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

Mr. Mehmood Akhtar
Consultant Urologist
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

31 May 2022

Dear Sir,

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 details 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/or 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 the USI
Mobile: Personal Information redacted by the USI

Issued by Urology Services Inquiry on 31 May 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 56 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:

Mehmood Akhtar
Consultant Urologist
C/O 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 **noon on 15th July 2022.**

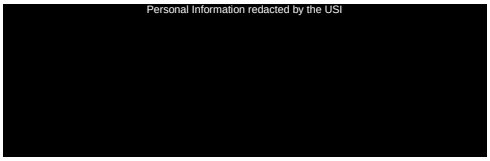
APPLICATION TO VARY OR REVOKE THE NOTICE

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 5th July 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 31st May 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 56 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. If you are uncertain about what documents have been provided to the Inquiry please liaise with the Trust's legal representatives. 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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

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.

7. With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, including your lines of management in respect of matters of clinical care, patient safety, administration and governance.

8. It would be helpful for the Inquiry for you to explain 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 the roles of the Clinical Lead, Clinical Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.

Urology Services

9. 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. As relevant, set out your involvement, if any, in the establishment of the Urology unit in the Southern Trust area.

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.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

11. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems with, for example, a backlog of patients, persist following the setting up of the Urology unit?

12. In April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

> 1.1 INTRODUCTION
>
> 1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.
>
> 1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the

hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

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

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

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

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

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

14. What, if any, performance indicators were used within the Urology unit at the start of, and throughout, your employment? If there were changes in performance indicators throughout your time there, please explain.

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

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

17. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of Urology Services? In your view, did staffing problems present a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples.

18. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

19. Has your role changed during your tenure? If so, do changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

20. Explain your understanding as to how the Urology unit and Urology Services were and are supported by administrative staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to you as a Consultant so that you may properly carry out your duties. Accordingly, please set out in full all assistance and support which you receive from administrative staff to help you to fulfil your role.

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

22. Do all Consultants have access to the same administrative support? If not, why not?

23. Have you ever sought further administrative assistance? If so, what was the reason, whom did you ask and what was the response?

24. Did administrative support staff ever raise any concerns with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you or anyone else did in response.

25. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

26. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Do you consider that the specialist cancer nurse, and all nurses within Urology, worked well with Consultants? Did they communicate effectively and efficiently? If not, why not.

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

28. What is your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain why, and whether you raised this issue with anyone (please name and provide full details).

29. As Consultant Urologist, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

30. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

31. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

32. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and refer to (or provide, if not provided by the Trust already) any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

33. Were you involved in the review or appraisal of others? If yes, please provide details. Did you have any issues with your appraisals or any you were involved in for others? If so, please explain.

Engagement with Urology staff

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

Governance

35. During your tenure, who did you understand as overseeing the quality of Services in Urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of Services?

36. Who oversaw the clinical governance arrangements of the unit and how was this done? As Consultant urologist, how did you assure yourself that this was being done properly? How, if at all, were you as Consultant urologist provided with assurances regarding the quality of urology services?

37. How, if at all, did you inform or engage with performance metrics overseen in Urology? Who was responsible for overseeing performance metrics?

38. 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?

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

40. How could issues of concern relating to Urology Services be brought to your attention as a Consultant, or be brought to the attention of others? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients or relatives. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

41. Did those systems or processes change during your tenure? If so, how, by whom and why?

42. How did you ensure that you were appraised of any concerns generally within Urology Services?

43. How, if at all, were any concerns raised or identified by you, or about you, reflected in Trust governance documents, such as Governance meeting minutes or notes, or in any Risk Register? Please provide any documents referred to (unless provided already by the Trust).

44. What systems were in place for collecting patient data in Urology Services? How did those systems help identify concerns, if at all?

45. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

46. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any performance objectives relevant to Urology during your time (and identify the origin of those objectives), providing documentation (where it has not been provided already) or sign-posting the Inquiry to any relevant documentation.

47. How well did you think the cycle of job planning and appraisal worked within Urology Services and explain why you hold that view?

48. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

49. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

Concerns regarding the Urology unit

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

    (i) The Chief Executive(s);
    (ii) The Medical Director(s);
    (iii) The Director(s) of Acute Services;
    (iv) The Assistant Director(s);
    (v) The Associate Medical Director;
    (vi) The Clinical Director;
    (vii) Clinical Lead;
    (viii) The Head of Service;
    (ix) Other Consultant Urologists.

    When answering this question please name the individual(s) who held each role during your tenure. When addressing this question you should appreciate that the Inquiry is interested to understand how you liaised with these post-holders in matters of concern regarding Urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety.

In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding Urology Services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

51. Were any concerns ever raised regarding your clinical practice? If so, please provide details.

52. Did you ever have cause for concern or were concerns ever brought to your attention regarding:

(a) The clinical practice of any medical practitioner in Urology Services?

(b) Patient safety in Urology Services?

(c) Clinical governance in Urology Services?

If the answer is yes to any of (a) – (c), please set out:

(i) What concerns you had or which were 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 action (if any) was planned in response to these concerns.

(ii) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.

(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?

(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

(ix) If any systems and agreements put in place to address concerns were not successful, please explain why in your view they were not and what might have been done differently.

53. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether in your view these issues of concern were -

    (a) Properly identified,
    (b) Their extent and impact assessed properly, and
    (c) The potential risk to patients properly considered?

54. What, if any, support was provided to you and Urology staff by the Trust given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q66 will ask about any support that you may have been aware of having been provided to Mr. O'Brien).

55. Was the Urology Services offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

Mr. O'Brien

56. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? In answering this question please indicate:

    (i) What were those issues of concern,
    (ii) When were they first raised with you?
    (iii) Who raised them?
    (iv) Do you now know how long these issues were in existence before coming to either your own, or anyone else's attention?

    Please provide full details in your answer. Please provide any relevant documents if not already provided to the Inquiry.

57. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:
    (a) Outline the nature of concerns you raised, and why they were raised?
    (b) Who did you raise it with and when?
    (c) What action was taken by you and others, if any, after the issue was raised?
    (d) What was the outcome of raising the issue?

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

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

59. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

60. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

    (i) In what way may concerns have impacted on patient care and safety?
    (ii) When did any concern in that regard first arise?
    (iii) What risk assessment, if any, was undertaken to assess potential impact? and
    (iv) What, if any, steps were taken to mitigate against this? If none, please explain. Who do you consider was responsible for carrying out a risk assessment or taking further mitigating steps and what do you think those steps should have been? Please explain why and identify that person?

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

62. Do you have knowledge of any metrics used in monitoring and assessing the effectiveness of any agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? Who was responsible for overseeing any agreed way forward, how was this done, where was record of the oversight recorded, and how long did this oversight last? Please include any documentation (unless already provided) and/or indicate where the Inquiry may find a record of any oversight.

63. How did you assure yourself as a Consultant urologist that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Do you know against what standards methods were assessed? Are there records of you having assured yourself that systems and agreements put in place to address concerns were effective?

64. Do you know if any such agreements and systems which were 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?

65. Did Mr O'Brien raise any concerns with you regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise (and if not with you, with whom), and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something? How far and in what way would you expect those concerns to escalate up the line of management?

66. Are you aware of any support being provided by the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

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

Learning

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

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

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

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

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

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

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

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

UROLOGY SERVICES INQUIRY

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

Witness Statement of: Mehmood Akhtar

I Mehmood A will say as follows:-

General

SCHEDULE [No 56 of 2022]

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

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

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

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

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

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

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

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

Services Inquiry **("USI"), except where those documents have been previously provided to the USI by the SHSCT. If you are uncertain about what documents have been provided to the Inquiry please liaise with the Trust's legal representatives. 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.**

2. I left the SHSCT in March 2012, more than 10 years ago, and I don't have any documents in my possession relating to this Inquiry. All the answers are based on my memory and my discussions with the Trust Inquiry Team to obtain documents.

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. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

3.1 I have contacted the Trust Inquiry Team and discussed the access to documents, and was given access to the following documents to write my response.

i. Regional Review of urology Implementation document *(this document can be located at S21 56 of 2022 Attachments 1. Team South Implementation Plan v0.3)*

ii. My letter to Ms. Alison Porter Head of Cancer Service at CAH Regarding the initial teething problems to establish and run the MDT and post MDT clinic *(located at Relevant to Acute/Evidence Added or Renamed 19 01 2022/Acute/Retired Staff/Dr Gillian Rankin/20100708 Lt re Uro MDM Issues K)*

iii. Chadha and Khan MHPS investigation report of Mr. O'Brien. Provided by Ms. Avril Frizell, Consultant Solicitor, Directorate of Legal Services *(relevant documents located at bates reference TRU-00661 - TRU-00705 and Relevant to MDO, Evidence after 4 November MDO, Reference no 77, no 77 Dr Khan and Dr Wright emails, 20180928 Email Case Manager Determination AO'B FINAL 280918 attachment).*

Your position(s) within the SHSCT

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

4.1 Please refer to my CV attached *and can be located at S21 56 of 2022 Attachments 2. CURRICULUM VITAE for USI.*

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.**

5.1 Please refer to my CV *(located at S21 56 of 2022 Attachments 2.*

CURRICULUM VITAE for USI). All the jobs held, as well as the duties included in each role, are reflected there to best of my knowledge after the long time lapse.

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.

6.1 Please see my CV *(located at S21 56 of 2022 Attachments 2. CURRICULUM VITAE for USI).* Each role, from my graduation and training post onwards, was managed by the Lead Consultant of the department I worked in.

7. With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, including your lines of management in respect of matters of clinical care, patient safety, administration and governance.

7.1 Regarding the post at SHSCT, my operational manager was the business manager of urology and ENT, Martina Corrigan who joined in September 2009. The clinical manager was Mr. Michael Young, consultant urologist and Clinical Lead in the urology service. I was consultant urologist and interim lead of the urology MDT when started in 2009. My responsibilities included caring for my patients and providing the best and safe service for their condition.

7.2 Mr. Michael Young was my clinical line manager at all times in urology. Ms. Martina Corrigan was business manager from September 2009. Mr. Eammon Mackle was the AMD for Surgery.

7.3 Clinical matters were discussed in a weekly peer review ward round, complex case meeting, monthly mortality and morbidity meeting, and also individually with the senior consultant, if required due to urgency of the matter.

7.4 Clinical governance and administration were addressed regularly in the business meeting per once month on a Thursday, where KPIs such as backlog waiting lists in patients and out patients were discussed. During this meeting we also discussed complaints, Datix, incidents, and risks or concerns raised. The Trust should have some documented minutes of these meetings (I confirm that I don't have such documents in my possession.)

8. **It would be helpful for the Inquiry for you to explain 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 the roles of the Clinical Lead, Clinical Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.**

8.1 I was a consultant urologist and responsible for the care of my, and my department's, patients. My job plan dictated my clinical and administration duties. Some responsibilities are administrative in this role like managing your waiting list, organizing the MDT, making sure the risk and concerns are addressed in time.

Urology Services

9. **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 centers, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the Urology unit in the Southern Trust area.

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

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

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

***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.**

I. What is your knowledge of and what was your involvement with this plan?

II. How was it implemented, reviewed and its effectiveness assessed?

III. What was your role in that process?

IV. Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

10.1 As mentioned in answer to question 9, a urology steering group was established by the Director of Acute Services (Dr. Gillian Rankin) to implement changes and I was part of the group along with other urologists.

