance now in place prevent these concerns arising again? If yes, please explain. If no, please explain why not and what you consider needs to be done to ensure the systems are sufficiently robust.

53. Do you believe that the areas of concern identified within urology services are no longer an issue?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

UROLOGY SERVICES INQUIRY

USI Ref: S21 No 2 of 2022

Date of Notice: 3rd March 2022

Witness Statement of: Heather Trouton

I, Heather Trouton, will say as follows:-

1. I currently occupy the role of Executive Director of Nursing, Midwifery and Allied Health Professionals within the Southern Health and Social Care Trust ('the Trust').

2. This statement is made in response to Section 21 Notice No.2 of 2022. It is made to the best of my recollection at this point in time and on the basis of the documents available to me. I therefore acknowledge that I may not have a complete view of all relevant matters.

3. In making this statement, I have also had the benefit (with the express permission of the Inquiry) of assistance from the following persons in obtaining documents and information: Martina Corrigan, Katherine Robinson, Sharon Glenny, Eamon Mackle, Lesley-Anne Reid, Andrea Turbitt, Lynn Magee, Emma Stinson and Lynn Lappin.

4. As required by Question 1, I have had regard to the Terms of Reference of the Inquiry and I consider that those which appear to be most relevant to my involvement in matters being investigated by the Inquiry are the first two (particularly the first one).

5. In this regard, I believe that it is important to note that my principal involvement with Urology Services in the Trust was in the period October 2009 to March 2016, when I held the position of Assistant Director for Surgery and Elective Care. My answers to the questions in this Notice therefore focus on this period.

General

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

[2] Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

[3] Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to,

or where someone else is better placed to answer, please explain and provide the name and role of that other person.

6. I have attempted to provide as detailed an answer as I can to each of Questions 4 to 53. I believe that, together, my answers provide a comprehensive account of my involvement in the matters being investigated by the Inquiry. However, conscious of the request made in Question 1, from paragraph 6 to 84 of this statement I offer a detailed overview (sometimes referring to my answers to other questions in this statement) of my role, responsibilities and duties pertaining to the provision of Urology Services within the Trust from October 2009 to March 2016, having regard to the Inquiry's Terms of Reference.

7. I have had a nursing career in the Trust for almost 26 years and have undertaken a number of nursing and management roles (please see full detail outlined in my answer to Question 5). Up until taking up the post of Assistant Director for Surgery and Elective Care in October 2009, my interface with Urology was either not at all or on the periphery of the service.

8. Following my transfer to the Post of Assistant Director for Integrated Maternity and Women's Health and Cancer and Clinical Services in April 2016, again the only interface with Urology services would have been through Laboratory, Radiology and Cancer services that provided services to Urology patients as with all other patients assessed and treated by the Trust.

9. My current role of Executive Director of Nursing, Midwifery and Allied Health Professionals, taken up in January 2018, oversees the quality of nursing, midwifery and Allied Health Professional care and the education and training of these professional workforces. Therefore, with regard to the Urology service since 2018, my interface would have been through the nursing management structure only.

10. Therefore for the purposes of this statement, and having regard to the Terms of Reference of the Inquiry, my statement will relate primarily to my Role as

Assistant Director for Surgery and Elective Care October ('AD SEC') from 2009 to March 2016.

11. For clarity, on the responsibilities of my role as AD SEC, please see my job description attachment located in Section 21 No 2 of 2022 - 1- AD of Surgery and Elective Care Band 8c JD. I was responsible for a number of surgical services , namely General Surgery (including Colorectal surgery, upper Gastro surgery and breast surgery), Endoscopy, Ear Nose and Throat Services, Trauma and Orthopaedic services, Oral Surgery, Ophthalmology, Urology services, all Outpatient Services for the Trust, 7 inpatient wards, one elective ward and a High Dependency Unit across two acute hospitals. I was a member of the Senior Management Team (SMT) in the Acute Services Directorate and reported to the Director of Acute Services. During my tenure as AD SEC, I reported to 4 different Directors, Joy Youart from October 2009 to November 2009, Gillian Rankin from December 2009 to March 2013, Debbie Burns from April 2013 to May 2015 and Esther Gishkori from June 2015 to March 2016.

12. As well as my role in directing surgical services, I also was, as a member of Acute SMT, responsible for ensuring good patient flow from our Emergency Departments, through surgical beds, with good discharge planning to maintain capacity for unscheduled and elective surgical admissions. I also was responsible for the financial management of the Division and the staffing relating to same, along with the clinical governance of the Division. Further information on this role is detailed in my answer to question 6 below.

13. Specifically regarding Urology, the Urology department was one of the surgical specialties that sat within the Division of Surgery and Elective Care ('SEC'). When I took up post in October 2009, it comprised of 3 Consultant Urologists, a small supporting junior doctor team, a GP with specialist interest in Urology, 3 specialist nursing staff, Urology inpatient beds, outpatient services and, of course, access to Trust day case and inpatient theatres. At that time in the Trust and regionally there were long waits for patient access to Urology services for new referrals and a long backlog of patients awaiting medical review. In the March of 2009, the regional commissioner had completed a regional review into Urology services, which concluded the need for 3 regional centres for Urology in

Northern Ireland, 1 in Belfast – 'Team East', 1 in the Northern Trust area – 'Team North' and 1 in the Southern Trust area – 'Team South'.

14. The Minister for Health approved the new model in March 2010 and the commissioner communicated with Trusts in April 2010, stating a regional implementation group would be established in July 2010 to take this forward setting out the funding for each Trust, the additional capacity to be recruited into each team, and the expectations both for activity and improvement through 26 recommendations and key performance indicators. Please see further information detailed in my answers to questions 8 and 9 and the attachment relating to these questions located in Section 21 2 of 2022 8 HM700 Letter to Trust Dir Acute re Urology Review Implementation.

15. The Trust's Director of Acute Services, Gillian Rankin, the Director of Performance and Planning, Paula Clarke, the Medical Director, John Simpson, and the Clinical Lead for Urology, Michael Young, were the Trust members of the Regional Implementation Group. There were many regional meetings, chaired by the Health and Social Care Board to agree on commissioned activity levels for each team and the numbers of new outpatient consultations, review consultations, day cases and inpatient surgeries. There was also much regional focus on implementing the 26 recommendations with discussions on for example, which surgical procedures should be performed as a day case as opposed to an inpatient, how practice should change to bring patients in for inpatient surgery on the morning of surgery as opposed to the day before, and how to reduce the new to review ratio (that is, how to reduce the number of patients for medical review). All are set out in more detail in the attachment to my answer to Question 8 below located in Section 21 2 of 2022 8 HM700 Letter to Trust Dir Acute re Urology Review Implementation.

16. The requirement of this work was to expand and modernize Urology services across Northern Ireland at both hospital and individual consultant level.

17. To support the work internally in the Trust, there were 3 regular meeting groups established.

18. One was chaired by the Director of Acute Services with all Consultant Urologists (Mr Michael Young, Mr Aidan O'Brian and Mr Mehmood Akhtar) and the Associate Medical Director (Mr Eamon Mackle), the Director of Performance and Reform (Paula Clarke), myself and the Head of Urology and ENT (Martina Corrigan). These were the core members of the meeting, although other staff may have attended on occasion, e.g., the (then) Chief Executive, Mrs Mairead McAlinden. These meetings occurred every Monday evening at 5 pm and lasted for approximately 1.5 hours. These meetings went on for 12 to 18 months approximately. I currently have been unable to locate any minutes of these meetings and have no recollection, in fact, as to whether the meetings were minuted. However, the function was to discuss new ways of working, review the clinical evidence for modernization, discuss and agree activity to be delivered in the new service and agree consultant job planning content for the proposed 5 consultant model.

19. The second group convened, as referenced above, was chaired by myself and focused on the operational delivery of the new service. This group involved consulting with other operational managers, making them aware of the new model, what the new larger service would require in terms of theatre space, outpatient clinic space, medical records support, administrative and patient booking support, etc. This group worked out the additional needs of the services that were in place to support the consultant activity and worked with the planning department to create the Investment proposal template for the Commissioner. Please see example notes of this meeting attached to my answer to Question 8 below located in Section 21 2 of 2022 8 Urology Implementation Group- 6 9 11.

20. The third group was the Clinical Assurance group which comprised of Mr Young, Mr O'Brien, Mr Akhtar, Mrs Corrigan, Mrs Shirley Tedford (Urology Nurse), and a GP representative.

21. The regional and local implementation processes took a long time. In December 2011 the Trust Investment proposal template was submitted to the Commissioner (HSCB) for allocation of funding with a timeline for full implementation which noted that the additional consultants would be in place in August 2012 and the new service would be fully functioning by March 2013. The Inquiry can therefore

see that, from the production of the initial new model in March 2009, it took 4 years for full regional and local implementation.

22. On reviewing the timeline for Urology, consultant recruitment and retention in the Trust post 2010 was the primary cause of delay internally in fully implementing the new model as was securing agreement of relevant job planning. Enough inpatient theatre capacity to meet the new 5 consultant model was also a challenge as all surgical specialties required access to theatre and capacity was limited. This was managed through extended day in theatre for Urology although again this was not ideal and had its own constraints.

23. From 2009 to October 2011 there remained 3 consultant Urologists in post. For a short period from October 2011 to April 2012 we had 4 consultants through securing a locum consultant. However, Mr Akhtar left the Trust in April 2012 which reduced capacity again to 3 consultants. In September 2012 we managed, through recruitment, to grow again to 4 consultants and further to 5 from November 2012 to March 2013 when we returned to 4 again because Mr Connolly left the Trust .In December 2013 we grew again to 5 consultants until January 14 when we were back at 4 because Mr Pahuja left the Trust. It was only from April 2015 that we managed to sustain a 5 consultant model for Urology that was permanent and consistent. It is important to note that at this time there was a regional dearth of consultant Urologists. As the Inquiry will see recruitment was very active however retention was an issue and this, combined with a lack of candidates for posts, was a problem for Unit growth and service delivery. For more detail on staffing, the concerns and the impact of staffing deficits please see my responses to questions 14 to 18 below.

24. As mentioned earlier, the new service was to be a 5 consultant model (involving the addition of 2 funded Consultant Urologists).This was supported by a number of additional support staff to enable the delivery of the additional agreed activity commensurate with both Southern Trust demand and that of the additional catchment area of the lower part of the Western Trust. Please see the detail provided in my answer to Question 12 located in Section 21 2 of 2022 12 Urology Revenue IPT Feb 2012.

25. The funding allocated by the HSCB was based on a calculation of patient demand for Urology services in 2008/2009. It neither took into consideration the backlog of patients waiting for Urology services nor the known year on year growth in demand for Urology services which sat at approximately 10% growth in demand per year. A particular concern for the Trust at that time was the extent of the Urology review backlog and it was noted, referenced and an action plan attached to the Team South Implementation plan in 2010 located in Section 21 2 of 2022 All appendices- App2.

26. There were a number of concerns for the Trust throughout my time as Assistant Director for Surgery and Elective Care relating in general to waiting lists in all specialties across medicine and surgery which most definitely included Urology Services. At that time there was a strong focus on meeting the HSCB waiting time standards for outpatient assessment, day case, and Inpatient surgical procedures and, of course, the cancer 31 and 62 day pathway standards, all of which was completely appropriate. This was in conjunction with a high demand for unscheduled care services, with multiple Emergency Department trolley waits, as described at that time, with a strong focus on meeting the needs of unscheduled patients along with elective patients and keeping patients flowing appropriately through our hospitals.

27. With regard to the Urology service I had four primary concerns at that time (which are addressed in further detail in my response to Question 31).

First Concern re Urology

28. The first concern that was a constant for the first four and a half years of my term as AD SEC was the difficulty the service had in recruiting and retaining Consultant Urology Staff. From April 2014 there was a consistent body of 5 consultant Urologists but prior to that it was inconsistent. Primarily, there was a dearth regionally and across the UK in the availability of Consultant Urologists. This was not particularly unusual as many specialties also found it difficult to secure consultant staff (e.g., Radiology) but with a new extended service to implement, increasing demand for patient care and treatment and in particular the increasing number of red flag referrals coming into the Urology secondary

care service, not having the required number of clinical staff to see and treat patients was a concern. This was compounded by no funding within the new service model for middle grade support staff, nor any increase in Urology training staff by the Northern Ireland Medical and Dental Training Agency. It is widely recognized that an effective medical team is made up of a number of doctors, supporting the service at different levels, across the 24/7 period. This was challenging for the Urology service. There was active recruitment throughout this period but retaining consultant staff was at times equally difficult in a service with a relatively small team and significant service demands.

29. While the Urology Unit was made up of a number of professionals, teams, support staff and services, the core of any service is the Consultant team. Without the requisite number of staff at that level, meeting patient demand is very challenging. Enhanced nursing roles were of course developed and effective but they were limited on addressing the overall capacity deficit.

30. Please see my response to Question 31, part 1 for further detail regarding the concerns on medical staffing, actions taken to address it, the impact of the concern on patient care and safety and how we monitored all actions taken.

Second Concern re Urology

31. My second concern during that period was the long patient access times and the large volume of patients waiting for secondary care Urology Services. As already stated demand for Urology services was already larger than the three consultant service could meet. In-Trust demand was rising year on year and the additional population of the lower part of the Western Trust was added in the new regional model and, while funding was supplied in 2012 for the additional staff to meet this demand, waiting times had grown in the interim period and, as noted in this statement, securing staff was difficult.

32. As appropriate, those patients referred by GP colleagues to the service who met the criteria for red flag designation were given priority access to the service. This was important as the diagnosis could have been life threatening and early diagnosis meant early treatment and care. However, as the number of red flag

referrals grew, they had to displace those referrals categorized as either urgent or routine. In essence, the waiting time for those categories continued to grow. This was a concern.

33. At this time there were often opportunities for services to avail of additional waiting list funding, both for outpatient activity and theatre activity. The Urology team would have availed of this opportunity to see and treat patients as their availability allowed. This was paid as additional to the consultant staff at an enhanced rate and was voluntary.

34. These sessions did go some way to reducing patient waits, however capacity was often limited, not only by the limits of consultant availability but limits on the availability of the supporting services. As the Inquiry will appreciate, all surgical specialties were trying to secure the same theatre capacity for their additional waiting lists and theatre capacity was limited. Outpatient additionality was somewhat easier as additional clinics would have happened in the out of hours period, however they depended on securing nursing and support staff to run the additional clinics. This was often difficult to secure.

35. Throughout this period a huge focus of the Head of Urology and ENT and the Operational Support Lead for the Division was on all aspects of waiting list management. The Director of Acute Services held weekly meetings with all Heads of Service to monitor waiting times across all specialties and all access points with often focus on specific patient pathways.

36. There were also monthly senior management team meetings at Director and Assistant Director level where senior staff from the Directorate of Performance and Planning would have attended to report on waiting list data and, from an independent perspective, to challenge and support the delivery of services.

37. While I was not a member of the Trust Senior Management Team, nor Trust Board, at that time, it was my understanding that performance data in its entirety was tabled at these senior meetings.

38. There were monthly meetings held in Linen Hall Street Belfast, the offices of the Health and Social Care Board, with each Trust, collectively and individually to go

through all waiting time and cancer pathway data. This data was extracted directly by the HSCB from Trust data systems. Trusts were held to account at these meetings for their performance and areas of concern were escalated to the HSCB by Trusts regularly.

39. The concerns relating to Urology waiting times, new and review outpatient waits, day case and inpatient surgery waits, and the cancer 31 and 62 day pathways were regularly escalated to the HSCB at these meetings and throughout the course of my tenure as Assistant Director.

40. As well as managing the waiting times through additionality, ensuring outpatient clinics and theatre lists were filled appropriately and so forth, there were also continual efforts to improve the patient pathway and, in that way, try to reduce patient waits. Please see paper attached that shows the vision for Urology services in 2014located in Relevant to PIT, Ref 77, Evidence added or renamed 19 01 2022, Evidence No 77, No 77, Heather Trouton amended emails with attachments, 20170915 Email Urology Board Paper V2 1st Sept and 20170915 Email Urology Board Paper V2 1st Sept A. A new Urology Outpatients and diagnostic centre was opened in 2013/4 which enabled a one-stop assessment, diagnostic and diagnosis pathway to be implemented for Red flag and urgent patients. This process commenced in January 2015. The Consultant staff worked with GP colleagues to try to agree patient pathways across primary and secondary care to improve access to appropriate care and monitoring for patients and our specialist Nurses were supported and mentored to train in cystoscopy and Trus biopsy, again to support as a multidisciplinary team good access to diagnosis and treatment.

41. Please see the answer to Question 31, section 2 for further detail on this concern, actions taken to address it, the impact of the concern on patient care and safety, and how we monitored all actions taken.

Third Concern re Urology

42. The third concern was regarding the amount and extent of the Urology review backlog. While patients had been seen initially by a consultant / senior doctor,

and an assessment made, diagnostics requested or a treatment plan commenced, with the lack of ability to offer patients a consultant review in the timescale specified by the consultant, we were unable to offer follow up / treatment review and assess development of symptoms as would have been required. The review backlog was already established when I took up post. General demand for services was increasing year on year. With the regional drive to meet the access standards for new outpatient appointments, specifically those designated as red flag, with no regional standard for review appointments and the funding of additional waiting list clinics without commensurate additional funding for the follow up review appointments, it was extremely difficult to catch up on the review backlog demand. There was a Trust plan in place to address the concern and a number of actions to address both the backlog and review practice at source to minimize the review demand, however while it was actively managed, we were not able to eradicate it completely, certainly with the clinical resource available at that time. Please see my response to section 3 of Question 31 below for further detail on actions taken to address this concern, the impact of the concern on patient care and safety, and how we monitored all actions taken.

Fourth Concern re Urology

43. The fourth concern during the 2009 to 2016 period was ensuring that all patients who were referred from a GP or by another secondary care consultant and designated as red flag were seen urgently, had the appropriate diagnostic tests completed, appropriate diagnosis made, and (if cancer was diagnosed) accessed their first definitive treatment in line with the 31 and 62 day cancer pathway standards.

44. Due to the staffing concerns noted earlier in the statement and the overall increasing demand for the service, meeting these standards was a continual challenge for every patient .As the whole cancer pathway involved other disciplines, the availability of diagnostic tests in the general Radiology department, the availability of consultant radiologists to report on the test result, timely pathology support in Trust and oncology support as an outreach service from Belfast and on occasion transfer to Belfast for treatment, lack of capacity / delay at any point in the cancer pathway could have had a detrimental effect on

patient diagnosis, care, and treatment. The daily management of patients at all stages of the cancer pathway was a focus for both the Urology clinical and management teams and the cancer tracking service.

45. There were weekly meetings chaired by the Head of Cancer Services in the Trust with the Specialty Heads of Service to report on, monitor, and seek solutions for particular patients.

46. The cancer standards were also monitored at Trust performance meetings and those with the Health and Social Care Board.

47. Please see my response to Question 31, section 4 for further detail on this concern, actions taken to address it, the impact of the concern on patient care and safety, and how we monitored all actions taken.

48. In summary, managing and seeking ways to address these four concerns was a primary focus for the Urology team, the Acute Directorate, and the Trust as a whole. Many patients were seen, treated, and cared for both electively and as an emergency admission .However, as our population continued to grow and age the demand for the Urology service increased and, despite best efforts, demand largely outstripped capacity, and therefore waiting lists, the review backlog, and the cancer standards, each remained a challenge. With regard to staffing, as mentioned already it did improve in 2014 and continued to be more stable thereafter.

49. So in a system under pressure and with many competing demands, good clinical governance systems and processes where really important. It is important to note that in 2009, clinical and social care governance systems were not as well developed as they are now. Thankfully, there has been much improvement over the years naturally within Trusts as they sought to improve patient safety and as a result of a number of national inquiries and service reviews and the recommendations that have emanated from same.

50. During my tenure as Assistant Director for Surgery and Elective care I did rely on a number of systems, production of data, meetings, and patient feedback both to

deal with safety and care concerns and be assured around care standards. Please see the details noted in response to Questions 22 and 23 in this regard.

51. As well as system and patient data being available for analysis and action, I was a very visible leader in the Division and the Directorate. As I had worked in the organization for many years at this point and in a variety of roles that spanned all services in the Acute Directorate, I was well known and approachable. Staff within the Division and the Directorate were able to share any concerns they had regarding patient care or professional practice. As a nurse, my knowledge and experience leant itself to the oversight of nursing practice within Urology to ensure that nursing practice was safe and effective. I had a close working relationship with both the Clinical Director for Surgery and Elective care (Mr Robin Brown) and the Associate Medical Director for Surgery and Elective Care (Mr Eamon Mackle) who, as medics, provided oversight from a medical perspective to medical practice. As a team, and using all information available to us, we endeavored to address concerns wherever they arose. There were also a number of staff in the Acute Directorate to support clinical governance: a governance lead, a complaints team, an officer for standards and guidelines, and a corporate clinical audit officer. There was a raft of data available to me and my team on patient access standards, complaints, adverse incidents, workforce data, nursing quality indicators, theatre utilization, new standards and guidelines; and these were used to indicate concerns either directly relating to patient care or the potential to effect patient care. There were a number of meetings at which this data was shared, discussed, and actions agreed. I met with my Heads of Service on a weekly basis to discuss all things governance, performance, finance, and staffing. I met with the Associate Medical Director weekly to discuss all things relevant clinically to the service, reviewing serious adverse incidents, and screening those for a serious adverse incident investigation according to the set criteria. Medical workforce issues would also have been discussed at this weekly meeting. I also held a monthly meeting with the Associate Medical Director, Clinical Director, and Clinical leads for each surgical specialty at which we discussed governance, performance, and staffing issues and, of course, it was a forum where they could bring concerns to the AMD, CD, and I. It also provided a forum for shared discussion and learning across their clinical teams.

52. The Director of Acute Services held two monthly governance meetings. One was with the Assistant Directors of Acute Services and was attended by the Governance lead, clinical audit lead, and standards and guidelines officer, who presented data and updates on progress with the implementation of guidelines, clinical audit data, and other governance information on complaints, compliments, adverse incidents, and the progress of ongoing serious adverse incident investigations. The second monthly meeting was held with the Acute Associate Medical Directors and the Assistant Directors. This meeting also discussed governance information but was particularly focused on learning from serious adverse incident investigations.

53. As Assistant Director for a number of surgical specialties, covering somewhere in the remit of 34 surgical consultants (the number varying over the years as services expanded), the management team – both operational and medical -was familiar with various concerns being raised at various times about various consultants across a number of teams. Such concerns were typically raised, discussed, and addressed. However, what was different in the case of Mr O'Brien was the ongoing challenge to address practices which, despite discussion at all levels within the organization and over a period of years, Mr O'Brien was either unwilling or unable to address consistently. However, it must be also noted that, throughout this period, Mr O'Brien did acknowledge and address some of the concerns. Some were addressed on a permanent basis and others intermittently.

54. Regarding concerns on Mr O'Brien's practice, the following (which are addressed in more detail below) were recurrent problems: (with the exception of that at paragraph e. below, management of inpatient Intravenous Antibiotics).

    a. From the beginning of my time in post October 2009 I was made aware of the extent of Mr O'Brien's review backlog.

    b. From the same time I was also made aware of the delays in Mr O'Brien returning completed consultant triage to the booking centre to enable them to book patients for appointment.

c. Further concerns regarding his practice of taking patients notes home and retaining them there for long periods emerged and continued throughout my tenure.

d. In 2015 it was discovered that there was often little or no record on the Patient Centre electronic patient notes recording system of the care, treatment or diagnosis of patients that Mr O'Brien had seen at his clinics.

e. A further concern identified was his practice of admitting a number of patients recurrently for proactive administration of intravenous antibiotics for urinary tract infection management. This emerged via an audit of patients admitted electively who had no surgical procedure. The concern was raised by the commissioner and when expert urological advice was taken, it was considered inappropriate practice. Through engagement with our microbiologist colleagues, patients and senior medical staff we were able to support this change in practice and this concern was addressed.

Review Backlog

55. With regard to the reduction in Mr O'Brien's review backlog this was a concern regarding the patient safety and care needs of those patients awaiting review. While it is clear that many consultants had the same challenge of a review backlog both in urology and other specialties, Mr O' Brien's review list was particularly extensive both in volume and length. Further detail on the actions taken to address this concern is set out in my response at Question 31 section 3 below (and the issue of the review backlog is also considered in my response to Questions 10, 34, 35, 37, and 39-42). .

Delayed Triage

56. The other recurrent concern regarding the administrative practice of Mr O'Brien was with regard to his delay in undertaking and returning patient referrals following secondary care triage (this issue is also addressed in my responses to Questions 24, 34, 35, and 39-41 below). The Northern Ireland Cancer Network developed clear criteria for GPs as to which referral category a patient referral to secondary care should be made under. From 2008, patients were referred as

either routine, urgent, or red flag if they had symptoms indicative of a potential cancer diagnosis. As a secondary safeguard, each consultant in the specialty team took it in turn to triage these referrals again to ensure they, with their specialist knowledge, agreed with the referral category or if they felt it needed either upgraded or downgraded. It was expected that Mr O'Brien would undertake his share of the consultant triage process. It is notable that Mr O'Brien often declared that he didn't agree with this system and felt that red flag referrals should not get precedence over urgent referrals. While in 2017 Urology moved to electronic triage, between 2009 and 2016 triage was paper-based. All red flag referrals were managed through the cancer tracking team who organized the consultant triage process and, while there were occasions where they had difficulty in retrieving completed triage from Mr O'Brien, a dedicated cancer tracker was in place who ensured they were returned in a timely manner.

57. Urgent and routine referrals were managed through the booking centre. They too shared the referrals with the relevant consultant on a rotational basis and sought return to the booking centre for patient booking. Intermittently, the booking centre team had great difficulty in securing timely return of triaged letters from Mr O'Brien. An escalation process was put in place if initial action through normal administrative processes had not proven effective. The issue was escalated both through the 'admin' management lines and directly to the Head of Urology and ENT. The Head of Urology and ENT would have contacted Mr O'Brien directly and requested urgent return of triage. This was usually effective but, on occasion, it was escalated to myself and the Director of Acute Services for action. On intervention at senior level, Mr O'Brien would then have completed and returned his triage. He would then have managed it appropriately for a time and then the cycle of delayed triage would start again. This concern was highlighted to his clinical lead as well as the Clinical Director for the service for peer intervention.

58. There were 2 primary concerns with the delayed triage. While the booking centre waited for Mr O'Brien to return the triage, the longer the delay the longer the patient waited to be added to the waiting list. The second concern was if the patient was deemed appropriate to be upgraded to a red flag

referral as per the expert opinion of the consultant Urologist, then the longer they waited for the triage to be complete and the potential upgrade requested, the longer they waited for essential and urgent care .This was very concerning and this was understood by Mr O'Brien. Please see attached some emails which may be helpful to describe some actions taken regarding triage practice for clarity *located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton, 18.06.2014 email missing triage, 04.12.2013 email URGENT NEEDING A RESPONSEMISSING TRIAGE, 17.04.2014 email missing triage 2117, 23.04.2014 email missing triage, 09.06.2014 email Urology missing triage.0743, 27.05.2014 email missing triage 1200, 20.05.2014 email missing triage 0854, 02.05.2014 email missing triage, 08.10.2013 Update on Chart with AOB, 14.10.2013 Email chart with AOB, Relevant to PIT Evidence added or renamed 19 01 22 Evidence no 77, No 77 – Heather Trouton amended emails with attachments, 20140609 Email Urology Missing Triage, 20130810 Email OUTSTANDING TRIAGE UROLOGY, 20140319 Email urology - untriaged letters, 20140319 Email urology – triaged letters, Document 20130810 Email Fw charts with Mr O'Brien 20131112 Email Mr O'Brien and Charts 20121112 Email Mr O'Brien and charts.*

59. It is important to note that, while Mr O'Brien was only required to undertake his share of referral triage in line with his consultant colleagues, in order to support him and ensure improved patient access, a number of actions were undertaken. On occasion, Mr O'Brien's colleagues would have undertaken his share of the triage for him.

60. I understand that, in March 2014, Mrs Debbie Burns met with Mr O'Brien regarding his triage practice and agreed at that meeting that Mr O'Brien would only be required to complete triage on his 'named referrals', that is only those GP referrals that were sent to him personally and that the rest of the team would undertake the rest of the triage. It is my understanding that this was accepted by Mr Young, the clinical lead for the service; however, it was seen to be an unfair system for the rest of the consultant team.

61. Mrs Burns also asked Mr O'Brien to consider what additional administrative support he would need to enable him to undertake his 'admin' duties in a timely manner. I understand that he said he would consider the issue and let her know but, to the best of my knowledge, this did not happen.

62. Around this time, to the best of my recall, in order to ensure that patients who were waiting on Mr O'Brien's triage return were not at a waiting time disadvantage, it was decided collectively between Mrs Burns (Director), Mr Mackle (AMD), Mrs Corrigan (HOS), and myself, that the booking centre staff would go ahead and book each patient as per the GP categorization while Mr O'Brien undertook his triage. To be clear, Mr O'Brien was still required to undertake his triage to ensure all patients were categorized appropriately as per his expert opinion and return same. At no point was the process of triage stood down, but it was felt that at least patients were on the list while triage was being completed. It was noted that the number of referrals upgraded following triage was small as a rule. However, in order to ensure every patient received an expert assessment the triage process continued.

63. Despite the reduction in Mr O'Brien's triage workload, intervention at all levels within the organization, and escalation processes in place, delays in triage continued.

64. On reflection, and particularly having regard to what transpired later in 2016 when a number of untriaged letters were found in Mr O'Brien's office, further checking mechanisms should have been put in place to ensure all triage referrals were returned. I regret that this was not put in place. I have, on preparing for this Inquiry, been appraised by Mrs Catherine Robinson that the booking centre allocated a code to the Patient waiting list to denote those letters not triaged by Mr O'Brien. I was unaware of that code / practice. Had I been aware of it, I would have been able to request that a report was run to ascertain the number of patients where triage had not been returned and then required return from Mr O'Brien. However, while checking mechanisms should have been applied, it was at all times expected that a senior and experienced consultant with patient safety at the core of medical practice would not neglect this process completely for a number of patients.

Patient Notes

65. With regard to the concern of Mr O'Brien taking patient notes to his own home and retaining them there for long periods, this was a concern from a number of perspectives. In the first instance, patient notes contain personal and private information. From the perspective of information governance, all patient notes should be secure. Holding notes at home therefore was an information governance risk .Secondly, when a patient attends our emergency departments, access to patient notes are required to assist accurate clinical assessment. Not to have patient notes available in the hospital for this purpose was a risk to patient safety. It is important to say that, since the introduction of electronic methods of medical recording as in the Northern Ireland Electronic Care Record, this particular concern is now not so important from this perspective, but that was not the case before the introduction of NIECR. Finally, patients attend many different services and specialties in the Trust. The Medical Records department prepared for outpatient clinics by ensuring that all patients' notes were available for the medical team at each clinic. On a number of occasions, they would not be able to find patient notes as they were at Mr O'Brien's home. Again, not only was this frustrating for the clinical team attempting to see a patient without notes but again had a direct impact on patient safety and care. However, the NIECR system has assisted in this regard.

66. Mr O'Brien did return notes on request, and we had no way of knowing how many charts were in his home. However, despite many conversations regarding the need to keep patient notes on the hospital premises or return them immediately if it was necessary to take them home, concerns were still raised periodically by the medical records team. (This issue is also addressed in my response to Questions 24, 34, 35, 37, and 39-41 below)

No Record of Care, Treatment, or Diagnosis

67. In 2015 a new concern emerged with regard to the practice of Mr O'Brien. By that time the additional consultants had started as members of the urology team. They had experience working in England and were working both to develop the Urology service and assist in reducing the waiting times for patients and in

particular the review backlog. At that time they began to see patients of Mr O'Brien who were in the review backlog. It is my understanding, through escalation by the new consultants to the Head of Urology and ENT, to myself, and to the Associate Medical Director, that after undertaking a number of clinics, they found that there was often little or no record on the patient centre electronic patient notes recording system of the care, treatment or diagnosis of patients that Mr O'Brien had seen at his previous clinics. In effect, there was often no record of clinic activity or outcomes. It is my understanding that, when Mr O'Brien was asked about this, he conceded that he would undertake his record keeping at a later time rather than most consultants' practice which was to dictate notes after each patient seen at clinic. As this was an emerging issue just prior to my change of role, it is my recollection that, on taking advice on required action, the advice was to address it in writing with Mr O'Brien as per the letter issued to him in March. However, as it was a new issue, I am not able to provide the same detail in respect of it (e.g., in respect of actions taken to address it) as I am regarding other issues such as triage, notes at home, and so on.

68. Following this discovery at the end of 2015 / January 2016, Mr Mackle and myself spoke with the then Medical Director, Dr Richard Wright, regarding our concerns with Mr O'Brien's practice, not only with regard to this latest discovery but also with regard to the other recurrent concerns we had not been able to fully address.

69. Dr Wright advised that he thought it was time to put all the concerns in writing to Mr O'Brien and request a plan from Mr O'Brien to address these concerns.

70. The resulting letter was delivered to Mr O'Brien by Mr Mackle and Martina Corrigan in March 2016.

71. At the end of March 2016, due to a general reshuffle of Assistant Directors in Acute Services by the then Director of Acute Services, Mrs Esther Gishkori, I was transferred to the post of AD for Integrated Maternity and Womens Health and Cancer and Clinical Services. Mr Mackle and Mrs Corrigan remained in post and Mr Ronan Carroll was transferred into my outgoing post. He was aware of the

situation and the letter to Mr O'Brien and the response required, as was Mrs Gishkori.

72. As I reflect now on the pressures generally within Acute Services and more specifically the Urology service during the period 2009 to March 2016, there is no doubt the service was trying to manage high demand with a team that was difficult to grow and maintain, while modernizing its practices in line with modern urology practice. There was a strong focus locally and regionally on patient access standards and, while this was completely appropriate, there was an acceptance and belief that once a patient secured access to consultant care and if their clinical pathway could be supported by diagnostics, bed availability, surgery and follow up, then they were safe. In the vast majority of clinical practice, this is an accurate belief. The service continually sought service development improvements to meet patient demand, improve patient experience, and provide safe and effective care, and worked very hard as a whole team. The clinical governance systems and processes that were in place were valued and used appropriately but, again and on reflection, they did not prove effective in providing accurate insight into the clinical care we now know (through a number of serious adverse incident investigations) was not at a standard we would expect or accept.

73. While governance systems and processes have been much strengthened in the Trust, particularly from 2018, I think there is more to do to audit consultant practice for full assurance.

74. Reflecting on the practices of Mr O'Brien during 2009 to March 2016, I recall Mr O'Brien as being a highly clinically respected, long standing, and experienced consultant Urologist. There were most definitely concerns raised regarding his style of administration management and it was widely known he had his own way of arranging his work. However, at no point were any concerns raised with me by his clinical colleagues regarding the standard of patient care, treatment, or clinical decision making. In fact, it was widely considered that, while one may have waited to see Mr O'Brien as a patient, once one did, patients were very happy with their care. With regard to his practice of admitting patients for intravenous antibiotics, and while that was challenged by Urology experts and

the practice stopped, that was considered by his colleagues to be a compassionate response to patients who were suffering from recurrent infections

75. There is no doubt that, while not overtly clinical, managers were very aware of the patient safety risks associated with his admin practices. These concerns were highlighted, articulated, and escalated to all Directors of Acute Services and Medical Directors. Mr O'Brien was engaged with and supported with his practice and Mrs Corrigan in particular spent many hours trying to manage around his preferred practice to ensure that patients had access to care. I was also assured by the Clinical Director, Mr Robin Brown, as to the clinical excellence of Mr O'Brien and advised to support rather than challenge his administrative practices.

76. There were no concerns that I was ever aware of regarding Mr O'Brien's clinical ability and patient feedback on care and treatment provided by Mr O'Brien was generally very good

77. On reflection, and knowing what we know now, the issues were greater than admin processes, although we were not aware of that at the time.

78. On further reflection, I consider that Mr O'Brien found it difficult to adjust to the expectations of the Commissioner with regard to activity and practice and he found the expectations of the British Association of Urology difficult to agree with and accept. I think he also found it difficult to adjust to the use of digital technology to support clinical practice and I also think he found it difficult to embrace the full multidisciplinary team and the collective roles that each played to support him and the service. On reflection, I think that Mr O'Brien found it difficult to adjust to the expectations of modern medical practice with regard to standardized pathways and practices.

79. However we now know that despite his portrayal of confidence in his practice and the confidence he enjoyed from his colleagues, the extent of the gaps in patient care escalated throughout his years of practice.

80. I consider this collectively led to a picture of holes in clinical care for a number of patients that remained undetected until a new, bigger consultant team in place were able and willing to identify and share their clinical concerns.

81. As I reflect on my role at the time I have of course asked myself what more could have been done to identify the effect on patient care earlier. I am assured that many actions were taken to support Mr O'Brien with his workload. He was required only to work to his job plan as were other consultants. He was supported by his consultant colleagues and the wider team. Governance data was available and monitored. Required action was taken where possible.

82. However what was not available to us at the time was robust and regular audit of medical recording keeping, audit of patient pathways, and audit of patient outcomes which would have been very helpful and patient centered.

83. On reflection, I sincerely wish I had pushed more to request, design, and implement such audits rather than expect and assure consistent clinical safety.

84. However, even as I reflect on that, I do not believe I would have had either the capacity nor the requisite support of either of the consultant team nor senior management at that time to undertake such audits. I say this because there was not the time capacity within the team to design and undertake such audits within Urology while managing so many teams, wards, access standards, and so forth. I also believe that, as there were no concrete concerns regarding Mr O'Brien's clinical recording (pre 2015) or concerns about patient pathways or outcomes, such audits would not have been approved.

Your Position(s) within the SHSCT

[4] Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

85. I commenced employment with the SHSCT in May 1996 as a newly qualified Registered Nurse. Prior to that, I spent 3.5 years in Nurse training with Queens University Belfast (the additional 6 months was to take maternity leave for my second child as I started my nurse training at 26 years old after I was married

and with one child). Prior to entering nurse training, I worked in the electronics industry, Bloomer Electronics Craigavon, where I was qualified to HNC level in Electrical and Electronic Engineering. I have 8 GCSEs and 3 A levels (grades AAB).

