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. Anthony Glackin
Consultant Urologist
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 57 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:

Anthony Glackin
Consultant Urologist
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.**

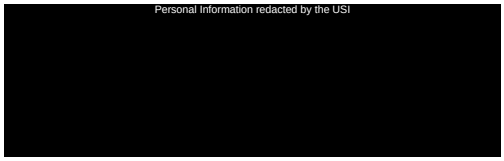
APPLICATION TO VARY OR REVOKE THE NOTICE

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 57 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 in Urology? During your tenure, who did you understand as being 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? If yes, please explain.

40. How could issues of concern relating to Urology Services be brought to your attention as 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 or others, 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) The 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,
(c) and 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 named 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 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

SCHEDULE

[No 57 of 2022]

General

USI Ref: Notice 57 of 2022

Date of Notice: 31st May 2022

Note: An addendum amending this statement was received by the Inquiry on 7 September 2023 and can be found at WIT-100352 to WIT-100353. Annotated by the Urology Services Inquiry.

Witness Statement of: Anthony Glackin

I, Anthony Glackin, will say as follows:-

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

1.1 I graduated MB BCh BAO from University College Dublin in June 1998. Following completion of internship at St Vincent's University Hospital in Dublin, I commenced a two-year basic surgical training programme in August 1999 rotating through SHO posts at the Royal Victoria Hospital in Belfast, Musgrave Park Hospital and Altnagelvin Hospital. I completed one year as a Surgical SHO in General Surgery at Craigavon Area Hospital between August 2001 and July 2002. I was appointed to a Urology Clinical Research Fellowship post based at Craigavon Area Hospital and Queen's University Belfast in August 2002. Based

on my research thesis into novel treatments for bladder cancer I was awarded the Degree of Doctor of Medicine by Queen's University Belfast in December 2005. I commenced higher urological training in the West Midlands Deanery in October 2006 where I remained until May 2012. I was conferred FRCSI (Urol) in December 2009. I was awarded Certificate of Completion of Training on 2nd January 2012.

1.2 I was appointed to my current post of Consultant Urologist at the Southern Health and Social Care Trust in June 2012 and commenced work on the 1st August 2012. At the commencement of my employment I was provided with a "Statement of Main Terms and Conditions of Employment" on 10th September 2012 *(relevant document can be located at S21 57 of 2022 Attachments 1. 20120910 Anthony Glackin Statement of Terms and Conditions of Employment)*. This document referred to various schedules in the "Terms and Conditions", however I was not supplied with this document by the trust so that I could cross reference the schedules against the "Statement of Main Terms and Conditions of Employment". On the whole the items set out in "Statement of Main Terms and Conditions of Employment" reflect my duties and responsibilities.

1.3 My duties included:

a. Outpatient clinics for new and review patients
b. In patient and day case operating
c. In patient care, triage of new referrals and consults as part of urologist of the week activity
d. On call to provide emergency cover out of hours cover by agreement with my consultant colleagues
e. Patient related administration of results and correspondence
f. Clinical and educational supervision of doctors in training
g. Participation in the Urology Cancer MDT and Morbidity and Mortality meetings
h. Compliance with appraisal and trust clinical governance procedures
i. Participation in job planning

j. Supporting professional activity to meet the requirements of annual appraisal and medical revalidation

1.3 The duties are described in my job plan in terms of the time allocated per week to each activity. My job plan has evolved over time. My job plan does not and did not ever describe: accountability arrangements, objectives, supporting resources, expected volumes of activity, timeframes for completion of triage of referrals or correspondence for results etc.

1.4 I held the role of Lead Clinician for Urology Morbidity and Mortality meeting from April 2015 to September 2021. I have not been provided with a job description for this role. I refer to my answer to Q7.

1.5 I have held the role of Lead Clinician for Urology Cancer MDT from 16th November 2016 to date. I have not been provided with a job description for this role. I refer to paragraphs 7.7 and 7.8 below. Since 2021 I have worked with Dr Tariq, AMD for Cancer Services to develop a Job Description for all Cancer MDT Lead Clinicians in the SHSCT. This work is almost complete and has formed part of the SHSCT Task and Finish response to the recommendations made by Dr Hughes's Independent Review into 9 SAIs.

1.6 I took up the post of Urology Training Programme Director at the Northern Ireland Medical and Dental Training Agency in February 2019. I have 3 hours per week in my job plan for this role which is adequate. NIMDTA provide training which has enhanced my ability to manage doctors in training with difficulties and also to keep me up to date with best practice in equality, recruitment and selection. One shortcoming of the role is the lack of administrative support available to me as TPD.

1.7 I have had patient safety concerns, since 2012, related to the long waiting lists for appointments and procedures within the Urology Department. I also have concerns regarding inadequate numbers of Consultants in the Department to deliver a safe timely service. Since my first experience of working in the

Department of Urology in 2002 and upon my return to the department in 2012 as a new consultant it was clear to me that there was and remains a persisting problem with excessive waiting times for new appointments, review appointments and surgical procedures. In contrast, my experience as a urology trainee in the West Midlands between 2006 and 2012 was incomparable. I would operate on urgent cases within weeks of listing and routine cases certainly with the same year, this was a revelation compared to the situation in Northern Ireland.

1.8 Other than a general sense that we were struggling to deliver a timely outpatient and surgical service I did not have any concerns regarding clinical governance processes within urology until January 2017 and again in 2020 following the Trusts announcement of the Independent Review of 9 SAIs related to Mr O'Brien's practice.

1.9 My first knowledge of serious concerns with the practice of Mr O'Brien came at a meeting that took place in January 2017. I was aware from a brief conversation with Mrs Heather Trouton that she had concerns before this time regarding the practice of Mr O'Brien (paragraph 50.8).

1.10 I attended the meeting on 3rd January 2017 with my consultant urology colleagues. I recall that Mr Mackle Assistant Medical Director, Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present. We were informed that the trust had found a number of areas of concern relating to Mr O'Brien's practice. I recall the issue of triage of referrals and the late dictation of clinic letters and results being discussed. We were advised by Mr Carroll that this was a confidential matter not to be discussed outside the group and that Mr O'Brien would not be returning to work until further notice. I recall that we were asked to participate in an exercise to clear the backlog of triage and outstanding results. We agreed to do this work. I undertook triage to clear a backlog. I supplied a list of completed cases to Mrs Corrigan and the Referral and Booking Centre. Similarly, I reviewed charts of Mr O'Brien's patients with outstanding results or clinic letters. I actioned the results and where necessary flagged up cases that

required further review to ensure a safe management plan was in place. I supplied a list of this work to Mrs Corrigan. I have no knowledge of how Mr O'Brien's workload and performance was monitored upon his return to work later in 2017, this process was not shared with me by the trust management.

1.11 In May 2017, I was interviewed about the same issues by Dr Chada, Associate Medical Director, on behalf of the trust. My statement from that interview has been supplied to the USI.

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.

2.1 I have provided all documents in my custody relating to the terms of reference of the USI, to the Public Inquiry Team at the Southern HSCT for uploading to the USI document library.

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.

4.1 I graduated MB BCh BAO from University College Dublin in June 1998. Following completion of internship at St Vincent's University Hospital in Dublin, I commenced a two-year basic surgical training programme in August 1999 rotating through SHO posts at the Royal Victoria Hospital in Belfast, Musgrave Park Hospital and Altnagelvin Hospital. I completed one year as a Surgical SHO in General Surgery at Craigavon Area Hospital between August 2001 and July 2002. I was appointed to a Urology Clinical Research Fellowship post based at Craigavon Area Hospital and Queen's University Belfast in August 2002. Based on my research thesis into novel treatments for bladder cancer I was awarded the Degree of Doctor of Medicine by Queen's University Belfast in December 2005. I commenced higher urological training in the West Midlands Deanery in October 2006 where I remained until May 2012. I was conferred FRCSI (Urol) in December 2009. I was awarded Certificate of Completion of Training on 2nd January 2012. I was appointed to my current post of Consultant Urologist at the Southern Health and Social Care Trust in June 2012 and commenced work on the 1st August 2012.

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 I have held the post of Consultant Urologist since 1st August 2012. At the commencement of my employment I was provided with a "Statement of Main

Terms and Conditions of Employment" on 10th September 2012. This document referred to various schedules in the "Terms and Conditions", however I was not supplied with this document by the trust so that I could cross reference the schedules against the "Statement of Main Terms and Conditions of Employment". On the whole the items set out in "Statement of Main Terms and Conditions of Employment" reflect my duties and responsibilities.

5.2 My duties included:

a. Outpatient clinics for new and review patients
b. In patient and day case operating
c. In patient care, triage of new referrals and consults as part of urologist of the week activity
d. On call to provide emergency cover out of hours cover by agreement with my consultant colleagues
e. Patient related administration of results and correspondence
f. Supervision of doctors in training
g. Participation in the Urology Cancer MDT and Morbidity and Mortality meetings
h. Compliance with appraisal and trust clinical governance procedures
i. Participation in job planning
j. Supporting professional activity to meet the requirements of annual appraisal and medical revalidation

5.3 The duties are described in my job plan in terms of the time allocated per week to each activity. My job plan has evolved over time. My job plan does not and did not ever describe: accountability arrangements, objectives, supporting resources, expected volumes of activity, timeframes for completion of triage of referrals or correspondence for results etc.

5.4 I was Lead Clinician for Urology Morbidity and Mortality meetings from April 2015 to September 2021. I have not been provided with a job description for this role. I refer to my answer to Q7

5.5 I have been Lead Clinician for Urology Cancer MDT from 16th November 2016 to date. I have not been provided with a job description for this role. I refer to my answers 7.7 and 7.8. Since 2021 I have worked with Dr Tariq, AMD for Cancer Services to develop a Job Description for all Cancer MDT Lead Clinicians. This work is almost complete and has formed part of the SHSCT Task and Finish response to the recommendations made by Dr Hughes's Independent Review into 9 SAIs.

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 Line Manager for Consultant Urologist post

6.2 Clinical Director with responsibility for Urology: Robin Brown Mid 2011 – January 2014, Sam Hall January 2014 – March 2016, Colin Weir June 2016 – December 2018, Ted McNaboe December 2018 – December 2021 – Currently Vacant
*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team, I believe this list to be correct.

6.3 In practice, I had no significant interaction with any of the post holders in their role as my line manager. I had job planning correspondence with Coin Weir and Ted McNaboe. I knew all of the individuals by name and would greet them if we passed on the corridor but that was it.

6.4 Line manager for Lead Clinician Cancer MDT

6.5 Clinical Director for Cancer Services: Rory Convery up to April 2017. David McCaul from January 2018 to January 2022. Post currently vacant. In my experience the post holders did not provide any line management and they did not seek to provide any input or oversight into the running of the Urology Cancer MDT. There was a disconnect between the clinical director for cancer services

and the Urology Cancer MDT. I do not know if this was the same for the other cancer MDTs but I strongly suspect that this was the case.