10.2 According to the recommendations of the review, the Trust looked at establishing regular meetings to implement these recommendations. The group developed Terms of Reference in April 2010 and looked at the capacity issues, backlog of inpatient waiting list, and out patients review list. OPD (Out Patient Department) reviews were assigned to Clinical Nurse Specialists, who reviewed the last letter and discussed with the consultant in a group to establish if the patient could be discharged. The Thorndale Unit for cancer diagnosis and fast track clinic was developed (a one stop clinic assessment for hematuria and prostate cancer assessment). Some extra theatre sessions were established for clearing the backlog of the waiting list. A review of the consultant job plans was undertaken for accommodating new clinics and clinic templates were developed according to BAUS (British Association of Urological Surgeons) recommendations.

The Local and regional MDT for cancer patients were established and the NICAN recommendation of red flag pathway for Cancer referrals was introduced.

10.3 I was part of the clinical group and was assigned to look after the red flag pathway and development of the local and regional MDT meetings, and development of one-stop clinic for hematuria in the Thorndale Unit.

10.4 We started working on this review in 2010 and achieved some objectives by the time I left in March 2012. We made significant progress in a short time from 2010 to late 2011. We developed regular MDT meetings (local and regional) in line with the NICAN and regional urology review recommendations, brought down the new to review ratio in line with the national average, a significant reduction in OPD review, and increased operating during weekends regularly to reduce the number of patients on waiting lists, using other facilities like the Ulster Clinic and Belfast Clinic to increase the capacity. I can say the Trust was well on the road to achieve some objectives well beyond 2012.

11.To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems with, for example, a backlog of patients, persist following the setting up of the Urology unit?

11.1 I was part of the team for less than 2 years. When the Review implementation started in that time (18 months), I believe the Acute Directorate and urology team worked very closely to implement all the recommendations proposed by the Review. As mentioned in question 10, we changed the structure of the clinics to accommodate more patients, undertook the review of the long waiters list, and increased capacity to operate from other facilities. Again, I believe it is important to mention that,

during my time with the Trust, there were significant improvements in some KPI (reduced new to review ratio, increased the day case ratio, establishment of MDT meeting, Red flag pathway for cancer referrals, and Reorganization of the radical pelvis surgery in Belfast).

12. In April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and

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

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

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

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

12.1 Yes, in 2008- 2009 we (Consultant Group, Mr. Young, Mr O'Brien and myself) were provided with the copies of new guidelines (IEAP) for the target to see the patients within the timeframe. According to IEAP Red flag patients were to be triaged within 24 hours after receiving the referral, and

seen in clinic with in 10 days, Routine new patients were to be triaged within 72 hours and be seen within 10 weeks from date of referral.

12.2 The new IEAP did change the working of the department. We had weekly meetings to look at the new referrals and help each other to triage these referrals on time. To achieve these targets we established the new clinics. (One stop hematuria and prostate assessment clinic in the Thorndale Unit and working in evening to meet the targets). We also worked some weekends to reduce the inpatient waiting list.

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

13.1 The IEAP changed the way the urology department and consultants worked, it put more responsibilities on consultants and the management team to have the new targets met. We had to establish regular weekly meetings to discuss the KPI of red flags, and new referral triage. Also, new clinics were established to see the cancer and new patients quickly and within time limits. During my tenure these targets and limits were monitored weekly and monthly and discussed in business meetings with Ms. Corrigan. Plans were made to meet any challenges or difficulties expected

14. What, if any, performance indicators were used within the Urology unit at the start of, and throughout, your employment? If there were changes in performance indicators throughout your time there, please explain.

14.1 I remember from 2009, since the introduction of the IEAP and review of urology services, the management team introduced regular meetings to discuss the key performance indicators. The indicators monitored were:

a. Target times for triage, the red flag and new referral (24 hours for red flag, 72 hours for new referral);
b. Percentage of the day case surgery benchmarked regionally;
c. New to review ratio of OPD;
d. LOS (length of stay) for inpatients elective and non-elective inpatients.

14.2 There were significant changes noted in our KPI, as seen in the review of urology services mentioned (see review document in Benchmarking urology service provided by Trust Appendix Q14 *which can be located at S.21 56 of 2022 Attachments 3. appendix Q14).*

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

15.1 When I joined the urology department in July 2007 the workforce consisted of 3 WTE (whole time equivalent) consultant urologists, 2 Clinical Nurse Specialists, and a team of middle grade registrars (I am not sure of the numbers with the passage of time). It was adequate in my view. However, when the review of service was discussed and recommended by Mr. Fordham to reorganize the service, it was recommended to increase the consultants to 5 WTE, and 5 CNS. This was part of the review steering group discussions (On Monday evening meetings) and I believe that, after

I left in March 2012, the new consultants were appointed in line with review recommendations. Due to recommendation in urology service review to increase the staff we discussed this in the steering group meetings.

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

16.1 During my tenure there were never any long-term vacant posts due to any reason. We always covered each other's annual leave prospectively. The Trust rule of 6 weeks' notice was followed to give enough time to reschedule the clinic and theatres by other members of team. I never had any discussion separately as it was part of the service review to increase the consultant and CNS posts.

17. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of Urology Services? In your view, did staffing problems present a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples.

17.1 Please refer to answer for question number 15 and 16.

18. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

18.1 There were some changes in roles and responsibilities in line with the recommendations from the review and NICAN. For example, I was asked to look after Red Flag pathways, Mr. Young managed the stone

pathways, and Mr. O'Brien looked after functional and reconstruction urology.

19. Has your role changed during your tenure? If so, do changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

19.1 Clinically, my role as consultant urologist did not change much but, as mentioned earlier, I took on the responsibilities for establishing the MDT meeting and Red Flag pathways. This was mainly an admin role and it was to help provide timely and efficient service for patients with suspected cancer.

20. Explain your understanding as to how the Urology unit and Urology Services were and are supported by administrative staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to you as a Consultant so that you may properly carry out your duties. Accordingly, please set out in full all assistance and support which you receive from administrative staff to help you to fulfil your role.

20.1 The urology department had full administrative support staff. Each consultant had a named medical secretary, who was supported by the typist to ensure the clinical letters were typed on time and sent to General Practitioners of the patients in primary care for any timely action, like the issue of prescription or change of medication and to inform of any investigations, outcome. The medical secretary looked after the waiting list and outpatients (OPDs) and helped to deal with the concerns on time. Each consultant had a different practice. I had meetings with my medical secretary twice weekly for signing the GP letters, and fortnightly to discuss the waiting lists patients and to populate my operation list six weeks in

advance. The Department was always supported by the Business Manager (Ms. Corrigan) to arrange the monthly business meeting and discuss any clinical governance issues, Datix, complaints and risks etc. Ms. Corrigan was very proactive and sometimes met weekly with individual consultants to discuss their waiting list, triaging of the referrals (red Flags and Routine) or any concerns raised by the patients.

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

21.1 During my tenure each consultant urologist had a named medical secretary, and there was a pool of typists for the department. I understood that the Business Manager monitored each medical secretary's workload and asked the typists to help if needed. During annual leave or unexpected leave, all the medical secretaries helped each other to support consultant work.

22. Do all Consultants have access to the same administrative support? If not, why not?

22.1 Yes, all consultants have access to their named medical secretary and business manager during working hours. The admin staff for MDT was separate and helped the organization of the MDT meetings, weekly, and discussed with the consultants during pre-meeting preparations.

23. Have you ever sought further administrative assistance? If so, what was the reason, whom did you ask and what was the response?

23.1 No, I had a named medical secretary (Ms. Elizabeth Troughton) and, if she was on leave, other medical secretaries helped with my admin work. I never had any issues in this regard.

24. Did administrative support staff ever raise any concerns with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you or anyone else did in response.

24.1 No, I never had any issue or any concern raised with me, formally or informally, from admin staff.

25. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

25.1 Yes, I was fully supported by the nursing and ancillary staff in clinics and in the Thorndale Unit. Clinical nurse specialists, J McMahon and K O'Neill, were part of the team and helped to establish the flexi cysto in Thorndale and TRUS biopsy for prostate cancer diagnosis. During my tenure, September 2007 – March 2012, I think we had adequate staff to help in clinics and with clinical urology work.

26. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Do you consider that the specialist cancer nurse, and all nurses within Urology, worked well with Consultants? Did they

communicate effectively and efficiently? If not, why not.

26.1 In 2007 when I joined the department there were 2 or 3 specialist urology nurses in the Thorndale Unit. The difference between specialist cancer nurse and urology nurse specialist is very minimal. I believe the cancer specialist nurse in urology was tasked to look after and arrange the investigation and perform some invasive test, if trained, for detection of cancer. They are trained to consult the patient about their diagnosis and treatment and, if eligible, can prescribe the medication. They also form part of the core MDT team. Whereas the urology nurse specialist is trained to see all urological conditions including BPH (benign prostate condition) symptoms, and female urological conditions like stress urinary incontinence to name only one. During my tenure in the department, I remember K O'Neil and J McMahon were the urology Nurse specialists. They played a very important part in developing the Thorndale Unit. I don't remember the name of the third urology nurse specialist. But I do remember that Jenny McMahon was trained to perform the flexi cystoscopy independently and K O'Neil helped in developing the Prostate Cancer Clinic and Urodynamic Clinic.

26.2 I believe these nurses were part of the team and helped to establish the department, cancer clinics and rapid diagnostic pathways. Ms. McMahon performed the Flexi cysto with me in the Thorndale Unit, K O'Neil developed prostate diagnosis pathway. There was never any issue and the team worked very closely helping each other.

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

27.1 From my memory, the relationships among the team were very good and we had a “can do” attitude. Whenever there was help needed, we helped each other to achieve the target and ICATS pathways. I had no concerns with any of the staff.

28. What is your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain why, and whether you raised this issue with anyone (please name and provide full details).

28.1 During my tenure from September 2007 – March 2012, the urology team worked very closely and had very good relationships with all the stakeholders including Medical Secretaries, Nursing ancillary staff, and the business operational team. The communication was very effective, and staff was sufficient. I believe that I had enough administrative staff to do my role and duties effectively.

29. As Consultant Urologist, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

29.1 I assured myself regarding patient risk and safety and clinical care in the following ways and through the following systems.

29.2 Timely triage of the new and red flag referrals, dictating clinic letters on time in clinic, and seeing the results of all investigations requested by me immediately.

29.3 As a team we had weekly Thursday morning team meetings to discuss any difficult cases and see radiology investigation with radiologist in complex case meeting. We had weekly peer review ward rounds with all the consultant colleagues to see each other's patients and discuss managements. This approach reassured the department that we were following good medical practice.

29.4 We also had a monthly business meeting with Ms. Corrigan (Business Manager of the service) to discuss operational issues and targets to achieve. The monthly business meeting also ensured the schedule of the department for next 4 weeks, prospective scheduling helped to cover any operation theaters or clinics in annual leaves.

30. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

30.1 The consultant on call was responsible for the day to day running of the department or urology unit. And he was answerable to the Clinical Lead (Mr. Michael Young).

