John O'Donoghue
Consultant Urologist
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

7 June 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

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

Chair's Notice

[No 62 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:

John O'Donoghue
Consultant Urologist
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 18th July 2022.**

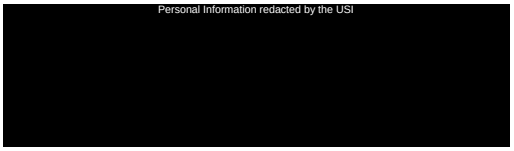
APPLICATION TO VARY OR REVOKE THE NOTICE

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 11th 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 6th June 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE

[No 62 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. For the purposes of your tenure, 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*?

10. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits and guidelines, etc., within it) impact or inform your role generally as a Consultant urologist? 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?

11. What, if any, performance indicators were used within the Urology unit during your tenure? If there were changes in performance indicators throughout your time there, please explain.

12. Do you think the Urology services generally were adequately staffed and properly resourced 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?

13. 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?

14. 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.

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

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

17. 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.

18. Did 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?

19. Did all Consultants have access to the same administrative support? If not, why not?

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

21. 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.

22. 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?

23. 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? Did 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.

24. What was 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?

25. What was 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).

26. 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?

27. 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.

28. 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.

29. 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.

30. 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

31. 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.

Governance

32. 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?

33. 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?

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

35. 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?

36. 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?

37. How could issues of concern relating to Urology Services be brought to your attention 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. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

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

39. How did you ensure that you were appraised of any concerns generally within or relating to Urology Services?

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

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

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

43. 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.

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

45. 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.

46. 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

47. 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.

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

49. Did you ever have cause for concern, or were concerns ever reported to you 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 if concerns 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.

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

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

51. 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. (Q64 will ask about any support provided to Mr. O'Brien).

52. 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

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. 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.

54. 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?

55. As relevant, 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.

56. If applicable, 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.

57. As Consultant urologist, 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, did you undertake, to assess potential impact? and
    (iv) What, if any, steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person?

58. 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.

59. What, if any, metrics were 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.

60. As relevant, how did you assure yourself 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? Against what standards were methods assessed? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

61. Did 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?

62. 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?

63. 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 would you expect those concerns to escalate through the chain of management?

64. What support was provided by you and 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.

65. 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

66. 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.

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

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

69. 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.

70. 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?

71. 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?

72. 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.

An addendum amending this statement was received by the Inquiry on 5 October 2023 and can be found at WIT-103266 to WIT-103269. Annotated by the Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No. 62 of 2022

Date of Notice: 7th June 2022

Witness Statement of: JOHN P. O'DONOGHUE

I, John P. O'Donoghue, 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 started as a Consultant Urologist in Craigavon Area Hospital on 4th August 2014. My role included inpatient and outpatient treatment, on call duties, teaching and supervision of junior doctors and administration associated with the position.

1.2 The first time I became aware of issues of concern was during Mr O'Brien's sick leave in mid-November 2016. Miss Martina Corrigan, Head of Service for Urology informed the consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) during our weekly departmental meeting that a lot of referral letters for triage had been found in Mr O'Brien's office. They had been found in a filing cabinet and had never been triaged. On his return to work in mid-2017, measures were put in place to enable him to do his triage in a more timely way. Most of the referrals for triage (except those from A + E) went online, He was given the Friday after on call off

to triage and the timeliness of his triage was looked at regularly by Miss Martina Corrigan, Head of Service. I had no involvement in monitoring the timeliness of his triage.

1.3 The failure of Mr O'Brien to triage the referrals for the above-mentioned group of patients was taken as a serious clinical issue. All four substantive consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) triaged the patients as quickly as possible and organised appropriate investigations and clinic appointments. I was not aware of any other clinical issues relating to Mr O'Brien's practice whilst he was working in the Southern Health and Social Care Trust (SHSCT). No person came to me expressing any concerns about Mr O'Brien's practice before he retired.

1.4 I submitted an IR1 on 03/10/2019 ***(relevant document located at S21 62 of 2022 Attachments 1. Datix 03102019)*** when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. The patient was seen in outpatients by Mr Haynes on the 7th October 2019. A plan was made for a nephrectomy and this was carried out in Belfast City Hospital on 9th January 2020. The patient concerned has no evidence of metastatic disease and his last urological review was on 5th April 2022 where he remained well. The datix is still under review in the Trust at present.

1.5 In relation to clinical governance issues, I understood that as a department, we were engaging with all seven pillars of Clinical Governance (Clinical Effectiveness, Risk Management, Audit, Staff Management, Education & Training, Information and Patient/Public Involvement Appraisals were kept up to date and there were no concerns in relation to my practice. I was aware of the Key Performance Indicators (KPI) presented to us at the departmental meeting every month and engaged with efforts to reduce waiting lists and improve performance ***(relevant documents located at S21 62 of 2022 Attachments 2. August 22 Urology Performance, 3. Urology Performance May 2015, 4. Review Backlog 2015).*** KPI included cancer wait times (31 and 62 day targets), red flag/urgent, routine wait times for inpatient, outpatients and day surgery). I engaged fully with the patient safety meeting (Combined and Speciality Specific). I kept up to date with all my patients' results, dictated letters and

signed off results on NIECR. All patient encounters had dictated letters. My relationship with the multidisciplinary team was excellent and this enabled everyone to contribute to efficient and effective patient care.

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 Documents related to the Inquiry can be located at S21 62 of 2022 Attachments:

1. ***Datix 03/10/2019***
2. ***August 22 Urology Performance***
3. ***Urology Performance May 2015***
4. ***Review backlog 2015***
5. ***Appraisal 2017 (Mr M Young)***
6. ***Appraisal 2018 (Mr M Young)***
7. ***Job Description for Consultant Urological Surgeon October 2013***
8. ***Vision for Urology Services 2015***
9. ***Vision for Urology Services 2015 (2)***
10. ***Urology Department PSM 20022019***

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative

and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

3.1 All other questions are answered separately to question 1

Your Position (s) within SHSCT

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

4.1 **Qualifications**

a) MSc in Biochemistry University College Cork 1990
b) MB BCh BAO University College Cork 1993
c) FRCSI 1997
d) Intercollegiate Speciality Examination in Urology FRCSI (Urol) 2012
e) Fellowship of the European Board of Urology FEBU 2012
f) Certificate of Completion of Training (CCT) in Urology 04/10/2013

4.2 **Occupational History**

a) July 1993 – June 1994 Cork University Hospital Intern / Medicine & Surgery
b) July 1994 – June 1997 Basic Surgical Training University Hospital Galway
c) October 1997 – February 1999 West Midlands UK Diagnostic Radiology Rotation
d) February 1999 – February 2000 Senior SHO Urology James Cook University Hospital, Middlesbrough
e) February 2000 – November 2002 Premier SHO Urology, Sunderland Royal Hospital

f) October 2002 – October 2003 Registrar in Urology, Churchill Hospital, Oxford
g) October 2003 – February 2007 Research Fellow in Urology, Department of Pharmacology, University of Oxford
h) March 2007 – September 2012 Oxford Urology Specialist Registrar Training Program
i) October 2012 – March 2013 BAUS Fellowship in Female and Functional Urology, Leicester General Hospital
j) April 2013 – August 2013 Specialist Registrar in Urology, Royal Berkshire Hospital, Reading
k) August 2013 – July 2014 Locum Consultant Urological Surgeon, Watford General Hospital/St Albans Hospital/Hemel Hempstead Hospital

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 am a Consultant Urological Surgeon in the Southern Health & Social Care Trust since 4th August 2014.

5.2 My duties and responsibilities include inpatient and outpatient care, 1: 7 on call for Urological emergencies, administrative duties, audit/research and teaching/supervision of undergraduate/ postgraduates doctors. Since 2015, I have been on the rota to chair the Uro-Oncology MDM. I have been Chair of the Patient Safety Meeting since October 2021. I have been Educational/Clinical Supervisor to Foundation Doctors since 2017. I have also been a clinical supervisor to Specialist Registrars in Urology since I began in the Trust in 2014.

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 Martina Corrigan was the Head of Service for ENT/Urology, Ophthalmology and Outpatients until the last few years when Wendy Clayton became acting head in October 2020. The day to day running of the department was co-ordinated by the head of service and the clinical director, Mr Michael Young, Consultant Urologist. I reported day to day operational issues to Martina Corrigan. This included issues in relation to outpatient clinics, inpatient issues, theatre problems and issues in relation to Key Performance Indicators (KPI). I reported to Mr Michael Young if I needed to change my on-call rota or if I had difficulties covering a clinic or theatre list.

6.2 I reported to the Head of Foundation Training in Craigavon Area Hospital if there were any issues concerning foundation doctors. The Training Program Director in charge of training for Urology Specialist Registrars was Miss Siobhan Woolsey, Consultant Urologist and in the last few years, Mr AJ Glackin, Consultant Urologist.

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 My role and responsibility with specific reference to the operation and governance of Urology Services was that of a Consultant Urologist with clinical and administrative duties. I acted as a clinical/educational supervisor to foundation doctors and specialist registrars in urology. Management in the department included a clinical lead, Mr Michael Young, Consultant Urologist and a Head of Service, Mrs Martina Corrigan. Weekly departmental meetings were held to discuss management issues. A weekly Uro-oncology MDM was held to discuss the management of patients with urological cancers. Patients with benign conditions needing reconstructive surgery were discussed at a Regional Urology Reconstructive Meeting in Lagan Valley Hospital monthly. Attendees included Mr John O'Donoghue, Mr Aidan O'Brien, Miss

Siobhan Woolsey, Mr Alex McCleod and Mr Brian Duggan. I attended a urogynaecology MDM monthly to discuss patients with urinary incontinence issues. Attendance included J O'Donoghue, Consultant Urologist, Edgar Boggs, Consultant Gynaecologist, Geoff McCracken, Consultant Gynaecologist, Richard de Courcey Wheeler, Consultant Gynaecolgist, Anitha Chinnadurai, Consultant Gynaecologist, Katherine Loane, Consultant Gynaecologist, Jenny McMahon, Urology Nurse Specialist, S Hasnain Urology Specialist Doctor, Katherine Niblock, Consultant Gynaecologist, Wendy McQuillan Continence Nurse, Sharon Ross, Continence Nurse, Anne Marie Anderson and Michelle Kearney, Pelvic Floor Physiotherapists.

7.2 A monthly patient safety meeting, either urology specific or combined surgical directorate was held to discuss clinical cases of concern/ deaths. Learning points were noted. Audits/studies were presented. Directives from various NHS sources were noted ***(relevant document located at S21 62 of 2022 Attachments 10. Urology Department PSM 20022019).***

Lines of management

7.3 Clinical care: Head of Service and clinical lead

a) Miss Martina Corrigan – Head of Service
b) Mr Michael Young – Clinical Lead

7.4 Administration: Head of Service

a) Miss Martina Corrigan

7.5 Lead for Patient Safety:

a) Mr AJ Glackin

7.6 Governance: Head of Service and Clinical Lead

a) Head of Service: Miss Martina Corrigan
b) Clinical Lead: Mr Michael Young

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 My role was to provide safe, appropriate and efficient urological care to the patients that I was looking after. As a urology team, we developed services to improve efficiency and care. My roles overlapped with that of the Clinical Lead (Mr M Young) in that we were both Consultant Urologists striving to provide an excellent and efficient service for our patients. In terms of overlap with the Head of Service, we were both concerned with the efficient running of the Urology Department. She made me aware of the KPI targets so that my patients were treated in a timely manner. We were both involved in modernising the department ***(relevant document can be located at S21 62 of 2022 Attachments 8. Vision for Urology Services 2015).*** The Clinical Director, Medical Director and Associate Medical Directors were all concerned with the safe, efficient and effective running of the department which was our common aim.

8.2 My role differed from the Head of Service, Clinical Director and Medical Director in that I am a practicing urologist with direct clinical contact with urology patients. They would have had more managerial responsibility. As both the incumbents of the Clinical Lead and Associate Medical Director positions were urologists, we had similar clinical roles but again, they would have had more managerial responsibility.

Urology Services

9. For the purposes of your tenure, 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*?

9.1 During my time working in Urology Services, I was not provided with the *Integrated elective Access Protocol* and its contents were not made known to me by the SHSCT.

9.2 When I applied for the consultant position, I was provided with a job description ***(relevant document located at S.21 62 of 2022 Attachments 7. Job Description for Consultant Urological Surgeon October 2013).*** This document outlined my roles and responsibilities. I engaged fully with all staff to treat patients effectively and fairly in terms of clinical need and length of time on waiting list.

9.3 Please also see my answer to Question 10.

10. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits and guidelines, etc., within it) impact or inform your role generally as a Consultant urologist? 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?

10.1 Whilst I was not aware of the *'Integrated Elective Access Protocol',* my practice was informed by the time limits and the latest urological guidelines (European

Association of Urology Guidelines, NICaN Guidelines, BAUS Guidelines and NICE Guidelines).

10.2 I was aware of the Department of Health Cancer targets as set out in the IEAP (31 and 62 day target) and the targets for outpatients (9 weeks) and inpatient/day case targets of 13 weeks. We were made aware if we were achieving these targets at our monthly departmental meetings by the Head of Service. If patient waiting times were breeching the KPI targets, corrective action was initiated. With regard to red flag patients who could not have their surgery under the named consultant, other consultants with extra availability in theatre completed the cases. If red flag waiting times for clinic were breeching targets, they were seen by the next available consultant (***relevant document located at S.21 62 of 2022 Attachments 2. August 22 urology Performance, 3. Urology Performance 2015, 4. review Backlog 2015***).

11. What, if any, performance indicators were used within the Urology unit during your tenure? If there were changes in performance indicators throughout your time there, please explain.

11.1 Key Performance Indicators (KPI) included cancer waiting times (31 and 62 day targets), red flag, urgent and routines waiting times for outpatient, inpatients and day surgery cases. There were no change to the KPI during my tenure.

12. Do you think the Urology services generally were adequately staffed and properly resourced 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?

12.1 The Urology Department always had difficulty recruiting doctors, both junior doctors and consultants despite actively recruiting on many occasions. Consultant positions were filled by several locum doctors (see question 13). On occasions, urologist of the week (UOW) shifts were covered by the substantive consultants in a locum capacity. This had an impact on clinical activity as clinical sessions were cancelled for the consultant doing the locum on call. Junior doctor positions proved

difficult to fill due to lack of interest/inadequately experienced doctors. This particularly impacted during on call and on occasions, the consultant had no junior support. The Trust was supportive and did all in its power to assist by going out to locum agencies to look for junior support.

13. 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?

13.1 The following locum consultants covered vacant consultant positions over the last few years.

a) Mr David Hickey 2016
b) Mr Zeeshan Aslam January 2016 for 6 months
c) Mr Derek Hennessy August 2018 – April 2019
d) Personal information redacted by USI January 2017 – December 2018
e) Mr Shawgi Omer 21/09/2020 – 30/06/2021 (backfill for Aidan O'Brien)
f) Saifeldin Elamin 19/07/2021 – 02/08/2021 (covered backlog clinics)
g) Shawgi Omer 16/08/2021 – 30/10/2021 (backfill for Aidan O'Brien)
h) Nasir Khan 02/11/2021 – to the present (backfill for Consultant 7)

13.2 The Trust did its best to fill these positions so to continue patient care and enable the service to run effectively. The locum doctors worked hard and provided a good service. With several locum consultants passing through the department over the years, it was difficult to provide continuity of care.

13.3 Staffing problems made it difficult to provide an elective clinical service. If one of the substantive consultants had to cover locum UOW, his elective clinical activity was cancelled. This impacted on the waiting list. In my opinion, there was no risk to patient care as red flag patients were always treated first although it did cause a delay in treatment of urgent and routine patients. The delay in treatment would have posed

a risk to patients, eg ureteric stents were often left in longer than 3 months as it proved difficult to treat the patients sooner.

14. 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.

14.1 Staffing problems made it difficult to provide an elective clinical service. If one of the substantive consultants had to cover as a locum UOW (Urologist of the week), his elective clinical activity was cancelled. This impacted on the waiting list and resulted in a clinical risk to patients, particularly those with urgent/routine problems as they had to wait significantly longer for treatment.

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

15.1 As mentioned in the previous question, several locum doctors passed through the Urology Department during my tenure (see question 13). This occurred after Mr Ram Suresh, Consultant Urological Surgeon left the Trust on 27/10/2016 to take up a post in [redacted]. The locum positions were filled for varying lengths of time, mostly due to the fact that the locum doctors moved to different positions in other hospitals.

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

16.1 My role did not change during my tenure.

17. 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.

17.1 All consultants have a secretary (my secretary now is Mrs Nicola Robinson) who provides indispensable administration support. As well as typing, they direct patient queries to the appropriate person, help keep waiting lists for theatre updated, ensure that GP queries are answered and generally provide a supportive role to the consultant.

17.2 They ensure that MDM patients are booked into clinic, help organise theatre lists and ensure that results are acted on. I find it is important to have good communication channels with the secretaries to ensure an effective service. My secretary from 4th August 2014 to May 2015 was Mr Eoin Daly. Since then, it has been Mrs. Nicola Robinson, The cancer coordinator and Uro-oncology MDM administration staff help to ensure that cancer patients are investigated and treated in a timely manner.

18. Did 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?

18.1 Secretaries are assigned to a consultant but there is a lot of co-operation and interaction between secretaries. Administration workload is monitored by the Service Administrator Orla Poland with monthly updates on typing backlog. My understanding is that the cancer trackers work with all the consultants rather than one person in particular.

19. Did all Consultants have access to the same administrative support? If not, why not?

19.1 I assumed we all had the same administrative support; it is not something I ever checked up on.

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

20.1 I have never sought further administrative assistance.

21. 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.

21.1 Administrative staff never raised concerns with me.

22. 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?

22.1 During my entire time in Craigavon Area Hospital, I have felt well supported by nursing and ancillary staff in the department. I have had a great relationship with the nursing and auxiliary staff. We have worked as a team for the benefit of patients. Their role was complementary, assisting me at procedures, some performing procedures independently, and running urology outpatient and inpatient wards. The nursing and auxiliary staff complement did not concern me that there was a risk to patient safety.

23. 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? Did 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.

23.1 Specialist cancer nurses provide skilled personalised care, improving the experience of both cancer patients and the multidisciplinary colleagues they work with. In my practice, they work very closely with me ensuring the patients' clinical journey occurs in a timely fashion and provide holistic care to the patients.

23.2 Urology specialist nurses are experienced trained nurses and are instrumental in reducing unnecessary hospital admissions and readmissions, reducing waiting times, freeing up a consultant's time to treat other patients and most importantly, being available to help, educate and reassure patients on how best to manage their health conditions. They are responsible for a number of outpatient clinics and have additional skills such as performing urodynamics, performing prostate biopsies and carrying out flexible cystoscopies

23.3 Specialist nurses work independently but again in my practice, work very closely with me to provide the best care possible for patients. I have respected and valued their contribution. Communication was excellent on both sides and we communicated effectively and efficiently every day for the benefit of patients. Specialist cancer nurses and urology specialist nurses are roles held usually by different people.

24. What was 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?

24.1 The working relationship between nursing and medical staff in my opinion was excellent and I certainly had no concerns.