[5] Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

86. My employment history with the Trust can be summarized as follows.

    a. I commenced employment on 20th May 1996 as a registered staff nurse in the Stroke Unit in Lurgan Hospital. I also worked as a staff nurse in the Nursing Development Unit in Lurgan Hospital (30th December 1996 to 14th December 1997) before transferring to Craigavon Area Hospital on 15th December 1997 to work in the Winter Ward (an acute medical ward) in Craigavon Area Hospital. When the Winter Ward closed on 6th April 1998, I returned to Lurgan Hospital to work as a staff nurse in the Continuing Care Ward until I went on maternity leave in June 1998. During my maternity leave I was offered a post in Ward 4 North, Surgical ward in Craigavon Area Hospital and returned from maternity leave on 18th October 1998 to take up that post. On 5th April 1999, due to family responsibilities, I asked for a reduction in contracted hours and was duly offered a part-time post in the neighbouring ward of 4 South in the hospital, another surgical ward. Neither ward managed urology patients but specialized in bowel and breast surgery. All of these nursing posts were at grade D level which is the equivalent of the current band 5 level and is the entry level for all registered nursing posts. The main duties of these posts were as follows - assessing, planning, implementing, and

evaluating all care related to patient need. This included admission assessment and planning care needs according to the activities of daily living relating to nutrition, mobility, toileting needs, pain relief, communication needs, etc. The role also involved administration of medications, surgical dressings, pre and post operative care, administration of Intravenous fluids, and good discharge planning. Please see job description attached and the Grade D job description is a true reflection of all the roles at this level. Attachment -1-Registered Nurse Grade D. This is located in Section 21 2 of 2022.

b. On 4th December 2000 I secured a promotion to a grade E staff nurse post in Ward 4 South Surgical ward. This was a senior staff nurse post. The duties of this post incorporated all the duties of a grade D post with the additional responsibility of being in charge of the ward when the ward sister and clinical sisters were not on duty. During this time, due to family reasons, I largely worked night duty and therefore would have been in charge of the ward frequently. Please see job description attached for grade E role and this is a true reflection of the role of that post. This is located in Section 21 2 of 2022 3 - Staff Nurse Grade E

c. On 9th December 2002, following a musculoskeletal injury at work, I secured a Grade F Night Nursing sister role in the hospital. This was a dual role of Bed Manager and Night Sister. The responsibilities of the Bed Manager role were to ensure that all patients who required admission to Craigavon Area Hospital, whether through the Emergency Department, electively for a planned operation or procedure, at the request of a GP, through an outpatient clinic appointment or through the Chemotherapy Unit, were placed in the most suitable bed possible for their treatment and care. Even in the early 2000s there were bed shortages in our hospital, with bed waits being a feature in the emergency department as there are today. The role therefore was challenging, required logical thought, a good understanding of clinical need and patient safety, negotiation skills and excellent communication with the ability to prioritize based on clinical need. The other part of this role was Night Sister. Effectively, this part of

the role was to be operationally in charge of the hospital in the Out of Hours Period, 8.30 pm to 8 am. It incorporated the bed management role during this period. The role of the Night Sister was a senior nursing role. All nursing issues relating to staffing levels, staff shortages, clinical incidents, staffing incidents, patient movements etc. would have been escalated to me to oversee and advise required action. This role spanned all areas within the hospital, all wards, ICU, neonatal ward, the Emergency Department, maternity wards and delivery suite. Please see attached Job description which is an accurate reflection of the role. See attachment located in Section 21 2 of 2022 4 - Charge Nurse Grade F (Acting). It was during this time that I completed a degree in Nursing studies at the University of Ulster and gained a First Class Honours degree in this subject.

d. On 21st March 2005 I took up the post of Patient Services Manager for Craigavon Hospital (Grade H). This post effectively managed the team of Bed Managers (now renamed Patient Flow coordinators), Night Sisters and a small team of Discharge Liaison Nurses. The primary function of this post was to ensure there was full 24/7 coverage of a patient flow service, that there was always Night Sister cover, that each staff member was trained effectively in managing the flow of patients across the hospital, all to ensure there were always beds available for patient need and that patients who were medically fit following treatment were able to be safely discharged under the care of district nursing or social care services if required. This role worked closely with all members of the multidisciplinary team to ensure that patient care and treatment was timely, that delays in required investigations were minimized, and that patients were able to have timely access to admission for care, treatment and effective discharge. Please see Job Description attached which is a true reflection of this role see attachment located in Section 21 2 of 2022 6 - Patient Services Manager Grade H

e. Following the regional review of hospital services, the Southern Health and Social Care Trust was formed in April 2007. Following the formation

the Trust, my role became Head of Patient Flow and was now also responsible for patient flow and out of hours management in Daisyhill Hospital, Newry, as well as in Craigavon Area Hospital. Please see Job Description attached which is a true reflection of the role. See attachment located in Section 21 2 of 2022 7 - Patient Flow Manager Band 8B

f. In December 2008, I was asked by the then Director of Acute Services, Mrs Joy Youart, to step out of my Head of Patient Flow role for a period of time to be Project Manager for an improvement piece of work that looked at a number of systems and processes to improve patient flow and the reconfiguration of the surgical wards in Craigavon Area Hospital. At that time, due to the demand for beds for patients from the emergency department, it was very difficult to secure beds in a timely way for patients who needed to come into hospital for elective surgery or treatment. This piece of work, was based on the need to configure surgical beds based on the needs of the patients rather than consultant named beds as was the traditional approach. There were a number of changes in how the surgical beds were configured but the chief output was the creation of a designated elective care ward which meant that each morning there were 18 beds to receive patients for surgery. This transformed both access for patients, improved their experience, and improved the efficiency of elective surgery. I don't believe there was a formal job description for this role which was in place for 9-10 months.

g. At the end of this improvement project, on 5th October 2009, I took up the post of Assistant Director for Surgery and Elective Care for the Trust. Please see Job description attached which is a true reflection of the role See attachment located in Section 21 2 of 2022 1 - AD of Surgery and Elective Care Band 8C JD. While the Urology service was involved in the improvement project of bed reconfiguration, it was only in this Assistant Director post that my direct involvement with the Urology service began. This post was responsible for the delivery of surgical services across the Trust and included the following areas: General Surgery, Breast Surgery, Upper and Lower Gastro Surgery, ENT, Urology, Ophthalmology, Oral

Surgery, Trauma and Orthopaedics, Endoscopy, 7 inpatient wards, and all of the Outpatient services across the Trust. There were three Heads of Service supporting this role: one Head of Service for General Surgery (which incorporated, Breast, Endoscopy, Oral surgery and upper and lower GI), one Head of Service for Trauma and Orthopaedics, and one Head of Service for Urology, ENT, Ophthalmology, and Outpatients. The wards were allocated across the Heads of Service. There was also an Associate Medical Director (AMD) for the Surgical and Elective Care Division, Mr Eamon Mackle, a Clinical Director (CD), Mr Robin Brown, and a Clinical Lead for each of the surgical specialties which, in the case of Urology, was Mr Michael Young. While we worked as a collective team, the AMD, CD, and Clinical Leads focused on clinical supervision, appraisal, job planning, and the professional management of the consultant and medical staff. My role was to oversee the provision of surgical and elective care across all the surgical specialties, monitoring waiting lists, patient access, nurse staffing, ward management, quality of nursing care, outpatient provision for all specialties (including but not exclusively surgical), and, of course, overseeing adverse incidents, complaints and other quality metrics.

h. For the period March 2012 to December 2012, I stepped out of my AD Surgery and Elective Care role to take up a 9-month secondment to lead, with another colleague, the then Department of Health ‘Transforming Your Care’ initiative for Acute Services. This primarily involved working with Primary Care colleagues to review patient pathways for a range of services to understand how Primary Care colleagues could undertake a greater role in the management of patients in the community rather than referral to secondary care. Mrs Trudy Reid was seconded into the role of Assistant Director for Surgery and Elective Care for that period.

i. In April 2016, the then Director of Acute Services Mrs Esther Gishkori, decided to reconfigure the Assistant Director roles in Acute Services. I was transferred to be the Assistant Director of Integrated Maternity and Women’s Health and Cancer and Clinical Services. This role oversaw the

provision of Maternity and Gynae services across 2 hospital sites and the community midwifery service, hospital laboratories, Allied Health Professional services, Cancer services (assessment and chemotherapy provision), and radiology services, again across a number of sites in the Trust. Please see attached job descriptions. While I fulfilled the full role of the Job Description as AD for Integrated maternity and Womens' Health, The Job Description attached for Cancer and Clinical Services shows more services than I was then responsible for. I did not assume responsibility for Theatres or anesthetic services. These were retained by Mr Ronan Carroll See attachments –located in Section 21 2 of 2022 Cancer and Clinical Services 12, 11-AD Integrated Maternity and Womens' health and AD

j. On 22nd January 2018, I applied for and was successful in securing the post of Executive Director of Nursing Midwifery and AHPs for the SHSCT. This post is responsible for providing leadership to the professions of nursing, midwifery and allied health professions across all programmes of care within the Trust. This is across Acute Services, Mental Health and Learning Disability, Older People and Primary Care, and Children's and Young Peoples Services. It is concerned with ensuring that we have a suitably trained and educated professional workforce that are appropriately regulated and revalidated according to the professional body requirements, that we can evidence as far as possible the provision of safe and effective professional care, and that these professions fulfill their roles as effective members of the multidisciplinary team, continually learning and developing to improve the quality and safety of care provided to patients and that they respond to patient feedback continually endeavoring to improve patient experience. Please see attached job description which is a true reflection of the role See attachment located in Section 21 2 of 2022, 9-Executive Director of Nursing I remain in this role at present.

[6] Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for. It would be helpful for the Inquiry to understand how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Associate/Medical Director(s) and the Head of Urology.

87. I offer the following in answer to this question:

a. In all my Grade D and Grade E staff nurse roles I reported to the ward sister of the ward in which I worked. As a grade D staff nurse I had a supervisory role for the nursing assistants who worked on the ward.

b. In my Grade E senior staff nurse role I had a supervisory role for both grade D staff nurses and the Nursing assistants who worked on the ward.

c. In all my ward staff nurse roles, there was no role of relevance to the operation and governance of Urology services nor anything relevant to the role of the Associate Medical Director or the Head of Urology , the latter being a post that did not exist during this period.

d. As a Night Nursing Sister (2002-2005), I reported to the Patient Services Manager in Craigavon Area Hospital. As a Night Sister, I had supervisory responsibility for all staff who worked in the hospital in the Out of Hours period while on duty only, with the exception of medical staff. The management of all staff in the hospital was undertaken by their ward manager or team manager over the 24/7 period. I would have reported any issues to the ward / team manager the next day to be managed at ward level. In these posts, there was no responsibility relevant to the operation and governance of the Urology service other than to place patients who required Urology treatment and care in the Urology ward from ED, to find appropriate beds for Urology elective admissions, and (as

Night Sister) to oversee the safe provision of nursing care in the Urology ward, as one of many wards in the hospital. There was no responsibility of direct relevance to the role of the AMD or Head of Urology Service.

e. As Patient Services Manager (2005-2007) I reported to the Assistant Director for Nursing, Mrs Anne McVey. I had line management responsibility for the team of Night Sisters, Discharge Liaison Nurses, and a small team of Phlebotomists. In this role I had no responsibilities of direct relevance to the Urology Service or the AMD or Head of Urology service roles other than to ensure that my staff fulfilled their responsibilities to patients requiring admission for Urology treatment in finding a bed, supervising the nursing / patient care provision at ward level in the Out of Hours period, undertaking phlebotomy for urology patients, and ensuring that Urology patients had access to an effective discharge plan when ready for home. The services that my team provided applied equally to Urology patients as to all others in the hospital.

f. Following the formation of the Southern Health and Social Care Trust, which amalgamated a number of hospital and community organizations, my Patient Services Manager role transferred into Head of Patient Flow (2007-2008) which recognized the new terminology of 'Head of Service' and brought in the remit of Daisyhill Hospital. In that role I reported to the Assistant Director of Medicine and Unscheduled Care, Mr Lindsey Stead. My line management responsibilities remained the same as noted under Patient Services Manager role with the addition of the same designated staff in Daisyhill Hospital. Again, there were no responsibilities of direct relevance to the Urology Service or to the AMD or Head of Urology roles at that time, other than the linkages detailed above.

g. My next role, which was a temporary secondment by the then Director of Acute Services, was an independent Project Manager role for a service improvement initiative (Dec 2008 – Oct 2009). My line manager in this role was the Director of Acute Services, Mrs Joy Youart. The only line management responsibility I had in that role was for a management student that joined the Trust at that time for a placement as part of her

educational postgraduate course. Her name was Amy Hunter (now Amy Nelson). This post had relevance to the Urology Service in that Urology was part of the surgical bed reconfiguration. While I had no managerial responsibility for the Urology service, as project manager I liaised with the Assistant Director of Surgery and Elective Care (Mr Simon Gibson), the Associate Medical Director (Mr Eamon Mackle), the Urology Consultants, the Urology Clinical Services Manager (Ms Noeleen O'Donnell), and Urology Ward Sister as to the project plan and how it would affect the delivery of Urology services at ward level. As an outcome of the project, the Urology ward that was based in Ward 2 South was relocated initially to Ward 4 North and then Ward 3 South where it continued to provide inpatient Urology treatment and care for emergency admissions and patients post operatively. There was no overlap with the work of the AMD in this role but he provided clinical direction across the reconfiguration of all surgical services including Urology.

h. Following 10 months in this role, the then Director of Acute Services, reconfigured the role of 2 posts. Mr Simon Gibson took up the 'Best Care Best Value' post for Acute Services and I took up, on a temporary basis, the post of Assistant Director of Surgery and Elective Care in October 2009. Following interview, the temporary post was made permanent and I remained in that post until March 2016.

i. On taking up post on a temporary basis I reported to the Director of Acute Services, Mrs Joy Youart. Mrs Youart left the Trust in December 2009 and was replaced by a new Director of Acute Services, Dr Gillian Rankin, who remained in this post until her retirement in March 2013. Dr Rankin was replaced as Director of Acute Services in April 2013 by Mrs Debbie Burns, who remained in this post until, I believe, May 2015 when she left the Trust. She was replaced in this role by Mrs Esther Gishkori in June 2015, who remained in this role for the remainder of my tenure in this post. All these Directors of Acute Services as listed were my line managers in this post.

j. In this role I was responsible for a number of services and staff. With regard to services I was responsible for the operational management of General Surgery, Breast Surgery, Upper and Lower Gastro surgery, Endoscopy, Ear Nose and Throat surgery, Urology, Trauma and Orthopedics, Oral Surgery, Ophthalmology, all Trust Outpatient services, and 7 inpatient wards and HDU in Daisyhill hospital. I was supported by three Heads of Service, Mrs Martina Corrigan (Head of Urology, ENT, Ophthalmology and Outpatients), Mrs Trudy Reid (Head of General Surgery which incorporated Breast, Upper and Lower GI, Endoscopy and Oral Surgery) and Mrs Louise Devlin (Head of Trauma and Orthopedics).

k. The wards were allocated across the Heads of Service according to the primary specialty work performed. Underneath the management of the three Heads of Service were a number of lead nurses, ward sisters / charge nurses, department managers, specialist nurses and administrative staff. The Heads of Service were responsible for working with medical staff to ensure the effective provision of their services.

l. In this role I had Assistant Director responsibility for the Urology Service. I was responsible for overseeing the outpatient and elective waiting lists both for new and review patients, monitoring demand and capacity, reporting to my Director as to the waiting times for patient access, linking with our Performance and Planning directorate to report to the Health and Social Care Board re waiting times and numbers of patients waiting access to service, and seeking additional funding to meet the needs of the service. I also oversaw the inpatient nursing care for urology patients, ensuring the professional standard of nursing care was high. I received escalations from my Head of Urology regarding significant adverse incidents, reviewed same for potential serious adverse incidents as per the designated screening criteria, and reviewed and approved complaint responses pertinent to the urology service. I worked closely with all my Heads of Service, including the Head of Urology, to support service provision and ensure safe and effective care.

m. While I worked quite closely with the Associate Medical Director for Surgery and Elective Care, inclusive of Urology, our roles were distinct. I was responsible for overseeing ward management, nursing care, administrative support outwith that provided to the consultants, the monitoring of waiting lists, and generally the operational management of the service. The Associate Medical Director was responsible, in collaboration with his Clinical Director and Clinical Lead Consultant, for consultant job planning, medical recruitment, appraisal and revalidation, clinical advice on medical professional issues, and the clinical oversight of consultants and medical staff. Please see attached the Job Descriptions for the AMD, CD and Clinical Lead roles. *See attachments located in Section 21 2 of 2022 associate medical director jd, General Surgery CD JD – Mr Brown and Job Plan for MY incl Clinical Lead*. The AMD reported to the Medical Director and worked closely with the Director of Acute Services with regard to medical management. There was some overlap in reviewing adverse incidents and complaints together, working together to continually improve services to patients, and working to address operational issues as they arose during the normal course of managing a range of clinical services.

n. With regard to the role of the Head of Urology and ENT see Attachment in Section 21 2 of 2022 Head of Urology and ENT Job description, there was overlap to the extent that we were both responsible for the provision of Urology services in the Trust. However, the Head of Urology would have had a much closer day to day contact with the Urology staff, medical and nursing, being actively involved with the provision of that service. My role was to support and address areas of escalation.

o. With regard to the role of Assistant Director Integrated Maternity and Women's Health (IMWH) and Cancer and Clinical Services (C&CS) (2016-2018), there were no IMWH responsibilities of relevance to the Urology Service. There were similarly no responsibilities of relevance in the work of C&CS to the Urology service other than the provision of laboratory,

radiology, AHP services, and Cancer services to this specialty as to all other specialties.

p. With regard to my role of Executive Director Nursing, Midwifery and AHPs (2018 onwards), here were no responsibilities of direct relevance to the Urology Service other than being accountable to the Chief Executive for the professional practice of all nurses and AHPs who worked in the Urology Service as with all other services. Also, I am a member of Trust Board in this capacity.

[7] It would also be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day basis. It may be helpful for you to explain the level of your involvement in percentage terms, over periods of time, if that assists.

88. As Assistant Director for Surgery and Elective Care from October 2009 to March 2016, I was responsible for the overall delivery of Urology Services in terms of service delivery as well as a number of other surgical specialties and services. It is with regard to this role that I will answer this question.

89. As with all specialties, the main issues I was involved in were as follows:-

a. Line management of the Head of Urology, Mrs Martina Corrigan.

b. Monitoring of access times for a new or review outpatient appointment, day case, inpatient surgery, cancer 31 and 62 day pathway adherence, and working with all members of the multidisciplinary team to meet regional standards.

c. Overall monitoring of the quality of nursing care on the Urology ward and outpatient clinics.

d. Screening of serious adverse incidents re meeting the criteria for a Serious Adverse Incident Review and, if such a review was required, ensuring that a review panel was set up through the Acute Governance team.

e. Overseeing patient complaint responses and ensuring that patient concerns were both addressed in a manner that answered patient needs and ensured that learning was identified from such complaints.

f. Responding to any concerns identified by the Quality and Patient Support Officer regarding quality of information / care issues at ward level. For clarification, this post was held by 2 experienced nurses who were present on the hospital site and acted as a support to patients and their families with regard to any concerns they had with a view to linking with the appropriate clinical team to resolve these concerns at the point of need.

g. Overseeing the financial management of the Surgery and Elective Care Division including invoice approval and balancing of budget.

h. Human Resources recruitment/ disciplinary / support / management of change processes.

i. Communication across 2 Acute hospitals via email, phone, meetings and in person visits.

j. Completion of investment proposals for new / changing services.

k. Work with the number of specialty Clinical Directors and the Associate Medical Director to approve job plans, consultant recruitment, implement clinical models, improve services etc.

l. Work with Heads of Service, Lead Nurses, and Medical Leads to ensure that patient lengths of stay were appropriate for safe and effective patient care.

m. Oversee the Infection prevention and control practices in all inpatient wards and outpatient facilities.

n. Generally, as a member of Acute Services Senior Management Team, attend all Directorate meetings, and be equally responsible for the management of

good patient flow throughout the hospital, undertaking the role of Assistant Director of the Week to ensure good Emergency Department flow.

o. Undertaking out of hours on call service at assistant Director level.

90. I undertook the above summary of daily activities for the total remit of surgical specialties and services that were part of the Surgical Division. It would be difficult to designate the percentage of time spent specifically on Urology. As an estimate, I would say that it occupied less than 10% of my time, considering that my role also involved the management of General Surgery (upper and lower GI surgery), ENT, Trauma and Orthopaedics, Breast Surgery, Oral Surgery , Ophthalmology , all Trust Outpatients , 7 wards , a HDU and be a member of Acute Service Senior Management Team with general responsibilities relating to that role and specifically my role in ensuring good patient flow throughout the hospital to ensure a fully functioning ED could be maintained.

2009-2010 Urology Services

[8] The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust- to treat those from the Southern catchment area and the lower third of the western area. Set out your involvement in the establishment of the urology unit in the Southern Trust area.

91. On taking up post as Assistant Director for Surgery and Elective Care in October 2009, I became responsible as part of the whole Urology team in managing the implementation of the 'Team South' model in the Southern Trust. As this was a major Trust investment and a regional shift creating a three team model for all of Northern Ireland, the Director of Acute Services and the Director of Performance

and Reform were also heavily involved in overseeing the development of the regional model and the implementation of the Team South service. They were members of the Regional Implementation Group. While the model was presented to the Department of Health in March 2009, it was not approved by the Minister of Health for implementation until 31st March 2010. Please see attached letter dated April 2010. See attachment located in Section 21 2 of 2022, HM700 – LTR to Trust Dir Acute re Urology Review

92. Please note that letter sked Trusts to start to develop their team model, their capacity requirements, and develop and submit a business case to the commissioner for the required investment. However, as outlined in the April 2010 letter, the budget for the regional model was already decided, as was how it was to be divided across each of the Trusts, before Trust models were developed. The letter also set out the activity to be delivered and the number of additional posts to be funded in each Team. It is notable that the investment as per recommendation number 21 was designed to deliver the level of activity from 2008/9. There was no consideration of population growth, nor population demographics, which would have affected service demand year of year.

93. The development of the model was managed by the Health and Social Care Board as it straddled three Trusts which served the whole of the population. There was a Regional Implementation Group set up and chaired by the HSCB with both clinical and managerial leads from across all Trusts and the HSCB.

94. The representatives on the group from the Southern Trust were Dr Gillian Rankin (Director of Acute Services), Mrs Paula Clarke (Director of Performance and Reform), Dr John Simpson (Trust Medical Director), Dr Stephen Hall (now deceased) (AMD Cancer and Clinical Services), and Mr Michael Young (Lead Consultant Urologist). I would have attended on occasion to deputize for Dr Gillian Rankin. Please see attached 2 sets of minutes of this regional meeting as have been available to me. See attachments located in *Section 21 2 of 2022 20101130 Uro review implementation Board and 20110624 Uro review implementation meeting notes*. These were HSCB meetings and all meeting minutes would be available from the HSCB

95. Within the Trust, there was an Acute Services Division Urology Implementation Group, which comprised representatives from Urology, radiology, theatres, Functional support services, outpatients, administration and planning. I was the Chair of that local implementation group. Please see an example set of notes from one of these meetings see attachment located in Section 21 2 of 2022 20110906 Urology Implementation group.

96. Please also see attached the following:

    a. Membership of the Team South Implementation Urology Steering Group and the Project team see attachment located in Section 21 No.2 of 2022, Team Membership

    b. Team South Implementation Plan dated 14/6/2010 See attachment located in Section 21 No.2 of 2022, Team South Implementation Plan v0 1

    c. Team South Implementation Plan revised version dated 9/11/2010. See attachment Team south Implementation Plan V 0.3 This located in Section 21 No.2 of 2022

97. As part of the Regional Urology Review there was a set of 26 recommendations, which each Team was required to implement. These are noted in the correspondence referred to above dated 10th April 2010 and are located in Section 21 No.2 of 2022, 8 HM700 - ltr to Trust Dir Acute re Uology Review Implementation. Please also see a copy of the Team South Urology Review summary of recommendations dated 21/8/2013, which shows the progress of implementation of each recommendation see attachment located in Section 21 No 2 of 2022, 201308 Urology Review Recommendations Progress.

98. In conjunction with the Director of Acute Services, the clinical team, the wider teams of relevant services, the Head of Service for Urology and ENT, and members of the Planning team within the Trust, I was required to work to meet each of the recommendations, to develop the Investment Proposal template for submission to the commissioner, and to manage all areas to successfully implement Team South. As my post was also responsible for many other services outlined earlier in this statement which also required development, a

large proportion of the day to day progress with the implementation of this model was taken forward by the clinical and managerial personnel within the Urology Unit.

[9] What performance indicators were used within the urology unit at its inception?

99. The performance measures designated and used are noted in the Letter dated 10th April 2010 located in Section 21 2 of 2022, 8 HM700 - ltr to Trust Dir Acute re Uology Review Implementation as part of my answer to Question 8 and are part of the 26 regional recommendations, numbers 12 to 17. I set these out below:

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre

facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. *Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.*

17. *Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.*

100. Other operational performance indicators which were relevant to Urology as with all other services were as follows:-

a. Outpatient access standards;

b. Day case and inpatient access standards;

c. 31 and 62 day cancer pathway standards.

[10] The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog. What is your knowledge of and what was your involvement with this plan? How was it implemented, reviewed and its effectiveness assessed? Did the plan achieve its aims?

101. On taking up post as Assistant Director in September 2009 I was informed regarding the substantial backlog of patients awaiting review at consultant led clinics, this backlog had been identified to the commissioner and required to be addressed.

102. Addressing the review backlog was a key focus for the team who recognized the patient safety and care concerns relating to this backlog.

103. While the action plan to address the backlog was developed by the clinical and managerial Urology team, I approved the actions planned on clinical advice.

104. The plan was implemented by the clinical team, administration teams, Operational Support Lead and the Head of Urology and ENT working both together and with other teams within the Directorate and including GP colleagues.

105. Please see attached Review backlog plan June 2010 as part of the first Team South Implementation plan. *See attachment All appendices – app 2 . This is located in Section 21 2 of 2022*

106. The plan was reviewed regularly with updates and progress noted. Please see attached update dated 6/5/2011 as an example of progress. See attachment Review action plan update. . This is located in S21 No.2 of 2022

107. I believe that I should emphasise at this point that the issue of the review backlog was one of the major issues and concerns I identified and tried to address during my time as Assistant Director for this service. I believe it is important to note that, due to many factors, there were review backlogs in almost all medical and surgical services in the Trust at that time and that, while the Urology review backlog was very concerning, it was not unusual. There were many contributing factors which I have identified in my answer to question 31 part 3 below and, in essence, the overall capacity of Urology services was not sufficient to meet all areas of patient need. Red flag referral demand, new patient demand and treatments often took required priority in a service with staffing pressures.

108. On the related issues of the effectiveness and success (or otherwise) of the plan, I would refer the Inquiry to refer you to my answers to paragraphs h to i (inclusive) of question 31 in this statement for my detailed views in respect of these issues.

109. I would also refer, in respect of this question (10), to the summary of review backlog data over a number of years as attached.

In summary , while the actions put in place kept a focus on reducing the review backlog and managing same , due to the contributing factors outlined in Q31 section 3 .*See attachments located in Section 21 2 of 2022, 20110504 Urology Review Backlog, 20220216 Urology Review Backlog and , Outpatient waiting list.*

[11] How, if at all, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Please provide any documents referred to.

110. The Acute Services Risk Register noted two aspects of risk relevant to the implementation plan:-

a. Urology Access waiting times

b. Insufficient capacity and resources to manage patients waiting for a review appointment in Acute Services. This was relevant to all surgical and medical services and included Urology.

Please see examples of risk registers located in *Section 21 2 of 2022, 20091209 Corporate Risk register and 20100621 Corporate Risk Register. Years 2011 – 2016 Attachments 20111206 CRR, 20121204 CRR, 20131203 CRR, 20141209 CRR, 20151208 CRR, 20161208 CRR.*

111. There are two sets of Trust Board Confidential meeting minutes, which reference the Urology Team South plan with reference to one recommendation relating to pelvic surgery being transferred to Belfast. *See attachments located in Section 21 2 of 2022, 201009 Trust Board Confidential Briefing Note and 201011 Trust Board Confidential Briefing Note.*

2010-2018

Staffing of the Unit

[12] Explain the original plan for the unit, to include details of staffing required to properly deliver all aspects of the service. How did this plan differ from what had previously been provided?

112. Please see the Investment Proposal Template attached for full details of the service to be delivered, *located in Section 21 2 of 2022, 12 Urology Revenue IPT Feb 2012*

113. Essentially, the original plan for Team South Urology Service was a number of additional staff to increase the size of the Urology Unit to enable it to manage both all Southern Trust patient demand and the Urology demand from the Southern half of the Western Trust.

114. The Urology Team prior to the investment and the creation of Team South was as follows:-

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts reverted to a Trust Grade Doctor from August 2010),
- 2 Trust Grade Doctors (but 1 post was vacant at that time)

- 1 GP with Special Interest (7 sessions per week),
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week),
- 2 Urology Specialist Nurses (Band 7).

115. To summarize, the additional Team South staff were to be:

- 2 additional consultant Urologists,
- 1 additional Consultant Anesthetist,
- 0.6 whole time equivalent radiologist,
- 0.1 whole time equivalent pathologist,
- 1.7 whole time equivalent specialist nurses,
- A number of other support staff.

[13] How were staffing needs for the unit identified? Was staffing for the unit optimal from the outset?

116. The staffing needs for the larger unit were identified / calculated as follows:-

a. Calculate patient referral demand from both Southern Trust and southern third of the Western Trust.

b. Through best practice guidelines from the British Association of Urology Surgeons (BAUS), define expected number of patients that can be seen at a new patient clinic and a review patient clinic. This number was designated by the HSCB for delivery.

c. The new to review ratio is taken as that recommended by the BAUS. The combination of these calculations determines the number of outpatient new and review clinics that are required to meet the overall outpatient demand. Recommended job planning templates as approved by the Urological Specialty advisor sets the number of outpatient clinics, new and review that a Urologist would be expected to do each week and that is calculated over 42 weeks (this allows for annual leave and study leave). To meet the overall demand, the next calculation is the number of Urology consultants that are required to totally deliver the number of outpatient clinics required to meet demand.

d. The same process is gone through, using BAUS guidelines for day case rates, numbers per list, numbers expected on inpatient surgical lists, expected numbers on diagnostic lists, etc. until the totality of demand is calculated and converted into the number of consultant / junior medical staff / nursing sessions which then is converted into the number of additional staff required.

e. This process included, anesthetist sessions, radiologist sessions, pathology sessions, etc., all converted into staff whole time equivalents or part thereof.

f. This is attached for further detail.

117. While the calculations were accurate according to BAUS guidelines, a whole patient service is more than a collection of mathematical calculations. We see people, electively and through an unscheduled hospital admission. The calculations also assume that every clinician works at the same speed whereas, in fact, clinicians are individuals and, as in every walk of life, they will work at different speeds. There are also many factors that can affect productivity: travel time to clinics, complexity in theatre cases, lack of bed availability for elective cases in times of increased unscheduled care demand, patient Can Not Attend and Did not Attend rates, junior doctor support as provided by the Northern Ireland Medical and Dental training agency, staff sick leave, and much more .

118. So with regard to whether the staffing levels funded by the HSCB were optimal from the beginning, my view would be that, on paper and as calculated,

they should have met demand. Practically, and taking into account human factors and the wider challenges with staffing and capacity within the health service, they were not optimal. My experience of the Health and Social Care Board is that they primarily worked within a funding envelope and Trusts were asked to accept what was available from a funding perspective and make the service fit. This was often challenging.

119. The other issue relevant was that the calculations were based on the demand for the service as it was in 2008/9. The commissioning letter was sent in April 2010, the Minister for Health endorsed the new model in March 2010, and the full service was not implemented until 2013. With a known 10% growth in service demand year on year, by the time the model was able to be implemented the demand outweighed the new agreed capacity.

[14] Are you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom. How have staffing challenges within the unit been responded to?

120. I am aware that there were ongoing staffing problems, primarily regarding medical staff and from the outset of the agreement to implement the new Team South structure. As noted in the June 2010 Team South Implementation Plan, page 4, there was at that time 1 Trust Grade Vacancy. *See attachment located in Section 21 2 of 2022, Team South Implementation plan V0 1.*

121. As per the IPT attached, the time line for implementation of the new model was as follows:- *located in Section 21 2 of 2022, 12 Urology Revenue IPT Feb 2012*

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 11
Completion of Job Plans/Descriptions for Consultant Posts	End December 11
Consultant Job Plans to Specialty Advisor	January 2012
Advertisement of Consultant Posts	End February 12
New Consultants in post	August 2012

122. I would have been made aware of staffing difficulties from the Head of Urology and ENT verbally as described in Question 31, section 1, and as an when they arose.

123. Please see the below record from Medical Human Resources of the staffing levels at consultant level and middle grade level from November 2009 to March 2016. *See attachment located in Section 21 2 0f 2022, Medical Staffing Urology 2009 - 2016*

124. As for responding to staffing challenges, there were a number of advertisements for medical staff at the required level. Advertisements would have been both locally and nationally, using all possible recognised methods.

125. Consultant staff would also have used their formal and informal networks to link with potential staff who may have been interested in a post. This was particularly useful for local trainees who may have gone abroad for further study.

126. The team also offered the opportunity of Clinical Fellow posts. These posts are attractive in that there is time allowed in the job plan for research and study with some direct patient care sessions.

127. There was also work with Medical Agencies through the Medical HR Department to see appropriately trained and experienced Locum Medical staff at all grades interested in taking up a locum post. All potential locum CVs were screened by the AMD for the Service.

128. Where possible, the Unit reviewed the potential for senior specialist nursing staff to develop the competency and confidence to take on roles that traditionally would have been undertaken by medical staff, i.e., Cystoscopy and Trus Biopsy.

129. While not part of the Urology team, a wider service team is essential for the management of patient care. At that time there was only one radiologist that had a specialist interest and expertise in Urology. The Trust was also dependent on the services of an Oncologist from the Belfast Trust to attend cancer MDT on a regular basis to discuss patient treatment plans. The effect of this small supporting resource to the urology cancer pathway had an effect on the effectiveness of the Urology MDT in that I am advised that there were many occasions when either or both of these experts were not available. It is my understanding that there was also a dearth of both radiologists and oncologists regionally and, despite all efforts, additional staff could not be secured.

[15] Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and explain how

this impacted on the unit and how these vacancies were managed and remedied.

130. With regard to the number of medical staff vacancies during that time, please see attached table *located in Section 21 2 0f 2022, Medical Staffing Urology 2009 – 2016* showing the start and end dates of consultant staff over this period. However in essence, there were varying vacancies in the 5 consultant model until August 2015, at which point the consultant workforce stabilized.

131. My views on the impact on the Unit of medical vacancies is noted in my response to Question 16 below.

132. How the vacancies were managed and remedied has already been noted in my response to Question 14 above.

[16] In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

133. All services in Health and Social Care are completely reliant on the availability of clinical staff to assess, diagnose, and treat patients appropriately. This is supported by a raft of disciplines to support the provision of the entire service.

134. With regard to patient access times for outpatient new and review appointments, day case procedures, diagnostic procedures, inpatient surgical procedures, and inpatient management, the requisite number of medical staff are essential.

135. Primarily consultant Urologists but also other senior medical staff (Registrars, staff grades, and Trust Grade doctors) are responsible for patient

consultation, diagnosis, and treatment. The effect of gaps in medical staffing in the unit primarily resulted in the following:-

a. Longer waits for a new outpatient appointment;

b. Longer waits for a review appointment;

c. Longer waits for a urology diagnostic procedure;

d. Longer waits for a required day case procedure;

e. Longer waits for an inpatient surgical procedure;

f. Less than optimum availability of medical staff to see inpatients for ongoing treatment and care;

g. Medical rotas and on call rotas that may struggle to meet European Working Time Directive standards;

h. When there are gaps in medical staffing, and medical rotas are small in number, this is not conducive to attracting new medical staff. It is acknowledged that medical staff, both consultants and more junior staff, are more attracted to larger teams where the rota cover can be provided over a larger number of staff. Therefore, having a small team in itself is challenging to grow.

i. Having a small consultant team, often with vacancies, put additional pressure on present consultants and the whole team to provide the patient access that met the standard set by the HSCB.

j. Having a limited consultant capacity, with or without vacancies, to meet patient demand, with a lack of Urology Consultants available to recruit as was the case, creates a Trust dependency to retain employed consultants to meet patient access needs.

k. Less capacity within the team for managerial duties and service improvement.

136. With regard to the impact on the governance of Urology service, capacity to undertake the following was limited –

a. Clinical Audit,

b. Research,

c. Patient satisfaction surveys.

137. The team was at full stretch to meet patient access and management needs. This included the whole team, medical, nursing, administrative and management, and while management of adverse incidents, complaints, direct patient feedback, and access standards were managed appropriately, the above aspects of clinical governance could have been stronger with appropriate staffing levels.

[17] Have staffing posts, roles, duties and responsibilities changed throughout the existence of the unit? If so, how and why?

138. As part of the implementation of the Team South Model over the course of 2010 – 2013, the Urology team expanded by 2 consultant surgeons, 2 nurse specialists, and a number of other multidisciplinary team members required to service the various aspects of the Urology service.

139. The roles, duties, and responsibilities of the majority of the multi-disciplinary team did not change other than as part of the increased funded model of 5 consultant urologists, job plans were adjusted accordingly.

140. Again as part of the modernisation of the service, a Consultant of the week model was implemented to manage the unscheduled work load more effectively.

141. While the core roles of the Urologists did not change, the larger team of 5 Urologists from 2014 allowed a level of specialisation to emerge. Mr Young

and Mr O'Donohue had a specialist interest in the management of Kidney stones, while Mr Haynes and Mr Glackin had a specialist interest in Cancer. Mr O'Brien remained undertaking his normal role.

142. With regard to the duties of the specialist nurses, these roles changed as they developed their capabilities.

143. Over the course of 2014, following the expansion of the Consultant team, the two experienced specialist nurses were trained, mentored, and approved to undertake two key diagnostic Urology tests that previously would have been undertaken by a medic.

a. In 2014 – 2015 Nurse Jenny McMahon undertook Cystoscopy , a scope to review the bladder.

b. In 2015-2016 Nurse Kate O'Neill undertook the procedure of Trus Biopsy.

144. Both these tests were carried out in the Thorndale Outpatients department as part of the one day assessment clinic.

[18] Explain how the unit was to be supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Furthermore, was there an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants?

145. The Urology Unit was supported by a number of non-medical professions across the raft of teams that supported the Urology Unit. I will explain taking each profession in turn.

146. The Urology Unit was constructed across a number of departments, supported by Directorate systems and processes and was made up of all members of the multi-disciplinary team.

147. The Unit was supported by nursing and nursing assistant staff in outpatient departments, the Thorndale Urology Outpatients Unit, the elective and inpatient wards, day case and inpatient theatres, the lithotripsy suite, and through the pre-operative assessment service. The district nursing service would have supported urology patients post discharge if required.

148. The Urology Unit was supported by Allied Health professional staff at ward level to support patients with physiotherapy, occupational therapy, dietetics, and speech and language therapy when required.

149. The Urology Unit was supported by social work staff at ward level to undertake assessment of needs primarily in planning for hospital discharge where home support was required.

150. The Urology Unit was supported by a significant number of administration staff, both particular to the Urology Unit and through wider Directorate administration teams who provided admin services to all clinical specialties including Urology.

a. Each consultant Urologist had 1 whole time equivalent secretary. *See attached located in Section 21 2 of 2022, Personal Secretary B4 JD.*

b. It is important to note at this stage that the HSCB only funded 0.5 whole time equivalent secretary for each Consultant. However, each of the Urology consultants, certainly at this time (2010-2018), had one whole time equivalent secretary. A particular secretary was allocated to a particular consultant. The secretary was also supported by an audio typist and I am given to understand that there were a collective group of audio typists.