30.2 The on call consultant of the day was responsible for the ward in patients, A&E referrals, and looking after the triage service for the referral.

30.3 The Thorndale Unit had a consultant of the day who ran the clinic with help of clinical nurse specialist. Overall, the Clinical Lead (Michael Young) was responsible for the department and the on call consultant would seek any advice or help from him.

30.4 The operational side of the department was looked after by Business Manager, Ms. Corrigan, and any operational issues were discussed with her and resolved.

30.5 During my tenure the communication and running of the department was very effective and everyone knew their role and responsibilities.

30.6 As I said, I was answerable to my Clinical Lead and Business Manager (Michael Young and Martina Corrigan respectively).

31. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

31.1 Yes, during my tenure both the operational team and the medical team worked effectively. We had weekly and monthly meetings with the business team and discussed any issues and expectations. I can only remember the business meetings to discuss the ICATS pathways and triage being discussed. I cannot recall any other example due to the long time since I left the department.

32. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and refer to (or provide, if not provided by the Trust already) any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

32.1 Yes, I had regular appraisals. My first appraisal in the Trust was with clinical Lead Mr. M. Young in 2010 and 2011 the consultant urologist. At the time, as part of clinical governance the appraisal was introduced in NHS.

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

33. Were you involved in the review or appraisal of others? If yes, please provide details. Did you have any issues with your appraisals or any you were involved in for others? If so, please explain.

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

Engagement with Urology staff

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

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

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

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

Governance

35. During your tenure, who did you understand as overseeing the quality of Services in Urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of Services?

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

36. Who oversaw the clinical governance arrangements of the unit and how was this done? As Consultant urologist, how did you assure yourself that this was being done properly? How, if at all, were you as Consultant urologist provided with assurances regarding the quality of urology services?

36.1 In addition to my answer to Q35, we had regular monthly business meetings and governance and performance was the part of the business meeting.

37. How, if at all, did you inform or engage with performance metrics overseen in Urology? Who was responsible for overseeing performance metrics?

37.1 We had a monthly business meeting with Business Manager and Operational Team, where the performances metrics were discussed and plans made for the next month to achieve these metrics. The Business Manager, Ms. Corrigan, her team, and the clinical lead Mr. M Young, were overall responsible for presenting this data.

38. 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?

38.1 Please see my answer to question 29, 34 and 37.

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

39.1 We had regular peer review of complex cases once weekly, peer review ward rounds, and local and regional MDT meetings to discuss the cancer and complex non-cancer cases and their management in line with the NICE guidelines. From the operational team, we were provided with data regarding complaints, risks, and Datix incidents, etc. I personally

during my tenure had no issues with clinical governance in the urology department.

40. How could issues of concern relating to Urology Services be brought to your attention as a Consultant, or be brought to the attention of others? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients or relatives. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

40.1 The business manager used to discuss any immediate and urgent concerns, risks or complaints with the Clinical Lead and relevant consultant. As I said before, the weekly and monthly meetings were used to discuss clinical governance issues at that time. I think the system may have changed a lot in the last 10 years but my belief was that the system available in 2007- 2012 was effective.

41. Did those systems or processes change during your tenure? If so, how, by whom and why?

41.1 No, but I was only there for a relatively short time. I didn't see any change in system during my time with Trust.

42. How did you ensure that you were appraised of any concerns generally within Urology Services?

42.1 The business team was very good and robust to appraise any concern to the urology team. As stated above (e.g., at question 40), we had a regular meeting monthly, but an urgent meeting could be called (if needed) to discuss any urgent concern.

43. How, if at all, were any concerns raised or identified by you, or about you, reflected in Trust governance documents, such as Governance meeting minutes or notes, or in any Risk Register? Please provide any documents referred to (unless provided already by the Trust).

43.1 The only concern raised by me was regarding the workload in clinic after rearranging the clinics format. I wrote to Director of Acute Services Dr Rankin about it (letter dated 5th July 2010). The clinic format was changed to accommodate more red flag patients (suspected cancer), and patients from MDT meeting discussion. These patients need more time to be seen and to explain the diagnosis of cancer to them. Our Professional organization (BAUS British Association Of Urological Surgeons) recommend a certain number of patients to be seen in a clinical session. This was a teething problem as our Trust was starting the new Red Flag pathway and MDT meetings. This was concern was resolved amicably.

44.What systems were in place for collecting patient data in Urology Services? How did those systems help identify concerns, if at all?

44.1 In 2007-12 the data collection system used by trust was Patient Administrative System (PAS). This was at the time a very good system to collect all the required data for the patient attendance, waiting lists.

45. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

45.1 See the answer to question 44.

46. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any

performance objectives relevant to Urology during your time (and identify the origin of those objectives), providing documentation (where it has not been provided already) or sign- posting the Inquiry to any relevant documentation.

46.1 When I joined the SHSCT in 2007, I do not believe that there were any targets for performance except looking at the waiting list and time to OPD appointment, and these were not compulsory. It was in late 2009, when ICATs was developed and the urology review implementation started, that performance targets were introduced. The performance measures used were:

a. Waitlist time;
b. New to review ratio in OPD;
c. Length of stay.

46.2 Later on with ICATS the new key performance indicators introduced were:

a. Red Flag referral to be triaged in 24 hours;
b. Red flag referral to be seen within, 10 days
c. New urgent referral to be triaged in 72 hours.

46.3 Please see my answer to question 14 along with this answer.

47. How well did you think the cycle of job planning and appraisal worked within Urology Services and explain why you hold that view?

47.1 During my tenure I believe I was given a standard job plan on arrival in 2007 and it was revised in 2009 after review implementation. It is very difficult to comment due to the short period I was with the Trust. I was appraised (as mentioned in my earlier reply to question 32) in 2010 by Mr.

Michael Young the clinical Lead for the urology department. I have attached both documents with this.

The appraisal cycle helps the doctor assess their performance, and reflect on their work, to know what needs to be improved, in order to do better. The future objectives and targets are discussed and agreed according to the need of the department and service need.

48. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

48.1 I believe the answer to this question can be found in earlier replies, in particular those to questions 29, 34, 39 and 40.

48.2 In particular in this regard, during my tenure we had a monthly urology business meeting to discuss the concerns, risks, incidents, and complaints in the department. These meetings were well structured and chaired by the Clinical Lead (Michael Young) and, in his absence, by the Business Manager, Ms. Corrigan. If no one was available we could approached the Director of Acute Services, Dr. Rankin.

48.3 In case of any urgent clinical concerns or risks, we used to meet on Thursday mornings or, when needed, within 24 hours. As an example, urgent concern raised by patient or cancellation of the clinic or theatre due to staff unavailability

Urology Services Inquiry

49. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

49.1 Yes, I felt fully supported during my tenure by my colleagues, by nursing staff, and by the operational team. Apart from a minor issue, (like change in clinic format, cancellation of theatre list on the day) I never had any problem. During my tenure we worked as one unit and helped each other and felt supported. For example, if a consultant colleague was on leave or busy and due on call, we would help to triage his red flag or urgent referral letters. It was mutual aid to each other without any issue.

Concerns regarding the Urology unit

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

- **(i) The Chief Executive(s);**
- **(ii) The Medical Director(s);**
- **(iii) The Director(s) of Acute Services;**
- **(iv) The Assistant Director(s);**
- **(v) The Associate Medical Director;**
- **(vi) The Clinical Director;**
- **(vii) Clinical Lead;**
- **(viii) The Head of Service;**
- **(ix) Other Consultant Urologists.**

When answering this question please name the individual(s) who held each role during your tenure. When addressing this question you should appreciate that the Inquiry is interested to understand how you liaised with these post- holders in matters of concern regarding Urology governance generally, and in particular those governance

concerns with the potential to impact on patient care and safety.

In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding Urology Services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

50.1 Please see below

i. Chief Executives: Mr. Colum Donaghy never meet him (to approx. September 2009 and Ms. Mairead McAlinden never met her (from approx. September 2009)

ii. Medical Director: Patrick Loughran – no meetings

iii. Director of Acute Services: Joy Youart (until approx. November 2009) and Dr. Gillian Rankin (from approx. November 2009) - I had regular engagement with Dr Rankin during the urology steering group meeting for the implementation of urology review document in approximately 2009-2010.

iv. Assistant Directors: Heather Trouton don't remember meeting her (until approx. October 2009) and then (from approx. October 2009 onwards)

v. Associate Medical Directors for Surgery and Elective Care: Mr Eamon Mackle (from approx. January 2008) - I had regular steering during steering group and Job Plan meetings with Mr Mackle.

vi. Clinical Director: Mr Mackle (until approx. January 2008), Robin Brown (from approx. January 2008), Met them regularly during the urology review implementation meeting and steering group meetings.

vii. Clinical Lead: Mr. Michael Young - I had regular engagement with him as Clinical Lead, including weekly meetings, and we helped each other

out regularly in respect of patient care and any important issues in the department.

viii. Head of Service: Ms Martina Corrigan (from approx. September 2009; I understand this was a new position and that there was no previous occupant of it) - I had regular weekly and monthly meetings with Ms. Corrigan and also additional meetings, when required, to address any urgent issue on short notice.

ix. Other consultant Urologists:

a. Aidan O'Brien, consultant urologist and senior member of team - I had regular daily meetings and he was mentor to me for my development. We undertook many complex cases together. He was always available to help and listen.

b. Michael Young, Clinical Lead and Stone Lead - We had regular meetings and discussions. He helped me to develop laparoscopy renal surgery skills.

50.2 I can only answer this question for my tenure. As there were no clinical concern raised during my tenure, we had regular meetings to discuss the departmental business, patient care.

51. Were any concerns ever raised regarding your clinical practice? If so, please provide details.

51.1 I am not aware of any concerns raised for clinical practice during my tenure. However, after I left I received a concern about a patient's management ([redacted] Personal Information redacted by the USI [redacted] The concern

was about a JJ stent left in his ureter while undergoing treatment for testicular cancer. Once he completed the treatment it was removed.

51.2 I sent my response as instructed by the Trust's solicitors - see letter attached *which can be located at S21 56 of 2022 Attachments 6. Akhter complaint response.*

52. Did you ever have cause for concern or were concerns ever brought to your attention regarding:

(a) The clinical practice of any medical practitioner in Urology Services?

(b) Patient safety in Urology Services?

(c) Clinical governance in Urology Services?

If the answer is yes to any of (a) – (c), please set out:

. **(i) What concerns you had or which were 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 action (if any) was planned in response to these concerns.**

. **(ii) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

. **(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.**

Urology Services Inquiry

. **(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?**

. **(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?**

. **(vi) How, if you were given assurances by others, you tested those assurances?**

. **(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?**

. **(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.**

. **(ix) If any systems and agreements put in place to address concerns were not successful, please explain why in your view they were not and what might have been done differently.**

52.1

a. It is very difficult to remember with complete certainty such a long time after I left the Trust, but no specific concern about any colleagues or practitioners in urology comes to mind. The matter I wrote about, to Alison Porter the head of cancer service is the usual teething problem when setting up the new MDT meeting. This can be the case with any new service set up due to many stakeholders involved. It takes time to Job Plan all the core members of the MDT and make their availability certain for the meeting.
My Letter to Alison Porter on 8/7/2010 is attached.

b. I recall no specific patient safety concerns in urology apart from the general delay in waiting lists / times, which was a demand and capacity issue. Setting up the Local and regional MDT meeting, the problem to set up these meeting were due to many stakeholders' availability for the meeting from local and other Trust (oncologist) involved. These were resolved by the job planning meeting of the relevant stakeholders.