25. What was 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).

25.1 With regards to relationships between Urology Consultants and administrative staff, I can only speak for myself. My relationship was excellent and I was available at all times to support and answer queries. It seemed that the relationships of my colleagues and the administration staff was also good.

26. 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?

26.1 I ensured that all patients who attended clinic, all theatre patients and clinical results had dictated letters. All results on NIECR were signed off. Cancer patients were discussed at the uro-oncology MDM and its decision was acted on. Kidney stone patients were discussed at the stone MDM and patients needing reconstruction for benign conditions were discussed at the Regional Reconstruction Meeting. Patients with urinary incontinence issues were discussed at a monthly Uro-gynaecology meeting. The Patient Safety Meeting was held monthly and discussed morbidity/mortality/SAIs/audits/complaints and department of Health Directives. I was satisfied that the seven pillars of Clinical Governance (clinical effectiveness, audit, education & training, staff management, information, patient & public involvement, risk management) were being used to monitor and maintain high standards.

27. 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.

27.1 The day to day running of the urology unit had a Head of Service and this was Martina Corrigan and more latterly Wendy Clayton from October 2020. They

were in charge of the day to day running of the unit. They were answerable to Ronan Carroll. Mr Michael Young, Consultant Urologist was clinical lead. He was answerable to the Clinical Director and Assistant Medical Director.

28. 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.

28.1 Medical and non-medical managers worked well in urology to run the department effectively and plan for the future. Communication was good and opinions were respected and encouraged.

28.2 In late 2014/ 2015, a plan was developed and brought to fruition to modernise the urology department. Both medical and non-medical mangers worked well to make this happen. Developments included an electronic referral system for GPs, an online platform for GPs to ask questions on clinical cases and the development of a Urology one-stop clinic ***(relevant documents can be located at S21 62 of 2022 Attachments 8. Vision for Urology Services 2015 and 9. Vision for Urology services 2015 (2)).***

29. 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.

29.1 Every year I had an appraisal and every 5 years a revalidation. My appraisals are up to date and copies are provided with names of the appraisers. All appraisals from 2014 to 2021 are included.

29.2 I did not have a formal performance review. As part of my appraisal, a personal development plan (PDP) from the previous year was discussed and assessed to see if all goals were achieved. A new PDP for the following year was devised.

30. 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.

30.1 I was not involved in the formal appraisal of Consultants. I was an educational/clinical supervisor for urology registrars and had no difficulties/issues doing these. I was also an educational/clinical supervisor for foundation doctors and again had no problems or difficulties. These assessments of junior doctors were not appraisals.

Engagement with Urology staff

31. 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.

31.1 Every month, the personnel of the department met to plan clinical activity for the following month. Attendance included head of service, consultant urologists, junior doctors, nurses and administrative staff. Weekly, the head of service and consultant urologists met to discuss issues effecting the department and plans for service improvement. Patient safety meetings occurred monthly and involved the urology department solely or the surgical directorate. A weekly uro-oncology meeting was held involving all staff treating patients with urological cancers to discuss diagnosis and management of patients. Patients with benign conditions needing reconstructive surgery were discussed at a Regional Urology Reconstructive Meeting in Lagan Valley Hospital monthly. Attendees included Mr John O'Donoghue, Mr Aidan O'Brien, Miss Siobhan Woolsey, Mr Alex McCleod and Mr Brian Duggan. A monthly uro-gynaecology meeting was held to discuss patients with urinary incontinence issues. Attendees include J O'Donoghue, Consultant Urologist, Edgar Boggs, Consultant Gynaecologist, Geoff McCracken, Consultant Gynaecologist, Richard de Courcey Wheeler, Consultant Gynaecolgist, Anitha Chinnadurai, Consultant Gynaecologist, Katherine Loane, Consultant Gynaecologist, Jenny McMahon, Urology Nurse Specialist, S Hasnain Urology Specialist Doctor, Katherine Niblock, Consultant Gynaecologist, Wendy McQuillan

Continence Nurse, Sharon Ross, Continence Nurse, Anne Marie Anderson and Michelle Kearney, Physiotherapists.

Governance

32. 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?

32.1 During my tenure, overseeing the quality of services in urology was within the remit of the Consultant Urologists and Head of Service (Martina Corrigan until October 2020 when Wendy Clayton took over). The Head of Service in turn was answerable to the Assistant Director of Acute Services, Anaesthetics & Surgery (Mr Ronan Carroll). Key Performance Indicators (KPI) including 62 and 31 day targets and waiting list targets (red flag, urgent and routine) were discussed at monthly departmental meetings.

33. 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?

33.1 Those overseeing clinical governance were the Clinical Director Mr T McNaboe, the Associate Medical Directors Mr Mark Haynes and Mr Ted McNaboe and the Clinical Lead Mr Michael Young. I assured myself that clinical governance was done properly by engaging fully with the pillars of clinical governance. In particular, active participation in the PSM, participation in MDMs (uro-oncology, stone meeting, benign reconstruction meeting and uro-gynaecology meeting). I attended educational meetings and training courses ***(relevant documents can be located at S21 62 of 2022 Attachments 5. Appraisal 2018 (Mr M Young))*** and engaged in audit. I was provided with KPI (Key Performance Indicators) at the monthly departmental meetings as an indicator of the quality of urology services.

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

34.1 I engaged fully with Performance Metrics which was overseen by the Head of Service and the information was relayed to the consultants at the monthly departmental meeting. KPI included 62 and 31 day targets and waiting list targets (red flag, urgent and routine). I engaged and used this information to improve my practice. In conjunction with the Head of Service and the other urologists, if patients were not reaching their targets, they were given earlier dates for theatre/clinic with one of the other consultant urologists.

35. 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?

35.1 It seemed to me that everyone was engaging with the PSM, attending the uro-oncology MDM and from what I understood, having yearly appraisals. I felt reassured that safe systems were in place to protect patients. Personally, I signed patients' results off on-line and acted immediately if I identified an abnormal result. My secretary sent me hard copies of the results and checked to make sure everything was signed off. I attended the uro-oncology PSM, stone meeting, urogynaecology MDM and reconstruction meeting to discuss relevant patient care.

I undertook annual appraisal and these are included in the list of documents.

36. 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?

36.1 All urology consultants participated in the PSM and the multidisciplinary meetings (Uro-oncology, urogynaecology, kidney stone and complex reconstruction). I felt satisfied that patients were receiving multi-disciplinary expert care. Online systems were put in place for triage and to sign off results. As I was having yearly appraisals, I assumed my colleagues were also been appraised.

36.2 I have worked in many hospitals in England and the Governance systems were similar. I had no concerns and felt confident that if issues of concern arose, they would be identified and dealt with immediately.

37. How could issues of concern relating to Urology Services be brought to your attention 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. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37.1 If patients had any concerns, they could write directly regarding those concerns or contact the Patient Advice and Liaison Services (PALS). I am approachable and my door was open for staff to come and talk to me about issues they were not happy about. The Patient Safety Meeting (PSM) was a forum for discussion for issues regarding concerns of medical management. Concerns can initially be discussed with either the Head of Service or the Clinical Lead. The efficiency of the system is dependant on someone reporting the issue through one of the systems mentioned. If that doesn't happen, the concern may not be dealt with.

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

38.1 To the best of my knowledge, the systems did not change during my tenure.

39. How did you ensure that you were appraised of any concerns generally within or relating to Urology Services?

39.1 I attended the weekly departmental meeting and that is where I first became aware of the issue with regard to the failure of Mr O'Brien to triage referrals in early January 2017. The multi-disciplinary meetings, in particular, the uro-oncology meeting is a forum where patient concerns can be highlighted. I am always approachable/available if someone wished to speak to me on a private basis although this did not happen.

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

40.1 The only issue I raised was an SAI from the Uro-Oncology Meeting in 2019. I submitted an IR1 on 03/10/2019 when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. It is documented on an IR2 form ***(relevant document can be located at S21 62 of 2022 Attachments 1. Datix 03102019)***. This is an ongoing investigation.

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

41.1 The head of Service identified KPI including 62 and 31 day cancer targets and waiting list targets (red flag, urgent and routine). Mortality is collected through the Clinical Governance Department and patient deaths and morbidity are discussed at the monthly patient safety meeting (PSM). Cancer trackers ensure that patients with cancer pass through the uro-oncology MDM in a timely manner. Issues with MDM patients are often only picked up when patients are discussed again at the MDM and this can be several months down the line from the original discussion.

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

42.1 KPI are accurate and discussed monthly allowing remedial action to be taken if necessary. In relation to the issue regarding the uro-oncology MDM, this is a much slower system to react and can potentially take weeks before issues are identified.

42.2 Patient mortality is picked up by the Clinical Governance Department from death certificates and put forward for discussion at the PSM. This is done on a monthly basis. The systems did not change during my tenure.

43. 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.

43.1 Performance objectives are set for consultants in the PDP section of their yearly appraisals. My performance objectives included developing the Greenlight laser service and developing a supervisory role for junior doctors ***(relevant document can be located at S21 62 of 2022 Attachments 6. Appraisal 2017 (Mr M Young))***.

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

44.1 I can only speak from my perspective. I had an appraisal every year and a revalidation in my 5th year as a consultant. I found it immensely useful in that it allowed me to reflect on past performance and plan for the future. I used my appraisal as a way of improving my performance. Job planning occurred yearly and encouraged discussion on planning weekly/monthly job activities.

45. 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.

45.1 Governance concerns impacting on patient care and safety initially can be recorded in the Trust using an IR1 form. This is investigated and reviewed at a level appropriate and proportionate to the complexity of the incident under review. The review team chosen is appropriate for investigation of the SAI. When the review is complete, it is discussed at the PSM (chaired by Mr Glackin) to identify learning outcomes.

46. 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.

46.1 I always felt supported by line management and the hierarchy. We worked together with common objectives as a team providing the best care possible for patients. In 2015 when we set about modernising the Urology Department, Miss Martina Corrigan and the consultant medical staff (M Young, R Suresh, JO'Donoghue, A O'Brien M Hayes and AJ Glackin) worked effectively and efficiently to provide a one stop outpatient department ***(relevant document can be located at S21 62 of 2022 Attachments 8. Vision for Urology Services 2015).***

Concerns regarding the Urology unit

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

(i) The Chief Executive(s); Shane Devlin and now Dr Maria O'Kane

(ii) (ii) the Medical Director(s); - Dr Maria O'Kane and new MD just started

(iii) The Director(s) of Acute Services; Melanie McClements, now Interim Trudy Reid

(iv) The Assistant Director(s); Ronan Carroll

(v) The Associate Medical Director; Mark Haynes and Ted McNaboe

(vi) The Clinical Director; Ted McNaboe, now vacant

(vii) The Clinical Lead; Michael Young, now vacant

(viii) The Head of Service; Martina Corrigan and now Wendy Clayton from Oct 2020

47.1 I never had any dealing with Chief Executive. The Medical Director (Dr Maria Kane), Director of Acute Services Melanie McClements, The Assistant Director Ronan Carroll, Miss Martina Corrigan former Head of Service and Miss Wendy Clayton Head

of Service met the Consultant Urologists on Zoom in late 2021 and early 2022 to provide support for the Urology Services Inquiry.

47.2 I worked with Mr Michael Young as a Urology Colleague and both Mr Michael Young and Miss Martina Corrigan attended the PSM and weekly departmental meetings where governance issues were discussed.

47.3 The issues with regards to Mr O'Brien's failure to triage were first discussed at the weekly urology departmental meeting with the head of service and consultants in early January 2017. Attendees included Miss Martina Corrigan, Mr J O'Donoghue, Mr M Young, Mr AJ Glackin and Mr Mark Haynes.

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

48.1 Concerns were never raised regarding my clinical practice.

49. Did you ever have cause for concern, or were concerns ever reported to you 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 if concerns 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.

49.1 The only issue I raised was a SAI from the Uro-Oncology Meeting in 2019. I submitted an IR1 on 03/10/2019 when I was chairing the Uro-oncology MDM. This was in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice 27/06/2019. He was seen in clinic the following week and arrangements were made for him to have surgery in the next few months. He had a nephrectomy in early January 2020. His latest review in relation to this was in early 2022 and he has suffered no consequences as a result of the delay up to now. The investigation with regard to the circumstances of the delay is ongoing.

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

(a) Properly identified,

(b) Their extent and impact assessed properly, and

(c) The potential risk to patients properly considered?

50.1 As mentioned previously, I submitted an IR1 in my capacity as chairman of the uro-oncology MDM on 03/10/2019.This failure on the part of Mr O'Brien to book a kidney biopsy was correctly identified and the patient went on to have a nephrectomy. He suffered no adverse consequences due to this short delay in having the biopsy. The IR1 is being investigated.

50.2 I had a good working relationship with Mr O'Brien and respected him as a senior colleague. The reason for submitting the IR1 was in my capacity as chair of the MDM and the failure of Mr O'Brien to carry out a previous recommendation from the MDM, It was not personal and my submitting an IR1 did not affect our relationship.

51. 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. (Q64 will ask about any support provided to Mr. O'Brien).

51.1 The Trust offered support to all staff in the Urology Department if needed. Senior management including the chief executive held regular meetings at the end of 2021 and the first few months of 2022 to provide support and this was very much appreciated (see question 47 for further information).

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

52.1 In 2015, the department set about modernising services, in particular, a one stop clinic in outpatients. Other initiatives included an online platform for GPs to ask clinical questions regarding their patients and the development of a Kidney Stone MDT. Management were totally supportive of this initiative and provided all the help needed.

Mr O'Brien

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. 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.

53.1 I was first aware of concerns about Mr O'Brien whilst he had been on sick leave.

53.2 Mr O'Brien went on sick leave in mid-November 2016 and we as a consultant body were informed at our weekly meeting with regard to the triage issues in early January 2017. Attendance at this meeting included Miss Martina Corrigan, MR J O'Donoghue, Mr Mark Haynes, Mr Michael Young and Mr AJ Glackin.

53.3 My understanding was that triage letters which had not been triaged were found in a filing cabinet in his office. I was not aware of the reasons why his office was searched and was not aware over what period this triage covered. I was involved in triaging the letters for the Trust.

53.4 I also raised an IR1 as chairman of the uro-oncology MDM in October 2019. See question 54.

54. 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?

54.1 The only time I raised concern in relation to Mr O'Brien was on one occasion when I was chairman of the Uro-Oncology MDM. I submitted an IR1 in my capacity as chairman of the uro-oncology MDM on 03/10/2019.This failure on the part of Mr O'Brien to book a kidney biopsy was correctly identified and the patient went on to have a nephrectomy. He suffered no adverse consequences due to this short delay in having the biopsy. The IR1 is being investigated.

55. As relevant, 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.

55.1 Apart from the IR1 mentioned in question 54, I was informed at a departmental meeting during Mr O'Brien's sick leave about un-triaged letters found in a filing cabinet in his office. These were triaged by the consultants in the department. On Mr O'Brien's return to work, he was offered support to enable him to do his triage in a more timely way.

56. If applicable, 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.

56.1 As mentioned in question 55, the letters were triaged by the consultants and Mr O'Brien was offered support to triage on his return to work. This was organised and supervised by Miss Martina Corrigan. An IR1 (see my answer to question 54) was submitted from the uro-oncology MDM 03/10/2019. The patient was seen in clinic the following week and since then had a nephrectomy. He has not come to harm.

57. As Consultant urologist, 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, did you undertake, to assess potential impact? and

(iv) What, if any, steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person?

57.1 I raised an IR1 after the MDM 03/10/2019. Mr O'Brien had not referred a patient for a kidney biopsy after the MDM 27/06/2019. The following week the patient was seen in clinic and referred for a nephrectomy which he had in January 2020. . He has not come to harm.

57.2 I became aware of issues of concern during Mr O'Brien's sick leave in mid-November 2016. Miss Martina Corrigan, Head of Service for Urology informed the consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) during our weekly departmental meeting that a lot of referral letters for triage had been found in Mr O'Brien's office. They had been found in a filing cabinet and had never been triaged. On his return to work in mid-2017, measures were put in place to enable him to do his triage in a more timely way. Most of the referrals for triage (except those from A + E) went online, He was given the Friday after on call off to triage the referrals and the timeliness of his triage was looked at regularly by Miss Martina Corrigan, Head of Service. I had no involvement in monitoring the timeliness of his triage.

57.3 The failure of Mr O'Brien to triage the referrals for the above-mentioned group of patients was taken as a serious clinical issue. All four substantive consultants (Mr John O'Donoghue, Mr Michael Young, Mr AJ Glackin, Mr Mark Haynes) triaged the patients as quickly as possible and organised appropriate investigations and clinic appointments.

58. 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.

58.1 As mentioned in question 55, the letters were triaged by the consultants and Mr O'Brien was offered support to triage on his return to work. An IR1 (see question 54) was submitted from the uro-oncology MDM 03/10/2019. The patient was seen in clinic the following week and since then had a nephrectomy. He has not come to harm.

59. What, if any, metrics were 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.

59.1 My understanding was that Mr O'Brien had no clinical duties on the Friday after a week on call. This allowed him to triage any remaining letters from the on call week. I understood the effectiveness of this system was monitored by the management team.

60. As relevant, how did you assure yourself 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? Against what standards were methods assessed? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

60.1 The triage system had mostly changed to an on line system (although not entirely) as hard copies were still coming from A + E. The on line system

was easy to use, patients details could not be erased and management were able to monitor how effective the triage was progressing. Mr O'Brien did not work on the Friday following on call and this enabled him to finish the triage.

61. Did 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?

61.1 I understood that the systems put in place in relation to triaging enabled Mr O'Brien to triage on time. I was aware that Miss Martina Corrigan was keeping an eye on Mr O'Brien's triaging and she was happy that it was getting done in a timely manner.

62. 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?

62.1 Mr O'Brien did not raise any concerns with me directly in relation to patient care and safety and clinical governance. I was aware of his difficulties triaging and the system put in place by the Trust to help him get it done in a timely manner.

63. 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 would you expect those concerns to escalate through the chain of management?

63.1 I was not aware of any concerns raised by Mr O'Brien or the Trust response if there were any.

64. What support was provided by you and 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.

64.1 The only issue that I was aware about concerned difficulty with triaging. The Trust managed this and wasn't something I had input into.

65. 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.

65.1 I did not have access to the Risk Register and have never seen it. I don't know if Mr O'Brien's concerns if there were any, are reflected in it. I also don't know if concerns raised by others are reflected in the register.

Learning

66. 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.

66.1 In my opinion, there were no issues of concern with urology per se. The issues of concern were with Mr O'Brien and his failure to carry out various tasks like triaging urology referrals and referral of patients from the uro-oncology MDM to other clinicians. His failure to perform these tasks were picked up and dealt with appropriately.

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

67.1 On the basis of the information presently available to me, I don't think anything went wrong with the Urology Service. In my experience, issues arising within the Service are dealt with effectively and efficiently. Miss Martina

Corrigan identified that a number of referrals had not been triaged by Mr O'Brien. The missing referrals were found in Mr O'Brien's office, triaged by the urology consultants (JODonoghue, AJ Glackin, M Haynes & M Young) and the patients needing urgent treatment seen in clinic quickly. Most of the referrals now for triage are on line so an issue like this is unlikely to occur again.