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

6.6 The line manager for Lead Clinician Morbidity and Mortality role was the Clinical Director with responsibility for Urology.

6.7 I was not the line manager for any other departments, services, systems, roles or individual members of staff within SHSCT.

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 I held the role of Lead Clinician for the Urology Morbidity and Mortality (M&M) meeting from its establishment in April 2015 until September 2022 when I handed this over to Mr O'Donoghue, Consultant Urologist. Prior to the establishment of specialty specific Urology M&M meeting the M&M was attended by all surgical specialties and anaesthetics. It is my recollection that the Medical Director Dr Simpson was of the view that specialty specific meetings were necessary to drive quality improvement and enhance patient safety.

7.2 My role was to facilitate a monthly review of M&M and to compile a report of cases discussed and learning identified from each case. The report was shared with all the members of the Urology Department and the Clinical Effectiveness Governance Team. The Urology M&M meeting minutes were provided to the other M&M chairs by email by the Governance Team, similarly I received copies of minutes from the other specialty meeting minutes . Learning that was applicable to a wider audience within the SHSCT was shared at a Combined

Surgical and Anaesthetic M&M meeting, which took place 3-4 times per year attended by doctors of all grades in surgery and anaesthetics.

7.3 At the establishment of the specialty specific Urology M&M in 2015 the Urology Consultants agreed that all in patient deaths of urology patients would be reviewed. In addition, all members of the Urology team were encouraged to bring forward any cases of morbidity from which a learning point could be derived. In order to strengthen the process and to draw from the widest possible experience the Urology M&M was opened up to include senior nursing staff from the urology ward and out-patient department and the Head of Service Mrs Corrigan from its inception in April 2015. This meeting provided a forum for the team to present audits of clinical activity, review complaints, share good practice and compliments and to discuss the reports of Serious Adverse Incidents (SAI's). Attendance at the M&M meeting was mandatory for all urology medical staff and was recorded in the minutes. The trust kept records of attendance and this was provided to doctors for their annual appraisal.

7.4 The running of the meeting was nominally supported by the department of clinical effectiveness. The support was limited to the provision of a list of Mortality cases. In 2017, the trust adopted a region wide electronic system to record attendance and the discussion points of each mortality case discussed at the meetings. This system does not provide any facility to review morbidity. Since 2020, a draft agenda with pre-populated items has been provided to the lead clinician for review before each meeting by the governance team. Items included in the draft agenda included:

Deaths within 30 days of discharge, mortality lists, morbidity, safety graphs, local incidents/themes/ward issues, pharmacy issues, medicine safety alerts, shared learning from complaints / SAI/ IR1 forms / Other meetings / Learning Letters, Shared learning from Litigation / Coroners cases / PM reports / Ombudsman, Safety alerts and Circulars, Local Audit reports/Quality Improvement, Consultant outcome data (NCEPOD / National / Regional / Speciality).

7.5 Support for clinical audit within the trust is insufficient. In practice, this means that medical staff complete clinical audits of their own choosing in their own time with no input or support from the trust. The utility of some of the audits presented at the M&M meeting was in my view questionable. They did not complete the audit loop (the audit process should measure practice against a set of standards, this should be followed by a change to improve practice and a further audit against the set of standards to see if the change in practice has led to an improvement in performance) and there was no strategic oversight. They simply served as a tick box for a doctor in their portfolio for appraisal.

7.6 The running of the M&M meeting and the associated administration fell to me as lead clinician with no administrative support. In my absence, the meeting often did not take place. Individual members were free to contribute as little or a much as they liked to the items on the agenda. There was no compunction on any Consultant to present audits of clinical activity or to bring forward morbidity cases to the M&M meeting.

7.7 I have been the lead clinician for the Cancer MDT since November 2016. Mr O'Brien was the lead clinician from 2012 to 2016.

7.8 All urology cancer cases are presented at the multidisciplinary team meeting. All suspected cancers cases are assigned red flag status upon receipt of referral within the trust. The cases are tracked by staff specifically employed to ensure that all cancer cases are progressed along the cancer pathways and are brought to the attention of the appropriate cancer MDT. The Urology Cancer MDT meeting is chaired in weekly rotation by 4 consultant urologists who each have allocated job planned time for pre-meeting preparation. This allows us to have oversight of each other's practice and permits challenge and discussion at the MDT meeting. The service is subject to internal and external peer review. During my tenure this service has been constrained by the absence of oncology and radiology quoracy. The clinical risks to patient care were noted in the peer review exercise in 2017, the annual reports of the MDT in 2016 and 2019 and escalated through to Trust management by myself and Mary Haughey (Cancer Services

Improvement Lead, SHSCT). I discussed my concerns with Fiona Reddick, Head of Cancer Services (3. 20170116 Quoracy email, 4. 20170120 Quoracy email and 5. 20170608 Quoracy email). From previous email correspondence I was aware that Fiona Reddick had brought the issue of oncology attendance at the SHSCT Urology Cancer MDT to the attention of Professor Joe O'Sullivan Consultant Clinical Oncologist at BHSCT. Later, I raised this matter both formally and informally with the Clinical Directors for Cancer Services Mr McCaul and Radiology Dr Yousuf in November 2018 (2. 20181126 Radiology Absence email). This issue is longstanding and has only recently been resolved following new Consultant Oncologist and Radiologist appointments in 2021 and 2022.

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 The roles that I have outlined in my answer to Q7 reported to the Clinical Directors for Urology and Cancer Services, who in turn reported to the Medical Director and Trust Board. The roles I held did not have line management responsibility. It is my view that issues of concern identified at either the Urology M&M meeting or the Urology Cancer MDT were to be escalated via the appropriate Clinical Director in the first instance.

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.

9.1 I had no role in the decision to establish three teams to provide Urology services in Northern Ireland or in the establishment of a urology unit based in the Southern Trust. This decision predates my employment as a Consultant from 1st August 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 I do not recall any details of this implementation plan which predates my employment by the trust. On my arrival in the SHSCT, I inherited an outpatient appointment review backlog from my predecessor. Over the first few years of my employment, I worked hard to clear this backlog and to maintain a manageable review waiting list. Similarly, I inherited a surgical operating waiting list that again I endeavoured to reduce over several years.

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 Since my first experience of working in the Department of Urology in 2002 and upon my return to the department in 2012 as a new consultant it was clear to me that there was and remains a persisting problem with excessive waiting times for new appointments, review appointments and surgical procedures. In contrast, my experience as a urology trainee in the West Midlands between 2006 and 2012 was incomparable. I would operate on urgent cases within weeks of listing and routine cases certainly with the same year, this was a revelation compared to NI.

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 I have no knowledge of the "Integrated Elective Access Protocol" published by the SHSCT in 2008. I have not been provided with a copy of this document to the best of my knowledge. During my employment, I have not been made aware of how the SHSCT was collecting, recording or reporting data.

12.2 I was granted access to Business Objects in January 2014, on the approval of my application by Mrs Corrigan and the IT Department. Business Objects is a software database utilised by the SHSCT to run clinic and operating waiting lists. Using this information, I was able to target my long waiters and over time reduce

my backlog. I did this systematically giving the greatest priority to cancer cases followed by urgent cases and then routine cases.

12.3 I am aware that the trust employs clinical coders to capture activity and diagnosis data. I am also aware that administrative staff enter data on behalf of clinicians for the purposes of building clinics and theatre lists.

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 I refer to my previous answer to Q12.

13.2 In my view waiting list management was sporadic. Waiting times varied widely across the team. Occasional drives to improve the situation took place but they were short lived and had little effect in the long term. I recall one such effort in 2015 involving the Consultant Urologist with support from Mrs Corrigan and Mrs Glenny. We met almost weekly for a period of time in an effort to improve access to theatre for long waiters and patients breaching cancer waiting times. Waiting list data was presented by the Head of Service Mrs Corrigan at the Urology Departmental meetings. Several colleagues, including Mr O'Brien and Mr Young, were carrying unmanageable backlogs. This remains the case to date. The COVID pandemic has exacerbated this situation. To a large extent, the waiting lists are a function of inadequate resource. There is also an aspect of individual working styles and differing case mix. For instance, if a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically.

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 The trust monitored cancer-waiting times and the data was presented at the Urology Departmental meetings. New referral numbers and waiting times for routine and urgent cases data were also presented. I am not aware that there were any changes to the performance indicators for cancer waiting times or referral to appointment standards since my appointment in 2012.

14.2 The trust used CHKS to present data as an annual CLIP report for each consultant covering a selection of metrics including average length of stay, in patient mortality etc. The data compared individual consultants against local and national peers. In my opinion, some of the data was useful such as new to review ratios and volume of patients seen under my care. Other data was meaningless because it did not take into account the fact that coding was often incorrect with respect to the name of the admitting consultant for emergency care. It did not take into account the fact that all elective cases were managed by a Consultant of the week model and therefore it was difficult to attribute meaning to the data which was presented on an individual consultant basis rather than on a team basis. My data would therefore reflect care and decisions taken by others and vice versa.

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 The Urology department has not been adequately staffed since I arrived in 2012. At present, we are funded for seven Consultant Urologists. We have relied on locum consultant appointments to fill gaps and have never reached seven

substantive consultants. Some of the locums have performed well but several have not been up to the standard of an NHS Consultant. This has caused problems for the substantive consultants having to manage poor care and decision-making and to provide additional cover for the shortcomings of the poorly performing locums. These facts were known to the Trust management: Head of Service for Urology, Assistant Director for Surgery, Clinical Directors and the HR department. We have been in a continuous cycle of recruitment since 2012.

15.2 We have suffered from the loss of a dedicated Urology ward. This resulted in patients being nursed on wards where staff were unfamiliar with urology care. Even when the ward was reconstituted on 3 South, there were problems with nurse recruitment and retention of senior nurses to run the Urology ward. We have been reliant on inexperienced agency staff. We have lost many dedicated experienced nurses from the Urology team.

15.3 The COVID period has exacerbated the staffing and ward issues. We have found ourselves looking after patients in as many as seven different locations around the Craigavon site. Communication from management to the consultant team about these changes has been poor. For example, I arrived on Ward 3 South in spring 2022 to conduct a ward round to be greeted by a junior staff nurse welcoming me back to the Urology ward. I had no knowledge of this change and was taken aback that, as the Urology Consultant of the week, I had not been advised of this change by anyone in management.

15.4 The outpatient department has been more successful. We have a purpose built facility in the Thorndale Unit staffed by experienced Urology Nurses and supported by healthcare assistants and administrative staff. During my time in post, we have expanded the Urology CNS workforce to five. The team is cohesive and supportive. As Consultants, we have supported the skills development and career progression of our nursing colleagues.