As said previously, we regularly discussed clinical governance issues in monthly meetings with the business team but I don't recall any specific issue apart from the waiting time and new pathways, like triage of patients according to red flag and urgent with in time frame provided by the Trust and NICAN, but most of the time these were sorted out by helping each other.

53. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether in your view these issues of concern were –

(a) Properly identified,
(b) Their extent and impact assessed properly, and
(c) The potential risk to patients properly considered?

53.1 Apart from the general issue in respect of service delivery, no specific concerns were ever raised. The general concerns were regarding, capacity in the NHS, waiting times, and so on. During my tenure, due to the review of the service and the Team South implementation, the majority of my time (nonclinical) was spent in steering group meetings to address the issues raised by the review.

54. What, if any, support was provided to you and Urology staff by the Trust given any of the concerns identified? Did you engage with other

Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q66 will ask about any support that you may have been aware of having been provided to Mr. O'Brien).

54.1 We generally had very good support from the Trust business team. As mentioned earlier, each consultant had a named medical secretary, business manager and team.

55. Was the Urology Services offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

55.1 During my brief tenure we had regular team meetings to improve the quality of service, but, as I have said, there was a lot going on during this period in terms of review implementation and ICATS and it was still going on when I left. I believe that there was good engagement from both the clinical and business operational teams.

Mr. O'Brien

56.When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? In answering this question please indicate:

- **(i) What were those issues of concern,**
- **(ii) When were they first raised with you?**
- **(iii) Who raised them?**
- **(iv) Do you now know how long these issues were in existence before coming to either your own, or anyone else's attention?**

Please provide full details in your answer. Please provide any relevant

documents if not already provided to the Inquiry.

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

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

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

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

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

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

the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

58.1 Same as answer to questions 56 and 57.

59. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

59.1 As I was not aware of any concerns during my time at the Trust. I believe the issue was raised in 2019-2020 and I read the report only.

60. Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

- **(i) In what way may concerns have impacted on patient care and safety?**
- **(ii) When did any concern in that regard first arise?**
- **(iii)What risk assessment, if any, was undertaken to assess potential impact? and**
- **(iv)What, if any, steps were taken to mitigate against this? If none, please explain. Who do you consider was responsible for carrying out a risk assessment or taking further mitigating steps and what do you think those steps should have been? Please explain why and identify that person?**

60.1 I was not aware of any concern ever being discussed with me so cannot comment.

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

61.1 Not applicable.

62. Do you have knowledge of any metrics used in monitoring and assessing the effectiveness of any agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? Who was responsible for overseeing any agreed way forward, how was this done, where was record of the oversight recorded, and how long did this oversight last? Please include any documentation (unless already provided) and/or indicate where the Inquiry may find a record of any oversight.

62.1 Not applicable.

63. How did you assure yourself as a Consultant urologist that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Do you know against what standards methods were assessed? Are there records of you having assured yourself that systems and agreements put in place to address concerns were effective?

63.1 I cannot comment specifically to Mr O'Brien but, yes there were systems in place (PAS, waiting list, Outpatient lists, Incidents reporting) in the Trust to address any concerns through the clinical governance.

64. Do you know if any such agreements and systems which were 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?

64.1 As I was not aware of the issue, it must have arisen after my departure so I cannot comment. As I mentioned in answer to question no. 63 when I left there were systems in place to monitor the waiting list, length of stay , day case rate, and incidents reporting.

65. Did Mr. O'Brien raise any concerns with you regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise (and if not with you, with whom), and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something? How far and in what way would you expect those concerns to escalate up the line of management?

65.1 I said in answer to question 50 that I had daily interaction with Mr. O'Brien while working there. Never have any concerns been raised by Mr. O'Brien to me. Even when I left the Trust he took over the MDT meeting chair, he was looking forward to continuing doing good work the cancer services.

The last time I had any interaction was some 6 months ago when called me to tell me about the investigation and report.

Urology Services Inquiry

66. Are you aware of any support being provided by the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

66.1 Not applicable to my tenure.

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

67.1 Not applicable during my tenure.

Learning

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

68.1 It is more than 10 years since I left and I was not aware of any governance issue raised by the Trust until, January 2022 when I got a phone call from Mr O'Brien and he discussed with me these concerns and investigation. In July 2022 after the service of the Section 21 notice Trust solicitor Ms Avril Frizell sent me a copy of Chadha and Khan MHPS investigation report. I don't recall any of these concerns ever arising during my tenure at the Trust.

Urology Services Inquiry

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

69.1 As these concerns and inquiry started long after I left I am not able to comment.

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

70.1 Not applicable as I have been part of the team since March 2012.

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

71.1 Unable to comment as during my tenure a lot of progress was made to the review implementation and introducing new targets and recruit more clinical staff as recommended by the review process. The department of urology was very progressive and engaging and we adopted a lot of changes after the reviews and NICAN recommendations.

72. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those

arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

72.1 Not applicable as concerns were raised after I left and I was not aware of the specific nature of the concerns.

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

73.1 I cannot comment as it is more than 10 years since I left. During my tenure at SHSCT I never had any concern. Governance arrangements were very robust and we had monthly and weekly meetings to discuss the issues in general.

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

74.1 No thanks.

NOTE:

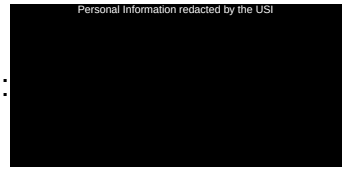
By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also

Urology Services Inquiry

include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

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

Signed: 

Date: 29/07/2022

Section 21 Notice Number 56 of 2022

Witness Statement: Mehmood Ahktar

Table of Attachments

Attachment	File Name
1	Team South Implementation Plan v0.3
2	CURRICULUM VITAE for USI
3	appendix Q14
4	m_akhtar_appraisal_2010
5	Appraisal 2011 M Young 29.3.12
6	Akhter complaint response

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 09 Nov 10

Contents

Tables

Appendices

1. 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 Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. 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 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 currently 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 urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

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 2011),
- 2 Trust Grade Doctors (1 post is 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)

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS 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 within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (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

ICATS	Weekly	Personnel
Prostate Assessment	1.5	Specialist Nurse & Registrar
Prostate Biopsy	1	Consultant Urologist/Radiologist & Specialist Nurse
Prostate Histology	1.5	Specialist Nurse & Consultant/Registrar
LUTS	3	Specialist Nurse & Registrar
Haematuria	2	Specialist Nurse & Registrar
Andrology	2.5	GPwSI & Nurse Lecturer
General Urology/Stable Prostate Cancer	2.5	GPwSI
	14	

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 240 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. This mistake has been corrected in the figures in Tables 2 and 3 below.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	850	474	0	**1324**
	ICATS/Nurse Led New OP	1220	30		**1250**
	Total New OP	2070	504	0	**2574**
	Cons Led Review OP	2151	70	0	**2221**
	ICATS/Nurse Led Rev OP	1509	0	0	**1509**
	Total Review	3660	70	0	**3730**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young	Mr O'Brien	Mr Akhtar[2]	All Core Activity
2009/10	New OP	482	174	193	**849**
	Review OP	724	903	327	**1954**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2]Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).
4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The first part of the meeting is the local MDT meeting and the local team then link in with the regional MDT meeting.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. The Trust is transferring all radical pelvic operations to Belfast Trust.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete) and submitted an analysis of its performance in version 0.2 of the Implementation Plan.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has agreed the methodology for calculating the outpatient demand for the service with the Performance Management and Service Improvement Directorate, based on the actual activity for 2009/10. It is important that when the demand and the capacity of the current and future services are being calculated, that the **whole service** is considered. A significant amount of both new and review activity is undertaken within the ICATS service. However the service is not an independent ICATS service. Consultants triage all urology referrals and decide which are suitable to be treated at ICATS clinics. They also supervise the clinics. Table 6 presents the projected demand for **outpatient slots** for the overall service.

It has been assumed that the Trust's proposal to manage the review backlog will be funded separately and the capacity required to eradicate the backlog has not been included in the demand analysis.

Using actual activity for 2009/10 as a proxy for demand:

Table 6: Projected Outpatient Activity for Team South

	New Attendances	Notes
2009/10 Actual Consultant Led	1084	1
2009/10 Actual Stone Treatment Centre	240	2
2009/10 Actual ICATS	1250	3
2009/10 Fermanagh referrals	318	4
DNA rate @ 3%	87	5
Growth @ 12%	357	6
Total **SLOTS**	**3336**	
2009/10 Actual Newry & Mourne	610	7
DNA rate @ 3%	18	
Growth @ 12%	75	
	704	

Notes:

1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.

2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.

3) Actual attendances at ICATS clinics.

4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).

5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.

6) The same growth rate was used as in the Board's model.

7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

For the purposes of calculating the required outpatient sessions 3336 new attendance slots has been used (ie excluding Newry and Mourne demand).

Projected inpatient and daycase activity has not been changed since the submission of version 0.2 of the Trust's Implementation Plan. It is summarised in Table 7 overleaf.

Table 7: 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 [3]**
2009/10	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) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
3) 18% added for Fermanagh, based on population size relative to SHSCT population

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The Trust has submitted the proposed pathways, as requested to the Performance Management and Service Improvement Directorate.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals (availability of sessions to be confirmed). Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

The majority of nurse led/ICATS sessions will be provided over 48 weeks with consultant led sessions being provided over 42 weeks. Due to the limited availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1. **Note –** as previously stated, demand from Newry and Mourne has not been included in the calculations.

Table 8: Weekly Sessions for New Service Model

	Weekly Sessions	Weeks	Personnel
Consultant Led OPs			
General	5.5	42	
Stone Treatment	1.5	42	
ICATS			
Prostate Assessment	1.5	48	Registrar & Specialist Nurse
Prostate Biopsy [1]	2	48	Consultant Urologist/ Radiologist & Specialist Nurse
Prostate Histology [2]	1	48	Specialist Nurse & Consultant/Registrar
LUTS	3	48	Specialist Nurse & Registrar
Haematuria	1.5	**42**	Specialist Nurse & Registrar
Andrology/General Urology/Stable Prostate Cancer	5	42	GPwSI & Nurse Lecturer
Urodynamics	1.5	48	Specialist Nurse
	15.5		
Main Theatres	9	42	
Day Surgery			
GA	4	42	
Flexible Cystoscopy	3	42	
Lithotripsy	2	42	

The detail of job plans is to be agreed with the existing Consultants but they will be based around the sessions identified in Table 8. The expected weekly consultant led sessions, which are subject to confirmation and agreement with consultants, are given in Table 9 overleaf.

Table 9: Proposed Consultant Led Sessions

	Weekly Sessions
Outpatients (including Stone Treatment)	
Craigavon	4.5
South Tyrone	1
Armagh	0.5
Banbridge Polyclinic	0.5
Erne	0.5
Total OPD	**7**
Prostate Biopsy	**2**
Day Surgery	
CAH	1
STH	2.5
Erne	0.5
Lithotripsy	2
Total Day Surgery	**6**
Main Theatre	**9**

The Trust accepts the need to move towards delivering activity volumes at outpatient clinics which comply with BAUS guidelines and has made good progress in this regard. The original consultant templates enabled the Trust to deliver the outpatient volumes in 2009/10 which are shown in Table 10.