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

68.1 In my opinion, the main learning point is to make sure robust systems are in place to ensure all 7 pillars of clinical governance operate effectively. This would involve fully engaging with Clinical Effectiveness, Audit, Risk Management, Patient & Public Involvement, Staff Management, Information and Clinical Governance.

69. 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.

69.1 Yes, I think there was a failure to engage by Mr O'Brien with the Urology Service

69.2 Mr O'Brien failed to triage urology referrals and he failed to refer a patient from the uro-oncology MDM onto another clinician. With regard to his failure to triage, he should have let the Head of Service know that he was struggling to complete the triage. I am not sure if the failures to triage could have been picked up sooner as the referrals at the time were hard copies.

69.3 With regard to his failure to refer a patient for a biopsy from the uro-oncology MDM, he should have involved the cancer nurses to provide oversight that these referrals were done.

70. 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?

70.1 No I do not think mistakes were made by either me or others in handling the concerns identified. When concerns were identified (failure to triage referrals, failure to follow through on MDM recommendation), systems were put in place to protect the patients.

70.2 Triage was improved by going online, ensuring that referrals were not lost and completed in a timely fashion.

71. 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?

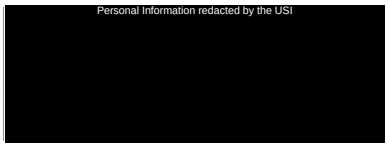
71.1 The clinical concerns with regards to Mr O'Brien were identified and appropriate action taken to protect the patients. As the systems in place addressed the problems, I felt reassured that they were working.

72. 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?

72.1 There is nothing else I would like to add as I feel I answered the questions as comprehensively as possible.

Statement of Truth

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

Signed: 

Date: 24/08/2022

Section 21 Notice Number 62 of 2022

Witness Statement: John O' Donoghue

Table of Attachments

Attachment	Document Name
1	datix 03/10/2019
2	August 22 Urology Performance
3	Urology Performance May 2015
4	Review Backlog 2015
5	Appraisal 2017 (Mr M Young)
6	Appraisal 2018 (Mr M Young)
7	Job Description for Consultant Urological Surgeon October 2013
8	Vision for Urology Services 2015
9	Vision for Urology Services 2015 (2)
10	Urology Department PSM 20/02/2019

Chris Wamsley

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by the USI
Submitted time (hh:mm)	16:25

Incident IR1 details

Notification email ID number	Personal Information redacted by the USI
Incident date (dd/MM/yyyy)	03/10/2019
Time (hh:mm)	15:00
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	This patient was discussed at Uro-Oncology MDM 3/10/2019 and it would appear outcomes from previous Uro-Oncology MDM (27/06/2019) have not been actioned.
Action taken Enter action taken at the time of the incident	Agreement by multi-disciplinary team at MDM (3/10/2019) that chair should request review of process that has led to this apparent delay. Patient will be seen in clinic next week to expedite process.
Learning Initial	To be determined
Reported (dd/MM/yyyy)	03/10/2019
Reporter's full name	john P. O'Donoghue
Reporter's SHSCT Email Address	Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	21/10/2019
Last updated	Carly Connolly 09/11/2020 15:35:08
Has safeguarding been considered?	
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 112

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient	Recipient E-mail	Date/Time	Contact	Telephone	Job title	Originated

Name			ID	Number		from
McAloran, Paula	Personal Information redacted by the USI	03/10/2019 16:26:30	Personal Information redacted by the USI		Senior Governance Officer	Level 1 Form
Cardwell, David	Personal Information redacted by the USI	03/10/2019 16:26:30		Personal Information redacted by the USI	Clinical Governance Manager	Level 1 Form
Kingsnorth, Patricia	Personal Information redacted by the USI	03/10/2019 16:26:30		Personal Information redacted by the USI	Risk Midwife	Level 1 Form
Connolly, Carly	Personal Information redacted by the USI	03/10/2019 16:26:30			Clinical Governance Manager	Level 1 Form
Burns, Sandra Mrs	Personal Information redacted by the USI	03/10/2019 16:26:30		Personal Informatio n	Clinical Governance Manager	Level 1 Form
Corrigan, Martina	Personal Information redacted by the USI	03/10/2019 16:26:29			Head of ENT and Urology	Level 1 Form
Carroll, Ronan MR	Personal Information redacted by the USI	03/10/2019 16:26:29		Personal Information redacted by the USI	Assistant Director of Acute Services	Level 1 Form
Young, Michael	Personal Information redacted by the USI	03/10/2019 16:26:29			Consultant	Level 1 Form
Haynes, Mark Mr	Personal Information redacted by the USI	03/10/2019 16:26:29			Consultant Urologist	Level 1 Form

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	
Date Notification Sent to External Agency	
Date Terms of Reference Due	
Date SAI Report Due	
SAI Level (1,2 or 3)	
External Agency SAI Ref No.	
Date SAI Report Sent to External Agency	
Date SAI Report Shared with Family/NOK	

Date HSCB/RQIA/Coroner Queries Received	

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	Treatment, procedure
Sub Category	Urinary
Detail	Delay

Datix CCS2

Type	Patient Incidents
Category	Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)
Sub-Category	Invasive Treatment Process/Procedures
Detail	Treatment/procedure delayed
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?
Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI? Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.	
Is this incident RIDDOR reportable? Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition): 1. Employee or self-employed person working on Trust premises is killed or suffers a major injury 2. A member of the public on Trust premises is killed or taken to hospital 3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not	

counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)

4. Dangerous Occurence attributable to the work of the Trust

5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

---

Is this a NIAIC Incident
NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;

- design or manufacturing problems

- inadequate servicing and maintenance

- inappropriate local modifications

- unsuitable storage and use conditions

- selection of the incorrect device for the purpose

- inappropriate management procedures

- poor user instructions or training (which may result in incorrect user practice

---

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm
This has been populated by the reporter. To be quality assured by the investigating manager.

Moderate

Risk grading
Click here

When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by

	Consequence				
Likelihood of recurrence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	○	○
Unlikely (Expected to	○	○	○	○	○

likelihood = risk grading. Refer to impact table here:						
	occur annually)					
	Rare (NOT expected to occur for years)	○	○	○	○	○
		Grade:				

Action taken on review
Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

Action Plan Required?
A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions

Lessons learned

Lessons learned
If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any person involved in the incident? No

Was any equipment involved in the incident? No

Notepad

Notes
Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information

Communication

Recipients

Message

Message history				
Date/Time	**Sender**	**Recipient**	**Body of Message**	**Attachments**
No messages				

Medication details

Stage
Prescriber Name
Medication error
Medication involved If multiple medications involved enter the primary medication affecting the incident, and record the others in the description
Correct medication
Form administered
Correct form
Dose and strength involved
Correct dose
Route involved
Correct route

Falls Information
Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or Community Setting?
Specific Location of Fall
Exact location of Fall Please describe in free-text exactly where the fall occurred
Injury Suspected?
Harm?
Buzzer / bell available within reach before fall?
Floor surface
Footwear suitable?
Walking aid in use / reach?
Mental State
First fall this admission or repeat?
Days since admission
Was the patient receiving medication which may affect the risk of falling?
Family informed of fall?
Outcome of Bedrails Assessment

Pressure Ulcers

Was this incident in respect of a Pressure Ulcer?

Equipment details

Product type
Brand name
Serial no
Description of device

Current location

CE marking?

Description of defect

Model/size

Documents added

No documents.

People Affected

	ID	Title	Forenames	Surname	Type	Approval status
▶	Personal Information		Patient 112	Patient 112	Patient/Client/Service User	Unapproved

Employees

No Employees

Other Contacts

No Other Contacts

Urology PERFORMANCE – August 2022

New Out Patient Waiting List (with no dates) report 1				
	06/07/2022		01/08/2022	
Urgency	No on WL	Longest Wait	No on WL	Longest Wait
Red Flags	45	17 weeks	129	16 weeks
Urgent	165	295 weeks	119	295 weeks
New Red Flag with 352	224	20 weeks	177	22 weeks
New Urgents with 352	190	203 weeks	220	297 weeks
Routine	3383	337 weeks	3366	339 weeks
Total	4007		4011	

New URGENT/ROUTINE Outpatients waiting with no dates. ***As at 01/08/2022***

- Removing the patients transferred to IS the total number of New Urgents is .
- Due to patients, returning to trust for reasons such as not being suitable for IS or refusing IS our Trust longest waiter is **weeks**. If we do not count the patients, who have been offered IS but returned to trust our Longest would have been **weeks (Due to upgrade from Urgent).**
- The average longest waits for patients who have not be transferred to IS is 1Weeks.
- All upgrades and new add ons will be transferred to 352 in Quarter 2

Total activity to date with 352 as at 01/08/2022

352 Activity
14.06.22

	Complete					Booked			TOTALS
	February	March	April	May	June	July	Aug	Sept	
Consultation	421	419	228	474	193		1	0	
Investigation	342	413	244	549	330		0	0	
Procedure	12	105	107	143	102		1	0	
Post Op Review	0	0	11	7	11		0	1	
Review	0	10	84	72	98		1	1	
TOTALS	775	947	674	1245	734		3	2	

NOP WL breakdown as at 01/08/2022

	Urgent	Routine	Urgent	Routine
	July- 22	July- 22	Aug-22	Aug-22
Weeks waiting	Total with no dates	Total with no dates	Total with no dates	Total with no dates
0-10	392	175	434	170
11-20	47	93	91	102
21-30	24	105	22	102
31-40	5	90	7	104
41-50	10	103	7	86
51-60	8	119	8	111
61-70	9	111	5	116
71-80	9	91	5	116
81-90	8	70	7	64
91-100	7	79	2	80
101-110	9	72	7	64
111-120	5	52	6	60
121-130	16	145	8	125
131-140	16	127	16	114
141-150	6	164	11	160
151-160	1	137	3	148
161-170	0	126	1	133
171-180	0	127	1	117
181-190	2	119	0	110
191-200	1	149	1	146
201-210	1	105	2	133
211-220	0	112	0	110
221-230	0	87	0	92
231-240	0	86	0	82
241-250	0	90	0	86
251-260	1	88	0	88
261-270	1	96	3	91
271-280	1	87	0	92
281-290	0	95	1	99
291-300	2	93	2	86
301-310	0	64	0	86
311-320	0	60	0	52
321-330	0	53	0	66
331-340	0	10	0	19
Total	**581**	**3380**	**650**	**3410**

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	6208	517
2018-2019	6622	551
2019- 2020	6338	528
2020-2021	4589	382
2021-2022	5747	479
2022-2023 (to July 2022)	1974	494

Review outpatient backlog update (as at for 1st August 2022)

	July 22		August 22	
	Total	Longest Date	Total	Longest Date
Glackin	52	Nov 20	46	Nov 20
O' Donoghue	422	March 17	408	March 17
Young	507	Dec 16	498	Dec 16
Haynes	105	Feb 19	108	Feb 19
Omer	41	Feb 21	32	May 15
Khan	91	Dec 21	84	Dec 21
O' Brien	143	March 16	137	Feb 17
Tyson	28	Oct 19	26	Oct 19
Jacob	34	July 17	33	Jul 17
Total	**1423**		**1372**	

Adult Inpatient and Day case waiting lists – position as at 01/08/2022

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	47	334	69	280	51	198	44	206
O'Donoghue	139	336	59	375	41	278	55	382
Young	148	411	72	**416**	128	388	142	**396**
Haynes	63	357	55	392	35	274	42	317
Khan	19	84	25	90	37	83	14	80
O'Brien	90	**417**	32	398	9	**415**	13	379
Tyson	33	189	28	228	18	167	24	282
SOM	8	381	0	0	27	102	7	89
TJA	9	313	13	331	8	244	21	299
Total	**556**		**353**		**354**		**362**	

Summary Adults – total = 1625 pts
Urgent Inpatients = 556 patients; longest wait **417** Weeks
Routine Inpatients = 353 patients; longest wait **416** weeks
Urgent days = 354 patients; longest wait **415** weeks
Routine days = 362 patients, longest wait **396** weeks

UROLOGY PERFORMANCE – 20 MAY 2015

New Outpatient waiting lists
Total on waiting list = 1842 patients
Total with a date = 70 patients

Total URGENT waiting a date is 266
(longest = 1x 45 weeks, 1 x 38 week and 1 x 34 weeks)
225 patients waiting 0-9 weeks
41 patients waiting 10-45 weeks – longest after the 34 weeks = 13 weeks

Total ROUTINE waiting a date is 1506 (longest = 50 weeks)
254 patients waiting over 40 weeks
312 patients waiting 30-39 weeks
330 patients waiting 20-29 weeks
345 patients waiting 10 – 19 weeks
265 patients waiting 0-9 weeks

Update on urology review backlog:

Data Validation (PAS) commenced December 2014 – to look for duplicate episodes etc. to ensure lists were cleansed before patient validation (letters) were sent.
There were a number of duplicates identified, as well as other PAS issues/errors such as:

- patients added to OPWL incorrectly, or to the wrong OPWL
- patients added to Consultant OPWL instead of Nurse-Led
- Date Required not changed (patient appeared to be in backlog, but should have had a future Date Required for review)
- Patients not booked from OPWL, but had been seen since their stated Date Required
- OP Discharges per Consultant letter not followed up on PAS – i.e. Episode not closed down on PAS
- Under 18 discharges – must receive confirmation from consultants first – not being processed efficiently

All PAS issues identified (mostly recurring problems) have been highlighted to Service Administrators/PAS User Group/Data Quality Team/Information Team – for action and future PAS training/refresher training

Total patients data validated – 1900 approx

Patient letter validation – commenced last week February 2015
Total 973 letters sent (to longest waiters).
260 patients were discharged (either didn't want appointment or didn't respond)
713 patients still wanted an appointment = 73%

Review Backlog position as of 30 April 2015

CONSULTANT	URGENCY	OPWL CODE	TOTAL	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0
MR M YOUNG	ROUTINE	CURMYR	406	Dec-12
MR M YOUNG	URGENT	CURMYUR	57	Jun-14
MR M YOUNG	ROUTINE	CMYUOR	0	0
MR M YOUNG	ROUTINE	CMYSTCR	286	Feb-14
MR M YOUNG		TOTAL	755	Dec-12
MR A O'BRIEN	ROUTINE	CAU4R	80	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	10	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	448	Dec-11
MR A O'BRIEN	URGENT	CU2UR	105	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	273	Sep-13
MR O'BRIEN		TOTAL	916	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	206	Apr-13
MR A GLACKIN	URGENT	CAJGUR	45	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	5	Apr-15
MR GLACKIN		TOTAL	256	Apr-13
MR K SURESH	ROUTINE	CKSR	54	Apr-13
MR K SURESH	URGENT	CKSUR	174	Apr-13
MR K SURESH	ROUTINE	CKSUOR	28	Feb-15
MR SURESH		TOTAL	256	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	0	0
MR MD HAYNES	URGENT	CMDHUR	0	0
MR MD HAYNES	ROUTINE	CMDHUOR	0	0
MR HAYNES		TOTAL	0	0
MR JP O'DONOGHUE	ROUTINE	CJODR	27	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	3	Feb-15
MR O'DONOGHUE		TOTAL	30	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	Feb-15
ENNISKILLEN		TOTAL	48	Dec-13
MR AKHTAR	ROUTINE	CMAR	125	Dec-12
MR AKHTAR		TOTAL	125	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2386	Nov-11

Inpatient and Daycase waiting lists

Total = 924 on waiting list = 172 with dates

249 urgent inpatients without a date longest = 91 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	56 patients	Longest = 84 weeks 38 between 14-84 weeks 19 between 0-13 weeks
Mr O'Brien	112 patients	Longest = 81 weeks 26 > 51 weeks 60 between 14-50 weeks 26 between 0-13 weeks
Mr Glackin	13 patients	Longest = 33 weeks 1 x 33 weeks 12 between 0-13 weeks
Mr Haynes	18 patients	Longest = 52 weeks 6 between 14-52 weeks 12 between 0-13 weeks
Mr Suresh	20 patients	Longest = 25 weeks 7 between 14-25 weeks 13 between 0-13 weeks
Mr O'Donoghue	30 patients	Longest 91 weeks 11 between 14-91 weeks 19 between 0-13 weeks

116 urgent daycases without a date longest = 69 weeks

Consultant	Total URGENT Inpts without date	Waiting time
Mr Young	48 patients	Longest = 69 weeks 17 between 14-69 weeks 31 between 0-13 weeks
Mr O'Brien	14 patients	Longest = 54 weeks 4 between 14-54 weeks 10 between 0-13 weeks
Mr Glackin	11 patients	Longest = 13 weeks 11 between 0-13 weeks
Mr Haynes	3 patients	Longest = 17 weeks 1 at 8 weeks 1 at 3 weeks
Mr Suresh	23 patients	Longest = 27 weeks 8 between 14-27 weeks 15 between 0-13 weeks
Mr O'Donoghue	17 patients	Longest 35 weeks 4 between 14-35 weeks 13 between 0-13 weeks

Flexible Cystoscopy

Consultant	Planned Flexis To be seen by end of June	Waiting time	On D/C list	Waiting time
Mr Young	6 patients	2 April 1 May 3 June	4 patients	7 weeks
Mr O'Brien	8 patients	1 Feb 6 May 1 June	4 patients	38 weeks
Mr Glackin	9 patients	2 May 7 June	12 patients	14 weeks
Mr Haynes	7 patients	2 May 5 June	0 patients	-
Mr Suresh	1 patient	1 April	12 patients	27 weeks
Mr O'Donoghue	0 patients	-	25 patients	25 weeks

Review Backlog as of 31 July 2015

Review Backlog position as of 31 July 2015

CONSULTANT	URGENCY	OPWL CODE	Total as of 31 May 2015	Total as of 31 July 2015	LONGEST WAIT
MR M YOUNG	ROUTINE	BURM4R	6	8	Mar-13
MR M YOUNG	URGENT	BURM4UR	0	0	0
MR M YOUNG	ROUTINE	CURMYR	375	380	May-12
MR M YOUNG	URGENT	CURMYUR	54	45	Aug-14
MR M YOUNG	ROUTINE	CMYUOR	0	0	0
MR M YOUNG	ROUTINE	CMYSTCR	320	351	Feb-14
MR M YOUNG		TOTAL	755	784	May-12
MR A O'BRIEN	ROUTINE	CAU4R	77	74	Nov-11
MR A O'BRIEN	URGENT	CAU4UR	19	28	Jan-15
MR A O'BRIEN	ROUTINE	CU2R	447	426	Dec-11
MR A O'BRIEN	URGENT	CU2UR	119	136	Sep-14
MR A O'BRIEN	ROUTINE	CAOBUOR	271	270	Sep-13
MR O'BRIEN		TOTAL	933	934	Nov-11
MR A GLACKIN	ROUTINE	CAJGR	214	215	Apr-13
MR A GLACKIN	URGENT	CAJGUR	56	58	Feb-14
MR A GLACKIN	ROUTINE	CAJGUOR	14	5	Apr-15
MR GLACKIN		TOTAL	284	278	Apr-13
MR K SURESH	ROUTINE	CKSR	56	59	Apr-13
MR K SURESH	URGENT	CKSUR	180	181	Apr-13
MR K SURESH	ROUTINE	CKSUOR	38	0	Feb-15
MR SURESH		TOTAL	274	240	Apr-13
MR MD HAYNES	ROUTINE	CMDHR	2	15	May 15
MR MD HAYNES	URGENT	CMDHUR	1	0	May 15
MR MD HAYNES	ROUTINE	CMDHUOR	1	0	May 15
MR HAYNES		TOTAL	4	15	May 15
MR JP O'DONOGHUE	ROUTINE	CJODR	47	73	Feb-15
MR JP O'DONOGHUE	URGENT	CJODUR	15	20	Feb-15
MR O'DONOGHUE		TOTAL	62	93	Feb-15
UN-NAMED REVIEWS	ROUTINE	EUROR	42	40	Dec-13
UN-NAMED REVIEWS	URGENT	EUROUR	6	6	Feb-15
ENNISKILLEN		TOTAL	48	46	Dec-13
MR AKHTAR	ROUTINE	CMAR	121	115	Dec-12
MR AKHTAR		TOTAL	121	115	Dec-12
OVERALL TOTAL AND LONGEST WAIT			2481	2505	Nov-11