15.5 Theatre provision across the Craigavon site is inadequate for the demands of a modern urology service. When I arrived in 2012, we shared nine half-day in patient lists across the team of five Consultants. In an effort to improve waiting lists, we collectively worked extra Saturdays. For a time this worked well however, within a few short years the year round bed crisis made this activity impossible. Another factor that hampered this effort was that the theatre nurses were expected to undertake this work as part of their normal shift pattern and were not paid additionality like the medical staff. In an effort to improve in patient theatre access 3 session days were trialled on Tuesdays and Wednesdays. This was not sustainable in the long term due to staffing issues from an anaesthetic and nursing perspective. The productivity of the 3 session days was not as good as we had hoped. In my view job planning for each Consultant Urologist should include 3-4 theatre sessions per week with a mix of in-patient and day case sessions to deliver the needs of the patients. For a team of 7 Consultants this would mean 21-28 sessions per week, a more than doubling of our current provision.

15.6 The trust has a long-standing problem with a shortage of trained theatre staff, which remains a live issue. We have not been able to get back to 11 in patient sessions per week since the pandemic.

15.7 The infrastructure across the trust is out of date for modern urology. We have no dedicated purpose built day case facility. The day surgery units in Craigavon and Dungannon are housed in facilities with insufficient space for patients to recover and this limits the case mix that can be accommodated, resulting in many cases appropriate for day case surgery having to go through the in-patient theatres in the main building at Craigavon. During my tenure, we have had meetings with planners and managers in the trust about development of new facilities but this has all come to nothing.

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 Consultant and junior medical staff posts have remained unfilled since I arrived in 2012. At present we are working with 4 full time Consultant staff (one of whom is a locum) and 2 less than full time Consultants (one working 60% of his time for SHSCT with the remaining 40% for BHSCT and the other 40% of full time at SHSCT alone). The impact on the unit has meant that we have growing waiting lists for outpatient appointments and surgical procedures. It has meant that existing post holders are working beyond capacity. During periods of leave or sickness, the team is stretched to provide cover for all the routine activities and this has meant cancellation of activity to try to sustain a safe core service for emergencies and in patients. The trust has repeatedly asked existing post holders to fill gaps for locum cover for out of hours work. This is not sustainable or safe.

16.2 For as long as I can remember since 2012 we have been continually trying to recruit substantive Consultant staff. There is a shortage of suitably qualified candidates. I have experience of interviewing candidates that are simply not appointable as a safe day 1 NHS consultants.

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 I refer to my answer to Q16. Staffing problems have led to delayed care for patients. This has also contributed to staff stress trying to balance competing interests with too little resource. In particular, the shortage of trained theatre staff has led to a sustained downturn in activity meaning many patients are waiting much longer than is acceptable for routine or urgent care. In some cases, this has led to patients presenting multiple times for the same problem and others developing complications or more advanced disease as a consequence of not

having treatment in a timely manner. A further consequence is that secretaries and consultants are spending time addressing avoidable complaints related to poor access to timely care.

17.2 The trust has no structured system for managing the workload of a departing or retiring consultant. In my experience, this has been managed in an ad hoc manner by redistributing work among the remaining consultants who are already unable to deliver timely care for their existing patients. Due to the volume of the overdue appointments and procedures, it is impossible to know what problems are lurking within the waiting list of a colleague. I simply do not have enough time to take on the work of others in addition to my own workload and to do so would place my patients and myself at risk.

17.3 The clinical governance aspects of the service have been neglected as a consequence of the other demands on the time of the medical staff in the Department of Urology. Without more robust support from the trust in terms of data collection and administration it is simply impossible for busy clinicians to do this important work as well as keep a clinical service running with all the challenges we have.

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

18.1 The core staffing within the unit has largely remained constant since 2012. Mrs Corrigan was Head of Service from my arrival in 2012 until Ms Clayton replaced her on an interim basis in May 2021. Mr Young was Lead Clinician until his retirement in 2022. Mr Haynes was AMD with responsibility for Urology from October 2017 to January 2022.

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 I refer to my answer to Q7. I took on additional roles of responsibility largely because I felt that if I did not take on the roles they would not be taken up by my consultant colleagues.

19.2 The running of the M&M meeting was onerous. The associated administration fell to me as lead clinician with no administrative support. In my absence, the meeting often did not take place.

19.3 In addition, I took up the post of Urology Training Programme Director at the Northern Ireland Medical and Dental Training Agency in February 2019. I have 3 hours per week in my job plan for this role which is adequate. NIMDTA provide training which has enhanced my ability to manage doctors in training with difficulties and also to keep me up to date with best practice in equality, recruitment and selection. One shortcoming of the role is the lack of administrative support available to me as TPD.

19.4 I completed training in Structured Judgement Review and Root Cause Analysis in 2021 to allow me to contribute meaningfully to patient safety and governance processes. I have chaired several SAI's on behalf of the trust including the cases of Patient 10 Patient 90 and Patient 128, which all relate to the subject matter of this inquiry.

19.5 I have reduced my contracted hours at the trust to ensure that I avoid risks to my own well-being and remain capable to deliver safe, effective high quality care.

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 Elizabeth Troughton has been my secretary since my appointment in 2012. She works 9am-3pm five days per week. I am not involved in her line management. My secretary is responsible for organising my theatre lists, liaising with the referral and booking centre to arrange clinics and managing day-to-day correspondence and enquiries. I use electronic sign off on NIECR for all laboratory and radiology results. She utilises the trusts DARO system to monitor results due for action. By working together in this way, we have checks and balances in place for outstanding results. I consider that I have sufficient support from my secretary for my primary role a as clinician.

20.2 As noted in my response to Q7. The trust provides minimal administrative support for the roles of Lead Clinician for M&M and Cancer MDT.

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 Each Consultant has a named secretary. It is my understanding that urology secretaries cross cover each other for leave on a rota basis determined by their line manager Orla Poland. Beyond this I have no knowledge of what the line manager for the secretarial staff expects in terms of collective working. The line manager for the secretaries monitors the administrative workload and sends an email of a spreadsheet detailing the outstanding administrative workload (such as results awaiting action, letters waiting to be typed or discharges yet to be completed) to the Urology Consultants.

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

22.1 I do not know the answer to this question. This would be best addressed by the secretaries' line manager Orla Poland.

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 I have sought administrative support for my role as Lead Clinician of the Urology Cancer MDT. This has started to come on stream in 2022, so far it is provided by Angela Muldrew, MDT Administrator & Projects Officer, but the trust hopes to appoint clerical staff to help with the running of audit activity to support the cancer MDTs. I have received assistance from Mary Haughey, Cancer Services Improvement Lead, to compile the annual Urology cancer MDT report and the peer review documentation.

23.2 The topic of clerical support for the M&M meetings has been discussed at the M&M forum but no clerical support has been forthcoming. This means that the chair of the M&M is still having to draft the agenda, take notes during the meeting and type up the minutes after the meeting.

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 During periods of consultant sickness absence or annual leave, I received clinical queries related to patient results from secretarial staff. I do not recall any concerns from secretarial staff outside of this.

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 As set out in my answer to Q15, the nursing staff in the Urology outpatient department are excellent. The team has expanded over the years to include five Clinical Nurse Specialists. I work closely with all of them. I have been involved in providing mentorship and training to four of the CNS's. The urology cancer

CNS's are an integral part of the cancer MDT. They attend my uro-oncology clinic each week to support patients and provide advocacy. They are in the room for all face-to-face consultations. Lines of communication are open and effective. We engage on a daily basis. I value them and I know from formal feedback that this is reciprocated. I consider that 5 CNSs is sufficient to provide for the needs of our Department and to ensure patient safety.

25.2 The in-patient Urology Theatre at Craigavon has been fortunate to have two excellent lead nurses during my tenure. Despite staffing challenges, they have provided us with a safe theatre environment. On occasions, productivity has been impeded by lack of experienced staff.

25.3 The ward situation has been difficult over the last 10 years with a heavy reliance on agency staff and a lack of consistent senior management. We have suffered from the loss of a dedicated Urology ward. This resulted in patients being nursed on wards where staff were unfamiliar with urology care. Even when the ward was reconstituted on 3 South, there were problems with nurse recruitment and retention of senior nurses to run the Urology ward. We have lost many dedicated experienced nurses from the Urology team.

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 I refer to the first paragraph of my answer to Q25. Essentially there is little difference in the roles of specialist cancer nurse and urology clinical nurse specialist other than the proportion of their time spent dealing with cancer or benign urological conditions. Both have consulting skills and deliver holistic care.

In our team, the CNSs also have a range of procedural skills such as flexible cystoscopy, urodynamics, botulinum toxin injections and prostate biopsy. Some of the CNSs are independent prescribers.

26.2 I understand that not all of my colleagues worked in the same manner with the urology cancer CNS's. Kate O'Neill and Leanne McCourt Urology cancer CNS's told me that they found that communication was difficult with some consultants and that they were not invited to be present at uro-oncology consultations.

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 Overall, I believe that medical and nursing staff worked well together to the benefit of patients despite the many challenges they faced. Apart from my answer above, 26.2, I did not have any concerns regarding the working relationships between nursing and medical 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 I have courteous professional and effective communication with all members of the administrative team. In my experience the relationships between the Urology Consultants and administrative staff including secretaries was good. I refer to my answer to Q20. I consider that I had appropriate administrative support to fulfil my primary role as a consultant. I refer to my answer to Q23.

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 The urology department participates in the following activities to mitigate risk and ensure high standards of patient care.

29.2 All cancer cases are presented at a multidisciplinary team meeting. The meeting is chaired in a 4 weekly rotation by a consultant urologist with allocated time for pre-meeting preparation. This allows us oversight of each other's practice and permits challenge and discussion at the MDT meeting. I have been the lead clinician for the MDT since November 2016. The service is subject to internal and external peer review. The Urology Cancer MDT produces an annual report which is circulated to the Clinical Directors for Urology and Cancer Services. I encourage an open, inclusive and evidence based atmosphere.

29.3 The urology department holds an M&M meeting each month. I refer to my answer to Q7 which covers the range of patient safety activities undertaken by the trust the results of which are presented at the M&M meeting.

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 day-to-day running of the unit was the responsibility of the Lead Clinician, Mr Young and the Head of Service, Mrs Corrigan.

30.2 Mr Young was responsible to the Clinical Director for Urology, who in turn was responsible to the Medical Director.

30.3

Medical Director - Dr Patrick Loughran - Dr John Simpson - Dr Richard Wright - Dr Ahmed Khan (Interim) - Dr Maria O'Kane	 April 2007 June 2011 July 2015 April 2018 December 2018	 July 2011 August 2015 August 2018 December 2018 February 2022 (appointed CEO)

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

30.4 Mrs Corrigan was responsible to the Assistant Director for Surgery and Elective Care, who in turn was responsible to the Director of Acute services:

Dr Gillian Rankin	1st December 2009 (Interim Director of Acute Services) 01/03/2011 – 31/03/2013 – Director of Acute Services

Mrs Debbie Burns	01/04/2013 – 31/08/2015
Mrs Esther Gishkori	17/08/2015 - 30/04/2020 Personal Information redacted by USI [redacted]
Mrs Anita Carroll (Acting)	July 2018 – September 2018
Mrs Melanie McClements	Interim Director of Acute Services: 07/06/2019 – 31/10/2020 Permanent Director of Acute Services: 01/11/2020 – July 2022

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

30.5 My line manager is the Clinical Director for Urology, who in turn is responsible to the Medical Director.

30.6 Clinical Director with responsibility for Urology: Robin Brown Mid 2011 – January 2014, Sam Hall January 2014 – March 2016, Colin Weir June 2016 – December 2018, Ted McNaboe December 2018 – December 2021 – Currently Vacant

*Information supplied by Ms Emma Stinson, Document Librarian, SHSCT Public inquiry Team

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 In my opinion the senior managers did not work well with Urology. Engagement with the department by the Clinical Directors, Medical Directors, Assistant Directors for Surgery and Directors for Acute Services was very limited and infrequent in my experience. I do not know how much job planned time they had allocated to management activity.