151. The Directorate operated a centralised booking centre for all GP referrals into the Trust. This comprised of a number of booking centre

administration operatives, who received referrals into the centre, registered the referral on the hospital patient administration system, sent to the relevant consultant for further triage, and ensured that patients were sent an outpatient appointment as appropriate. *See attachment located in Section 21 2 of 2022, Booking Centre Clerk B3 JD*

152. Up until 27th March 2017 this was a paper based referral / triage system in Urology but moved to an electronic system at that point. The Urology unit was supported fully by the functions of this team.

153. The specialist Urology nurses also had admin support to their roles.

154. The Cancer team supported the Urology Unit in the management of Red Flag referrals into the service. They logged these referrals, supported consultant triage of these referrals, and arranged appointments at outpatients for those referred patients. They also tracked the investigative journey of these patients until either a diagnosis of cancer was confirmed and the patient received their first treatment or until a diagnosis of cancer was ruled out. *See Attachment located in Section 21 2 of 2022, Cancer Tracker B3 JD.*

155. The Urology Unit was also supported by two senior administrative posts that supported all specialties in the Surgical and Elective Care Directorate including Urology. They were a Service Administrator (Mrs Jane Scott) and an Operational Support Lead (Mrs Sharon Glenny) who monitored patient access times and worked with the consultant team regarding chronological management of routine and urgent patients both from an outpatients perspective but also from a day case and inpatient surgery perspective. *See attachments located in Section 21 2 of 2022, Directorate Administrator B5 and Operational Support Lead B7.*

156. With regard to inpatient ward activity, the Urology Unit was supported by a ward clerk who maintained inpatient notes, filed blood results and other investigations, and ensured that records where maintained appropriately. *See attachment located in Section 21 2 of 2022, Health Records Ward Clerk B3 JD.* The Urology Unit was also supported by the Health records department who filed and retrieved patient notes for outpatient clinics, surgical procedures

and ward admissions. *See attachment located in Section 21 2 of 2022, Health Records Clerk B2 JD*

[19] Who was in overall charge of the day to day running of the unit? To whom did that person answer, if not you?

157. The Urology Unit comprised of a number of departments, each of which managed the day to day running of their area. I will take each in turn.

a. There was the Consultant body, responsible for the management of all medical staff within the Unit, referral triage, outpatient clinics, referral for investigations, undertaking clinical procedures both investigative and therapeutic, surgical procedures both electively and following an unscheduled admission to hospital, patient review, cancer diagnosis and management, and overall clinical management of every patient. The urology consultants from 2009 to January 2012 were Mr Michael Young, Clinical Lead, Mr Aidan O'Brien, and Mr Akhtar. Mr Akhtar left the Trust in January 2012. Mr Tony Glackin joined the Trust as a consultant in August 2012, Mr Haynes joined the Trust in May 2014, and Mr O'Donohue joined the Trust in August 2014.

b. There was the Thorndale Unit, which was a Urology outpatient and investigative unit, consultant-led but staffed by doctors and Urology specialist nurses. The specialist Nurses were Jenny McMahon and Kate O'Neill who would have overseen the running of this department. *Please see attachments for clarity, located in Section 21 2 of 2022, McMahon Jennifer Eliz – JD and O'Neill Kathleen - JD.*

c. Other outpatient clinics also occurred in a variety of settings across the Trust to enable easier patient access as part of the wider Trust Outpatient service. The Outpatients managers at that time were Judith Mulligan, Caroline Moorcroft, and

Cathy Rocks for the Craigavon clinics and Jacinta McAlinden who managed the clinics at Armagh and South Tyrone hospitals. *Please see Job description located in Section 21 2 of 2022, Outpatient service manager JD.*

d. There was the inpatient bed ward which received patients from the Emergency Department and from theatre post operatively following elective admission. The ward was managed by the ward sister and comprised of a multidisciplinary team of nurses, doctors, allied health professionals, pharmacists, and social workers. There were a number of ward managers of the Urology inpatient ward. They were Sr Shirley Telford, Sharon Kennedy, Cathy Hunter and Patrick Sheridan. The ward manager role was to ensure safe and effective nursing care for all inpatients and to ensure the ward was run effectively. *See attachment located in Section 21 2 of 2022, Band 7 Ward Sister Charge Nurse JD.*

e. In 2013/14 all the administrative staff in Acute Services in the Divisions of Medicine and Unscheduled care and Surgery and Elective Care were collectively managed by the Functional Support Division. The Assistant Director of that Division was Mrs Anita Carroll. She was supported by Mrs Katherine Robinson, Head of the Booking Centre and Secretaries and Mrs Helen Forde, Head of Health Records. *See attachments located in Section 21 2 of 2022, Head of Health Records JD, AD of Functional Support, Booking Centre Manager Band 6.* These staff managed the day to day function of booking patients, consultant secretary staff and admin processes and the provision of medical records for all specialties including Urology.

f. Prior to that time the administration team in Surgery and Elective Care, including Urology was managed on a day to day basis by the Operational Support lead, Mrs Sharon Glenny who was also responsible for monitoring patient access times both from a new outpatient, review outpatient, investigative, day case, and inpatient surgical waiting list perspective. *See attachment located in Section 21 2 of 2022, Operational Support Lead B7.*

g. All operational function of all of these teams was overseen by the Head of Urology and ENT, Mrs Martina Corrigan, however each team lead managed the day to day function of their part of the service. *See attachment located in Section 21 No.2 of 2022, Head of Urology and ENT Job Description*

h. The Lead Clinician, Mr Michael Young, managed the medical team on a day to day basis. *See attachment located in Section 21 No.2 of 2022, Job Plan for MY incl Clinical Lead.*

i. The Operational Support lead was managed directly by the Head of Urology as was the lead nurse, Mrs Dorothy Sharp, for the urology ward. *See attachment located in Section 21 No.2 of 2022, Lead Nurse B8A JD.*

j. The Head of Service (Mrs Corrigan) reported to myself, the Assistant Director for Surgery and Elective Care, and I reported to the Director of Acute Services. *See attachment located in Section 21 No.2 of 2022, Head of Urology and ENT Job Description.*

k. The lead Clinician for Urology Services reported to the Clinical Director for Surgery and Elective Care, who reported to the Associate Medical Director for surgery and elective care who in turn reported to the Trust Medical Director. *See attachment located in Section 21 No.2 of 2022, Medical Director – JD.*

Engagement with Unit Staff

[20] Describe how you engaged with all staff within the unit. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

158. My direct interaction with staff in the Unit was limited.

159. My primary interface regarding the Urology service was with the Head of Urology and ENT, Mrs Martina Corrigan, and the Associate Medical Director, Mr Eamon Mackle. This was primarily due to the scope of my whole

role as Assistant Director for Surgery and Elective Care. I met with Mrs Corrigan regularly to discuss a range of issues pertinent to the delivery of Urology, ENT, Outpatients and ward services.

160. I would have visited the Urology ward, linking with the ward sister and nursing staff around any issues of concern. I would have visited the Thorndale Unit, a Urology outpatients unit again to link with staff and ask re any issues of concern primarily around nurse staffing levels, nursing quality indicator levels, patient lengths of stay etc.

161. The primary interface with the Urology Consultants would have been informally as they were working with the Head of Urology and ENT or if asked by the Head of Urology to support her in a performance / scheduling meeting which she held on a weekly basis. Any conversations with the Urologists would have been general conversation re how they were etc. or if at the scheduling meeting would have been regarding actions required to meet waiting times.

162. For a period of time during the implementation of the Team South model, the Director of Acute Services, Dr Gillian Rankin held a regular meeting at 5pm each Monday evening which lasted typically 1.5 hours with the Urology consultant team , the Head of Urology and ENT , Mrs Martina Corrigan, The director of Performance and Reform Mrs Paula Clarke and the AMD , Mr Eamon Mackle to discuss the implementation of the Team South model . I also attended those meetings. At those meetings we discussed the progress with implementation of the recommendations from the regional review and modernization of Urology practice.

163. I also held a number of Urologist / GP interface meetings during that period to review and discuss patient review pathways. I cannot source meeting notes of these meetings

164. Where I have taken a note of any of these interactions I have submitted notebook entries in general discovery *located in Relevant to PIT, Evidence*

after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton – Document 16.06.2009 notebook1, Document 2009 4,Document 2015 Esther , Document 21.09.2009 2 , Document 8th Feb 2016, Document Feb 2010 notebook , Document July 2011 notebook , Document July notebook 1 of 2 , Document July 2011 2of2, Document March 2016 notebook , Document May 2011 notebook page 1 of 3 , Document May 2011 page 2 of 3 , Document May 2011 Page 3 of 3 , Document October 2015 , Document Sept 2009 Notebook and Document june 2011 page 2 of 2 notebook located in Section 21 2 of 2022.

Governance – generally

[21] What was your role regarding the consultants and clinicians in the unit, including on matters of clinical governance?

165. My role was the delivery of high quality care to patients in the Trust's Surgery and Elective Care division. *Please see attached located in Section 21 No.2 of 2022, 1 - AD of Surgery and Elective Care Band 8C JD.*

166. The consultants and clinicians were key members of the Division and were central in providing high quality care to patients. They were managed within the Medical management structure and responsible to the Director of Acute Services and Chief Executive.

167. My role was to work closely with the Associate Medical Director (AMD) and escalate any clinical concerns that were brought to my attention to him for intervention / resolution .

168. As an assistant to the Director of Acute services I was also responsible for working with the AMD to support the consultants and clinicians with a multidisciplinary team to enable them to provide a high quality service for

patients, ensuring all appropriate Information Technology, staffing, systems, processes, planning, monitoring, provision of data, complaints management, and the management of all other team members was in place to support delivery of their clinical activity.

169. The primary interface in supporting the consultants/ clinicians in this work was through the Head of Urology and ENT.

170. I was a member of the Acute Clinical Governance Forum which met monthly and was chaired by the Director of Acute Services and was made up of all Acute Associate Medical Directors, Operational Assistant Directors and Governance leads. This forum reviewed clinical governance data, including serious adverse incidents investigation reports.

171. While I worked with Mr Mackle (AMD) to oversee the Urology Unit and its clinical governance as a whole, a key responsibility of the AMD role was regarding the clinical governance of the consultants and clinicians. Please see attached job description with relevant extracts detailed below. *See attached located in S21 No.2 of 2022, Associate Medical Director jd.*

172. The job description of the Associate Medical Director provides as follows:-

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

• To contribute strategically as a member of the Directorate Management Team

• To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.

• Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office

• To take responsibility for performance management including appraisal of designated clinicians

• To provide leadership to medical staff to enhance collaboration on Reform and Modernisation agenda KEY RESULT AREAS: Strategy Development:

• Contribute to strategy development as part of Directorate Senior management team.

Professional Leadership

• To develop and lead a team of Clinical Directors and Specialty Leads to assist the Trust in the redesign, modernisation and improvement of service delivery and ensure a senior professional clinical lead on the major Trust facilities.

• To identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate

• To ensure the highest standards of clinical effectiveness and medical practice in the Directorate, including the implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports

• Contribute as an effective member of Directorate Governance Committee

• To place Patient Safety at the centre of Directorate activity

Leading the Medical Team

„ Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives

• Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets

• Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.

• Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors

• Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.

• Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively
• Influence the modernisation of the workforce as systems for delivering care change
• Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Quality & Information Management

• Support the development of clinical indicators and outcome measures relevant to the Directorate clinical specialities.
• Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate
• Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate Collaborative Working
• Actively promote the development of clinical and professional networks across primary, secondary and social care
. • Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated
• Promote and develop effective multi-professional team working and communication.

Corporate Responsibilities

• Maintain good staff relationships and morale amongst the staff reporting to him/her.
• where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
• delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
• participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

• take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
• promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

173. *Please see relevant job descriptions as attached located in Section 21 No.2 of 2022, –Consultant Urologist JD, Clinical Director Surgery and Elective Care, see attachment General Surgery CD JD- Mr Brown, Associate Medical Director Surgery and Elective Care, see attachment Associate Medical Director JD, Assistant Director Surgery and Elective Care see attachment 1-AD of Surgery and Elective Care band 8C, as these will be helpful is establishing roles and responsibilities regarding the consultants and clinicians in the Unit, including matters of clinical governance.*

174. As per Urology consultant job description, '*The Chief Executive has overall responsibility for Acute Services within the Southern health and Social Care Trust. The consultant will have accountability to the Chief Executive, through the Director of Acute Services, the Associate Medical Director and the Lead Consultant for the appropriate and smooth delivery of the service.' Page 12*

[22] Who oversaw the clinical governance arrangements of the unit and how was this done? How did you assure yourself that this was being done appropriately?

175. The clinical governance arrangements for all medical and surgical specialties, including Urology, were made up of a number of systems and processes designed to ensure good governance and safe and effective care.

176. The range of systems and processes used to ensure, review, monitor, learn and improve patient safety and care were as follows;-

a. Datix reporting and review of clinical incidents registered,
b. Screening serious adverse incidents for a serious adverse incident investigation,
c. Complaints review,
d. Patient feedback,
e. Audit,
f. Implementation of nursing quality indicators,
g. Good recruitment standards,
h. Continual Education and Training,
i. Monitoring workforce data,
j. Monitoring medical appraisal compliance and Personal development plans and clinical supervision for other professions,
k. Reviewing national and regional published standards and guidelines and ensuring implementation of same were possible,
l. Reviewing risks to service delivery and patient safety,
m. Reviewing national safety alerts and reports,
n. Clinical Benchmarking from the Comparative Health Knowledge System (CHKS),
o. Process for Escalation of concerns that could not be addressed at certain level,
p. The promotion of the Trust Whistleblowing policy encouraging staff to escalate concerns at any level, involving any member of staff or process if it was deemed to have an adverse impact on patients or other members of staff,
q. Implementation of RQIA recommendations following Inspections,
r. Ensuring Information governance processes to maintain patient confidentiality were in place and utilized appropriately,
s. Ensuring staff were aware of and managing child and adult safeguarding concerns by reporting through designated teams,
t. Having a culture of continuous improvement and in latter years using Quality Improvement methodologies,
u. Seeking digital solutions to support effective and efficient clinical practice, e.g., Digital Dictation, Computers on wheels, etc.,

v. Good communication channels, open door policy for all staff and senior management visibility,
w. Appropriate Financial Management of resources,
x. Support of research and development team within the Trust,
y. Appropriate management of clinical equipment,
z. Supporting Leadership development,
aa. Continual professional development including the development of enhanced roles.

177. Clinical and Social Care governance arrangements at Unit level were overseen by the Head of Urology and ENT, Clinical Director for SEC, the Lead Consultant Urologist and the Lead Nurse for the Division.

178. Any concerns that could not be addressed would have been escalated to myself and the Associate Medical Director for SEC for further action.

179. If we could not successfully address concerns at this level, I would have escalated to the Director of Acute Services and the AMD would have escalated to the Medical Director.

180. The oversight of Clinical & Social Care Governance concerns was done through a variety of established systems and processes as listed above and supported by a small number of governance staff both within the Acute Directorate and corporately. From 2009 to 2016 these systems and processes were not as well developed as they are today and the number of staff who supported clinical governance systems and processes was very much less than today. Some examples of how clinical and social care governance systems, processes and capacity have improved are: additional dedicated governance staff in the Acute Directorate and Corporately, a dedicated Trust Quality Improvement team, a weekly Trust governance meeting chaired by the Medical Director, the introduction of dedicated family liaison officers for patient / family communication and inclusion in serious adverse incident investigations and the introduction of Care Opinion, an online direct patient feedback facility.

181. The following show what was available to the Division in the form of data and information on which to assess the safety and effectiveness of patient care.

a. Data was provided on the number and severity of clinical incidents,
b. Data on number and trends within patient complaints.
c. The Acute Standards and Guidelines coordinator, Mrs Caroline Beattie, collated all new standards and guidelines that were received into the Trust and managed the dissemination to the correct clinical team or teams and monitored and reported on progress of implementation.
d. The Acute Directorate governance coordinator commenced and oversaw the completion of any Serious Adverse Incident reviews with reports, findings and recommendations coming to the Monthly Acute Governance forum for review and approval.
e. The corporate complaints team supported patients through the complaints process and supported clinicians in responding effectively to complaints.
f. The Acute Directorate employed 2 Patient Liaison Officers, both senior nursing staff, to whom patients and relatives could escalate any concerns they had re care and treatment at ward / hospital level. The officers would liaise directly with Urology management / clinicians to resolve and deal with raised concerns.
g. There were a number of Nursing Quality Indicators that were reported on, on a monthly basis to monitor the standard of nursing practice and patient care.
h. The Performance and Reform Directorate submitted clinical data to CHKS for benchmarking and reported on same.
i. The Medical Director's Office reported on a number of Clinical Indicators including Morbidity and Mortality data, job planning and appraisal.
j. RQIA undertook announced and unannounced inspections of services, usually at ward level and usually in relation to the clinical environment and nursing care.
k. The lead nurse oversaw all nursing staff in the directorate from a professional and workforce perspective dealing with nurses in difficulty, supporting same or managing through HR processes or through the Nursing and Midwifery Council. She also oversaw the Personal

development plans, clinical supervision and education and training processes for all nursing staff.

182. One weekly Acute Senior Management Team meeting per month was dedicated to reviewing Clinical and Social care governance in the Directorate. This was chaired by the Director of Acute Services and all Assistant Directors including myself attended this meeting.

183. Within SEC, Clinical Social Care governance data would have been discussed at Head of Service and lead nurse meetings for information and any action required .Governance staff would have supported discussion at meetings with relevant data.

184. I also co-chaired with the AMD a Clinical Leads meeting with the Clinical Leads and Clinical Director of all the surgical specialties which again would have presented relevant governance data for information, discussion and required action. This meeting occurred monthly.

185. It is my understanding, but for checking with Martina Corrigan, Head of Service for Urology and ENT, that she chaired specialty team meetings at which CSCG information would also have been shared for information, discussion and required action.

186. Clinical Governance was therefore a key element at all levels within services, the Division and the Directorate.

187. While not involved as an Assistant Director I am aware that there was a Trust Governance Committee at Trust Board Level at which all Directors and Non-executive Directors would have reviewed Trust Clinical and Social Care data.

188. I assured myself that all C&SC governance systems and processes were being done appropriately by attending all relevant meetings , reviewing relevant data , engaging with my staff regularly , having a very open door policy for any member of staff to bring a concern to my attention , by being visible at ward and department level and encouraging feedback on patient care and safety, by working closely with the Clinical and AMD seeking assurance on the professional competence and practice of consultants and other medical staff, working closely with the Directorate Governance lead to be aware of concerning incidents and trends, and monitoring all across a number of surgical specialties, wards and departments . At that time, I had no concerns that clinical governance systems and processes were not working effectively.

[23] How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

189. To assure myself regarding patient risk and safety in Urology services I undertook the following actions and relied on the following systems:-

a. Reviewed adverse incidents generated by the adverse incident recording system, Datix.
b. Screened for potential SAI and commissioned any SAIs required, reviewing for learning and improvement and supporting the implementation of same.
c. Reviewed complaints and compliments for response and learning.
d. Liaised with front line teams and undertook ward and department visits to hear directly from front line clinical staff re concerns of patient care.
e. Ensured relevant standards and guidelines were reviewed and shared with clinicians for implementation.

f. Monitored a raft of Nursing quality Indicators at inpatient ward level which were collated as part of the professional practice monitoring system and sought improvement plans to be developed when improvement was required.
g. Monitored levels of training and development of nursing staff to ensure nurses were competent and updated in their practice.
h. Monitored staffing levels in Urology services to ensure the funded staffing level was in place and ensuring recruitment was taking place as appropriate.
i. Ensured the Whistle blowing Policy was well disseminated across the Division to encourage staff to come forward, even anonymously, if they were concerned re patient care.
j. Ensured all Trust recruitment procedures were followed for nursing and management staff to ensure appropriateness of qualifications, skills, abilities and experience to ensure a high standard of patient care.
k. Ensured non-medical staff had annual personal development plans undertaken where clinical practice was reviewed and continuous development plans agreed.
l. Oversaw and monitored a raft of access standards – Outpatient access times, new and review, Urology investigation waiting times, day case waiting times, inpatient surgery waiting times, inpatient length of stay - elective and unscheduled, percentage of patients admitted on day of surgery, and the numbers on each waiting list. There was a continual focus on meeting the 9-week new outpatient waiting time standard, the 13-week elective waiting time standard, the 31 and 62 day cancer standards, and while there was not a regional standard for review appointment access times, they were monitored also.

190. In addition, I was aware that the Associate Medical Director undertook the following actions:-

a. Monitored CVs of all locum medics to be assured of clinical capability, qualifications and experience.
b. Oversaw medical appraisal.
c. Took part in medical Morbidity and Mortality meetings.
d. Oversaw job planning to ensure it was appropriate.

[24] How could issues of concern concerning urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

191. Internal concerns could be brought to my attention through a variety of staff:-

a. Primarily, concerns were brought to my attention by the Head of Urology and ENT, Mrs Martina Corrigan.
b. The Divisional Lead nurse, Mrs Dorothy Sharp brought any concerns re nursing practice and staffing levels to me.
c. The Operational support lead, Mrs Glenny, brought concerns regarding waiting list length or management to me.
d. The Clinical Director / Associate Medical director brought concerns regarding medical clinical practice.
e. The Booking centre manager brought concerns re GP referral management.
f. The Head of Medical Records brought concerns regarding patient notes availability.
g. The Ward manager brought concerns re staffing issues at ward level, quality of care issues, patient feedback, etc. Primarily, these would have been brought to the attention of the lead nurse in the first instance, then the Head of Urology, and only to my attention when additional support was required on a particular issue.

h. Any other staff member, both from within the Urology Unit or from any other Trust service, could bring concerns to my attention.
i. The Patient Liaison service regularly brought concerns regarding patients to my attention for action.
j. Members of staff from the Performance and Reform Directorate brought concerns regarding waiting lists to my attention for action and improvement.

192. Internal Concerns were brought to my attention by staff through a variety of channels:–

a. Verbal – one to one basis in person.
b. Email.
c. Phone.
d. Using the whistleblowing policy.
e. Inter-departmental meetings.
f. Performance meetings with Performance and Reform Directorate staff.
g. Adverse Incident recording.
h. During ward / department visits.

193. With regard to external concerns the following methods were available:-

a. Patient complaints.
b. Health and Social Care Board performance meetings.
c. Patient Client Council enquiries.
d. MLA / MP enquiries on behalf of their constituents.
e.

194. Regarding concerns raised internally, the following systems and processes were in place, depending upon the nature of the concern.

195. In respect of concerns relating to conduct / clinical practice of staff:-

a. Clinical practice concerns (Nursing) – The Lead Nurse would investigate the concern initially. If appropriate, Human Resource colleagues would be

involved and a formal joint clinical and HR investigation commenced. The outcome could be a HR sanction or, if required, a referral to the Nursing and Midwifery Council.

b. Clinical Practice concerns (Medical) – The Clinical Director / Associate Medical Director would investigate the concern. If appropriate, Medical HR would become involved and, if required, a formal joint HR / Medical investigation commenced. The outcome could be a HR sanction or, if required, a referral to the GMC.
c. For concerns raised regarding other non-clinical personnel, an investigation by the appropriate line manager would be commenced, with HR support and guidance and appropriate action taken to address same.

196. As for concerns raised by patients and/ families:-

a. Immediate concerns raised by patients / families at ward level were dealt with by either the ward sister, the clinician involved, and/or the Patient Liaison Nurse, with action taken to resolve the concern at source.
b. If the concerns were received through the complaints process, each complaint was investigated by the appropriate team, a response made and learning captured.
c. Concerns raised through public representatives were investigated and responded to in the same way.

197. In respect of concerns raised by teams managing the patient journey:-

a. Concerns raised by the booking centre team regarding delays in triage were escalated to the Head of Service in the first instance. There was also a weekly meeting in place held by the Head of Administration, Mrs Catherine Robinson, and all the Heads of Service to review each of the backlogs of patients waiting triage or appointments. Plans to address the concerns raised were agreed at this weekly meeting. The issue of Mr O'Brien's intermittent delays in triage were raised at this meeting. If the response to triage request was not forthcoming from Mr O'Brien, the issue would have

been escalated both to me (via Mrs Corrigan) and to the Assistant Director for Functional Support Services for further action. I would then have corresponded with Mr O'Brien either in person or via email requesting urgent return of triage. If the approaches from myself were not effective, I would have escalated both to my Director of Acute Services and his clinical lead and Clinical Director.

   a. On many occasions, Mr O'Brien responded to early requests but on a number of occasions he either did not or he promised to respond but delays persisted.
   b. Peer intervention was often the most effective method of seeking resolution to delay concerns.
   c. On one occasion, Dr Gillian Rankin and Mr Mackle had to meet with Mr O'Brien to request that his triage work was returned immediately.

b. Concerns raised by medical records regarding missing notes were escalated to Mrs Corrigan on a number of occasions. Mrs Corrigan would link with Mr O'Brien to seek urgent return of patient notes and he would have returned same. Mr O'Brien was spoken to about this unacceptable practice on a number of occasions by his Clinical Director with little effect.
c. Concerns raised by the Cancer tracking team regarding delays in red flag triage were dealt with both directly with Mr O'Brien by the Cancer tracking team and escalated to Mrs Corrigan and on occasion myself through the then AD for Cancer and Clinical Services, Mr Ronan Carroll . The same process of resolution was used of chasing Mr O'Brien to return his work.
d. Concerns were raised by the Clinicians regarding the frequent lack of the Urology radiologist and the Oncologist at the Cancer MDM.
   a. There was only one radiologist in the Trust that specialized in Urology, Dr Marc Williams, and he frequently couldn't attend the MDM due to competing work pressures. This was escalated to the CD and AMD for radiology with little opportunity for resolution due to a shortage of radiologists in the Trust and region.
   b. With regard to the lack of oncology support at MDM, this was raised by Dr Rankin to managers in Belfast Trust. However, again due to

gaps in their oncology rota, little resolution on a consistent basis was found.

198. With regard to my view of the efficacy of these systems.

a. With regard to the clinical oversight of nursing staff and the management of nursing issues, these were effective as managed by the nursing sister and lead nurse.

b. With regard to clinical oversight of medical staff and the management of clinical concerns, with regard to junior medical staff, these were managed appropriately. With regard to the recurrent concerns raised regarding the practices of Mr O'Brien with regard to delays in triage both urgent and routine and red flag and keeping patient notes at home, this was less effective. The escalation process was effective from the booking centre in raising the concern. The Head of Urology and ENT spent a significant amount of time chasing Mr O'Brien for his required return of both triage and patient notes. On occasion it was effective, on occasion it was not. However despite intervention with Mr O'Brien at many levels in the organization and despite reducing his workload regarding referral triage, the Trust was not successful in changing the administrative practices of Mr O'Brien. Please see attachments referenced on paragraph 61 for emails on triage. *Please see document located in Relevant to PIT, Evidence Evidence Added or Renamed 19 01 2022, Evidence no 77, No 77 – Heather Trouton amended emails with attachments, 20130410 email Fw charts with Mr O'Brien, 20130810 email Fw Charts with Mr O'Brien, 20131112 email Mr O'Brien and Charts, Email 121113 Mr O'Brien and charts, 20131112 Email Mr O' Brien and charts, located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton, 08.10.2013 Update on Chart with AOB , 14.10.2013 email chart with AOB, Document 26.10.2014 Email NOTES WITH AOB, Document 22.01.2015 email Confidential FW AOB CHART, Document 27.01.2015 email Aob and charts at home.*

c. With regard to the efficacy of efforts to have full and consistent Cancer MDM, the persistent lack of consultant staff, particularly in radiology and oncology was not resolved during my tenure as AD.
d. With regard to the efficacy of the management of patient / family concerns, the Patient Liaison nursing service was very effective and working collaboratively with the ward staff, clinical staff, patients and families to address concerns at the point of need.

e. With regard to the efficacy of written responses to patient complaints, the system was conducive to hearing the concerns / complaints of patients, investigating those complaints, being an avenue for both offering a sincere apology or explaining the rationale for action taken by the clinical team. There was always room for improvement however in learning from patient feedback to improve care and treatment to prevent the same issue occurring.

199. In summary, many systems were used to deal with concerns across a wide clinical team. Many were effective but there were many constraints which meant that not all concerns could be resolved. Many recurring issues emanated from staffing deficits which were not easily remedied. Many were due to genuine demand and capacity challenges which were not easily resolved. Many were due to human factors which, despite support and challenge, were ultimately not resolved.

[25] Have these systems or processes changed since the unit's inception? If so, how and why?

200. The core systems and processes have not changed since the Unit's inception. However, in my opinion the emphasis on clinical and social care governance has most definitely increased since 2015.

201. At the Unit's inception, the primary focus of the HSCB and the Trust was to focus on patient access. It was largely accepted that the highest risk to

patient safety was the inability of patients to be able to access specialist care. Therefore, during that period the focus was primarily from an operational perspective, working to reduce waiting volumes and waiting times and ensuring timely access for a specialty bed for Emergency Department admissions. There was of course a focus on the safety and care of patients in the service as noted in the raft of systems and processes noted above. However, I do consider that there has been a most appropriate, greater focus on learning, quality improvement, patient involvement and engagement by the Trust since 2015.

202. To describe what changes I have seen to illustrate this view I refer to the following -

a. A review of Clinical and Social Care Governance in December 2010, with a number of new governance posts implemented - It is my understanding that not all recommended posts were implemented but key posts were put in place to strengthen the focus on governance.
b. There was a further review of Clinical and Social Care Governance in 2019 with a number of recommendations being implemented.
c. There has been a review of the Management of Serious Adverse Incidents with much more focus on patient involvement and engagement.
d. Implementation of corporate Patient Liaison Roles to support patients and their families involved in serious adverse incidents.
e. An increase in the volume of Serious adverse Incident Investigations and, while this may not be seen as an improvement in itself, it does show an increased focus on investigation and learning for improvement.
f. A funded Quality Improvement team within the Trust.
g. The use of an information tool within the corporate clinical and social care governance team to categorise patient complaints not only to address each one but to collate data to show trends in complaint subjects to support learning and improvement.

h. The implementation of the Online Patient feedback system – 'Care Opinion' - which is used widely throughout the Trust to invite patient feedback with a view to improvement.
i. Closer and supportive oversight of nursing practice by the Corporate Nursing team.
j. Closer monitoring of workforce data.
k. The development of Clinical MDT meetings across a range of specialities.
l. Publication of Morbidity and Mortality data with review at Trust Governance Committee.

203. The Trust Clinical and Social Care Governance team would be able to provide further evidence of change in answer to this question, beyond that provided by me above and in my Question 22 response.

[26] How did you ensure that you were, in fact, appraised of any concerns generally within the unit?

204. I ensured that I was appraised of any concerns within the Unit in the following ways:-

a. I ensured there were open and effective communication channels with managerial, administrative, Assistant Director colleagues, clinical consultants and clinical leads at all levels.
b. I had an open door policy: staff did not have to wait until a pre-arranged meeting if they had any concerns.
c. I was visible at ward and department level to see for myself regarding nursing care and treatment and where, for example, any member of staff could have approached me with a concern.
d. While I could constructively challenge poor nursing practice and require improvement, I was not able constructively to challenge medical practice to the same extent. However, I maintained good relationships with my

Clinical Directors and Associate Medical Director who provided that clinical peer challenge role when it was required.

e. I used available data to review for concerns, for example, length of review backlog, adverse incident data, etc.
f. I attended relevant meetings where issues of concern through data / other information were presented, for example, the Directorate monthly governance meeting.
g. I liaised with other professional experts for advice on standards of good practice, e.g., administration duties and standards, medical standards, etc.
h. I maintained close working relationships with the governance leads, operational and professional.
i. I liaised closely with the patient liaison officer, ward sister, theatre manager, outpatient managers etc. who had direct patient contact and who could advise me of any concerns noted.

[27] How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

205. I used all systems and processes that were available to me to monitor the quality of patient care, safety and treatment across all the clinical teams in the Division.

206. At the time I did not have concerns that governance issues were not being identified.

207. On reflection and following the investigation of practice that was undertaken in 2016 and thereafter, I now know there were issues that were not fully identified at the time.

208. For those issues that were identified at the time that could not be resolved within the division such as, for example, the recurrent issue with delayed patient referral triage, they were escalated to the Director of Acute Services and the Medical Director appropriately.

209. With regard to addressing the concerns identified through the recognised governance systems and processes, all actions pertaining to adverse incidents, serious adverse incidents, complaints, real time patient feedback, etc. were managed appropriately as is the daily management within health and social care.

210. However, there were certain issues relating to governance within Urology, that we as a team were not able to resolve. Those issues were:-

a. Satisfactory volumes and lengths of patient access times to urology services. Demand continually outstripped capacity
b. Consistent meeting of cancer pathway waiting times due to service capacity, not only within Urology but also within radiology, pathology, and oncology services locally and in the regional cancer centre.
c. Eradicating the review backlog.
d. While after a number of years medical staffing levels improved and became more stable, the service existed for a number of years with less than needed medical staffing.
e. Inconsistent timely return of referral triage by Mr O'Brien.
f. Delays in returning patient notes to the hospital by Mr O'Brien
g. As emerged in the latter part of 2015, and as noted in the letter to Mr O'Brien in March 2016, concerns regarding his lack of recording of patient care and treatment on the electronic system, 'Patient Centre'. As I left the AD SEC post in March 2016, I am unable to comment on the effectiveness of the management / resolution of Patient Centre recording once it was identified. *Please see for*

clarity letter entitled. 20160822 Email confidential - AOB SG A located in Relevant to PIT, Evidence Added or Renamed 19 01 22, Evidence no 77, No 77 – Heather Trouton amended emails with attachments.

211. While I could constructively challenge poor nursing practice and require improvement, I was not able constructively to challenge medical practice. I heavily relied on the Clinical Lead, Clinical Director, and Associate Medical Director to advise me on what was, or was not, good and acceptable practice and to challenge professionally and clinically poor peer practice.

212. It was apparent that, while within nursing there were clear standards for professional practice in patient care, within the Consultant body there was an acceptance, to a certain degree, of individual practice preference within (of course) the bounds of patient safety.

[28] How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

213. To the best of my knowledge, there is no reflection of the concerns raised regarding delays in patient triage, retaining notes at home nor Patient Centre recording in Governance meeting minutes or notes nor in the Risk Register. Generally, these issues were not prevalent in surgical service consultant practice. It was generally accepted that timely triage, not keeping notes at home, and recording clinic outcomes on Patient Centre were normal consultant practice and therefore the risk of not adhering to normal practice was not considered across the Directorate. However, once these concerns

were identified in relation to Mr O'Brien's practice, they were managed as a specific practice issue and were not publically discussed or documented as part of general risk register or governance information.

214. However, the Acute Directorate Risk Register noted the risk to patients regarding the lack of capacity in a number of services, including Urology and the risk to patients in being part of the review backlog.

215. In December 2009 the Corporate Risk Register noted meeting general access targets a risk. *For clarity, please see attachment 20091209 Corporate Risk Register located at Section 21 2 of 2022.*

216. In June 2010, the Corporate Risk Register also included the risk of the Review backlog of patients and the lack of staff to manage and utilise all patient safety information regarding adverse incident, complaints, etc. *For clarity, please see attachment 20100621 Corporate Risk Register located at Section 212 of 2022.*

217. Please see attached yearly risk registers from 2011 to 2016. *For clarity, please see attachments of Risk registers located in Section 21 2 of 2022.*

- *20111206CRR*
- *20121204CRR*
- *20131203CRR*
- *20141209CRR*
- *20151208CRR*
- *20161208CRR*

[29] What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

218. There were few systems for collecting patient data in the unit to the best of my knowledge in the period from 2009 to 2016.

219. I have been advised by the clinical audit team in the Trust that clinical audit was not practiced in Urology during 2009 to 2016, to the best of their knowledge.

220. Morbidity and Mortality data emerged gradually during this time but was not available to me at that time as I recall.

221. The function of Clinical Multidisciplinary teams emerged and strengthened during that time. The Urology team were part of the over-arching surgical Multidisciplinary team meetings which, again, developed over that period of time.

222. I would refer the Inquiry to the Medical Directorate for further information and clarity on the development of each of these clinical data review systems and processes, each of which I believe they led on at the time.

223. Data on the number of patients meeting the cancer access and pathway standards was available, monitored and managed according to capacity available.

224. Data on a raft of patient access standards was available, monitored and managed according to capacity available.

225. Data on patient complaints was available and reviewed.

226. Data on adverse and serious adverse incidents was available and was reviewed by the team.

227. Data on a number of nursing quality indicators was available and was monitored regularly with appropriate action taken.

228. Data on staffing levels was available and was monitored weekly.

229. Data on the implementation of standards and guidelines was available and was monitored by the Standards and Guidelines Manager who liaised directly with clinical teams and managers to monitor progress of implementation of recommendations.

230. Data was available on the number of non-medical staff who had completed an annual personal development plan with their manager.

231. Data was available on the number of medical staff with outstanding job plans to be finalised.

232. There was a raft of information daily on Emergency department waits, delayed discharges and length of stay.

233. There was data available on the number of patients admitted on the day of surgery.

234. There was data available on Theatre Utilisation.

235. Those systems and the raft of data available did help to identify concerns and much action was taken following concerns identified. For example, improving the rate of admission on the morning of surgery, improving theatre start times, reducing the number of delayed patient discharges, improving nursing quality indicators, and reducing wait times for outpatient review for urgent or very long reviews.

236. However, there was little or no information available on:-

a. The standard of medical practice.
b. The standard of medical recording.
c. Patient outcomes.

d. Overall patient satisfaction with the service – proactively.

237. Therefore, while much patient data was collected and used, it was, at that time, widely accepted that patients were managed appropriately under the care of experienced consultants, that they adhered to good recording practice and accepted professional practice with a view to preserving the safety of patients and providing best care and treatment in line with the resources available to them. What we did not have data on was the robustness and effectiveness of Mr O'Brien's, or indeed any consultant's, patient recording, nor data on the experience of the patient pathway through cancer diagnosis and support. We also did not have data on patient outcomes in a way that would be compared with expected outcomes.

[30] What is your view of the efficacy of those systems? Have those systems changed over time and, if so, what are the changes?

238. As referenced in answer to Question 29, there was a huge amount of patient and service data collected across all the medical and surgical specialities, and Urology was part of that data collection.

239. The systems were effective in collecting the data they were set up to collect. However, data is only useful if it is read, analysed, and responded to.

240. In my experience, the data was read, analysed, and responded to by the clinical and managerial teams. As I recall during 2009 to 2016, there was a huge focus on patient access data and data relating to the efficiency of the service and patient throughput. There was also significant focus on adverse incident and serious adverse incident data and complaints, seeking to improve systems and processes to improve patient safety and experience. Nursing quality indicator data has always been, and remains, a key focus to monitor standards of professional nursing practice.