Southern Health and Social Care Trust
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MEDICAL APPRAISAL DOCUMENTS CHECKLIST

PLEASE USE THESE FORMS FOR ALL SOUTHERN TRUST MEDICAL APRAISALS

Remember to include:- *[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]*	✓
Your name, GMC No, and the appraisal period covered in the footer of the forms. Simply double-click on the relevant section at the bottom of the document.	☒
Evidence of Reflection on Practice and use of Structured Reflective Templates – click here	☒
Evidence of Research Activity (if applicable)	☒
Have accounted for 100% Attendance / non-Attendance at all M&M / Patient Safety / Governance or equivalent Meetings throughout the year	☒
Have reflected on a Significant Event and included implications for own practice or have used the M&M SBAR Template with appropriate detail of involvement – click here	☒
Evidence of Regular Participation in Clinical Audit	☒
Remember to send the following:- *[Please ensure all boxes are checked before returning the documentation – simply click on the box to put an 'X' in it]*	✓
FRONT PAGE CHECKLIST – with all boxes ticked	☒
FORM 1 – all parts completed by Appraisee	☒
FORM 2 – all parts completed by Appraisee to include whole practice i.e. Private / Medico Legal Work etc. *NB: There is an updated requirement to include a signed Paying / Private Patient Declaration if the appraisee undertakes any work of this nature inside or outside the Trust. There is also another new requirement to explain at what stage the appraisee's job plan is in the approval process*	☒
FORM 3 – All four GMP Domains completed jointly by Appraisee and Appraiser to include list of supporting information and evidence of the discussion that took place during the appraisal meeting – click here	☒
FORM 3 – Inclusion of agreed actions against all four GMP domains – click here	☒
FORM 4 – Review of Last Year's PDP	☒
FORM 4 – PDP for the Year Ahead Developed from the Discussions Around the Four GMP Domains – click here	☒
FORM 5 – all parts completed with FIVE signatures, one for each section, and one of the options for both the Health Declaration and the Probity Declarations ticked	☒
FORM 6 – completed, signed and dated by both Appraisee & Appraiser	☒
FORM 7 – Completed in respect of where the appraisee is in their forthcoming Revalidation Cycle i.e. Year 1, 2, 3 etc. Please ensure last section also completed in relation to whether the Revalidation Requirements have been met or when they are proposed to be met.	☒
APPENDIX 1 – all parts completed, signed and dated by Appraisee & Appraiser	☒
APPENDIX 2 – NOT REQUIRED / COMPLETE AND KEEP FOR YOUR OWN RECORDS	☒

PLEASE DO NOT SUBMIT THESE FORMS UNLESS ALL OF THE ABOVE BOXES HAVE BEEN TICKED AS THEY WILL NOT BE ACCEPTED FOR PROCESSING.

You can submit the documentation by scanning and emailing the original signed copies to:-

Personal information redacted by USI

Or send the signed originals by internal mail to the Revalidation Support Team at the address below where they will be scanned in, saved and returned to you:- (Copies will not be accepted).

Revalidation Team, Beechfield House, CAH or Revalidation Team, Clanrye House, DHH

For further guidance and FAQ's – click here

Southern Health and Social Care Trust
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APPRAISAL DOCUMENTS

CONTENTS

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information – click here to navigate to the relevant guidance in Appendix 4 of these forms.*

1.1	Full name	John Paul O'Donoghue
1.2	GMC Registered address (contact address if different)	Personal Information redacted by the USI
1.3	Main employer	Southern Health and Social Care Trust
1.4	Main place of work	Craigavon Area Hospital
1.5	Other employers/ places of work	Hillsborough Private Clinic/Ulster Independent Clinic/Kingsbridge Private Hospital
1.6	Date of primary medical qualification	MB BCh BAO, 1993
1.7	GMC registration number and type	4393418 Registered with a licence to practice
1.8	Start date of first substantive appointment in HSC as a trained doctor	4th August 2014
1.8	GMC Registration date and specialties	John Paul O'Donoghue
1.9	Title of current post and date appointed	Personal Information redacted by the USI
1.10	For any specialist registration / qualification outside UK, please give date and specialty	Southern Health and Social Care Trust
1.11	Please list any other specialties or sub-specialties in which you are registered	None
1.12	Is your registration currently in question?	No
1.13	Date of last revalidation (if applicable)	15/8/2013
1.14	Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	Consultant Urological Surgeon – SHSCT, Hillsborough Private Clinic/Ulster Independent Clinic/Kingsbridge Private Hospital

ANY ADDITIONAL INFORMATION

I have worked in the Trust as a substantive Consultant in Urological Surgery since August 2014. My specialist interest is in Female and Functional Urology and I continue to develop my knowledge base and skills. Towards the end of 2015, my colleague Michael Young and I engaged with Neotract® to introduce Urolift into the Trust. After attending training in Frimley Park Hospital in England, we performed the first cases in Northern Ireland successfully.

Because of the continuing concerns about mid-urethral slings and mesh complications, I wrote the business plan and introduced Bulkamid® into the Trust. Bulkamid® is a bladder neck bulking agent and is a relatively non-invasive surgical treatment option for stress incontinence and an alternative to major surgery.

During 2016, I set up a clinic in conjunction with iMEDicare to treat Peyronies disease and Erectile Dysfunction with vacuum devices. This is now running successfully with a specialist nurse and company representative.

Professional relationships continue to be made with colleagues in several disciplines. Multi-disciplinary working has a strong base in the Trust and I have embraced this enthusiastically. I attend a monthly Uro-Gynaecology MDT to discuss cases of common interest.

Professional relationships have also developed with colleagues in the region. I attend a Urology Reconstruction Meeting once a month. Difficult cases are discussed in a multi-disciplinary forum and inter-departmental referrals made

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

Click here to navigate to the relevant guidance in Appendix 2.

2.1 Please give a short description of your work, including the different types of activity you undertake	I participate in two one stop urology outpatient clinics per week where patients have all their investigations at the initial visit. Patients are then discharged or transferred to specialist clinics. Other outpatient activities in the week include one uro-oncology clinic and a urology review clinic. I also participate in urodynamics. There are two half day theatre sessions and a day surgery list alternate weeks. Meetings include a weekly uro-oncology MDT , monthly uro-gynaecology MDT and Urology Reconstruction MDT. A departmental business meeting is held weekly. On call has now changed to Surgeon of the Week (SOW) and is 1:6 rota. This works very well and allows continuity of care for the atients. I practice privately on an *ad hoc* basis at the Ulster Independent Clinic, Hillsborough Private Clinic and Kingsbridge Private Hospital. My practice is similar to my NHS practice in scope.
2.2 List your main sub-specialist skills and commitments / special interests	My sub-specialist interest is Female Functional and Reconstructive Urology. I am trying to develop professional relationships with the Uro-Gynaecologists as there is considerable overlap in our practices.
2.3 Please give details of any emergency, on-call and out of hours responsibilities	I do a 1:6 Urology on call for Urology with my colleagues. This involves being SOW seeing emergencies, triage of GP referral letters, doing regular ward rounds and answering GP queries on the telephone and online.
2.4 Please give details of out-patient work if applicable	The department has run a one stop outpatient clinic where all new patients are seen and have investigations at the time. They are then either discharged or transferred to a specialist clinic. I have enthusiastically engaged with this and see the benefits for the patient and the department.
2.5 Details of any other clinical work	I practice privately at Hillsborough Private Clinic, Ulster Independent Clinic and Kingsbridge Private Hospital on an *ad hoc* basis.
2.6 In which non-HSC hospitals and clinics do you enjoy practicing privileges or have admitting rights? ***(Include Paying / Private Declaration if relevant).*** Please give details including:	Hillsborough Private Clinic, Ulster Independent Clinic, Kingsbridge Private Hospital There are no issues with regards to my clinical practice in these hospitals. Cases are sporadic and clinics tend to be ad hoc. Surgical

▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	cases reflect my NHS practice and there have been no problems. I have good relationships with other consultants and nurses in my private practice.
2.7 List any non-clinical work that you undertake which relates to teaching	I actively teach the registrars in all clinical areas. I regularly assess work based assessments and have done 43 WBA from Jan 2016 – Dec 2016 (these are available on the ISCP web site). For registrars about to do the FRCS (Urol) viva, I offer practice vivas. When the regional urology teaching for specialist registrars rotates to Craigavon Area Hospital, I participate in the teaching.
2.7.1 List any non-clinical work that you undertake which relates to management	As part of the consultant team, I was involved in the review, design and implementation of our new one stop outpatient clinic.
2.7.2 List any non-clinical work that you undertake which relates to research	I am involved in departmental audits and research. These are regularly discussed at our departmental audit days. I have participated in the Regional Urology Review in relation to Female Urology and Uro-Gynaecology services.
2.7.3 List any work you undertake for regional, national or international organisations.	
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	

CURRENT JOB PLAN

If you have a current job plan, please attach it. If not, please explain below at which stage of the approval process your job plan is currently:-

Southern Health and Social Care Trust.

This job plan started 01 August 2016.

Job plan for Mr O'Donoghue, John Paul in Urology

Basic Information

Job plan status	3rd sign-off agreed
Appointment	Full Time
Cycle	Rolling cycle - 6 weeks
Start Week	1
Report date	04 Jun 2018
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	Yes

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		3 Aug 2016	Mr Malcolm Clegg
In 'Discussion' stage - awaiting 1st sign-off agreement		6 Sep 2016	Mr John Paul O'Donoghue
In 'Discussion' stage - sign-off not agreed	**John** I just want to make adjustment for MDM preparation 3 hour 13 weeks a year	10 Oct 2016	Mr Colin Weir
In 'Discussion' stage - awaiting doctor agreement		10 Oct 2016	Mr Colin Weir
1st sign-off agreed - awaiting 2nd sign-off agreement		11 Jan 2017	Mr John Paul O'Donoghue
2nd sign-off agreed - awaiting 3rd sign-off agreement		17 Jan 2017	Mr Ronan Carroll
Signed off		18 Jan 2017	Mrs Esther Gishkori

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.982	9.982	39:56
Supporting Professional Activities (SPA)	1.563	1.563	6:15
Private Professional Services (PPS)	Does not attract a value		1:40
Total	11.545	11.545	47:51

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	6	6	A	5%	1.000

Type	Normal	Premium	Cat.	PA

				Total:	1.000
	Predictable	n/a	n/a	DCC	0.000
	Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 6.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 6.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Clinical Manager	Role: Board Member	Role: Clinical Director
Name: Mr Weir, Colin	Name: Mr Carroll, Ronan	Name: Mrs Gishkori, Esther
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 New patient Clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Continuous professional development. 12:30 - 13:30 Day surgery 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Continuous professional development. 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Continuous professional development. 11:00 - 13:00 Continuous professional development. 13:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports,	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions	Uroradiology meeting 08:30 - 10:00 Grand Round	Private Professional Services 09:00 - 11:00		

results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:00	08:00 - 12:00 Post-op ward round 12:00 - 12:30 Continuous professional development. 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:30	10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Continuous professional development. 17:00 - 17:30	Continuous professional development. 11:00 - 13:00 Continuous professional development. 13:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 New patient Clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Continuous professional development. 12:30 - 13:30 Day surgery 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Continuous professional development. 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Continuous professional development. 11:00 - 13:00 Continuous professional development. 13:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Continuous professional development. 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Continuous professional development. 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Continuous professional development. 11:00 - 13:00 Continuous professional development. 13:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 New patient Clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Continuous professional development. 12:30 - 13:30 Day surgery 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Grand Round 10:00 - 12:00 Departmental meeting 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Continuous professional development. 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Continuous professional development. 11:00 - 13:00 Continuous professional development. 13:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00		

Activities

A Additional To Contract
H Hot Activity
Unaffected by hot activity
Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
								Total:	10.313	42:55
	Mon	09:00 - 13:00	wks 1-5	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Mon	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Mon	13:00 - 13:30	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Mon	13:30 - 17:00	wks 1-5	Sub Specialty clinic Comments: uro-oncology + urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.729	2:55
	Tue	07:30 - 08:00	wks 1-5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Tue	08:00 - 12:00	wks 1-5	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Tue	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Tue	12:00 - 12:30	wks 1-5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Tue	12:30 - 13:30	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
	Tue	13:30 - 17:00	wks 1, 3, 5	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.438	1:45
	Tue	13:30 - 17:00	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	14	0.292	1:10
	Wed	07:30 - 08:00	wks 1-5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Wed	08:00 - 12:00	wks 1-5	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Wed	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Wed	12:00 - 12:30	wks 1-5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Wed	12:30 - 13:30	wks 1-5	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.208	0:50
	Wed	13:30 - 17:30	wks 1, 3, 5	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.500	2:00
	Wed	13:30 - 17:30	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	14	0.333	1:20
	Thu	08:30 - 10:00	wks 1-5	Uroradiology meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.313	1:15
	Thu	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Thu	10:00 - 12:00	wks 1-5	Grand Round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.417	1:40
	Thu	12:00 - 14:00	wks 1-5	Departmental meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.417	1:40
	Thu	14:00 - 17:00	wks 1-5	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.625	2:30
	Thu	17:00 - 17:30	wks 1-5	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.104	0:25
	Fri	09:00 - 11:00	wks 1-5	Private Professional Services	Southern Health and Social Care Tru..	Craigavon Area Hospital	PPS	35		1:40
	Fri	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Fri	11:00 - 13:00	wks 1-5	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.417	1:40
	Fri	13:00 - 15:00	wks 1-5	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.417	1:40
	Fri	15:00 - 16:00	wks 1-5	Admin other (please specify)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50

No specified day

"( )" Refers to an activity that replaces or runs concurrently
Additional To Contract
Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	0.232	0:56
	3:00	0:00	Surgery MDT	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.232	0:56

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

FORM 3 - SUPPORTING INFORMATION & SUMMARY OF APPRAISAL DISCUSSION

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Supporting Information	Applicable Date
1.1	Medical appraisal Documents and Checklist	
1.2	Regular attendance at departmental and hospital M & M meetings	
1.3	Reflection on attendance at M + M	
1.4	CLIP Report	
1.5	Reflection on CLIP Report	
1.6	Job Plan	
1.7	Stone MDT	
1.8	Uro-gynaecology MDT	
1.9	Uro-oncology MDT	
1.10	Quality Improvement Initiative	
1.11	Logbook	
1.12	Courses attended	
1.13	Mandatory training Passport	
1.14	Bulkamid Training Day	
1.15	Recruitment and Selection Certificate	
1.16	Supervisory Skills Workshop	
1.17	Teach the Teacher Workshop	
1.18	Advanced Communication Skills Workshop	
1.19	Fire Awareness	
1.20	Information Governance	
1.21	COSHH and Waste Management	
1.22	Manual Handling	
1.23	Certificate of Recognition as Postgraduate Medical Trainer	
1.24	Level 1 Trainee Support	
1.25	Lisburn Masterclass	
1.26	Certificate of Attendance EAU	
1.27	ISU Meeting Cork	
1.28	Certificate of Attendance 8th Masterclass in Female Urology	
1.29	Urolift Study in Conjunction with Registrar	
1.30	5 year CPD	
1.31	Radiation Exposure Audit with Registrar	
1.32	Reflection on Radiation Exposure Audit	
1.33	Bladder Cancer Access Standards Audit	
1.34	Reflection on Bladder Cancer Access Standards Audit	
1.35	Form 4	
1.36	Reflection on form 4	

Discussion

- Discussion on Clip report defines a good day surgery rate and low readmissions. Outpatient activity high but outpatient with procedure is falsely recorded as our unit performs cystoscopies along side the patients attendances, also urodynamics carried out in same way.
- Operative logbook matches clinical interests and MDT in Oncology, Stones and Urogynae has a high attendance rate (80%).
- Job plan enclosed and content.
- Several audits discussed and thoughts about further studies discussed
- Mandatory training up to date
- Has taken up a major role in training by involvement in the FY1 supervision, Teaching course completed recently and has post-graduate medical trainers certificate
- CPD annual record excellent. Discussion on how best to define CPD collection
- Reflections on Clip report, audit and previous Form 4 included MY

Actions Agreed

- hyponatraemia module should be completed
-
- future audits
-
- maintain input to teaching role and MDT commitment MY

CLICK HERE for further guidance about completing Form 3 and HERE for the Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Supporting Information	Applicable Date
2.1	Attendance at Clinical Governance	See 1.2
2.2	Attendance at Hospital M & M	See 1.3
2.3	Active participation in team brief at beginning of theatre sessions	
2.4	Documents from Hillsborough Private Clinic stating that there have been no concerns and no complaints	
2.5	Documents from Ulster Independent Clinic stating that there have been no concerns and no complaints	
2.6	Attendance at Uro-Oncology MDT	See 1.9
2.7	Attendance at Uro-Gynaecology MDT	See 1.8
2.8	Attendance at Stone MDT	See 1.7
2.9	BAUS Stent Register to keep track of stents	
2.10	Record of Immunisations	
2.11	Reflection on no significant events	
2.12	MDU	
2.13	GMC	
2.14	CCT	
2.15	GP Registration	
2.16	Registrar WBAs	
2.17	Educational and Clinical Supervisor Roles	
2.18	Reflection on Education and Clinical Supervisor Roles	

Discussion

- Participation in several MDT as discussed in Domain 1.
- Has helped in the setting up of the recently introduced Stone MDT and continues to be active in its running despite lack of administrative support for the service.
- Risk factor associated with ureteric stents is actively considered by involvement with the national stent register.
- No issues from Private Practice
- No significant events declared
- GMC and MDU membership enclosed as is GP registration
- Reflection on educational roles. Clear enjoys this component of job.
- M and M attendance low but active participant when attends. Discussion on how this could be improved by time-shifting other activities
- Reflections included MY

Actions Agreed

- Minor data collection readjustment to the stent register (in view of ICO regulations)
- Improve M&M attendance by way discussed will adequately address MY

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Supporting Information	Applicable Date
3.1	Attendance at Stone MDT	See 1.7
3.2	Attendance at Uro-oncology MDT	See 1.9
3.3	Attendance at Uro-Gynaecology MDT	See 1.8
3.4	Compliment from Registrar	
3.5	Reflection on above	
3.6	Compliment from Registrar	
3.7	Reflection on Above	
3.8	Thank you card from Nurse Practitioner	
3.9	Reflection on above	
3.10	Thank you card from Registrar	
3.11	Reflection on above	
3.12	Colleague Feedback	
3.13	Reflection on above	
3.14	Patient Feedback	
3.14	Reflection on above	