31.2 Mr Young tried his best to lead the Urology team. However, despite his best efforts Mr O'Brien, Mr Haynes and Mr O'Donoghue frequently failed to attend departmental meetings or arrived late. All too often I sat across the table from Mr Young wondering why my colleagues had not shown up. Due to the number of fronts on which the service was failing to deliver (growing waiting lists for appointments and surgery), it was difficult to achieve a consensus as to how to move forward without engagement from our colleagues.

31.3 In my opinion Mrs Corrigan was asked to cover too many departments (Urology, ENT, Ophthalmology and out patients). It was clear that urology was always struggling and this meant that the process was reactive and not strategic.

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 My role is not subject to performance review.

32.2 My role is subject to an annual appraisal with a medically qualified appraiser in order to meet the requirements for medical revalidation. This is not a performance related review. Appraisal in this context is a confidential reflective conversation between 2 colleagues. My appraiser has been a consultant from within the Trust on all but one occasion when the role was fulfilled by an associate specialist doctor. My appraisers have come from Urology, ENT, General Surgery and Emergency Medicine backgrounds. Since 2019 the trust has allocated the appraiser to all doctors, prior to this we had a choice of appraiser. The appraisal meeting usually takes 2 hours and is completed using an online portfolio. The appraiser ensures that all the necessary documentation is presented by the appraisee to meet all the domains of good medical practice set out by the GMC. At the end of the process the appraiser makes a recommendation to the medical revalidation team in the trust.

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 I am not involved, nor have I been involved in the appraisal or performance review of consultants or nurse colleagues. I am responsible for the Annual

Review of Competency Progression for Urology Higher Specialty Trainees in my role as training Programme Director at NIMDTA.

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 My engagement with all members of the urology team was courteous and professional.

34.2 Weekly departmental meetings took place at Thursday lunchtime for approximately 45 to 60 minutes. The meetings were chaired by Mr Young and attended by Urology Consultants and Mrs Corrigan. Urology trainees and members of the nursing team attended when the agenda required their input. The trust has supplied minutes of these meeting to the USI. The purpose of the meetings was to provide an update on matters concerning the running of the department such as waiting times, referral data, reports from theatre user groups, equipment issues and plans to purchase new equipment etc.

34.3 At the beginning of my tenure in 2012 a grand ward round took place on Thursday mornings to handover the patients to the incoming Consultant on call. As the consultant team expanded from 3 to 5 and then 6 consultants, it was agreed that this was unwieldy, did not encourage patient confidentiality due to the number of people around a bed and was not the best use of consultant time. We developed a consultant of the week model of working and this led to the handover ward round taking place between the outgoing and incoming consultant of the week together with junior staff and the senior nurse on the ward. In my experience, this development was useful and served to improve communication and patient care.

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 During my tenure, no one person held responsibility for quality assurance of urology services. In a broad sense, each clinician was responsible for their own practice. The degree to which individuals engaged with quality improvement or audit was variable and there was no mandatory element or structure to this activity. Audit activity remains poorly supported by the trust and is left up to clinicians to complete with minimal administrative support. From my own perspective I completed and presented audits related to prostate, kidney, bladder and testis cancer at the Urology M&M. With the help of Mary Haughey, Cancer Services Improvement Lead, I completed peer review and authored annual reports for the Urology Cancer MDT. I participated as an external peer reviewer for the Urology Cancer MDT at the South Eastern Trust.

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 order to assure myself of the quality of my own practice I completed audits of cancer outcomes relating to kidney, bladder, testicular and prostate cancer management. The audits were presented at the departmental patient safety meeting. Mr Haynes and I submitted data to a national urology audit for kidney cancer surgery until instructed to stop by the trust due to data control concerns specific to NI law. The data was measured against key performance indicators for kidney surgery and compared to peers and units across the UK.
I refer to my answer above 35.1

36.2 I chaired the Urology Morbidity and Mortality Meeting from April 2015 to September 2022. I refer to my answer to Q7.

37. How, if at all, did you inform or engage with performance metrics in Urology? During your tenure, who did you understand as being responsible for overseeing performance metrics?

37.1 The only metrics presented at the Urology departmental meetings related to waiting times for outpatient appointments and procedures.

37.2 Use of key performance indicators (such as positive surgical margin rates during partial nephrectomy or transfusion rates following prostate surgery) for individual conditions or procedures has not been routine. There is no data collection mechanism to support this activity in the trust. I refer to my answer to 36.1

37.3 Patient related outcome measures are only beginning to be used by the department. For example the routine collection of symptom scores following prostate surgery (REZUM procedure).

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 I refer to my answer to Q7.

38.2 I do not have line management responsibility for my consultant colleagues therefore unless advised by the clinical or medical director I would not necessarily be aware of concerns regarding the practice of my colleagues.

38.3 From a more general standpoint, I had an awareness of SAIs, complaints and mortalities through the Urology M&M meeting.

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? If yes, please explain.

39.1 I chaired the Urology M&M meeting from April 2015 and from the outset sought to include all available governance information not just mortality and morbidity cases. This was further developed with the assistance of the Clinical Effectiveness Team. Governance information was fed into the M&M meeting from various sources including: Deaths within 30 days of discharge, mortality lists, morbidity cases, safety graphs, local incidents/themes/ward issues, pharmacy issues, medicine safety alerts, shared learning from complaints / SAI/ IR1 forms / Other meetings / Learning Letters, Shared learning from Litigation / Coroners cases / PM reports / Ombudsman, Safety alerts and Circulars, Local Audit reports/Quality Improvement, Consultant outcome data (NCEPOD / National / Regional / Speciality).

39.2 The Urology M&M meeting served as a forum to share information relating to clinical governance with the whole team. Only those issues identified to me by members of the urology team or the clinical effectiveness team were included in the agenda for the meeting. I now know that there were issues of professional performance relating to Mr O'Brien, that I was not aware of, that had a direct bearing on patient safety.

39.3 I flagged concerns related to patient safety up to the responsible clinical director and or head of service. For example, the issue of non-quoracy at the Urology Cancer MDT was raised with the clinical directors for cancer services and radiology respectively.

40. How could issues of concern relating to Urology Services be brought to your attention as 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 Concerns from members of staff could be discussed with any Consultant in person, by telephone, letter or email and if not resolved could be escalated through the complaints process or via a DATIX for grading to determine if it met the criteria for an SAI.

40.2 Similarly, concerns from patients or relatives would follow a similar process.

40.3 Many concerns and complaints can be resolved informally. Complaints or concerns requiring a formal process can take months to complete, largely because the process relies on the availability of a panel to meet several times to finalise a report. The efficacy of the process is in my view questionable. Sharing learning from this activity is challenging. The volume of information cascading down the management structure means that most if it goes unread and therefore unactioned.

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

41.1 I have not noted any substantial changes to the systems for raising concerns during my tenure. The only change to the process was the introduction of the specialty specific morbidity and mortality meetings in 2015.

41.2 Dr O'Kane supported training for consultants in clinical governance during her tenure as medical director. She also established a forum for Chairs of M&M meetings to meet and share ideas and good practice.

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

42.1 I relied on information brought to the Urology M&M and Cancer MDT as well as discussions with Mr Young and Mrs Corrigan to keep me appraised of any

concerns related to the urology service. Latterly, following Mr Haynes appointment as AMD I discussed our shared concerns regarding service provision and patient safety with him.

42.2 I took part in peer review for the Urology Cancer MDT. This identified the deficiencies of the service against national guidelines. I escalated the matters identified to the Clinical Directors for Surgery and Cancer Services as well as the respective Heads of Service.

43. How, if at all, were any concerns raised or identified by you, or about you or others, 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 Governance concerns were noted in the Urology M&M meeting minutes. Issues of concern relating to the service were also identified at the Departmental meetings and I sought assurance from the Heads of Service Mrs Corrigan and Ms Clayton that such matters were escalated to the Board via the trust's risk register, for example the patient safety risk due to patients waiting inappropriately long times for first appointments and surgery.

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 Patient data was collected from the complaints process, DATIX, waiting time information and the CLIP reports provided to the Trust by CHKS. The waiting time data for outpatient appointments and procedures demonstrated a self-evident risk to patients. Similarly, complaints from patients, families and representatives should have alerted the trust to the unsatisfactory position of the waiting lists and the risk of patients coming to harm.

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 The systems described in my answer to Q44 are passive and in my opinion do not offer any reassurance that corrective action will be implemented. I do not believe that the data collection systems have changed during my tenure.

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 Performance objectives are not utilised for Consultant Medical staff. A consultant job plan sets out sessions of direct clinical care and supporting professional activity. It records the frequency of clinics, theatre lists, on call activity etc.. In my case it also captures the time allocated to my roles as an educational supervisor, Training Programme Director, Chair of the Urology Cancer MDT and preparation time for MDT. My job plan does not specify how many patients I am expected to see per clinic or theatre list. It does specify how many clinic and theatre/procedural sessions I am expected to deliver over the course of a year.

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 My job plan is supposed to be reviewed annually. On the whole, with the exception of the COVID period, this happened by way of an email conversation with the CD or AMD. Job planning happens in isolation from the whole team. There is no discussion with the team about the overarching view of the needs of the service. I am not aware of any standard setting for productivity across the team.

47.2 Appraisal is a process of collating information required by the trust to permit medical revalidation. In my opinion, the appraisal process has morphed from a confidential reflective exercise in professional development between two professionals into a formulaic capture of documents such as reflections on complaints, records of continuous professional development etc. to evidence a recommendation for revalidation by the trusts responsible officer.

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 My first knowledge of serious concerns with the practice of Mr O'Brien came at a meeting that took place in January 2017. I acknowledge my conversation with Mrs Trouton noted in paragraph 50.8 but at the time of this conversation I did not perceive this to be an immediate or substantial risk.