241. I think that, over time and following Corporate Reviews of Clinical and Social Care Governance, the use of governance data has improved and I have indicated a number of those improvements in my answer to Question 25.

242. In addition:

a. There is now weekly Corporate Governance meeting, chaired by the Medical Director and attended by Governance staff from all Directorates and corporate teams where a raft of clinical governance data is shared, discussed, constructive challenge made, and actions agreed. Please see attached document as an example of the data discussed at this weekly meeting. *For clarity please see attachments 20220329 Weekly Clinical and Social Care Governance Report 1-6 located at Section 21 2 of 2022.*

b. The emphasis on patient involvement and experience is now a much stronger focus for the Trust. In 2020, we implemented the online User Feedback system 'Care Opinion'. This enables patients and families to feedback their views on their experience across a wide range of services using an online app, and, whilst much of the feedback is complimentary, where they wish to express a concern this is read at ward / department level and a response is provided by return. There have been a number of improvements made based on this feedback.

c. The Nursing Directorate which implemented and oversees this system is working with the Deputy Medical Director to see if patient feedback relating to consultants can be made available as part of their appraisal. This is getting patient views directly to the heart of clinical practice.

d. The Trust has developed a New Strategy for Patient Involvement and Experience which it is about to launch in the new financial year. This strategy was co-produced by staff and service users and sets out how the Trust intends to strengthen even further the role played by patients in their care delivery.

For Clarity please see attached the 'Working Together - A strategy to ensure the best possible patient experience through involvement and improvement'. Document Working Together PCE' located at Section 21 2 2022.

Concerns regarding the urology unit

[31] Following the inception of the urology unit, please describe the main problems you encountered in respect of the operation of the unit? Without prejudice to the generality of this request, please address the following specific matters: -

243. There has always been a Urology Service in the Craigavon Area Hospital which pre-dates the formation of the Southern Health and Social Care Trust in 2007. However, for the purposes of this question, I will describe the main problems I encountered during the implementation of the 'Team South' model from 2010 to 2013, some of which continued throughout my tenure until 2016.

244. The main problems, in summary, were:-

a. Inability to recruit and retain medical staff;
b. Long patient access times and large patient volumes;
c. Long review backlog;
d. Consistently meeting cancer waiting times.

245. I will answer each of the questions (a to j) below relating to each of the 4 identified problems.

1. Recruitment and Retention of Medical staff

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

246. At the outset of the Southern Trust Urology Unit the following staff were funded:

The Urology Team

The integrated urology team comprised:
3 Consultant Urologists,
2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2012 and one post is currently vacant),
2 Trust Grade Doctors (2 posts are currently vacant)
1 GP with Special Interest (7 sessions per week)
1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
2 Urology Specialist Nurses (Band 7)

At this time in 2010, the waiting times for Urology access were in excess of the regional standards.

247. The output of the Urology review, which completed in 2009, took some time to work through. The new model recommended funding an additional 2 Consultant Urologists and the associated support staff. It is notable that funding for these additional staff was received by the Trust in financial year 2012/2013, with the Commissioner's expectation that the Team South model would be fully operational by March 2013. The additional 2 consultants were to meet the outstanding demand for urology services within the Southern Trust and also to take on the management of the southern section of the Western Trust, an additional population, taking the total catchment area for team South up to 410,000 people.

248. From the staffing information noted above, the original service had medical staff vacancies from the beginning of the process.

249. The provision of middle grade medical staff to Trusts is largely from 2 sources:-

a. Allocation of doctors in training from the Northern Ireland Medical and Dental Training Agency (NIMDTA).
b. Trusts trying to recruit middle grade doctors who are not in training and wish to take up a medical post either on a temporary / locum arrangement or very rarely a permanent opt out of further training to take up permanent staff grade post in a specialty.

250. Trusts have no input into NIMDTA allocations. In fact, over many years Trusts have challenged the allocation of doctors in training across the various hospitals in Northern Ireland to no effect.

251. Doctors with any level of expertise in Urology services who are not in training are very difficult to find and secure.

252. Throughout my tenure as AD for Surgical and Elective care, securing adequate middle grade medical staff for all surgical specialties was a challenge. For Urology, this challenge was constant.

253. It is widely acknowledged in Northern Ireland that the adequate provision of many specialty consultants to meet both funded and patient demand falls short. The supply of Consultant Urologists has always been inadequate in Northern Ireland to meet patient demand.

254. Please see the staffing complement available to the Southern Trust throughout the years 2010 to 2016, when I left this role. *For clarity please see attachment Medical Staffing Urology 2009 – 2016 located at Section 21 2 2022.*

255. Any service, while supported by a number of other professional and administrative disciplines, completely depends on the correct number of Medical Consultants being in post. The rest of the service is largely there to support the consultant body, to support their access to and assessment of patients (Outpatient services), to undertake diagnostic tests for consultant diagnosis (radiology and laboratories), to nurse patients admitted for medical assessment and treatment (ward staff), to support surgical intervention by the consultant in day-case or inpatient theatres (theatre services), and to support cancer diagnosis and treatment by the medical teams (cancer tracking services).

256. The concerns in respect of adequate staffing to meet the demands of the Team South Model was evident and recognised across Northern Ireland, at Trust, HSCB and Department of Health level.

257. At Trust level, the consultant body, the Clinical Director, Associate Medical Director, Director of Acute Services, and Director of Performance and Reform were aware of the difficulties recruiting and retaining consultant Urologists.

258. Actions taken to address recruitment included the following:-

a. Formulating attractive job plans which both met the needs of the service but also facilitated a specialty interest which is attractive to consultant surgeons. In the case of Urology, this could have been a specialty interest in cancer, Kidney stone treatment, male or female Urology etc;
b. Creating job plans with acceptable levels of SPA – protected time in one's job plan to professionally update and keep up to date with changes in clinical practice;
c. Creating as attractive as possible on call rotas;

d. Recruiting using all medical journals to reach as wide a population of prospective applicants as possible including international recruitment;
e. Ensuring a good experience for Registrars in training on placement within the Trust in order both to support excellence in training but also to support applications for a consultant post following qualification;
f. Contacts through medical lines to trainees in other parts of the UK who may have been interested in a consultant post within the Trust on qualification.

259. The primary challenge was that there were more posts available in Northern Ireland than qualified Consultant surgeons.

260. Other challenges to recruitment and retention included:-

a. Even a 5 consultant model is a small consultant team. Small consultant teams mean a more frequent on-call rota which is not attractive. Building a consultant team from 3 to 5 is therefore extremely challenging.
b. The Southern Trust, especially taking in the southern half of Fermanagh, is a rural Trust. Unless a consultant has family in this area, consultants will more often chose to work in a Trust which is close to Belfast.
c. A regional District General Hospital cannot always provide the ability to practice at a highly specialised level, therefore many surgeons will choose to work in Trusts that are tertiary centres with more specialised surgery.
d. Consultant surgeons rely heavily on an appropriate level of middle grade medical staff. Vacancies at middle grade level make the recruitment of consultant staff even more difficult.

261. With the Urology Unit at this time there was much effort in creating job plans for the 5 consultant model that would be both attractive to recruitment and also meet the very stringent commissioning demands in the provision of specified outpatient, day case, and inpatient activity. Please see attached Investment proposal template that sets out the expected activity of the 5 consultant team. For clarity please see Urology Investment proposal template, 12 Urology Revenue IPT Feb 2012 located at Section 21 2 2022

262. Job planning is a collaborative process between the consultant, medical HR, and the Clinical Director for that specialty. There are widely accepted parameters for formulating job plans. All must have a balance of direct patient activity sessions, administration sessions, on call allowance, SPA sessions, unscheduled care patients management sessions (ward rounds), and (potentially) allowance for private work modelled in to the working week. Following collaboration to create a job plan by the Clinical Director, the job plan must then be sent to a regional specialty advisor for that particular specialty who will review the job plans and either approve or require changes. A job cannot be advertised before specialty approval is secured.

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263. With regard to the process of the implementation of the Job Plans for the 5 consultant model, Mr Robin Brown (Clinical Director at that time for the service) was tasked with creating a 5 consultant job plan that met the needs of the service and the specialist interests of both those in post and those we needed to recruit.

264. This was a long and difficult process. *Please see for clarity documents showing the challenges of securing agreement on the content of the job plans located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Heather Trouton amended emails with attachments, . 20110307 Email Urology Job plans, 20110107 Email O'Brien Aidan DRAFT job plan Jun 2011, Document 20120306 Email re Urology Job-plans final (I hope) A1, , Document 20120606 email RE Urology job plans, Document 20130212 Email FW Urology job plans, and located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton, 05.07.2011 young Michael job Document 07.07.2011 email O'Brien Aidan draft job plan Jun 2011, Document 14.07.2011 email comments regarding draft job plan proposal., Document 14.07.2011 Email AMENDED Comments regarding draft Job plan proposal. Document 01.09.2011 email O'Brien Aidan draft job plan jun 2011, Document 01.02.2013 email Meeting with Mr Young. Document 06.06.12 urology job plans located in Section 21 2 of 2022, . Document 06.06.12 urology job plans located in Section 21 2 of 2022. Document 20.02.13 urology job plans, Document 27.02.13 urology job*

plans. Document 04.03.13 Urology, Document 29.10.13 urology rota, Document 16.05.14 urology job plan

265. While consultant availability was most definitely a problem, the long process of job planning for this group of surgeons did not assist in the process.

266. There were numerous meetings led by medical staff regarding job planning, recruitment, locum recruitment, etc. I would not have been party to those meetings.

267. However, there were a number of meetings at which I was present where job planning was discussed, as was the need to recruit to medical posts as this affected service delivery. For clarity, please see letters to Mr O'Brien, Mr Young and Mr Akhtar with notes of meetings held including discussion on Job planning. *Please see for clarity Document 20110627 Email urology meetings memo A2 located in Relevant to PIT, Evidence Added or Renamed 19 01 22, Evidence No 77, No 77 – Heather Trouton amended emails with attachments.*

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

268. Risk assessment in health and social care is continuous as it is a rapidly changing environment.

269. Please see attached Acute Directorate Risk Registers dated from 2009 to 2016 which note the risk associated with the delivery of elective services including Urology. *Please see document Acute Risk Registers 2009 to 2016 located at Section21 2 of 2022.*

270. The risks of the potential impact of reduced medical staffing were identified as follows:-

a. Long waits for new outpatient appointment following GP referral.
b. Long waits for an outpatient review.
c. Long waits for day case surgery / procedure.
d. Long waits for inpatient surgery / procedure.
e. Long waits for cancer diagnosis and treatment.
f. Risk of not being able to recruit to a team which is viable to be attractive to potential applicant.
g. Risk of not being able to meet regional expected activity nor access standards for patients.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps did not take to mitigate against this? If not, why not.

271. All provision or lack of provision in health and social care has an impact on patient care, safety and experience. It was a serious concern that the inability of the Trust to successfully recruit and retain both Consultant and middle grade medical staff had the impact on men and women within our local population not being able to have timely access to services they needed. As already stated, our medical staff form the core of Urology service, their number directly dictates the number of patients that can be accessed, diagnosed, and treated. While nurses are also key to patient care and treatment as are all other supporting services, senior medical staff are core to service delivery and therefore patient care and safety.

272. Actions taken to mitigate risk included the following:–

a. The Trust continued to actively recruit on a permanent basis.

b. The Trust continued to seek locum medical staff at all levels - this was successful on occasion. Cognizance must be taken regarding the quality of locum medical staff: all CVs were checked and either approved or rejected by the Associate Medical Director for SEC. The expertise, knowledge, practice, and experience of senior medical staff is essential for patient safety.
c. The Trust trained specialist nursing staff (2 specialist nurses) to take on enhanced roles, e.g., one nurse was trained in cystoscopy (a bladder investigation), previously only performed by a medic. Training was also given in Urodynamic studies and Trus Biopsy. These enhanced roles supported the service as a whole and reduced the workload for the medical staff to enable them to concentrate of other clinical activities.
d. The Trust used patient referral categorisation to prioritise patient activity based on both GP and consultant referral and triage. Northern Ireland Cancer Network had agreed specific referral criteria for patient pathways that assisted both GP and secondary care medics to categorise patients into the following categories: routine, urgent and red flag.

    - Patients who were categorised as Red Flag were considered to have symptoms that had the potential to indicate a diagnosis of cancer.

    - Patients who were categorised as Urgent were considered to need to be seen urgently for symptoms that were not thought to indicate a cancer diagnosis.

    - Patients who were categorised as Routine were considered to require a specialist consultation but were neither urgent not suspected of cancer.

    To mitigate patient safety, all red flag patients had priority of access to consultant assessment, urgent patients were allocated residual access appointments, and routine patients were allocated further residual access appointments. All appointments within each category were allocated in chronological order based on the date of referral.

e. The management of unscheduled care admissions to Urology was always prioritised and medical staff were always available to assess and treat patients admitted through ED or from an outpatient clinic.
f. Patients who required a surgical operation for a cancer diagnosis were always prioritised for theatre.
g. The on call rota was always populated to ensure timely access 24/7 for emergency care and treatment.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

273. Please see above systems and agreements put in place to manage the concerns and effects of reduced medical staffing.

274. There was continual monitoring of medical staff availability by both the Lead Clinician for Urology, the Clinical Director, the Head of Urology and ENT and the Human resources department. The Director of Acute Services would also have been informed of vacancies at this level.

275. The Lead Clinician in collaboration with the Head of Urology and ENT ensured that medical staff were always available for wards, theatres, red flag outpatient clinics, and on call rotas. There was a weekly scheduling meeting comprising all consultant staff, the operational support lead, and the Head of Urology and ENT to ensure that staff were allocated to priority areas and that elective activity was planned to meet red flag patient demand as a priority.

276. The Operational Support Lead, Mrs Sharon Glenny, monitored all patient access times for each of the areas of activity and in particular access times for red flag patients.

277. The Operational Support Lead also monitored the chronological management of patients within each category, linking with the relevant consultant where a patient had been selected for treatment outside of chronology as often there were clinical indications for such selection.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

278. I assured myself that the relevant measures were working in the following ways:-

a. Regular verbal updates from Head of Urology and ENT and the Associate Medical Director on recruitment and job planning progress.
b. Regular reports from the Operational Support Lead on patient access times in each of the referral categories both for outpatient assessment and day case / inpatient treatment and cancer standards.
c. Verbal escalation / report by exception regarding any concerns regarding gaps in the medical in hours or out of hours on call rotas with action taken to address and ensure medical cover was secured.
d. Regular verbal updates by the Lead Nurse for Surgery and Elective Care regarding any concerns re patient review / care / discharge at ward level.
e. Update on progress of specialty nurses undertaking enhanced roles.
f. Review of Datix – adverse incidents.
g. Review of patient complaints.
h. Liaison with Patient Support Officer.

(f) If you were given assurances by others, how did you test those assurances?

279. I tested assurances in a number of ways:-

a. With regard to recruitment activity, it was a small team and monitoring progress was tested with medical HR colleagues as independent support to medical recruitment.
b. With regard to job planning, verbal reports from Clinical Director and Associate Medical Director supported by updates from Medical HR as independent support to medical recruitment. I could also check on the electronic Job planning system called Zircadian for the status of job plan completion.
c. Re access times across all areas – there was availability of data showing access times.
d. Monitoring periodically theatre lists collaboratively with the Head of Service to check for chronological management and cancer management.
e. There were weekly theatre scheduling meetings with the Head of Service for Theatres with the HOS Urology and ENT to ensure all theatre capacity for Urology was secured and lists were filled appropriately.
f. Reports to the Head of Service from the booking centre monitoring triage return times and escalating delays in same to be addressed by the HOS with the relevant consultant.
g. Periodic visits to Urology Ward to speak to Ward Sister re the quality of patient care and to ascertain any concerns.
h. Periodic visits to the Thorndale Outpatients Unit to see staff re any concerns.
i. Adverse incidents, patient inquiries and complaints, correspondence from MLA/ MP representatives / media issues were all indicators of patient safety / care which were monitored for concerns / trends.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

280. The Urology Service had always been, according to my understanding, historically under-funded and under-resourced to meet the need of the Trust population from its inception. Prior to my role as Assistant Director for Surgery and Elective Care, and prior to the formation of the Southern Health and Social Care Trust, the previous Craigavon Area Hospital Group Trust had such a volume of patients requiring urology assessment and treatment that it took the unprecedented step of bringing in from Australia a clinical team to see and treat the backlog of patients in a facility in South Tyrone Hospital. This was in 2006.

281. That initiative, though welcome and effective, did not create a sustainable solution that would be able to manage the ongoing demand for urology services which continued to be greater than the capacity commissioned to meet patient need.

282. In 2009 the region undertook a regional review of Urology services as capacity across the region did not meet regional demand and this created the 3 team model as referenced earlier. However, undertaking a regional review, while welcome, did not improve the supply of medical staff available to enable the timely implementation of the new model.

283. It is also notable that while the model was developed in 2009 / 2010, approval to proceed with the implementation plan was not given by the HSCB until July 2011, the Investment Proposal Template was not approved by the commissioner for funding until December 2011, and the additional consultants were not funded until expected in post in August 2012.

284. Therefore, the question whether the systems and processes put in place to rectify the problems of the Urology service were successful, gives rise to a complex answer:

i. Over the course of the implementation plan and the welcome extension of the service, recruitment, though ultimately successful, was incredibly slow.

ii. The agreement of a 5 consultant team job plan, though ultimately achieved, was very slow to agree and secure.

iii. Despite the growth of the Urology Unit, it was alongside a continual annual increase in patient need / demand. Therefore, by the time the new Urology model was successfully implemented, demand had outgrown the new capacity and the gap in demand and capacity regretfully remained.

iv. Please see paper attached developed in September 2014 which indicates both a 17% rise in the population served by the SHSCT and year on year urology referral rises of 10%. *For clarity, please see paper entitled The Vision For Urology Services Southern Health and Social Care Trust. Document 20170915 email Urology Board paper v2 1st Sept located in Relevant to PIT, Evidence No 77, No 77 – Heather Trouton amended emails with attachments.*

v. With regard to the success of the initiatives to manage the risks associated with staff vacancies, i.e., continual monitoring of waiting times, prioritisation of patients based on clinical need as per the regional categorisation of red flag, urgent, and routine, monitoring of chronological management of patients, ensuring emergency ward and on call staff were always available, these systems and processes were generally successful in managing a service where the overall demand was greater than its capacity to deliver. However, it must be noted that, despite careful management, the service could not deliver patient access to care and treatment as it would have wished to do.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

285. Performance metrics that were relevant to determining the success or otherwise of steps taken to address the problem of recruiting and retaining medical staff the included the following:

a. A reduction in staff vacancies .
b. Appropriate Ward and emergency inpatient medical cover in and out of hours.
c. Full Theatre utilisation.
d. Full Outpatient activity, new and review patients.
e. A reduction in the Length and volume of access waiting times.
f. Meeting Cancer 31 and 62 day standards.
g. Quality measures – adverse incidents, patient feedback, complaints.
h. Increased enhanced nursing roles.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

(a) properly identified,

(b) their extent and impact assessed,

(c) and the potential risk to patients properly considered?

286. It is important to set the context of the regional and local environment in Health and Social Care provision in Northern Ireland during the period 2010 to 2016 in order to usefully answer this question.

287. In Northern Ireland at this time it is my recollection, in my role as Assistant Director for Surgical and Elective Care Services, that the culture, both at the Health and Social Care Board regionally as commissioner and locally as a Trust, was one of Performance being the key driver of service delivery.

288. In light of long regional elective waiting lists at that time, there was a commissioner focus on driving and maximising elective activity across all specialities to meet patient access targets. It would be correct to say that this

in itself is a quality standard as well as a quantitative standard, as timely access to care is essential in the provision of a quality service.

289. This culture and drive from the commissioner therefore became the overriding culture within the Trust (I would assess in all Trusts), with regular accountability meetings with Trusts held at the Health and Social Care Board.

290. It is also important to note that, during this period and to my recollection, there was also a commissioner HSCB drive for efficiency and cost reduction in Trusts. Therefore, the drive and expectation both from the commissioner and the Trust was continually to seek more efficient ways to provide services.

291. During this time a culture of finance and performance pervaded.

292. With regard to the problem with inadequate medical staffing available to meet the needs of the service, I understand that the extent of this deficiency was properly identified by the Urology Service and by the Trust but not by the HSCB. With the knowledge of growing demand year on year and the knowledge of the unavailability of medical staff, the Team South model could never have delivered appropriate capacity in a timely manner.

293. With regard to whether the impacts were properly assessed, within the Trust I believe that the impact of staffing deficits was recognised. Further detail showing how is given in the response to Question 16 above.

294. With regard to whether the potential risk to patients was properly considered with regard to staffing deficits, I also think that this was recognised, as detailed in the response to Question 16 above.

(j) What, if any, support was provided to any urology staff, including Mr Aidan O'Brien (Consultant Urologist), by you and the Trust, given any of the concerns identified?

295. Mr O'Brien, as with all surgical consultants, was a member of a clinical team supported by a wider multidisciplinary team to provide care and treatment to Urology patients. These supports were available at all times.

296. He was, along with all others supported at ward level by a team of nurses, administrative staff, junior and middle grade medics, physiotherapists, occupational therapists, social workers, etc. to enable him to assess, prescribe, and deliver appropriate care to inpatients supported by the whole MDT. He was only ever required to undertake his role as a consultant Urologist. This was available to all consultants and at all times.

297. He received the support from locum / agency junior medical staff to support him in outpatients, wards, and theatre. It is important to note that additional medical staff would have been secured for the service (within funding allowances) if they had been available.

298. During that time it was agreed that urology patients would be seen by the General surgery team in the out of hours period and only escalated patients would require to be seen by the Urology team in the out of hours period, this was to relieve the pressure on a small urology medical team.

299. It was always ensured that he and other consultants had appropriate medical assistance in theatres.

2. <u>Long patient access times and large patient volumes for Urology Services</u>

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

300. Concerns were evident on reviewing data on the volumes of patients waiting for access to an out-patient appointment, treatment, or surgery.

301. As outlined above, this was not a problem new to Urology. It is also helpful to note that it was not a problem that affected Urology exclusively but was prevalent in the majority of medical and surgical specialties across the region.

302. It is noted that this problem was recognised by the Health and Social Care Board, hence the regional review of urology services in 2009, moving to implementation of the new regional model from 2009 through to 2013.

303. Meeting patient access times and reducing the numbers of patients waiting access to assessment and treatment was a key focus of the entire clinical and managerial teams within Acute Services, Surgery and Elective Care Division and the Urology Unit. This was continually monitored by the HSCB and local commissioning teams.

304. There were a range of regular meetings to address and monitor waiting time and patient volumes. These meetings can be summarised as follows:-

a. The Head of Service Urology and ENT would have had monthly meetings with the Urology consultant body to discuss all issues within Urology and performance measures would have been presented at that meeting with creative solutions sought to improve same for patients. I do not have notes of this meeting as I did not attend but the Head of Service may have.
b. Performance measures were monitored and discussed at my weekly meetings with my Heads of service, reviewing all performance measures for General surgery, Breast surgery, upper and lower GI, Trauma & Orthopaedics, ENT, Ophthalmology and Oral Surgery, and seeking solutions to improve for patients. This included seeking solutions for individual patients who required urgent access to care and treatment. I have checked my notebooks and I have cannot locate any notes of these meetings.

c. Tuesday morning weekly performance meeting chaired by the Director of Acute Services and attended by all Assistant Directors, Heads of Service, and Admin team leads. At this weekly meeting each Head of Service had to report on current waiting times and volumes including updating on individual service waiting times. As well as a reporting meeting, this was one of constructive challenge by the Director of Acute Services seeking solutions across all services to ensure patients' access time wait was minimised. This meeting was weekly up until June 2015. I have no notes of these meetings.
d. There were monthly performance meetings where staff from the Trust Performance and Reform Directorate attended the Acute Senior Management Team meeting to report on performance and request improvement where it was required. These continued from 2009 and, I believe, still continue today. I have no notes of these meetings.
e. Performance of all services would have been reported at Trust Board.
f. There were meetings with local commissioners to monitor waiting times and to review progress with the implementation of the Urology Team South implementation plan. These meetings were intermittent.
g. There were regional performance meetings with the Director of Commissioning at HSCB in Linenhall Street, Belfast. These again looked at Trust performance as they gathered and analysed Trust data before the meeting, presented it back to the Trust, challenged where performance was less than expected, and sought solutions from the Trust. The HSCB would have been very aware of the challenges within Urology, in the Southern and other Trusts, of large patient volumes awaiting access to service and long waiting times. My recollection is that these meetings were monthly. Please see notes of meetings between the Trust and the Health and Social Care Board. *Please see attachment 20150501 actions issues register and attachment 20160226 Internal prep notes. Located at Section 21 2 2022.*

305. As for actions taken to address concerns regarding long patient access times and large patient volumes, these included the following:-

a. Close monitoring of the management of referrals and surgery to ensure prioritised categories of patients where seen as appropriate, e.g., the target access time for a red flag patient was shorter than an urgent patient which was, in turn, shorter than a routine patient. Individual solutions for access to care and treatment were often actively sought for individual patients.
b. Consultant triage of GP referrals.
c. Monitoring of patients awaiting access to day case or inpatient theatre to ensure they were selected in chronological order according to clinical acuity and that clinics and theatre lists were fully utilised.
d. Utilisation of backfill lists for urology patients where a consultant urologist was available, i.e., if another surgeon (for example, an ENT surgeon) was on annual leave, where possible vacant staffed lists would be utilised by Consultant Urologists to treat additional patients.
e. Seeking opportunities to put on additional outpatient clinics in the evening and/or at weekends to see additional patients over and above day to day commissioned services. The ability to do this was completely dependent on Consultant willingness to undertake the additional clinic/ theatre session, availability of the outpatient / theatre space and the availability of the nursing staff to support the clinic/ theatre list. For additional sessions, Consultants were paid a specific Waiting List Initiative rate which was attractive for some consultants who would have done considerable amounts of waiting list activity. For other consultants, choosing work life balance as a priority, this would not have been an option. Waiting list initiative work was greatly appreciated by the Trust but it was completely voluntary with additional payment. ‘Agenda For Change’ pay and conditions for nursing staff meant that they did not receive waiting list initiative rates for additional clinics and theatre work. There was no financial incentive for support staff to undertake additional activity.

f. For many specialties, the use of the Independent Sector Providers ('ISPs') was a helpful and regularly used option. The process involved ISPs bidding for NHS activity, having to meet strict criteria and performance measures, and meeting all elements required by the agreed contract. This worked well for patients requiring one-off procedures, e.g., hernia repair, hip replacement, tonsillectomy. However, the nature of Urology patients are generally more complex in nature in that their urological condition can be chronic and not conducive to independent sector activity. That said, there were a number of patients that did meet the criteria for ISP Urology work so the independent sector was used on occasion to improve access times for patients. However, the consultant body generally did not like to send their patients to the Independent sector. All patients who availed of the ISP service were approved by the Urologist before being transferred to Independent sector care. It is useful to note that the consultant Urologists employed by the Independent sector where largely NHS consultants. One exception was an ISP in Ireland which provided Urological services for the Trust as a one-off initiative. All practitioner CVs from the independent sector providers where screened and approved by the Associate Medical Director in the Trust for appropriate clinical experience and expertise.
g. As well as striving to increase activity, there were constant efforts to reduce demand through appropriately working with GP colleagues to enable them (through consultant agreed clinical pathways) to manage patients at local GP practice level where this was appropriate.
h. There was intermittent waiting list validation where patient conditions were reviewed to ascertain if an appointment was still required.
i. In 2015, patient pathways were reviewed with one-stop-shop clinics being implemented to provide for patients following a red flag referral to attend the Urology centre, have all the appropriate tests performed on the same day, get the results of their tests the same day, and be able to leave the clinic having a cancer diagnosis ruled out or, if diagnosed with cancer, having a plan of treatment discussed for their consideration. While the clinic was long and involved much activity, patients reported

that it greatly reduced their anxiety, provided a rapid diagnosis, and quicker access to treatment.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

306. The Urology team were very aware of the risk of poor access to secondary care assessment and treatment. They were aware of the potential for no access to diagnosis of a life threatening illness, poor quality of life, pain and discomfort, lack of ability to maintain a job effectively (and therefore have financial insecurity), the psychological effect of ill health and a poor physical quality of life, worry and concern of family members, and many more factors associated with ill health. Therefore, access to secondary care assessment and treatment was risk assessed and systems put in place to reduce same.

a. The GP referral categorisation of routine, urgent and red flag was one key way to ensure that those patients at greater risk of a life threatening illness were prioritised for diagnosis and treatment.
b. A system of GP escalation was also in place, whereby they could either contact the consultant secretary to advise a change in patient condition that required an urgent appointment or they could re refer the patient with a higher acuity referral designation.
c. All efforts were made to fully utilise all available capacity, create additional capacity either within the Trust or through the Independent sector, and seek additional funding from the Commissioner for more resources.

Please see response to Question 31, section 2, part (a) for further detail regarding actions taken.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps did not take to mitigate against this? If not, why not.

307. Patient care and safety are our core objectives. From both the perspective of the commissioner and the Trust, the first action to ensure patient care and safety was to provide access to a Urology specialist who had the expertise to assess their condition, request further investigations, reach a diagnosis, and prescribe and provide the treatment necessary. Northern Ireland has a regrettable history, still prevalent today, of long access waiting times for patients. It has been a constant endeavour to meet the access needs of our population to ensure initial care and safety.

308. In my experience, clinical teams and management were very aware of the impact of high volumes and long waiting access times for patients and the effect that had on their clinical care and safety if they could not get access to specialist assessment, diagnosis, and treatment.

309. Therefore all steps described above (i.e., close monitoring of fairness of chronological management, consultant triage, full use of clinics and theatres, the use of additional clinics and theatre lists within Trusts, and the use of the Independent Sector Providers where appropriate and approved by the Urology consultants) were used.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

310. Systems and agreements put in place to address patient access concerns are noted above, in particular in my response to Question 31, section 2, part (a).

311. The primary staff involved in implementing and monitoring these systems were the consultant team and support multidisciplinary team. The Heads of Service for Urology and ENT and Theatres, Outpatient managers, the Operational Support Lead for Surgery and Elective care, and other administrative staff.

312. Overseeing these actions from a monitoring perspective were myself as AD SEC, the Clinical Director and Associate Medical Director for Surgery and Elective Care, the Director of Acute Services, the assistant Director and Director of Performance and Reform, the Chief Executive, and Trust Board,, the Local commissioner, and the Regional commissioner HSCB.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

313. I monitored the following data :-

a. The provision of regular data to check the volume of patient access waits and lengths of waits.
b. Theatre Utilisation data, both day case and inpatient theatres, to ensure all lists were fully utilised.
c. Outpatient clinic data, including patient 'Can Not Attend' and 'Did Not Attend' rates.
d. The number of Waiting List Initiative sessions undertaken.
e. Independent sector activity including quality measures.
f. Triage return time escalation processes.
g. Chronological management data.
h. Patient feedback – inquiries / complaints.

(f) If you were given assurances by others, how did you test those assurances?

314. I tested assurances given by others by the following methods:-

a. Data monitoring as described above;
b. Team meetings as described above;
c. Independent review of data both internally by the Directorate of Performance and reform and by the HSCB;

d. Performance data on the quantity and quality of Independent Sector activity;
e. Escalations from the Booking Centre re referral triage times;
f. Escalations from Theatre Manager re theatre Utilisation;
g. Escalations from the manager of Outpatients re clinic utilisation.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

315. They were successful in ensuring that all capacity that was available was used to the maximum possible extent, both within core commissioned time and through Trust additional sessions and the use of the Independent Sector.

316. However, due to the challenges securing adequate staff at consultant and middle grade level, there was never enough capacity to meet the demand for patient access to the level of the regional agreed standards.

317. We were successful in improving patient pathways to improve patient experience and expediency of diagnosis for red flag patients.

318. There was limited success in supporting GPs to manage patients locally due to the nature of urological conditions.

319. There was limited success in reducing waiting times by waiting list validation.

320. There was reasonable success in securing additional Trust additional sessions.

321. There was limited success in securing ISPs due both to issues surrounding availability and the approval of consultants to send patients to the ISPs.

322. Timely triage of referrals was a standard process undertaken by all consultants irrespective of what surgical or medical specialty they worked in. It was accepted good practice. This process was successful in all specialties and amongst all clinicians. However, Mr O'Brien was inconsistent in undertaking referral triage in a timely manner. Despite much work and support in this area (referenced in particular in my answers to Question 37, we were not successful in ensuring that all patient referrals sent to Mr O'Brien for triage were always returned in the required timeframe. Escalation processes were put in place to monitor same. Further information will be given with respect to this concern in my answers to Question 37

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

323. Monitoring data, as indicated above in my answer to Question 31, section 2, part (e) was the primary measure used. Other measures were patient feedback – both complaints and compliments - and adverse incident data was also considered.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

(a) Properly identified

324. I believe the extent of the capacity and demand and waiting time issues in Urology were properly identified.

(b) their extent and impact assessed,

325. I believe that their extent was well assessed.

326. I believe the impact of the lack of capacity to meet demand in line with access standards was assessed with regard to the worry / concern / pain / distress that patients could have been experiencing while waiting on either a consultant assessment or treatment and I am certain that huge efforts were made by both the Trust, the management, and the clinical teams to do everything that was possible to improve access for patients.

327. The Trust was very mindful however that, despite all efforts, patients were waiting longer than they should have been and the impact of not being able to see all patients as we would have wished did cause distress to the whole team.

(c) and the potential risk to patients properly considered?

328. I believe the potential risks to patients on the whole were properly considered.

329. There were processes to ensure that, while we tried to secure locum medical staff, the standard of their practice was appropriate, and many CVs were rejected if a high standard of experience and expertise could not be met.

330. Patients were only transferred to the care of Independent Sector Providers if they could evidence a high standard of practitioners and service and all patients selected for transfer to the ISP were screened by the Urology Consultant team to ensure patient safety.

331. The risks to patient safety were considered through the use of consultant triage as a recognised practice.

332. The risks to patient safety were considered at ward level with a range of quality indicators in place around nursing care.

333. Close scrutiny of waiting lists was in place to ensure that no patients waited an extraordinary length of time for assessment or treatment to ensure their safety and care.

(j) What, if any, support was provided to any urology staff, including Mr Aidan O'Brien (Consultant Urologist), by you and the Trust, given any of the concerns identified?

334. Each consultant Urologist had his own personal job plan as agreed between them, their medical lead, and the independent specialty advisor.

335. They were only ever required to undertake the sessions in their agreed job plan.

336. Additional clinic and theatre sessions were voluntary and were paid at additional rates.

337. Each consultant was supported by their personal secretary to assist with administrative duties. It is notable that, while the HSCB funded a 0.5 whole time equivalent ('WTE') secretary for each consultant, Mr O' Brien and each consultant Urologist at that time had 1 WTE secretary.

338. Each consultant was supported by a wide multidisciplinary team, in outpatients, theatre, day case, stone treatment centre, cancer tracking team, booking centre team, and ward staff. They were only required to undertake the duties expected regarding fulfilling their job plan sessions, maintaining their clinical competency through continual education, training and reading, complying with accepted standards of practice, managing their patients in a safe and effective manner, and working as part of a multidisciplinary team.

339. Mr O'Brien was given additional support with referral triage in that -

a. When the return times for his triage were longer than required, Mr Young would have done his triage for him.

b. At a point all red flag triage was performed by Mr Akhtar, one of the other Consultant Urologists.
c. At a point, all triage (except for those referrals directly named to Mr O'Brien) were shared between the other consultants to reduce the triage load on Mr O'Brien.
d. Mr O'Brien was asked to consider what additional admin support he would need to support triage return. He was asked to advise but did not return with his requirements, to the best of my knowledge.

340. To the best of my knowledge, no other consultant in any specialty had issues with returning patient triage in a timely manner.

3. Long Review Backlog

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

341. When I took up post in September 2009 there was a long backlog of patients requiring review by a consultant Urologist. These patients had been seen at least once by the Urologist, had a diagnosis, and had treatment prescribed. At the end of their outpatient appointment, a review appointment was requested by the consultant in a timeframe which he felt appropriate.

342. Review appointments were also generated both by consultant staff and middle grade / junior medical ward staff when discharging unscheduled or elective patients from the ward.

343. For a number of patients a consultant review would not have been required and they would have been discharged back to the care of their GP.

344. Due to data not being available from our system back to 2009, the earliest figure I can retrieve is from January 2011. At that time there were 3,293 patients awaiting review. Please see attached document which shows the review backlog numbers from 2011 until January 2022. This meant that 3,293 patients were awaiting a consultant review longer than the indicated timescale requested by the consultant / junior medical staff. *Please see for clarity attachment Outpatient waiting list Located at Section 21 2 2022*

345. This was a major patient care and safety concern and was evident by the data we monitored.

346. There were a number of contributory factors to the long review backlog:

a. There were driven and well monitored standards for waiting times for new outpatients by the HSCB but no standard for review waiting times. Therefore, with the huge demand for new outpatient consultations, there was a greater requirement by the HSCB to see more new patients than review patients. The thought process was that there was greater risk in not seeing new patients who were undiagnosed and untreated, than patients who had been seen and treatment started. However, the effect of that was the more new patients seen, the more review requirements were generated, without a commensurate capacity available to see the review patients.
b. Again, there was a considerable amount of additional waiting list clinics performed. The HSCB would primarily fund new outpatient activity as additional. These clinics generated review requests, again without commensurate additional review capacity being funded.
c. It was always a challenge for middle grade and junior medical staff (applicable in all specialties, not just Urology) to be able to make the decision not to review any patient they saw in clinic or indeed discharged from the ward. This generated a significant number of

patient review requests which may not always have been appropriate.

d. The clinical nature of the urology specialty means that many urology conditions can be of a chronic nature. Some can be followed up by the patient's GP successfully but many do require follow up by the specialist urology team.

347. The review backlog, while not a monitored standard, was discussed at all performance meetings indicated above in part a, within the Trust. It is of note that the issue of review backlogs, for the reasons indicated above, was unfortunately not only relevant to Urology but was prevalent in all medical and surgical specialties at that time. It was a continual effort to ensure there was a balance as far as possible between new and review slots at clinics for all specialties.

348. The risk of insufficient capacity and resources to manage patients waiting on a review appointment was on the Acute Services Risk Register and was still there in 2014. *Please see for clarity Acute Risk Register 2009 to 2016 located in Section 21 2 of 2022.*

349. Concerns regarding the review backlog were also discussed at meetings with the Consultant Urologists.

350. As well as internally within the Trust, the local and Regional Commissioner were very aware of our concerns and it would have been discussed at regional meetings.

351. The modernisation of review practice was a recommendation on the Team South model, number 16. The practice of the then medical team was benchmarked against peer urologists across the UK and it was considered by the HSCB that the 'new to review ratio' in the ST Urology team was high in comparison with UK Trusts.