Discussion

- Team membership excellent and involved in departmental meeting, which addresses urology unit issues and how the unit functions.
- As in domain 2 has helped in the setting up of the new Stone MDT
- feedback from junior doctors clearly shows involvement in their education and general wellbeing
- Reflections enclosed
- Patient and colleague feedback enclosed and shows high standard and the regard that John holds within his workplace. MY

Actions Agreed

- Consolidate position within the various MDT committees and don't get overstretched. MY

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Please ensure there is a detailed record of the Discussion & Actions Agreed for each of the 4 Domains of GMP

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients
Attribute:4.2 Treat patients and colleagues fairly and without discrimination
Attribute:4.3 Act with honesty and integrity

	List of Supporting Information	Applicable Date
4.1	Current MDU Certificate supplied	
4.2	Curent GMC Certificate supplied	
4.3	GMC Certificate of Completion of Training	
4.4	Thank you email from grateful patient in Private Sector	
4.5	Thank you card	
4.6	Refection on thank you card	
4.7	Thank you card	
4.8	Thank you card	
4.9	Reflection on thank you card	
4.10	Thank you card	
4.11	Reflection on thank you card	
4.12	Thank you card	
4.13	Reflection on thank you card	
4.14	Thank you card	
4.15	Reflection on Thank you card	
4.16	Signed Probity and Health Form	
4.17	No Complaints - Reflection	
4.18	No significant events - Reflection	
4.19	Medical Card (GP registration)	See 2.15
4.20	Immunisation history report	
4.21	COMPLAINT	

Discussion

- Colleague, patient and junior doctor feedback as well as health and probity declaration confirms John is active in this Domain
- No complaints nor significant events are declared
- Reflections enclosed
- Compliment cards enclosed and reflection on meaning MY
-

Actions Agreed

- Maintain current level activity
-
- Enclose Trust documents on complaints
-
- Although lack of significant events to reflect on a case where patient pathway could be improved
- MY

CLICK HERE for further guidance about completing Form 3 and HERE For Structured Reflective Templates

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 4 - PERSONAL DEVELOPMENT PLAN

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

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan

Development needs	Actions agreed	Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?
Further development of Greenlight PVP		December 2017
Attend courses relevant to Urology		December 2017
Attend courses relevant to my subspecialist area Female and Functional Urology		December 2017
Organise further masterclass in bladder neck bulkng agents		December 2017
Get involved as educational/clinical supervisor of students		December 2017
Organise teaching for medical students in Urology		December 2017

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**
Attend courses relevant to my subspecialist area Female and Functional Urology	ATTEND THIS MEETING AS WAS FOUND VERY USEFUL	December 2018
Continue to develop experience of Greenlight PVP	CONSOLIDATE	December 2018
Attend courses relevant to Urology	AGREED	December 2018
Continue as educational/clinical supervisor of students	AGREED	December 2018
Develop further an educational role for undergraduate medical students	AGREED	December 2018

CLICK HERE for further CPD/PDP guidance. To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 4 of this document, click here.

FORM 5- HEALTH AND PROBITY STATEMENTS

HEALTH DECLARATION

To navigate to the relevant section in the Aide Memoire and Checklist in Appendix 2 of this document, click here.

Professional Obligations

The GMC's guidance *Good Medical Practice* (2006) states that;

77. You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

I accept the professional obligations placed upon me in paragraphs 77 to 79 of *Good Medical Practice* and where they apply am taking the appropriate action.

Signature: Personal Information redacted by the USI Date: 21/6/18

Name in Capitals: John P. O'Donoghue

NB: Additional Health and Probity forms are on the Southern Docs website – click here

Regulatory and Voluntary Proceedings *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.
- Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

OR

☐ If I have been subject to either of the above, I have discussed these with my appraiser.

Signature: Personal Information redacted by the USI Date: 21/6/18

Name in Capitals: John P. O'Donoghue

PROBITY DECLARATION

Professional obligations

I accept the professional obligations place upon me in paragraphs 56 to 76 of *Good Medical Practice (2006).*

Signature: Personal Information redacted by the USI Date: 21/6/18

Name in Capitals: John Paul O'Donoghue

Convictions, findings against you and disciplinary action *[Please check relevant box by clicking on it and then sign below]*

☒ Since my last appraisal/revalidation **I have not,** in the UK or outside:

- Been convicted of a criminal offence or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

OR

☐ If I have been subject to any of the above, I have discussed this with my appraiser.

Signature: Personal Information redacted by the USI Date: 21/6/18

Name in Capitals: John Paul O'Donoghue

INDEMNITY DECLARATION

I confirm that I have the relevant indemnity as per the GMC's Guidance – click here

Signature: Personal Information redacted by the USI Date: 21/6/18

Name in Capitals: John Paul O'Donoghue

FORM 6 - SIGN OFF

Please ensure this section is fully completed, signed and dated by both Appraisee and Appraiser.

CIRCUMSTANCES MITIGATING AGAINST ACHIEVING FULL REQUIREMENTS	APPRAISER SIGNATURE	DATE

When you have completed the appraisal, the appraiser should check and sign the following:

GMC REQUIRED INFORMATION			PRESENT
Continuing professional development			Yes
Quality improvement activity			Yes
Significant events review			Reviewed an hour.
Review of complaints and compliments			Yes.
Feedback from colleagues	Year undertaken OR Planned Year:	2017	Yes
Feedback from patients (where applicable)	Year undertaken OR Planned Year:	2017.	Yes

APPRAISAL CHECKLIST	COMPLETED
Check that all sections of the documentation have been completed.	Yes
Ensure the previous year's Personal Development Plan has been reviewed.	Yes
Forward required Forms according to the organisation's appraisal policy.	

APPRAISAL COMPLETION

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

APPRAISEE

Signature of Appraisee: Personal Information redacted by the USI Date: 2/8/18

APPRAISER

Signature of Appraiser: Personal Information redacted by the USI Date:

GMC Number: 2846385

CO-APPRAISER (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Revalidation and award of Certificate of Completion of Training 2013

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Appraisal in West Hertfordshire Hospitals NHS Trust by Dr Michelle Soskin – January 2014 to July 2014
Appraisal in Southern Health & Social Care Trust by Mr Michael Young August 2014 – October 2014

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: Mr Michael Young

GMC Number: _____ Date: November 2016

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

FORM 7- REVALIDATION PROGRESS

Ensure these sections are fully completed to indicate where the appraisee is in their 5 Year Revalidation Cycle.

Year 1

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2013 has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution
Revalidation and award of Certificate of Completion of Training 2013		

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year 2

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2014 has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution
Appraisal in West Hertfordshire Hospitals NHS Trust by Dr Michelle Soskin – January 2014 to July 2014 Appraisal in Southern Health & Social Care Trust by Mr Michael Young August 2014 – October 2014		

Signature of Appraiser: Personal Information redacted by the USI Name of Appraiser: M. Young

GMC Number: 2846385 Date: oct.14

Year 3

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2015 has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: Personal Information redacted by the USI Name of Appraiser: Mr Michael Young

GMC Number: 2846385 Date: ~~November 2016~~ 2015.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2016 has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: Personal Information redacted by the USI Name of Appraiser: DAVID GARDES

GMC Number: 4A Date: 24/10/17.

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year 2017 has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution
None.		

Signature of Appraiser: Personal Information redacted by the USI Name of Appraiser: M Young

GMC Number: 2446585 V Date:

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues:	Action Required	Resolution

Signature of Appraiser: Name of Appraiser:

GMC Number: Date:

Please ensure the section below is fully completed.

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years	2016	Personal Information redacted by the USI	24/10/17
Feedback from patients (where applicable) 1 in 5 years	2016		24/10/17.
Significant Events Review	2016		24/10/17
Review of complaints and compliments	2016		24/10/17
Continuing Professional Development	2016.		24/10/17
Quality Improvement Review	2016		24/10/17.

Appendix 1 Education and Training Competencies Available for Medical Staff

Right Patient, Right Blood	Method	Core / Optional	Date Completed
RPRB Theory (Every 3 years)	Elearning Blood Transfusion Module Click Here	Core	
Competency 1,2 & 4 (Every 3 Years)	Face to face – Trust Haemovigilance Staff Contact Patricia Watt on Personal Information redacted by the USI	Core	
Desist Notice	To obtain a desist notice, click here	Core	

Annual Updates	Method	Core / Optional	Date Completed
Fire Safety	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development@southerntrust.hscni.net to book a place.	Core	
2 Yearly Updates	**Method**	**Core / Optional**	**Date Completed**
Infection Prevention and Control	SHSCT E-Learning Module Click Here	Core	
Resuscitation	Face to Face. CAH - Helen Cullen Personal Information redacted by the USI / Bleep: Personal Information Personal Information redacted by the USI DHH - Bernie O'Connor Personal Information redacted by the USI / Bleep: Personal Information Personal Information redacted by the USI	Optional	
3 Yearly Updates	**Method**	**Core / Optional**	**Date Completed**
Safeguarding Children & Vulnerable Adults	Face to Face. Part of the Trust mandatory training day – click here for dates and program. Email learning.development@southerntrust.hscni.net to book a place.	Core	
Information Governance/Data Protection/IT Security	SHSCT E-Learning Module Click Here	Core	
Moving and Handling	SHSCT E-Learning Module Click Here	Core	
Health & Safety / Control of Substances Hazardous to Health (COSHH)	SHSCT E-Learning Module Click Here	Core	
Discovering Diversity	HSC E-Learning Module Click Here	Optional	
Recruitment & Selection	HSC E-Learning Module Click Here	Optional	
Sickness & Absenteeism Training	Face to Face. Contact ELD on Personal Information redacted by the USI or email learning.development@southerntrust.hscni.net	Optional	
Hyponatraemia	BMJ E-Learning Module Click here	Optional	
Management of Actual or Potential Aggression	Face to Face. Contact ELD on Personal Information redacted by the USI or email learning.development@southerntrust.hscni.net	Optional	
Fraud Awareness	HSC E-Learning Module Click here	Optional	
Seeking and Obtaining Consent for Hospital Post Mortem Examination	SHSCT E-Learning Module Click here	Optional	

Year 4

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: Dr David Gracey

GMC Number: _____ Date: October 2017

Year 5

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Year

I confirm that I have reviewed all the supporting information required by the GMC and that the appraisal for the year _____ has been satisfactorily completed.

Current Outstanding Issues: **Action Required** **Resolution**

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

Please ensure the section below is fully completed.

GMC Supporting Information Requirements	Year Completed	Reviewed by	Date
Feedback from colleagues 1 in 5 years			
Feedback from patients (where applicable) 1 in 5 years			
Significant Events Review			
Review of complaints and compliments			
Continuing Professional Development			
Quality Improvement Review			

Once off Training	Method	Core / Optional	Date Completed
National Early Warning System	National NEWS e-learning Click here	Optional	
Obstetrics Early Warning System	Online Module Click here	Optional	
Paediatrics Early Warning System	Face to Face. Contact CAH Dr S Shah [redacted] Contact DHH Dr B Aljarad [redacted]	Optional	
Consent	In House E-Learning Module Click here	Optional	
Blood Culture	In House E-Learning Module Click here	Optional	
Peripheral Line	In House E-Learning Module Click here	Optional	
Oral Anticoagulants	MHRA Module Click here Once on the site choose the Anticoagulant Module. On completion of the module, complete the assessment and print a completion certificate. Takes 24 hours for registration.	Optional	
Naso Gastric Tube Placement	In House E-Learning module Click here	Optional	
Protocol following death of patient	In House E-Learning module Click here	Optional	
Guide to Prescribing in SHSCT	In House E-Learning module Click here	Optional	
Research and Development - Good Clinical Practice Training	Elearning Module Click here	Optional	
VTE	King's Thrombosis Centre E-learning Click here	Optional	
Safe Sedation [Module 1,2 & 3]	In House Elearning Modules Click here (Part 1) Click here (Part 2) Click here (Part 3)	Optional	
Gastrointestinal endoscopy	Face to Face Contact Dr A Murdock [redacted]	Optional	
Chest Drain Insertion	Face to Face Contact Dr A Ferguson [redacted]	Optional	
Blood Gas Instrument	Face to Face Contact Derek McKillop 028 38613709 [redacted] Face to face	Optional	
Appraiser Training	Face to face Dates available here	Optional	
Appraisee Training	Face to face Dates available here	Optional	
Insertion and Management of Indwelling Urinary Catheters	Online Module Click here	Optional	
Coroner's Investigations and Inquests Programme	Online Module Click here	Optional	
HIV Awareness Training	Face to Face Contact Lyndsey Hasson Tel: [redacted]	Optional	
Patients enrolled in Clinical Trials	In House E-Learning module Click here	Optional	

Waste Management	SHSCT E-Learning Module Click Here	Optional	
Modules proposed for E-Learning	**Method**	**Core / Optional**	**Date Completed**
Better Communication/Complaint Handling	Face to face	Optional	
Incident Reporting	Face to face	Optional	
Clinical Negligence	Not currently available	Optional	

Your training record will be updated following this submission, a copy of which can be obtained from the Revalidation Support Team, medical.revalidation@southerntrust.hscni.net

Please note that when you complete a training module either face-to-face or via elearning, you need to email the Revalidation Support Team in order that your training passport can be updated as the Team are not automatically informed.

TRAINING DECLARATION

I understand that it is my responsibility to make the necessary arrangements to allow me to complete the Trust's Mandatory Training Core Modules and those Optional Modules as agreed between myself and my Appraiser that are necessary for me to undertake my role within the Southern Health and Social Care Trust.

APPRAISEE

Signature of Appraisee: Personal Information redacted by the USI Name of Appraisee: John Paul O'Donoghue

GMC Number: 4393418 Date: 3/8/18

APPRAISER

Signature of Appraiser: Personal Information redacted by the USI Name of Appraiser: M. O'Donoghue

GMC Number: 2846385 Date: 3/8/18

APPENDIX 2

Southern Health and Social Care Trust
Quality Care - for you, with you

Medical Staff Appraisal

Aide Memoire and Quality Assurance Audit Tool

(Revised January 2017)

(PLEASE RETAIN FOR OWN RECORDS)

Doctor's Name: John Paul O'Donoghue

Specialty: Urology

Appraisal Year: January – December 2017

Form 1 – Background Details	Yes	No	Partial	Comments (attached document or written statement)
Details of registration/licence to practice	✓			
Brief details of employment in the previous year	✓			
Supplementary Information e.g. membership of medical and specialist societies	✓			

Form 2 – Current Medical Activities	Yes	No	Partial	Comments (attached document or written statement)
Job Plan – Fully Signed Off	✓			
Summary of Clinical Activities inc. Private Practice both inside and outside the Trust	✓			
Evidence of MPS / MDU Membership	✓			
Information on non-clinical work – such as teaching or management responsibilities (to include Educational Appraisal form and Appraiser Structured Reflective Template if individual is an Appraiser (see link at end for all templates)	✓			
Location of all current practices	✓			

NB: Evidence must be held in your folder against all of these domains

Form 3 – Supporting Information and Summary of Appraisal Discussion	Yes	No	Partial	Comments (attached document or written statement)
DOMAIN 1: Knowledge, Skills and Performance				
Workload Records	✓			
Evidence of how educational activity may have affected service delivery outcomes	✓			
Evidence of Teaching and Training Activities – Proof of Completing Required Competencies (if applicable)	✓			
Evidence of Reflective Practice	✓			
Evidence of Audit Activity	✓			
Evidence of Research Activity (if applicable)	✓			
Evidence that CPD follows the recognised best practice in your field or specialty as set out by the Colleges.	✓			
Evidence of Published Articles and/or Presentations to Peers	✓			
Previous and Current Personal Development Plan	✓			

O'Donoghue, John(4393418) - 2018 appraisal

Form 1 - Background

Personal Details

Title Dr

Forename John

Surname O'Donoghue

Division Surgery & Elective Care

Specialty Urology

Grade Consultant

Optional Appraisal Start/End Dates

Appraisal Start Date 01/01/2018

Appraisal End Date 31/12/2018

GMC/GDC Registered Address 4393418

Personal Information redacted by the USI

Personal Information

Postcode Personal Information

Contact Address (If different from above)

Contact Address

Postcode

Registration Details

Primary Medical or Dental Qualification (in the UK or elsewhere)

Qualification Date 28/06/1993

GMC/GDC Registration

Registration Type Full

Registration No 4393418

Registration Date 28/04/1997

Registration Specialty Urology

Specialty (Other)

Specialist Registration/Qualification outside the UK

Specialty --Please Select--

Specialty (If Other Give Details)

Date obtained

Country obtained / Awarding Body

Please list Other Specialties or Sub-Specialties in which you are registered.

Other Specialties / Sub-Specialties

Has your registration been called into question since your last appraisal (or if this is your first appraisal, is your registration in question)?

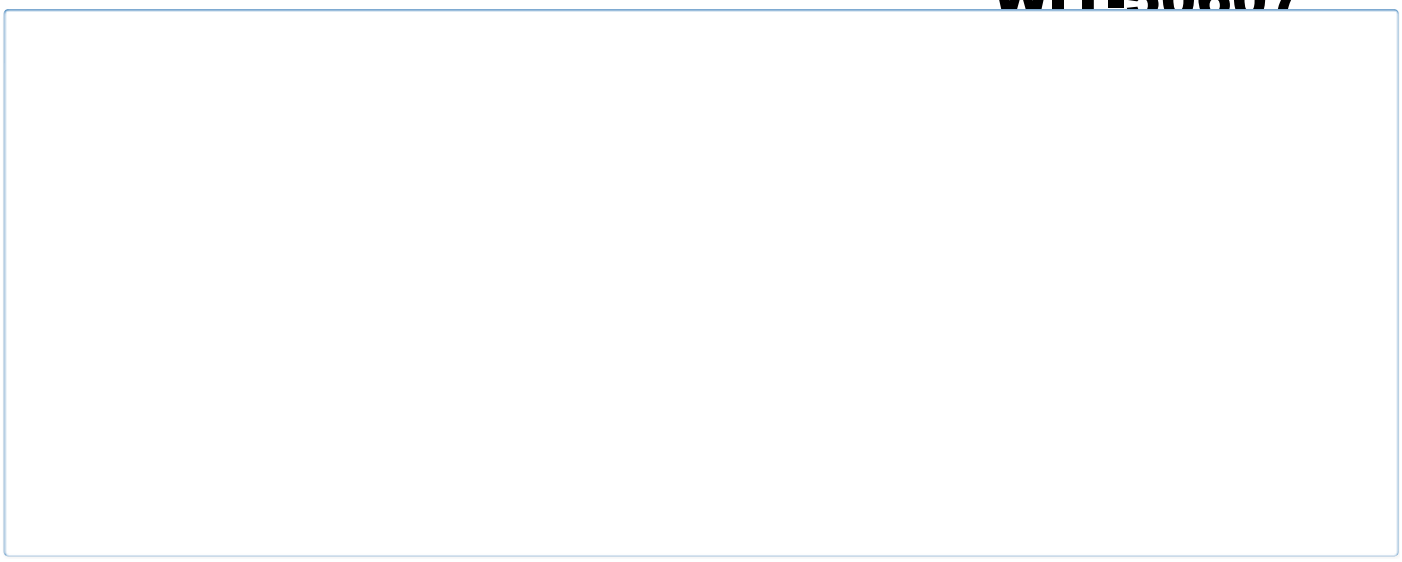
If Yes, Please Give Details

Date of next Revalidation 13/08/2023

Employers / Posts

Please list all employers / places of work

Employer Name	Address	Main Employer
Southern Health & Social Care Trust	Craigavon Area Hospital 68 Lurgan Road, Portadown, Armagh, BT63 5QQ	Yes



Other Information

Please add any other relevant personal details.