48.2 I attended the meeting together with my consultant urology colleagues. I recall that Mr Mackle Assistant Medical Director, Mr Weir Clinical Director for Surgery, Mr Ronan Carroll Assistant Director for Surgery and Mrs Corrigan Head of Service for Urology were present. We were informed that the trust had found a number of areas of concern relating to Mr O'Brien's practice. I recall the issue of triage of referrals and the late dictation of clinic letters and results being discussed. We were advised by Mr Carroll that this was a confidential matter not to be discussed outside the group and that Mr O'Brien would not be returning to work until further notice. I recall that we were asked to participate in an exercise to clear the backlog of triage and outstanding results. We agreed to do this work. I undertook triage to clear a backlog. I supplied a list of completed cases to Mrs Corrigan and the Referral and Booking Centre. Similarly, I reviewed charts of Mr

O'Brien's patients with outstanding results or clinic letters. I actioned the results and where necessary flagged up cases that required further review to ensure a safe management plan was in place. I supplied a list of this work to Mrs Corrigan. I have no knowledge of how Mr O'Brien's workload and performance was monitored upon his return to work later in 2017, this process was not shared with me by the trust management.

48.3 In May 2017, I was interviewed about the same issues by Dr Chada, Associate Medical Director, on behalf of the trust. My statement from that interview has been supplied to the USI.

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 I do not feel that I have been supported in my role by my line managers or the medical or operational hierarchy in the trust. Interaction between the medical managers and myself was very limited before 2020. Only when the Minister Swann announced the USI did the senior managers engage with the Urology Consultants. Despite all the problems in the trust the remaining urology consultants are asked to take on more activity to cover service gaps and address the patient risks identified by the various inquiries. This feels overwhelming and I have said so at meetings with Shane Devlin, Maria O'Kane and Melanie McClements. I will not take on more work when I know that I cannot safely deliver it. I have not received any specific support other than signposting by Dr O'Kane to occupational health and psychology should I feel that I need to self-refer.

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) The 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 (i) I did not interact with the Chief Executives namely Mairead McAlinden, Kieran Donaghy, Francis Rice or Shane Devlin prior to the announcement of the USI.

50.2 Following the public announcement by the Minister of Health to establish the USI I participated in video conference meetings with the Chief Executive Mr. Shane Devlin, the Medical Director Dr Maria O'Kane, the Director of Acute Services Mrs. Melanie McClements, Assistant Director for Surgery Mr. Ronan Carroll, Head of Service for Urology Mrs. Martina Corrigan and my colleagues in the urology department. The matters discussed pertained to the Trust's response and action plan to the initial Independent Review conducted by Dr Hughes and later the matters related to the USI.

50.3 (ii) I first met Dr O'Kane in her role as Chair of the forum for M&M Chairs on a number of occasions following her appointment to the trust. Prior to the

announcement of the USI I had no interaction with the previous Medical Directors (John Simpson, Richard Wright and Ahmed Khan) on matters of governance. I refer to my answer 50(i).

50.4 (iii) I met Dr Gillian Rankin prior to my appointment as a consultant in 2012 as part of a pre-interview visit. I do not recall meeting her again during her tenure.

50.5 I met Mrs Debbie Burns on many occasions during her tenure. The meetings were related to service improvement and management of waiting lists within the Urology Department. I did not have any meetings with her related to governance concerns other than to say that we recognised the harm that could arise from patients waiting too long for assessment and treatment.

50.6 I did not meet or interact with Mrs Ghiskori.

50.7 I have met with Mrs Melanie McClements primarily by video conference to discuss service provision and issues relating to delivery during COVID. I also refer to my answer to 50(i).

50.8 (iv) I met Mrs Heather Trouton when she was AD for Surgery. I recall we had a very brief corridor conversation, following a Urology Team meeting on the administration floor. The entire conversation amounted to 2 or three sentences from my recollection. She expressed her concerns relating to how Mr O'Brien was managing his workload. I cannot recall the exact wording but the substance of it was "how are we going to manage Aidan". No management plan was discussed, nor were any specific details discussed. I did not perceive that there was an immediate or substantial risk, rather I felt that Mrs Trouton was expressing a degree of exasperation with Mr O'Brien's backlog. The backlog was longstanding, widely known and was not solely related to Mr O'Brien. All of the consultant team had backlogs of varying degrees. I think that this conversation took place before I became aware of the SAIs in 2016 and before the subsequent meeting of January 2017 when the Consultant Team was told that Mr O'Brien

would not be returning to work as planned. I do not recall any other discussions concerning governance matters with Mrs Trouton.

50.9 I have met Mr Ronan Carroll in person and by video conference on many occasions. One of my first interactions with him was in January 2017 when the Urology Consultant Team was told that Mr O'Brien would not be returning to work as planned. I was shocked by this information and the extent of the problem outlined to us. It was my impression at the meeting that Mr Carroll and other managers present were party to information about Mr O'Brien's practice that was not shared with the urology consultants at the meeting.

50.10 I have discussed the urology waiting lists and my concerns related to delayed assessment and treatment for patients at meetings with Mr Carroll present. I have participated in a number of SAIs on behalf of the trust. Mr Carroll had sight of the outcomes and recommendations as part of his role as Assistant Director. Similarly, Mr Carroll and I have worked on responses to complaints or enquiries on behalf of patients. Mr Carroll worked with the Urology team to deliver a recovery plan following the findings of the January 2017 meeting.

50.11 (v) I had no interaction with the associate medical director on matters of governance until 2017. Following Mr Haynes appointment to this role, he and I had frequent discussions about how to improve performance and mitigate patient safety risks across the team.

50.12 (vi) I had no interaction with the clinical director with responsibility for urology on matters of governance. As stated previously I did bring concerns regarding the functioning and quoracy of the Urology MDT to the clinical directors for cancer services and radiology.

50.13 (vii) I had frequent engagement with Mr Young in his role as lead clinician. We discussed matters concerning the running of the department informally and at the

departmental meetings (I refer to my answer 34.2). We discussed concerns regarding the performance of medical staff as stated below 52.1, 52.2 & 52.3.

50.14 (viii) I had frequent, often daily engagement with Mrs Corrigan the Head of Service for Urology. We discussed and managed complaints, responses to SAIs, concerns regarding waiting list for procedures and appointments.

50.15 (ix) During my tenure the following Substantive Consultants not already named above worked in the department: Ajay Pahuja, David Connolly, Ram Suresh, John O'Donoghue, Matthew Tyson.
I do not recall discussing any governance concerns with Mr Pahuja or Mr Connolly during their brief tenures. Mr Suresh, Mr O'Donoghue and Mr Tyson did not raise any governance concerns outside of matters routinely discussed at M&M.

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 about my clinical practice.

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.

52.1 (a) I am aware that concerns were raised by the nursing staff in the Thorndale Unit about the clinical practice and manner of [redacted], [redacted] [redacted]y. This matter was dealt with by Mr Young and [redacted]

employment was terminated. Mr Young would be best placed to comment on the details of this matter and provide answers to parts (i) to (ix).

52.2 I am aware that concerns regarding the clinical practice and interpersonal manner of Dr [redacted], [redacted] and Mr [redacted], [redacted] were raised by members of the nursing staff in theatre and outpatients. Both [redacted] had their contracts terminated. Mr Haynes dealt with this matter on behalf of the Urology Department and he would be best placed to comment further on the details of these matters and provide answers to parts (i) to (ix). Subsequently the caseloads of both locum consultants were reviewed, and their outstanding results and patients redistributed within the consultant team. Any clinical concerns were escalated via the DATIX process or the Cancer MDT accordingly.

52.3 Concerns regarding the scope of Mr [redacted]'s practice were discussed by the consultant urology team including myself, Mr O'Brien, Mr Young, Mr O'Donoghue and Mr Haynes. Primarily, this related to support he required when he was on call with respect to decision making and in the event that a patient required open surgery. We agreed to provide a second tier of consultant on call to support [redacted]. This matter was dealt with by Mr Young in a supportive manner. Mr Young would be best placed to comment on the details of this matter and provide answers to parts (i) to (ix).

52.4 (b) I had patient safety concerns since 2012 related to the long waiting lists for appointments and procedures within the Urology Department. I also had concerns regarding inadequate numbers of Consultants in the Department to deliver a safe timely service.

52.5 (c) Other than a general sense that we were struggling to deliver a timely outpatient and surgical service I did not have any concerns regarding clinical governance processes within urology until January 2017 and again later following the Trusts announcement of the Independent Review of 9 SAIs related to Mr O'Brien's practice. I acknowledge that there were differences in performance

across the team and that some Consultants had larger backlogs than others. In addition, working styles differed and both aspects were reflected in concerns expressed to me by Mrs Trouton in our brief conversation noted above 50.8. In the period since January 2017 I am not aware that any of the investigations have raised concerns about the practice of the remaining consultant urologists.

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

53.1 My recollection of events following the meeting of January 2017 is that the Urology Consultant team and Mrs Corrigan worked together to properly identify any areas of potential risk to patients resulting from Mr O'Brien's work. We reviewed case notes to ensure that an appropriate management plan was in place. If a safe plan was not identified, we arranged for review of the patient by another consultant. The untriaged referrals were completed by members of the consultant team starting with red flags then urgent and finally routine referrals. This process was started within days of the meeting. I do not recall specific dates for this activity. I do not have any notes from these meetings. I did submit lists of cases that I reviewed or triaged to Mrs Corrigan to be cross-referenced with the whole piece of work. In my view the team did their best to properly identify the extent and impact of deficiencies in Mr O'Brien's practice and to put in place appropriate measures to manage patients safely and to mitigate further risk to patient safety.

53.2 At a later point, sometime in 2020 or 2021, I recall being advised that on the basis of a review of cases managed by Mr O'Brien that an issue with prescribing

had been identified and that with the help of regional pharmacy all affected patients were identified and management was reviewed.

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 No specific support was provided to me. Dr O'Kane did sign post the occupational health and psychology services within the trust in 2020. I am not aware of any specific support provided to Personal Information redacted by the USI by the trust other than our agreement as consultant colleagues to provide support to him when he was on call as set out at paragraph 52.3.

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 Support for Quality Improvement to the Urology Service has been absent since my tenure began in 2012. Essentially any QI activity is undertaken by individual clinicians on top of their clinical workload and with negligible trust support. QI training programmes are recently available but I have not had time to explore this further or to avail of this resource.

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 I was aware from 2012 that Mr O'Brien had a long review backlog for outpatients and in patient operating. He was not unique in this regard. I was also aware that he had a backlog for completing correspondence from my experience as a urology clinical research fellow between 2002 and 2005 and again when I returned as a consultant in 2012.

56.2 On many occasions Mr O'Brien raised concerns at the urology departmental meetings, meetings with directors and Assistant Directors of Acute Services and Commissioners from HSCB.

56.3 At the urology Department Meetings, he expressed the view that he did not have enough time to complete triage of new referrals during his week on call. He also expressed the view that the two most pressing concerns for the urology department were the provision of a safe in-patient service and tackling the long waiting times for surgery.

56.4 Prior to the meeting in January 2017, I was not aware of the extent and range of the issues concerning Mr O'Brien's practice. I acknowledge that I was aware from 2012 that there were differences in performance across the team and that some Consultants had larger backlogs than others. In addition, working styles differed and both aspects were reflected in concerns expressed to me by Mrs Trouton in our conversation noted above 50.8. It is important to note that many of the issues raised by Mr O'Brien featured in the content of the meeting.

56.5 I became aware in 2020 through discussion with Kate O'Neill and Leanne McCourt Urology CNS's that they felt excluded from his outpatient clinics and were not present to advocate on behalf of patients.

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 I wish to state that Mr O'Brien was invariably courteous and professional in my interactions with him for more than 30 years. He was supportive of my development as a medical student, doctor in training and as a consultant colleague following my appointment in 2012. Even when times became difficult after 2017, he remained so. I appreciate that this must have been very difficult for him.

57.2 I was interviewed in May 2017 by Dr Chada. I expressed my concerns about the factors contributing to the patient safety risks in Mr O'Brien's practice. My concerns included Mr O'Brien's working style of not completing dictation contemporaneously. His insistence on "advanced triage", which I did not think was a good use of time. I also shared my concern that Mr O'Brien and all the other urology consultants were carrying too great a workload and that this was a cause of stress and a factor in adversely affecting performance. I did not name my colleagues in the statement given to Dr Chada but I was referring to Mr Young, Mr Haynes, Mr O'Donoghue and myself.

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 I refer to my answer to Q48, Q50.8 and Q57.
At the request of the Governance Team I chaired 3 SAI investigations concerning patients under the care of Mr O'Brien ([redacted], [redacted] and [redacted]). The reports were provided to the Medical Director via the Governance Team and were presented at M&M.

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 named 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 I refer to my answer to Q53 which describes the immediate actions taken by myself, fellow consultants and Mrs Corrigan after the meeting of January 2017. As stated above I was not party to any monitoring arrangements for Mr O'Brien's performance following his return to work later in 2017.

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 steps and what do you think those steps should have been? Please explain why and identify that person?

60.1 (i) The impact on patient care and safety relates to delayed time to assessment and treatment, the risk of failing to appropriately escalate routine referrals to urgent or red flag at triage, delays to treatment caused by the absence of or late correspondence to GPs and others.

60.2 (ii) These concerns were known about before the meeting in January 2017, but it was only at this meeting that I became aware of the range and extent of the concerns.

60.3 (iii) and (IV) I refer to my answer to Q53. I consider that the responsibility for carrying out a risk assessment and planning further management lay with the CD with responsibility for Urology and the AD for Surgery and Elective Care. Each was answerable to the Medical Director and the Director of Acute Services respectively. I would have expected that the Medical Director and the Director of Acute Services would have been fully briefed given the seriousness of the matters advised to us at the meeting of January 2017.

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 I was not party to any discussion about Mr O'Brien's return to work in 2017 or any measures put in place by the trust to monitor performance at work. I became aware later in 2017 that Mr O'Brien's work was subject to managerial oversight. I am not aware of any specific restrictions or conditions made on his practice or the methodologies used by the trust to assess compliance.

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 I refer to my answer to Q61.

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 have no knowledge the systems put in place to monitor Mr O'Brien's performance. This information was not shared with me. I think that this question could be answered fully by the Clinical Director for Urology Mr Weir and Medical Director Dr Wright.

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 I refer to my answer to Q61. In my view it would have been better to have shared the performance management plan and any timelines with the consultant urology team. This would have encouraged an open and transparent discussion of the problems identified and provided the opportunity for the urology consultant team to work collaboratively for the improvement and safety of the service all the while supporting our colleague.

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 refer to my answer to Q56.

65.2 I do not recall any specific input at meetings from the Medical Directors (John Simpson, Richard Wright, Ahmed Khan & Maria O'Kane), Assistant Medical Directors (Eamon Mackle & Charlie McAllister) or Clinical Directors with responsibility for Urology (Robin Brown, Sam Hall, Colin Weir & Ted McNaboe) regarding Mr O'Brien's concerns. In my recollection, it was mostly the operational managers (Mrs Corrigan HOS, Mr Carroll AD, Mrs Trouton AD and Mrs Burns Director of Acute Services) who were present when issues were raised. I would have expected the Head of Service and AD to escalate concerns to the Director of Acute Services who in turn should notify the Trust Board and risk register. Similarly, I would have expected any concerns notified to the Clinical Director to have been shared with the Assistant Medical Director and Medical Director.

65.3 It is my view that the operational side was very aware of the performance issues with respect to waiting times, triage etc. I have no knowledge of how well informed the medical managers were prior to 2017. From 2017 onwards the medical managers were involved but again communication to me from them was minimal.

I do not recall a single meeting to discuss governance issues or patient safety concerns related to Mr O'Brien or the Urology Department with any of the following post holders who held tenure in the period following the meeting in January 2017 up until June 2020: Medical Directors (Richard Wright, Ahmed Khan & Maria O'Kane), Assistant Medical Directors (Eamon Mackle & Charlie

McAllister) or Clinical Directors with responsibility for Urology (Colin Weir & Ted McNaboe)

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 I am not aware of any support provided by the trust to Mr O'Brien.

66.2 I advised my medical and nursing colleagues to engage with their union and indemnity organisation following the ministerial announcement in 2020.

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 I do not know if any issues raised by Mr O'Brien were included on the Trust's risk register.

67.2 At a video conference meeting in 2021 with senior medical and operational mangers with the Urology Team, I sought assurance from Mrs McClements that the known issues of long waiting times for appointments and surgery as well as the lack of in-patient bed and theatre capacity were on the Trust's risk register.

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 I am not aware of any new governance issues since the meeting of January 2017. The issues surrounding long waiting times for outpatient appointments and surgical procedures remain a risk to patient safety.

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

69.1 The failure by the trust to deliver timely care and to monitor the performance of individual consultants activity arise from the absence of performance management of clinicians and managers and longstanding issues regarding inadequate resources to provide a timely safe service for the population. Workload pressures meant that we spent most of our time trying to keep our heads above water balancing the competing interests in an inadequately resourced department.

69.2 In my experience of working in the trust as a consultant since 2012 performance data was not collected, shared or discussed routinely. The trust used data from CHKS for the CLIP report, but this was viewed by clinicians as inaccurate. I refer to my answer 14.3

Behaviours of individuals, custom and practice went unchallenged with respect to the timeliness of correspondence, triage and results, monitoring of volumes of activity and chronological listing of cases for theatre.

69.3 Routine collection of outcomes data was not supported by appropriate infrastructure. Prescribing practice was not routinely audited. This meant that it was difficult to recognise variance in practice across the team and to have a meaningful discussion as to why variance was occurring.

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 I refer to my answer to Q69.

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 I do not know how engaged the senior medical managers were with the problems related to Mr O'Brien's practice. In my experience they did not engage with me regarding these issues until the meeting in January 2017. As stated in my answer above 65.3 : I do not recall a single meeting to discuss governance issues or patient safety concerns related to Mr O'Brien or the Urology Department with any of the following post holders who held tenure in the period following the meeting in January 2017 up until June 2020: Medical Directors (Richard Wright, Ahmed Khan & Maria O'Kane), Assistant Medical Directors (Eamon Mackle & Charlie McAllister) or Clinical Directors with responsibility for Urology (Colin Weir & Ted McNaboe). From July 2020 the Medical Director Dr O'Kane did engage with the whole team on a frequent basis. I am aware from a video conference call and subsequent written statement that Mr Devlin CEO expressed his confidence in the remaining Urology Consultants and that in his view that our performance was not in question.

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 I do not believe that I made or contributed to any mistakes in the handling of the concerns related to Mr O'Brien's practice. I openly and transparently shared the outcomes of the 3 SAI's I was tasked with chairing (Patient 128 , Patient 10 and Patient 90). The reports were provided to the Medical Director via the Governance Team and were presented at M&M meetings. I participated in an interview with Dr Chada, Assistant Medical Director, in May 2017 regarding the same concerns in a frank and truthful manner.

72.2 I cannot account for the actions of others, particularly when their actions were not shared with me. I did not have any line management responsibility for Mr O'Brien or my other Consultant colleagues.

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 do not think that the governance arrangements as applied in this case were fit for purpose. The largest failure in my view is the absence of performance management for all clinicians. This is entirely separate to appraisal, which in my view is a reflective learning process undertaken by a doctor and a trained appraiser. To address this the trust needs to invest time and resources for medical and operational managers to collect data, analyse outcomes and discuss this with individuals and teams. There may be many valid reasons why an individual doctor is struggling or underperforming in aspects of their role. By committing to this type of process the trust could intervene in a timely manner to maintain a safe service and to support staff. This process would feed into job planning.

Urology Services Inquiry

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?

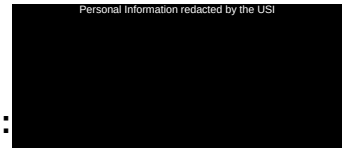
74.1 I have nothing further to add.

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.

<u>Statement of Truth</u>

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

Signed: 

Date: 15th August 2022

Section 21 Notice Number 57 of 2022

Witness Statement: Anthony Glackin

Table of Attachments

Attachment	Document Name
1	20120910 Anthony Glackin Statement of Terms and Conditons of Employment
2	20181126 Radiology absence
3	20170116 Quoracy email
4	20170120 Quoracy email
5	20170608 Quoracy email

Southern Health and Social Care Trust

Quality Care - for you, with you

Statement of Main Terms and Conditions of Employment

CONSULTANT APPOINTMENT

Irrelevant information redacted by the USI

10 September 2012

Mr Anthony Glackin
Personal Information redacted by the USI

THE POST

1 Consultant
Your job title is Consultant Urologist.

Your employing organisation is the Southern Health and Social Care Trust.

2 Commencement of Employment
Employment under this contract began on 1 August 2012. Your payscale code on commencement is M400.

Your continuous employment with this employing organisation, for the purposes of the Employment Rights (Northern Ireland) Order 1996, began on 1 August 2012.

For the purposes of certain HPSS conditions of service, previous service within the HPSS, whether with this Trust or another HPSS employer, although not continuous for the purposes of the Employment Rights (Northern Ireland) Order 1996 will count as reckonable, so that for some purposes other dates prior to the dates set out above may count.

Schedule 1 of the Terms and Conditions contains guidance on commencement of employment.

3 General Mutual Obligations
Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

- to co-operate with each other;
- to maintain goodwill;
- to carry out our respective obligations in agreeing and operating a Job Plan;
- to carry out our respective obligations in accordance with appraisal arrangements;
- to carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols.

THE WORK

4 Location

Your principal place of work is Craigavon Area Hospital. Other work locations including off site working may be agreed in your Job Plan where appropriate, e.g. for supporting professional activities and some direct clinical care such as audit notes. You will generally be expected to undertake your Programmed Activities at the principal place of work or other locations agreed in the Job Plan. Exceptions will include travelling between work sites and attending official meetings away from the workplace.

You may be required to work at any site within the Southern Health and Social Care Trust, including new sites.

5 Duties

5.1 Main Duties and Programmed Activities

Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities and undertaking the Programmed Activities set out in your Job Plan, as reviewed from time to time in line with the provisions in section 6 below.

5.2 Associated Duties

You are responsible for the associated duties set out in Schedule 2 of the Terms and Conditions of Service.