352. The HSCB on occasion did fund additional clinics to see review patients, which was helpful. Please see attached email showing funding

received for additional review backlog clinics. *Document 29.04.14 funding email located in Section 21 2 2022.*

353. With regard to actions taken to address the concerns regarding patient safety on the review backlog, I refer to the review backlog action plan attached and the document setting out plan in 2011. *Please see attachment Review backlog action plan which can be located in Section 21 2 2022*

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

354. As indicated in my answer to part (a) of my answer to this Question (Q31, section 3, part (a)), the risk of insufficient capacity and resources to manage patients waiting on a review appointment was on the Acute Services Risk Register.

355. The risk assessed was that to patient safety, treatment, care and outcome. The Urology team were very aware that, while a patient remained on the review backlog, their condition could have deteriorated, resolved, caused daily limitations to their quality of life, function and ability to work, and potentially caused distress for patients and their families.

356. In addition, the following steps were taken:-

a. Patients with a diagnosis of cancer were not part of the review backlog; review for cancer patients was prioritised.

b. In 2012 we asked the consultants to indicate in clinic if the review request was for an urgent or a routine review. Again, to manage patients as safely as possible in a capacity-constrained environment, this was to ensure we could identify those more at risk if not reviewed than those awaiting a routine review. The Inquiry is referred to the following documents showing waiting times for review backlog appointments - *Document Outpatient waiting list located in Section 21 2 2022*, that, although those waiting an urgent review were less that those waiting a routine review, there were still significant numbers of patients awaiting an urgent review. Please

see attached table showing the review backlog data for 2022, *20220216 Urology Review Backlog located in Section 21 2 2022*.

c. There was also a consultant categorisation of 'top of list' which they used for specific patients that had to get a review in the specified timescale.
d. There were periodic waiting list validation programmes, where patients were contacted by telephone to ascertain if they still required a consultant review. This was both to see if patients no longer required a review as they potentially had been seen and treated at another Trust or as an unscheduled admission within the Trust but also to establish if there were patients who needed escalated for a review appointment.
e. There was also a very clear agreement with our GPs that, if they were concerned about any patient who was waiting a review, they could contact the service for an escalated appointment. GPs were also advised that, if they thought their patient's condition had changed and they were now concerned about a cancer diagnosis, they should re-refer the patient as a red flag.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps did not take to mitigate against this? If not, why not.

357. We were very aware, as a Urology team and as a Trust, that not having the capacity to review all patients in the timescale requested could have an impact on patient care and safety.

358. Steps taken in response are set out in the answer to the previous part (Question 31, section 3, part (b)) of this question and in the *Review Backlog Action Plan, located in Section 21 2 2022*. Steps taken can be summarised as follows:-

a. Worked with GPs to agree patient pathways where they were both competent and confident to manage ongoing treatment without a consultant review to reduce unnecessary secondary care reviews.
b. Worked with middle grade / junior medical staff to educate them regarding the appropriateness of review for patients at clinic and following inpatient discharge. This was supported by the Ward Sister for ward discharge reviews.
c. Ensured there was a balance between new and review patients at clinic.
d. Prioritised urgent review requests for appointments.
e. Sought funding for additional review backlog clinics to see review patients.
f. Performed waiting list validation work both to ensure reviews were still required and to escalate patients who now needed urgent review.
g. Where possible, working as a consultant team to review each other's patients if one consultant had a much shorter review backlog than his colleague.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

359. Please see my answers above (in particular, Question 31, section 3, parts (b) and (c)) for details of systems and processes put in place to address these concerns.

360. Regarding implementing and monitoring, this was collaborative work between medical teams in working with GPs, Middle grade and Junior medical staff, and the ward sister. It also involved challenging their own review request practice and administrative and nursing staff undertaking the review validation programme, as well as ensuring outpatient clinics were balanced with both new and review patient slots, ensuring urgent review patients were prioritised for clinics and monitoring each consultant review list, and working with the

consultant team re the sharing of reviews to balance the risk were appropriate.

361. I believe that the Head of Urology and ENT, along with the Operational Support Lead, would have overseen this activity

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

362. I relied on the following steps in this regard:

a. Review backlog data was monitored on a weekly basis by the operational Support lead, Mrs Sharon Glenny, reported through the Head of Service for Urology and ENT and to myself.
b. New and review clinic templates were monitored for balance of both types of appointments by the Head of Service for Urology and ENT
c. Reports on the outcome of validation programmes would have been available to see the outcome of such work. Initially monitored by the Head of Service for Urology and ENT, the outcome was then reported to myself.
d. The administrative team would have monitored the number of patient review requests at ward level by junior medical staff following consultant education sessions.

363. I believe that it is important to note that the whole clinical team, including management and administration, were concerned regarding all review backlogs and did everything possible to manage same within the severe capacity constraints (as noted earlier) regarding staffing challenges.

(f) If you were given assurances by others, how did you test those assurances?

364. I tested assurances in a number of ways:

a. Primarily, data review of the number of patients on the review backlog and the length of wait. The review of the review backlog data was a core element of all performance meetings where practice was constructively challenged to ensure that all that could be done to improve was being done.
b. Testing, through conversations with the GP / Trust Medical link, that GPs were aware of approved patient pathways and their role in managing appropriate patients at GP practice level.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

365. In my opinion, the systems and agreements put in place went some way to preventing further deterioration of the review backlog but, as the Inquiry can see from the data, even in 2022 there still remains a review backlog issue with a much larger team in place. *Please see review backlog data for 2022 in this regard, 20220216 Urology Review Backlog located in Section 21 2 2022.*

366. Due to a combination of:-

a. High numbers of new referral demand;
b. High number of red flag referrals which were prioritised;
c. Long waiting lists for day case and inpatient treatment;
d. A significant unscheduled care demand;
e. Instability in the medical workforce from a turnover and vacancy perspective;
f. Lack of availability of trained Consultant Urologists;
g. Instability in the junior medical workforce from a vacancy perspective;
h. Frequent additional waiting list clinics for new patients that generated review requests with no matching additional review capacity;

i. Regional prioritisation of new patients; and
j. The overall gap between demand for Urology services and the Urology capacity available;

the appropriate reduction of the established review backlog was always a very challenging task.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

367. While further deterioration in the review backlog was curtailed by all the actions taken above, I believe that, due to the challenges and competing pressures noted above, we never successfully eliminated the review backlog.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

i. **Properly identified**;

368. I do believe that the issue of the review backlog was properly identified and escalated both within the Trust and Regionally to the Commissioner of services.

369. I cannot comment as to whether there were deficiencies in clinical practice regarding the number of reviews requested – that is very much a clinical decision.

370. Regarding my view of deficiencies within the service as a whole in managing the review backlog, I believe that it was primarily a demand and capacity issue which affected every part of the service including the team's ability to see review patients in a timely way.

ii. their extent and impact assessed;

371. I believe that their extent and impact were well assessed.

372. The Trust was very mindful, however, that despite all efforts, patients were waiting longer than they should have and the impact of not being able to see all patients as we would have wished did cause distress to the whole team.

iii. and the potential risk to patients properly considered?

373. I believe the potential risk to patients was considered, hence the actions put in place to prioritise cancer patients and patients requiring urgent review, link with GPs, provide clear guidance to escalate concerns or re-refer as a red flag patient, seek funding for additional review clinics, and work to reduce inappropriate reviews, etc.

374.

(j) What, if any, support was provided to any urology staff, including Mr Aidan O'Brien (Consultant Urologist), by you and the Trust, given any of the concerns identified?

a. Funding was sought from the commissioner for additional review backlog clinics.
b. Arranged meetings with GPs to discuss and agree clinical pathways that would enable appropriate discharge from secondary care review to GP care.
c. Arranged a validation of review backlog lists to ensure that all patients on the list still required a review.
d. Arranged support for the junior doctors at ward level, by the ward sister, to enable them to make appropriate review arrangements.

<u>4. Consistently meeting cancer waiting times</u>

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

375. Standards for cancer waiting times were developed in 2008 (– *please see 'A Guide to Cancer Waiting Times' setting out the standards in 2008 located in Section 21 2 2022*) and are largely still in place today.

376. The concerns raised with me under this heading were as follows:-

a. Growing number of red flag referrals which was greater than the number of red flag slots at outpatient clinics (i.e., a lack of capacity). This was raised by the Cancer tracker team through the Head of Urology and ENT.
b. Long waits for first patient appointment due to lack of capacity, raised through the Head of Urology and ENT.
c. Long waits for essential radiological investigations as part of the diagnostic pathway. This was raised by the Cancer tracking team.
d. Patients breaching the 31 and 62 day pathway standards due to a combination of waits at various stages throughout the pathway. This too was raised by the cancer tracking team. *Please see for clarity documents located in Relevant to PIT, evidence added or renamed 19 01 22, Evidence No 77, No 77 – Heather Trouton amended emails with attachments, referrals located in PIT, Document 20110909 Email RE urology red flag triage process, Document 20130409 Email Urology late triage, Document 20131112 Email Mr O'Brien and Charts, Email 19022013 Urology referrals, located in Section 21 2 of 2022.*

e. Lack of full multidisciplinary attendance at Cancer MDMs. Attendance of the whole team, in particular, inconsistent attendance by the Radiologist with specialist interest in Urology and the Belfast Oncologist, was raised by Mr Akhtar in July 2011 to the Director of Acute Services, Dr Gillian Rankin. *Documents located in Relevant to PIT, evidence added or renamed 19 01 22, Evidence No 77, No 77 – Heather Trouton amended emails with attachments 20110721 Oncology involvement in tye urology mdm and Document 20110610 Email FW urology MDT.*

f. A greater number of patients to be discussed at each MDM meeting than the time available permitted. This was raised to the consultants by the cancer tracking team

377. There were weekly cancer performance meetings chaired by the Head of Cancer services and which the Heads of Services for each specialty attended. I did not regularly attend these meetings and therefore I have no meetings notes from same. Mrs Martina Corrigan Head of Service for Urology & ENT may have notes of these meetings. I was made aware of these issues from Mrs Corrigan and Mrs Glenny Operational Support lead. I am advised that these meetings were the main forum for reviewing all patients on the cancer pathway, escalating concerns regarding access to a particular part of the pathway to seek a solution for same and seeking solutions to other areas of delay in a particular pathway. I am advised that following these meetings, action would be taken to try to deal with the issues raised.

378. The actions taken or directed to be taken as a result can be summarised as follows:-

a. With regard to the growing number of red flag referrals, there were only 2 ways to manage same initially:-

i. Fund additional clinics in the Out of Hours period to see patients;
ii. Displace routine patients and potentially urgent patients in core clinics.

b. Enabling red flag patients to be seen within 2 weeks of referral was a priority. When additional capacity could not be secured, regretfully the proportion of red flag / urgent / routine clinic slots had to be readjusted to meet red flag demand.

c. In January 2015, following the increase in the team to 5 consultants, a new one-stop-shop model was introduced in a new Thorndale Outpatient Centre in Craigavon Area Hospital. Please see The Vision for Urology Services *Document 20170915 Email Urology Board paper v2 1st sept located in Relevant to PIT, Evidence No 77, No 77 – Heather Trouton amended emails with attachments.*

d. One of the key aspects of this new model was to implement an all-day clinical assessment clinic for patients primarily referred as a red flag referral but also for Urgent patients. The premise was that each patient referred would have (i) a consultant assessment, (ii) all relevant investigations, (iii) the result of their tests, and (iv) (frequently) diagnosis, all in the same day and before they left the clinic. This was deemed an exemplar model by the HSCB.

e. The model worked well at first, assisting the clinical team in meeting the cancer pathway standards. However, as red flag demand grew, the clinic only managed to see red flag referrals with no capacity for urgent patients. Again, as demand grew further, the clinic also struggled to meet red flag demand. Once again, the service struggled to meet the 31 and 62 day pathways consistently.

f. The consistent theme of higher demand than funded and available capacity has been evident throughout the course of the Urology Unit. It must be noted

that Urology neither was nor is the only service to experience these challenges.

g. Clinical consultant teams in regional district hospitals are generally small. The impact of any prolonged vacancy, maternity leave, sickness absence, or any other absence has a huge impact on patient access times and this is most concerning in the case of a potential diagnosis of cancer, with the time critical element evident.

h. The red flag referral pathway was also a priority for the radiological department who again prioritised outpatient investigations based on referral category with red flag referrals taking precedence over urgent and routine referrals. The concern regarding the radiology part of the pathway was not primarily the undertaking of the investigation but the consultant reporting of same.

i. In the Trust there was only one consultant radiologist from 2009 to at least 2018 who specialised in Urology reporting. It is my understanding that, as the activity grew within Urology services and particularly following the increase to the 5 consultant model, one consultant could not keep up with reporting demand.

j. In my role as Assistant Director for Cancer and Clinical Services (2016 to January 2018), in which sits radiology, I had many discussions with the then clinical director for Radiology (Mr David Gracey) and the then Associate Medical Director (Dr Tariq) as to the need to increase the number of radiologists trained in Urology. The constraints to this were a general lack of radiologists in the Trust and Northern Ireland, with a number of vacant consultant posts in the department. Despite a number of recruitment initiatives, there were no available consultants who had the relevant specialist interest in Urology available to recruit. I also suggested that one of our consultant radiologists in post could train in Urology reporting. However, I was advised that there was no capacity to release from another specialty to undertake Urology training.

k. The other option available to the Trust was to use out-sourcing of specialist reporting through the Independent sector. This option was utilised as required to support reporting. However, this option could not support at cancer MDM.

l. All attempts were made in all sectors to address relevant capacity issues that impacted on the whole patient pathway but challenges remained.

m. With regard to the lack of oncologist support at MDM, this was addressed with Belfast Trust who tried to meet the needs of the Trust but, again due to staffing issues, this was not completely resolved.

n. There were actions taken re patient tracking and escalation of patients delayed on the pathway at various stages to seek urgent solution (whether that be a needed clinical appointment, an investigation, the reporting of an investigation, or a review with the relevant team). There was a clear drive to facilitate each stage of the patient pathway to meet the 31 and 62 day standards. Many patients did meet the standard but a significant number of patients breached the standard. Data on cancer standards was reported within the Trust at Acute Senior Management Performance meetings, performance data at Trust Board, and to the HSCB as commissioner.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

379. The potential impact of patients not being able to access timely appointments, investigations, results and access to first definitive treatment were risk assessed.

380. For example, even within the number of red flag referrals, the consultant Urologists undertook a clinical triage of these referrals both to review if the patient did indeed meet the red flag criteria but more importantly to prioritise those patients deemed at great risk of life threatening disease. The red flag triage process was very important as a risk assessment tool.

381. Each patient was tracked through the system until either they received a non-cancer diagnosis or until they received their first definitive treatment, whether this was hormone therapy, other therapies, or surgery. It is important to note that the commissioned system did not track patients after that point.

382. The risks of delay in diagnosis and treatment for cancer were well understood by the clinical and tracking teams and all was done to make the pathway as short as possible for patients (please see detail of the one stop clinic implemented in 2014 with this as a key focus). *Please see The Vision for Urology Services Document 20170915 Email Urology Board paper v2 1st sept located in Relevant to PIT, Evidence No 77, No 77 – Heather Trouton amended emails with attachments.*

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps did not take to mitigate against this? If not, why not.

383. We did consider that concerns raised regarding access to assessment, diagnostics, reporting, review, and treatment impacted on patient care and safety. The steps taken to mitigate are noted above but summarised as follows:-

a. Prioritisation of red flag referrals at clinics.
b. Additional waiting lists clinics for red flag patients when they could be secured.
c. A dedicated team to manage red flag referrals.
d. Support by the cancer tracking team to consultant red flag triage.
e. Prioritisation of red flag diagnostics.
f. Use of the Independent sector for reporting when demand was greater than in house reporting capacity.
g. Active tracking of all red flag patients through their active assessment and diagnostic journey.
h. Close working with Belfast Cancer centre re Oncologist availability for cancer MDM.

i. Urologist Chair of the Urology Cancer MDM with a focus on patient journey and outcome.
j. Review of the patient pathway and the implementation of the One stop assessment / diagnosis clinic in 2014.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

384. The systems and agreements have already been outlined in my answer to part (c) of this question (Question 31, section 4, part (c)).

385. Both the Urology clinical team, the cancer tracking team, the booking centre team, and the radiology team were involved in their respective parts of monitoring and implementing these systems. All was overseen by the Head of Urology and ENT, the Head of Cancer Services and the Operational Support Leads for both services.

386. There was a robust escalation process in place by the cancer tracking team to alert of any delays that required action.

387. There were weekly meetings chaired by the Head of Cancer Services with each Specialty Head of Service to go through each patient on the pathway, reviewing those patients on track as appropriate, those patients waiting longer for a certain element of the pathway for appropriate intervention, and to overview the data relating to the cancer standards for their service as a whole.

388. As noted above, data on the cancer standards was tabled at senior performance meetings and was monitored at all levels.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

389. I monitored the cancer standard 31 and 62 day pathway standards for all the surgical services for which I was responsible.

390. I was included in the escalation process so that I could see the challenges in finding enough capacity at all parts of the pathway to meet the standards.

391. I attended the weekly cancer meetings periodically to ensure that the problem-solving approach at this weekly meeting was still in place and working where it was possible.

392. I reviewed the 31 and 62 day breach report to ensure that there were either no breaches or that all had been done that could possibly have been done for those patients who did breach the standard, seeking solutions for those patients.

(f) If you were given assurances by others, how did you test those assurances?

393. I did this in a number of ways:

a. By reviewing data, as described above.

b. By attending meetings with the cancer team to hear their challenges and be assured that my team were working with the cancer team to prioritise patients as needed.

c. By reviewing patient complaints / concerns / inquiries regarding their experience of their journey.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

394. The systems and agreements were successful to an extent, in that the patient's diagnosis journey was closely tracked and patients were prioritised for access to assessment and diagnostics. However, due to a lack of sufficient capacity within the Urology team, radiology, and oncology, it was not possible to completely rectify the situation and totally prevent pathway breaches. It is my understanding that the problem remains today but the current Urology team would have the specific data and be better able to address the current position.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

395. The primary metric used was the number of patients that breached the 31 or 62 day pathway standard. The aim was to have no patients breach the standard.

(i) Is it your view that the extent of the issues within urology services and the deficiencies in practice were:

(a) Properly identified

396. I think the issues relating to the patient journey up to diagnosis and first definitive treatment were identified with a focus on early diagnosis, MDM discussion on clinical management, and decision on treatment.

397. However, knowing what we know now regarding the practice, on occasions, of Mr O'Brien not referring patients on for treatment post-diagnosis nor referring patients with a cancer diagnosis to the specialist cancer nurse for support and follow up, I would have to say that the extent of the issues in this regard were not properly identified at that time. Again, it was expected that the consultant would have accessed all relevant support for their patients and

ensured appropriate referral for treatment. At no point did anyone suspect this would not be the case for a number of patients.

(b) their extent and impact assessed

398. The extent and impact of not being able to access timely assessment, diagnosis, and treatment was assessed.

399. What was not assessed was the potential extent and impact of deficiencies in consultant practice post-diagnosis.

(c) and the potential risk to patients properly considered?

400. As above, the potential risk to patients of not getting timely access to assessment, diagnosis, and treatment was properly considered and all action was taken to mitigate against this risk.

401. However, the potential risks to patients arising from deficiencies in consultant practice post-diagnosis were not properly considered.

(j) What, if any, support was provided to any urology staff, including Mr Aidan O'Brien (Consultant Urologist), by you and the Trust, given any of the concerns identified?

402. The Trust implemented a dedicated Cancer tracking team who were focused on receiving all red flag referrals into Urology, working with consultants to ensure effective secondary care triage of same, and working with the booking centre to ensure that enough red flag appointment slots were available at clinic to see the patients requiring same. The cancer tracking team also worked with radiology to seek urgent diagnostic appointments for these patients. Effectively, the tracking team prepared the pathway for red flag patients so that the consultant could see at a clinic, review their diagnostic

test results, diagnose, discuss at MDT, and prescribe treatment which only the consultant could do.

403. Where consultants were available and willing to undertake additional clinic sessions, these were provided by the Trust to ensure timely assessment.

404. The Trust also worked to create a new Thorndale outpatient clinic facility in the centre of the hospital for one stop assessment, investigation and diagnosis of patients.

2009 - 2020

Mr O'Brien

[32] Please set out your role and responsibilities in relation to Mr O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

405. My Roles and responsibilities in relation to Mr O'Brien were as per my Job Description for my role as *AD SEC (Document 1- AD of Surgery and Elective Care band 8C JD located at Section 21 2 2022.* They were:-

a. To collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's delivery plan and ensure effective multidisciplinary working.
b. Provide clear leadership to staff within the Division and ensure all specialties have a highly skilled flexible and motivated workforce.
c. Ensure that management structures and practices in the Division support a culture of effective team working, continuous improvement and innovation.

d. Ensure the effective management of staff health and safety and support in the Division.
e. Maintain staff relationships and morale amongst the staff reporting to him/her.

406. I would have had minimal direct contact with Mr O'Brien. The Head of Urology and ENT would have had direct contact with the Urology Consultants and medical staff. I would have been present at Urology meetings at which Mr O'Brien was also present, chaired by the Director of Acute Services, during the implementation of the Team South model. Mr O'Brien would also have attended a small number of meetings with GP colleagues to discuss patient pathways at which I was present. Infrequently, I would have attended the Urology team scheduling meeting to support the Urology Head of Service and Operational Support Lead in discussing how the team could address patients waiting a long time for surgery to ascertain if they could be scheduled for surgery.

407. My primary contact with medical services in Urology would have been through the Clinical Director for Surgery and Elective Care or the Associate Medical Director for Surgery and Elective Care. I would have primarily shared any concerns with the CD and AMD to address with the Urology Medical team. There were a very few times that I approached Mr O'Brien directly in his office to discuss concerns regarding his attitude to triage and taking medical notes home and not returning same in a reasonable time period. On these occasions Mr O'Brien promised to address the issues raised. I would also have met Mr O'Brien informally if he was visiting the Head of Urology, whose office was in the same corridor as my own. I cannot recall the dates and times of these conversations with Mr O'Brien.

408. With regard to percentage terms, the percentage contact I would have had directly with Mr O'Brien over the years as a percentage of my work time would, in my estimation, have been less than 1%.

[33] What, if any, was your role and involvement in the formulation and agreement of Mr O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

409. I had minimal involvement in the formulation and agreement of Mr O'Brien's job plans. Job planning was primarily the responsibility of the Clinical Director and Associate Medical Director. My involvement was as follows:-

a. To link with the Health and Social Care Board as the commissioners for all services including Urology as to commissioned activity and how that related to consultant job plans. For example, it was generally accepted that a Surgeon's job plan consisted of a set number of sessions to undertake specific service delivery activities. Consultant job plans were constructed to meet both the needs of the service and the consultant. My role was to check that the expected number of direct patient care sessions required by the commissioner was present in the job plan to deliver the activity commissioned per consultant. Job plans had also to be approved by an external specialty advisor.
b. Once the job plans were agreed by both the CD, the AMD, the relevant consultant, and medical HR, I was the final approver on the electronic Zircadian job planning record system.
c. I did not engage directly with Mr O'Brien with regard to his job plan.

[34] When and in what context did you first become aware of issues of concern regarding Mr O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?

410. As I recall, my first awareness of the practice of Mr O'Brien was when I took up the post of Assistant Director of Surgery and Elective Care in October 2009. At that early point, there were 3 Consultant Urologists in post: Mr Young, Mr Akhtar and Mr O'Brien. Mr Young was the Clinical Lead.

411. I would refer the Inquiry to my note book entry which, while not dated, refers to Joy Youart as Director of Acute Services. She left the Trust in December 2009 so I can conclude that this note was made between 10th October 2009 and December 2010. *Please see notebook entry located in*

relevant to PIT, Evidence after 4 November 2021 PIT. Reference 77, Reference 77 – Heather Trouton document Sept 2009 notebook.

412. I believe that I can take from the note the following: it referred to delays in referral triage, with a medical audit on the volumes involved requested. Mr Brown (CD) was to be involved in the data analysis, a report to Mr Mackle AMD of the data outcome was to be made, with a plan for Mr Mackle to meet to address with Mr O'Brien (as this was a clinical practice issue), with a further plan to escalate to the Director (Mrs Joy Youart) and Medical Director (Dr Patrick Loughran) if the issue could not be successfully resolved.

413. I am afraid I cannot see a note of the outcome of this particular planned approach nor can I recall the outcome.

414. The primary concerns regarding Mr O'Brien that were brought to my attention were as follows. These particular concerns came to my attention when I took up post as Assistant Director for Surgery and Elective Care.

a. Taking patient notes home and not returning them in a timely fashion.
b. Not returning patient referrals following consultant triage in the required timeframe.
c. Large number of patients awaiting his review.
d. Proactive prescription of IV antibiotics for management of Urinary Tract Infection.

415. There were other more singular issues brought to my attention over the period September 2009 to March 2016 but those noted above were recurrent concerns. The 4th concern was resolved, the first 2 concerns resolved intermittently but recurred, and the 3rd concern did not resolve, primarily due to general capacity issues.

416. Singular issues noted included the following:-

a. Not referring patients for pre-operative assessment in a timely fashion or at all. This was brought to my attention in November 2015 for the first time .Please see email denoting issue with pre op assessment. *I refer you to document DSU list 05.11.2015 email Urology DSU List located in Relevant to PIT, Evidence after 4th November PIT, Reference 77, Reference 77 – Heather Trouton.*

b. Periodic concerns regarding listing patients he had seen privately as outpatients but referring to NHS for surgical treatment and listing these patients in a short timeframe. When noted and asked re short waiting time for surgery, Mr O'Brien would always have had clinical justification for the short wait. This concern arose at various times throughout my tenure as AD.

c. Towards the end of my tenure as AD for Surgery and Elective Care, in 2015, a new concern was raised to me and Mr Mackle by the Head of Urology and ENT as to Mr O'Brien not recording patient outcomes on the electronic patient centre administration system or often in patient notes. This issue came to light with the expansion of the Urology team. The new consultants were undertaking a review of Mr O'Brien's patients in the review backlog as one of the measures introduced to reduce same. As they were relatively new consultants they had not at that point generated a review backlog of their own. While reviewing the patients, they noticed they could not find any record of the outcome of the last review by Mr O'Brien on the patient centre record and escalated same to Mrs Corrigan. This was in turn escalated through medical management lines.

417. I do not know how long these particular concerns were known about prior me taking up post but I am aware that while Mr O'Brien was a highly esteemed Urologist and it was known he had his own way of managing patients from an administrative perspective.

418. It is important to note that, throughout my time as Assistant Director for Surgery and Elective Care, while there were concerns regarding Mr O'Brien's

administrative management and the potential links to patient safety and care relating to those concerns, at no time were any concerns raised to me regarding the safety of his clinical management of patients.

[35] Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr O'Brien, whether with Mr O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

419. There were numerous discussions regarding the recurrent concerns detailed above. I base my recollections on emails and notebook notes referring to patient triage, patient notes, IV antibiotic management, and review backlog. Please see further detail in attachments referenced in the responses to Question 3. However there were other discussions of which I cannot remember the exact detail nor the dates.

420. Discussions regarding the recurrent concerns took place with the following individuals to seek to address the concerns:-

a. Mr O'Brien – to address his triage, patient notes and review backlog.
b. Mr Young – Lead Urology Clinician for assistance in Mr O'Brien undertaking timely triage and returning patient notes .Please see attached email.
c. Mr Brown – Clinical Director for assistance in speaking to Mr O'Brien as his Clinical Director to address his triage work and not keep patient notes at home .Please see attached email.
d. Mr Mackle - Associate Medical Director regarding my concerns on Mr O'Brien's administrative practice.
e. Dr Gillian Rankin – Director of Acute Services December 2009 to March 2013 on all concerns relating to Mr O'Brien's administrative practice.
f. Mrs Debbie Burns – Director of Acute Services April 2013 to June 2015 on all concerns relating to Mr O'Brien's administrative practice.

g. Mrs Esther Gishkori – Director of Acute Services July 2015 to June 2019 on all concerns relating to Mr O'Brien's administrative practice.
h. Dr Richard Wright - Medical Director on all concerns relating to Mr O'Brien's administrative practice.
i. Mrs Martina Corrigan – Head of Urology, ENT and Outpatients.
j. Mrs Anita Carroll – Assistant Director of Functional Support Services (including the Outpatient booking centre and administration staff).

421. The majority of discussions regarding concerns about Mr O'Brien were as part of one to one conversations or escalation of concerns for action by his clinical colleagues and medical managers. On most occasions, there would not have been documented evidence of the content of one to one discussions with any of the parties noted above. I am certain, however, that all staff listed above were aware of the concerns regarding Mr O'Brien's practice regarding triage, patient notes, IV antibiotic prescribing, and the review backlog of patients and the actions taken to address these concerns. *Please see for clarity notebooks located in Relevant to PIT, Evidence after 4 November PIT, Reference 77, Reference 77 – Heather Trouton Document 16.06.2009 notebook1, Document 2009 4,Document 2015 Esther, Document 21.09.2009 2 , Document 8th Feb 2016, Document Feb 2010 notebook , Document July 2011 notebook , Document July page 1 of 2, Document July 2011 2of2, Document March 2016 notebook , Document May 2011 notebook page 1 of 3, Document May 2011 page 2 of 3 , Document May 2011 Page 3 of 3 , Document October 2015 , Document Sept 2009 Notebook and Document june 2011 page 2 of 2 notebook located in Section 21 2 of 2022*

422. Other than the records mentioned above, I do not have the dates of these conversations available to me.

Discussions with Mr O'Brien

423. One to one discussions were held in either Mr O'Brien's office, Mrs Corrigan's office, my office, Director of Acute Services' office, or Mr Brown's office. These were the areas where one to one meetings would have been held.

424. The content of the discussions were centred around concern regarding the timely response to patient triage, patient notes, and the review backlog.

425. These discussions directly with Mr O'Brien were primarily via the Head of Urology and ENT but on occasion by Mr Young, Mr Brown, Mr Mackle, Dr Rankin, Mrs Burns, Mrs Gishkori, or myself. Following discussion with Mr O'Brien, his practice would improve for a period. However, this improvement was not sustained and, through alert systems, we would have been alerted to delayed triage / missing notes which was then followed up for action. Review backlog numbers were also constantly monitored.

426. Despite conversations at a very senior level with Mr O'Brien and assurances that triage would be undertaken, this issue was regretfully recurrent on an intermittent basis. In January 2016, Mr Mackle and I met with the Medical Director (Dr Richard Wright) to discuss our concerns regarding these recurrent issues. Dr Wright advised at this meeting that it was time to put the concerns in writing to Mr O'Brien and seek a plan to address these concerns. A letter was issued to Mr O'Brien in March 2016. *Please attached letter, document Relevant to PIT, Evidence Added or Renamed 19 01 2022, reference 77, No 77 – Heather Trouton amended emails with attachments attachment 20160822 Email Confidential- AOB SG A.*

Discussions with Mr Young

427. Discussion of concerns relating to patient triage, patient notes, and review backlog took place with Mr Young, Clinical Lead for Urology. Mr Young would have undertaken to speak to Mr O'Brien regarding this unacceptable practice as his medical lead. Mr Young also assisted on a number of occasions to address the triage for Mr O'Brien. Mr Young also, at a point in time, agreed that only named referrals (i.e., those specifically addressed by the referring party to Mr O'Brien) would be sent to Mr O'Brien for triage and that all unnamed referrals would be sent to the other consultants for triage. Mr

Young attempted both to address the concerns with Mr O'Brien which resulted in temporary improvement and also to practically assist with taking all or part of the workload from Mr O'Brien. It is worth noting, however, that as the consultant team grew and new consultants came into the team, they were not willing to undertake Mr O'Brien's share of triage.

428. With regard to holding of patients notes at home, Mr Young addressed this issue with Mr O'Brien with temporary positive results.

429. With regard to concerns about the volume and length of review backlog, Mr Young also had a considerable review backlog.

Escalation

430. As Clinical Director, the next escalation point would have been to Mr Robin Brown. I understand that Mr Brown had a number of discussions with Mr O'Brien in his role as CD regarding his need to address patient triage, return patient notes, and reduce his review backlog. Again, the outcome was that improvement was secured but not sustained.

431. As Associate Medical Director, Mr Mackle was the next escalation point to address concerns regarding clinical practice with regard to triage, patient notes, and review backlog. I understand Mr Mackle also had a number of conversations with Mr O'Brien to address these concerns. Again, the outcome was that improvement was obtained but not sustained.

432. On occasion, the Director of Acute Services was the next escalation point. I refer in this regard to notes of a meeting held on June 9th 2011 with Dr Rankin *(Please see for clarity Document 20110627 Email urology Meetings Memo A2 located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Heather Trouton amended emails with attachments)* which notes a discussion with Mr O'Brien regarding various issues including concerns around his review backlog and need to address same. I refer also to Mr O'Brien's response to the notes of that meeting *(Please see attached document Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton, Document entitled 29.08.2011 Issues and Actions from meeting held on 09 June 2011).* I believe

that the Directors of Acute Services were aware of all recurrent concerns and intervened directly with Mr O'Brien when required.

Other Discussions

433. Other discussions were had between the Head of Urology and ENT directly with Mr Young, Mr Brown, Mr Mackle, successive Directors of Acute Services, and myself regarding action that was required to address these recurrent concerns. In essence, the approach was primarily to request Mr O'Brien to address the concerns and to support him to do so. During my tenure, while these were recurring concerns, they were intermittent. Mr O'Brien did evidence improvement in practice and did show a willingness to meet his administration commitments. At no time did Mr O'Brien say that he would not undertake triage, not return patient notes, or not try to reduce his review backlog. However, it is also the case that, despite Mr O'Brien's endeavours to improve, acceptable clinical administrative practices regarding triage, patient note availability, and review backlog were not consistently not achieved. My concerns regarding patient safety were:-

a. Patient notes not being available in the hospital for either emergency admission of use at another patient clinic.
b. While red flag patient triage was done appropriately, I had a concern that any delay in triage of urgent and routine referrals would delay addition to the outpatient waiting list and potentially delay appointment offer.
c. I was concerned that delay in triage would delay the potential to identify the need to upgrade a GP referral from urgent / routine to red flag. While this was rare (as GPs used the NICAN guidance to indicate which category of referral to use), I was concerned that triage delay would delay this potential opportunity to upgrade. Mr O'Brien was very aware of these concerns and his responsibility to triage all referrals with this in mind. Mr O'Brien did state, however, that he did not believe that the categorisation developed by the Health and Social Care Board of Routine, Urgent, and Red Flag was an appropriate way to categorise patient referral.

d. I was concerned that, while Mr O'Brien did maintain a separate review list for cancer patients, the scale and length of his review backlog for non cancer patients led to the potential for patients to have become clinically urgent. There was an arrangement with GPs that, if they were concerned about their patient and a change in condition, they could re-refer or escalate to the consultant secretary for urgent review appointment.

434. With regard to the concern noted regarding the practice of admitting a number of patients for Intravenous Antibiotic therapy for Urinary Tract Infection, this concern was raised initially by the Commissioner and then the Trust Lead Microbiologist who raised the concern that IV antibiotics should only be prescribed based on infection markers present in urine samples and that prescribing and administering IV antibiotics on a very regular basis without such diagnostic basis would cause harm to these patients in that they would become immune to the beneficial effects of the IV antibiotics and therefore would run out of effective treatments over time. It is my understanding that expert Urological opinion was sought concerning this practice which advised that there was no similar practice undertaken in other Urology Units and that the practice should cease. Mr O'Brien was requested to cease this practice and a process was put in place, overseen by the Microbiologist and the Clinical Director for General Surgery at that time, to ensure that appropriate microbiology input and approval was secured by Mr O'Brien for all cases where he wished to prescribe an IV antibiotic regime. This practice was clinically managed appropriately and ceased to be a concern.

[36] What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

435. Some of the actions planned and taken have already been discussed in my answer to Question 35 above. Other actions planned and taken are covered at Question 37 below.

[37] Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so, what steps did you take to mitigate against this? If not, why not?

436. As mentioned earlier in my statement, patient safety is the central concern of all clinical, managerial, and multidisciplinary staff in the Trust. My concerns regarding patient care and safety in the context of Mr O'Brien have been touched upon in other answers above. However, they are set out in more detail below under a number of headings (each one corresponding to a concern about Mr O'Brien).

Timely Patient triage

437. Mr O'Brien not undertaking patient referral triage in the required timescale was my primary concern.

438. While GPs and other secondary care clinicians had very clear cancer referral criteria and guidance to help them decide on the appropriate referral type, i.e., red flag (cancer indicators), urgent, or routine, on occasion the referral would have been either upgraded or downgraded in level of urgency by the Consultant undertaking the triage. They were appropriately deemed experts in symptom assessment. This was an important part of the referral process as a patient safety measure.

439. Consultant triage is a core accepted process in all consultant teams irrespective of the medical or surgical specialty. At no time as AD for SEC were there any concerns raised to me regarding any other surgical consultant indicating either an unwillingness to undertake their share of triage or veer way outside of the indicated triage return times.

440. Triage was also shared equally among each member of the consultant team.

441. Regarding the concerns of untimely triage in relation to patient safety, these were:-

a. Patients not being afforded the expert opinion of a consultant Urologist as to their level of referral urgency (i.e., not having the opportunity to be upgraded from routine to urgent or red flag or from Urgent to red flag) and the potential to come to harm if not seen as quickly as their condition indicated.
b. Patients not being added to the waiting list in a timely manner and therefore missing their rightful chronological management for a routine or urgent appointment.

442. Red flag referrals were managed through the cancer team and were listed for a red flag appointment outside of outpatient Triage.

443. Over the course of the period 2009 to 2016 the following steps were taken to address this issue:-

a. Discussion of the importance of Triage by his Associate Medical Director with him and the AMD seeking Mr O'Brien's commitment to performing same as required and in line with his colleagues from 2010 and intermittently thereafter.
b. Escalation to the Director of Acute Services for a more senior approach, with Mr O'Brien being asked for a commitment to perform same as required and in line with his colleagues from 2009.
c. Mr Young (his consultant colleague and Clinical Lead) offering help with Mr O'Brien's triage on a number of occasions - An example of this can be found in an email from Mr Young dated 2nd December 2013 at 15.28 *(Please see document 04.12.2013 email URGENT NEEDING A RESPONSEMISSING TRIAGE, located in Relevant to PIT, Evidence*

after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton).

d. Mr O'Brien being offered practical support from a team perspective to ensure timely triage, e.g., email dated 6th March 2014 referring to a meeting between Mr O'Brien, Mrs Debbie Burns (Director of Acute Services) and Martina Corrigan (HOS), where Mr O'Brien was relieved of his duty to triage general Urology referrals and only had to triage those referrals on which he is named directly (*Please see email attached following meeting with Mr O'Brien reference 20140306 email Mr O'Brien Triage located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton)*

e. Putting an escalation system in place where the central booking centre would escalate any delay in triage return both to the Head of Service for Urology and the Assistant Director for Functional Support Services (under which Admin Services sat) for action.
f. Mrs Corrigan requesting urgent triage returns from Mr O'Brien, directly and through his secretary.
g. Mrs Corrigan addressing the issue in person with Mr O'Brien, with Mr O'Brien promising to return outstanding referrals.
h. On occasion, escalation to me for my direct action with Mr O'Brien.
i. On occasion, escalation to Director of Acute Services for direct intervention with Mr O'Brien.
j. Escalation of concerns to the Clinical Lead and Clinical Director for direct action with Mr O'Brien. *Please see attachment Document 04.12.2013 email Urgent needing a response located in Relevant to PIT, Evidence after 4 November 2021 PIT, Reference 77, Reference 77 – Heather Trouton.*
k. Discussion with the Associate Medical Director for his action about concerns regarding triage returns from Mr O'Brien.
l. In 2014 an amended process was put in place, in that the booking centre was to go ahead and register any referral on the waiting time system (in line with the GP's categorization of the referral) to ensure that referrals were not lost and would be accurately managed in chronological time

while waiting for Mr O'Brien to return triage to the booking centre. This system was agreed following consideration by the AMD, Director of Acute Services, HOS, and myself as a safeguard. At no point did this process set aside the responsibility for Mr O'Brien to complete triage.