Form 2 - Current Activities

Current Activities 1

Please give a short description of your work, including the different types of activity you undertake

I participate in two one stop urology outpatient clinics per week where patients have all their investigations at the initial visit.

Patients are then discharged or transferred to specialist clinics. Other outpatient activities in the week include one Uro-Oncology clinic and a urology review clinic. I also participate in urodynamics.

There are two half day theatre sessions and a day surgery list alternate weeks. Meetings include a weekly Uro-Oncology MDT, monthly Uro-Gynaecology MDT and a Urology Reconstruction MDT. I also participate in a weekly Stone Meeting.

A departmental business meeting is held weekly. On call has now changed to Surgeon of the Week (SOW) and is a 1:6 rota. This works very well and allows continuity of care for the patients.

I practice privately on an *ad hoc* basis at the Ulster Independent Clinic, Hillsborough Private Clinic and Kingsbridge Private Hospital. My private practice is similar to my NHS practice in scope.

I am educational/clinical supervisor to F1/F2 doctors and a clinical supervisor to urology specialist registrars. When required, I also teach undergraduate medical students.

List your main Sub-specialist skills and commitments / special interests

My sub-specialist interest is Female, Functional and Reconstructive Urology and I also have a considerable commitment to the treatment of Stone Disease.

I am developing professional relationships with the Uro-Gynaecologists and there is considerable overlap in our practices.

Details of any emergency, on-call and out-of-hours responsibilities

I do a 1:6 Urology on call with my colleagues. This involves being SOW seeing emergencies, triage of GP referral letters, doing regular ward rounds and answering GP queries on the telephone and online.

Details of out-patient work if applicable

The department has run a one stop outpatient clinic where all new patients are seen and have investigations at the same time. They are then either discharged or transferred to a specialist clinic. I have enthusiastically engaged with this and see the benefits for the patient and department.

Details of any other clinical work

I practice privately at Hillsborough Private Clinic, Ulster Independent Clinic and Kingsbridge Private Hospital on an *ad hoc* basis.

In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights?
Please give details including:
• Number and type of cases
• Any audit or outcome data for the private practice
• Details of any adverse events, critical incidents
• Details of any investigations into the conduct of your clinical practice or working relationships with colleagues

Hillsborough Private Clinic, Ulster Independent Clinic and Kingsbridge Private Hospital.

There are no issues with regards to my clinical practice in these hospitals. Surgical cases reflect my NHS practice and there have been no problems. I have good relationships with other consultants and nurses in my private practice.

List any non-clinical work that you undertake which relates to Teaching

I actively teach the registrars in all clinical areas. I regularly assess work based assessments for the registrars.

I am a Clinical Supervisor/Educational Supervisor to F1/F2 trainees.

When the regional urology teaching for specialist registrars rotates to Craigavon Area Hospital, I participate in the teaching.

List any non-clinical work that you undertake which relates to Management

I participate in departmental management activities as required.

List any non-clinical work that you undertake which relates to Research

I am involved in departmental audits and research. These are regularly discussed at our departmental audit days.

I have participated in the Regional Urology Review in relation to Female Urology and Uro-Gynaecology services.

List any work you undertake for regional, national or international organisations

Please list any other activity that requires you to be a registered medical practitioner

Job Plan

If you have a current Job Plan, please attach it.
If you do not have a current job plan, please summarise your current workload and commitments in the Job Plan Details field.

Attached Job Plan

Job Plan Details

Southern Health and Social Care Trust.

This job plan started 01 April 2018.

Job plan for Mr O'Donoghue, John Paul in Urology

Basic Information

Job plan status	1st sign-off agreed
Appointment	Full Time
Cycle	Rolling cycle - 6 weeks
Start Week	1
Report date	21 Jun 2019
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	Yes

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		28 Mar 2018	Mr Zircadian Support
In 'Discussion' stage – awaiting doctor agreement		21 Nov 2018	Mr Colin Weir
1st sign-off agreed – awaiting 2nd sign-off agreement		23 Nov 2018	Mr John Paul O'Donoghue
In 'Discussion' stage		24 Jan 2019	Mr Mark Dean Haynes
In 'Discussion' stage – 2nd sign-off not agreed	The Consultant of the week activity is not listed as hot activity so needs changed.	24 Jan 2019	Mr Mark Dean Haynes
In 'Discussion' stage – awaiting 1st sign-off agreement		10 Apr 2019	Mr John Paul O'Donoghue
In 'Discussion' stage – request cancelled		10 Apr 2019	Mr John Paul O'Donoghue
In 'Discussion' stage – awaiting 1st sign-off agreement		11 Apr 2019	Mr John Paul O'Donoghue
1st sign-off agreed – awaiting 2nd sign-off agreement		26 Apr 2019	Dr Edward James McNaboe

Hours Breakdown

Trust Approval Required:

You have entered work which falls under the category External Duties or Additional HPSS Responsibilities. This work must have Trust approval before it can be entered onto your job plan. Please ensure you have completed the appropriate approval proforma to obtain Trust authorisation. Please refer to the Policies and Procedures section for more information.

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.935	9.935	39:45
Supporting Professional Activities (SPA)	1.563	1.563	6:15
Additional HPSS Responsibilities (AHR)	1.000	1.000	4:00
Private Professional Services (PPS)	Does not attract a value		1:40

Total	12.497	12.497	51.40

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	6	6	A	5%	1.000

Type	Normal	Premium	Cat.	PA
			Total:	1.000
Predictable	n/a	n/a	DCC	0.000
Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 6.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 6.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Clinical Manager	Role: Clinical Director	Role: Board Member
Name: Dr McNaboe, Edward James (Con)	Name: Mr Haynes, Mark Dean (Con)	Name: Mr Carroll, Ronan
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00	Uroradiology meeting 08:30 - 10:00 Core SPA	Private Professional Services 09:00 - 11:00		

(reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 New patient Clinic 13:30 - 17:00	Post-op ward round 12:00 - 12:30 Core SPA 12:30 - 13:30 Day surgery 13:30 - 17:30	12:00 - 14:00 Surgery MDT 14:00 - 17:00 Core SPA 17:00 - 17:30	Core SPA 11:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Core SPA 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Core SPA 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Core SPA 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Core SPA 11:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 New patient Clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Core SPA 12:30 - 13:30 Day surgery 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Core SPA 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Core SPA 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Core SPA 11:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 13:30 Sub Specialty clinic 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Patient related admin (reports, results etc) 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:00	Pre-op ward round 07:30 - 08:00 Planned in-patient operating sessions 08:00 - 12:00 Post-op ward round 12:00 - 12:30 Core SPA 12:30 - 13:30 Patient related admin (reports, results etc) 13:30 - 17:30	Uroradiology meeting 08:30 - 10:00 Core SPA 12:00 - 14:00 Surgery MDT 14:00 - 17:00 Core SPA 17:00 - 17:30	Private Professional Services 09:00 - 11:00 Core SPA 11:00 - 15:00 Admin other (please specify) 15:00 - 16:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Pre-op ward round	Pre-op ward round	Uroradiology meeting			

Sub Specialty clinic

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00	Consultant of the week 09:00 - 17:00		

Activities

- H Hot Activity
- U Unaffected by hot activity
- S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
								Total:	9.979	41:35
	Mon	09:00 - 13:00	wks 1-5	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Mon	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Mon	13:00 - 13:30	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Mon	13:30 - 17:00	wks 1-5	Sub Specialty clinic Comments: uro-oncology + urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.729	2:55
	Tue	07:30 - 08:00	wks 1-5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Tue	08:00 - 12:00	wks 1-5	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Tue	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Tue	12:00 - 12:30	wks 1-5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Tue	12:30 - 13:30	wks 1-5	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
	Tue	13:30 - 17:00	wks 1, 3, 5	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.438	1:45
	Tue	13:30 - 17:00	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	14	0.292	1:10
	Wed	07:30 - 08:00	wks 1-5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Wed	08:00 - 12:00	wks 1-5	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.833	3:20
	Wed	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Wed	12:00 - 12:30	wks 1-5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
	Wed	12:30 - 13:30	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.208	0:50
	Wed	13:30 - 17:30	wks 1, 3, 5	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.500	2:00
	Wed	13:30 - 17:30	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	14	0.333	1:20
	Thu	08:30 - 10:00	wks 1-5	Uroradiology meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.313	1:15
	Thu	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Thu	10:00 - 12:00	wk 5	Grand Round Comments: Grand round is now handover to new Urologist of week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.083	0:20
	Thu	12:00 - 14:00	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.417	1:40
	Thu	14:00 - 17:00	wks 1-5	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.625	2:30
	Thu	17:00 - 17:30	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.104	0:25

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	Fri	09:00 - 11:00	wks 1-5	Private Professional Services	Southern Health and Social Care Tru..	Craigavon Area Hospital	PPS	35	[illegible]	1:40
	Fri	09:00 - 17:00	wk 6	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	7	0.333	1:20
	Fri	11:00 - 15:00	wks 1-5	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	35	0.833	3:20
	Fri	15:00 - 16:00	wks 1-5	Admin other (please specify)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50

No specified day

"( )" Refers to an activity that replaces or runs concurrently

H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	1.518	6:05
	3:00	0:00	Surgery MDT Comments: Rotates chairmanship of MDT with 3 others	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.232	0:56
	4:00	0:00	Trust Clinical supervisor	Southern Health and Social Care Trust.	Craigavon Area Hospital	AHR	42	1.000	4:00
	6:00	0:00	Triaging of new patients referrals Comments: e-triage	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	8	0.286	1:09

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

Additional Information - please record issues which impact upon delivery of patient care

Medical Education

Trainer Recognition

Are you a recognised trainer with the GMC

Yes ◉
No ○

Please list below Trainer Recognition/Discontinued Dates

Date of Recognition	Date Discontinued
15/12/2017	

Have you had an Annual Educational Review this year?

Yes ○
No ◉

If Yes, please attach evidence of this year's educational review.

No File Attached

Undergraduate Medical Education

Do you have a formal role in Undergraduate Medical Education

Yes ○
No ◉

Description

I teach medical students when required.

Postgraduate Medical Education

Do you have a formal role in Postgraduate Medical Education

Yes ◉
No ○

Description

I am Clinical/Educational Supervisor for F1/F2 doctors and clinical supervisor for Specialist Registrars in Urology.

WIT-50619

Form 3 - Supporting Information & Discussion

Document Library

Unordered Documents

Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3

Full Documents List

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
		Job Plan		✓												
1		Certificate of proof on GMC register	22/06/2019										✓		✓	
2		Certificate of Completion of Training	04/10/2013										✓		✓	
3		Immunisation History	04/07/2013												✓	
4		MDU Membership	22/06/2019										✓		✓	
5		GP Registration	22/06/2019										✓		✓	
6		GMC Colleague Feedback Report	22/03/2017							✓	✓	✓	✓	✓	✓	
7		GMC Patient Feedback Report	10/05/2017							✓	✓	✓	✓	✓	✓	
8		Workplace Assessment Summary for Trainees	31/12/2018				✓									
9		Logbook from January 2018 to December 2018	31/12/2018	✓	✓	✓	✓	✓		✓					✓	
10		Letter of Good Standing - Hillsborough Private Clinic	24/06/2019		✓			✓	✓	✓		✓	✓	✓	✓	
11		Letter of Good Standing - Ulster Independent Clinic	24/06/2019	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
12		WHO document	08/08/2019			✓	✓	✓	✓	✓	✓		✓			
13		WHO document	08/08/2019			✓	✓	✓	✓	✓	✓		✓			
14		WHO document	08/08/2019			✓	✓	✓		✓	✓		✓			
15		WHO document	08/08/2019			✓	✓	✓	✓	✓	✓		✓			
16		Complaint	05/11/2019				✓			✓		✓	✓	✓	✓	
17		CLIP Report	05/11/2019	✓	✓	✓	✓	✓		✓	✓	✓			✓	
18		List of Courses Attended	05/11/2019	✓	✓	✓	✓	✓								
19		Mandatory Training	05/11/2019	✓	✓	✓	✓	✓	✓				✓		✓	
20		Meeting on Nocturia	05/11/2019	✓	✓	✓	✓	✓								
21		Thank You Card	05/11/2019	✓		✓				✓		✓	✓	✓	✓	
22		Ulster Urogynae Meeting	05/11/2019	✓	✓	✓	✓			✓	✓		✓			
23		Reflection on Thank You Card	05/11/2019	✓		✓	✓			✓	✓			✓	✓	

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	2.1	2.2	2.3	3.1	3.2	3.3	4.1	4.2	4.3	Actions
24		Reflection on Complaint	05/11/2019	✓		✓	✓	✓		✓		✓	✓	✓	✓	
25		Reflection on PDP	05/11/2019	✓	✓	✓	✓	✓			✓					
26		CPD points for 2018	12/11/2019	✓	✓	✓	✓	✓		✓	✓			✓	✓	
27		CLIP Report Reflection	12/11/2019	✓	✓		✓	✓		✓	✓				✓	
28		Regional Urology Teaching	12/11/2019	✓	✓	✓				✓	✓			✓	✓	
29		Morbidity & Mortality Meeting attendance Reflection on attendance at M + M meeting	19/12/2019	✓		✓	✓	✓		✓			✓		✓	
30		Multidisciplinary Meetings	19/12/2019	✓	✓	✓	✓	✓	✓	✓	✓				✓	

Domain 1 Knowledge, Skills and Performance

Documents

Order	Attd	Document Details	Applicable Date	1.1	1.2	1.3	Actions
		Job Plan		✔			✎ ✖
9		Logbook from January 2018 to December 2018	31/12/2018	✔	✔	✔	✎ ✖
10		Letter of Good Standing - Hillsborough Private Clinic	24/06/2019		✔		✎ ✖
11		Letter of Good Standing - Ulster Independent Clinic	24/06/2019	✔	✔	✔	✎ ✖
12		WHO document	08/08/2019			✔	✎ ✖
13		WHO document	08/08/2019			✔	✎ ✖
14		WHO document	08/08/2019			✔	✎ ✖
15		WHO document	08/08/2019			✔	✎ ✖
17		CLIP Report	05/11/2019	✔	✔	✔	✎ ✖
18		List of Courses Attended	05/11/2019	✔	✔	✔	✎ ✖
19		Mandatory Training	05/11/2019	✔	✔	✔	✎ ✖
20		Meeting on Nocturia	05/11/2019	✔	✔	✔	✎ ✖
21		Thank You Card	05/11/2019	✔		✔	✎ ✖
22		Ulster Urogynae Meeting	05/11/2019	✔	✔	✔	✎ ✖
23		Reflection on Thank You Card	05/11/2019	✔		✔	✎ ✖
24		Reflection on Complaint	05/11/2019	✔		✔	✎ ✖
25		Reflection on PDP	05/11/2019	✔	✔	✔	✎ ✖
26		CPD points for 2018	12/11/2019	✔	✔	✔	✎ ✖
27		CLIP Report Reflection	12/11/2019	✔	✔		✎ ✖
28		Regional Urology Teaching	12/11/2019	✔	✔	✔	✎ ✖
29		Morbidity & Mortality Meeting attendance Reflection on attendance at M + M meeting	19/12/2019	✔		✔	✎ ✖
30		Multidisciplinary Meetings	19/12/2019	✔	✔	✔	✎ ✖

Commentary

Appraisee Commentary

I have demonstrated competence in all aspects of medical practice including management, research and teaching. Evidence is provided where I apply my knowledge and experience to the care of patients. I keep accurate, timely and neat records available for all to view.

Discussion

Discussion Summary

John has documented well all his requirements for Domain 1.

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
continue to maintain and enhance specialist interests	attend relevant courses	31/12/2019	

Domain 2 Safety and Quality

Documents

Order	Attd	Document Details	Applicable Date	2.1	2.2	2.3	Actions
8		Workplace Assessment Summary for Trainees	31/12/2018	✓			
9		Logbook from January 2018 to December 2018	31/12/2018	✓	✓		
10		Letter of Good Standing - Hillsborough Private Clinic	24/06/2019		✓	✓	
11		Letter of Good Standing - Ulster Independent Clinic	24/06/2019	✓	✓		
12		WHO document	08/08/2019	✓	✓	✓	
13		WHO document	08/08/2019	✓	✓	✓	
14		WHO document	08/08/2019	✓	✓		
15		WHO document	08/08/2019	✓	✓	✓	
16		Complaint	05/11/2019	✓			
17		CLIP Report	05/11/2019	✓	✓		
18		List of Courses Attended	05/11/2019	✓	✓		
19		Mandatory Training	05/11/2019	✓	✓	✓	
20		Meeting on Nocturia	05/11/2019	✓	✓		
22		Ulster Urogynae Meeting	05/11/2019	✓			
23		Reflection on Thank You Card	05/11/2019	✓			
24		Reflection on Complaint	05/11/2019	✓	✓		
25		Reflection on PDP	05/11/2019	✓	✓		
26		CPD points for 2018	12/11/2019	✓	✓		
27		CLIP Report Reflection	12/11/2019	✓	✓		
29		Morbidity & Mortality Meeting attendance Reflection on attendance at M + M meeting	19/12/2019	✓	✓		
30		Multidisciplinary Meetings	19/12/2019	✓	✓	✓	

Commentary

Appraisee Commentary

I have demonstrated that I take part in systems of quality assurance and quality improvement to promote patient safety.

Discussion

Discussion Summary

John participates in several MDT forums - Uro-oncology, Stones and uro-gynae. Clearly evident that he is committed to standard setting.

- Theatre safety participant
- CPD activity is broad and shows evidence of registrar teaching
- letters of good standing enclosed from activity outside of the Trust

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
- continue with participation in the MDT forum - commit to increasing M&M attendance	prioritize time tabling	31/12/2019	

Domain 3 Communication, Partnership and Teamwork

Documents

Order	Attd	Document Details	Applicable Date	3.1	3.2	3.3	Actions
6		GMC Colleague Feedback Report	22/03/2017	✓	✓	✓	
7		GMC Patient Feedback Report	10/05/2017	✓	✓	✓	
9		Logbook from January 2018 to December 2018	31/12/2018	✓			
10		Letter of Good Standing - Hillsborough Private Clinic	24/06/2019	✓		✓	
11		Letter of Good Standing - Ulster Independent Clinic	24/06/2019	✓	✓	✓	
12		WHO document	08/08/2019	✓	✓		
13		WHO document	08/08/2019	✓	✓		
14		WHO document	08/08/2019	✓	✓		
15		WHO document	08/08/2019	✓	✓		
16		Complaint	05/11/2019	✓		✓	
17		CLIP Report	05/11/2019	✓	✓	✓	
21		Thank You Card	05/11/2019	✓		✓	
22		Ulster Urogynae Meeting	05/11/2019	✓	✓		
23		Reflection on Thank You Card	05/11/2019	✓	✓		
24		Reflection on Complaint	05/11/2019	✓		✓	
25		Reflection on PDP	05/11/2019		✓		
26		CPD points for 2018	12/11/2019	✓	✓		
27		CLIP Report Reflection	12/11/2019	✓	✓		
28		Regional Urology Teaching	12/11/2019	✓	✓		
29		Morbidity & Mortality Meeting attendance Reflection on attendance at M + M meeting	19/12/2019	✓			
30		Multidisciplinary Meetings	19/12/2019	✓	✓		

Commentary

Appraisee Commentary

I demonstrate that I communicate effectively and work collaboratively with colleagues.