5.3 Objectives

The purpose of including agreed personal objectives in your Job Plan is to set out in clear and transparent terms what you and your clinical manager have agreed should reasonably be achieved in the year in question. These objectives are not contractually binding in themselves, but you have a duty to make all reasonable efforts to achieve them.

5.4 On-Call Duties and Emergency Responses

You may also be required to participate in an on-call rota to provide emergency cover (see section 9). When not on an on-call rota, we may in exceptional circumstances ask you to return to site for emergencies if we are able to contact you. You are not, however, required to be available for such

eventualities. Where emergency recalls of this kind become frequent, we will review the need to introduce an on-call rota.

6 Job Planning

You and your clinical manager have agreed a prospective Job Plan that sets out your main duties and responsibilities, a schedule for carrying out your Programmed Activities, your managerial responsibilities, your accountability arrangements, your objectives and supporting resources.

You and your clinical manager will review the Job Plan annually in line with the provisions in Schedule 3 of the Terms and Conditions of Service. Either may propose amendment of the Job Plan. You will help ensure through participating in Job Plan reviews that your Job Plan meets the criteria set out in the Terms and Conditions of Service and that it contributes to the efficient and effective use of HPSS resources.

7 Programmed Activities

7.1 Scheduling of Activities

You and your clinical manager will agree in the schedule of your job plan the programmed activities that are necessary to fulfil your duties and responsibilities, and the times and locations at which these activities are scheduled to take place. You and your clinical manager will seek to reach agreement in the scheduling of all activities. We will not schedule non-emergency work during premium time without your agreement.

Subject to the provisions for recognising work done in Premium Time (see section 8 below), a Programmed Activity has a timetable value of four hours. Each Programmed Activity may include a combination of duties.

A job plan will contain 10 Programmed Activities per week on average, subject to the provisions below for recognising emergency work arising from on-call rotas and in Paragraph 7.6 to agree up to two extra Programmed Activities. Remuneration for Programmed Activities is set out in section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service.

7.2 Flexibility

Attaching a time value to Programmed Activities is intended to provide greater transparency about the level of commitment expected of consultants by the HPSS. However, you and your clinical manager can agree flexible arrangements for timing of work.

Programmed Activities may be scheduled either as a single block of four hours, or in half units of two hours each.

The precise length of Programmed Activities may vary from week to week around the average assessment set out in the Job Plan.

You and your clinical manager may agree, as part of your Job Plan, arrangements for the annualisation of Programmed Activities. In such a case, you and your clinical manager will agree an annual number of Programmed

Activities and your Job Plan will set out variations in the level and distribution of Programmed Activities within the overall annual total.
You and your clinical manager may agree, as part of your Job Plan, other arrangements for flexible scheduling of commitments over an agreed period of time.

Any variations in your scheduled weekly commitments should be averaged out over 26 weeks, so that your average commitment is consistent with the provisions of the Working Time Regulations.

7.3 Balance between Direct Clinical Care and Other Programmed Activities

Subject to the provisions for recognising emergency work arising from on-call rotas below, the schedule in a Job Plan will typically include an average of $7^1/_2$ Programmed Activities for Direct Clinical Care duties and $2^1/_2$ Programmed Activities for Supporting Professional Activities. Where your agreed level of duties in relation to supporting professional activities, additional responsibilities and other duties is significantly greater or lower than $2^1/_2$ programmed activities there will be local agreement as to the appropriate balance between activities. Part-time consultants need to devote proportionately more of their time to Supporting Professional Activities. This should be agreed on an individual basis. Refer to the guidance on part time and flexible working for further information

The precise balance will be agreed as part of Job Plan reviews and may vary to take account of circumstances where the agreed level of duties in relation to Supporting Professional Activities, Additional HPSS Responsibilities and External Duties is significantly greater or lower than 2½ Programmed Activities.

Responsibilities as a Medical Director or Clinical Director may be reflected by substitution for other whole or part Programmed Activities or by additional remuneration agreed locally.

7.4 External Duties

Where you wish to seek agreement to have External Duties included in your Job Plan, you must notify your clinical manager in advance. Scheduling of such duties will be by agreement between you and your clinical manager. Where carrying out these External Duties might affect the performance of direct clinical duties, where possible you will give us sufficient notice to ensure that, where such external duties are agreed, you and your clinical manager can agree a revised schedule of activities at least a month in advance.

7.5 Recognition for Emergency Work arising from On-Call Duties

Where emergency work takes place at regular and predictable times, your clinical manager will seek to schedule it as part of the Programmed Activities in your Job Plan schedule. You may, however, be required to participate in an on-call rota to respond to less predictable emergencies.

The provisions in Schedule 5 of the Terms and Conditions of Service apply to recognise unpredictable emergency work arising from on-call rota duties that takes place other than during a Programmed Activity scheduled in your Job Plan.

7.6 *Extra Programmed Activities*

You and your clinical manager may agree that you will undertake extra Programmed Activities over and above the 10 Programmed Activities that constitute your standard contractual duties, up to the maximum permitted under the Working Time Regulations. The remuneration for these activities is covered by section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service.

Any such agreement will be made in writing and the additional Programmed Activities will be incorporated into your Job Plan schedule.

Subject to the provisions in section 7.7 below, and without prejudice to section 7.8 below, you do not have to agree to carry out more than 10 Programmed Activities on average per week. However, where you do give your agreement, you must undertake such activities. The remuneration for these activities is covered by section 21 below and Schedules 13 and 14 of the Terms and Conditions of Service. Any additional Programmed Activities that you carry out beyond the standard Programmed activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions of Service.

7.7 *Extra Programmed Activities and Additional Professional Capacity*

Where you intend to undertake private professional services other than such work carried out under the terms of this contract, whether for the HPSS, for the independent sector or for another party, the provisions in Schedule 6 of the Terms and Conditions of Service will apply.

8 Premium Time

From 1 April 2004, the provisions in Schedule 7 of the Terms and Conditions of Service will apply to recognise the unsocial nature of work done in Premium Time and the flexibility needed by consultants who work at these times as part of a more varied overall working pattern.

On any occasion where a consultant is scheduled to work during the Premium Time period, the employing organisation will ensure that the consultant has adequate rest both before and after this period of duty.

9 On-Call and Emergency Duties

9.1 *On-Call Rotas*

Where you are on an on-call rota, the provisions in Schedule 8 of the Terms and Conditions of Service will apply.

Your on-call duties will be set out in the published rota or in accordance with any alternative arrangements that you agree with your colleagues for providing on-call cover.

9.2 *On-Call Availability Supplements*

Where you are on an on-call rota, you will receive an on-call availability supplement according to the provisions in Schedule 16 of the Terms and Conditions of Service. The level of supplement will depend on the frequency

of your rota and the typical nature of the required response when you are called.

OTHER CONDITIONS OF EMPLOYMENT

10 Registration Requirements

It is a condition of your employment that you are, and remain a fully registered medical practitioner and are included on the Specialist Register held by the General Medical Council (GMC), and continue to hold a licence to practice.

11 Fee Paying Services and Private Professional Services

11.1 Minimising Potential for Conflicts of Interest

In carrying out any Fee Paying Services or Private Professional Services, you will observe the provisions in Schedule 9 of the Terms and Conditions of Service in order to help minimise the risk of any perceived conflicts of interest to arise with your work for the HPSS.

11.2 Fee Paying Services and HPSS Programmed Activities

Examples of Fee Paying Services are set out in Schedule 10 of the Terms and Conditions of Service.

You will not carry out Fee Paying Services during your Programmed Activities except where you and your clinical manager have agreed otherwise. Where your clinical manager has agreed that you may carry out Fee Paying Services during your Programmed Activities, you will remit to us the fees for such services except where you and your clinical manager have agreed that providing these services involves minimal disruption to your HPSS duties. Schedule 11 of the Terms and Conditions of Service contains guidance on this subject.

11.3 Private Professional Services and HPSS Programmed Activities

Subject to the provisions in Schedule 9 of the Terms and Conditions of Service, you may not carry out Private Professional Services during your Programmed Activities.

11.4 Publications, lectures, etc

A practitioner shall be free, without prior consent of the employing authority, to publish books, articles, etc., and to deliver any lecture or speak, whether on matters arising out of his or her HPSS service or not.

12 Deductions from Pay

We will not make deductions from or variations to your salary other than those required by law without your express written consent.

13 Appraisal and Clinical Governance

The Appraisal Scheme for Consultant Staff (DHSSPS Circulars HSS(TC8) 3/01 and HSS(TC8) 11/01) applies to your post. You must co-operate fully in the operation of the appraisal scheme. You must also comply with our clinical governance procedures.

14 Gifts and Gratuities

You are required to comply with our rules and procedures governing the acceptance of gifts and hospitalities.

15 Policies and Procedures

You are required to comply with our Policies and Procedures as may from time to time be in force.

16 Grievance Procedures

The grievance procedures, which apply to your employment are set out in Trust policies.

17 Disciplinary Matters

Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour may be in breach of Trust policies or that your professional competence has been called into question, we will resolve the matter through our disciplinary or capability procedures, (which will be consistent with the 'Maintaining High Professional Standards in the Modern HPSS' Framework), subject to the appeal arrangements set out in those procedures.

18 Intellectual Property

You will comply with our procedures for intellectual property which are in line with 'A Framework for the Management of Intellectual Property in the HPSS'.

19 Other Conditions of Service

The provisions in Schedule 12 of the Terms and Conditions of Service will apply.

PAY

20 Salary

20.1 Basic Salary and Pay Thresholds

Your basic salary is Personal Information redacted by the USI per annum. This has been calculated in accordance with the provisions in Schedules 13 and 14 of the Terms and Conditions of Service.

Your basic salary will increase when you receive pay thresholds in accordance with the provisions of section 20.2 and Schedule 15 of the Terms and Conditions of Service.

The value of each pay threshold and the number of years' service required before you become eligible for pay thresholds are set out in Schedules 13 and 14 of the Terms and Conditions of Service.

Where a pay threshold is awarded, the date on which your salary will increase to take account of the threshold will be the anniversary of transfer to this contract.

Your basic salary, together with any payments for extra Programmed Activities (see section 21 below) includes payment for all Contractual and Consequential Services.

20.2 ***Criteria for Pay Thresholds***

You will not receive pay thresholds automatically, but it is expected that you will progress through the thresholds and will do so if the criteria set out in Schedule 15 are met. We will make all reasonable efforts to support you in meeting the criteria for pay thresholds.

21 Payment for Additional Programmed Activities

Any additional Programmed Activities that you carry out, beyond the standard 10 Programmed Activities, will be paid at the rates set out in Schedules 13 and 14 of the Terms and Conditions of Service.

22 Clinical Excellence Awards

Where the Clinical Excellence Awards Committee has recommended that you receive a Higher Award, or we have decided that you should receive one or more Local Award/s, these will be paid at the rates set out in the latest Circular from the Department of Health, Social Services and Public Safety concerning pay and conditions of service for hospital medical and dental staff and doctors in public health medicine and the community health service.