444. Following many attempts to constructively address the requirement to triage with Mr O'Brien, putting processes of escalation in place, reducing his triage workload, amending registration systems and processes to ensure chronological management of patients was maintained, and following many conversations with senior Trust staff regarding non-compliance, in January 2016 Mr Mackle and myself met with Dr Richard Wright (Medical Director) to escalate concerns again and seek direction on next steps. Dr Wright felt that it was time to put all the recurrent concerns in writing to Mr O'Brien and seek a plan to address. The final agreed letter to Mr O'Brien of March 2016 is attached *(located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Heather Trouton 20160822 Email Confidential-* Personal Information redacted by the USI *).*

<u>Holding Patient Notes at home for prolonged periods.</u>

445. Mr O'Brien would have taken patient notes home potentially for 2 reasons:-

a. For use at his Private Practice clinic in his own home.
b. To undertake patient recording at home.

446. While there were not clear Trust guidelines forbidding the taking of patient notes home, there were guidelines on how patient notes were to be tracked and managed. Please see Policy for the Safeguarding, Movement and Transportation of Patients, Client, Staff Trust Records, *located at Section 21 2 of 2022, Safeguarding Movement Transportation.*

447. Patient safety concerns arising from this included the following:-

a. Patient notes not being available for an emergency patient admission.
b. Patient notes not being available for use at another consultant clinic – an example of this occurred on 12th November 2013 when Dr Convery complained of no notes for his clinic. *Please see attached email reference 20131112 Mr O'Brien and charts, located in Relevant to PIT, Evidence Added or Renamed 19 01 2022, Evidence No 77, No 77 – Heather Trouton.*
c. This was before Northern Ireland Electronic Care Record was in place and paper notes were required to enable all staff to have a patient record to support safe patient care and treatment at the point of access to secondary care.

448. Steps taken to mitigate or address the patient notes issue included the following:-

a. A patient notes tracking system was put in place by administration / medical records team.
b. The importance of patient note availability was addressed with Mr O'Brien on a number of occasions by a number of senior staff.
c. There was escalation to Mrs Corrigan for required action with Mr O'Brien for urgent return or notes.
d. To my knowledge, there was consideration of putting in a system where each patient note set would be chipped and an alarm would sound if they were taken off the premises but I believe this was not thought to be a practical and efficient solution.

<u>Large Numbers of patients awaiting Backlog review</u>

449. In respect of this issue, I would refer the Inquiry to my answer to Question 31, section 3 which details all actions taken to address this concern with Mr O'Brien.

Inappropriate practice relating to the prescription of IV antibiotics for recurrent Urinary Tract Infection

450. It was identified in Spring 2009 that the clinical practice of managing recurrent urinary tract infections (UTIs) by intravenous (IV) fluids and antibiotics had become part of local urological practice over many years. This was discovered in Spring 2009 during an audit of bed usage, and was considered to be unusual. At that time the therapy was discussed with the clinicians involved and the Trust subsequently took expert advice and was persuaded that this therapy is not evidence based. About 35 patients were in the cohort, and following discussions with the commissioner, the Director of Acute Services at that time, and the clinicians, it was agreed that each member of the cohort would be reviewed with a view to ceasing IV therapy. The Clinicians involved were Mr O'Brien and Mr Young.

451. By January 2010, 10 patients remained active in undertaking this inpatient treatment.

452. The Trust then received a letter from the Commissioner seeking an assurance that this treatment had ceased and that no patient had central venous access. The Director of Acute Services and Associate Medical Director of Surgery and Elective Care met the two surgeons individually to require an immediate review of each patient in the remaining cohort of 10. The review was chaired by the Clinical Director of Surgery and Elective Care and Dr Damani, Consultant Microbiologist, who was to advise on optimum antimicrobial therapy. It was agreed that all potential future patients for IV therapy would also be reviewed in this manner. Both surgeons agreed to participate in this process.

453. A process was put in place whereby, before a patient was considered for admission for this treatment, the microbiologist was required to review the results of their urine and blood samples and collaboratively with the consultant

urologist agree the most appropriate treatment pathway. The then Clinical Director for Surgery and Elective Care was also to oversee any admissions for this treatment to ensure the correct evaluation process had been used.

454. A further patient-facing process was put in place to support those patients who were involved in a changing pathway. Some patients who had been treated as an inpatient for a long time found this change of practice very difficult to understand and adjust to but were supported in this change.

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[38] If applicable, please detail any agreed way forward which was reached between you and Mr O'Brien, or between you and others in relation to Mr O'Brien, given the concerns identified.

455. All actions and ways forward to address the concerns identified are noted above.

456. I believe it is important to note that Mr O'Brien, during many discussions with various senior staff, acknowledged that he needed to comply with triage, bring notes back in a timely manner, and work to reduce his review backlog. While he did cite that he struggled with time to undertake all his admin duties in a timely way, at no point was I ever aware of him saying that he would not do them.

457. I believe it is also important to note that the HSCB funding protocol for secretary support to Consultants was 0.5 whole time equivalents per consultant whereas Mr O'Brien had the support of a full time secretary to support his administrative workload. It was practically difficult to give Mr O'Brien even further direct admin support and, furthermore, it was deemed by his clinical colleagues to be unfair to other consultant staff for one consultant to be given potentially three times the level of admin support as other consultants enjoyed. Nonetheless, it is my understanding that, during a meeting with Mrs Debbie Burns (the then Director of Acute Services) in March 2014, she asked Mr O'Brien to consider what additional admin support he would require to assist timely triage and other admin duties. However, there is no record that I am aware of Mr O'Brien returning with a specific request in response.

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458. With regard to the issue of IV antibiotic therapy, I was not involved in that review / process. This was led by the Associate Medical Director and the

Director of Acute Services so I cannot comment on agreements reached, other than to advise the outcome of such agreements as already noted above.

[39] What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

459. The measures used were as follows:

a. Triage - Constant monitoring of triage return by the booking centre senior staff and appropriate escalation to Head of Service.

b. Patient notes at home - Constant monitoring by Health Records staff but it was difficult to trace and monitor.

c. Review Backlog - Regular reports to myself, the Director of Acute Services and Senior Management Team of review backlog data (volumes in each year and longest wait per category). In addition, a review of clinic templates by the Head of Urology and ENT to ensure review slots were available.

d. 4.IV antibiotics - Monitoring by Ward Sister of admissions for treatment and escalation where appropriate; Input of Microbiologist; Monitoring by Clinical Director of admissions for appropriateness. This was a new process to assist with appropriate clinical management of these patients.

[40] How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

Triage

460. I considered at that time that the escalation process from the booking centre to the Head of Urology was robust in itself to ensure patient referrals with Mr O'Brien were tracked and, through direct engagement, returned. However, on reflection and knowing what I now know regarding the number of untriaged referrals located in his office in 2016, this system was not sufficiently robust. There were not sufficient systems in place to regularly monitor and address the return of all referrals post-triage from Mr O'Brien. I sincerely regret not ensuring the implementation of a much more proactive monitoring system.

461. Because of the seriousness of the triage concerns raised and due to clinical assistance to resolve this practice being sought, there were long periods of time when no concerns were raised and the systems and agreements put in place appeared to be working. For example, Mr Young assisting with triage, Dr Rankin speaking to Mr O'Brien regarding undertaking triage appropriately and so forth.

462. The escalation and immediate action taken by staff to retrieve triage was robust but proactive monitoring was not as robust. However, the ability to secure corrective action by Mr O'Brien as a permanent change of his practice was not achieved. Mr O'Brien did respond to management and peer

intervention to return triage, and there were periods were he appeared to be returning same appropriately, but then delays would occur again.

463. The standard against which referral triage is to be returned was, as I recall, 72 hours.

464. During the time of the weekly performance meetings chaired by Dr Rankin and Mrs Burns, consecutive Directors of Acute Services, Mrs Catherine Robinson, Head of the Booking Centre, presented triage times for review at performance meetings with outstanding triage data being presented, discussed and action required. Mrs Robinson also held weekly meetings with the Heads of Service to discuss all issues pertaining to clinic booking, triage and attendance. I was aware of this at the time.

Patient notes

465. There were not sufficiently robust actions in place to address this issue. It was reliant on Mr O'Brien understanding the risks for patient safety associated with no patient notes being available in hospital for emergency admission and other clinics and being vigilant in returning patient notes in a timely manner. There was no mechanism put in place to fully ascertain the situation regarding patient notes retained at Mr O'Brien's home.

Review backlog

466. I was assured by the Head of Service and the Operational Support Lead at the time that all that could be done to reduce the review backlog, in light of other competing pressures, was being done and that the systems and agreements to address same were working as far as was possible. I believe that these assurances were correct. As already noted, the finite capacity of the Urology team was used to meet a number of competing demands with red flag referrals and cancer patients requiring prioritisation.

IV antibiotics

467. I was assured through the oversight of the Clinical Director, the Ward Sister, and evidence of reduced / eliminated inpatient practice that systems and agreements were working.

[41] Did any such agreements and systems put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

468. This question overlaps with Questions 38, 39 and 40 and I would refer to my answers to those questions where I give my view on whether the actions taken remedied each relevant concern. Below, I offer my views on the reasons for the lack of success of the measures adopted (save in respect of the IV antibiotics issue, which I believe was remedied successfully, as explained above).

469. In respect of the Review backlog, this improved but was not remedied. I believe that this was primarily due to the continuing mismatch between demand and capacity including, in particular, demand for new referrals and additional new referral outpatient clinics creating additional review demand with no matching additional review capacity. There was very little that could have been done differently and a review backlog remains today.

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470. Regarding patient notes, this issue was not remedied. I believe this to have been due to a disregard on the part of Mr O'Brien for the needs of other clinicians and services who may have needed patient notes. As the remedy necessitated a change of mindset of Mr O'Brien, the only other option would have been to check Mr O'Brien on leaving the Building each night. This was not practicable nor should it have been required in relation to an experienced clinician.

:-

471. In respect of Patient Triage, Mr O'Brien periodically improved his practice but the problem was never remedied. In my opinion, I believe this was due to a number of reasons:-

a. Mr O'Brien stated openly that he did not agree with the regional categorisation of patient referral, i.e., Red Flag, Urgent, and Routine. He stated that he did not believe that red flag referrals were any more important than non-red flag referrals and therefore should not be prioritised. I think that this belief held by Mr O'Brien influenced his commitment to timely triage.
b. Mr O'Brien did not, as I recall, use the function of his admin support as other consultants would have done and therefore found less time available to undertake admin duties that only he could do. For example, normal practice, when compiling a list of patients for theatre, involved the consultant giving his secretary the required theatre list and the secretary would have contacted each patient and made the arrangements for admission. It is my understanding that Mr O'Brien preferred to undertake that process himself.
c. Considering the response from the Clinical Lead and the Clinical Director when I sought assistance with this clinical issue, they chose a very facilitative and helpful approach which is often completely appropriate. However, knowing the patient safety issues apparent and the length of time for which the concern was prevalent, a more assertive requirement for appropriate triaging would, in my opinion, have been helpful and appropriate.
d. In my opinion, the peer challenge was not evident (with the exception of Mr Mackle, AMD) and it was only when the Urology Unit had grown to the 5 consultant team, with new and younger consultants that were willing to challenge peer practice, that a difference was made.

472. I believe Mr O'Brien should have been held to account for his clinical triaging practice by his Clinical Lead, Clinical Director, AMD, Director of Acute Services, and ultimately the Medical Director for patient safety. It was impossible to manage a consultant's practice outside of that medical Management structure.

[42] What support was provided by you and the Trust to Mr O'Brien given the concerns identified by him and others?

473. There were 2 issues identified by Mr O'Brien in relation to the concerns detailed above.

a. Time for triage.
b. His review backlog.

474. To the best of my knowledge he did not raise issues regarding patient notes at home.

475. In respect of triage, it was normal and accepted consultant practice that new GP referrals would be triaged by a consultant. It was accepted practice in all teams that this would be shared equally among each member of the consultant team on a rota basis.

476. To assist Mr O'Brien with this process, the following steps were taken:-

a. Only his own named referrals were sent to him for triage. These would have been the minority of new referrals as GPs were encouraged not to send named referrals.
b. On occasion he was totally relieved of triage by his consultant colleagues.
c. Mr O'Brien was encouraged to fully utilise the functions of his secretary, including theatre list management, to free up time for triage.
d. He was offered additional admin support by Mrs D Burns Director of Acute Services but, to the best of my knowledge, did not take up the offer.

477. In respect of the Review Backlog, the following steps were taken:-

a. Mr O'Brien was offered the opportunity to undertake paid additional clinics to see review patients.
b. He was supported, through agreed patient pathways with GPs, to discharge patient care to GPs where appropriate.
c. It was ensured there were review slots in his clinic template.

478. While there was no 'support' possible to address the issue of Mr O'Brien keeping notes at home, if this was a consequence of Mr O'Brien not having enough admin time to address all his administration during working hours, all the other supports offered to him (e.g., in respect of triage) would have collectively freed up time to enable him not to feel the need to take patient notes home. For example, as well as the supports noted above the offer of technology in the form of Digital dictation was offered to enable him to dictate after every patient in clinic, as was the practice of other consultants.

[43] What, if any, steps were taken to address the concerns identified following *Maintaining High Professional Standards Formal Investigation, Case Manager Determination* (prepared by Dr Khan, 28th September 2018) both regarding Mr O'Brien, as well as in respect of the wider systemic failings within urology services? Explain how the impact and effectiveness of such steps taken were monitored and reviewed.

479. At the time of this report, I was not involved in the Urology Service and therefore cannot answer this question. I would direct you to Mr Ronan Carroll, who was the Assistant Director for Surgery and Elective Care at this time, and to the Associate Medical Director, who I believe at that time was Dr C McAlister. As a member of Senior Management Team and Trust Board, this report did not come to my attention.

[44] What, if any, metrics were used in monitoring and assessing the effectiveness of these measures? How did these measures differ from what existed before?

480. As per my answer to Question 43, I would not be in a position to answer this question but would refer to the persons named there as persons who might be better able to do so.

[45] Is it your view that the problems identified by Mr Khan in his report were adequately addressed? If yes, set out how. If not, explain why you consider that to be the case.

481. I repeat my answer to Question 44 here.

[46] How, if at all, were the concerns raised by Mr O'Brien and others, and identified in the report of Mr Khan, reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to.

482. As a member of SMT and Trust Board, I do not recall the concerns raised by Mr O'Brien or identified in the report of Dr Khan being tabled at any Trust Governance meeting nor identified in the Corporate Risk Register.

[47] What is your view of the adequacy and/or effectiveness of the measures put in place during or at the conclusion of the MHSPS process, given what we now know of the problems which the Trust identified in respect of Mr O'Brien in 2020?

483. Details on any measures that have been put in place, during or at the conclusion of the MHPS process, have not been made available to me as a member of Senior Management Team or Trust Board. However, as part of my preparation for the Public Inquiry, I have appraised myself of a number of

documents. Please see attached for clarity, Final Report of the Stage 1 Grievance Mr A O'Brien O'Hare, Grievance Response Report Diamond and Young, and The report of Maintaining High Professional Standards Formal Investigation Case manager Determination Dr Khan report. *Attachments located at Section 21 2 of 2022, dr khan report, Grievance Response Report Diamond and Young.*

484. While they conclude that the practice of Mr O'Brien was not appropriate, they also raise the issue of "missed opportunities by managers to effectively and fully assess and address the deficiencies in practice of Mr O'Brien" and conclude that no one formally assessed the extent of the issues or properly identified the risk to patients". While I cannot comment from an informed position on the effectiveness of measures put in place post March 2016, I can conclude that, on reflection, there were missed opportunities by me and those operational and clinical managers that worked with me and to whom I reported during my tenure as Assistant Director from October 2009 to March 2016. I sincerely tried to ensure patient safety through all of my actions at that time as detailed in this statement, however I now know that I should have done more to better manage and monitor the triage process to ensure that no referral went untriaged and unreturned in the expected timeframe. I should not have relied on the clinical assurances given to me regarding Mr O'Brien's clinical excellence, but undertook a more robust objective investigation process. I sincerely regret that more was not done at the time. As my experience has developed, particularly in the last 4 years in a corporate role, I have learned and have grown in confidence and ability in speaking up against accepted practices which are not conducive to the best in quality care provision.

485. I am aware of a Review of Administration Process in Acute Services which was a recommendation of the Report of Dr Khan Maintaining High Professional Standards Formal Investigation, was completed on 10th May 2021. *Please see attached document Admin Review Process Nov 2021 1 - 6 located in Section 21 2 of 2022.*

Learning

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

486. Having had the opportunity to reflect, particularly several years later and from a different perspective outside of Acute Services, I consider the following to explain, at least in part, what went wrong:-

a. The demand and capacity for Urology services had been completely mismatched for a number of years, with demand far outstripping either the funded capacity to deliver Urology services in the Southern Trust or indeed medical workforce planning that enabled the availability of Urology medical staff at consultant and middle grade level to provide the extent of service required.
b. The resultant mismatch in demand / capacity necessitated a system which effectively had to ration the clinical expertise available to those deemed by the region to be most in need. This effectively meant meeting the needs of red flag patients first, urgent patients next, and routine and review patients last.
c. Unfortunately, this was not unusual at the time across almost all services and, regretfully, remains largely the case today. Consequently, the focus of the regional commissioner and the Trust was on creating systems to get patients seen, with less focus on the effectiveness of the patient pathway once in the consultant system.
d. While good systems of clinical and social care governance have developed incrementally over the last 10 years, championing standardised patient pathways, constructive clinical challenge, clinical benchmarking, constructive medical management, increased multidisciplinary team working, increased investigation following serious adverse incidents, and greater patient participation in care planning, these systems were not as well developed in the 2009 – 2016 period (when I had a responsibility for Urology Services).
e. I believe that the concerns within Urology services at that time were primarily due to a service that was simply not funded, nor able to secure the medical

staff required, to deliver the needs of our population. It was a service under pressure and that pressure included all members of the team including admin and management.

f. Knowing the clinical issues that we now know and, on reflection, I believe there was an over-reliance of trust in Mr O'Brien to manage patients clinically safely. While there was an acknowledgement at all levels of his different ways of managing administratively, there were no concerns raised regarding his clinical ability and therefore his admin management, although it differed from all his colleagues, was tolerated.

g. I believe that, while the patient safety concerns were identified relating to the deficiencies in admin management, the team were required to try to work around those deficiencies rather than have the support to require Mr O'Brien to address them effectively. On reflection, and while that was the culture of Acute Services during my tenure as Assistant Director, I take responsibility for not doing more to fully investigate and report on the effects of Mr O'Brien's administrative practice and ensure that action was taken to preserve the quality and safety of patient care in all its parts.

h. I also reflect that there was, potentially, an over reliance at the time on patient feedback. It was widely considered that, if you got access to the care of Mr O'Brien, then patient feedback indicated a super patient-centred service. The fact that Mr O'Brien phoned you himself to arrange your date for surgery was much appreciated by his patients. Patients reported him as attentive and considerate.

i. IT systems were not as well developed at this time, with most reliance still being on paper-based recording.

487. In conclusion and on reflection, I believe that Mr O'Brien was able to practice independently and not adhere to accepted systems and processes as he saw fit, primarily due to his status within the department and the Trust. Knowing what we know now, there could have been more independent audit into the practice of all consultants, checking the effectiveness of all patient pathways, reviewing patient outcomes, patient experience, and patient safety. However,

regretfully there was little or no capacity within the service at that time for such independent audit.

[49] What have you learned from a governance perspective from the issues of concern within urology services and the unit, and regarding the concerns involving Mr O'Brien in particular?

488. My Learning regarding or arising from the issues involving Urology services can be summarized as follows:-

a. While it is important to work to secure patient access to the service, it is also important to have better quality measurement systems, processes and metrics in place to monitor the quality and safety of patients as they transition through the service.
b. Within the NHS today, and in Northern Ireland in particular, the service capacity gaps, waiting lists, waiting times, and the challenges of meeting the needs of patients requiring an emergency admission are well-known from the front line of healthcare to the Minister of Health and the NI Executive and are well shared through our media channels. However, these well-known statistics involve individual patients and their families and we, as a system, cannot lose sight of the human impact of such gaps in capacity. So, not only do we need to work together, as a system, to increase the capacity to see and treat patients but we also need to see each individual and ensure that our governance systems serve to protect each and every one.
c. There is a greater need for patient experience and quality metrics to be part of Trust Board reports so that everyone, at every level, is aware of the challenges and can act to address them.
d. As a system, we must address the medical (and nursing / allied health professional) staffing gaps in our province. The lack of trained staff is the primary inhibitor in delivering the service we need to deliver for patients. While funding is

important, it will not be able to effect the change needed in the provision of safe and effective healthcare without the supply of trained staff to deliver that care.

e. Regarding the delivery of cancer care, from a governance perspective there is a need for a more integrated cancer service in Northern Ireland which transcends Trust barriers and looks at the staffing need across all cancer-related professions to ensure that the whole pathway for the patient is suitably staffed and available. Patients suffering from cancer need seamless and agile assessment, diagnostics, clinical diagnosis, and multidisciplinary treatment and support across Trusts. There is no place for silo working.

489. My key learning from the particular issues involving Mr O'Brien can be summarized as follows. I am given to understand that the medical management process has become more developed, inquisitive and independent. I think that, while there is a need for trust with regard to honesty, integrity, and patient-centred clinical excellence in regard to a consultant's practice, there also needs to be a healthy quality assessment / assurance process that supports both the Consultant, the patient, and the Trust.

[50] Do you think there was a failure to engage fully with the problems within urology services? Please explain your answer.

490. With regard to the problems with insufficient capacity to meet service demand, I believe there was a failure by the commissioner to invest sufficiently in the service to meet demand fully.

491. I believe that the Trust Urology team worked incredibly hard to identify the problems within the urology service, identifying same to the commissioner and seeking support for reform and development. I refer in this regard to the Urology Vision paper in 2014 and the internal reforms implemented to improve patient pathways. *Please see for clarity Document 20170915 Email*

Urology Board paper V2 1st Sept located in Relevant to PIT, Evidence No 77, No 77 – Heather Trouton amended emails with attachments.

492. I think that, as the capacity and demand problems within Urology were replicated across many acute services, the ability to fully address the same issues across a wide number of services was incredibly challenging for the limited management hours available.

493. I think that, as the problems of demand and capacity were replicated across many services regionally and across all Trusts, the ability to fully address by the commissioner with regard to funding was very challenging. The budget allocated to the Department of Health is limited with many competing demands for funding across all programmes of care, e.g., Mental Health, Learning Disability Services, Childrens and Older Peoples Services. Regionally, there is simply not sufficient funding to meet all health needs.

494. I believe there has been and still is a failure of regional medical workforce planning and training to engage meaningfully with service providers to ensure that enough medical staff are trained to meet the needs of the service to ensure patient safety. This includes meaningful engagement with all service providers in allocating training grades / junior doctors across all Trusts equally in Northern Ireland.

495. I think that the regional shortage of many medical consultants, across many specialties, created a significant dependence on those who were available and in post.

496. With regard to the problems specifically related to Mr O'Brien's practice, I think, as stated previously, that there was a failure to challenge and deal with his administrative practices that were out with the rest of his colleagues and, as we now understand (but did not fully appreciate then), were not just his personal preferences with regard to a way of working but had consequences for patient outcomes. This required both peer clinical challenge

and senior management challenge that, at that time, was not forthcoming in regard to referral triage management and notes at home in particular.

497. I do not think there was a failure to engage fully with the problems of the Urology service from an Acute perspective. I think there could have been a much more constructive interest in recurring concerns from the senior management team level including the Chief Executive with associated support.

[51] Do you consider that mistakes were made by you or others in handling the concerns identified? If yes, please explain. What could have been done differently?

498. I have reflected much on the handling of the concerns raised and noted in this statement.

499. When I read the emails of that time from myself and others, I can see a frustration regarding the lack of capacity across the board, a frustration with the practice of Mr O'Brien regarding delays in triage, leaving patient notes at home, and his often dismissive attitude to core systems and processes (which were often regionally directed and locally agreed). I also see a relatively small number of clinicians and managers working extremely hard to manage many services, elective and unscheduled care flow across 2 acute hospitals, under-funding, and staffing constraints.

500. I also see a consultant who struggled to adjust to the use of technology and to working in a multidisciplinary team who were there to support his practice (to allow his expertise to focus on the aspects of care that only he could do, leaving other aspects of care that could be done by others to those others). I believe that he genuinely struggled to adjust to the volume of patients needing to be managed. I think that, while other consultants adjusted their practice to meet time slots at clinics etc., Mr O'Brien was just unable or unwilling to adjust.

501. On reflection, I believe the Head of Urology and ENT, myself and the Associate Medical Director handled the concerns to the best of our ability at

the time and within the culture of Acute Services during those years; a culture that was focussed on Performance and Financial Efficiency. Both the Head of Service and I, as non-medics, found it very difficult to challenge Mr O'Brien's clinical practice. We were reliant on his clinical colleagues to provide that clinical challenge and this, I believe, did come, but only at a later stage when a number of new consultants came into post, who had experience outside the Trust and outside Northern Ireland, who knew what was acceptable practice and what was not, and who were not afraid to speak up.

502. I believe that, at the time, concerns were escalated appropriately by ourselves, solutions sought, support offered and work-around processes put in place. However, 6 to 13 years later, experiencing the developments in clinical governance systems, learning from national reports, and through my experience in my current role as Director of Nursing, Midwifery and AHPs, I believe there was too much tolerance for his resistance to change and not enough focus on the patient pathway, experience and outcome and this was reflective to the culture of the organisation at that time.

503. I take my share of responsibility for that and, on reflection, I could have challenged more and suggested increased independent audit into patient outcomes and patient experience. I also refer to my response in paragraph 485

504. Whilst I do not believe that I could have done more to meet the demands of the service with the resources available, including eradicating the review backlog, having reflected on the matter and with what I know now, I regret not having zero tolerance for triage delay, with robust weekly checking mechanisms and monitoring of it in place in the same way that we monitored patient access data. So I accept there were missed opportunities to fully address the risk to patient safety.

52. In your view, would the systems of governance now in place prevent these concerns arising again? If yes, please explain. If no, please explain why not

and what you consider needs to be done to ensure the systems are sufficiently robust.

505. For the last four years I have been in the role of Executive Director of Nursing and AHPs and, while a member of SMT and Trust Board, I would not have been involved in the changes regarding the clinical governance of the Urology Unit. However, I am very aware of the improvements in clinical and social care governance across the Trust more broadly.

506. To address the concerns relating to the Urology services as a whole, they were primarily concerns of patient demand that was greater than the Urology Team and Trust capacity to meet those demands with the resultant risk to patient safety, care and treatment. Excess demand for services including access, review, cancer diagnosis and treatment, in conjunction with medical staffing deficits, contributed to the overall service concerns. It is regretful that today in 2022, patient demand has continued to rise and, regretfully, the concerns remain not only in Urology but across many services. The Covid-19 pandemic has certainly exacerbated waiting time issues but they were present prior to March 2020.

507. From a wider governance perspective, the Trust instituted a new Performance Committee which meets monthly to discuss all matters relating to the performance measures, challenges, improvements, and concerns across all Programmes of Care. This Committee is made up of Non-Executive Directors and Directors and is Chaired by the Chief Executive. Prior to this committee being established, performance was tabled as part of the Trust Board meeting agenda and it was considered that there was not enough time available at Trust Board meetings to give it the attention that it warranted.

508. This committee does review data relating to waiting times, staffing challenges, etc. However, without the resource to address the waiting times effectively in terms of staffing and facilities, the Trust has been unable to address these concerns and will continue to be unable do so unless capacity can be increased.

509. With regard to the concerns relating to the practice of Mr O'Brien, I believe that governance systems and processes have improved. There is a more proactive method of seeking real-time patient feedback on experience/concerns by a team of staff who visit patients at ward level to seek out their views as well as the provision of an online patient feedback service that seeks a response from the team.

510. Morbidity and Mortality data is now produced regularly with comparative data with our peer Trusts and services so we can see how we are performing from a patient safety perspective.

511. There is a much more developed Serious Adverse Incident process which is patient-centred for learning and improvement and a weekly focus on all clinical and social care governance data.

512. There is now a weekly cross-directorate Governance meeting chaired by the Medical Director and attended by all professions and governance staff where updated information is shared for learning, action, and monitoring.

513. With regard to the concern of referral triage return, since 2017 this changed to electronic triage and I am advised therefore that it is much easier to monitor and address outstanding triage. Prior to that it was paper-based. This new system would help address the missing triage concern.

514. With regard to keeping patient notes at home, I do not believe that there is a system in place to prevent this, should the clinician want to do so. However, it is my understanding that the Northern Ireland Electronic Care Record, since its recent introduction has transformed the way medics access patient records, so making the issue of missing patient notes less impactful.

515. With regard to patient recording at clinic, I am not in a position to say whether new IT systems, e.g., Digital Dictation, have created the situation where recording must be done during the clinic; however, the Medical Director would be in a position to advise on same.

516. With regard to systems of governance in place now and whether they would prevent such concerns happening again, I know that there has been much work done to strengthen medical oversight and appraisal in the Medical Directorate. As a member of SMT and Trust Board however, I can see that there is much risk in healthcare. The Trust employs over 14,000 staff over 9 large Directorates. It can be difficult to stratify what is escalated to SMT and Trust Board and what is managed at Directorate level. I think that, where persistent concerns remain that cannot be successfully dealt with at Directorate level, there should be a mechanism to differentiate between those concerns that can be successfully managed through normal management processes and those that need to be escalated to Senior Management Team and, further, to Trust Board for remedial action.

517. With regard to what I believe needs to be done:–

a. I believe that, as a region, there needs to be the required investment in both physical resources and trained professionals to meet the needs of patients with a urological condition.
b. I consider that, as a Trust, we have invested in our governance capacity, structures, systems and processes and there is most definitely a significant shift in the culture of the organisation towards a focus on patient safety, quality, and experience as well as performance. However the delivery of healthcare is complex; the system is under severe pressure in all programmes of care and further investment is needed to fund clinical audit, monitor patient pathways and experience and to support clinical teams to provide safe and effective care at all times.

53. Do you believe that the areas of concern identified within urology services are no longer an issue?

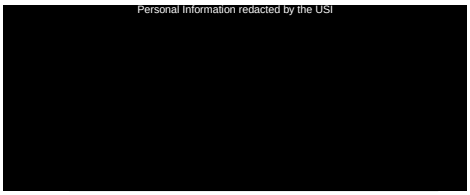
518. As a member of Senior Management Team and the Performance Committee, and on reviewing performance data on patient waiting times, regretfully the concern regarding demand for urology services which outstrips the capacity to meet that demand is still present. As our population continues

to grow and with an aging demographic, so we see Urology demand increasing. The Covid-19 pandemic has detrimentally affected all services including Urology.

519. With regard to the standard of clinical practice within the Urology team today, I have no reason to believe that the concerns regarding triage, record keeping, or patient notes at home are still issues. However, information on these issues does not currently come to the Senior Management Team or Trust Board for oversight. This should be considered.

Statement of Truth

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

Signed: __ 

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Southern Health and Social Care Trust

Job Description

JOB TITLE	Assistant Director of Acute Services - Surgery and Elective Care Division
BAND	8C
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Surgery and Elective Care Division. He/She will be responsible for the operational management of all specialties in the division. This will incorporate all surgical specialties: general surgery, ENT, breast, vascular, urology and T&O, colorectal, and outpatient services including Pre Operative Assessment in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

1. Lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's surgery and elective care division.

2. Ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.

3. Work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services and

achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

4. Contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

5. Ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.

6. Ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.

7. Ensure the division complies with all professional, regulatory and requisite standards.

8. Ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.

9. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.

10. Ensure the management of complaints within the division comply with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

11. Lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

12. Ensure that the quality of the patient journey and experience is enhanced and improved by the Patient Support Service, working across all acute services/sites.

13. Provide leadership of the Quality and Patient Support Officer to ensure the Public and Personal Involvement and Health and Wellbeing Strategies are implemented to continually improve the quality of patient/client experience by involving users in shaping services and improving the health of the Trust's clients/patients.

14. Provide an early intervention service in the management of potential patient/client complaints and dissatisfaction by advocating independently on behalf of the patient/client and enhancing experiential learning by interfacing with the Acute Service Governance system.

Southern Health and Social Care Trust

Service Planning and Development

15. Promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.

16. Assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.

17. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.

18. Liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.

19. Act as a member of the directorate's senior management team and contribute to its policy development processes.

20. Represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

21. Responsible for the management of the division's budget and the meeting of all financial targets by each specialty.

22. Ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.

23. Participate in contract and service level negotiations with commissioners.

24. Ensure the effective management, use and maintenance of all physical assets in the division.

People Management

25. Provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.

26. Work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.

27. Ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.

28. Ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.

29. Ensure the effective management of staff health and safety and support in the division.

Information Management

30. Ensure the effective implementation of all Trust information management policies and procedures in the division.

31. Ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

32. Develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.

33. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

34. Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

35. Adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.

36. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

Southern Health and Social Care Trust

Human Resource Management Responsibilities

37. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

38. Maintain staff relationships and morale amongst the staff reporting to him/her.

39. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

40. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

41. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

42. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

43. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

44. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

45. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

46. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

Southern Health and Social Care Trust

47. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

48. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Personnel Specification

JOB TITLE Assistant Director of Acute Service
Surgery and Elective Care Division

Ref No: 73211009 February 2011

Notes to applicants:

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*
2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted.*** *Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn.*

ESSENTIAL CRITERIA *– these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview.* ***Applicants should therefore make it clear on their application form how they meet these criteria. Failure to do so will result in you not being shortlisted.*** *The stage in the process when the criteria will be measured is stated below:*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

ELIGIBILITY

1. Applicants must provide evidence by the closing date for application that they are employed within a Health & Social Care organisation as defined[8]

QUALIFICATIONS / EXPERIENCE

2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant subject[9] AND have a minimum of 2 years experience in a senior management[10] role in a major complex organisation[11]
   OR
   Have a minimum of 5 years experience in a Senior Management[10] role in a major complex organisation[11]

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[8] *This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the NI Social Care Council*

[9] *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification*

[10] *'senior management' is defined as experience gained at Head of Service level or equivalent or above in a major complex organisation*

[11] *'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*

Southern Health and Social Care Trust

AND

3. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[12] improvements.

4. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[12] change initiative.

5. Have a minimum of 2 years experience in high level people management,

6. Have a minimum of 2 years experience in governance related activity

7. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[13].

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

8. Have an ability to provide effective leadership to enable transformation of services.

9. Demonstrate evidence of highly effective planning and organisational skills.

10. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

11. Demonstrate effective communication skills to meet the needs of the post in full.

12. Have an ability to effectively manage a budget to maximise utilisation of available resources.

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[12] 'significant' is defined as contributing directly to key Directorate level objectives of the organisation concerned.

[13] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Southern Health and Social Care Trust

***DESIRABLE CRITERIA** – whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable criteria. **Applicants should therefore make it clear on their application form how they meet these criteria.** Failure to do so may result in you not being shortlisted.*

13. Experience in the management of care services within a health and / or social care setting.

14. Experience of Financial Flows in a major complex organisation[14]

PLEASE NOTE:

It is intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Drive for improvement
- Effective and strategic influencing

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out a Protection of Children and Vulnerable Adults check (POCVA) before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

[14] *'Major Complex Organisation' will be interpreted as per essential criteria 2.*

Health and Social Care Board

Performance Management and Service Improvement Directorate

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : *028* Personal Information redacted by USI
Fax : *028* Personal Information redacted by USI
Email: Personal Information redacted by the USI

Trust Directors of Acute Services

Our Ref: HM670
Date: 27 April 2010

Dear Colleagues

REGIONAL UROLOGY REVIEW

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to Personal Information redacted by the USI by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

Personal Information redacted by the USI

HUGH MULLEN
Director of Performance Management and Service Improvement

Enc

cc Trust Directors of Performance
John Compton
Paul Cummings
Beth Malloy
Michael Bloomfield
Iain Deboys
Lyn Donnelly
Paul Cavanagh
Paul Turley
Bride Harkin

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Appendix 2

Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.

	Team South	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs							
Consultant Urologist – additional wte team allocation	2 wte	1 wte	3 wte	6	6		
Consultant Urologists wte	£208,000	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	£124,800	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	£62,400	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 Radiographer @ 6 per wte Con Radiologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 3 Nursing @ 0.46 wte per Con. Urologist	£17,870	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist Nursing *1	£103,605	£0	£103,605	£207,210	5	£41,442	£207,210
Band 5 Nursing @ 0.64 wte (day surgery)	£5,972	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
Band 4 Personal Secretary @ 0.5 wte per consultant urologists	£23,265	£11,633	£34,897	£69,795	3	£23,265	£69,795

Band 3 Admin support to radiologists at 0.5 wte per Radiologist	6,618	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	£31,438	£0	£28,129	£59,567	3	£19,856	£59,568
Band 4 Medical Records support 0.5 per unit *3	£11,632	£23,265	£23,265	£58,162	2.5	£23,265	£58,162
Band 7 MLSO – Bio-medical Science *4			£41,442	£41,442	1	£41,442	£41,442
Staffing Costs Sub Total	**£797,164**	**£348,510**	**£1,172,174**	**£2,317,848**			**£2,317,853**
Support Costs							
Surgical G&S @ £94,500 per Con. Urologist	189,000	94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	100,000	50,000	150,000	£300,000	X 6	£50,000	£300,000
Radiology G&S per Con. Urologist	5,000	2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	64,000	32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	40,000	20,000	60,000	£120,000	X 12	£10,000	£120,000
Support Costs Sub Total	**£398,000**	**£199,000**	**£597,000**	**£1,194,000**			
Sub Total	**£1,195,164**	**£547,510**	**£1,769,174**	**£3,511,848**			**£3,511,853**
Less funding in 2008/09			**£637,076**	**£637,076**			**-£637,076**
FINAL TOTAL	**£1,195,164**	**£547,510**	**£1,132,098**	**£2,874,772**			**£2,874,777**

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment	Number of consultants with a sub-specialty interest	Additional CNS
Team South	0	2	2
Team North	2	2	0.5
Team East	2	4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse

*3 – 0.5 allocated to each Trust Unit within each Team

*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

Appendix 3

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41
Outpatients: 1176 – 1680 per Consultant
Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post
Outpatients 19,992 to 28,560
IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments
Outpatients 7,056 to 10,080
IP/DC FCEs – 6,000 to 7,500

Regional Total
Outpatients 27,048 to 38,640
IP/DC FCEs – 23,000 to 28,750

Please note:
This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

Southern Health and Social Care Trust

Acute Services Division – Urology Implementation Planning Group Meeting – Tuesday 6th September 2011 – Meeting Room, Admin Floor, CAH at 10.30am

Present: Alexis Davidson, Mary McGeough, Heather Trouton, Martina Corrigan, Kate Courley, Connie Connolly and Pauline Matier.