I demonstrate that I teach colleagues.

I establish and maintain partnerships with patients

Discussion

Discussion Summary

- John participates in several teams to provide patient care and teaching of junior staff.
- 360 feedback from last years revalidation enclosed.
- gets on well with his colleagues in the department and within the Trust as a whole

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
maintain team approach	continued participation the MDT forums	31/12/2019	

Domain 4 Maintaining Trust

Documents

Order	Attd	Document Details	Applicable Date	4.1	4.2	4.3	Actions
1		Certificate of proof on GMC register	22/06/2019	✓		✓	
2		Certificate of Completion of Training	04/10/2013	✓		✓	
3		Immunisation History	04/07/2013			✓	
4		MDU Membership	22/06/2019	✓		✓	
5		GP Registration	22/06/2019	✓		✓	
6		GMC Colleague Feedback Report	22/03/2017	✓	✓	✓	
7		GMC Patient Feedback Report	10/05/2017	✓	✓	✓	
9		Logbook from January 2018 to December 2018	31/12/2018			✓	
10		Letter of Good Standing - Hillsborough Private Clinic	24/06/2019	✓	✓	✓	
11		Letter of Good Standing - Ulster Independent Clinic	24/06/2019	✓	✓	✓	
12		WHO document	08/08/2019	✓			
13		WHO document	08/08/2019	✓			
14		WHO document	08/08/2019	✓			
15		WHO document	08/08/2019	✓			
16		Complaint	05/11/2019	✓	✓	✓	
17		CLIP Report	05/11/2019			✓	
19		Mandatory Training	05/11/2019	✓		✓	
21		Thank You Card	05/11/2019	✓	✓	✓	
22		Ulster Urogynae Meeting	05/11/2019	✓			
23		Reflection on Thank You Card	05/11/2019		✓	✓	
24		Reflection on Complaint	05/11/2019	✓	✓	✓	
26		CPD points for 2018	12/11/2019		✓	✓	
27		CLIP Report Reflection	12/11/2019			✓	
28		Regional Urology Teaching	12/11/2019		✓	✓	
29		Morbidity & Mortality Meeting attendance Reflection on attendance at M + M meeting	19/12/2019	✓		✓	
30		Multidisciplinary Meetings	19/12/2019			✓	

Commentary

Appraisee Commentary

I demonstrate respect for patients and treat patients and colleagues fairly and without discrimination.

I show that I communicate effectively and act with honesty and integrity.

Discussion

Discussion Summary

John will continue to develop Domain 4

Action

Actions Agreed today

Action Agreed	How action will be achieved	Action completion date	Add to PDP
continue to improve on domain 4	aim for excellence in clinical practice	31/12/2019	

Meeting Dates

Documents

Add a Meeting Date

Dates of meetings	Brief Details	Actions
17/12/2019	Meeting with Appraiser, Mr Michael Young	

Form 4 - Personal Development Plan

Form 5 - Declarations

Health Declarations

Professional Obligations

I accept the professional obligations placed on me in paragraphs 28 to 30 of Good Medical Practice (2019) and where they apply I am taking appropriate action.

Appraisee Name

O'Donoghue, John

Declaration ☑

Date Tue Nov 05 2019

Regulatory and Voluntary Proceedings

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.

• Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness or physical condition.

Appraisee Name

O'Donoghue, John

Declaration ☑

Date Tue Nov 05 2019

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Probity Declarations

Professional Obligations

I accept the professional obligations placed upon me in paragraphs 65 to 80 of Good Medical Practice (2019).

Appraisee Name

O'Donoghue, John

Declaration ☑

Date Tue Nov 05 2019

Convictions, findings against you and disciplinary action

Since my last appraisal/revalidation I have not, in the UK or outside:

• Been convicted of a criminal offense or have proceedings pending against me.

• Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.

• Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practice.

Appraisee Name

O'Donoghue, John

Declaration ☑

Date Tue Nov 05 2019

OR If I have been subject to any of the above, I have discussed these with my appraiser.

Declaration ☐

Date

Indemnity Declarations

Indemnity Declaration

I declare that I accept the professional obligations placed on me in Good Medical Practice in relation to probity, including the statutory obligation on me to ensure that I have adequate professional indemnity for all my professional roles and the professional obligation on me to manage my interests appropriately. My HSC role is covered by DOH/employer indemnity in the understanding that it is the organisation that is indemnified and not the individual. In relation to other roles that require me to hold a licence to practise I have included relevant evidence in my supporting information in accordance with GMC/Employer requirements.

For further information see Useful Links for GMC guidance.

If you feel that you are unable to make this statement for whatever reason, please explain why below.

You must ensure you are appropriately covered and include evidence in your appraisal supporting information. If this is not possible within the timeframe of your appraisal meeting your appraiser will note this as an outstanding issue with an agreed resolution date. You must therefore make arrangements for adequate cover as a matter of priority, and when it is available your appraisal can be re-opened in order to include this evidence.

You must sign off the declaration below, which is subject to any explanations noted.

Appraisee Name

O'Donoghue, John

Declaration ☑

☑

Date Fri Jun 21 2019

Form 6 - Signoff

Mitigating Circumstances

Circumstances mitigating against achieving full requirements

Outstanding Issues

Appraisal Year	Appraiser	Outstanding Issue	Actions Required	Resolution	Resolved
No records					

Appraisee Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraisee Name

O'Donoghue, John

Declaration ☑

Date Tue Dec 31 2019

Appraiser Checklist

To be completed by Appraiser

When appraisee has completed the appraisal, the appraiser should check the following:

GMC Required Information

Continuing Professional Development

Yes

Quality Improvement Activity

Yes

Significant Events Review

Yes

Review of Complaints and Compliments

Yes

Feedback from Colleagues

Yes

Year Undertaken (or Planned)

2017

Feedback from Patients

Yes

Year Undertaken (or Planned)

Appraisal Checklist

Check that all sections of the documentation have been completed

Yes

Ensure previous year's Personal Development Plan has been reviewed

No

Appraiser Sign Off

Appraisal Completion

I confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan.

Appraiser Name

Young, Michael

Declaration ☑

Date Tue Dec 31 2019

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB TITLE: Consultant Urological Surgeon (with a special interest that will complement the Urological team)

SPECIALTY: Urology

DEPARTMENT / LOCATION: All Consultants are appointed to the Southern Health and Social Care Trust. The base hospital for this post is Craigavon Area Hospital however the post holder may be required to work on any site within the Southern Health and Social Care Trust.

REPORTS TO: Mr E Mackle, AMD, Surgery & Elective Care Division

ACCOUNTABLE TO: Mrs D Burns, Interim Director of Acute Services

INTRODUCTION

This is a replacement post and the successful candidate will join 4 other Consultants to provide the full range of inpatient and outpatient urological services. While the post will be mainly based at Craigavon Area Hospital, there are also existing commitments to South Tyrone Hospital, Armagh Community Hospital, Daisy Hill Hospital, Banbridge Polyclinic and at the new South West Acute Hospital in Enniskillen. As a member of the Consultant team, the successful candidate will play a key role in the promotion of the service including the development and implementation of plans to enhance the Urological service provided by the Southern Trust. It is anticipated that the successful candidate will be able to provide a general urology service for elective and emergency care, though a subspecialty interest that would complement the unit would be advantageous.

PROFILE OF SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community Trust, Newry & Mourne Trust and Armagh & Dungannon Health and Social Services Trust. Craigavon Area Hospital is the main acute hospital within the SHSCT, with other facilities on the Daisy Hill Hospital, Newry, Lurgan Hospital, South Tyrone Hospital, Dungannon and Banbridge Polyclinic sites.

Craigavon Area Hospital

Craigavon Area Hospital is the main acute hospital within the Southern Health and Social Care Trust and provides acute services to the local population and a range of services to the total Southern Trust area, covering a population of 324,000.

The current bed complement is distributed over the following specialties; General Surgery, Urology, General Medicine, Geriatric Acute, Dermatology, Haematology, Cardiology, Obstetrics, Gynaecology, Paediatrics, Paediatric Surgery, Paediatric Urology, Paediatric ENT, ENT, Intensive Care, Special Care Babies, Emergency Medicine (A&E), Trauma & Orthopaedics.

Many additional specialties are represented as outpatient services including Ophthalmology, Neurology, Maxillo-Facial and Plastic Surgery, Orthodontic and Special

Dental Clinics.

In October 2001 The Macmillan Building opened and provides dedicated accommodation for Oncology and Haematology outpatient clinics and day procedures. It is also the designated Cancer Unit for the Southern Area and is one of the main teaching hospitals of Queen's University, Belfast.
The Emergency Medicine Department underwent major refurbishment in 2002 and a Medical Admissions Unit opened in March 2003. A postgraduate medical centre and a Magnetic Resonance Imaging facility opened in 2004. The new Trauma and Orthopaedic Unit was officially opened in April 2010. This comprises of 2 adjoining Theatre Suites (1 Orthopaedic & 1 Trauma), an Admissions suite, 7 bedded recovery area and ancillary accommodation and a 15-bed ward.

UROLOGICAL SERVICE

Urology is part of the Surgical Directorate, which comprises of the following specialities:

- General Surgery
- ENT
- Urology
- Orthodontics
- Trauma and Orthopaedics

The Directorate is headed by an Associate Medical Director, a Clinical Director and each Specialty also has a designated Lead Clinician.

The service provided at Craigavon Area Hospital encompasses the entire spectrum of urological investigation and management, with the main exceptions of radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Neonatal and infant urological surgery provided by the Regional Paediatric Surgical Service in Belfast.

Craigavon Area Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urological Cancer Unit for the Area population of 324,000. A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotopic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

Craigavon is a pathfinder Trust for Urology services with regard to the establishment of Integrated Clinical Assessment and Treatment Services (ICATS). This service is currently supported by 2 nurse practitioners and a General Practitioner with a special interest in urology. The following ICAT services are provided:

- LUTS
- Prostate Diagnostic (One-stop Clinic)
- Haematuria (One-stop Clinic)
- Urodynamics
- Oncology Review
- Andrology
- Stone Service

The department has a fixed site ESWL lithotripter with full facilities for percutaneous surgery and the department also have a holmium laser.

Flexible cystoscopy services are undertaken by Specialist Registrars on the Craigavon/Daisy Hill and South Tyrone sites.

Outreach outpatient clinics are currently provided in Armagh (10 miles from Craigavon) and Banbridge (12 miles from Craigavon) and South Tyrone Hospital (18 miles from Craigavon). Currently one of the General Surgeons in Daisy Hill Hospital who has an interest in Urology provides outpatient and daycase sessions in Daisy Hill Hospital. It is anticipated that further outreach services [outpatients/day surgery] will also be provided at Erne Hospital, Enniskillen in the future.

CURRENT STAFFING IN UROLOGY:

Consultants

Mr M Young
Mr A O'Brien
Mr R Suresh
Mr A Glackin
Vacant post

2 Specialist Registrars
1 Specialty Doctor (currently vacant)
1 Temporary Specialty Doctor (currently vacant)

Supported by:

1 Lecturer Nurse Practitioners
2 Nurse Practitioners
1 GP with Specialist Interest in Urology

CLINICAL DIAGNOSTICS

There is access to a full range of clinical diagnostic facilities on the Craigavon Area Hospital Group Trust site.

The Department of Radiodiagnosis has up-to-date technology including a repertoire ranging from general radiological procedures, through to specialised radiological examinations of ultrasounds, nuclear medicine, MRI and CT scanning.

The hospital pathology department provides full laboratory facilities on Craigavon Area Hospital site, including biochemistry, haematology, microbiology and histopathology as an area service. A comprehensive pharmacy service exists at Craigavon Area Hospital.

There is also a full range of professions allied to medicine available including physiotherapy, occupational therapy, social services, and dietetics.

OTHER FACILITIES

Secretarial support and office accommodation will be provided from within the Directorate.

LIBRARY AND TEACHING RESPONSIBILITIES

Craigavon Area Hospital has a Medical Education Centre with excellent library facilities provided in association with the Medical Library at the Queen's University, Belfast. There is access to electronic online medical databases, such as Med-line and Cochrane.

Regular teaching sessions take place in the Medical Education Centre and general practitioners are invited to participate in and attend meetings.

Craigavon Area Hospital is a recognised teaching hospital for the Queen's University Medical School and attracts a large number of undergraduates. Craigavon Area Hospital is responsible for undergraduate medical teaching for third year students onwards.

The post holder will be expected to participate in undergraduate and postgraduate teaching and general teaching within the Trust and partake in the urology SPR training scheme on a rota basis.

DUTIES OF THE POST (To include Personal Objectives)

The appointee will:

- Have responsibility for urological patients.

- Be expected to share in the on call rota with the existing post holders. While maintaining clinical independence he/she will be expected to work as a member of the urological unit. An emergency theatre is staffed and available 24 hours per day.

- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.

- Be expected to take a full part in the teaching of undergraduates and post graduates.

SUPPORTING PROFESSIONAL ACTIVITY

You will:

- Be expected to undertake administrative and audit duties commensurate with the post and associated with the care of patients and the efficient running of the department.
- Work, where appropriate, with the development of Care Pathways.

- Be expected to take a full part in the teaching of undergraduates and postgraduates.

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30				Uroradiology meeting			
08:45							
09:00	Clinic	Patient related admin (reports, results etc)	Continuous professional development.				
09:15							
09:30							
09:45							
10:00				Grand Round			
10:15							
10:30							
10:45							
11:00							
11:15							
11:30							
11:45							
12:00				Continuous professional development.			
12:15							
12:30		Pre-op ward round					
12:45							
13:00		Planned in-patient operating sessions	Day surgery				
13:15							
13:30							
13:45							
14:00				Clinic			
14:15							
14:30							
14:45							
15:00							
15:15							
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16:00							
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18:00							
18:15							

18:30							
18:45							
19:00							
19:15							
19:30							
19:45							
20:00		Post-op ward round					
20:15							
20:30							
20:45							
21:00							

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Pre-op ward round	Pre-op ward round				
08:15							
08:30				Uroradiology meeting			
08:45							
09:00	Clinic						
09:15							
09:30							
09:45							
10:00				Grand Round			
10:15							
10:30		Planned in-patient operating sessions	Planned in-patient operating sessions				
10:45							
11:00							
11:15							
11:30							
11:45							
12:00				Continuous professional development.			
12:15							
12:30							
12:45							
13:00	TRUS & biopsy	Post-op ward round	Post-op ward round		Continuous professional development.		
13:15							
13:30			Continuous professional development.				
13:45							
14:00		Patient related admin (reports, results etc)		Surgery MDT			
14:15							
14:30							
14:45							
15:00							
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15:45							
16:00							

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18:30							
18:45							
19:00							

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30				Uroradiology meeting			
08:45							
09:00	Clinic	Patient related admin (reports, results etc)	Continuous professional development.				
09:15							
09:30							
09:45							
10:00				Grand Round	Day surgery		
10:15							
10:30							
10:45							
11:00							
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11:30							
11:45							
12:00				Continuous professional development.			
12:15							
12:30		Pre-op ward round					
12:45							
13:00		Planned in-patient operating sessions			Clinic		
13:15							
13:30			Continuous professional development.				
13:45							
14:00				Surgery MDT			
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19:15							
19:30							
19:45							
20:00		Post-op ward round					
20:15							
20:30							
20:45							
21:00							

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00		Pre-op ward round	Pre-op ward round				
08:15							
08:30		Planned in-patient operating sessions	Planned in-patient operating sessions	Uroradiology meeting			
08:45							
09:00	Clinic						
09:15							
09:30							
09:45							
10:00				Grand Round			
10:15							
10:30							
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11:30							
11:45							
12:00				Continuous professional development.			
12:15							
12:30							
12:45							
13:00	TRUS & biopsy	Post-op ward round	Post-op ward round				
13:15							
13:30			Continuous professional				

13:45			development.				
14:00		Patient related admin (reports, results etc)		Surgery MDT			
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18:30							
18:45							
19:00							

Week 5

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
07:00							
07:15							
07:30							
07:45							
08:00							
08:15							
08:30				Uroradiology meeting			
08:45							
09:00	Emergency operating sessions	Emergency operating sessions	Emergency operating sessions		Emergency operating sessions		
09:15							
09:30							
09:45							
10:00							
10:15							
10:30							
10:45				Emergency operating sessions			
11:00							
11:15							
11:30							
11:45							
12:00							
12:15							
12:30							
12:45							
13:00	Continuous professional	Continuous professional	Day surgery		Planned in-patient operating sessions		
13:15							

13:30	development.	development.					
13:45							
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18:30							
18:45							
19:00							

Surgery MDT

Post-op ward round

Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	9.60	38:12
Mon	09:00 - 13:00	2, 4	Clinic Comments: Prostate clinic	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency operating, triage and virtual clinc	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Mon	09:00 - 17:00	1, 3	Clinic Comments: Oncoloyy Clinic	Southern He..	Craigavon A..	DCC	16.8	0.80	3:12
Mon	13:00 - 17:00	2, 4	TRUS & biopsy	Southern He..	Craigavon A..	DCC	16.8	0.40	1:36
Mon	13:00 - 17:00	5	Continuous professional development. Comments: CONSULTANT OF THE WEEK	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	08:00 - 08:30	2, 4	Pre-op ward round	Southern He..	Armagh Comm..	DCC	16.8	0.05	0:12
Tue	08:30 - 13:00	2, 4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	16.8	0.45	1:48
Tue	09:00 - 12:30	1	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	8.4	0.18	0:42
Tue	09:00 - 12:30	3	Patient related admin (reports, results etc)	Southern He..	Armagh Comm..	DCC	8.4	0.18	0:42
Tue	09:00 - 13:00	5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward rounds, emergency operating, triage and virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Tue	12:30 - 13:00	1, 3	Pre-op ward round	Southern He..	Craigavon A..	DCC	16.8	0.05	0:12
Tue	13:00 - 13:30	2, 4	Post-op ward round	Southern He..	Craigavon A..	DCC	16.8	0.05	0:12
Tue	13:00 - 17:00	5	Continuous professional development. Comments: cow	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Tue	13:00 - 20:00	1, 3	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	16.8	0.73	2:48

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
Tue	14:00 - 17:00	2, 4	Patient related admin (reports, results etc)	Southern He..	Craigavon A..	DCC	16.8	0.30	1:12
Tue	20:00 - 20:30	1, 3	Post-op ward round	Southern He..	Craigavon A..	DCC	16.8	0.07	0:12
Wed	08:00 - 08:30	2, 4	Pre-op ward round	Southern He..	Craigavon A..	DCC	16.8	0.05	0:12
Wed	08:30 - 13:00	2, 4	Planned in-patient operating sessions	Southern He..	Craigavon A..	DCC	16.8	0.45	1:48
Wed	09:00 - 13:00	5	Emergency operating sessions Comments: cow - Ward Rounds, Emergency operating, Triage and virtual clinic	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	09:00 - 13:00	1, 3	Continuous professional development.	Southern He..	Craigavon A..	SPA	16.8	0.40	1:36
Wed	13:00 - 13:30	2, 4	Post-op ward round	Southern He..	Craigavon A..	DCC	16.8	0.05	0:12
Wed	13:00 - 17:00	1	Day surgery	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:00 - 17:00	5	Day surgery Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Wed	13:30 - 17:00	2-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	25.2	0.53	2:06
Thu	08:30 - 09:30	1-5	Uroradiology meeting	Southern He..	Craigavon A..	DCC	42	0.25	1:00
Thu	09:30 - 13:00	5	Emergency operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.18	0:42
Thu	10:00 - 12:00	1-4	Grand Round	Southern He..	Craigavon A..	DCC	33.6	0.40	1:36
Thu	12:00 - 14:00	1-4	Continuous professional development.	Southern He..	Craigavon A..	SPA	33.6	0.40	1:36
Thu	14:00 - 17:00	2-4	Surgery MDT	Southern He..	Craigavon A..	DCC	25.2	0.45	1:48
Thu	14:00 - 17:00	1	Clinic	Southern He..	Craigavon A..	DCC	8.4	0.15	0:36
Thu	14:00 - 17:00	5	Surgery MDT Comments: cow	Southern He..	Craigavon A..	DCC	8.4	0.15	0:36
Fri	08:15 - 13:00	3	Day surgery 45 minutes travel from Craigavon Area Hospital.	Southern He..	Daisy Hill ..	DCC	8.4	0.24	0:57
Fri	09:00 - 13:00	5	Emergency operating sessions Comments: COW - ward Rounds, Emergency Operating, Triage and Virtual clinics	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:00	5	Planned in-patient operating sessions Comments: COW	Southern He..	Craigavon A..	DCC	8.4	0.20	0:48
Fri	13:00 - 17:00	2	Continuous professional development.	Southern He..	Craigavon A..	SPA	8.4	0.20	0:48
Fri	13:00 - 17:45	3	Clinic 45 minutes travel to Craigavon Area Hospital.	Southern He..	Daisy Hill ..	DCC	8.4	0.24	0:57
Fri	17:00 - 17:30	5	Post-op ward round	Southern He..	Craigavon A..	DCC	8.4	0.03	0:06

On-call

Type	Normal	Premium	Cat.	PA
			Total:	1.00
Predictable	n/a	n/a	DCC	
Unpredictable	n/a	n/a	DCC	1.00

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	8.68	8.68	31:18
Supporting Professional Activities (SPA)	1.93	1.93	7:42
Total	10.60	10.60	39:00

On-call availability

On-call frequency?	1 in 5
Category	Category A
PA Count:	
The number of PAs arising from your predictable on-call work is:	0.00
The number of PAs arising from your unpredictable on-call work is:	1.00
Your on-call availability supplement is:	5%

Balance between Direct Clinical Care and Other Programmed Activities

Supporting Professional Activities including participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management and local clinical governance activities are recognised within the Southern Health and Social Care Trust. The Trust expects that all consultants undertake a minimum of 1.5 SPA's (6 hours) in their job plan every week. The Trust also recognises that there are various activities as identified by all the Associate Medical Directors in each directorate and approved by the Medical Director where additional SPA time will be necessary. Where a newly appointed consultant will be involved in these additional SPA commitments, the precise balance of Programmed Activities in their job plan will be reviewed on appointment and agreed as part of their individual Job Plan review.

Programmed Activities for additional HPSS responsibilities and external duties will also be allocated for special responsibilities that have been formally approved and/or appointed by the Trust.

JOB PLAN REVIEW

This Job Plan is subject to review at least once a year by you and the Clinical Director before being approved by the Chief Executive. For this purpose, a copy of the current Job Plan (and Job Description, if appropriate), including an up-to-date work programme which may result from a diary exercise and objectives agreed at annual appraisal, together with note(s) provided by either side – of any new or proposed service or other developments need to be available. In the case of a new employee, a review of the Job Plan will take place 3 months after commencement and annually thereafter.

If it is not possible to agree a Job Plan, either initially or at an annual review, there are agreed procedures for facilitation and appeal with the final decision normally being accepted by the Trust Board.

MANAGEMENT ARRANGEMENTS

The Chief Executive has overall responsibility for Acute Services in the Southern Health and Social Care Trust. The Consultant appointed will have accountability to the Chief Executive through the Director of Acute Services, the Associate Medical Director and the Lead Consultant for the appropriate and smooth delivery of the service.

QUALIFICATIONS AND EXPERIENCE

See Employee Profile.

EMPLOYING AUTHORITY

Southern Health and Social Care Trust.

TERMS AND CONDITIONS

- Employment will be on the Terms and Conditions of the New Consultant Contract.
- Salary Scale is currently equivalent to NHS Remuneration for Hospital Consultants.
- The appointment may be on the basis of either whole time, part time or job share.
- Annual leave will be 32 days per annum initially, rising to 34 days after 7 years' seniority plus 10 statutory and public holidays.
- The post will be superannuable unless the successful candidate decides to opt out of the scheme.
- The Trust is committed to Continuing Professional Development (CPD) and will provide adequate study leave and financial support.
- The successful candidate will be required to reside within a reasonable distance of Craigavon Area Hospital.
- The successful applicant will be required to undergo a Health Assessment in the Trust's Occupational Health Department, to establish fitness to undertake the duties attached to the post. He/she will be required to bring evidence of immunisations/vaccinations to this assessment.
- The post will be subject to termination at any time, by three months' notice given on either side.

GENERAL REQUIREMENTS

The post holder must:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
- Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Infection Control
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour
- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances.
- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

ADDITIONAL POINTS

- From 1 January 1990 medical staff have not been required to subscribe to a Medical Defence Organisation. It should be noted, however, that the Trust's indemnity only covers the Trust's responsibilities and, therefore, the appointee is advised to maintain membership of a recognised professional defence organisation for any work which does not fall within the scope of the Indemnity Scheme.
- Canvassing will disqualify.
- Application forms can be obtained by contacting the Recruitment & Selection Department, Hill Building, St. Luke's Hospital site, Loughgall Road, Armagh, BT61 7NQ. Telephone number: (028) 3741 2551.
- For informal enquiries regarding this post please contact Mr Michael Young, Lead Clinician, Urological Surgeon, Craigavon Area Hospital, telephone Personal information redacted by USI.
- You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.
- Candidates wishing to apply online can do so at www.HSCRecruit.com, alternatively application forms for the post may be downloaded and forwarded to the Recruitment & Selection Department.
- Applications should be made on the prescribed form, and must be returned to the Recruitment & Selection Department, **no later than 4:30pm on Thursday 5 December 2013.**
- As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
- A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.
- Where there are large numbers of applicants, the panel reserves the right to include the Desirable criteria in the Essential Criteria for shortlisting purposes.
- Following interviews, a waiting list may be compiled for future permanent/temporary full-time/part-time/job share posts which may arise throughout the Trust initially within the next 6 months although some lists may be extended up to a maximum of 12 months.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE: **Consultant Urological Surgeon (with a special interest that will complement the Urological team) – Craigavon Area Hospital**

DIRECTORATE: **Acute Services**

HOURS: **Full-time**

Ref No: **73813109** **October 2013**

SALARY: **£74,504 - £100,446 per annum**

Notes to applicants:

1. ***Your application form:*** *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.*
2. ***CVs:*** *If you decide to submit a CV, you should note that CV's will only be accepted in support of a properly completed application form. For shortlisting purposes the panel will only be assessing your application form, therefore do not rely on your CV to evidence shortlisting criteria. You MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you will not be shortlisted.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*
4. *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

Do not rely on your CV to evidence shortlisting criteria. You MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you may not be shortlisted.

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold Full registration with the General Medical Council (London) with License to Practice.
2. Hold FRCS (Urol) or equivalent qualification.
3. Entry on the GMC Specialist Register via
    - CCT (proposed CCT date must be within 6 months of interview)
    - CESR or
    - European Community Rights
4. Hold a full current driving license valid for use in the UK and have access to a car on appointment.[1]

The following are essential criteria which will be measured during the interview stage.

5. Ability to work well within a multidisciplinary team.
6. Ability to lead and engender high standards of care.
7. Ability to develop strategies to meet changing demands.
8. Willingness to work flexibly as part of a team.
9. Good communication and interpersonal skills.
10. Ability to effectively train and supervise medical graduates and postgraduates.
11. Awareness of changes in the Health Service nationally and locally.
12. Understanding of the implications of Clinical Governance.
13. Knowledge of evidence based approach to clinical care.
14. Knowledge of the role of the post.
15. Interest in teaching.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Higher Degree e.g. MD/MCh or equivalent.
2. Completed ATLS Certification.
3. Have additional skills other than those specified in the job title.
4. Have some formal training in teaching methods.
5. Have management experience.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

[1] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Designing ‘the vision’

Current Status…

- Our current demand vs capacity is;
  - 416 OP referrals received vs 366 New OP slots per month
  - 160 hours of Theatre work listed vs 140 hours delivered per month (IP and GA day case)
- Demand vs Capacity mismatch;
  - 50 new referrals per month
  - 20 hours operating per month
- Our current Backlog is;
  - 1390 New outpatients without appointments (1250 waiting > 9 weeks, 880 waiting > 15 weeks)
  - 802 patients listed for IP or Day case procedures (Flexi and ESWL excluded)
  - 3600 FU appointments pending
- Expansion requirements;
  - 10% increase per year
  - Sheffield this figure was 17% (ie 10% may be conservative)

Demand > Capacity

What does the board want?

- Sustainable delivery
- Efficient models of care
- Acceptable waiting times
- Uniquely they have asked the specialist clinicians for solutions.

What does the board expect?

- Low expectation of clinicians ability to deliver service change.
- Clinicians tend to act as clinicians, managers as managers.
- In order to deliver the boards expectations we (clinicians) need to think and act as managers
  - Process design / mapping
  - Capacity planning and management
  - Risk assessment and mitigation
  - Presentation and delivery of ‘vision’

Approach…

- What is different about the Ulster vs SHSCT?
- NHS processes tend to evolve rather than be designed.
  - Multistep pathways with new processes being simply added in resulting in complex elongated pathways
  - How many people (steps) does a new patient referral letter pass through before the patient comes to clinic?
- Service modernisation can only be achieved by redesigning the entire process and not by tinkering at the edges.
  - Without redesign all that is achieved is further ‘evolution’ of current pathways and continuation of current practice.

Patient Pathway…

- A patients interaction with us can be summarised as…
  - GP referral
  - New OP visit
  - Diagnostic tests
  - Treatment
  - Follow-up
  - Discharge
- For each aspect ask the question ‘what can be done differently to reduce our capacity requirement?’

GP referral…

- Are all referrals necessary?
  - 48 GP referrals, majority LUTS.
  - 50% could have been not referred.
  - Routine referrals (not red flag / urgent).
- How can referrals be prevented where not necessary?
- How can primary care involvement and integration into delivery of urological care be maintained?
- How can referrals be policed to prevent slippage back to current systems?
- Demand Management

New OP Visit / Diagnostic tests…

- Do all patients need to be seen?
- What could be done before the OP visit?
  - What is needed for this to happen?
  - Who can arrange this?
- What could be done at the time of the OP visit?
  - What is needed to deliver this?
- What can't be done at the time of the OP visit and why?
  - Where possible we should be approaching everything with the default position being delivery at the time of OP visit
- What can't be done at time of OP visit, can it be delivered without additional consultant contact?

Treatment…

- Are we utilising all our available resource?
  - Turnaround in theatre
  - On time (start and finish)
  - Off site theatres
- Do all cases need to be done in IP theatres?
  - Cystoscopy & Botox (flexi?)
  - TURBT (small / recurrent) in day theatres?
  - Vasectomy all LA?
- ESWL, Flexi, UDS, TRUS
  - What can be delivered at time of OP visit?
  - What capacity is required?

Follow Up / Discharge…

- Is Follow up necessary?
  - Can it be done by GP?
  - Can it be done by another Healthcare professional?
  - Does the patient need to come to hospital for FU?
  - How much FU is needed?
  - Best timing of FU (TURP example)?
- When is discharge occurring?
  - Immediately after treatment?
  - Patients with problems, how do they get seen?

Key Aspects…

- Three key areas of service design;

    1. Demand management
    2. Service delivery Model
    3. Capacity management

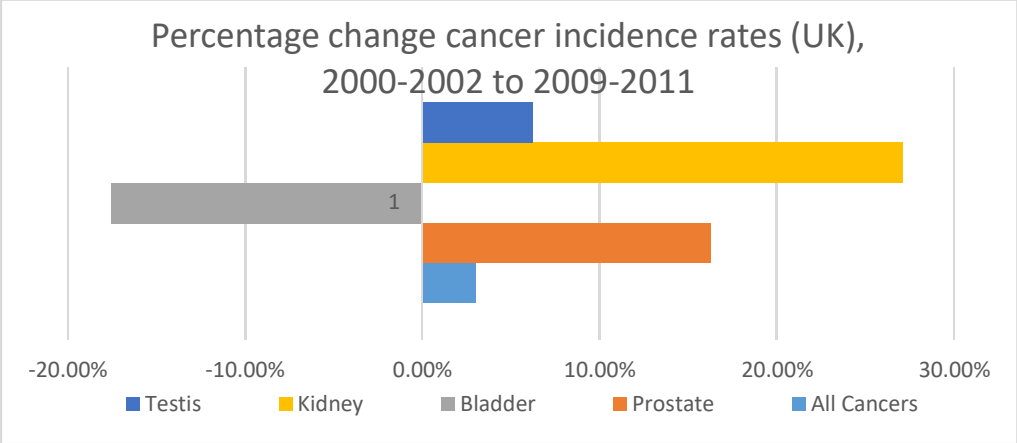
- Start broad before focussing on individual aspects.
- Nothing is off limits.
- Can’t and Won’t are not sufficient in dismissing ideas.
- Identification of risks essential.

The Vision for Urology Services
Southern Health and Social Care Trust

Background

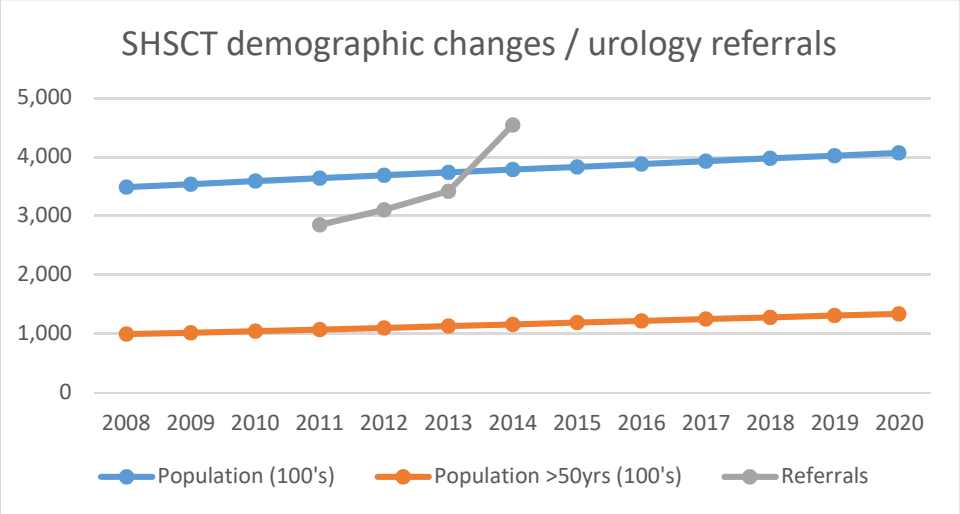
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015.

Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team).

For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question 'what can be done differently to reduce our consultant capacity requirement?'. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway currently provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively, as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals have been delayed

rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral.

All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be ‘what speciality do you wish to refer the patient to?’ which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral.

These systems are used in other areas of the NHS and to a limited extent in specific conditions within NI (e.g. post-menopausal bleed clinic referral). Unfortunately we are advised that this ideal is a considerable distance from being available within the NI ‘gateway’. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms).

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move immediately to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use considerable consultant time and in order to maximise efficiency of consultant time we would

envisage this as a ‘stop gap’ measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non-consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the Trust and wider NHS is that whilst they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects.

In order to deliver a sustainable service there is recognition that the number of Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. It was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of

patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on Craigavon Area Hospital site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.

- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations so as to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12 months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of

a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379
June	395

July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10 min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres.

As discussed in the service plan, utilisation of offsite theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously, work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work.

We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation Trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this demand. However, it is noted that in order to get to the benchmark timings, the

Benchmark Trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new outpatient consultations the haematuria and diagnostic / Lower Urinary Tract Symptoms (LUTS) assessment patients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Extracorporeal shock wave lithotripsy (ESWL- Stones)

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within Trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requirement for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. Follow-up demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been performed prior to the first outpatients attendance. Where investigations are arranged, writing with results and if required telephone follow-up. Those patients who do need to attend for follow-up will be seen either by CNS or consultant. A significant proportion of this required follow-up will be consultant led and nurse delivered (in particular oncology follow-up), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led

service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood.

A separate plan is required for reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing follow-up while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requirements are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the Trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session	Weekly sessions required	Weekly Hours	Weekly PA's

	(including admin time)			
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service within Southern Health and Social Care Board and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and reduce this consultant input but presently we believe this aspiration is some considerable time away.

Urology Department Governance Meeting 20 February 2019

1. Minutes of last meeting and matters arising
    a. Stent on strings
    b. TRUS biopsy of prostate service
        1. Develop a prostate biopsy booking proforma **Action: Kate O'Neill**
        2. All patients on DOACs require a green form to be completed by Urologist
        3. Risk vs Cost analysis for sepsis after TRUS biopsy versus moving to Trans-perineal biopsy to be undertaken by HOS **Action: Martina Corrigan**
        4. Implement a Trust waiting list for prostate biopsy cases to be coded as a nurse led procedure where appropriate **Action: Kate O'Neill and Martina Corrigan**

2. Morbidity & Mortality

Personal Information redacted by the USI, case forwarded by Mr Thompson on behalf of General Surgical PSM

Health & Care Number	Method of Discharge	Date of Death	NIECR Consultant(s) in order they are recorded on NIECR	For detailed review	Comment
Patient 90	PM	09/05/2018	Shevlin C Dr/Urology Chair to advise	No	SAI - Discussed at Urology 16/8/18
Personal Information redacted by the USI	No PM	31/08/2018	O'Donoghue J Mr	No	
Personal Information redacted by the USI	No PM	21/04/2018	Mohamed I Dr / Urology Consultant		Discussed at Urology 19/10/18

3. Complaints & Compliments

4. Learning from SAI's, DATIX etc.

5. Audits.
    i. Snapshot audit of compliance with NICE guidelines for bladder cancer. Mr Evans and Mr Glackin.
    ii. Audit of waiting times for surgery of patients with indwelling ureteric stents. Mr Hiew and Mr Young.

6. Any other business
    a. New Departmental Guidance Surrounding Death
    b. Change to blood transfusion guidelines

7. Next meeting 20th March 2019 PM