23 On-Call Availability Supplement

If you are required to participate in an on-call rota, you will be paid a supplement in addition to your basic salary in respect of your availability to work during on-call periods. The supplement will be paid in accordance with, and at the appropriate rate shown in, Schedule 16 of the Terms and Conditions of Service.

24 Recruitment and Retention Premia

We may under certain circumstances decide to award a recruitment or retention premium in addition to your basic salary in line with the provisions in Schedule 16 of the Terms and Conditions of Service.

25 Directors of Public Health

Directors of Public Health will be entitled to supplements in addition to basic salary in line with the provisions in Schedule 16 of the terms and conditions of Service.

PENSION

26 Pension

The provisions in Schedule 17 of the Terms and Conditions of Service shall apply.

You will be eligible for membership of the HPSS Superannuation Scheme, the provisions of which are set out in the HPSS Superannuation Scheme Regulations 1995 (as amended). The Scheme is a final salary scheme with benefits based on the best of the last three years pensionable pay. Pensionable pay will include basic salary (up to ten programmed activities, but

not any additional programmed activities above this), on-call availability supplements, any discretionary points or distinction awards (or their agreed replacement), and any other pay expressly agreed to be pensionable.

You are contracted out of the State Second Pension Scheme.

LEAVE AND HOLIDAYS

27 Leave and Holidays

Schedule 18 of the Terms and Conditions of Service sets out your entitlements in respect of:

- annual leave and public holidays
- professional and study leave
- sabbaticals
- sick leave
- special leave
- maternity leave and domestic personal and care relief.

The leave year runs from 1 April to 31 March the following year.

OTHER ENTITLEMENTS

28 Expenses

You are entitled to be paid expenses, which should be submitted in a timely manner (normally within one month), for:

- excess travel
- subsistence; and
- other expenses in accordance with schedule 21.

29 Charges for Residence

Except where facilities are provided for a doctor to be on-call a charge may, where appropriate, be made for residing at your place of work in accordance with our local procedures.

DURATION OF EMPLOYMENT

30 This is a permanent post.

TERMINATION OF EMPLOYMENT

31 Provisions governing termination of employment are set out in Schedule 19 of the Terms and Conditions of Service.

The employment is subject to 3 months' notice on either side subject to Schedule 19 of the Terms and Conditions of Service.

ENTIRE TERMS

32 Entire Terms

This contract and the associated Terms and Conditions of Service contain the entire terms and conditions of your employment with us, such that all previous agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference such incorporation is only to the extent so stated and not further or otherwise.

I, Mr Anthony Glackin, and the **Southern Health and Social Care Trust** have understood and agree to honour the terms and conditions set out in this contract of employment.

Representative of employing authority's signature: Personal Information redacted by the USI

Consultant's signature: _____

Date of this agreement: _____

Please sign both copies of your contract of employment. One copy should be retained by you and the other copy should be returned to the address below:

Medical Staffing Section (HR Department)
Ground Floor – Trust Headquarters
College of Nursing
CRAIGAVON AREA HOSPITAL
68 Lurgan Road
PORTADOWN
BT63 5QQ

Southern Health and Social Care Trust

SUMMARY OF JOB PLAN

Name:	Mr Anthony Glackin
Specialty:	**Urology**
Contracted Programmed Activities:	**10 PA's**
Additional Programmed Activities:	**0.5 PA's**
Management Allowance (if applicable): **Medical Director / Clinical Director**	--
Total Programmed Activities:	**10.5 PA's**
On-Call Category:	**Category A**
On-Call Frequency:	**Medium Frequency** ***(5% of basic salary)***

Medical Staffing Section
Human Resources Department

10 September 2012

STRICTLY PRIVATE & CONFIDENTIAL

Mr Anthony Glackin
[redacted]

Dear Mr Glackin

RE: CONTRACT FOR ADDITIONAL PROGRAMMED ACTIVITIES

Following your Job Plan Review and in accordance with Clause 7.6 of your Statement of Main Terms and Conditions of Employment, the Trust has agreed to offer, and you have agreed to undertake, 0.5 Additional Programmed Activities over and above the 10 which constitute your standard contractual duties, in recognition of additional workload. The Additional Programmed Activities have been incorporated into your Job Plan schedule.

Your on-call category has been determined as CATEGORY A with the frequency of your on-call commitment being MEDIUM, that is FREQUENCY (i.e. 1:5 – 1:8).

This contract for 0.5 Additional Programmed Activities will commence on 1 August 2012 and will continue until 31 March 2013, but may be terminated earlier subject to 3 months' notice by either party. The requirement for you to continue to undertake Additional Programmed Activities will be reviewed at least annually as part of your Job Plan review, which should take place no later than 3 months before the expiry set out above. As job planning is based on a partnership approach, Consultants and Clinical Directors are jointly responsible for ensuring interim job plan reviews take place as necessary, for instance where duties, responsibilities or objectives have changed or need to change within the year.

Remuneration for Additional Programmed Activities is covered by Clause 21 of your Statement of Main Terms and Conditions of Employment and Schedules 13 and 14 of the Consultant Terms and Conditions of Service (Northern Ireland) 2004. It should be noted that Additional Programmed Activities are not pensionable and are not of course subject to pay protection arrangements. Equally so, termination of your Contract for Additional Programmed Activities will have no effect on your Statement of Main Terms and Conditions of Employment.

Yours sincerely

Personal Information redacted by the USI
[redacted]

p.p. **ZOE PARKS (MRS)**
Medical Staffing Manager

Glackin, Anthony

From: McCaul, David
Sent: 26 November 2018 16:15
To: Yousuf, Imran; Glackin, Anthony
Cc: Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; Williams, Marc; McConville, Richard
Subject: RE: radiology presence?

Hi all it would be great if we have a long term solution

David

From: Yousuf, Imran
Sent: 26 November 2018 14:00
To: Glackin, Anthony; McCaul, David
Cc: Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael; Williams, Marc; McConville, Richard
Subject: RE: radiology presence?

Hi Tony,
I am aware of the situation and am working with Richard to try and improve Urology MDT cover.
Urology MDT is on a Thursday which coincides with Richard's interventional list.
Presently , we do not have any other Radiologist who feels competent enough to provide Urology MDT cover. We only have two radiologists who can report prostate MRI scans.

The Urology MDT is a significant workload in terms of preparation time and Presentation. 1 full PA will be required in addition to training time. Hopefully, attendance will improve with further recruitment in the new year.

In the meantime, we can find ways to reduce Marc's "other" clinical commitments and also try to free up Richard in advance for leave cover. Happy to discuss in person.

Regards,
imran

From: Glackin, Anthony
Sent: 26 November 2018 10:19
To: Yousuf, Imran; McCaul, David
Cc: Reddick, Fiona; Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Dear Imran and David,
Please see the email trail below setting out the concerns of our Consultant Radiology colleagues at the Belfast Trust regarding the Craigavon Urology MDT meeting and Radiology cover.
As you are aware this is an ongoing issue. Since the departure of Dr McClure we have had Dr Williams attending as the sole Consultant Radiologist. Due to other clinical priorities he has not been able to attend every week.
The clinicians and Trust are in a very exposed position if a clinical decision made at the Craigavon Urology MDT meeting without the review of a Radiologist turns out to be incorrect and a patient(s) comes to harm.
I am seeking your advice on how we should proceed until such time as a Radiologist can attend all meetings.
For completeness it should be noted that we do not have oncology input present at the Craigavon Urology MDT meeting, except over the video link from the Specialist Urology MDT meeting when we link in for cases listed for central discussion. That is to say that the majority of cases do not have the benefit of an oncology opinion either.

I await your response.

Yours sincerely

Tony Glackin

Chair of Urology MDT

From: McVeigh, Shauna
Sent: 21 November 2018 12:04
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Jacob, Thomas; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Hi,

Please see below email from BCH regarding regional cases and radiology.

Thanks
Shauna

From: Evans, Angelae [mailto:Personal Information redacted by the USI
Sent: 21 November 2018 12:02
To: McVeigh, Shauna
Subject: FW: radiology presence?

Hi Shauna,

Just to keep you informed – please see response from our radiologist below

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: Personal Information redacted by the USI
Email : Personal Information redacted by the USI

From: Grey, Arthur
Sent: 21 November 2018 11:22
To: Vallely, Stephen Personal Information redacted by the USI >; Evans, Angelae Personal Information redacted by the USI >
Cc: Mitchell, Darren Personal Information redacted by the USI >; OKane, Hugh Personal Information redacted by the USI >; Lee, Davinia < Personal Information redacted by the USI
Subject: RE: radiology presence?

Hi all,

I have not reviewed these cases.

I would be happy to display the cases and read out the reports.

This whole situation is dangerous and unsatisfactory.

This issue has been raised numerous times before.

It is up to the clinical director to assign a radiologist to cover Marc Williams. This may involve having to outsource clinical work or to allocate as WLI to accommodate this.

An mdm cannot function without a radiologist.

Given the number of patients on the lists and the debacle of the SRMs, we cannot offer a review service for them.

Art

From: Vallely, Stephen
Sent: 21 November 2018 10:47
To: Evans, Angelae [redacted]; Grey, Arthur [redacted]
Cc: Mitchell, Darren [redacted]; OKane, Hugh [redacted]
Subject: RE: radiology presence?

No but this means there will be no radiology review of the significant number of CAH cases which is not really satisfactory from anyones point of view. Did they give a reason why they could not provide a radiologist?

S

From: Evans, Angelae
Sent: 21 November 2018 10:46
To: Vallely, Stephen [redacted]; Grey, Arthur [redacted]
Cc: Mitchell, Darren [redacted]; OKane, Hugh [redacted]
Subject: FW: radiology presence?

Hi both,

See reply below

Will Hugh's patient need to wait until next week?

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: [redacted]
Email : [redacted]

From: McVeigh, Shauna [mailto:[redacted]
Sent: 21 November 2018 10:26
To: Evans, Angelae
Subject: RE: radiology presence?

Hi Angela

Unfortunately we don't have radiology this week.

Thanks
Shauna

From: Evans, Angelae [mailto: Personal Information redacted by the USI
Sent: 21 November 2018 10:03
To: McVeigh, Shauna
Cc: Vallely, Stephen; Grey, Arthur
Subject: radiology presence?
Importance: High

Hi Shauna,

Can you check re: below?

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: Personal Information redacted by the USI
Email : Personal Information redacted by the USI

From: Vallely, Stephen
Sent: 21 November 2018 10:02
To: Mitchell, Darren; Evans, Angelae; Grey, Arthur
Subject: RE: addition to MDM?
Importance: High

Angela

Please confirm that there will be a Southern trust radiologist available to present their cases this week as we will not have reviewed them due to volume of Belfast radiology cases

Thanks

Stephen

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any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you receive this in error, please contact the sender and delete the material from any computer.

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Southern Health & Social Care Trust IT Department Personal Information redacted by the USI