Apologies: Anita Carroll, Sandra Waddell

Topic	Issue for Discussion	Action	Lead
Implementation Funding - Mrs Trouton outlined that the purpose of the meeting was to get key stakeholders together to plan the implementation of the Urology project. She read the contents of the Departmental letter confirming funding and shared copies of the Department's indicative calculations for allocation of funding.			
Theatre Sessions and Equipment – Mrs Trouton advised that as part of implementation it was proposed that two addition consultant urologists would be recruited each	Mrs Davidson advised that the current compliment of image intensifiers for the Trust was as follows: 1 in CAH - for Urology Service		

requiring theatre sessions and an image intensifier at each session. Mrs Trouton outlined the services identified for funding allocation and requested the group to scope what would be required in their individual areas. She further advised that the service needed to achieve end of year targets with existing resources and that work was in progress to achieve this.	1 in STH - not for Urology Service 0 in DHH She further advised that funding would be required for any additional equipment including MRI scanning requirements.	Mrs Davidson to scope requirements and impact.	Mrs A Davidson
Business Case for Implementation – Mrs Trouton advised that a business case needed to be developed for implementation and that Sandra Waddell would take the lead on this. She further advised that she would hope that a full years activity would be delivered by April 2013.	Time scale for recruitment – depended on business case being completed by end of September 2011, allowing for a six month recruitment period. Mrs Davidson did not think this achievable in respect of Consultant Radiologists Mrs Connolly advised that she needed to identify nursing requirements for 4 x OP clinics per week	Mrs Sandra Waddell to progress with Mrs Corrigan and Mrs Matier Consultant Radiologist job plan to be developed Consultant Anaesthetist job plan to be developed	Mrs Sandra Waddell/Mrs Martina Corrigan/Mrs P Matier Mrs Davidson/Dr Hall Mrs Mary McGeough/Dr McAllister Mrs Connie Connolly

		Nursing requirements to be identified	
Theatre Accommodation – Mrs Trouton queried availability of additional theatre space to facilitate additional sessions and the feasibility of extended theatre hours of 8am – 2pm and 2-m – 8pm. OPD Accommodation – Mrs Trouton advised that it would be preferable to have C&B and ACH OPD activity centralised to CAH. Mrs Trouton queried whether or not the provision of a radiographer for ureteric stones impacted on the radiology service.	Mrs McGeough advised that availability was limited and recovery support and scheduling of lists was a consideration also. Mrs Trouton suggested the 5th consultant backfilling as a proposal. Mrs Davidson advised that any HR issues around extended theatre hours for anaesthetists should be resolved by April 2012. Accommodation required : Office accommodation for x 2 Consultants, 1 secretary and a Specialist Nurse. ? Anaesthetist Mrs Davidson advised that no accommodation was required for the Consultant Radiologist. Mrs Connolly advised that pre-op facilities need to be provided and that pre-op services could assist with this aspect of the business plan.	Feasibility of options to be scoped with Dr McAllister Mrs Kate Corley to scope Mrs Mary McGeough to scope Mrs Davidson to scope Mrs Davidson to liaise with Radiological Consultants to identify best fit pathway for development	Mrs Mary McGeough Mrs Kate Corley Mrs Mary McGeough Mrs Alexis Davidson Mrs Alexis Davidson Martina Corrigan

	Mrs Davidson queried the diagnostic pathway for Erne Hospital patients. Mrs Corrigan confirmed that sessions are 1 day per month at the Erne but patients may go to STH for diagnostics.		
Support Services – medical records, portering, CSSD, domestic services, etc. Theatre Nursing Staff – Mrs Trouton advised that as funding had been confirmed that recruitment of permanent theatre nursing staff could proceed and that said staff could be utilised in the interim to provide support for additionality until April 2012.	Mrs Corley advised that there would be a big impact on these services with the proposed increase in volume of turnover.	Mrs Corley to liaise with Mrs Helen Forde re medical records implications and scope all other support service requirements. Mrs McGeough to discuss with Mr Ronan Carroll to progress.	Mrs Kate Corley Mrs Mary McGeough
For Next Meeting – Mrs Trouton advised that everyone should identify any gaps/issues/requirements(including equipment requests) and forward these to Martina Corrigan for meeting with Sandra Waddell on 14th September 2011.		All members.	All members.

Investment Proposal Template (IPT3)
Revenue funding > £500,000 < £1,500,000
(unless in exceptional circumstances and approved by Commissioner for >£1,500,000)
Commissioner's Statement

Reference Number	
Commissioner Representative	**Mrs Lyn Donnelly**
Title	**Assistant Director of Commissioning for the SLCG**
Contact Tele No. & Email	Personal Information redacted by the USI
Date	**December 2011**

1. **Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**
Outline of Strategic Context within which the Commissioner is seeking service proposals. Reference should be made as appropriate to:
   - Priorities for Action.
   - HWIP.
   - Strategy, Policy or Service Review documents, Local, Regional, National.
   - Compliance with NICE, SMC and other appropriate recognised guidance on effectiveness.
   - Likely Board/LCG service shares.
   - Legislative/Statutory requirements.

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The overall purpose of the review was to develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN)

The review made a wide range of recommendations that are required to be implemented (see appendix A). A number of the key recommendations have been highlighted below.

- Acute services should be reconfigured into a 3 team model, to achieve long term stability and viability. The three teams are as follows:
  - Team East comprising of the catchment area of Belfast HSCT, SET and the southern sector of the Northern HSCT. Team increasing from 11 consultants to 12 consultants.
  - Team Northwest comprising of the catchment area of northern sector of the Northern HSCT and the catchment area of Altnagelvin hospital and Tyrone County Hospital in the Western HSCT. Team increasing from 5 consultants to 6 consultants.
  - Team South comprising of the catchment area of the Southern HSCT and the Erne Hospital catchment in the Western HSCT. Team increasing from 3 consultants to 5 consultants.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Surgeons carrying out small numbers of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- To modernise and redesign outpatient clinic templates and administrative booking processes to maximise capacity for new and review patients.
- The requirement to redesign and enhance capacity to provide single visit outpatient

and assessment for suspected urological cancer patients.

The formation of a Team South ensures that patients receive safe and effective care within clinically recommended timeframes and PfA targets. It will also ensure that staff are equipped and motivated to adopt innovative and efficient ways of working.

The recommendations are in line with the regional strategy, *Developing Better Services* (2002). It also reflects the Southern Trust's commitment to localise services where possible, protect elective services and reduce any unnecessary duplication of services.

2. **Description of Services - (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**

The current service model is an integrated consultant led and ICATS model. The service base is at Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are General Surgery inpatient beds at Daisy Hill Hospital, Newry and at the Erne Hospital.

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the Urology team also undertakes some Urology outpatient and day case work.

Network Development

A Urology Review Project Implementation Board has been established consisting of clinical representation from all Trusts. This group meets regularly to agree the key actions required to deliver the review recommendations.

Activity Assumptions

New indicative activity levels have been agreed with Team South and work is underway to finalise these volumes.

Table 1 below details the full year effect of the outpatient and finished consultant episode activity for each team.

FYE Team South Outpatients		
	New	Review
MY	504	756
AOB	504	756
MA	504	756
Cons4	504	756
Cons5	504	756
Total	2520	3780
Less Travel Impact	192	99
Total	2328	3681
ICATS	1620	1724
Overall Total	**3948**	**5405**

Team South Proposed FCE Activity		
	DC	Admissions
MY	877	248
AOB	877	248
MA	877	248
Cons4	877	248
Cons5	877	248
Total	4385	1240
Less Travel Impact		40
Overall Total	**4385**	**1200**

Pathway Development

The Urology Review Implementation Project Board has discussed and is finalising the details of patient pathways for the following areas:

- Diagnosis and management of an acutely obstructed kidney with sepsis
- Diagnosis and management if acute urinary retention
- Diagnosis and management of suspected renal colic
- Haematuria Single Visit Pathway
- Lower Urinary Tract Symptoms (LUTS) Pathway
- Prostate Pathway
- Scrotal lumps or swelling (in discussion)

Performance Indicators

The HSCB PMSI directorate is working with Trust management and clinicans across each of the Trusts concerned to agree a range of service quality indicators and clinical quality indicators which will help all stakeholders to measure the quality of the urology service and the long term benefits and outcome for patients.

Objectives

- Implement recommendations of Urology Review
- Deliver agreed volumes of activity
- Establish Team South – to be based at the Southern Trust and to treat patients from the southern area and also the lower third of the western area (Fermanagh)
- To increase from a 3 consultant team to a 5 Consultant team plus two nurse specialists
- Meet PfA target for outpatients (within 9 weeks) and IPDC (within 13 weeks)

3. **Funding -**Summary of sources and amounts of available funding including:
   - Recurrent and/or non recurrent funding from commissioners (detailed by LCGs as appropriate)
   - Potential recurrent/non-recurrent funding from other agencies e.g. Supporting People monies from NIHE.
   - Capital funding where appropriate.

The HSCB has confirmed to the Trust that an additional £1.233m uplifted for 2011/12 is available to fund the full year impact of the new 5 Consultant team known as Team South and the associated activity. This funding also covers the support staff costs including radiology, theatre staff, anaesthetics, nurse specialists, secretarial, administration and goods and services associated with each new consultant appointments.

The Trust is asked to submit a Business Case outlining all capital and recurrent costs concerning the development of Team South.

4. **Timescale and process for submitting**
Timescale within which providers should submit the completed investment decision making proformas to commissioners.
Timescales which providers will be advised of the commissioner's decision.
Arrangements for submitting completed documents.

Trusts must submit the completed IPT by 31 January 2012 to allow for HSCB approval in the final quarter of 2011/12and ensure that the service is fully operational by 1st April 2012.

Completed proposals should be submitted to Mrs Lyn Donnelly, SLCG, Tower Hill Armagh BT61 9DR

PROVIDER SECTIONS

Provider	Southern Health and Social Care Trust	Submission date	**06 Feb 12**
Scheme Title	Urology Team South Business Case **FINAL V1.0 (Approved SMT 08 Feb 12)**		
Responsible Officer - including title	Mrs Heather Trouton, Assistant Director of Acute Services, Surgery and Elective Care		
Contact Details – Tele no. & Email	Personal Information redacted by the USI Personal Information redacted by the USI		

- This business case should be prepared in line with the Green Book and NIGEAE Guidance
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

1a) Explain how this proposal specifically meets the needs for this investment (linked directly to the Commissioner statement)

Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended. The Team South share of the available funding to implement the review has been estimated at £1.233m.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans and business cases to take forward the recommended team model.

The Trust's preferred option which is described in more detail later in this document is to appoint the necessary staff to enable the recommendations made in the regional review to be implemented for the population of Armagh and Dungannon, Craigavon and Banbridge, Newry and Mourne and Fermanagh.

1b Describe how this proposal will reduce inequalities in Health and Wellbeing

The specialty of urology predominantly covers the care of urogenital conditions involving diseases of the kidneys, bladder, prostate, penis, testes and scrotum. Bladder dysfunction, male and female continence surgery and paediatric peno-scrotal conditions are also included. The proportion of the male population over 50 years old has risen by approximately 20% over the last 20 years and referrals to secondary care have been rising at 5-10% per year[1].

Prostate cancer is the most common cancer in men. Each year in the UK about 36,000 men are diagnosed with prostate cancer. It accounts for 25% of all newly diagnosed cases of cancer in men. The chances of developing prostate cancer increase with age. Most cases develop in men aged 70 or older. The causes of prostate cancer are largely unknown.[2]

This proposal will enable the Trust to provide an equitable service to residents of the Southern area and Fermanagh. Reduced waiting times for outpatient assessment and inpatient and day case treatment will be facilitated.

2a) Objective(s) of this development - these will be examined in more detail in section 10 and 11)
Please complete the list below - please note that this list is not exhaustive but is a ***minimum requirement***

OBJECTIVES	DATE/ACTIVITY	EXPLANATORY TEXT IF REQUIRED
Development implemented by what date?	End of August 2012	The Trust expects to have the new consultants in post by August 2012
Target met by what date?	March 2013	Compliance with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.
Provide the total capacity (agreed with the HSCB) within the integrated urology service on completion of the project -	March 2014 3,948 new outpatient appts 5,405 review outpatient appts 4,385 day cases/23 hour stays 1,200 inpatients	The first full fiscal year for delivery of the increased volume of activity will be 2013/14
Facilitate the establishment of Team South as specified in the regional review	End of August 2012	The Trust expects to have the new consultants in post by August 2012
Provide an accessible service across the Team South	March 2013	The first full year for delivery of the enhanced service will be 2012/13

[1], [2] British Association of Urological Surgeons

catchment area		

2b) What are the Constraints of the Project?

Availability of staff, recruitment difficulties, Constraints in, space, time and funding etc.

- Availability of Consultant staff
- Funding for equipment
- Access to additional theatre & outpatient sessions

Current Service Model

The current service model is an integrated model comprising a consultant led outpatient, day case and inpatient service supported by a range of outpatient clinics delivered by a GP with special interest in urology (GPwSI), a nurse practitioner and two specialist nurses. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The GPwSI/specialist nurse services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital. Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2012 and one post is currently vacant),
- 2 Trust Grade Doctors (2 posts are currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either a GPwSI, specialist nurse or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided by the GPwSI and specialist nurses:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics
- Andrology
- Uro-oncology
- General urology clinic
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

GPwSI & Specialist Nurse	**Weekly**
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1.5
LUTS	3
Haematuria	2
Andrology	2.5
General Urology/Uro Oncology	2.5
	14

Main Theatres (CAH)	**Weekly**	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly	1 monthly
Flexible Cystoscopy	1.5 weekly[2]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) 2 lists/1 list on alternate weeks

Current Activity

Activity for 2010/11 for the service is shown in Table 2. Core activity and in house additionality have been included in the table

Table 2: 2010/11 Actual Activity for the Urology Service

		Core Activity	IHA	Totals
2010/11	**New OP Activity**			
	Consultant Led	1086	375	1461
	GPwSI	475		475
	Specialist Nurse Led	825		825
	Total New OPs	**2386**	**375**	**2761**
	Review OPs			
	Consultant Led	2843	90	2933
	GPwSI	971		971
	Specialist Nurse Led	571		571
	Total Review OPs	**4385**	**90**	**4475**
	Day Cases	1589	152	1741
	Elective FCEs	1021	61	1082
	Non Elective FCEs	613	0	613

The current service is unable to meet the demands of the Southern area and a significant amount of in house additionality was required in 2010/11 to meet agreed back stop access targets for outpatients and inpatients/day cases.

A 9 week waiting time for new outpatient appointments is currently being achieved but only with a high level of in house additionality, which is not sustainable. The waiting time for routine inpatient procedures has risen to 56 weeks and for day cases to 62 weeks. The Trust is striving to reduce these waiting times to 36 weeks by the end of the fiscal year.

3) Option one: Status Quo or Base Case

Option 1 involves continuing to provide the current level of core activity as shown in Table 1.

Advantages

There would be no requirement for additional recurrent investment (although if the Trust continued to provide in house additionality non recurrent funding would be required to support this).

Disadvantages

The Trust would be unable to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits

longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could not be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service would not be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would not be achievable for all patients.

The Trust would be unable to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

The additional investment required to enable the Trust to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, would not be provided.

4) Option Two – Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients

Option 2 involves expanding the current service in line with the recommendations of the regional view to meet the demand from the Southern and Fermanagh areas.

Advantages

The Trust would be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would be appointed;
- The service would be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would be achieved.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

A sustainable service model would be facilitated and the Trust would be able to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

Disadvantages

Additional recurrent revenue investment will be required.

5) Option Three - Provide the Current Level of Service within the Trust and Supplement with Independent Sector Provision.

Option 3 involves continuing to provide the current level of core activity and supplementing this with independent sector provision to meet the demand from the Southern and Fermanagh areas.

Advantages

There would be the potential for the Trust to be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

Some, though not all of the recommendations set out in the regional review could be implemented eg:

- The service would be expanded to encompass patients from the Fermanagh area;

The Trust may be able to deliver the annual levels of service which are expected by the HSCB by using IS provision:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

Disadvantages

Additional non recurrent revenue investment will be required.

A sustainable service model would not be facilitated and the Trust would be unable to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases.

The service would be difficult to manage and the current 3 consultant model would not enable any outreach services to the Fermanagh area. The service would therefore not be an equitable service.

Not all of the recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service provided to patients from the Fermanagh area would be limited.
- Compliance with the 62 day cancer target for all patients would be a challenge within the current staffing levels.

Independent sector provision is comparatively expensive and this option would therefore not represent good value for money.

7) Identify and evaluate the overall benefits of all of the options

Consider costs and benefits to other parts of the public and private sectors

PLEASE LIST & SCORE BENEFITS THEN SHOW RANK OF OPTIONS

			1 Base case		**2** Expand Service - Create Team South		**3** Current Service + IS	
	Criterion	**Weight**	Score	Score x Weight	Score	Score x Weight	Score	Score x Weight
1	Implement Regional Review recommendations	45	6	270	9	405	7	315
2	Provide agreed capacity	20	6	120	10	200	9	180
3	Compliance with targets	20	6	120	9	180	9	180
4	Accessible service across Team South area	15	7	105	9	135	8	120
	Totals	**100**		**615**		**920**		**795**
RANKING				**3**		**1**		**2**

Robustness/Bias Test (Sensitivity Analysis)	If benefits are not delivered as expected above would the ranking change? There is a considerable difference between the total scores of options 2 and 3 which suggests that the ranking is relatively robust. The biggest risk to the scores achieved by the preferred option is around the ability to appoint one or more of the consultant urologists (this risk is addressed in more detail in section 13 below). However, it is the Trust's view that any detrimental effect on the benefits would be short term – ie if both consultant posts cannot be filled immediately, they will be able to be filled later. How much would costs increase before VFM (Ref Box 9 is impacted?

8) Financial Quantification of chosen option

Express Costing in total rather than incremental terms to expose full resource consequences

Please note which option is the preferred option -

OPTION NUMBER AS ABOVE	Option Name	Total £ (Rec)	Total £ (Non-Rec)
BASE CASE		£1,346,611	
OPTION 2		£1,494,081	
OPTION 3			
OPTION 4			
Additional Cost (Marginal Increase: Preferred Option less Status Quo Option		**£147,470**	

Note: Detail to be contained in costing appendix.

The estimated funding indicated in the *'Review of Urology Services in NI, A Modernisation & Investment Plan',* uplifted for 2011/12 pay and prices has been stated at £1.233m. The staffing identified in the modernisation and investment plan has been replicated in Appendix 2. However as Appendix 2 indicates, if these are re-costed at HSCB rates (yellow columns), then the total recurrent funding is £1,346,611 (ie an additional £113,611). This figure has been used as the base case revenue cost above.

Appendix 1 provides the Trust's required staffing levels and associated costs for the Team South model detailed in option 2. The Trust's staffing and costs are shown in the first two (grey) columns. For ease of comparison the second two (pink) columns show the staffing and costs given in the urology review investment plan and the third two (orange) columns show these costs uplifted to HSCB rates.

The main areas of deficit have been denoted with a red bar. The following notes apply to the Trust's costs:

Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.

The consultant urologist posts have been costed at 11 PAs as 11 PA contracts will maximise the amount of direct clinical PAs. If these are reduced to 10 PAs there will be an associated reduction in activity. The Trust also wishes to highlight the fact that no staff were included in the review investment plan for either Labs or Pharmacy. Both of these support services will be impacted upon by the increase in urology activity.

9) Value for Money

A) Efficiency Savings (Where applicable)

- Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).

It is not anticipated that this proposal will generate efficiency savings.

B) Further demonstrate overall Value for Money by including benchmarking evidence

B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.

B2 *Please explain the reason for any positive or negative variances that exist when the preferred option is compared to B1 above.*

Positive Variances: eg Better working practices, more efficient use of resources etc. These will indicate VFM.

Negative Variances: eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.

B3) *If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.*

10) Preferred Option (Insert option number)

Please rank costs and benefits and summarise reasons for selection.

	Current Funded Position	**1** Base case	**2** Expand Service - Create Team South	**3** Current Service + IS
Benefit Appraisal Weighted Score	-	615	920	795
Ranking	-	3	1	2
Revenue				
Ranking				

Option 2 - Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients is the Trust's preferred option.

Option 2 will enable the Trust to implement the recommendations set out in the regional review of urology services and will facilitate the delivery of the annual levels of service which are expected by the HSCB.

The urology service will be able to comply with the 2011/12 PfA access targets by the end of March 2013 and a sustainable service model would be facilitated.

11) What are the Specific Outcomes of the preferred option
Quality, Timescales, Quantity (detailed in box 11)

The recommendations set out in the regional review of urology service could be implemented.

A sustainable service model for the urology service would be facilitated forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

2 additional consultants and associated support staff would be appointed;

The service would be expanded to encompass patients from the Fermanagh area;

The 62 day cancer target would be achieved for all patients.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

12) Activity Outcomes
Activity, contacts, placements, procedures etc, please identify

SBA Activity

	New OP[1]	Review OP[2]	FCEs	Day Cases/ 23 Hour Stays
Original Baseline Activity	1,014	2,390	1,596	1,239
Additional Baseline Activity	2,934	3,015	- 396	3,146
New Baseline Activity	3,948	5,405	1,200	4,385

1) New outpatient appointments comprise 2328 slots at consultant led clinics & 1,620 at support staff clinics.
2) Review outpatient appointments comprise 3,681 slots at consultant led clinics & 1,724 at support staff clinics.

If approved, activity will be added to Indicative volumes in Organisation's Service and Budget Agreement (if applicable)

The above table must be completed for each discreet element of the service in question, please replicate as required. If activity is for more than one LCG please detail separately.

13) Assess Risks and Uncertainties
Identify the main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers recognized risk scoring method

The following main risks have been identified in relation to this project:

- Inability to appoint consultant urologists
- Inability to appoint other key staff
- Activity projections are not achieved

These have been assessed using the Trust's scoring methodology:

Consequence		Likelihood	
1	Insignificant	**1**	Rare
2	Minor	**2**	Unlikely
3	Moderate	**3**	Possible
4	Major	**4**	Likely
5	Catastrophic	**5**	Almost certain

The consequence and likelihood are combined to provide a risk rating

Risk Rating

H	Red Risk - High = 20 - 25
M	Amber Risk - Moderate = 12 -19
L	Yellow Risk - Low = 6 - 11
VL	Green Risk - Very Low = 1 - 5

Description of Risk	Consequence	Likelihood	Risk Rating
Inability to appoint consultant urologists	4	3	M
Inability to appoint other key staff	4	3	M
Activity projections are not achieved	2	3	L

Inability to Appoint Consultant Urologists

There is a risk that whilst projected activity levels may be accurate, that they may not be achievable if consultant urologists cannot be appointed. This would have a major impact and is possible. However the Trust believes that if one or both posts are not filled immediately they will be filled if advertised again when further staff qualify and are able to apply.

Inability to Appoint Other Key Staff

There is also a risk that other key staff such as anaesthetic and radiology staff may not be appointed immediately. As with the urologists the Trust would advertise again until posts are filled. In the interim sessions would be provided on and in house additionality basis.

Activity Projections are Not Achieved

There is a risk that the activity projections may be too high and that they may not be achievable within the available outpatient and theatre sessions. BAUS

recommendations have been used to model the projected activity and the Trust is aware that BAUS is in the process of reviewing its standards and guidelines to reflect current clinical practice. The outcome of this review is awaited.

14) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner's Statement

Mrs Heather Trouton Assistant Director of Acute Services, Surgery and Elective Care will manage the implementation of this scheme. Depending on the date of approval it is anticipated that the development will be fully implemented by March 2013 (2012/13 will be the first full year for delivery of the enhanced service).

Timetable for Implementation

Task	**Timescale**
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 11
Completion of Job Plans/Descriptions for Consultant Posts	End December 11
Consultant Job Plans to Specialty Advisor	January 2012
Advertisement of Consultant Posts	End February 12
New Consultants in post	August 2012

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation of the proposal if approved. This evaluation will be undertaken by the Head of Service for ENT and Urology.

15) Other relevant information
Please note any other appendices or attachments

HSCB Costing Schedule
Appendix 1 Team South Staffing and Costs
Appendix 2 Estimated Team Costs form the 'Review of Urology Services in NI, A Modernisation & Investment Plan'

16) Signature of individuals responsible for this bid – Provider Section

Trust Authorising Officer		Date
Title		

Trust Director of Finance Signature		Date
Trust Chief Executive Signature		Date

17) Approval or rejection (Local/Regional Commissioning Use only-HSCB and PHA)

	Approved	Rejected (if yes detail reasons)	Approved in Principle (if yes detail reasons)
Yes/No			

Responsible Person

Signature Date Position

Authorising Person

Signature Date Position

Director of Finance Authorisation or delegated officer

Signature Date Position

Chief Executive Authorisation

Signature Date Position

SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL

TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS	**FYE of project (£)**	**CYE of project (£)**	**Non Recurrent (£)**
SOURCE OF FUNDS			

Summary Costing schedule for Investment Decision Making Templates	Ref Number	
Provider	SOUTHERN	
Hospital Site or Community development	CRAIGAVON	
Scheme Title	UROLOGY REVIEW	
Pay and Price Levels	2011/12	

Commissioner Use only
Sign and Date for TRAFFACS update

****PLEASE NOTE ATTACHED FINANCIAL COSTINGS APPENDIX 1 AND 2 PROVIDE MORE DETAILED ANALYSIS OF AMOUNTS NOTED IN COSTING SCHEDULE***

		Base Case - option 1				Option 2				Option 3				Option 4			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
BAND 1					0				0				0				0
BAND 2					0	0.00	3.43	73,433	0				0				0
BAND 3					0	0.00	3.45	81,472	0				0				0
BAND 4					0	0.00	2.10	56,644	0				0				0
BAND 5					0	0.00	6.50	216,287	0				0				0
BAND 6					0	0.00	2.36	94,056	0				0				0
BAND 7					0	0.00	1.70	81,003	0				0				0
BAND 8A					0				0				0				0
BAND 8B					0				0				0				0
BAND 8C					0				0				0				0
BAND 8D					0				0				0				0
BAND 9					0				0				0				0
Non-AFC posts please detail below					0				0				0				0
Consultant Urologist					0	0.00	2.00	282,460	0				0				0
Consultant Anaesthetist					0	0.00	1.00	125,941	0				0				0
Consultant Radiologist						0.00	0.60	75,565	0								
Consultant Pathologist						0.00	0.10	12,594	0								
Upgrade 2 Band 5 nurse posts to Band 6						0.00	0.00	12,172	0								
Base Case assumed to be proposed funding of £1.233m, restated at HSCB Costing Schedule 11-12 rates (Pay)		0.00	18.04	991,538	0				0				0				0
Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)					0				0				0				0
					0				0				0				0
TOTAL PAY COSTS			18.04	991,538	0		23.24	1,111,627	0		0.00	0	0		0.00	0	0
Non-Pay Costs - please detail below																	
Base Case assumed to be proposed funding of £1.195m, uplifted by 3.18% to 11-12 rates to £1.233m . (Goods proportion only)		0.00		355,073													
Outpatient Attendances 1540 new & 334 review					0	0.00		95,574									
Day Case/23 hr stays 3146					0	0.00		314,600					0				0
FCE's -396					0	0.00		-27,720					0				0
					0								0				0
					0				0				0				0
TOTAL NON-PAY COSTS				355,073	0			382,454	0			0	0			0	0
GRAND TOTAL				1,346,611	0			1,494,081	0			0	0			0	0

Phasing/Timescale	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*	*(Can development be phased, if so provide details in this box)*
PROGRAMME OF CARE	acute	acute		
SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known	daycases	daycases		
LCG	Southern	Southern		
If more than one LCG in option above please give details				
LGD				
If more than one LGD in option above please give details				

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

Urology Staffing and Costs

v0.1 updated 12 Jan 2012

APPENDIX 1

Recurring	**WTE**	**Full Year Cost per SHSCT** £	**Funding per HSCB** £	***Deficit***	**Funding per HSCB restated at 11 12 rates**	***Deficit***	***Main areas of deficit***
Medical Staff							
Consultant Urologist	2.00	282,460	208,000	*-74,460*	244,530	*-37,930*	
Consultant Anaesthetist	1.00	125,941	124,800	*-1,141*	146,718	*20,777*	
Consultant Radiologist	0.60	75,565	62,400	*-13,165*	73,359	*-2,206*	
	3.60	**483,966**	**395,200**	***-88,766***	**464,607**	***-19,359***	
Specialist Nursing							
Upgrade 2 Band 5 posts to Band 6		12,172		*-12,172*		*-12,172*	
Band 5	1.00	33,275	103,605	*70,330*	119,123	*85,848*	
	1.00	**45,447**	**103,605**	***58,158***	**119,123**	***73,676***	
Theatres/Recovery Nurses							
Band 6	0.26	10,362		*-10,362*		*-10,362*	
Band 5	4.74	157,724	106,754	*-50,970*	126,778	*-30,946*	
Band 3	0.43	9,906	17,870	*7,964*	21,195	*11,289*	
Band 2	1.21	24,657		*-24,657*		*-24,657*	
	6.64	**202,649**	**124,624**	***-78,025***	**147,973**	***-54,676***	
Preassessment							
Band 6	0.13	5,181		*-5,181*		*-5,181*	
Band 5	0.26	8,652	13,833	*5,182*	13,833	*5,182*	
	0.39	**13,833**	**13,833**	***0***	**13,833**	***0***	
Outpatients							
Band 3	0.52	11,980	11,980	*0*	11,980	*0*	
	0.52	**11,980**	**11,980**	***0***	**11,980**	***0***	
Radiography							
Radiographer Band 7	1.00	47,649		*-47,649*		*-47,649*	
Radiographer Band 6	1.00	39,854		*-39,854*		*-39,854*	
Radiographer Band 5	0.50	16,638	100,782	*84,145*	119,790	*103,153*	
Radiography Helper Band 3	1.00	23,038		*-23,038*		*-23,038*	
	3.50	**127,179**	**100,782**	***-26,397***	**119,790**	***-7,389***	
Laboratory							
Consultant Pathologist	0.10	12,594		*-12,594*		*-12,594*	
BMS Cellular Pathology Band 6	0.20	7,971		*-7,971*		*-7,971*	
BMS Blood Sciences Band 6	0.77	30,688		*-30,688*		*-30,688*	
	1.07	**51,252**	**0**	***-51,252***	**0**	***-51,252***	
Pharmacy							
Clinical Pharmacist Band 7	0.70	33,354		*-33,354*		*-33,354*	
Pharmacy Technician Band 4	0.60	16,184		*-16,184*		*-16,184*	
	1.30	**49,538**	**0**	***-49,538***	**0**	***-49,538***	
CSSD							
Band 3	0.38	10,745		*-10,745*		*-10,745*	
ATO Band 2	0.76	19,024	29,770	*10,746*	29,770	*10,746*	
	1.14	**29,770**	**29,770**	***0***	**29,770**	***0***	
Admin Support							
PAS/Clinical Coding Band 4	0.50	13,487	11,632	*-1,855*	13,487	*1*	
Personal Secretary Band 4	1.00	26,973	23,265	*-3,708*	26,973	*0*	
Booking Clerk Band 3	0.62	14,284	31,438	*17,154*	36,400	*22,116*	
Health Records Band 2	0.48	9,781		*-9,781*		*-9,781*	
Radiology support Band 3	0.30	6,911	6,618	*-293*	7,602	*691*	
Theatres Band 2	0.14	2,853		*-2,853*		*-2,853*	
	3.04	**74,289**	**72,953**	***-1,336***	**84,462**	***10,173***	
Hotel Services							
Band 2	0.84	17,118		*-17,118*		*-17,118*	
Stores							
Band 3	0.20	4,608		*-4,608*		*-4,608*	
TOTAL RECURRING PAYROLL COSTS	**23.24**	**1,111,627**	**852,747**	***-258,880***	**991,538**	***-120,089***	
Goods & services							
Outpatient attendances 1540 new & 334 review		95,574	14,187	*-81,387*	15,459	*-80,115*	
Day case/23 hour stays 3146		314,600	328,230	*13,630*	339,614	*25,014*	
FCEs **-396**		-27,720		*27,720*		*27,720*	
TOTAL GOODS & SERVICES		**382,454**	**342,417**	***-40,037***	**355,073**	***-27,381***	
Inflation at c3.18%			37,836	*37,836*			
TOTALS		**1,494,081**	**1,233,000**	***-261,081***	**1,346,611**	***-147,470***	

Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.

Appendix 2

Estimated Team Costs for the 'Review of Urology Services in NI, A Modernisation & Investment Plan' Recommendations.

	Team South	Recosted at HSCB General Costing 11-12 rates	Whole Time Equivalent	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs									
Consultant Urologist – additional wte team allocation	2 wte			1 wte	3 wte	6	6		
Consultant Urologists wte	£208,000	£244,530	2.00	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	£124,800	£146,718	1.20	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	£62,400	£73,359	0.60	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 Radiographer @ 6 per wte Con Radiologist	£100,782	£119,790	3.60	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	£100,782	£119,790	3.60	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 3 Nursing @ 0.46 wte per Con. Urologist	£17,870	£21,195	0.92	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist Nursing *1	£103,605	£119,123	2.50	£0	£103,605	£207,210	5	£41,442	£207,210
Band 5 Nursing @ 0.64 wte (day surgery)	£5,972	£6,988	0.21	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
Band 4 Personal Secretary @ 0.5 wte per consultant urologists	£23,265	£26,973	1.00	£11,633	£34,897	£69,795	3	£23,265	£69,795
Band 3 Admin support to radiologists at 0.5 wte per Radiologist	6,618	7,602	0.33	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	£31,438	£36,400	1.58	£0	£28,129	£59,567	3	£19,856	£59,568
Band 4 Medical Records support 0.5 per unit *3	£11,632	£13,487	0.50	£23,265	£23,265	£58,162	2.5	£23,265	£58,162

	Team South	Recosted at HSCB General Costing 11-12 rates	Whole Time Equivalent	Team North	Team East	Total	No	Unit Cost	Total
Band 7 MLSO – Bio-medical Science *4					£41,442	£41,442	1	£41,442	£41,442
Staffing Costs Sub Total	**£797,164**	**£935,955**	**18.04**	**£348,510**	**£1,172,174**	**£2,317,848**			**£2,317,853**
Support Costs									
Surgical G&S @ £94,500 per Con. Urologist	189,000	195,010		94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	100,000	103,180		50,000	150,000	£300,000	X 6	£50,000	£300,000
Radiology G&S per Con. Urologist	5,000	5,159		2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	64,000	66,035		32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	40,000	41,272		20,000	60,000	£120,000	X 12	£10,000	£120,000
Support Costs Sub Total	**£398,000**	**£410,656**		**£199,000**	**£597,000**	**£1,194,000**			
Sub Total	**£1,195,164**	**£1,346,611**		**£547,510**	**£1,769,174**	**£3,511,848**			**£3,511,853**
Less funding in 2008/09					**£637,076**	**£637,076**			**-£637,076**
Less Funding allocated		**£1,233,000**							
DEFICIT		**£113,611**							
FINAL TOTAL	**£1,195,164**			**£547,510**	**£1,132,098**	**£2,874,772**			**£2,874,777**

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

3.18% inflation

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment			Number of consultants with a sub-specialty interest	Additional CNS
Team South	0			2	2
Team North	2			2	0.5
Team East	2			4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse
*3 – 0.5 allocated to each Trust Unit within each Team
*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

Appendix 2

Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology - Total = 4037 (2008 - 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Urology specialist nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

Category 1: Urgent appointment required
Automatically arrange an urgent review appointment

Category 2: Decision required on review management
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

Category 3: ?Discharge based on clinical results available
Lead nurse to get permission from consultant to discharge and send letter to GP +/- patient

Category 4: PAS errors/duplication
Lead nurse to get permission from consultant to discharge from PAS

Appendix 3

Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

New : Review Ratio
1/04/06 - 28/02/10

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	1.63	2.09	1.77	1.72
Northern Trust	1.97	1.67	1.31	1.75
South Eastern Trust	1.15	1.1	1.15	1.25
Southern Trust	4.04	3.27	3.28	2.09
Western Trust	2.65	2.32	2.49	1.73

Note – the review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

Day Case Rates by Trust

April 06 - Feb 10

(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

		2006/07	2007/08	2008/09	2009/10
All Trusts	Day Cases	3793	3733	4255	3492
	Elective Admissions	3780	3963	4293	3710
	DCs+ElecAdm	7,573	7,696	8,548	7,202
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	3.9	3.5	3.5	3.3
Northern Trust	2.3	2.9	2.4	1.9
South Eastern Trust	3.8	4.0	3.4	3.2
Southern Trust	3.7	4.3	3.9	2.7
Western Trust	3.6	2.9	3.2	2.9

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	5.5	4.9	5.4	5.0
Northern Trust	4.3	5.4	4.9	3.7
South Eastern Trust	3.9	4.4	3.5	3.8
Southern Trust	4.5	4.8	4.6	4.7
Western Trust	3.9	3.8	4.1	3.4

Appendix 4

British Association of Day Surgery (BADS)

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The tables overleaf compare the Trust's performance with the BADS targets for urology. The following notes apply:

- The first table relates to Trust activity for 2009/10. At 2nd June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis.

British Association of Day Surgery (BADS) Basket of Procedures for Urology
2009/10 SHSCT Data

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%	
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%	
3	Removal of prosthesis from ureter	M29.3	100			38%		
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%	
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%	
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%	
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%	
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%	
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%
11	Dilation of outlet of female bladder	M58.2		90	10	100%		
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%	
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%		
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%

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			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%	
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10				
17	Operations on urethral orifice	M81	90	10		33%	50%	
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%	
19	Excision of lesion of testis	N06.4, N07	90	10				
20	Orchidopexy - bilateral	N08	60	35	5			
21	Orchidopexy	N09	75	20	5	60%	40%	
22	Correction of hydrocoele	N11	90	10		80%	10%	
23	Excision of epididymal lesion	N15	90	10		90%	0%	
24	Operation (s) on varicocoele	N19	90	10		60%	40%	
25	Excision of lesion of penis	N27	50	50		100%		
26	Frenuloplasty of penis	N28.4	90	10		100%		
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%	
28	Optical urethrotomy	M76.3	90	10		7%	56%	
29	Laparoscopic nephrectomy	M02.1,M02.5,M02.8, M02.9 (+Y75.2)	5	75	25	0%	11%	0%
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10			
31	Laparoscopic radical prostatectomy	M61.1,M61.2,M61.9 (+Y75.2)		5	90		0%	0%

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Appendix 5

Projected Activity & Sessions v0.1 17 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the projected activity for 'Team South'.