Table 10: Draft Outpatient Volumes at Consultant Clinics in 2009/10

		Core Activity
2009/10	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

Revised templates which provide significantly more new outpatient capacity have been agreed with the consultant urologists and these have been implemented. They are shown in Table 11 overleaf.

Table 11: Current Consultant Templates (Recently Revised and Extended)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Mr Young	BBP	Mon am	Monthly	10	45	6	6	60	60
	ACH	Mon am	Monthly	10	50	6	6	60	60
	CAH (STC)	Mon am	Weekly	42	0	5	11	210	462
	CAH	Fri pm	1,2,4 & 5	32	0	5	7	160	224
Mr O'Brien	BBP	Mon am	Monthly	10	45	5	7	50	70
	ACH	Mon am	Monthly	10	50	5	7	50	70
	CAH	Tues pm	Weekly	42	0	5	7	210	294
Mr Akhtar	CAH	Mon pm	Weekly	42	0	4	7	168	294
	STH	Tues pm	Monthly	10	60	6	3	60	30
Total Annual Slots								**1028**	**1564**

These templates will be used initially as the basis of the new (5 consultant) service model giving a projected capacity of 1533 new and 2310 review appointments at consultant clinics, subject to the agreement of consultant job plans (Table 12 overleaf). It is anticipated that an overall new to review ratio across the service (consultant led and ICATS) of 1:2 will be achieved initially.

Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates aligning all consultant templates with the BAUS guidelines. Draft templates which are subject to agreement with the consultants, are shown in Table 13 overleaf. Travelling time has been accommodated within the templates. The new to review ratio across the service (consultant led and ICATS) will be reduced to the recommended 1:1.5.

Table 12: Draft Initial Consultant Outpatient Templates for 5 Consultant Model (for first 12 – 18 months)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	8	252	336
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	8	126	168
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2310**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

Table 13: Draft Final Consultant Outpatient Templates for 5 Consultant Model

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	9	252	378
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	9	126	189
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2436**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Re-submission of Team South Implementation Plan	09 Nov 10
Approval to Proceed with Implementation from HSCB	17 Nov 10
Completion of Job Plans/Descriptions for Consultant Posts	Nov 10
Completion of Job Plans/Descriptions for Specialist Nurses	Nov 10
Consultant Job Plans to Specialty Advisor	Dec 10
Advertisement of Consultant Posts	January 11
Advertisement of Specialist Nurse Posts	January 11
New Consultants and Specialist Nurses in post	July 11

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

A reduction from the current 4 appointments to 3 appointments is planned in the current service model with the assessment and prostate biopsy taking place on the same day (for appropriate patients).

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 434 patients will require biopsy.

321 patients for assessment @ 5 per session = 64 sessions per annum = 1.4 assessment sessions per week.

378 patients had prostate biopsy in 2009/10 (Note some patients will come directly for biopsy from the ward or OPD). Uplifting this for Fermanagh region gives a requirement for 434 slots @ 5 per session = 87 sessions per annum. 2 biopsy sessions per week (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. 180 patients had positive pathology. Uplifting this for Fermanagh region gives a requirement for 215 patients needing a second appointment. These patients will be seen by a consultant or registrar.

3rd appointment will be discussion of treatment with the estimated 215 patients per annum, following 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
- Other urgent cases.

LUTS

419 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 336 reviews.

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

103 + 42 = 147 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.

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.

241 new patients @ 5 per session = 48.2 sessions = **1.5 per week** (over 42 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

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.

639 @ 3 news per session = 213 sessions = **5 per week** (over 42 weeks)

Urodynamics

These will be located alongside consultant clinics.

306 cases at 5 per all day session = 61 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.

Consultant Clinics

1405 new patient slots are required at consultant clinics, including the capacity to review urodynamics results/patients. The table below provides the draft outpatient clinic templates for the 5 consultant model. These templates will provide a capacity for 1533 new and 2310 review outpatient slots initially as shown below. Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates increasing the templates to provide 1533 new and 2436 review slots.

Stone Treatment

311 attendances @ 6 news = 52 sessions. 1.3 session per week will be required.

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 = 3.5 lists (over 42 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

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).

CURRICULUM VITAE
OF
MR.MEHMOOD AKHTAR

MB BS, FRCPS (GLASGOW)

Inter Collegiate Speciality Board. FRCS (Urol)

Fellowship European Board of Urology (FEBU)

Diploma In Management for medical Doctors (RCSI)

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Mr Graham Sole Consultant Urological surgeon

Date: 01/04/2012 – Permanent

Wye Valley NHS Trust is in west midland, it is mainly rural part of the UK. Urology department is DGH level and close association with Gloucester NHS Foundation Trust for regional cancer services. Urology department is staffed with 3.5 whole time consultant with variety of specialist interest. We are also part of west midland SpR training network and always praised by the SAC for the number of procedures done by the trainee here. We provide all the diagnostic and therapeutic services for general urology and cancers and for pelvic oncology patients are discussed on Specialist MDT and treated at Cheltenham general hospital.

My responsibilities as lead MDT and urology include leading weekly MDT meeting for all cancer diagnosed and attending Specialist MDT for complex cancer patient's discussion. I am Chair of trust's cancer board which meet every month to discuss the target and issue for cancer services in the trust. I also attend as member west midland urology strategic advisory group meeting every three month and discuss the issues and cancer services in the trust and region. As lead clinician I also take role of surgical lead in clinical governance and involve in various meeting to improve patient safety in the trust

As Associate chief Medical officer surgical division, I am involved in strategic development of the surgical division in trust. Division has four surgical speciality directorate with clinical directors. I am answerable to Trust's executive board. My responsibilities are the medical workforce, future planning for the division, and work with the operational and nursing team as divisional Tri to look after the division.

As Clinician I perform Laparoscopy / Open Nephrectomies Nephroureterctomies at Hereford hospital and being part of prostate team Robotic prostatectomies at Cheltenham hospital. I have weekly Cancer clinic as speciality interest and general urology clinic at Hereford and biweekly clinic at Cheltenham general hospital for prostatectomy follow up.

I perform on average 35-40 renal surgeries including laparoscopic, open and partial nephrectomies, 45-50 Robotic prostatectomies and these cases are audited by BAUS and data available on BAUS web site. Since 2001 I have performed more than 500 renal cases. I have performed more 1000 TURP and BTs. Current robotic programme is working successfully and I completed and advanced level training and now performing robotic prostatectomies independently. Next step is advance in nephron sparing robotic surgery.

Previous Appointments

Consultant Urological Surgeon
Lead Urology MDT
Date: 03/09/2007-Permanent

Southern Heatlh and Social Care Trust
Craigavon Area Hospital
64 Lurgan Road Portadown BT63 5QQ
Northern Ireland UK

Mr. Michael Young M Ch, FRCS
Consultant Urological surgeon

Job Description

Southern trust Urology department is team South in Northern Ireland. Its catchment population is 410,000, Department of urology is one of the three cancer centre in Northern Ireland. Department strength is 3 consultant urologist and expansion plan for further 2 consultants by the end of this year. The team south work on hub and spoke model with main inpatient base at Craigavon area hospital, and peripheral clinic and day care centres at South Tyrone hospital, Daisy Hill Hospital and soon Eirn hospital will join as day care centre. Inpatient at Craigavon area hospital has 21 beds and day care facility, on site lithotripter, the only one in the province. There is also a state of the art outpatient diagnostic centre for cancer, lower urinary tract symptoms, and urodynamic. The department currently provide the specialised services in cancer, Laparoscopy, stone treatment and reconstruction and general urology. Team south has developed its own MDM urology and all the cancer cases are discussed for treatment.

I am with department for three years and lead MDM, cancer and laparoscopy. My duties are arranged as ten programme activities per week. It includes prostate diagnostic clinic, general out patient, Day surgical theatre, and full day operating theatre. On alternate week I go to South Tyrone day hospital for outpatient and day surgical theatre for minor cases. As consultant I undertake regular undergraduate teaching programme and for urological trainees every week in the department. Other academic activities includes weekly X-ray meeting, Multidisciplinary team meeting for cancer cases. Monthly audit, morbidity and mortality, research and development meetings are organised by the department. .

Locum Consultant Urologist
Date: 01/09/2005 – 31/08/2007

Addenbrooke Cambridge University Hospitals Foundation Trust
Cambridge CB2 2QQ UK

SDU Urology
Professor DE Neal FMed Sci MS, FRCS
Professor of Surgical Oncology and Consultant Urologist

Job Description

Addenbrooke's is a prestigious NHS Foundation Trust based in Cambridge. It employs over 6500 staff dedicated to the provision of a wide range of clinical and non-clinical services. The Trust is a leading international centre for biomedical research and medical education, and shares its site with the University of Cambridge, the Medical Research Council, the Welcome Trust, the British Heart Foundation and Glaxo SmithKline. The Urology department is staffed with one Professor, one Lecturer, one Paediatric Urologist and 7 NHS Consultants in adult urology, each with his own sub-specialist areas of interest. Together, the Consultant staffs now provide a full range of urological expertise.

As a locum consultant my duties are arranged as ten programme activities per week. It includes prostate diagnostic clinic, general out patient, Day surgical theatre, and full day operating theatre, once a week is based in Hinchinbrook hospital for outpatient and day surgical theatre for minor cases. The consultant undertakes regular undergraduate teaching programme in clinical school and for urological trainees every week in the department. Other academic activities includes weekly X-ray meeting, Multidisciplinary team meeting for cancer cases. Monthly audit, morbidity and mortality, research and development meetings are organised by the department. .

During my period in Addenbrooke’s I got one to one training in HoLeP laser prostate surgery and presently performing the procedure regularly independently with some mentoring. I have also gained expertise in PVP laser prostatectomy, which can be performed as day case surgery.

Research Fellow Urology
Date: 01/01/05 – 31/11/2005

Conway Institute of Biomedical & Biomolecular Sciences University College Dublin, Belfield, Dublin 4.

Professor J. M. Fitzpatrick M.Ch, FRCSI, FRCS Glasgow, Professor of surgery consultant urologist UCD

Dr. R. W.G. Watson Ph.D. Director surgery group Conway institute UCD Belfield D4

The Conway Institute of Bio molecular and Biomedical Research is a major new research enterprise at University College Dublin. The Conway Institute was founded in 1999 and received funding from the Higher Education Authority. The research programme at the Conway Institute focuses on biological molecules, examining how individual molecules contribute to the normal operation of our cells and organs, and how this is disrupted by disease. The knowledge gained contributes to an ever more detailed understanding of the causes and effects of disease, leading to simpler and more reliable diagnostic tests, and new and more effective treatments for human and animal disorders.

My project is related to the prostate cancer to determine the differentiation of prostate cell lines in the presence of inflammatory substrate under supervision of Professor J.M.Fitzpatrick and Dr. William Watson PhD. The successful research will award a degree of M.Ch. in surgery.

Hypothesis

"Inflammatory cells or the inflammatory response leads to the development of a precursor cancer cell, through an alteration in the differentiation process of prostate epithelial basal cell to luminal cell, which can cause carcinogenesis"

1. To establish in vitro 2D and 3D prostate epithelial cell differentiation models.
2. To assess alterations in markers of cellular stress and apoptotic phenotype of cells during differentiation.
3. To establish an in vitro model of inflammation in the established prostate differentiation models and assess there effects on cellular differentiation stress and alteration in apoptotic phenotype.

Temporary Consultant Urologist

Date: 13/06/2004-14/12/2004

Mater Misericordiae University Hospital Eccles Street Dublin 7 R.O. Ireland

Consultant

Professor J. M. Fitzpatrick M.Ch, FRCSI, FRCS Glasgow,

Professor of surgery consultant urologist UCD

Job Description

The Mater Misericordiae University Hospital is a tertiary referral acute hospital in the North Inner city of Dublin, with over 500 beds. Along with urology it caters for major surgical specialities, including Cardio thoracic surgery, Orthopaedic/ Spinal surgery, vascular surgery, General surgery, Plastic surgery, ENT Maxillo Facial surgery, and uro-gynae. It has a full complement of medical and laboratory backup services. It is the designated national referral centre for cardio thoracic surgery and spinal injuries, bladder and renal cancer with IVC involvement.

The aim of the Hospital is to provide a healthcare service of the highest quality. Its services are delivered in an environment of holistic care, education, training and research in addition to graduate and post graduate medical and nurse training. It has significant teaching and research commitments in association with the largest university in Ireland, University College Dublin.

The Surgical Professorial Unit and Department of Urology are involved in the co-ordination of undergraduate and postgraduate teaching and research in the Mater Hospital and University College, Dublin. Special areas of interest in research include prostate cancer, benign prostatic hyperplasia, Bladder cancer and renal physiology. Clinical commitments include the Uro-Oncology services in collaboration with Colo-proctology, gynaecology and general adult urology.

Consultant duties include in-patient opd and OT twice weekly. There is one OPD and OT in Children university hospital Temple street Dublin alternate week. There is one senior resident from higher surgical training in urology, and one BST SHO attached for training. Department is currently involved in clinical research helping the well-established laboratory work in Conway institute in University college Dublin.

Locum Consultant Urologist

Date: 01/01/03—30/06/04

Adelaide & Meath Hospital,
Incorporating National Children's Hospital
Tallaght Dublin 24 R.O. Ireland
Consultant
Mr Michael R. Butler FRCSI FRCS

Job Description

Meath Hospital, the oldest hospitals of Dublin was founded in 1753. In more recent times the hospital developed specialised services in the fields of Urology, psychiatry, orthopaedics, haematology, endocrinology and nephrology. In 1998 Meath, Adelaide and National children's hospitals were merged together and moved to new location under the name of Adelaide Meath, Hospital Incorporating National Children's Hospital (AMNCH). It has 513 beds and affiliated to Trinity College Dublin.

The Urology Department based at the Adelaide & Meath Hospital accepts secondary and tertiary referrals on a nationwide basis. Patient throughput at inpatient and outpatient level remains significantly higher than any other department in the country. The department offers specialist services, uro-oncology, ESWL, female urology, and andrology, urodynamic, walk-in haematuria clinic. In-patient service has 35 beds; the day care service includes 8 beds. The department has 4 Consultant Urologists, 4 Urological Registrars, 2 Senior House Officers, 2 Junior House Officers/Intern and 1 research registrar

This post has the responsibility of undertaking three operating room sessions, one OPD session, one session of TRUS clinic and flexicysto-scopy per week. There is a trainee SpR. and a BST SHO attached for training. The academic activities include uro-radiology meeting weekly, pathology meeting monthly and clinical audit in line with surgical advisory committee guidelines every month. The post is also designated as a lecturer in department of surgery Trinity College Dublin undertaking undergraduate teaching and clinical research.

Senior Lecturer Urology
Date: 01/07/02 --30/12/02

Adelaide & Meath Hospital,
Incorporating National Children's Hospital
Tallaght Dublin 24 R.O. Ireland
Consultant
Mr Michael R. Butler FRCSI FRCS

Job Description

AMNCH is 513-bedded hospital with affiliation to Trinity medical college Dublin. There are surgical speciality including orthopaedic and gynaecology, all the medical specialities are on sites, and a separate children's hospital also. The Adelaide & Meath Urology unit is a National Stone Centre. It has 35 beds, 4 Consultants, 4 registrars. Lecturer's duties are 1 in 4 on calls for A&E, weekly urology clinic, VIP study clinic, TRUS Biopsy clinic and flexible cystoscopy list. He assists the consultant in the operation theatre and performs procedures under supervision of the consultant. The academic activities in the department include, Weekly uro-radiology meeting, Pathology meeting monthly and clinical audit in line with surgical advisory committee guidelines every month.

Registrar Urology
Date: 01/07/01 --30/06/02

Adelaide & Meath Hospital,
Incorporating National Children's Hospital
Tallaght Dublin 24 R.O. Ireland
Consultants
Mr. Michael R. Butler FRCSI FRCS
Mr. T.E.D. McDermott FRCSI

Job Description

AMNCH is 513-bedded hospital with affiliation to Trinity medical college Dublin. There are surgical speciality including orthopaedic and gynaecology, all the medical specialities are on sites, and a separate children's hospital also. The Adelaide & Meath Urology unit is National Stone Centre. It has 35 beds, 4 Consultants, 4 registrars. Registrar duties are 1 in 4 on calls for A&E, weekly urology clinic, VIP study clinic, TRUS Biopsy clinic and flexible cystoscopy list. Registrar assists the consultant in the operation theatre and performs procedures under supervision of the consultant. The academic activities in the department include, weekly uro-radiology meeting, Pathology meeting monthly and clinical audit in line with surgical advisory committee guidelines.

Registrar Urology

Date: 01/07/00 - 30/06/01

Adelaide & Meath Hospital,
Incorporating National Children's Hospital
Tallaght Dublin 24 R.O. Ireland

Consultants
Mr. Ronald Grainger FRCSI
Mr. J. Thornhill M.Ch FRCSI

Job Description

AMNCH is 513-bedded hospital with affiliation to Trinity medical college Dublin. There are surgical speciality including orthopaedic and Gynaecology, all the medical specialities are on sites, and a separate children's hospital on site. The Adelaide & Meath Urology unit is National Stone Centre. It has 35 beds, 4 Consultants, 2 senior registrars and 2 registrars. Registrar duties are 1 in 4 on calls for A&E, weekly urology clinic, VIP study clinic, TRUS Biopsy clinic and flexible cystoscopy list. Registrar assists the consultant in the operation theatre and performs procedures under supervision of the consultant. The academic activities in the department include, Weekly uro-radiology meeting, Pathology meeting monthly, and clinical audit in line with surgical advisory committee guidelines

Registrar Urology/ Transplant

Date: 01/07/99 30/06/00

Beaumont Hospital Dublin 9
Republic of Ireland

Consultants
Miss. M.G.Donavon FRCSI FEBU
Mr. Tom Creagh M.Ch FRCSI

Job Description

Urology/Transplant unit has 35 beds 4 consultants 2 S/registrars 4 registrars .It is one of the leading transplant centres in the Europe. More than 140 renal transplants are carried out annually. Registrar duties are 1 in 3 calls for A&E and transplant. Urology clinic once weekly flexible cystoscopy lists twice weekly and twice weekly theatre. Registrar assists the consultant in theatre and performs procedures under the supervision of consultant. Other academic activities in department are following.

Uroradiology meeting weekly, Pathology case conference monthly, Transplant mortality and morbidity conference monthly, Urology tutorials once month, Monthly morbidity and Mortality audit

Registrar Urology/ Transplant

Beaumont Hospital Dublin 9
Republic of Ireland

Date: 01/07/98 - 30/06/99

Consultants
Mr. D.Murphy M.Ch FRCSI
Mr. D. P. Hickey M.Ch FRCSI

Job Description

Urology/Transplant unit has 35 beds 4 consultants 2 S/registrars 4 registrars .It is one of the leading transplant centres in the Europe. More than 140renal transplants are carried out annually. Registrar duties are 1 in 3 calls for A&E and transplant. Urology clinic once weekly, flexible cystoscopy lists twice weekly and twice weekly theatre. Registrar assists the consultant in theatre and performs procedures under the supervision of consultant. Other academic activities in department are following.

Radiology meeting weekly, Pathology case conference monthly, Transplant mortality & morbidity conference monthly, Urology tutorials once weekly, Monthly morbidity and mortality audit

Registrar Urology

University College Hospital Galway
Republic of Ireland

Date: 01/07/97-30/06/98

Consultants
Mr.M.Corcoran M.Ch FRCSI
Mr.H.C.Bredin FRCSI

Job Description

Urology department in University College Hospital is 32-bedded unit with two Consultant Urologists and two registrars and 3 SHOs, 2 interns. This unit provides urology service for west of Ireland with population of more than 100,000. Registrar's duty is 1 in 2 on call, twice weekly theatre assisting as assistant in all major cases and performing procedures under supervision of consultant and independently. There are surgical day ward facilities weekly for minor cases and Flexible cystoscopies and a weekly session of lithotripsy. Out patient is once weekly and once a month peripheral clinic. Registrar is actively involved in organising uro-radiology conferences, fortnightly case presentations and under graduates teaching.

SHO Urology
Date: 01/01/97-30/06/97

University College Hospital Galway,
Republic of Ireland

Consultants
Mr.H.Bredin, FRCS
Mr.M.Corcoran, M.Ch FRCSI

Job Description

Urology department in University College Hospital is 32-bedded unit with two Consultant Urologists and two registrars and 3 SHOs, 2 interns. This unit provides urology service for west of Ireland with population of more than 100,000. SHO duty is 1 in 4 on call, twice weekly theatre assisting as assistant in all major cases. There are surgical day ward facilities weekly for minor cases and Flexible cystoscopies and a weekly session of lithotripsy. Out patient is once weekly and once a month peripheral clinic. SHO is actively involved in organising uro-radiology conferences, fortnightly case presentations and under graduates teaching.

SHO Surgery
Date: 01/07/96-31/12/96

Bon Secures Hospital, College Road
Cork Republic of Ireland
Consultant
Mr.Peter C.Rayn M.Ch FRCSI

Job Description

Bon Secures hospital is a private organisation involved in providing health care facilities in south of Ireland. Surgical unit has two Consultant Urologists and 3 general surgeons and two registrars and 3 SHOs, 2 interns. This unit provides general surgery and urology service for south of Ireland with population of more than 900,000. SHO duty is 1 in 3 on calls, twice weekly theatre assisting as assistant in all major general surgical/urological cases. There are surgical day ward facilities weekly for minor cases and Flexible cystoscopies and a weekly session of lithotripsy. Out patient is once weekly. SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

SHO Surgery
Date: 01/07/95-30/06/96

General Hospital Tullamore, Co. Offaly, Republic of Ireland
Consultant
Mr.D.J.Hehir M.Ch FRCSI

Job Description

Tullamore general hospital is the regional centre for the trauma, orthopaedics and vascular surgery in the midlands. The surgical department has 2 general surgeons and two registrars and 3 SHOs, 2 interns. This unit provides general surgical and vascular services for the midland region of the Ireland with population of more than 1 million. SHO duty is 1 in 3 on calls, twice weekly theatre assisting as assistant in all major general surgical/vascular cases. There are surgical day ward facilities weekly for minor cases and gastro and colonoscopy. Out patient is once weekly. SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

SHO Paediatric Ortho
Date: 01/01/95-30/06/95

Our Lady's Hospital for Sick Children Crumlin, Dublin, Republic of Ireland
Consultant
Mr.E.E.Forgaty FRCS

Job Description

Our Lady's hospital for sick children is one of the main paediatric hospitals in Ireland and only paediatric trauma and orthopaedics centre in the country. The trauma and orthopaedics department has 3 paediatric orthopaedic surgeons and two registrars and 2 SHOs, 2 interns. This unit provides specialist services for the treatment of congenital hip and spinal deformities and general trauma and orthopaedic services for the whole country. SHO duty is 1 in 3 on calls, twice a week theatre assisting and helping in the fracture clinic. There are surgical day ward facilities weekly for minor cases. Out patient is once weekly. SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

SHO Accident & Emergency
Date: 01/07/94-31/12/94

Limerick Regional Hospital, Limerick
Republic of Ireland

Consultant
Mr.C.O'leary FRCSI FRCS (A&E)

Job Description

Limerick regional hospital is the university hospital in the west midland of the Ireland, Providing the service for >150,000 population. The A & E department is one of the busiest centres in the country with annual attendances of 300,000 cases. The department has one consultant two registrars and 6 SHOs, 2 interns. This unit provides emergency treatment and for the medical surgical and trauma cases before shifting them to the appropriate discipline of medicine. . SHO duty is shift based 65 hours per week. . There are surgical day ward facilities weekly for minor cases in the A&E. SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

Locum SHO Orthopaedic
Date: 11/04/1994-30/06/1994

Merlin Park regional Hospital Galway
Republic of Ireland

Consultant
Mr. M.Gilmore M.Ch FRCSI

Job Description

Merlin park regional hospital is the main Trauma and orthopaedic regional centre for the west of Ireland providing service of specialist trauma and orthopaedic for a population of >250,000. The trauma and orthopaedics department has 6 orthopaedic surgeons, 5 registrars and 4 SHOs, 3 interns. This unit provides specialist services for the treatment of spinal trauma and general trauma orthopaedic and hand surgical services. SHO duty is 1 in 4 on calls, twice week theatre assisting and helping in the fracture clinic. There are surgical day ward facilities weekly for minor cases. Out patient is once weekly. SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

Previous Appointments in Pakistan

Medical Officer Orthopaedic
Date: 01/08/93-31/01/94

Mayo Teaching Hospital, Lahore Pakistan
Consultant
Professor N.M.Akhtar FRCS FCPS

Job Description

Mayo teaching hospital is the main tertiary centre in the province of Punjab, Pakistan Trauma and orthopaedic department is regional centre for Lahore City providing service for a population of >5 millions. The trauma and orthopaedics department has 8 orthopaedic surgeons, 12 Medical officer and 4 SHOs, 3 interns. This unit provides specialist services for the treatment of spinal trauma and general trauma and hand surgical services, Joint replacement surgery. Medical Officer's duty is 1 in 7 on calls, twice weekly theatre assisting and helping in the fracture clinic. There are surgical day ward facilities weekly for minor cases. Out patient is once weekly. Medical officer is actively involved in organising fortnightly case presentations and under graduates teaching. Post is recognised by the RCS Edinburgh for the FRCS Subspecialty training.

Resident General Surgery
Date: 12/08/92 - 31/07/93

Mayo Teaching Hospital Lahore Pakistan
Consultant
Professor S. Ahmed FRCSI
FRCSGlas FRCSEdin

Job Description

Mayo teaching hospital is the main tertiary centre in the province of Punjab, Pakistan General Surgical department is regional centre for Lahore City providing service for a population of >5 millions. The surgical department has 4 independent surgical professorial units. This unit provides specialist services for hepato-bilary disorders and general surgical ailments. Resident Officer's duty is 1 in 5 on calls, twice week theatre assisting and performing intermediate cases under the supervision of the consultant. There are surgical day ward facilities weekly for minor cases. Out patient is once weekly. Resident officer is actively involved in organising fortnightly case presentations and under graduates teaching. Post is recognised by the RCS Edinburgh for the FRCS training.

Res. Medical Officer Gen. Surgery
Date: 12/02/92-11/08/92

Mayo Teaching Hospital, Lahore
Pakistan
Consultant
Professor S.Ahmed, FRCSI
FRCSGlas FRCSEdin.

Job description

Mayo teaching hospital is the main tertiary centre in the province of Punjab, Pakistan General Surgical department is regional centre Lahore City providing service o for a population of >5 millions. The surgical department has 4 independent surgical professorial units. This unit provides specialist services for hepato-bilary disorders and general surgical ailments. Resident Officer's duty is 1 in 5 on calls, twice a week theatre assisting and performing intermediate cases under the supervision of the consultant. There are surgical day ward facilities weekly for minor cases. Out patient is once weekly. Resident officer is actively involved in organising fortnightly case presentations and under graduates teaching. Post is recognised by the RCS Edinburgh for the FRCS training.

Res. Medical Officer Medicine
Date: 11/08/1991- 11/02/1992

Mayo Teaching Hospital, Lahore
Pakistan

Job Description

Mayo teaching hospital is the main tertiary centre in the province of Punjab, Pakistan Internal medicine department is regional centre for Lahore City providing service for a population of >5 millions. The medical department has 4 independent medical professorial units. This unit provides internal medical services. Resident Officer's duty is 1 in 5 on calls. Out patient is twice weekly and A&E on call. Resident officer is actively involved in organising fortnightly case presentations and under graduates teaching.

SHO Accident & Emergency
Date: 01/09/1990-10/12/1990

Nishtar Teaching Hospital, Multan
Pakistan
Consultant
Professor J.Jaffery FRCSE FACS

Job Description
Nishtar Teaching hospital is the university hospital in the southern part of the Pakistan, providing the service for population of 8 million. The A & E department is one of the busiest centres in the country with annual attendances of 900,000 cases. The department has 5 surgical consultant 7 medical officer registrars and 6 SHOs, 4 interns. This unit provides emergency

treatment and for the medical surgical and trauma cases before shifting them to the appropriate discipline of medicine. . SHO duty is shift based 65 hours per week. . There are surgical day ward facilities weekly for minor cases in the A&E SHO is actively involved in organising fortnightly case presentations and under graduates teaching.

Internship

General Medicine
Date: 21/08/89-28/02/90

Nishtar Teaching Hospital, Multan Pakistan
Consultant
Professor A. Shakoor FRCPEdin

Job Description
Nishtar teaching hospital is the main tertiary centre in the south of Punjab province, Pakistan. Internal Medicine department is regional centre for Multan City providing service o for a population of >5 millions. The medical department has 4 independent medical professorial units. This unit provides internal medical services, with special interest in hepato-biliary diseases. Pre registration House officer duty is 1 in 5 on calls in house pre-clerking the admission and other administrative duties. Intern is involved in daily ward round with the consultants and senior registrar and carrying out the orders of the round. Out patient is twice weekly and intern attend the outpatient with senior registrar for pre-clerking the patients. Intern is actively involved in organising fortnightly case presentations and under graduates teaching.

General Surgery
Date: 01/03/90-31/08/90

Nishtar Teaching Hospital, Multan Pakistan
Consultant
Professor J.Jaffery FRCSEdin.FACS

Job Description
Nishtar teaching hospital is the main tertiary centre in the south of Punjab province , Pakistan Internal Medicine department is regional centre for Multan City providing service o for a population of >5 millions. The surgical department has 4 independent surgical professorial units. This unit provides general surgical services, with special interest in hepato-biliary and upper GI tract diseases. Pre registration House officer duty is 1 in 5 on calls in house pre-clerking the admission and other administrative duties. Intern is involved in daily ward round with the consultants and senior registrar and carrying out the orders of the round. Out patient is twice weekly and intern attend the outpatient with senior registrar for pre-clerking the patients. Intern present every month in the mortality and morbidity and audit meeting. Intern is actively involved in organising fortnightly case presentations and under graduates teaching.

Southern Health and Social Care Trust

Urology Service

Benchmarking of Current Service (v0.1)

The guidance relating to the implementation plan for the urology review included a requirement to benchmark the current urology service. The following pages provide some benchmarking information.

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

Average Length of Spell

Healthcare Resource Groups (HRG) are a method of grouping inpatient and daycase episodes. Data items recorded on the Patient Administration System are used to allocate episodes to a particular HRG. The data items include:

- Primary and secondary procedures
- Primary, subsidiary and secondary diagnoses
- Age
- Sex
- Method of discharge (to indicate whether the patient was dead on discharge)
- Length of stay (duration of Finished Consultant Episode)

HRGs are used to produce casemix information which can be used for costing and comparative purposes. Chapter L relates to urinary tract and the male reproductive system.

The table below compares the Southern HSC Trust's average length of spell with the Northern Ireland peer group for the period 1st January 2009 – 31st December 2009.

Peer Group Comparison for Length of Spell
Peer Group is the Northern Ireland Peer for January 2009 - December 2009

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

Note – 'Non OR' indicates a procedure which is so minor that it does not affect the resources used within the episode.

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 table overleaf compares the Trust's performance with the BADS targets for urology. The following notes apply:

- Trust activity for 2009/10 has been used (from Business Objects). 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;
- The numbers of day cases and FCEs are given in the column on the right. The numbers of FCEs with a zero length of stay are also noted as these could potentially have been recorded as day cases.

British Association of Day Surgery (BADS) Basket of Procedures for Urology

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%		0 DCs, 41 FCEs. **8 FCEs had 0 LOS**
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%		0 DCs, 8 FCEs. **1 FCE had 0 LOS**
3	Removal of prosthesis from ureter	M29.3	100			38%			6 DCs, 10 FCEs. **4 FCEs had 0 LOS**
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%		1 DC, 18 FCEs. **10 FCEs had 0 LOS**
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%		11 DCs, 73 FCEs. **16 FCEs had 0 LOS**
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%		0 DCs, 10 FCEs.
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%	2 DCs, 63 FCEs. **6 FCEs had 0 LOS**
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%		0 DCs, 10 FCEs. **1 FCE had 0 LOS**
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%		775 DCs, 114 FCEs. **26 FCEs had 0 LOS**
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%	1 FCE
11	Dilation of outlet of female bladder	M58.2		90	10	100%			1 Daycase
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%		1 DC, 6 FCEs. **1 FCE had 0 LOS**
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%			6 DCs
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%	0 DCs, 111 FCEs.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%		3 FCEs
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10					None recorded
17	Operations on urethral orifice	M81	90	10		33%	50%		2 DCs, 4 FCEs. **2 FCEs had 0 LOS**
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%		4 DCs, 5 FCEs. **2 FCEs had 0 LOS**
19	Excision of lesion of testis	N06.4, N07	90	10					None recorded
20	Orchidopexy - bilateral	N08	60	35	5				None recorded
21	Orchidopexy	N09	75	20	5	60%	40%		3 DCs, 2 FCEs. **1 FCE had 0 LOS**
22	Correction of hydrocoele	N11	90	10		80%	10%		8 DCs, 2 FCEs.
23	Excision of epididymal lesion	N15	90	10		90%	0%		9 DCs, 1 FCE.
24	Operation (s) on varicocoele	N19	90	10		60%	40%		6 DCs, 4 FCEs. **3 FCE had 0 LOS**
25	Excision of lesion of penis	N27	50	50		100%			1 DC
26	Frenuloplasty of penis	N28.4	90	10		100%			5 DCs
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%		36 DCs, 15 FCEs. **6 FCE had 0 LOS**
28	Optical urethrotomy	M76.3	90	10		7%	56%		2 DCs, 25 FCE.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
29	Laparoscopic nephrectomy	M02.1,M02.5, M02.8,M02.9 (+Y75.2)	5	75	25	0%	11%	0%	9 FCEs
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10				None recorded
31	Laparoscopic radical prostatectomy	M61.1,M61.2, M61.9 (+Y75.2)		5	90		0%	0%	1 FCE

Corrigan, Martina

From: Corrigan, Martina [redacted] >
Sent: 03 June 2010 13:21
To: McCorry, Monica; [redacted]; [redacted]); Akhtar, Mehmood; O'Brien, Aidan; Young, Michael Mr
Cc: Rankin, Gillian; Mackle, Mr E; Trouton, Heather; Waddell, Sandra; Stinson, Emma M
Subject: FW: Benchmarking of Current Urology Service v0.1
Attachments: Benchmarking of Current Urology Service v0.1.doc

Dear all

As per our meeting on Monday evening, section 4 of the implementation plan requires us to include benchmarking information of the current urology service.

Please see attached some information in response to this request.

Kind regards

Martina

<<Benchmarking of Current Urology Service v0.1.doc>>

For the attention of the
Medical Director.

Annual Appraisal 2010 for
Mehmood Akhtar.

Completed 2-March-2011.

By. Michael Young
lead clinician
urology

FORM 4 - SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

The aim of this section is to provide an agreed summary of the appraisal discussion based on the documents listed on **Form 3** and a description of the action agreed in the course of the appraisal, including those forming the personal development plan.

This form should be completed by the appraiser and agreed by the appraisee. Under each heading the appraiser should explain which of the documents listed in **Form 3** informed this part of the discussion, the conclusion reached and say what if any action has been agreed.

SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary: Mehmood trained in the ROI and has GMC and specialist registration in the UK. C.V of training has been enclosed in his appraisal folder. He has membership of the MDU. His main place of work is in Craigavon Hospital but has sessions in South Tyrone Hospital. He has admitting rights to the Ulster Independent Clinic and sees outpatients at Newry Private Clinic. His Urology Practice is broad based with a special interest in upper tract laparoscopy, which he continues to develop. His caseload on this front is impressive. Job plan for 2010 is enclosed though it has recently changed due to the introduction of oncology MDT. A log of total outpatients and FCE is recorded. These figures are very acceptable in the current system. Correspondence notes a resource shortfall in theatre equipment Prior documentation records several of the Consultant and Doctor training courses eg haemovigilence / fire lectures
Action agreed: Job plan changes expected with Review of Urology Services in N.I Logbook recording in more detail – already doing so via RCS Ed website

2. Maintaining good medical practice

Commentary: Has continued to attend update courses on laparoscopy. Also with taking on the Lead role in Uro-Oncology MDT, he has been attending educational forums, including NICAN arranged activities. M&M attendance is recorded at 65% which is acceptable. Currently undertaking an audit on his laparoscopy practice and is involved in a regional prostate cancer study. There was the intention of attendind the European Urology meeting last year but could not do so do the volcanic eruption but is going this year instead. To date he has had no particular hindrance to attending his preferred courses and education needs.
Action agreed: Have suggested he become a member of a Urological society which enables him to record CME and logbook in an easier fashion (although existing College or EAU membership could do the same) Update and display that he has attended Trust courses

3. Working relationships with colleagues

Commentary: Works on a 1:3 Urology rota Appears to have a good relationship with other colleagues in the team and within the hospital. Good relationship with nursing staff and all work well in a team environment eg TRUS biopsy work in the Thorndale Unit
Action agreed: NIL

4. Relations with patients

Commentary: Thank-you letters enclosed. One particular letter- a very lengthy correspondence noting thanks on a personal level as well as about the whole service. Only one complaint and this relates to a system failure (in another dept) – now resolved
Action agreed: ==

5. Teaching and training

Commentary: Mehmood was an AES in Urology for SPR trainees during the first half of 2010 Teaches trainees on ward and in theatre Examines in Final MB
Action agreed: Continues with QUB studies on Certification of Education

6. Probity

Commentary: No issues raised
Action agreed: GMC form available for this section

7. Health

Commentary: Good
Action agreed: GMC form available for this section

8. Any other points

Commentary: Glad to have urology ward status reinstated. Had felt the disruption had been affecting service provision and patient care. Unsure of recent Review of Urology N.I and its potential outcome but partakes fully in the CAH unit discussions on planning for the future. However is discontented about losing radical pelvic surgery as it may cause some deskilling and impact on emergency cover
Action agreed: To continue to be involved in service reconfiguration at Trust level etc.

PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should identify key development objectives for the year ahead, which will relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met on the template provided here.

Consultants approaching retirement age may well wish to consider their retirement intentions and actions that could be taken to retain their contribution to the HPSS.

The important areas to cover are:

- action to maintain skills and the level of service to patients
- action to develop or acquire new skills
- action to change or improve existing practice

PERSONAL DEVELOPMENT TEMPLATE

This should be used to inform discussion on development provided for on ***Form 4****. It should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified.*

What development needs have I?	**How will I address them?**	**Date by which I plan to achieve the development goal**	**Outcome**	**Completed**
Explain the need.	*Explain how you will take action, and what resources you will need.*	*The date agreed with your appraiser for achieving the development goal.*	*How will your practice change as a result of the development activity?*	*Agreement from your appraiser that the development need has been met.*
1. Developing oncology service to achieve the DOH targets in relation to uro-oncology	Develop a service plan with management for outpt referrals Assigning protected time in theatre	By end 2011	Decreased hospital stay for patients Effective service provision as per DOH targets	
2. MDT development	Peer review Audit of the effectiveness	June 2011		
3.				
4. etc				

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser: Personal Information redacted by the USI M.D FRCS (urol) Date: 2-3-11

GMC/GDC Number: Personal information redacted by USI

Appraisee: Personal Information redacted by the USI Date: 2-3-2011

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SUMMARY OF APPRAISAL DISCUSSION

1. Good medical care

Commentary:
An introductory commentary for Mehmood is found in the 2010 appraisal. Form 2 documents activities, interests and relationships within the unit. This is unchanged.
Mehmood's working week has a good spread of activity to complement the unit. Since last appraisal his job plan has been more precisely defined. This logs his total PA as 13.3 of which 1.87 is SPA (SPA activity is not disjointed). A better definition of his role in oncology is now evident. He has been the Urology Lead for MDT for two years and has been instrumental in its smooth running despite several obstacles. Smoother running of the prostate cancer assessment clinic has also been his goal this post year. His laparoscopy for renal tumour surgery has also progressed. He is currently collecting data for a further audit on this subject.
Mehmood would agree that he has had a slight change in practise in that he has a clearer focus on oncology issues – MDT and ensuring oncology targets are met to the best of his and the department's abilities. Again Mehmood's caseload for outpatients, inpatient and theatre activity is impressive both in terms of routine sessions and extra sessions (to reach targets).
There are only a few issues logged under the complaint section – Incidence reports note three minor self-limiting issues and are unrelated to each other. There are two complaints and these relate to a delay in treatment follow-up. (This is an endemic problem within the unit and well known to the Trust. This will be addressed by the Review of Urology Services in N.I). A further complaint relates to a cancelled clinic (which frankly is outside of the consultant's remit)

Action agreed: Mehmood will be moving to a new Trust in England very soon and there is no doubt he will continue his good work there. This will be a new system and he should have a clear period of induction as he is taking on an important role.

2. Maintaining good medical practice

Commentary: CME article readings are included – these have a good spread of topics. He has attended the EAU Annual conference (2011 Vienna). All of this indicates an up-to-date CME activity. Courses on Good Clinical Practice, Oncology Research Forum and Palliative Care Course support his principles in providing good oncology care. He has attended the mandatory Consultant training courses within the Trust. M&M attendance is below average at 58% (this % can be easily affected by missing a meeting or two). It should be mentioned that Mehmood has not had a need to present too much anyway. Mehmood has now joined BAUS.
Action agreed: Mehmood should ensure he obtains and is given adequate time for an introduction and induction at his new Trust and not expected to take on his full role at 'full steam' initially.

3. Working relationships with colleagues

Commentary: Has continued on a 1:3 rota in Urology. Mehmood has a very good relationship with colleagues in the team. He is very accommodating in the need of the unit. His recent '360' appraisal scores highly in all domains. Comments recorded are generally very positive. One apparently negative comment in his organization of MDT could in fact be construed as positive in my opinion.
Action agreed: Nil required

4. Relations with patients

Commentary: Mehmood has an observed good relationship with his patients. Incidence and complaints are system related rather than personal. Even though system related they are low in number.
Action agreed: Nil required

5. Teaching and training

Commentary: Mehmood has been an AES in the recent past and continues as a clinical supervisor. He has a registrar attached to his theatre list and as the SPR educational supervisor I know they very much appreciate being at and partaking in his lists. Mehmood is involved in the SPR teaching programme. Mehmood examines at Final MB
Action agreed: Has had involvement in formal teacher evaluation studies at QUB– whether this is to be pursued is at Mehmood discretion.

6. Probity

Commentary: None recorded
Action agreed: GMC form available for this section

7. Health

Commentary: No issues
Action agreed: GMC form available for this section

8. Any other points

Commentary: Lead for Urology MDT Difficulties getting full support internally and externally continued to be an issue this past year. It has been highlighted within the Trust to Mehmood's best ability and regionally at MDT's AGM. This now really is outside of his remit.
Action agreed:

PERSONAL DEVELOPMENT PLAN

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Explain the need.	*Explain how you will take action, and what resources you will need.*	*The date agreed with your appraiser for achieving the development goal.*	*How will your practice change as a result of the development activity?*	*Agreement from your appraiser that the development need has been met.*
1. **Moving to new Trust**	Discussions on arrival and during the coming year			
2.				
3.				
4. etc				

SIGN OFF

We agree that the above is an accurate summary of the appraisal discussion and agreed action, and of the agreed personal development plan.

Appraiser: Personal Information redacted by the USI Date: 29.3.12

GMC/GDC Number: Personal Information redacted by USI

Appraisee: Personal Information redacted by the USI Date: 29/3/12

Avril Frizell
Consultant Solicitor
Directorate of legal Services

Ref: MN S71/791

Patient Name: Personal Information redacted by the USI

Dear Ms Frizell

Personal Information redacted by the USI

Claim regarding long term damage to his kidney, I think the stent saved the remaining function in his left kidney it didn't caused any deterioration. That is what he came with at presentation. CT scan can tell the difference.

I am sure this report will be helpful for you to write the response.

Yours sincerely

Personal Information redacted by the USI

Mr Mehmood Akhtar
Consultant Urological surgeon
Personal Information redacted by the USI

Personal Information redacted by the USI