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Private Patients have been excluded.
3) Activity has been counted on specialty of clinic
4) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
5) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
6) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
7) 18% added for Fermanagh, based on population size relative to SHSCT population

Outpatients

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

Table 2: New Outpatient Attendances

Clinic	Core	IHA [1]	Total	%	Growth [2]	SHSCT Total	Team South [3]
Prostate TRUSA (&B)	248		248	10.6%	20	268	316
LUTS	323		323	13.8%	26	349	412
Andrology/Dr Rodgers gen urology	476	30	506	21.6%	40	546	645
Haematuria	186		186	7.9%	15	201	237
Consultants clinics	374	474	848	36.1%	68	916	1080
Urodynamics (consultants)	236		236	10.1%	19	255	301
	1843	504	**2347**	100.0%	187	2534	**2990**

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated by approximately 240 attendances.

Sessions are based on 48 weeks unless otherwise stated.

Prostate Pathway (Revised)

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum (53 if 6 patients are seen) = 1.3 (or 1.1) assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients – have asked Brian Magee for actual figure for 2009/10). Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 48 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

3rd appointment will be discussion of treatment with the estimated 88 patients per annum. Could these be dealt with promptly on a weekly basis by the surgeon of the week following the MDT? The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients

LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar (Friday flexi sessions).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 news per session = 215 sessions = **5 per week** (over 42 weeks)

Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 news and 11

reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

Stone Treatment

240 attendances @ 6 news = 40 sessions. 1 session per week will be required.

Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

APPENDIX 6

Draft Patient Flow and Clinical Pathways

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pylelonephritis

The patient needs to be assessed by the Surgical Team at the presenting hospital.

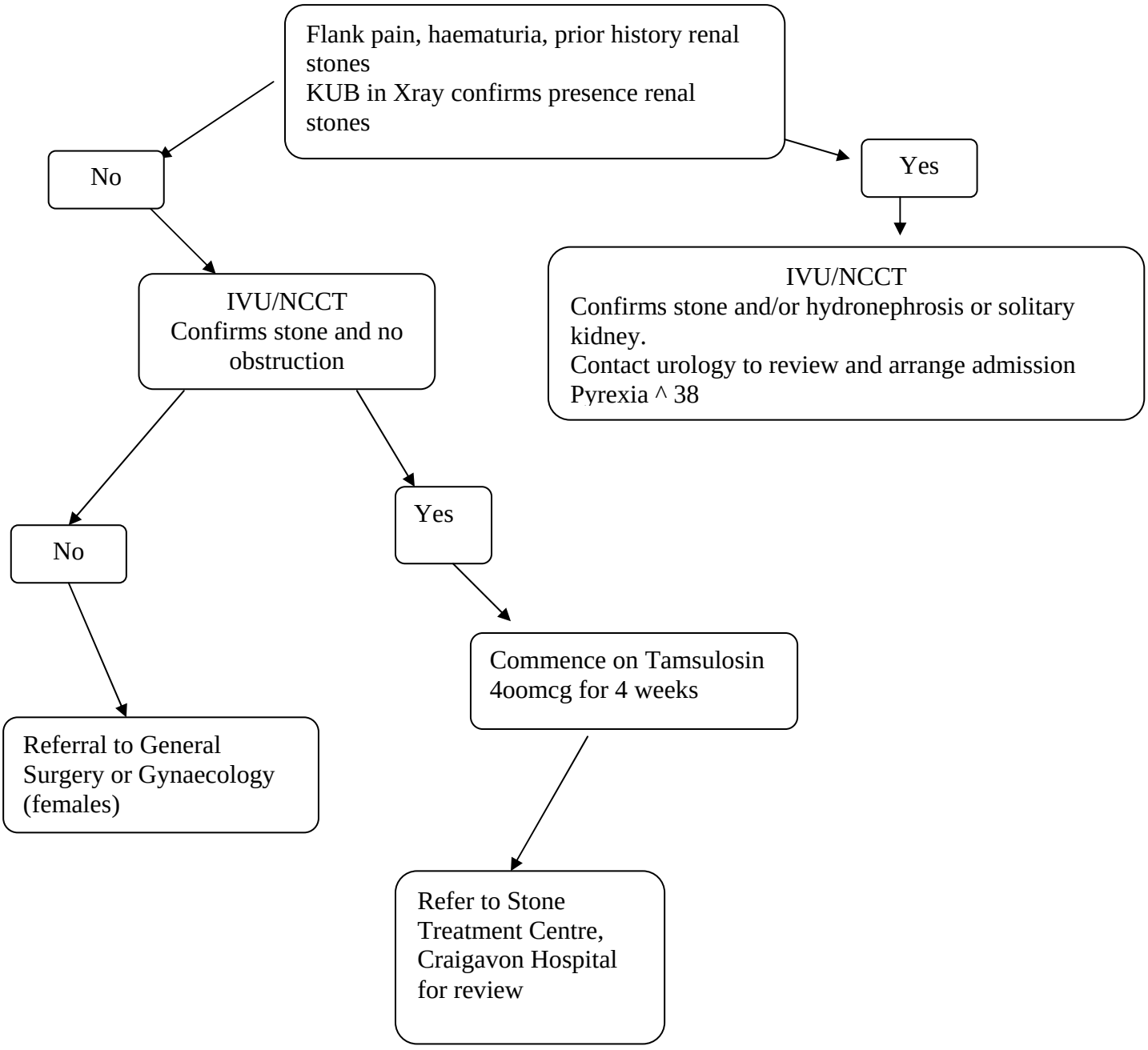
The patient will need a catheter inserted
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

Personal Information redacted by the USI

Suspected Renal colic



Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics (clarify)
Pass correct length urethral catheter –
Send a CSU for culture

↓

Catheterisation Successful

Catheterisation Unsuccessful

↓

Contact Urology unit
Admit

Admit to Craigavon Urology unit if

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

Less than 400ml
Consider alternative diagnosis (UTI) or cause painful abdomen

400-700ml
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

Discharge Home

Refer to either Ambulatory Care Manager or Community Continence Team for follow up and or TWOC.

Ensure catheter discharge form completed and take home pack is given to patient

Recurrent Urinary Tract Infections

Step 1 – Nurse Led Service

Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.

Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

Step 2 – Intravenous Antibiotic Regime

Nurse led Service
Day case attendance

IV/SC Therapy
Co-ordinator
community

Inpatient
Culture sensitivity
Symptomatic
Venous access easily obtained

Step 3 – Intravenous Fluids and Antibiotic Regime

Nurse Led Service
Day case attendance Monday – Friday
Consultant to prescribe Intravenous Antibiotic regime as per Culture and with input when from Bacteriology

Inpatient
Symptomatic
Culture Sensitivity
Venous access compromised

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

Prostate Pathway

Notes

1

GP referral
Triage by Urology Consultant

Referral
Other Consultant/LUTS or Andrology Clinic

2

OP – Same day Assessment & biopsy if required
History/DRE/counselling/possible TRUS Biopsy

Appt 1

No biopsy

Discharge to GP
With appropriate instructions for future management

biopsy

Local MDT – next meeting

3

Benign pathology
Inform patient by telephone if appropriate or follow up appointment

Positive Pathology
Results clinic - Diagnosis discussed with patient

Appt 2

4

Discharge to GP
With appropriate instructions for future management

OP Waiting List
For review/repeat biopsy

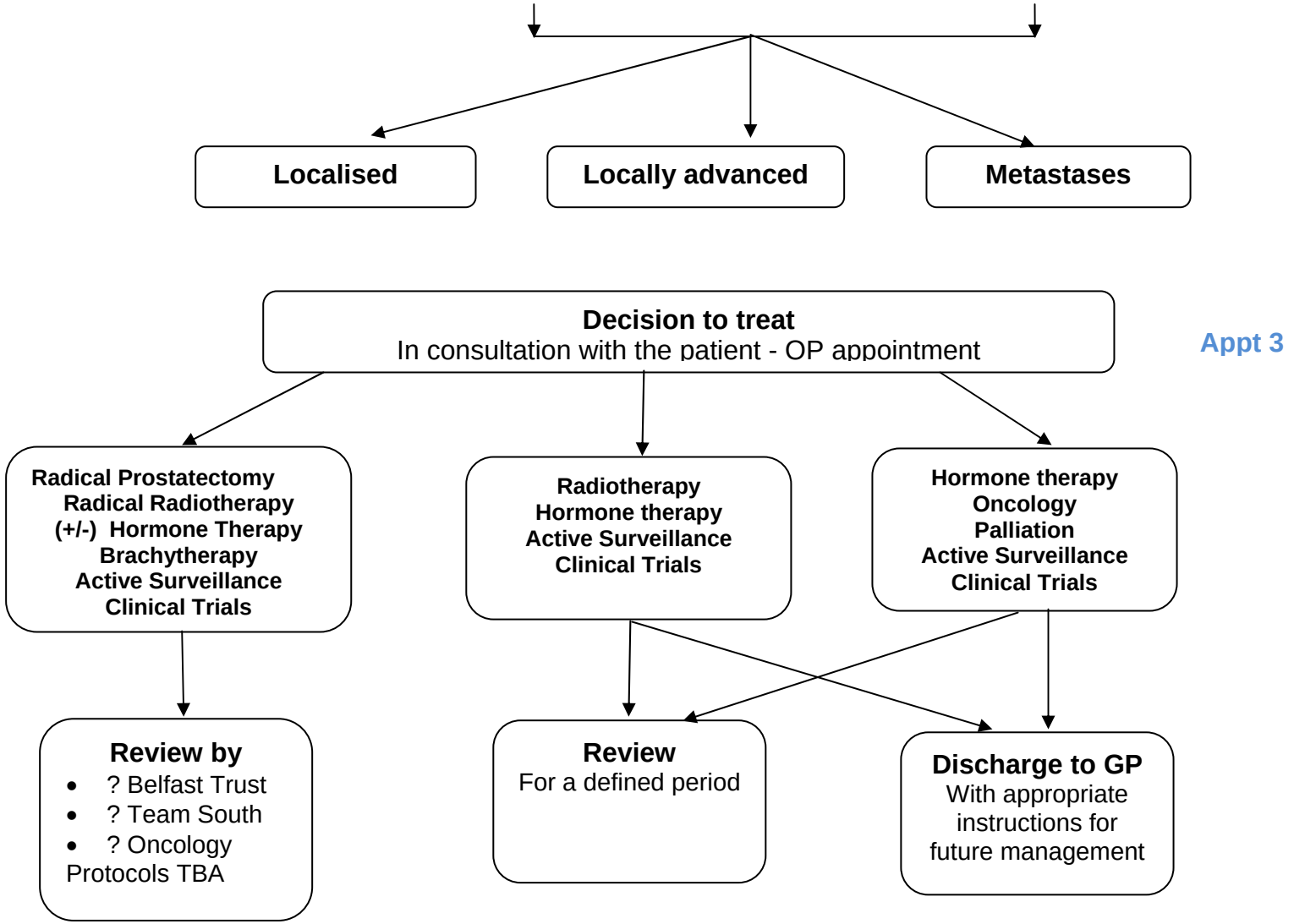
Staging
MRI/CT & Bone scan if appropriate

5

Local MDT
Present at local MDT when staging complete.
If patient meets regional referral criteria discuss at specialist MDT on the same day.

Specialist MDT
Present at specialist MDT

Inter Trust Transfer by Day 28



6

Notes

1. **Referral protocol for GPs** is required. Also an information leaflet for GPs describing what will happen at the OP assessment/biopsy appointment so that they can inform and counsel the patient.
2. **First appointment** – assessment and where clinically indicated a biopsy. Results are normally back from Pathology in 5-10 days.

   Specialist Nurse should assess at this appointment if the patient is suitable to receive the results (if benign) by telephone and should discuss this with the patient.

   Scans should be booked at this point for those patients who have biopsy (to be cancelled if the biopsy is benign). **Note** another PC in Tutorial Room1 with access to NIPACS will be required to facilitate this.

   Only Dr McClure and Mr Akhtar do biopsies at present. One or both of the new consultants will also need to be trained.

   248 new patients attended TRUSA/TRUSB in 2009/10. Factoring in growth in the waiting list and also 18% of SHSCT activity for Fermanagh gives 316 patients @ 4 per session = 79 sessions = 1.7 per week. At 4 patients per clinic this will require **60 sessions** per annum.

   165 patients attended TRUSB in 2009/10 (69% of patients who were assessed). Therefore approximately 30 patients from Fermanagh will require biopsy.
3. **Benign biopsy** – will need to consider management of the outpatient waiting list for patients who need future review or repeat biopsy to ensure they do not get lost in the system.
4. **Staging** – there is a 6 week suspension between biopsy and scanning. The MRI/CT and bone scan can be done on the same day if the MRI/CT is done first. However we need to check if both scans can be booked for the same day to save 2 journeys for the patient (NIPACS issue).

   Reports need to be available within 2 – 5 days (need to be available for the next MDT).
5. **Local/Specialist MDT** – where appropriate inter Trust transfer must be made by day 28 from receipt of referral.
6. The review programme awaiting confirmation of who will review the patients managed by Belfast surgical team and also radiotherapy?

<u>Patients to be discussed at local MDT</u>

All patients with biopsies for suspected cancer (NICE)

All patients diagnosed with prostate cancer (peer review)

(From NICAN Urology Network)

Prostate cancer

Patients with locally advanced or metastatic disease, to be referred for specialist discussion if clinically appropriate. Patients over 85 do not require discussion.

H595/38 NOVEMBER 1995

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

GRADE: Registered General Nurse Level 1 Grade 'D' (Temporary)

REPORTS TO: Sister/Charge Nurse

RESPONSIBLE TO: Nurse Clinical Specialist

ROLE: The postholder is responsible for the assessment of care needs and the development of programmes of care and/or the implementation and evaluation of these programmes. The postholder is expected to carry out all relevant forms of care without direct supervision and may be required to demonstrate procedures to and supervise other qualified/unqualified staff.

DUTIES AND RESPONSIBILITIES:

1.0 Professional

1.1 Is responsible for planning, assisting and evaluating individual programmes of nursing care and ensures that patient care is carried out to an agreed standard.

1.2 Co-operates with other members of the Patient Care Team.

1.3 Adheres to the DHSS Guidelines for the Safe Handling, Administration, Storage and Custody of Medicinal Products.

1.4 Ensures that accurate nursing records are maintained.

1.5 Communicates with patients, relatives and gives guidance, support and advice as required.

1.6 Liaises with multi-disciplinary teams and Community Services to ensure Continuity of Care.

1.7 Accepts responsibility for his/her own continuing professional development.

1.8 Participates in research to enhance patient care.

1.9 Complies with the UKCC Code of Professional Conduct.

2.0 Administration

2.1 Participates in Off Duty/Annual Leave arrangements of the Ward/Department to ensure adequate cover at all times.

2. Ensures a safe environment for patient care and in the absence of same, communicates with the appropriate Department to take corrective action.

2.3 Adheres to all Hospital Policies including the following:

a. Health and Safety at Work

b. Fire Precautions

c. Reporting of sick leave/absenteeism

d. Confidentiality

e. Hospital Disaster Plan

f. Infection Control

2.4 Accepts responsibility for the Ward/Department for a span of duty in the absence of the Nurse-in-Charge in order to gain managerial experience.

3.0 Personnel

3.1 Participates in the orientation and induction of new members of nursing staff.

3.2 Observes any signs of ill health or stress factors in staff assigned to the Ward/Department and reports same to the Ward Manager.

4.0 Education

4.1 Participates in the teaching of Student Nurses.

4.2 Participates in in-service training for trained and untrained nursing staff.

4.3 Attends in-service lectures, study days and courses to comply with UKCC Policy.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

- Comply with the Trust's policy on smoking.

- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something with is rigid and inflexible.

CRAIGAVON AREA HOSPITAL GROUP TRUST

EMPLOYEE PROFILE

POST: Registered General Nurse Level 1 Grade 'D' (Temporary)

LOCATION: Craigavon Area Hospital, Lurgan Hospital, Banbridge Hospital

FACTORS	ESSENTIAL	DESIRABLE
Skills/Abilities	An ability to work effectively as part of a ward team. Must be willing to work in all areas of the Craigavon Area Hospital Group Trust as required. Must be conversant with current professional issues.	
Qualifications/Experience/ Training, etc.	RGN 1st Level. Currently on UKCC Live Register.	
Other Requirements/ Work Related Circumstances	Able to complete lifting/handling training. Be available to work full-time/part-time, day or night duty.	

CRAIGAVON AREA HOSPITAL GROUP TRUST

GENERAL INFORMATION - TRAINED NURSING STAFF

HOURS:	Full-time/Part-time
DAY DUTY HOURS COVERED:	7:30 am - 9:00 pm
NIGHT DUTY HOURS COVERED:	8:30 pm - 7:45 am

MEAL BREAKS:

Day:	Coffee 15 mins Tea 15 mins	Dinner 45 mins Supper 30 mins
Night:	Meal 45 mins	Tea 30 mins

An orientation programme to the hospital is given to all staff. Documentation and uniform fitting are carried out during this period.

UNIFORM:

FEMALE: Uniform frocks are provided and laundered free of charge. White low-heeled shoes and beige stockings/tights are worn and provided by the Nurse.

MALE: Uniform jacket and grey trousers are provided and laundered free of charge. Black shoes are worn and provided by the Nurse.

JEWELLERY: No jewellery is permitted to be work other than a wedding ring and gold coloured stud earrings measuring not more than 5mm in size.

HAIR: Should be neat and worn off the collar.

MAKE-UP: Should be discreet.

A locker in Staff Changing Room is available and the wearing of uniform is not permitted beyond the confines of the hospital.

Meal and snacks are available in Staff Dining Room at reasonable prices.

Further information may be obtained from the Clinical Specialists, Craigavon Area Hospital.

H500/75

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

POST: Staff Nurse Grade E'

REPORTS TO: Ward Manager

RESPONSIBLE TO: Clinical Services Manager

ROLE: The postholder is responsible for the assessment of care needs and the development, implementation and evaluation of programmes of care.

The postholder is expected to carry out all relevant forms of care without direct supervision and will be required to teach and supervise qualified or unqualified staff.

DUTIES AND RESPONSIBILITIES:

1.0 Professional

1.1 Ensure that individualised nursing care is maintained and carried out to agreed standards set for the Ward/Department.

1.2 Participate in audit of clinical practice.

1.3 Co-operate with all members of the multidisciplinary team.

1.4 Adhere to the DHSS Guidelines for the Safe Handling, Administration, Storage and Custody of Medicinal Products.

1.5 Maintain an awareness of clinical and professional developments in nursing and participate in Nursing Research.

1.6 Accept responsibility to improve his/her knowledge and professional competence.

1.7 Adhere to the UKCC Code of Professional Conduct and Scope of Professional Practice.

1.8 Maintain effective communications with patients, relatives and all members of the multidisciplinary team.

2.0 Administration

2.1 Participate in Off Duty/Annual Leave arrangements to ensure Ward/Department has adequate cover.

2.2 Ensure a safe environment for patient care and in the absence of same communicate with appropriate department to take corrective action.

2.3 Adhere to all Hospital Policies including:-

(a) Health and Safety at Work Order

(b) Fire Precautions

(c) Reporting of sick leave/absenteeism

(d) Confidentiality

(e) Hospital Disaster Plan

(f) Infection Control

(g) COSHH

2.4 Take charge regularly of a Ward/Department in the absence of the Ward Manager who has continuing responsibility.

3.0 Personnel

3.1 Participate in the induction and orientation of new staff.

3.2 Observe any signs of ill health or stress factors in staff assigned to the Ward/Department and report same to Ward Manager.

3.3 Provide support, guidance and counselling for junior staff.

4.0 Education

4.1 Participate in the clinical training of qualified staff, students and nursing auxiliaries.

4.3 Attend In-Service study days, lectures and courses to comply with the UKCC Policy and Trust Policies.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Comply with the Trust's policy on smoking.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

October 2000

CRAIGAVON AREA HOSPITAL GROUP TRUST

EMPLOYEE PROFILE

POST: Staff Nurse Grade 'E'

DEPARTMENT/SPECIALTY: Surgical Directorate, Craigavon Area Hospital

FACTORS	ESSENTIAL	DESIRABLE
Skills/Abilities	An ability to maintain and audit standards of care. Innovative and progressive. Ability to teach. Ability to manage and lead a team. Be able to communicate effectively. Good interpersonal skills.	
Experience	Minimum of two years nursing experience in General Surgery within the last three years.	
Qualifications/Training, etc	On Part 1 or 12 of the UKCC "Live" Register.	Evidence of further study/ professional development.
Knowledge	Must be conversant with current professional issues.	Knowledge of current relevant research.
Other Requirements/ Work Related Circumstances	Be available to work day or night duty as required. Flexible with regard to working hours to facilitate the demands of the post. Able to complete Lifting and Handling training.	

October 2000

CRAIGAVON AREA HOSPITAL GROUP TRUST

GENERAL INFORMATION - TRAINED NURSING STAFF

HOURS: Full-Time/Part-time (Any 5 days per week)

DAY DUTY HOURS COVERED: 7:30 am - 9:00 pm

NIGHT DUTY HOURS COVERED: 8:30 pm - 7:45 am

MEAL BREAKS:

Day:	Coffee 15 mins Tea 15 mins	Dinner 45 mins Supper 30 mins
Night:	Meal 45 mins	Tea 30 mins

An orientation programme to the hospital is given to all staff. Documentation and uniform fitting are carried out during this period.

UNIFORM:

FEMALE: Uniform frocks are provided and laundered free of charge. White low-heeled shoes and beige stockings/tights are worn and provided by the Nurse.

MALE: Uniform jacket and grey trousers are provided and laundered free of charge. Black shoes are worn and provided by the Nurse.

JEWELLERY: No jewellery is permitted to be worn other than a wedding ring and gold coloured stud earrings measuring not more than 5mm in size.

HAIR: Should be neat and worn off the collar.

MAKE-UP: Should be discreet.

A locker in Staff Changing Room is available and the wearing of uniform is not permitted beyond the confines of the hospital.

Meal and snacks are available in Staff Dining Room at reasonable prices.

Further information may be obtained from the Clinical Services Managers, Craigavon Area Hospital.

H502/32

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

JOB TITLE: Acting Night Nursing Sister/Charge Nurse Grade 'F'

REPORTS TO: Night Nursing Co-Ordinator/Bed Manager

JOB SUMMARY: The Night Nursing Sister/Charge Nurse has overall responsibility for the co-ordination of all services to patients during his/her span of duty. He/She will act as a resource to support staff at ward level, undertake the bed management role and have the authority to make decisions in respect of nursing services which are in the interests of patient care.

The post holder will liaise with the senior nurse on call/director on call and provide reports for the Chief Executive and the Directorate of Nursing and Quality on untoward incidents.

The Night Sister/Charge Nurse will be part of the total bed management rota and will be required to rotate across the 24 hour period in order to fulfil this role. The Night Sister/Charge Nurses' role covers both Craigavon Area and Lurgan Hospitals.

DUTIES & RESPONSIBILITIES

1.0 Managerial Role

1.1 Act as Site Co-Ordinator, including the bed management function, for the night duty period.

1.2 Be familiar with Bed Management Policy for the Trust.

1.3 Maintain an up-to-date record of bed statistics.

1.4 Relieve the bed manager on day duty for annual leave, as required.

1.5 Ensure that there is a safe working environment for staff in accordance with the Health and Safety at Work NI Order, conducting risk assessments as required.

1.6 Investigate and deal with complaints according to the Trust's Complaints Policy.

1.7 Liaise with ward managers, Medical staff, director on call, chaplains and other outside agencies e.g. PSNI, Fire Officer.

1.8 Act as nominated fire officer during the night period and co-ordinate the fire incident plan in the event of a fire, according to "Action Card".

1.9 Participate in the major disaster plan in conjunction with Accident & Emergency staff.

1.10 Ensure that night duty staff adhere to all policies, protocols and procedures within the Trust.

1.11 Observe any signs of ill health or stress factors in staff on night duty and report same to their manager.

1.12 Manage all non-medical staff in the facility during the night duty period.

1.13 Participate in the night duty rota for Lurgan Hospital.

2.0 Professional Role

2.1 Monitor the quality of patient care during the night duty period and provide professional advice and guidance to nursing staff.

2.2 Ensure that nursing practice during the night duty period reflects the standards set by the NMC Code of Professional Conduct.

2.3 Take responsibility for own professional development and ensure that PREP requirements are achieved.

2.4 Communicate to ward managers any educational or training needs identified for night duty nursing staff.

GENERAL REQUIREMENTS

The post holder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Comply with the Trust's policy on smoking.
- Treat those with whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances an should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

July 2002

CRAIGAVON AREA HOSPITAL GROUP TRUST

EMPLOYEE PROFILE

POST: Acting Night Nursing Sister/Charge Nurse Grade 'F'

DEPARTMENT/SPECIALTY: Night Duty, Craigavon Area Hospital/Lurgan Hospital

FACTORS	ESSENTIAL	DESIRABLE
Skills/Abilities	Clear verbal and written communication skills. Ability to evaluate information and make appropriate decisions. Ability to work effectively within a multi-disciplinary setting. Ability to take responsibility for the co-ordination of all services to patients during a span of duty.	
Qualification/Experience/ Training, etc	Part 1 or 12 of the NMC "Live" Register. 4 years' post-registration experience, within the last 5 years, exclusive of post basic courses. Diploma in Nursing or equivalent or be currently undertaking same. Evidence of having taken charge of a ward or department.	Evidence of management training / experience.
Knowledge	Knowledge of developments in clinical practice and relevant research. Knowledge of the bed management function. Working knowledge of Disaster Plans. Working knowledge of Fire Policies. Understanding and knowledge of Professional Regulations and Scope of Practice.	
Other Requirements/Work Related Circumstances	Flexible with regard to working hours to facilitate the demands of the post. Rotate to day duty as required. Be willing to respond to emergency "call-in".	

July 2002

H505/12

CRAIGAVON AREA HOSPITAL GROUP TRUST

JOB DESCRIPTION

JOB TITLE: Senior Nurse / Patient Services Manager (Grade H)

REPORTS TO: Assistant Director of Nursing & Quality

RESPONSIBLE TO: Director of Nursing & Quality

JOB SUMMARY: The postholder will ensure effective and efficient use of beds within the Trust, so as to provide a quality service to patients. He/she will also ensure 24-hour cover for Bed Management and Site Management.

The postholder will manage the Night Managers, the Bed Management team, Hospital/Community Liaison team, the Internal Ambulance Co-ordinator and the Internal Ambulance Service.

KEY TASKS:

The postholder will:

- Manage a team providing integrated 24/7 management of the day to day admission and discharge of patients.
- Manage the Night Managers and Internal Ambulance Co-ordinator
- Integrate the team of Bed Managers and Hospital/Community Liaison Staff.
- Proactively manage bed occupancy for both the elective and emergency whole patient journey from admission to discharge.
- Maintain a clear focus on the management of emergency patient flows, working to ensure that all emergency patients are admitted in a timely manner, based on clinical priority and balanced with the wider Trust constraints around elective patient services.

DUTIES AND RESPONSIBILITIES:

1.0 **SERVICE MANAGEMENT**

1.1 Retain overall managerial responsibility for Night Managers/Bed Managers/Internal Ambulance Co-ordinator and Hospital/Community Liaison Team.
1.2 Function as Bed Manager as required.
1.3 Ensure timely and accurate record of bed statistics are maintained.
1.4 Collect, prepare and collate bed statistics on a daily basis for Senior Management, Social Health and Social Services Board and the Department of Health, Social Services and Public Safety.
1.5 Meet regularly with Clinicians/CSMs/DMs across the Trust.
1.6 Manage Internal Ambulance Service.
1.7 Attend meetings at Trust, Community and Board level to promote and develop good communication and working relationships.
1.8 Participate in the Major Incident Plan as per Bed Managers "Action Card".
1.9 Ensure that all policies in relation to Bed Management, Admission and Discharge processes and management of the site at night are adhered to and updated regularly.
1.10 Ensure that staff adhere to all policies, protocols and procedures within the Trust.

1.11 Investigate and deal with complaints / accidents / incidents according to the Trust Policies and provide written reports as requested.
1.12 Manage the budget for staff and goods and services.

2.0 PATIENT FLOW MANAGEMENT

2.1 Maintain good communication networks with:
- All Wards/Departments in the Trust
- CSMs and Senior Management
- Medical Staff
- GPs
- Bed Managers in other Trusts and the Emergency Admissions Co-ordination Centre in Belfast
- Multidisciplinary team
- Ambulance Service
- Community Trusts

2.2 Communicate as required with Senior Managers/Clinicians re: bed availability, and associated pressures.
2.3 Participate in the development of Nurse-Led discharge.
2.4 Encourage, monitor and review the use of the Discharge Lounge
2.5 Liaise with Community Trusts regarding intermediate care arrangements
2.6 In collaboration with Senior Management / Clinicians, identify initiatives and areas of service development for the purpose of maximising patient throughput and bed efficiency.
2.7 Collaborate with medical staff and other members of the multi-disciplinary team to develop arrangements to provide patient/carers with an expected date of discharge.

3.0 STAFF MANAGEMENT

3.1 Observe any signs of ill health and stress factors amongst staff reporting to him/her and take action as appropriate.
3.2 Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making.
3.3 Plan duty rotas and annual leave.
3.4 Identify education and training needs for staff reporting to him/her. Encourage professional, personal and team development.
3.5 Maintain staff morale and working relationships
3.6 Ensure there is an effective communication system within the Team and external to the Team.
3.7 Participate in the Selection and Recruitment of staff.
3.8 Implement the Disciplinary Process as appropriate according to Procedure laid down by Trust.
3.9 Ensure that an appropriate induction programme is in place for new staff.
3.10 Review at least annually the performance of staff.
3.11 Ensure there is a safe working environment for staff in accordance with the Health and Safety at Work NI order conduct Risk assessments as required.

4.0 PROFESSIONAL ROLE

4.1 Take responsibility for own professional development.
4.2 Ensure PREP requirements are met.
4.3 Adhere to NMC Code of Professional Conduct.
4.4 Participate in audit / research projects as required.

GENERAL REQUIREMENTS

The postholder must:-

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Comply with the implementation of the Trust's Health & Safety arrangements and report any accidents / incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Comply with Trust's policy on smoking.
- Treat those with whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

January 2005

CRAIGAVON AREA HOSPITAL GROUP TRUST

EMPLOYEE PROFILE

POST: Senior Nurse (Patient Services Manager) Grade H

DEPARTMENT/ SPECIALITY: Directorate of Nursing & Quality

FACTORS	ESSENTIAL	DESIRABLE
Skills / Abilities	Effective verbal and written communication skills. Ability to take the lead in managing emergency and elective patient flows. Ability to evaluate information and make appropriate decisions. Ability to develop and maintain good interpersonal relationships. Ability to work effectively within a multi-disciplinary setting. Ability to influence and manage change effectively, including effective negotiating skills.	Knowledge of PAS / computer literacy.
Qualifications / Experience / Training etc.	Part 1 or 12 of the NMC "Live" Register (Part 1 of the revised register) 5 years experience within the last 6 years, 2 of which must have been at Grade F or above. Degree in Nursing or a Health related subject or willing to undertake the same	Evidence of management training / experience. Evidence of further professional or managerial development.
Knowledge	Knowledge of the Modernisation Agenda currently being progressed by the NHS in England and by DHSSPS in Northern Ireland	Working knowledge of Disaster Plans. Working knowledge of Fire Policies. Understanding of Health & Safety legislation
Other requirements Work Related Circumstances	Flexible with regard to working arrangements. Be willing to respond to emergency "call-in".	

January 2005

- CRAIGAVON AREA HOSPITAL GROUP TRUST -

JOB INFORMATION

POST:	**SENIOR NURSE (PATIENT SERVICES MANAGER) GRADE H – H505/12**
LOCATION:	**DIRECTORATE OF NURSING & QUALITY, CRAIGAVON AREA HOSPITAL**
REMUNERATION:	The salary is £[redacted] rising by annual increments to £[redacted] per annum (under review), payable monthly. Payment is made on the third last banking day of each month, by the Bank Automatic Clearing System (BACS).
HOURS OF DUTY:	The hours of duty will be 37½ per week, exclusive of meal breaks.
ANNUAL LEAVE:	The annual leave year starts on 1 April. You will be entitled to 27 days annual holidays. If you join the Trust after 1 April you will be entitled to annual holidays proportional to your length of service in the remainder of the leave year. If you join the Trust on a part-time basis, the annual leave entitlement will be pro-rata to the number of days worked per week.
STATUTORY LEAVE:	The Trust recognises 10 statutory holidays each year.
SUPERANNUATION:	The post is superannuable. Unless you opt out of the scheme your remuneration will be subject to deduction of superannuation in accordance with the HPSS Superannuation Scheme (Currently 6% per annum).
MEDICAL:	You may be required to have a health assessment at the Occupational Health Department, to determine that you are fit to carry out the duties of the post.
PROBATIONARY PERIOD:	Any permanent appointment will be subject to a probationary period, during which time, progress and attendance are monitored. Provided a satisfactory standard is achieved and maintained, the appointment will be confirmed.
SICKNESS:	Staff are required to comply with the Trust's Sickness and Absenteeism Policy and the reporting requirements and procedures contained within it. The Trust is committed to monitor and control absenteeism because of its responsibilities to patients and the organisation as a whole. It should be noted that you will be asked at interview about your sickness record for the previous 2 years and you will be required to give details of this to the interview panel.
NOTICE:	You may terminate your appointment by giving one month's notice in writing. Should notice have to be given to you it will be a period commensurate to length of service.
CLOSING DATE:	**Completed application forms must be returned to the Human Resources Department, General Recruitment Section – Beechfield House, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Co Armagh, BT63 5QQ no later than Tuesday, 1st February 2005.**

References Sent 12/10 C.D.

Patient Flow Manager

Ref: 88207143
Closing Date: 19 September 2007 16:00
Location: To be Confirmed
Contract: Permanent
Salary: Band 8B (£39,346 - £50,733)
Hours: Full Time / Job Share will be considered
Interview Dates: Expected to be held Friday 28 September

Southern Health and Social Care Trust

Job Description:

Southern Health and Social Care Trust

JOB DESCRIPTION

POST TITLE:
Patient Flow Manager

RESPONSIBLE TO:
Assistant Director of Acute Services – Medicine & Unscheduled Care

JOB SUMMARY
Reporting to the Assistant Director of Acute Services – Medicine & Unscheduled Care (ADASMUC), this post is responsible for proactively managing bed occupancy for both the emergency and elective whole patient journey from admission to discharge. The Patient Flow Manager will be responsible for actively managing demand patterns and resolving short-term operational/institutional conflicts as they arise. To be responsible for bed management, discharge management and the efficient flow of patients throughout all acute hospital facilities within the Southern Health & Social Care Trust (SHSCT) area.

The post holder will also be responsible for initiating efficient and effective patient focused care from admission to discharge as part of a team using research based practice; and contribute to a harmonious working environment that supports clinical colleagues.

The post holder will work with clinicians and colleagues to deliver a quality patient focused service.

DUTIES

1. Management – Operations

1.1 Harmonise bed and discharge management working practices across all SHSCT sites and the wider community using best practice in bed management resources including the NHS Modernisation Bed / Discharge Management Toolkit.
1.2 Forecast, co-ordinate and manage the number of elective and non-elective admissions in order to ensure optimum occupancy of hospital beds.
1.3 Manage and coordinate activities involved in scheduling patient admissions and daily bed assignments for incoming medical and surgical patients; resolve

problems and respond to special needs of individuals involved in the admitting process. Chair twice daily meetings of the Bed Management Group and prepare/publish daily bed status information across the acute services network.
1.4 Develop and recommend operating policies and procedures for hospital reservations, bed control and discharges.
1.5 Determine fiscal requirements of the unit and prepare budgetary recommendations; monitor, verify and reconcile expenditure of budgeted funds.
1.6 Prepare reports and analyses, including operating statistics and financial statements, setting forth progress, adverse trends and appropriate recommendations or conclusions.
1.7 Plan and conduct meetings with subordinates to ensure compliance with established practices, to implement new policies and to keep employees abreast of current changes and standards to ensure the safe and appropriate care of patients.
1.8 Plan and schedule work for the group ensuring proper distribution of assignments and adequate manning, space and facilities for subsequent performance of duties.
1.9 Improve trust-wide capability to meet its demand for beds. Develop risk assessment capability to ensure all risks to bed capacity are identified, assessed and remedial action taken.
1.10 Develop systems to communicate and review robust bed management and effective escalation/de-escalation policies.
1.11 Utilise performance forecasts and benchmark data to develop and implement efficient plans that ensure achievement of Trust-wide and DHSSPS targets.
1.12 Ensure placement of patients in line with Trust wide priorities and directorate models.
1.13 Ensure processes and polices are in place for the Trust's management of delayed discharges.
1.14 Prepare and present a yearly business plan for the service in line with the Trust strategy and business plan.
1.15 Audit length of patient stay, ensuring regular report feedback and recommendations for action within the wider Trust forums.
1.16 Provide feedback to staff and patients as necessary on bed and discharge capacity issues.
1.17 Responsible for the provision of out of hours 365 day a year service across all acute sites.
1.18 Be proactive with regard to complaints in order to reduce tension and the number of formal complaints. Take a lead in complaint responses and managing the dissemination of any resultant learning throughout the Trust.

2. Management of Finance

2.1 Manage the budget for the Bed Management and Discharge team services.
2.2 Provide a cost- effective service by using resources with care and minimising waste.
2.3 Monitor and control all relevant financial resources.

3. Leading & People Management

3.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.
3.2 Ensure the contributions and perspectives of staff are heard, valued and

considered when management decisions are taken within the division.
3.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.
3.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.
3.5 Ensure the division implements and adheres to Trust HR policies and procedures.
3.6 Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

4. Information Management

4.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.
4.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

General Management Responsibilities

- Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training;
- Ensure that the review of performance identified above is performed for all levels of staff within your remit of responsibility in accordance with the Trust policy;
- Maintain good staff relationships and morale amongst the staff reporting to you;
- Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate;
- Delegate appropriate responsibility and authority to the level of staff within your control consistent with effective decision making whilst retaining responsibility and accountability for results;
- Participate as required in the selection and appointment of staff reporting to you in accordance with procedures laid down by the Trust;
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust;
- Promote the Trust's policy on equality of opportunity through your own actions and ensure that this policy is adhered to by staff for whom you are responsible.

General Responsibilities

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.

- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of Acute Services – Medicine & Unscheduled Care.

September 2007

Personnel Specification:

Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- a university degree or relevant professional qualification and have at least 2 years relevant experience in a senior role*

OR

- have at least 5 years experience in a senior role*

AND

- delivered against challenging performance objectives for a minimum of 2 years in the last 6 years meeting a range of key targets and making significant** improvements.
- worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational skills for a minimum of 2 years in the last 6 years.
- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified